ABSTRACT

“How Did We End Up Here?”
A CRITICAL INQUIRY REGARDING THE EVOLUTION
OF THE AMERICAN NURSING HOME
AND OHIO’S MEDICAID FUNDING FORMULA

by Mike Payne

The purpose of this critical inquiry is to explore the cultural norms, socio-political history and legislative actions that helped to shape American and Ohio nursing homes as they are now. Culturally, how was it that we arrived at the harsh conditions existing in the almshouses of the 19th and early 20th centuries – the ancestors of our nursing homes - and how is it that some of those problems have carried over to nursing facilities today? Politically, what have been the forces that have shaped nursing home policy over the past eight centuries as well as during the past eight decades or so? How have Social Security, Medicaid, Medicare and other government programs for the poor, elderly and disabled affected the nursing home industry and its funding and regulations? Our ongoing general acceptance of what many consider to be minimal standards for the care of our elders will be viewed here through the major legislative events in the history of public welfare and nursing homes as they evolved in England, America and in Ohio.
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A Critical Inquiry

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Dedicated to:

Bob Applebaum,

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who smiled
trough a serious illness
and made these pages possible.
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Preface

Last Home

Arriving to see my old friend, Jack, in the hospital, I was informed that a medical transport squad would be coming that afternoon to take him to a local nursing home. The transport people arrived soon thereafter and began stuffing his clothes and a few personal items – a photograph of his cat, a get-well card and some flowers – into small plastic bags. They placed the bags on the gurney with Jack and wheeled him into the elevator and down two floors to their vehicle for the ride to the nursing home.

Jack was 84, a retired professor who had lived alone in a modest, but comfortable, home for the past 40 years. He had suffered a stroke, was still conscious, but not coherent. He seemed to recognize me, but I wasn’t sure. He smiled when I told him I’d be over to visit him in the nursing home.

That evening at the nursing home, I was taken by the sparseness of Jack’s new room, the narrowness of his bed, the crude folding chair that served visitors, and the flimsy curtain that functioned as a façade of separation for Jack and his roommate, another older man who listened to Cincinnati Reds’ games at a deafening volume.

On the floor along the wall, four or five hours after his arrival, were the transparent bags that held Jack’s clothes, photograph, card and flowers. I put the flowers, card and photograph up on the table alongside Jack’s bed, so he could see them – a knee-jerk reaction that, apparently, had gone unprompted among nursing home personnel.

When I came the next day, around noon, Jack was slouched silently at a table in the dining hall with three other men, eating his lunch. Or, more to the point, trying to eat lunch. With no one assisting him, and with very poor motor coordination in his shaking hands, a great deal of his lunch – turkey, mashed potatoes, gravy, green beans and Jell-O – had ended up in his lap. I got him several napkins, wiped the food off his pants and gave him some help eating the rest. No nurse or nurse’s aide moved in our direction to offer further assistance.

I called Jack’s other friend, the young lady from the senior-service agency who had been cleaning and running errands for him the past five years, and shared some of my observations about the nursing home he was in. She had been there that very morning and found Jack parked in a wheelchair, alone out in the hall, with heavy drool running down his whiskers and onto his shirt. She’d had a word with one of the staff members.

We took some steps to find out why Jack, a fairly wealthy man with a good retirement pension, had not been sent to the nursing home he requested and had taken measures to get into should such an occasion ever arise. The hospital that discharged him into the nursing home had never even called Jack’s preferred nursing home to check on availability of a bed for him there.

While further calls of inquiry were being made, the purpose became moot. Jack died within the week of his arrival at the nursing home. One can only hope that his awareness of his final days was minimal, if not altogether non-existent.
Chapter 1

America’s Almshouses and Early Nursing Homes

When listening to talk about how much better American nursing homes are now compared to the past, the story serving as a preface to this critical inquiry – recent and, sadly, true – comes quickly to mind. Yes, incrementally - with improved building and fire codes, better food, more thorough inspections, stepped up enforcement and the implementing of the landmark 1987 Omnibus Budget Reconciliation Act (OBRA) over the past 19 years - our nursing homes have improved. Some would say significantly. But, as Jack’s tale suggests, not nearly enough.

As heirs to the almshouses and poor farms that housed most of the frail, destitute elderly in this country until the late 1930s, publicly funded nursing homes have not had a tough act to follow. And, to a considerable extent, the less-than-ideal conditions in our nursing homes continue today because our expectations for them are based upon centuries of indifferent – and, sometimes, punitive – treatment of those falling on hard times in old age. As a government (which now pays for two-thirds of America’s nursing home residents), we’ve never wanted to spend much on (or make things too nice for) the poor, elderly and/or those otherwise in need of assistance.

It is a tradition deeply rooted in the Anglo-Saxon laws and customs that continue to inform so much of our culture today. This is particularly true regarding our approach to poverty and nursing homes, and brings to mind the opening sentence of Thomas Paine’s noted work, Common Sense, penned some 230 years ago: “A long habit of not thinking a thing wrong gives it a superficial appearance of being right, and at first raises a formidable outcry in defense of custom” (Paine, 1999, pg.1).

Custom in caring for the poor is discussed in some length in this chapter’s overview of early English Poor Laws on the following pages, going back several centuries to provide a better understanding of the connection that today’s nursing homes maintain with their ancestors – the poor farms and almshouses of England and America.
**Earliest nursing homes**

Despite Englishman Sir Francis Bacon’s observation roughly four centuries ago that “in charity, there is no excess” (Applebaum & Payne, 2005), it has been a continuing tradition of western civilization that poverty, illness and affliction should be treated with tight, guarded public purse strings. It is a legacy that goes back at least 800 years, shortly before government first got involved in the business of poverty, when the Catholic Church in England played a large role in providing for those unable to provide for themselves, especially widows, orphans and the aged. Precursors to American nursing homes today can be traced to the mid-1200s, when some 700 small, crude shelters, attached to Catholic monasteries, were set up to house and feed elderly English citizens no longer able to look after themselves (Dennis, 2004).

Even in those times, no less a saint and scholar than Thomas Aquinas held that it would be prudent to give no more to the poor than that necessary to relieve their need, and that assistance to the sick and destitute could be considered a matter of judgment when not involving strict cases of life and death. This was a sentiment echoed in harsher terms by members of the English clergy more than 500 years later when discussing systems of public relief (Quigley, 1996). That philosophy took wider root during the decline of the feudal days of England in the 1300s. No longer the indentured servants and tenants (and, thus, the property and responsibility) of their respective barons, and noblemen, former serfs and their families without means of support often took to begging throughout the countryside and in the streets - an unsightly, unwanted phenomenon that the upper class wished to regulate and curtail, which they did with a succession of laws passed throughout the next 500 years.

**Statute of Laborers**

The English government had all the more motivation to control begging after the Black Plague of Europe wiped out nearly a third of the country’s population in 1348-49, hitting the working class (as disasters often do) the hardest. The plague resulted in a shortage of workers and gave impetus to England’s Statute of Laborers of 1349 (enlarged by a second act in 1350), a set of laws designed to subvert incipient laws of supply and demand and return the advantage - if not the feudalism - to employers by:
* outlawing begging by the able-bodied;
* forcing the able-bodied into long-term employment;
* restricting worker’s autonomy and lowering wages.

The statute also prohibited even giving to able-bodied beggars, as evidenced by the exquisitely archaic legal prose that follows:

> “Because that many valiant beggars, as long as they may live of begging, do refuse to labour, giving themselves to idleness and vice, and sometimes to theft and other abominations; none, upon the said pain of imprisonment shall, under the colour of pity or alms, give any thing to such, which may labour, or presume to favour them towards their desires, so that thereby they may be compelled to labour for their necessary living” (Quigley, 1996).

Not a bad way to dampen the charitable impulses of individuals and society as a whole. Beyond its historical intrigue, the statute is significant for two reasons:

1) it overrode the church in dictating conditions for the giving of alms;
2) it marked the first time that begging was regulated with a firm distinction between the able-bodied and the impaired. This distinction remains a key component of our public benefits system today, affecting the distribution of welfare benefits in the 1990s by mandating that those able to work do so and cutting off benefits to thousands of Americans in the process.

Almost two centuries after the inception of the Statute of Laborers, Acts of Parliament further addressed England’s treatment of and provision for the destitute in 1531 and 1536, which set up a comprehensive system of poor relief in the country’s law. Under the acts, impoverished frail and aged persons (and others precluded from labor because of blindness and/or other physical or mental conditions) could qualify to ask for alms, but needed government approval and documents to do so. Begging without a
document might result in three days in the stocks on bread and water, or, if the public official was not in good humor, the unfortunate beggar might be stripped and whipped.

Still, it was far better - penalty wise - at the time to be an unauthorized old, poor and disabled beggar than the able-bodied sort. Local law officials were under obligation to punish alms seekers judged able to work, especially those thought to be vagrant, i.e., not citizens of the parish, village or city where the crime of begging was committed. In these cases, as stated in the statute, officials had the discretion to:

"Cause every such idle person to be had to the next market-town, or to other place most convenient, and there be tied to the end of a cart naked, and beaten with whips throughout the same town or other place, till his body be bloody by reason of such whipping; and after such punishment he shall be enjoined upon his oath to return forthwith the next straight way to the place where he was born, or where he last dwelled the space of three years, and there put himself to labour like as a true man oweth to do" (Quigley, 1996).

Elizabethan Poor Laws

In later years, the penalty for unauthorized begging was stepped up to include the lopping off of an ear and, in repeated cases, death.

Spurred by the Protestant Reformation - and the six wives of Henry VIII - England put an end to the Catholic Church’s substantial place in government and in providing for the poor during the first half of the 16th century. The English government relegated priests and nuns to the common workforce, and closed down the monasteries, abbeys and the attached shelters that once housed and provided care for those who were old, destitute and disabled.

England’s Poor Law of 1601 (also known as “the 43rd act of Elizabeth, Chapter 2,” or, the Elizabethan Poor Law), and the incorporation of much of the previous acts of parliament, formalized the English government’s role in caring for the impoverished, isolated elderly, blind and those otherwise unable to perform labor now that this responsibility was no longer overseen by the Catholic Church. This law, and later amendments, established three major principles that heavily influenced government’s role
(in America as well as in England) in responding to poverty for the next 350 years; i.e., until roughly 1950, and, in some cases, beyond:

* a distinction between deserving and undeserving poor;
* local responsibility for those unable to care for themselves;
* family responsibility.

The basic distinction between the deserving poor (unable to work) and the undeserving poor (those able to work) was carried over from prior laws. Under the Elizabethan law (traces of which can be found in our welfare system today, as earlier noted), assessments of those unable to work became more systematized and government assumed more responsibility for providing work to those judged able to engage in it.

Local responsibility meant that the parish, a political division of a county set up for enforcing civil government (usually corresponding to the church parish) assumed responsibility for raising funds and assisting impoverished parish residents who were not able to work and had no family members able to care for them.

The law mandated the collection of taxes to aid the poor and called for the election of two or more administrators who were to work with the local justice of the peace in the provision of relief, including housing, for those deemed justifiably and deservedly in need. This was, in part, designed to provide an organized system of alms and shelter (often small cottages and dwellings that belonged to the parish, the workhouses and poor farms would come later) for the destitute that would decrease open begging. An extended concept of local responsibility can be seen in our Medicaid nursing home reimbursement system, which has given the 50 states a great deal of autonomy in its provisions for the frail elderly.

But local responsibility was a last resort and not assumed unless those in need had no family members to look out for them. The 1601 law made it clear that: "The father and grandfather, and the mother and grandmother, and the children of every poor, old, blind, lame and impotent person, or other poor person not able to work, being of sufficient
ability, shall, at their own charge, relieve and maintain every such poor person” (Quigley, 1996).

Poor Act of 1722 - The Workhouse

England’s Poor Act of 1722 was a further attempt to discourage those seeking public relief and reduce the money directed to the poor. It did so by authorizing parishes to build workhouses for the joint shelter of the indigent, able-bodied, invalid, young, old and insane alike, and halting payments to impoverished persons living in their own abodes or elsewhere outside the workhouse itself. Hence, relegating one’s self and/or family to the workhouse became England’s conveniently rigorous and foreboding standard of poverty.

Living in a workhouse was a stigma - and a fate - far worse than the “P” badge forcibly worn by paupers outside of public institutions. Significantly, this institutionalization of the poor (and forcing cohabitation of the poor, regardless if the reason for their poverty was age, blindness, infirmity, insanity or drunkenness) was a policy adopted by the colonies in America. This practice serves as a direct link to the institutional bias that, to a certain extent, prevails in our country. It is still found in Ohio and other states regarding long-term care funds for Medicaid. To this day, a waiver is necessary for frail, older Ohioans to receive Medicaid money for in-home services.

As the name of the institution implies, those able to perform labor in the workhouse were forced to do so in hopes that their toil would cover the cost of their support. Men sometimes were sent out to work in the community and women were

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1 As with the other three principles, laws of filial responsibility crossed the ocean to America, but have rarely been applied since the advent of Social Security in 1935. Remarkably, 30 states (including Ohio) still have filial responsibility statutes that establish a duty for adult children to care for their indigent elderly parents. If enforced, according to the National Center for Policy Analysis (NCPA), “the statutes can require the adult child to reimburse state programs or institutions that have cared for the indigent parent with either a one-time contribution or installment payments.” The law is ignorable, however. There is no uniform federal statute on filial responsibility statute, and the state laws, as noted, in most cases have rarely, if ever, been enforced. Additionally, according to the NCPA, “Since the 1960s, federal law [United States Code Title 42, §1396a(a)(17)(D)] has prevented the states from considering the financial responsibility of any individual (except a spouse) in determining the eligibility of an applicant or recipient of Medicaid or other poverty programs. Apparently, the politically sensitive nature of filial responsibility has put it on the back-burner for keeps.
occupied with knitting and sewing. Children might find themselves doing repetitive work like bottle washing. Those too old, ill or mentally unfit to work were left alone to idle.

While the workhouse provided food, clothing and shelter, it unnecessarily restricted socializing, family relations, alcohol and tobacco, accenting the punitive character of these institutions and all the more assuring that only the truly impoverished, those on the brink of starvation, would apply for entrance. As one observer at the time - unknowing of how apropos his remarks might yet be for a number of American almshouses and poor farms more than a century-and a-half later - put it:

“One thing is too publicly known to admit of denial, that those workhouses are scenes of filthiness and confusion; that old and young, sick and healthy, are promiscuously crowded into ill-contrived apartments, not of sufficient capacity to contain with convenience half the number of miserable beings condemned to such deplorable inhabitation, and that speedy death is almost ever to the aged and infirm, and often to the youthful and robust, the consequence of removal from more salubrious air to such mansions of putridity” (John Scott, 1773, as quoted in Quigley, 1996).

Amendment Act of 1834

The English Poor Law Amendment Act of 1834 - brought about by increasing public funds spent on the poor and the need to bring more displaced agrarians into the growing factories in the city - put an end to temporary assistance outside of the workhouse and other institutions that reformers had ushered in subsequent to the poor Act of 1722.

The amendment act was adamant concerning the cessation of assistance to the able-bodied, making public relief as undesirable as possible (by providing it only through workhouses).

Another important aspect of the 1834 act included its regulation ensuring that the non-working poor would not receive funds or conditions better than the lowest paid laborer. This is a sturdy ancestor to a principle upon which America continues to base its distribution of public assistance. For example, Supplemental Security Income, designed to assist the elderly (who receive little or no Social Security) and those with visual
impairments and other infirmities diminishing their ability to work, is set at a maximum rate of just 75 percent of the official poverty rate in this country (Applebaum & Payne, 2005).

*The Past in the Present*

As touched on previously, from early Colonial times America has taken much of its lead on addressing public assistance from England and its Poor Laws. The core philosophy that informed and led to those laws remains a strong undercurrent of our country’s approach to addressing those in need today in two broad perspectives:

1. regardless of the economy, social structure and other variables outside of individual control, the poor are, at least in part, responsible for their condition;

2. relief to the poor should be kept minimal so as to ensure that poverty is not rewarded or deemed desirable.

The preceding is essential in examining the evolution of the nursing home from the poor farm and almshouse in America and England, and understanding how it has arrived in its current form. As a nation, we seem inclined to accept and demand so little, even when it comes to the care of our elders, our own mothers and fathers, in their final years - because the past remains so very much alive in the present.

Indeed, in researching America’s care of its elderly, one’s ears do not have to be bent toward overstatement to notice how social observers’ descriptions of conditions in the almshouses applied to nursing homes of the 20th century.
America’s Early Almshouses

Though America, in its earliest days, provided relief to the poor of all ages in the community and in individual homes, in the late 1700s and early 1800s our country turned, like its English ancestor, increasingly to the poorhouse as a means of simultaneously deterring, treating and punishing poverty.

Government reports on rising poverty in Massachusetts (The Quincy Report, 1821) and New York (The Yates Report, 1824) took the standard view of poverty by largely seeing the victim and the perpetrator as one and the same: i.e., the poor have brought their fate upon themselves. This resulted in the sprouting of hundreds of almshouses of uninviting architecture and ambiance in the nation’s larger cities, especially those along the eastern coast.

Designed and overseen, often by those benefiting from political patronage (Vladeck, 1980. p. 33) with little care for the comfort, dignity or health of their occupants, these almshouses became home to impoverished older persons without family as well as to a range of others without means of subsistence. These included children, the mentally ill and the mentally retarded as well as the chronically inebriated and other social outcasts.

In not-so-subtle shades of the past and things to come, these almshouses, by and large, were intentionally inhospitable, even to those whose poverty was obviously due not to lack of initiative or industry but to the infirmities of old age and/or illness. Though not yet in common parlance, the “woodwork effect” (the fear that if public assistance and accommodations were made too inviting - or not dreadful and humiliating enough - friends, neighbors and families might start lining up to have the government look after those they once felt obliged to look after themselves) was already a long-standing concern of social policy makers. Accordingly, the almshouses - ironically trying to cover costs through the labor of residents whose entry qualification was usually the inability to work - were run on very tight budgets.
Records for the almshouse in Tewksbury, Massachusetts, for example, reveal that in 1854 the facility, with more than 500 residents at the time, was expending 94.5 cents per-resident, per-week (www.rootsweb.com/~asylums/tewksbury_ma/). Adjust roughly for inflation, and one arrives at a government cost of approximately $10 per-resident, per-day. (This Tewksbury facility, which housed the young Anne Sullivan, who later gained renown as the tutor and companion of Helen Keller, stands as the Tewksbury State Hospital.)

The sorry plight of many of the penurious, frail elderly (and other impoverished unfortunates) in this country was made sorrier still by a uniquely British export, Victorian morality. Building on prior religious philosophy, this ethos reinforced a tendency to view those in favorable circumstances as having lived a life smiled upon by a rewarding, puritan God; and those enduring fortune’s wrath as having lived in a manner inviting the Lord’s punishment on earth. Thomas Cole and Martha Holstein summarize that sentiment with the following:

“Victorian moralists came to devalue those who experienced poverty, disease and frailty in old age. Viewing these conditions as signs of personal moral failure, health reformers and ministers believed that one’s economic and medical condition in old age was entirely within individual control. ... Blinded to the social and economic causes of poverty and ill health, many reformers accused poor men of profligacy ... lack of foresight and other non-Protestant characteristics” (Holstein & Cole, 1996, p. 23).

America’s First Private Nursing Homes

Almshouses became more commonplace as abodes of last resort for older persons in the 19th century. At the same time, America’s first non-public nursing homes, or old aged homes as they were called at the time, arose from a desire by certain immigrant groups, churches and members of the middle- and upper-classes to provide an alternative to keep members of their groups from the feared fate of the almshouses. It was an attempt to keep the more genteel members of society from falling, through no fault of their own, into decrepit almshouse conditions and company that might include the degenerate and deranged as well as the crippled, the sick and the aged. In large part, it sprung from a
fundamental desire to separate one class of people, and one set of social conditions, from another.

These were usually small, private homes that generally accommodated aging spinsters, widows, widowers and others who did not have family members or other arrangements to care for them in their later years. Many functioned more as boarding homes (Holstein & Cole, 1996) than anything approaching a nursing home with any real medical treatment. Hospitals assumed the bulk of that role. Hundreds of them sprouted up across America during the 1800s and early 1900s.

One of the country’s earliest such homes was the Indigent Widows and Single Women’s Society, founded in Philadelphia in 1817 (Holstein & Cole, 1996), an institution that catered to the middle- and/or upper classes who had lost the means to care for themselves. But Philadelphia, the city of brotherly love, with the help of Quakers in 1867, also opened a private facility for elderly African Americans. By the end of the century, the city was also the home of more than 100 homes for aged and infirm African Americans

One of the first private homes in Ohio was Cincinnati’s Society for the Relief of Aged Indigent Women (founded by the stepdaughter of humanist and “Uncle Tom’s Cabin” author Harriet Beecher Stowe), established in 1848 with $1,423 in charitable contributions. In line with its name, this altruistic entity offered, mainly through private donations, a haven for "penniless aged women" who otherwise would have been relegated to Cincinnati’s "Commercial Hospital, where the other habituees were often drunk and degraded." The society has evolved into the continuing care organization known today as “Lifesphere,” which still operates a nursing home and assisted and independent living facilities near the original home in northern Cincinnati; Lifesphere, 1998.

Though charitable operations, these private homes often asked for entrance fees and could require certificates of good character. As there was little in the way of alternatives to almshouses for the isolated and infirm elderly, the private institutions continued growing into the early 20th century, and often remained segregated by gender, race and religion. Protestants, Lutherans, Catholics and Jews all had their own homes, as did African Americans. As one might suspect, the African Americans experienced this
segregation the most. Very early on, they developed a strong heritage of looking after their own as American racial segregation, even in matters of public health care, was alive and all too well deep into the 20th century.

By the early 1920s, some 50,000 older Americans resided in more than 1,000 private old age homes, about the same number as those living in the almshouses (Holstein & Cole, 1996). But it was not the private homes that grabbed public and government attention as the care of older citizens became an increasingly unignorable issue in American society.

*(Beginning of the) End of America’s Almshouses*

Rather, it was the almshouses, where - due to the shifting of orphans to children’s facilities, the mentally ill to psychiatric hospitals, and the visually impaired to schools for the blind - older persons had become, by default, the majority population. Those age 65- and older had grown from a third of the total residents in U.S. almshouses in 1880 to two-thirds of all residents by 1923 (encyclopedias.families.com). Some almshouses, as in New York City, changed their names to Home for the Aged and similar titles denoting the older population they now served.

As the dominant population in these almshouses, the elderly began drawing more sympathetic attention from the public and from social reformers. Issues regarding the historical dividing lines between the “deserving poor” and the “undeserving poor,” bubbled to the surface as it became increasingly apparent that a great many older persons had been relegated to the almshouse due to infirmity brought on solely by age and not lack of character or industry. In short, changing times were accelerating the public’s distaste for seeing the punitive and degrading conditions of the almshouse as a life sentence for the proliferating “crime” of growing old. Many, if not most, of these almshouses remained distinctively uninviting places, funded in miserly fashion by the municipalities and county governments that ran them, right up until the bulk of them faded away in the early 1950s. Mabel Louise Nassau’s study of almshouses in 1913 opened more eyes to the idea that old age itself - regardless of moral character - could be a major contributor to poverty in a society without widespread pensions and retirement plans. (Holstein & Cole, 1996, p28).
In 1925, the United States Department of Labor conducted a study of the country’s almshouses and, in part, concluded that most almshouses were undesirable places and that “... dilapidation, inadequacy, and even indecency are the outstanding physical features of many of our small almshouses. Ignorance unfitness, and a complete lack of comprehension of the social element involved in the conduct of a public institution are characteristic of a large part of their managing personnel” (Vladeck, 1980, p. 33-34).

The report additionally emphasized almshouse management’s inability to grasp “the social element” by adding that “insanity, feeble-mindedness, depravity and respectable old age are mingled in haphazard unconcern.” In 1926, just a year after the Dept. of Labor’s report, social activist Harry Evans published “The American Poor Farm and Its Inmates,” a severe indictment of the American almshouse, which he viewed as “a word (i.e., “almshouse”) of hate and loathing, for it includes the composite horrors of poverty, disgrace, loneliness, humiliation, abandonment, and degradation.”

As with love and politics, timing is everything in social reform (and, as Tom Paine astutely declared in his introduction to Common Sense, “Time makes more converts than reason”). Thus, did the relatively late hour of America’s growing clamor for old age pensions help speed along the decline and demise of our country’s almshouses.
Chapter 3
The Advent of Social Security and a Farewell to Alms

Social Security

The declining conditions of America’s almshouses, and the cruel fate of some 50,000 older Americans in them, coincided with a gradual growth in the country’s older population as a percentage of the whole. The plight of so many older persons subjected to the deplorable conditions of almshouses became, during the Depression years, an instrumental symbol in a growing movement for a national old-age pension plan, much like those initiated in Germany in 1889 and in England in 1908. Supporters of the national pension plan believed that old-age pensions would go a long way in emptying out America’s almshouses, as the inhabitants would then have money to support themselves in more respectable, dignified accommodations.

One of the leading social reformers and social security advocates at the time, Abraham Epstein, wrote in 1929 that America’s almshouse “stands as a threatening symbol of the deepest humiliation and degradation before all wage earners after the prime of life” (encyclopedias.families). To further guard against the ravages of poverty, Epstein and other social progressives also pushed for a national health insurance program and enhancement of the nation’s unemployment insurance program.

Though unsuccessful with the health insurance and much of the unemployment advances, Epstein, with the support of President Franklin D. Roosevelt and bipartisan consensus in the Congressional House and Senate, played a key role in getting the country’s Social Security Act passed and signed into law on August 14, 1935, during the middle of the Great Depression.

The extent to which these pensions and old age assistance funds were expected to put an end to almshouses in this country is evidenced in the statement of U.S. Supreme Court Justice Benjamin Cardozo, in his majority opinion upholding the constitutionality of the Social Security act in 1935: “... The hope behind this statute is to save men and
women from the rigors of the poorhouse as well as the haunting fear that such a lot awaits them when the journey’s end is near” (encyclopedias.families.com).

That hope was realized largely because the act, designed, in part, to discourage government-operated homes for the aged, forbade any of the Social Security Act assistance dollars, which were to be augmented by state matching funds, to go to government institutions. That meant the almshouses, which were municipal, county and state-operated institutions, could no longer receive government funds.

The Social Security Act initially called for a federal appropriation of $49,750,000, and put a cap of $30 a month on the maximum federal matching amount on the Old Age Assistance (OAA) checks. But, most importantly, as far as the development of U. S. nursing homes is concerned, the act mandated that the checks must go only to “an individual who at the time of such expenditure is 65 years of age or older and is not an inmate of a public institution” (Social Security Online History, www.ssa.gov/history/35actpre.html).

*Refined Approach to Poverty*

The Social Security Act constituted the United States’ first major legislative action on behalf of its older citizens - about 7 million of them, representing close to 6 percent of the overall population at the time (Mendelson, 1975).

Arguably the most successful social legislation ever implemented in this country, Social Security lowered the poverty rate among older Americans from some 40 percent in the first half of the century to about 10 percent today - less than the average for all ages (U.S. Dept. of Labor, 2006). Social Security signified a fundamental shift in our government’s approach toward poverty.

By providing financial support outside of punitive, inhospitable institutions, OAA and Social Security formalized the sociopolitical view that being poor was less a personal, personal failing and more of a unfortunate condition brought about by unfavorable economic times (e.g., the Depression) and/or unfortunate circumstances, such as injury, illness and isolation in old age.
A Farewell to Alms and Unintended Consequences

Still, OAA - the government benefit not based on wages, funded through general tax revenues and aimed at poorer, more disadvantaged older Americans - would not be of such largesse that it would result in people striving to be poor enough to qualify for it. Distributed by the states with up to $30 in maximum matching funds by the federal government (Social Security Act, Title I) the initial checks were not much more than $50 per-month, total. But, this amount did give older persons the opportunity to purchase care services and assistance as they saw fit outside of public institutions, i.e., almshouses.

But the board-and-care homes the almshouses emptied into were not altogether prepared for the extensive health problems of many of their clients. Nor was the government ready to adequately regulate these increasing board and care homes. In haste to clear out and close down the public almshouses, social planners and government officials somewhat overlooked the dominant number of older persons who were in almshouses not due only to lack of personal funds, but also because they were unable to care for themselves and/or their families were gone or otherwise unavailable to care for them in their own homes.

These were mostly older persons with chronic illnesses, infirmities and/or cognitive problems. While municipal, state and other government hospitals took over the care of some of the more pronounced cases of mental and physical illness from the emptying of almshouses, private board-and-care facilities became a growing enterprise and increasingly took on the care of older persons with a range of physical and cognitive impairments. Many were not equipped to care for the more extreme cases. Now, the government had another problem on its hands.

Holstein and Cole summarize the happenstance development and unforeseen results of the United States’ private nursing homes succinctly, surmising that: “The unintended consequences of (Social Security) offer a revealing example of how nursing home policy evolved through indirection and incomplete efforts to solve one problem - indigence - without addressing another problem - chronic illness” (Holstein & Cole, 1996, p.34).

Vladeck seconds that sentiment with the following “Only rarely have nursing home issues occupied the attention of high officials in the executive branch as anything
other than temporary interruptions. By and large, nursing home policy has been made not only with limited foresight, but largely by people who, at the time, were primarily concerned with doing something different (e.g., closing almshouses). It has been an afterthought, a side-effect of decisions directed at other problems - mainly those of health care or poverty” (Vladeck, 1980, p. 30-31).
Chapter 4

Rise of for-Profit Nursing Homes and the Attraction of Profiteers

Rise of the for-profit Nursing Home

Via dependable, monthly old-age assistance and Social Security checks to the elderly, combined with a lack of health benefits and suitable medical facilities, our government provided incentives for the development of the proprietary nursing home industry. It was an enterprise launched with little in the way of regulations, licensing requirements and planning related to the health care of the older citizens that it oversaw.

Accordingly, one of the larger ironies concerning nursing homes in this country is the fact that many of the facilities that the government wanted to shut down simply continued operating, only now under private ownership. A related incongruity arose with the new board-and-care homes that cropped up: many of them were as problematic as the institutions that they replaced.

Regarding the early development of nursing homes, social researchers found that: “In Kansas, for example, immediately following the enactment of Social Security, officials transferred well-established county homes into private control, although neither the residence not its supervisors changed. Most importantly, however, the inmates could now be classified as recipients of private care, and the institution was able to receive residents’ monthly annuities” (encyclopedias.families.com).

At the same time, little mom-and-pop type boarding homes and care facilities, which had always existed in small numbers, began sprouting widely to serve the growing number of older persons with enough government money to cover monthly payments on room, board and some help with day-to-day living. These were mainly operated by necessity-inspired entrepreneurs - families opening their homes to take in much-needed money during the Depression and while men were away during the war (“when money was scarce but large, private homes were not,” Holstein & Cole, 1996, p.33), and/or nurses seeking a way to stay employed. Many of these small homes were run by women who started out caring for their own sick husbands and took in others as a way to make ends meet.
By the end of the 1930s, 10,000 or more aging Americans resided in these small facilities, some of them in passable health, and others in need of moderate nursing services (Johnson, 1985).

_Echoes of the Almshouse_

Here, even in this early phase of America’s private nursing home enterprise, reports of resident abuse and exploitation comparable to that of almshouses surfaced almost immediately. According to Vladeck: “There was widespread dissatisfaction with proprietary nursing homes. Facilities were often dilapidated and frequently unsafe; medical and nursing care was minimal” (Vladeck, 1980, p. 38).

Accenting Vladeck’s, Cole’s and Holstein’s previous views of nursing homes as byproducts of other aims, Robert Kane emphasizes that the quality of care in our nation’s nursing homes has, from the beginning, been shaped not so much by concern for optimum treatment of our elders but by external considerations - mainly funding. And the new funding from Social Security was surely instrumental in the inception of a new system of looking out for America’s infirm elders - a system, likes its predecessor, “based on reaction rather than initiative” (Kane, 1996, p. 145).

Additionally, by devising a system of care driven chiefly by funding to private entities (most of them for-profit), our government set in motion the rounding, ultimate irony of the nursing homes it spawned: i.e., it had created institutions that could be described in terms very similar to those they had just knocked down. In Kane’s words, “The nursing home has been viewed as the refuge of last resort, avoided by potential residents and health care professionals alike” (Kane, 1996, p. 145).

_Lack of Licensure and Regulations_

As private nursing homes grew with minimal regulation and licensure in the late 1930s and 1940s, the distinction between those offering mainly residential services - room, board, and housecleaning - and those offering nursing assistance “was vague and variable” (Holstein & Cole, 1996, p. 36).

Because private facilities for the care of the aged were in short supply, licensing and regulations were generally held in abeyance as government health care
administrators, not wanting to exacerbate the shortage of beds, tried to cajole providers into higher standards of care and better overall conditions. It was an approach that widely softened and/or prevented the enforcement of nursing home standards and regulations throughout the 20th century and, some might argue, beyond. As Vladeck explains the government perspective: “Licensing would mean the closing of some facilities, aggravating the shortage. Better to wait and to rely on education and exhortation of existing operators in the hope that they would upgrade their facilities” (Vladeck, 1980, p.38).

So, America’s private nursing homes, still small boarding homes for the most part, continued their gradual growth largely unregulated throughout World War II and into the next decade. These small homes provided little in the way of medical or nursing services for their residents, “few ... provided more than token nursing care” (Johnson, 1985, p. 6). Thus, older persons in need of significant personal care and health services often wound up in the hospital.

But, as America began to feel the hospital shortage brought on by lack of construction investment and government funds due to the Depression (as well as by the more pressing priorities of war), pressure began building to sharpen hospitals’ focus to matters of acute care. Chronic cases, often represented by older patients whose conditions were often deemed incurable, became less welcome in the hospital setting, where beds were becoming harder to come by. Nursing home historian Nancy Johnson boils the situation down to its essence:

“As hospitals became increasingly specialized treatment centers for acute illness, the needs of the chronic patients were incompatible with those changing functions. They took up expensive beds, and the chronicity of their conditions was less interesting to treat” (Johnson, 1985, p. 6).

Growing adherence to this view by the medical establishment accentuated and expedited the need for more residential care facilities for the aged in the United States, and would eventually help alter the types of patients and illnesses treated in hospitals.
Within a decade of Social Security’s broad implementation, after World War II, government increased funding for building hospitals and began to take a more active role in health-care regulations. Many of these regulations were related to the Hill-Burton Act of 1946 (i.e., Public Law 79-725, The Hospital Survey and Construction Act). This legislation was co-sponsored by Ohio’s own Republican Senator Harold Burton, along with Senator Lester Hill (D-Alabama). Sparked by the nation’s declining medical institutions, an economic boom and a renaissance in medical technology propelled by wartime emergency practices, Hill-Burton provided federal funds for the construction and renovation of hospitals across the country in return for the hospitals’ rendering of free or reduced-charge medical services to the indigent.

In just 25 years from its inception (from 1946 to 1971), the legislation would spend $2.5 billion and be responsible for the development of some 350,000 beds in 6,000 hospitals (Vladeck, 1980). The growth in hospitals, and amendments to Hill-Burton in the 1950s, would heavily influence the size and shape of the U.S. nursing home industry.

Interestingly, not long after the Hill-Burton Act passed, U.S. President Harry Truman again took up the mantle for a government-funded national health-care plan. His 1948 proposal was sponsored by Senator Robert Wagner (D-NY), the same man who successfully co-sponsored the 1935 Social security Act, but the push for national health insurance never moved out of legislative committee meetings. The American Medical Association, an even stronger force than it was a decade previous, used the mounting post-war hype and fear of communism to nip any widespread ideas of socialized medicine in the bud (Vladeck, 1980).

Though Truman would again carry the torch for government-funded health insurance, with a special emphasis on care for the elderly, his initiative in the matter failed to gain momentum in Congress or with the general population at the time.

As history testifies, Truman, to his credit, was on target (and somewhat visionary) in his recognition of the need for health coverage for America’s older population. The 1950 U.S. Bureau of the Census showed that America’s age 65-plus population had grown from 3 million in 1900 to 12 million in 1950, and had increased from 4 to 8
percent of the total population. Two-thirds of those 65-plus had yearly incomes of less than $1,000; and only one of eight had health insurance. Older people had long been considered "bad risks" by the insurance industry, and employer-sponsored programs for retired workers were few and far apart.

In its history of the Medicare program, Social Security Online, the official internet information source of the Social Security Administration (www.ssa.gov/history), attributes a portion of the legwork for what would ultimately come to be known as “Medicare” to the Truman administration. In fact, in a nod to his early role in trying to gain a national health-care policy, former President Truman became the first American to enroll in Medicare when it was launched on July 1, 1966 (www.ssa.gov/history, 2006).

**Social Security Amendments**

While the original Social Security Act had already been amended in 1939, 1946 and 1948 to broaden coverage and extend benefits to survivors of those receiving checks, it was the 1950 amendments to the Social Security Act (which also introduced means-tested benefits for those under age 65 with disabilities) that had the most significant bearing on nursing facilities. These amendments were crucial to development of America’s nursing home system in three major ways:

1. The amendments reversed the original act and lifted the government ban on OAA payments to older persons residing in public institutions. This was a result of government’s waning confidence in private nursing homes (usually small board-and-care facilities) to adequately care for their elderly residents combined with the acknowledgment of the need for more facilities for the care of older Americans. Despite the growth in private nursing homes since the late 1930s, more than half of older Americans needing care in 1950 still lived in institutions, mostly mental facilities, homes for the blind and deaf, public hospitals and the scattering of almshouses still operating (Johnson, 1985). As Vladeck describes: “It was the clear hope of Congress that counties and municipalities would convert what remained of the almshouse/county hospital system into public facilities providing some level of health care along with custodial services” (Vladeck, 1980, p. 40).
2. The amendments allowed for OAA and Social Security pension funds to be used as payments (linked to those of state and local agencies) made, in some cases, directly to providers of health-care services (i.e., nursing facilities) rather than sending checks to the beneficiaries themselves. This had the effect of eliminating the middleman—the resident/patient, who just so happened to have the most at stake in the transaction—and paved the way for the direct government-to-provider system we have today via Medicaid. It also gave the newly evolving nursing home lobby, the American Nursing Home Association, a consolidated target, government, to take aim at in negotiating rates and regulations for those it represents. The immense repercussions were noted by Catherine Hawes and C. Phillips in their 1986 publication, *The Changing Structure of the Nursing Home Industry and the Impact on Quality, Cost and Access*: “The vendor payment program thus shaped a system in which the cost, quality and level of services are decided in a transaction between vendors (providers) and the state, creating the politics of long-term care” (Hawes & Phillips, 1986, p. 495). Another poignant observation offered by Hawes a decade later gets even closer to the point: “Public payments created the modern, proprietary nursing home industry and, in so doing, created an industry with economic interests to be protected” (Hawes, 1997-98 p. 5).

3. The amendments marked the first federal attempt to impose licensure standards on the states. Prior to 1950, most states did not have regulations on board and care homes and nursing facilities; after the amendments, most did (Vladeck, 1980). Though it’s more than questionable how much good these requirements did at the time, they nonetheless provided a long overdue start in that area. Specifically, government ordered that states receiving federal matching social security funds for the care of older persons in nursing homes had to develop operating standards for the licensure of the facilities. However, there was little in the way of uniformity and detail about these standards and even less about penalties for those who ignored them. In short, according to Vladeck, these standards “varied enormously from one state to another, contained only the most minimal requirements, and were totally unenforced” (Vladeck, 1980, p.41).
Regardless of the varied and limited utility of the licensure standards, the other aspects of the 1950 Social Security amendments – i.e. the lifting of the ban on public money spent in public institutions and the allowance of federal matching funds to be paid directly to providers - were crucial to the expansion and development of the American nursing home industry. In 1950, only 35 percent of older Americans not living in their own or family members’ homes lived in nursing facilities. By 1960 that figure would jump to 50 percent, and in 1970 to 72 percent (Johnson, 1985).

**Hill-Burton Amendments**

But just as critical to the development of American nursing homes, if not more so, were several amendments to the Hill-Burton Act. These were enacted subsequent to a 1953-54 U.S. Public Health Services and Commission report that found serious inadequacies regarding health services in America’s long-term care facilities, which, of course, included nursing homes. These amendments originally provided $10 million, annually (Vladeck, 1980), in federal construction grants to public and private non-profit nursing homes and long-term care facilities with the stipulation that such newly constructed homes and facilities be affiliated (and operated in conjunction) with a hospital. The amendments further specified that these facilities adhere to licensing standards, staffing requirements, health planning and other medically-oriented regulations as a condition of receiving Hill-Burton grants.

One result in evidence to this day is that these Hill-Burton nursing homes, and many that came after, have the look, and sometimes the feel, of small hospitals. The intent was to emphasize the term *nursing* in the nursing home, to increase the medical services and professionalism associated with nursing facilities, an element that was becoming unignorably conspicuous by its absence in an industry still providing largely custodial services to its residents at the mid-point of the 20th century.

Vladeck stressed the importance of the 1954 Hill-Burton amendments and their advancement of medical and nursing services by noting that:

> “Most nursing homes of the 1950s were overwhelmingly residential and custodial in character. Only a small fraction employed licensed nursing home personnel other than
the owner; even fewer had any kind of physical involvement. But incorporation of nursing homes into Hill-Burton - and thus into the jurisdiction of Public Health Service, which administered the program - transformed them, by definition, into medical facilities. Nursing homes would never again be solely an extension of the welfare system; they now belonged to public policy as well. ... Nursing homes were redefined as the final stage of institutionalization for the chronically ill requiring long-term convalescence. Once the need for acute care services was past, patients could be taken care of in nursing home facilities more appropriately and at lower cost. That, at any rate, was the developing rationale” (Vladeck, 1980, p. 43).

Attraction of Profiteers

In the learned opinion of Mendelson, it was at this point - when the Hill-Burton amendments, combined with the 1950 amendment to Social Security allowing for direct payments to nursing home providers - that nursing homes started being seen as potentially lucrative and began attracting private investors. “They were the first to see the exciting profit potential in the nursing home, the first to view it as a business rather than a service or an occupation. The percentage of homes being run for profit has been rising ever since,” she wrote (Mendelson, 1975, p.36).

Accelerating this increase were acts of legislation appeasing the American Association of Nursing Homes, the lobbying body for proprietary nursing homes (now known as the American Health Care Association).

Disappointed at being left out of the 1954 Hill-Burton grants exclusively handed out to non-profit facilities, and buoyed by a continuing shortage of nursing home beds, the AANA successfully stepped up its efforts with the federal government. In 1956, Congress authorized the Small Business Administration to make participatory loans to for-profit nursing homes, and in 1959 directed the Federal Housing Administration to

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2. The American Nursing Home Association, which represents for-profit nursing homes, was initiated in 1949, when what is now the Ohio Health Care Association (initiated in 1946] united with a similar group in Indiana to form the American Association of Nursing Homes. In 1956, this group merged with the American Association of Registered Nursing Homes to become the American Nursing Home Association. The ANHA was renamed the American Health Care Association in 1975 (Giacalone, 2001, p. 24).
offer loan guarantees to for-profit nursing homes for amounts up to 90 percent of their construction expenses (Holstein & Cole, 1996)

**Survey of American Nursing Homes**

The 1954 Hill-Burton amendments also required the U.S. Public Health Service to conduct the nation’s first comprehensive survey of the country’s nursing homes. The survey identified 9,000 nursing homes with 260,000 beds that were “distributed very unequally across the country” (Vladeck, 1980, p. 43). Facilities termed “skilled nursing homes” averaged 25 beds; those identified as “personal care homes with skilled nursing” had an average of 40 beds, though it is noted that these personal care facilities ranged from small homes to large, public institutions.

Meanwhile, the number of Americans age 65-and-older continued to grow as a total number (12 million) and as a percentage of the country’s overall population (8%), according to 1950 U.S. Census data. And, despite the advances of social security, more than 35 percent of older Americans lived in poverty (U.S. Dept. of Labor) at the decade’s close.

This growth would continue even faster over the next 10 years, with the number of persons in nursing home beds doubling from about 200,000 to over 400,000 (though the number of nursing homes would remain steady at about 9,000, due to consolidation and the decline in small board-and-care facilities). Total U.S. nursing home expenditures would climb from $187 million in 1950 (of which government paid only 10%) to over $500 million in total nursing home costs in 1960 (of which government now paid 22 percent, Hawes, 1986, p.496). At the same time, OAA payments to health-care providers surged from $36 million in 1950 to $280 million by the end of the decade (www.elderweb.com/history).

In 1957, a bill aiming to include government-sponsored hospital insurance for the disadvantaged elderly under the Social Security program was introduced in Congress by Representative Aime Forand, a Rhode Island democrat (Vladeck, 1980). The bill included 120 days of nursing home service. Though this bill failed, it reappeared in Congress in one form or another for the next several years and eventually proved to be a forerunner for the passage of Medicare and Medicaid in 1965.
Chapter 5
Medicaid and Medicare

Kerr-Mills Legislation

A more direct link to Medicaid/Medicare came in the form of Congress’s Kerr-Mills Act, (Sen. Robert Kerr, D-Oklahoma; Rep. Wilbur Mills, D-Arkansas), also known as Medical Assistance for the Aged (MAA). A watered-down, less costly cousin to the Forand proposal, MAA called for federal matching funds to states offering financial assistance to older persons who either did not qualify for Old Age Assistance (about $1,500 in annual income) or who did not receive enough in the way of finances from the fund to fully cover medical expenses (www.college.hmco.com/history/readerscomp). The health-care pinch on Americans at the time, particularly the elderly, is evidenced by the following introduction to a 1959 report of the U.S. Department of Health, Education and Welfare to the House Ways and Means Committee (whose chair was Wilbur Mills):

"The rising cost of medical care, and particularly of hospital care, over the past decade has been felt by persons of all ages. Older persons have larger than average medical care needs. As a group they use about two-and-a-half times as much general hospital care as the average for persons under age 65, and they have special need for long-term institutional care. Their incomes are generally considerably lower than those of the rest of the population, and in many cases are either fixed or declining in amount” (www.ssa.gov/history, 2006)

Its importance emphasized by such language, the Kerr-Mills legislation passed with overwhelming support of both the House (381-23) and Senate (91-2) and was signed into law Sept. 13, 1960, 1960 www.ss.gov/history). The legislation, like OAA before it, gave great leeway to the states in determining thresholds for eligibility and benefits. But, Kerr-Mills extended this leeway in two key areas that would carry over and become part of Medicaid law: it let states define medical indigency apart from the federal
government’s OAA standards; and it set no maximum amount for federal matching funds, meaning the states could spend as much, or as little, as each desired (Giacalone, 2001, p. 24)

Federal matching grants would cover between 50 to 80 percent of the total expenses, with higher amounts of money allotted to participating states with the lowest per-capita income. The states were also granted a great range in the medical services they chose to cover, but skilled nursing services, were highly ranked among those supported by the program (Vladeck, 1980). The effectiveness of Kerr-Mills - or, more aptly, its relative ineffectiveness - became a topic of considerable discussion in Congress. Then-Senator Edmund Muskie (D-Maine) argued in 1962 that Kerr-Mills had resulted in limited and extraordinarily disparate implementation in the 50 states. He noted that only 23 of the 50 (though eventually 41 of 50) states were operating the program and just four of every one-thousand older persons in the country were actually benefiting from it.

Muskie additionally emphasized that more than 90 percent of Kerr-Mills beneficiaries lived in five states (New York, Massachusetts, California, Minnesota and Pennsylvania) most of them in New York and Massachusetts. In these two states alone, about half of the 66,000 total Kerr-Mills recipients had been transferred directly from OAA lists. Congressional record, Senate, May 16, 1962 - www.muskiefoundation.org).

Though the overall success of MAA was limited, Vladeck argues that impact that the impact the program had on the burgeoning nursing home industry in its five years of operation was undeniable, with government payments for indigents in nursing homes increasing almost 10 times over from 1960 to 1965, from about $50 million to roughly $450 million in that timeframe. By 1965, educated estimates indicate that half of all U.S. nursing home residents (300,000 of the 600,000 total) were covered by MAA payments (Vladeck, 1980).

Growing Nursing Home Population

It is notable that the U.S. nursing home population grew by more than one-third in the 1960-'65 life of the Kerr-Mills/MAA program, from approximately 400,000 to 600,000 and that about half of that 600,000 were funded by Kerr-Mills (Vladeck, 1980). As expected, the number of nursing homes in America continued to grow right along
with it (from 9,582 homes in with 331,000 beds in 1960 to 23,000 homes with 1.3 million beds by 1976 (Moss & Halamandaris, 1977). The nursing home population was about 225,000 in 1950 (Vladeck, 1980).

Looking ahead a little further, it is interesting to note that while the number of older persons in nursing homes quadrupled, the costs of caring for them increased more than 20 times over, from $500 million in 1960 to $10.5 billion in 1976, with more than half of it paid for by the government. All this while the American age-65-and-older population grew by less than 25 percent, from 17 million to 21 million in the same 16-year period (Moss & Halamandaris, 1977).

As the supply of nursing home beds grew, hospital administrators and dischargers became all the more inclined to take advantage of them, referring older indigent patients with chronic illnesses not amenable to cure through treatment to nursing homes. This provided a more economical means of caring for the indigent elderly (as hospital rates continued to rise dramatically in the later 1950s and throughout the ‘60s) and expedited the trend toward treating those without need for high levels of acute care in nursing homes - especially those without adequate insurance to afford the higher cost of care associated with hospitals.

**Medicare**

Still, the Kerr-Mills legislation was seen largely as a compromise measure not adequately addressing the problems of the country’s frail, older population. Prompted further in 1961 by the first White House Conference on Aging’s call for making “a broad spectrum of institutional and in-home services available to the elderly” (Moss & Halamandaris, 1977, p. 135), Congress responded almost immediately by introducing follow-up legislation to expand medical benefits for older Americans.

In February 1961, then-President John Kennedy, strongly influenced by the Presidential task force on Health and Social Security for the American People’s recommendation for health insurance for the elderly under social security, put the wheels in spin on the legislation that would become Medicare. In February of that year, Kennedy delivered a special message on senior health care to Congress. The result was the
introduction of a hospital insurance bill (S. 909 and H.R. 4222) by Representative King and Senator Anderson.

Maybe not altogether coincidentally, the American Medical Association formed its first political action committee, the American Medical Political Action Committee (AMPAC) in July of that same year. The King-Anderson legislation, opposed by AMPAC and the American Hospital Association, stalled and resurrected itself in various forms under several designations. It weathered the Kennedy assassination and was given new life by President Lyndon Johnson and his Great Society initiative. In 1964, Johnson pleaded the case for what is now known as Medicare in his Health of the Nation address, leading to the passage of the "Mills bill" (H.R. 6675), a substitute for the old King-Anderson legislation and his signing of Medicare into law on July 30, 1965 (passed 307-116 in the House and 70-24 in the Senate - ssa.gov/history).

Crucial to nursing home funding, then and today, was Medicare’s adoption of a federal hospital funding formula that reimbursed owners not only for both capital interest payments on their mortgages (as was standard at the time) but for depreciation and accelerated depreciation as well. With pressure from the American Hospital Association, reimbursement for depreciation, accelerated and otherwise, was allowed under the Medicare program.

Increasingly critical in the years to come, this funding principle was extended to nursing homes, meaning that, as Vladeck wrote:

“Profit-seeking nursing homes would be repaid the entire cost of their investment, plus a return on actual invested equity, while retaining ownership of the facility and the right to resell it for capital gain. In short, the government would gradually buy the nursing home from the lender - and then give it to the investor” (Vladeck, 1980, p. 108).

But all that was a relatively small matter, with unforeseen consequences, at the time. The Medicare legislation, financed through an additional, compulsory social security tax, and funded solely via the federal government, provided Americans age 65 and older with a range of health care benefits, including extensive hospitalization benefits and 100 days in a skilled nursing facility. Most Medicare components were effective
July, 1, 1966; but nursing home coverage under the program did not begin until January 1, 1967.

Fittingly, the Medicare bill, Title XVIII of the Social Security Act, was signed at a special ceremony at the Truman Library in Independence, Missouri, with former President Truman on hand as a special guest in tribute to his attempts to initiate government-sponsored health care under Social Security two decades earlier. (U.S. Dept. of Health and Human Services, Centers for Medicare and Medicaid Services: www.cms.hhs.gov/History/).

*Medicaid*

Medicaid, of course, was initially limited in its provisions for the nursing home care of older Americans. Medicaid, Title XIX of the Social Security Act, supplied Medicare’s complement in that regard. Essentially an expansion of the Kerr-Mills legislation (suggested as a companion piece to Medicare by Wilbur Mills), Medicaid allotted federal matching funds to states for the provision of health services to low-income Americans of all ages, including those needing nursing home care.

As with the Kerr-Mills legislation, Medicaid would use direct Social Security and OAA payments from the federal government to help states cover costs of persons receiving social security benefits. Also in accordance with Kerr-Mills, state participation would be optional (by 1982, all 50 states were participating in Medicaid), and there would be no ceiling on federal matching funds, i.e., the federal government would let states set the price for Medicaid medical services and agree to add matching funds with no maximum amount prescribed.

While the program became effective just six months after President Johnson signed Medicaid into law in tandem with Medicare, its regulations were not published until July 1966 (Vladeck, 1980). Although regulations under Medicare (administered by the Bureau of Insurance within the Social security Administration) were very specific on what type of services would be reimbursed in which type of facilities, Medicaid (administered by the Dept. of Health, Education and Welfare), as with Kerr-Mills, left a great deal of discretion to the states. This continuing discretion accounts for the wide variety in quality and costs of nursing homes in the 50 states today.
It is worth noting that in first regulations, published in July 1966, skilled nursing homes under Medicaid would be governed under the same requirements for skilled nursing homes under Medicare. This called for more advanced conditions and medical services than most nursing homes had to offer, and it marks what appears to be the first major backlash felt from the American Nursing Home Association (ANHA) and the political officials that supported the association’s point of view.

The initial Medicaid policy was devised by Wilbur Cohen, undersecretary (and later, secretary) of Health, Education and Welfare. A career policymaker who was highly instrumental in crafting Medicare, Cohen held firm in his opposition to funding what he considered to be a welfare service, i.e., custodial care in nursing homes under a health program, namely Medicaid.

But Cohen’s influence and opposition were no match for the ANHA - or the stark reality of the situation: many thousands of low-income, older Americans who did not qualify for Medicare still needed some type of custodial, residential care, and it would be, in theory, less costly to look after these people in places with fewer, less stringent standards regarding medical staffing and services. Vladeck delivers an adept description of the forces that overrode Cohen and his original proposal for upgraded nursing facilities:

“Howls of protest soon arose from the ANHA, supported by members of Congress who reflected the states’ concern that if HEW’s initial ruling held, they would be left holding an expensive bag. Thousands of individuals were being supported by Kerr-Mills payments in facilities that could never meet Medicare standards. If those facilities were ineligible for Medicaid matching payments, the states might get stuck with the full amount. Instead of providing fiscal relief, Medicaid would thus actually force the states to increase expenditures” (Vladeck, 1980, p.58).

The howls were heard, and Medicaid was officially ushered in with softened federal regulations for the operation of the nursing facilities it would fund, though states would be welcome to enact stiffer standards as each saw fit.
Decisions Directed at Other Problems

There is no arguing that Medicare and Medicaid have been of enormous value to millions of Americans of all ages. But, to deflect any fledgeling impression that Medicare and Medicaid were created as anything resembling a direct, rational address of America’s mounting nursing home issues, it would be extremely apropos to revisit Vladeck’s (as well as Holstein & Cole’s) earlier observations on our country’s nursing home policy development, or lack thereof; to pause and contemplate how, in Vladeck’s view, our government’s indirect, incomplete, compromised (and sometimes afterthought) efforts to solve one problem - i.e., health insurance for a disproportionately impoverished older population and other low-income persons - spawned unintended consequences in the nursing home industry that evolved as an ill-formed “side-effect of decisions directed at other problems” (Vladeck, 1980, p. 31).

These are not a maverick’s observations, but points bolstered by several other prominent U.S. nursing home historians and policy experts. In their chapter on policy in the landmark, “Too Old, Too Sick, Too Bad,” former Senator (and chair of the Congressional Subcommittee on Long-Term Care) Frank Moss (D-Utah) and his aide, Val Halamandaris, wrote: “If there is unanimous agreement anywhere in the field of long-term care, it is that the United States lacks any kind of comprehensive and consistent policy with respect to the infirm elderly” (Moss & Halamandaris, 1977, p.35).

Colleen Johnson, in the introduction of her book, stated that: “Nursing homes have rarely been addressed as a policy problem in themselves; instead today’s nursing homes have evolved out of several different types of custodial care facilities, most of which were originally designed to serve the pauper” (Johnson, 1985, p. 5). Holstein and Cole look back at the evolution of American nursing homes, including the Social Security Amendments of 1965, and elaborate on statements quoted earlier in this inquiry: “We are now literally and figuratively paying the price for our earlier history, when policies were developed incrementally and in a piecemeal fashion, with little coordination and without adequate attention to their possible consequences” (Holstein & Cole, 1996, p. 20). In the same book, Robert Kane, M.D., opened his chapter on “The Evolution of the American Nursing Home” with: “The nursing home is the product of mixed lineage, none of which is especially attractive” (Kane, 1996, p. 145).
And all of the above sentiments seem mild and measured compared with the furious indictment on the Social Security amendments leveled by Mary Mendelson in her 1975 book, “Tender Loving Greed,” written just nine years after the inception of both Medicare and Medicaid in 1966.

“Those two (programs) set off a series of profound changes in the health industry, nowhere more than in nursing homes. Because they were conceived in illusion and borne through political compromise, Medicare and Medicaid have cost far more and produced far less than their sponsors had hoped. Money was suddenly pumped into a system that had neither the capacity nor the desire to expand rapidly, with the result that much of the new money disappeared into higher costs rather than for more service to those who needed it. Health-care prices, including those for nursing homes, went up much faster than the general price level in the years after Medicare and Medicaid, and in the nursing home industry especially, the new programs as they were became a guarantee of excess profits with no benefit to the patient” (Mendelson, 1975, p. 37).

Problems in the Making
The above views on the lack of a coherent, comprehensive policy regarding America’s nursing homes are most readily supported by the glaring fact that the two programs set up to oversee the nursing homes were housed in separate branches of government: the Social Security Administration (Medicare) and the Dept., of Health, Education and Welfare), with Medicare being a compulsory, strictly federal program and Medicaid being an optional program operated by the states (augmented by federal matching funds).

Not until 1977, with the institution of the Health Care Financing Administration - now the Center for Medicare and Medicaid Systems (CMS) within the former Department of Health, Education and Welfare (now the Dept. of Health and Human Services, did Congress place the oversight of Medicare and Medicaid under one government agency, though Medicare enrollment and processing of premium payments were still handled by the Social Security Administration. (In 2001, to further emphasize and facilitate the coordination and cooperation of Medicare and Medicaid, the two
programs were placed within the newly created CMS, a division of the U.S. Dept. of Health and Human Services.)

The aforementioned negative perspectives were also buttressed by the late, lax and fragmented regulations attached to Medicaid from the get-go. Initial regulations were continually watered down to allow for participation from more vendors, and the disparity in eligibility and licensing requirements, as well as fee-setting, proved problematic.

Medicare had its own problems, particularly in the area of a newly formulated concept called “substantial compliance.” This concept arose to cover for the fact that framers of Medicare failed to take into account that relatively few American hospitals (or nursing homes) would be of sufficient capacity and quality to qualify for reimbursement under Medicare and that large numbers of Americans would have no place to go for the health services the government had been promising them.

Medicare also experienced more dilution in its nursing standards. These original standards called for the presence of a licensed practical nurse to be in charge of any shift lacking a registered nurse, but the Bureau of Insurance, which wrote the rules, decided to allow for a waiver of the license requirement for nurses who had a certain amount of on-the-job experience.

**Politics of Compromise**

Policymakers remedied the anticipated paucity of qualified homes by sanctioning substantial compliance, legalizing reimbursement to facilities that appeared to be vaguely close to compliance “and demonstrated an intention to improve” (Vladeck, 1980, p. 53). The result: 3,200 nursing homes not in compliance were accepted as Medicare vendors even though they were only in substantial compliance. It can be argued that there wasn’t much choice - only 740 nursing homes nationwide were found to be in full compliance.

Another Medicare issue that would develop over time pertained to its funding mechanism (still much higher than Medicaid’s), which was based upon the semantically flexible term “reasonable”: that is, government officials agreed to reimburse Medicare providers based upon reasonable costs and charges, without much prior discussion on the interpretation of the word regarding its medical- or profit-related meaning.
Mendelson’s vitriol was fueled by associated problems that arose almost immediately upon the influx of Medicare and Medicaid dollars into the highly and disparately unregulated nursing home industry, problems she believed that government helped create through a serious lack of forethought and an overly broad bow to laissez faire policies toward the business interests that were increasingly influencing politicians and controlling nursing homes. She felt that, in so many words, a great deal of regulation of nursing homes was ceded to the nursing home industry (ANHA) and medical establishment (AMA and the AHA) as a way to help get the Medicare and Medicaid legislation through Congress; that those influential groups opposed anything resembling socialized medicine as it could interfere with their right to decide who received treatment where and for how much; and that government appeased these powerful players by letting them call far too many of their own shots concerning nursing home standards and government reimbursement. The result, in Mendelson’s words:

“ What did come out of the long struggle over federal health insurance were programs under which Washington poured money into the health industry with a minimum of regulation of how that money was used. In effect, the sponsors of Medicare and Medicaid said to the industry: ‘Let us give you the money, and we won’t look too closely at how it’s spent.’ That fatal compromise is the root cause of the nursing home industry’s ability to extract excess profits from the government” (Mendelson, 1975, p. 37).
Chapter 6
Playing Politics with a Rapidly Growing Industry

Moss-Kennedy Amendments

Mendelson’s sharp words closing the previous chapter draw credence from the various reports on the poor quality, questionable administration and prevalent hazards of America’s nursing homes prior to, during, and long after, the time she wrote them. She documented scores of these administrative shenanigans involving the financial, physical and emotional abuse and exploitation of nursing home residents in her aforementioned 1975 book, “Tender Loving Greed.” Much of the financial abuse, Mendelson suggested at the time, resulted from a collusion between government, the nursing home industry and a host of others in line to benefit from the vulnerable situation of the frail, low-income elderly.

Nearly a decade earlier, the substandard quality of a large portion of America’s nursing homes - and the indifferent, uncoordinated manner in which most states went about inspecting and regulating them - was the topic of hearings by Congress’s Subcommittee on Long-Term Care, formed in 1963 and chaired by Senator Frank Moss, D-Utah (Moss & Halamandaris, 1977).

The subcommittee’s findings on the high numbers of poorly administrated, low-quality facilities posing health and safety hazards led to the Moss and Kennedy (Ted, D-Massachusetts) Amendments of 1967. While theoretically strengthening regulations, the Moss amendments serve mainly as frightening testament as to what can happen to a law between passage and actual implementation. As signed in 1967, the Moss-Kennedy amendments required the Dept. of Health, Education and Welfare to write and distribute new, stricter regulations for skilled nursing home care covered by Medicaid by January 1, 1969.

These new regulations, which exceeded Medicare standards in several areas (Vladeck, 1980), required, among other measures: disclosure of nursing home ownership and others with financial interest in the enterprise; formulation of standards for record-keeping, food services, medication disbursement and other medical services;
development of stiffer licensing standards for nursing home administrators; and establishment of tighter nurse-to-patient ratios.

As implemented - three years later and 18 months overdue on July 1, 1970 - the amendments were written in such a watered down fashion (by the Dept. of Health Education and Welfare) as to have dispensed altogether of nurse-to-patient ratios and were, according to many experienced insiders at the time, “weaker than those required by Medicaid before the passage of the Moss amendments” (Vladeck, 1980, p. 62). The amendments’ stiffer requirements for upgrades in nursing home facilities, however, did make it into the rules and regulations, though in essence these upgrades consisted mainly in meeting fire codes.

Moss later lamented the situation with the following summation: “Unfortunately, as so often happens, the battles won on the floor of the Senate are lost in the Federal Register” (Moss & Halamandaris, 1977, p. 148). Getting specific on the upshot of his hijacked legislation, Moss said it meant, “in effect, that a single, untrained practical nurse on duty in a home with two hundred or three hundred patients or more constitutes (so-called) ‘properly supervised’ nursing services” (Vladeck, 1980, p. 62).

Moss’s co-author Val Halamandaris, had sterner words for HEW, labeling the agency’s delay and softening of the Moss Amendments as “bureaucratic lawlessness” (Moss & Halamandaris, 1977, p.148).

Aggravating the situation was the dilution of Kennedy’s licensure amendments. Though passed as legislation, Kennedy’s call for more sensible licensure requirements for nursing homes and nursing home administrators was never put into practice as intended. The law called for licensure boards not to be dominated by those with financial interests in the nursing home industry. The actuality was otherwise, thanks to rules written by HEW. The somewhat laughable consequence, in the words of Ohio’s then-Senator Stephen Young (D-Youngstown): “Licensure of nursing homes by operators is as good as regulations of saloons by bartenders” (Moss & Halamandaris, 1977, p. 149).

It should be added that despite opposition from the nursing home industry, Moss and Kennedy were eventually successful in keeping nursing home interests from dominating licensure boards, but it was not until 1977 that Moss noted all states to be in
compliance with the stricter nursing home licensure regulations (Moss & Halamandaris, 1977).

Without making direct accusations, both Moss and Vladeck mention, individually, that HEW just so happened to employ a consultant who was also in the employ of the ANHA - a lobbying organization for the nursing home industry that stridently opposed the proposed nursing home reform - to help write up the Moss-Kennedy amendment rules and regulations for the Federal Register (Moss & Halamandaris, 1977, p.148; Vladeck, 1980, p.61). ³

Medicare Woes

In the meantime, Medicare, though initiated with seemingly more rigor, coordination and forethought, was having new troubles manifested most overtly in the form of out-of-control expenditures. These financial troubles arose after the very first year of the program’s actual operation, in 1968, when Medicare extended care (i.e., nursing home) costs, predicted by SSA analysts in the area of $25 million to $50 million in the first year, neared $275 million, more than a five-fold miscalculation (Vladeck, 1980). The huge error in estimation was largely related to three Medicare policies, all of which Mendelson and most other nursing home reformers opposed:

1) The concept of substantial compliance allowed for the participation of many more nursing homes in the extended care provisions of Medicare than actuarial strategists had allowed for. The result was much increased utilization of the extended care benefit in nursing homes.

³ How often nursing home consultants or industry lobbyists help write legislation, or the rules, regulations and reports related, or leading to it, is an intriguing question not answered here. But, it is interesting - and, perhaps, telling - to briefly fast forward and note that, in the 1995-96 Congressional budget debates, a Senate-House conference committee report attempting to weaken nursing home standards “was viewed as taking the exact language offered by one of the nursing home trade associations” (Hawes, 1997, pg. 5). And, in 2004, the Ohio Health Care Association, the chief lobbying group for the state’s for-profit nursing homes, had a hand in writing the 35-page summary conclusions of the Ohio General Assembly’s requested “Report of the Nursing Facility Reimbursement Council.”
2.) The decision to reimburse nursing home providers for “reasonable costs,” which the nursing homes themselves were given the autonomy to establish pretty much carte blanche, without caps, resulted with the nursing homes interpretation of “reasonable” per-diem costs exceeding the government’s by about 50 percent.

3.) The decision to add a provision for profit (based on net investment) in the reimbursement system for proprietary nursing homes; and to provide both hospitals and nursing homes with reimbursement for mortgage interest and depreciation of the facility and capital equipment. (This had the effect of virtually guaranteeing a profit for investors, Hawes, 1986).

Miscalculations and a penchant for generosity in the three preceding areas were exacerbated by perhaps an even larger misassumption in another. Government number crunchers had counted on Medicare’s extended care benefit, projected to cost only half of a comparable continued stay in a hospital, to significantly reduce Medicare hospital costs; and they had factored that imaginary savings into the net costs of extended care.  

_Tightening Medicare Eligibility: Intermediary Letter Number 371_

By 1969, the first year of the Nixon administration, Medicare nursing home expenses were growing unsustainably at nearly $500 million a year. Government officials took abrupt action to dam the flow of Medicare dollars to nursing homes by tightening eligibility requirements for the extended care benefit.

As first initiated, those qualifying for extended care had to have been hospitalized for at least three consecutive days and had to be admitted to a nursing facility within 14

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4 History seems intent on repeating itself in matters of government health-care funding, and it is hard to review these Medicare fiscal underestimates of 40 years ago and not be reminded of recent financial lowballing in Medicare cost projections for the Medicare prescription drug program in 2006. A year prior to 2006 implementation, New York Times Medicare beat reporter, Robert Pear, revealed that $534 billion budgeted for the first 10 years of the program was at least one-third, if not more than half, off the actual probable costs. Many in Congress, are concerned that the program could end up costing more than twice as much as originally proposed” (Pear 2004).
days of discharge from the hospital. Also, a doctor had to affirm that the individual in question required skilled nursing care.

Under the new regulations posted by the Bureau of Health Insurance in April 1969 (what nursing home historians call “Intermediary Letter 371, Holstein & Cole, 1996, p. 39), Medicare beneficiaries qualifying for extended care still had to meet the aforementioned 3-day and 14-day hospital stay criteria, but also had to:

1. Have potential for rehabilitation in the eyes of a treating physician.

2. Meet new, stricter criteria for requiring “skilled nursing.”

As Moss pointed out, “potential for rehabilitation” served as a way of disqualifying older persons diagnosed with terminal illnesses. The new requirements for skilled nursing included intravenous feeding and injections, both rarely provided in nursing homes at the time (Moss & Halamandaris, 1977).

Accenting and extending the effect of these two new requirements, was that the intermediary letter made it clear that government claims’ officials should begin erring on the side of extended care denials rather than approvals. The effect of Intermediate Letter 371 was immediate, nearly tripling the percentage of claims denied in the first two years (Vladeck, 1980). The story is better told in dollars: in 1968, Medicare paid $348 million in extended care benefits; by 1972, that figure was down to $156 million. The rapid acceleration in denials of these extended care claims left thousands of older Americans and their families with hospital bills they could ill afford, and left many nursing homes unable to collect fees, resulting in 500 fewer extended care facilities participating in Medicare.

The repercussions of this strategy lingered on for decades. As Vladeck saw it:

“From the time of Intermediary Letter 371 on, Medicare was no longer a significant factor in the nursing home industry. At great cost, with great confusion and not inconsiderable pain to thousands of old people and their families, Medicare was
doing, relative to nursing homes, what its sponsors first intended - hardly anything” (Vladeck, 1980, p. 57).

Origin of Intermediate Care Facilities - The Miller Amendment

As the date for new Medicaid requirements (under the Moss Amendment) calling for upgraded nursing facilities neared (July 1970), Senator Jack Miller (R-Iowa), acting on behalf of nursing homes in his home state - many of which would not meet the upgraded standards for care - proposed allowing for government reimbursement to “intermediate care facilities.” These were facilities that did not provide extensive nursing services as first planned under Medicaid but, nonetheless, did offer some basic health services to their residents.

As first implemented, the intermediate care facilities had been funded with Old Age Assistance under Social Security. Medicaid, initially aiming at improved care facilities, had not planned on offering reimbursement for care in these largely custodial homes. But the potential savings available by funding these intermediate care facilities at lower rates were too tempting for the program’s policymakers to pass up. In 1971, intermediate care facilities, funded at a lower rate than skilled nursing home facilities, became part of Medicaid under Title XIX. Federal standards for the operation of these facilities were issued in the same year.

A major consequence was that in many states, nursing home residents were almost immediately reclassified from needing skilled nursing to needing only intermediate care, saving owners of the nursing homes the trouble of trying to pass muster as skilled nursing facilities and indicating that, as one might guess, there was often little, if any, real difference in the care provided in skilled and intermediate facilities.

In Ohio and Oregon, Vladeck wrote, the two states “simply reclassified all of their substandard facilities as ICFs, saving them the prospect of having to comply with the Moss Amendments” (Vladeck, 1980, p.64). By 1980, about half of America’s nursing homes were classified as intermediate care facilities, though today, given current funding formulas, the distinction is meaningless.
Growing Industry

Not much seems to have been written about the woodwork effect related to the inception of Medicare/Medicaid and the proliferation of nursing homes in this country. Perhaps it is because the numbers speak so well for themselves. In 1963, according to the National Center for Health Statistics and the Bureau of the Census (Hawes, p. 1986, 496), the United States had roughly 500,000 nursing home residents. By 1969, the number of people in nursing homes in this country had nearly doubled to 973,000 and increased to approximately 1.1 million by 1972.

The costs associated with this care rose even faster. Joseph Giacalone, in his 2001 book, “The American Nursing Home Industry,” estimates the total costs of nursing homes in the United States at $526 million in 1960; $1.3 billion in 1965; and $6.5 billion by 1972. So, as the nursing home population was roughly tripling between 1960 and 1972, the costs of care for that growing population increased more than 12 times over in that same time period.

While the increased nursing home costs represent both a jump in residents, inflation, and generous government payments to providers, the rise in nursing home residents was attributable to a host of factors:

1. an increase in America’s older population, due to medical advances, with those age 65 and older constituting 10 percent of all citizens in the 1960s;
2. an increase in mobility among American citizens, accompanied by cultural shifts, rendering family members less able (or willing) to look after elderly relatives;
3. an increase in older individuals transferred from state mental hospitals to nursing homes, as these facilities could care for the elderly at roughly half the cost of a state institution (Moss & Halamandaris, 1977); and state and federal court decisions in the late 1960s and early 1970s called for removing persons from mental institutions who posed no threat to themselves or society.

The effect of transferring older residents from state mental institutions to nursing homes newly funded via Medicare and Medicaid should not be underestimated. Hawes cites Morton Research Company data that estimates “25 percent of the increases in nursing home utilization between 1960 and 1970 can be attributed to the
deinstitutionalization or diversion of individuals from mental institutions into nursing homes” (Hawes, 1986, p. 497).

While Moss does not offer hard data on those entering nursing homes from mental institutions, his view is that these transfers happened nationwide in “tremendous numbers” (Moss & Halamandaris, 1977, p. 104). According to his Senate Subcommittee on Long-term Care, the number of persons age 65 and older in America’s state mental hospitals dropped by 44 percent between 1969 and 1974, from about 428,000 to 237,000. (In Ohio, the comparable figure was 16,934 to 9,793.) Additionally, between those same years, state prisons released some 75,000 persons age 65 and older, cutting the number of older prisoners more than in half, from around 135,000 to 60,000. Countless thousands from both the mental institutions and the prisons went directly into nursing homes (Moss & Halamandaris, 1977).

1972 Social Security Amendments (Public Law 92-603)

It is surprising to be so often reminded of just how much ex-president Richard Nixon, the conservative stalwart, did for social programs in America. A good example is his 1972 Social Security Amendments, which consolidated Old Age Assistance and aid to the blind and disabled under the umbrella of Supplemental Security Income (SSI). The legislation increased Old Age Assistance payments but, more importantly, it permanently tied SSI and other social security benefits to the consumer price index - i.e., inflation. That act had the effect of substantially cutting the poverty rate of older Americans continually ever after, from more than 20 percent at the time until it reached its current 10 percent - compared with an average of about 13 percent for all ages (U.S. Bureau of the Census, 2006).

These 1972 amendments granted Medicaid eligibility to all those qualifying for SSI payments (Giacalone, 2001) and contained several important provisions related to nursing homes. The provisions included increased inspection and enforcement of nursing home standards and mandated that the states reimburse Medicaid skilled nursing and intermediate nursing facilities on a “reasonable cost-related basis” (Hawes, 1986, p. 505, Giacalone, 2001, p. 28 - PB 92-603, Section 249).
The reasonable cost measure, already in use in several states, served as another attempt to neutralize nursing home owner’s ongoing complaint that poor conditions were related to low reimbursement rates from the government. This measure was also aimed at the strict flat-rate, per-capita funding methods that too often tempted nursing home operators to cut corners on care for the sake of profit. Within the concept of reasonable-cost reimbursement, however, the government still allowed some flat-rate calculations (Moss & Halamandaris, 1977) and encouraged states to experiment with an array of funding methodologies in practice at the time, since states still had broad autonomy regarding the regulations and costs of their respective nursing home programs. Regulations for this “reasonable-cost” funding, however, were put off until 1976 and delayed again until 1978 (Moss & Halamandaris, 1977).

Sparked by nursing home scandals uncovered by reports from Moss’s subcommittee and a young Ralph Nader, as well as the recurring and inexcusable death by fire of more than 300 nursing homes residents in a rash of such calamities across the country (104 of them in Ohio, 63 in Fitchville in 1963; 31 in Marietta in 1970; and 10 in Lincoln Heights in 1972), government made what seemed to be earnest attempts to institute nursing home reforms.

These reforms were headed by Elliot Richardson, who took over as director of HEW in 1970. The efforts gained further momentum from a July 1970 salmonella outbreak in a Baltimore nursing home that took 36 lives, and a series of government reports that estimated somewhere between 50 and 80 percent of America’s nursing homes were likely substandard (Moss & Halamandaris, 1977).

In 1971, nursing home inspection and enforcement staff were expanded and the federal government mandated that states be reimbursed for all of their inspection efforts. The federal government also instituted training programs for nursing home personnel and created the Office of Nursing Home Affairs (ONHA) to oversee these initiatives. HEW also threatened to cut off funding to substandard nursing homes not making efforts to provide acceptable services.

While Vladeck concedes these measures had some positive effect, he suggests that they also involved some political posturing and were sacrificed without much fight to political realities, noting that early 1970s reform efforts “trod on some politically
sensitive toes, especially in several states where Republican politicians had financial interests in less than superior nursing homes” (Vladeck, 1980, p. 66-67). The measures were thus largely reined in and ONHA soon found itself on a lower rung of the HEW ladder. The maelstrom of Watergate swallowed up a great deal of presidential momentum and attention on these, and other, domestic policies as well.

Moss took an even less enthusiastic view of the Nixon administration’s performance regarding nursing homes, writing that, “In reality, however, the Nixon nursing home ‘reforms’ amounted to little. For all the publicity, few homes were closed” (Moss & Halamandaris, 1977, p. 151). By Moss’s count, only 125 of 7,000 Medicaid skilled nursing homes at the time left the program involuntarily, and a nationwide survey of long-term care officials indicated that Nixon’s initiatives had not addressed the major problems in the field.

Part of the reason these problems were not successfully addressed is that while the federal government agreed to fund inspections and enforcement of standards in nursing homes, there was little coordination of these inspection and enforcement measures applied to a system already infamous for its ineffectiveness. As Richardson unsuccessfully warned Nixon early on: “Reliance on state enforcement machinery will lead to widespread non-enforcement of standards” (Moss & Halamandaris, 1977, p. 152). More than 30 years later, in 2006, individual states remain largely responsible for their respective enforcement.
Chapter 7
Rising Costs, Continuing Scandals

State Medicaid Funding Systems

Medicare had already established a cost-based system of reimbursement that was much higher than the reimbursement offered through Medicaid. U.S. Cost of Living Council figures (Moss & Halamandaris, 1977) indicate that the average nursing home reimbursement per-resident, per day in 1972 was $14 for Medicaid and $32 for Medicare. Still, the rising cost of Medicaid was pressing itself on federal and state budgets (roughly 55 percent federal and 45 percent state, overall) and cost-containment through any of the various funding mechanisms employed by the states proved difficult. The three major formulas that the 50 states used to reimburse nursing home providers for care of residents throughout the 1970s were:

1. Flat-Fee System: This system paid providers a flat, per-diem fee for residents, such as $21 per-day, per-resident for skilled nursing care and $18 per-day, per-resident for intermediate care. (While this funding mechanism was discouraged by the 1972 Social Security amendments, Moss wrote that flat fees were still allowable so long as states could prove that the formulas “were somehow based upon costs.” Moss & Halamandaris, 1977, p. 140). This system allowed for owner profit, but also expected a certain amount of the fee to go toward the facility itself, nursing care, food and so forth. The virtue of the flat-fee is that it establishes limits for more accurate budget planning; the vice is that the system invites profiteering providers to cut corners on care and to seek out residents who need relatively minimal care. (In Mendelson’s opinion: “Flat-rate Medicaid money is the most profitable to the owner, and the hardest on the patient. If the government will pay ... $14 a day per patient, the way to make money is obviously to cut daily costs as far below $14 as you can.” The incentive to care for healthy patients, she continued, resulted in nursing homes housing a great many residents who did not need to be there - as many as 40 percent, according to a Government Accounting Office study in 1971, Mendelson, 1975, p.39-41).
2. Cost-Related Reimbursement: This was the system used by Medicare at the time. It basically reimbursed providers, within loose limits, for expenses related to care provided in the nursing home. An additional amount was added to cover the owner’s investment and profit. The virtue is that owners, being fully reimbursed, would more likely spend to provide better care for residents; the vice is that this system offered little incentive to contain costs and many exorbitant costs were passed onto the government.

3. Prospective Payment: A method practiced by Colorado at the time (and by Ohio in the 1990s and early 2000s) that based reimbursement rates on the previous year’s expenses, adjusted for inflation and significant changes in residents and their medical conditions. As employed by Colorado, this system allowed for $1 profit per-day, per-resident. The virtue is the system, in its early days of application, allowed for more accurate planning and increased accountability; the vice is there was no real incentive to control costs and little incentive for better resident care. Government would add more incentives for cost control and resident care as this system was refined in later years.

Many states adhered to the flat-rate system, although those flat rates were justified in a variety of ways. Some states used a combination of flat rate and cost-based formulas, with a flat rate set for intermediate care and cost-based reimbursement system used for skilled nursing care. Moss singles out two states for their respective funding systems, Connecticut and Illinois. Connecticut, under the plan called “The Connecticut Points System,” rewards nursing homes meeting particular standards with higher reimbursement levels, about a $1 more per-day, than homes not meeting the standards. The benefit here is that facilities better at meeting standards receive more money, thus giving facilities incentives for compliance. The downside is that the incentive does not actually pertain to the quality of care, only the number of standards met, but one may assume there is a fair amount of intersection between the two.

Illinois in the 1970s offered an interesting example, known as “The Illinois Points System,” which was innovative in establishing the “case-mix” basis for funding, used
today in Ohio and many other states. Unfortunately, it was also innovative as a model of how to offer incentive for poor care.

The Illinois system was well-intentioned, in theory. It encouraged nursing homes to take in more severely impaired “high-maintenance” residents by offering financial incentives, i.e., points, for increased levels of impairment. For example, providers might receive an extra $50 per-month for a resident needing catheterization; or an extra $40 a month for a resident classified as having behavioral problems or bedsores. The system, which holds obvious incentives for poor care, was so absurd as to allow for an extra $1,000 per-month, per-resident to the nursing home.

Though then-Senator Charles Percy (D-Illinois) agreed that his state’s reimbursement formula featured an incentive to keep residents in their beds, Moss inserts that five years after that admission, at the time of the book’s publication (1977), Illinois still had the same formula in place (Moss & Halamandaris, 1977, p. 143).

States in the latter part of the 1970s had a wide variation in their Medicaid reimbursement rates to nursing home providers, and sometimes this variation was seen within the same state. New York City, for example paid in the neighborhood of $60 per-resident, per-day while the state average was $40 per-resident. In California, the rate was about $30 per-resident; in Illinois it was closer to $20.

But Moss could see little connection between payment rates and quality of care. (It should be noted that New York, with its relatively high rate of reimbursement was the setting for some of the more notorious nursing home scandals brought to light by Mendelson and others in the 1960s and 1970s).

Moss mentioned Connecticut as the only state attempting to provide incentives for good care, but lamented that these incentives, in actuality, were tied more closely to compliance with standards rather than the quality of the care delivered.

Citing the built-in difficulties of a system in which government shells out huge sums of money to a largely for-profit industry for third-party consumers (as Vladeck noted, 80 percent of nursing home care in America is publicly funded, and roughly three-fourths of U.S. nursing homes receiving that public money are for-profit - and nearly all of them are private-sector, i.e., not publicly owned), Moss shared a bleak viewpoint on the situation as a whole: “One thing is certain. The structure of reimbursement systems in
most states tends to distort the operation of the free enterprise system, providing U.S. nursing homes with direct built-in financial incentives in favor of poor care” (Moss & Halamandaris, 1977, p. 139).

_Rising Costs, Continuing Scandals_

Naturally, as the number of nursing homes and beds continued to increase in the 1970s, so did the cost of funding them - immensely. Between 1974 and 1976, federal nursing home expenses rose by more than 50 percent, from $3.5 billion to $5.3 billion (Vladeck, 1980, p. 69).

This tremendous jump in costs coincided with the accelerating scandals uncovered in the nursing home industry by reporters, activists like Mary Mendelson and government itself, through the Government Accounting Office and subcommittees on long-term care and other aspects of aging in the 1960s and 1970s. Mendelson, in “Tender Loving Greed,” was exceptionally thorough in her recounting of the physical and emotional abuse inflicted upon nursing home residents by those paid for their care since at least the 1950s. She was just as comprehensive in exposing the financial chicanery, a great deal of it apparently legal, employed by an increasingly profit-driven nursing home industry in large and in small facilities alike. She felt strongly that our government - aware of it or not - was acting in collusion with the nursing home industry by allowing policies that incentivized poor care - and by looking the other way when it came to enforcing regulations.

Looking the other way, or not looking at all, was a habit of both the state and federal governments, according to Mendelson, Moss and Vladeck. Disclosures to Moss’s Subcommittee on Long-term Care in 1975 (gathered in a 1975 report titled: “Nursing Home Care in the United States: Failure in Public Policy”) revealed that 21 out of 50 states had never so much as audited a single nursing home since Medicaid first began funding the facilities in 1966. Michigan was the most conscientious state in this regard, having conducted 1,370 audits, followed by Massachusetts (600), Maryland (543), Wisconsin (487), Illinois (398) and Texas (375), Pennsylvania (319), New Jersey (316) and New York (222). Ohio, despite being the sixth most populous state and having
earned an infamously prominent place in Mendelson’s catalog of scandal, had conducted only four nursing home audits as of 1975 (Moss & Halamandaris, 1977).

This regulatory approach provided a fertile environment for the pervasive abuses and irregularities routinely chronicled in the 1970s. Mendelson detailed nursing home operators’ standard shell game of leasing their facilities to dummy partners, or to themselves, at exorbitant rates and then passing off the expenses to the government. The nursing homes played a similar charade when purchasing supplies, buying from essentially self-owned subsidiaries at high prices, billing the government and benefiting from the huge mark-up. These subsidiary businesses included: construction companies, real estate development, food and laundry services and linen supplies.

Doctors were in on the huge profits available from nursing homes, too, she added, with nursing homes encouraging investments, and subsequent referrals, from them so that the doctors would have an interest in sending nursing home patients their way. Pharmacists were dealt in as well, according to Mendelson, with lots of nursing home business coming their way in exchange for a nice kickback to the nursing home.

“The awe in which we hold the doctor makes it particularly easy for him to defraud us” she wrote (Mendelson, 1975, p. 44). A typical abuse of the Hippocratic oath and that trust in nursing homes at the time (and likely still today) is what Mendelson termed the “gang visit,” a euphemism for a doctor’s method of coming to a nursing home, glancing over the medical charts of dozens of patients and billing the government as if the doctor had actually visited and attended to each patient. She cited a GAO account of a physician in Ohio who had billed the government for 71 such visits in a single day and 56 visits on another (Mendelson, 1975, p. 44). A podiatrist billed for 32 visits on one Sunday. These individuals were trumped in Mendelson’s book by the optometrist who billed the government for a pair of prescription sunglasses for a patient who was blind.

Moss provides a lengthy rundown of abuses of his own in the chapter of his book title “Profiteering: Services to the Needy by the Greedy.” In those pages he attests to the well-known profitability of the nursing home industry among those in the stock market and banking industries at the same time nursing home owners were complaining of unprofitable government reimbursement rates. He also cites the single-digit profit
margins of most of the top Fortune 500 companies compared to the double-digit profitability of the nursing home industry, around 15 percent according to one study, or about twice that of the top Fortune Five Hundred businesses.

In 1972, the Reverend John Mason, former director of Services to the Aging for the American Lutheran Church, which ran a number of non-profit nursing homes, got fed-up with what he saw as the avaricious whining of for-profit homes and shared his findings with Moss’s subcommittee: that the average cost for residents’ care in the Lutheran Homes was provided at a cost of about $2 a day per-resident less than what the government provided through Medicaid. In other words, at the time “present payment rates are quite sufficient to support a level of services exceeding federal minimum requirements” (Moss & Halamandaris, 1977, p. 82).

Moss also found problems with nursing homes’ handling and borrowing of residents’ funds, including their $25 social security allowance and savings of deceased residents. And he made a long, itemized list of “hidden charges,” i.e., billing of patients’ families for what they assumed to be covered in the monthly nursing home bill. An air mattress, for instance might cost an unsuspecting resident (or family members) $45 per month, even though it would likely be paid for in total in far less than a year. Patients were billed for the TV set in their rooms separate from the basic room charge and, among other items, would find themselves with itemized bills for the ingredients of their enemas, the restraints used to immobilize them and the plastic gloves put on by aides to handle them. Patients were even billed for the tissues they used to blow their noses (Moss & Halamandaris, 1977, p.86-88).

It bears repeating that, in Mendelson’s opinion, the above were pervasive practices in an industry of which 21 states had yet to conduct a single financial audit; and this was the general existing state of affairs in which Ohio looked at the books of four nursing homes in nine years.

These scandals and lack of regulatory oversight (evidenced by reports that perhaps as much as 10 to 20 percent of the $7 billion government was spending on nursing homes was being siphoned off through fraud and waste, Vladeck, 1980, p. 70, 72) resulted in another round of federal and state reforms in the mid-to-late 1970s, most
of which targeted the somewhat contradictory task of reducing expenditures while trying to improve and guarantee better services.

One of the reforms resulted in the inception of Ohio’s nursing home ombudsman program in 1975. Following the lead of a few other states, the program began as a demonstration project and became fully operational in 1978 after federal legislation mandated the program in all states (Hornbostel, 2006).
Chapter 8

Ohio Nursing Home Commission Addresses “a Program in Crisis”

Reforms in Ohio

In the early 1960s, Ohio perhaps escaped a great deal more negative attention than it might have received regarding its nursing homes due to the date of a devastating fire at the Golden Age Nursing Home in Fitchville (Huron County, Ohio). In the early morning hours of Nov. 23, 1963 - less than 24 hours after the assassination of President John F. Kennedy - a fire broke out killing 63 residents, many of whom were bedridden and/or held down by restraints. Twenty-one of the bodies were unclaimed and later buried in a mass grave under a single headstone in the rear section of the Woodlawn Cemetery in nearby Norwalk.

The story got about a day’s worth of national attention but was largely swallowed up in the non-stop news broadcasts on the killing, funeral, and the live-TV murder of the prime suspect, Lee Harvey Oswald.

The Fitchville fire, however, did lead to the production of the 1965 Ohio Legislative Service Commission’s Staff Research Report No. 68, simply titled “Nursing Home Regulation.” The 44-page pamphlet was devoted mainly to building standards, fire safety codes and regulatory procedures and allowed just over two pages for proposed regulations on resident care (primarily concerned with nurse and staff ratios). At the time, national standards did not go much farther than vaguely recommending “sufficient” staffing with at least one LPN or RN on duty at all times. The same national standards held for Ohio’s (then)1,200 nursing homes caring for some 33,000 residents (roughly 27 persons per home, up from 22 in 1958, according to the report). About 12,000 (35-40 percent (Staff Research Report No. 68, p. 40) of Ohio’s nursing home residents in 1965 were covered by Old Age Assistance, with maximum monthly rates set at $145 for rural residents and $170 for those in metropolitan areas (Staff research Report No. 68, p. 44).

Worth more than a passing mention is the report’s discussion of how the Ohio Federation of Licensed Nursing Homes (a previous version of the Ohio Health Care Association) diluted and postponed (even after the Fitchville fire) revised building and
safety regulations for Ohio nursing homes first proposed by the Ohio Department of Health’s Public Health Council in 1960. The federation did so by filing a series of legal actions, up to the state’s Supreme Court, that kept the regulations from being implemented until after the Supreme Court denied a final appeal in December 1964 (Staff Report No. 68, pgs. 11-12), more than a year after the Fitchville fire. The diluted, but still stiffer, building and fire safety codes finally went into effect in 1965. But, the report’s recommendations for at least one nurse and one nurse’s aide on duty for every 5 residents went unacted upon until 1972 (U.S. Dept. of Health and Human Services, 2003).

According to the report, the Ohio Dept. of Health inherited oversight of nursing homes from Ohio’s Dept. of Public Welfare in 1959 (which had overseen Ohio’s nursing home licensing and regulations since their formal inception in 1941) and was initially eager to improve upon the regulations transferred to it. But, meaningful safety code and other reform advances in those years remain questionable, at best, considering the fatal fires that followed in Ohio nursing homes in 1970 and 1972 (Marietta, 31 casualties; and Lincoln Heights, 10 casualties), and the overall state of Ohio’s nursing homes as seen in the reports of the Ohio Nursing Home Commission in 1978 and 1979.

The Ohio Nursing Home Commission

Ohio, nursing home fires aside, had come in for more than its share of mention in Mendelson’s chronicles of nursing home abuses. The state convened the Ohio Nursing Home Commission in 1977 to study the Ohio’s long-term care system and facilities and make recommendations for improvement. It was the most significant and comprehensive attempt at the time to examine Ohio’s nursing homes in regard to regulations, funding and patient care.

The commission - comprised mainly of legislators, state department heads and nursing home officials - examined the conditions and effectiveness of Ohio’s nursing homes, after years of lax regulation and oversight, in the context of five major questions:

1. Is acceptable care being delivered to aged and disabled Ohioans in nursing homes?

2. Are needed long-term care services readily and uniformly available?
3. Are nursing home patients effective consumers?

4. Are Ohio’s laws and regulations, its regulatory agencies, and its enforcement mechanisms effective in ensuring that quality in nursing home care is provided to the aged and disabled?

5. Is Ohio’s Medicaid reimbursement system for nursing homes fiscally sound?

The answer to each question (the report was subtitled “A Program in Crisis”) was a resounding “no,” with the commission calling overall conditions in Ohio’s nursing homes “profoundly disturbing” (Final Report of the Ohio Nursing Home Commission 1979, vi).

(Rather than singling out Ohio for poor nursing homes, it should be emphasized that the findings of the Ohio commission are much in line with the broad assessments of nursing homes across the country offered by Mendelson, Moss, Vladeck and, later, the 1986 Institute of Medicine’s report on the nation’s nursing homes. All indicate that much of what was found wrong with nursing homes in Ohio would be found in most other states as well.)

1) Regarding “acceptable care,” the commission, while making the obligatory concession to the good nursing homes in the state, stressed in its interim report that “acceptable quality of care is not uniformly provided to patients in nursing homes. ... The very fact of uneven care, excellent in some homes, terrible in others, is a sure sign of the nursing home program’s failure.” Problem areas itemized in the report included such basics as: “lack of a clean and safe environment, inadequate nutritional care, inadequate health care, and insufficient activities and quality of life factors.”

2) In relation to the availability of long-term care services, the commission labeled physician and nursing services in many of the state’s nursing homes as “inadequate,” and stated that “many patients do not receive proper social and psychological care.” The commission also found the state lacking in both Medicaid nursing home beds as well as in-home and community alternatives to institutional care. Regarding these alternatives, the report asserted: “The multiplicity of agencies involved,
the bewildering array of eligibility standards and funding sources, and the near total lack of coordination among agencies have rendered the existing program quixotic at best.”

(It is worth noting that the fragmented system noted above was still solidly in place more than a decade later when Carol Austin, then-director of the Ohio Department of Aging, led the state’s first major push toward developing a statewide system of home and community care for the elderly. It should also be emphasized that the need for a national program of home and community services for the elderly was promoted earlier by Richard Nixon in an address at the 1971 White House Conference on Aging, with Nixon telling attendees that: “The greatest need is to help more older Americans go on living in their own homes.” But, as Moss observed in 1977 - and as Ohio and other states found out: “It is symptomatic of our lack of a coherent policy that reality never follows rhetoric, and older Americans continue to suffer without the services they need. ... It is paradoxical that as a nation, we are willing to pay as much as $15,000 a year to keep a patient in a New York nursing home but are unwilling to pay the family $1,000 a year to help provide for their loved one at home” Moss & Halamandaris, 1977, p. 138).

3) In answer to the question about the effectiveness of nursing home patients as consumers, the commission stated that nursing home patients in that role “are extremely vulnerable and lack economic power and legal rights.” Getting to the heart of the matter, the commission added: “Moreover, patients cannot depend on competition among nursing homes to cause upgrading of care.” The commission also specified that Ohio lacked a patients “bill of rights” for nursing home patients, leaving them, essentially, with fewer legal rights than prison inmates and wards of mental hospitals.

4) The commission elaborated most upon the effectiveness of Ohio’s nursing home regulations and the enforcement mechanisms, or lack of them, attached to those regulations. Foremost, the commission found that Ohio’s licensure protocol and overall regulations lacked “clear and adequate definitions of standards which would ensure quality of care and effective enforcement.” The commission also took the state’s regulations to task for measuring compliance on paper and by bureaucratic review rather than measures designed to assess actual quality of care provided.
Echoing its comments on the provision of long-term care in general in the state, the commission noted: “There are a “multiplicity of agencies purporting to regulate and inspect nursing homes, but there is a serious lack of coordination, communication and cooperation between and within these agencies.” The commission faulted inspection practices as being predictable and more in the line of consultation than enforcement, concluding that “few enforcement actions are taken against facilities which provide poor care.” And, even when such actions are taken the commission’s report said, “Nursing home operators, through use of court injunctions, can prevent or delay the enforcement of the law, making patients remain in a facility which fails to meet minimum health and safety standards.”

Noting the need for unexpected inspections designed to catch nursing homes off-guard, the commission’s final report quoted the testimony to it of an unnamed Catholic priest serving as an advocate for better nursing homes in Ohio:

“You’ve got to go at night. And you’ve got to go unannounced. ... I’ve gone in at night to different units to tend to some patient who is dying and turn the light on in the room and the bugs are all over, crawling on people who don’t have the strength to wipe the bugs away from themselves. I’ve given communion to people who’ve asked me for a glass of water, and I can’t find a glass to put water in. I’ve seen clothing, or the lack of clothing. There’s no dignity. You die in disgrace, abandoned” (Final Report of the Ohio Nursing Home Commission, 1979 p. 53-54):

Though this recommendation for unannounced visits was not addressed in Am. Sub. H.B. 600 or other immediate Ohio legislation, the federal Omnibus Reconciliation Act of 1987 did stipulate that nursing home inspectors should vary their visits from between 9 and 15 months to keep operators from predicting inspections. Night visits, except in unusual, circumstances, have not been instituted in Ohio (Hornbostel, 2006).

In its final report, the commission was straightforward in its observation that “the central problem of Ohio’s nursing home program is the failure of its regulatory process”
(Final Report of the Ohio Commission on Nursing Home Reform, 1979, p. X). While the commission spread some of the blame in this regard to the various agencies involved in the state’s unwieldy, fragmented and fractured regulatory system, it was especially critical of the Ohio Department of Health (ODH) and its director at the time, Dr. John Ackerman. The report termed ODH’s reliance on consultation rather than statutory citation “a spectacular failure,” and chided Dr. Ackerman for testimony indicating that he did not view himself or his department in the role of “a policeman” (Final Report, 1979 X). An excerpt from the final report provides a startling example of the bureaucratic callousness toward life in nursing homes that existed at the cabinet-level of Ohio government at the time:

Senator John Mahoney: “Dr. Ackerman, how soon would you investigate a complaint about inadequate food, no cook in a nursing home six days a week, and patients having to eat from cans?”

Dr. Ackerman: “Of course we would investigate such a complaint as soon as possible, but it’s not that serious. All of us have eaten out of cans once in a while. It’s not that bad” (“Final Report of the Ohio Commission on Nursing Home Reform,” 1979, p52-53).

5) Finally, the commission found serious fault with Ohio’s Medicaid nursing home funding system, which, in 1977, was based on prospective/flat-fee reimbursements. The state had previously employed a flat-rate fee and a system of retrospective/flat-fee reimbursement, both of which were deemed flawed due to incentives to cut corners on care for the former and little incentive to cut costs for the latter. The prospective system the commission studied employed ceiling rates on items such as food and linens, and overall maximum payments capping rates at $31 per-resident, per-day, for skilled nursing; and $26, per-resident, per-day, for intermediate care.

The commission leveled various criticisms at the prospective/flat-fee system in use at the time, warning that late and irregular payments to providers were beginning to lead to a two-tiered nursing system in Ohio (public and private-pay), resulting in some of the state’s better nursing homes declining to take Medicaid patients. The report also
warned that the system “discouraged nursing home providers from providing needed services, ... embodied no incentives for high quality care; and they have not encouraged containment of nursing home costs.” The report further found that the funding system had vastly overpaid some providers while underpaying others. It declared the state’s nursing home reimbursement practices fiscally unsound and specifically faulted the Ohio Department of Public Welfare for its failure to perform on-site audits. The commission estimated the agency’s shoddy auditing practices were costing the state between $18 million and $46 million per year in overpayments to nursing homes.

In its final report, “A Program in Crisis: Blueprint for Action,” the commission made a number of recommendations pertaining to the five above-referenced problem areas. The recommendations - most of which were acted upon, resulting in either legislation or adjustment in revised code rules and regulations - included a call for: incentives for accepting Medicaid-reimbursed residents; tighter staff-to-patient ratios; improved access to, and involvement of, nurses and physicians; expanded and enhanced psychiatric services and dietary practices; more staff training, especially for nurse aides; stricter licensure standards and clearer, better coordinated enforcement of existing regulations; and expanded home and community services as alternatives to institutional care. (Reinforcing the views of Senator Frank Moss, The final report noted at the time that Ohio spent some $20 million a month in Medicaid nursing home reimbursement, but only $22,000 a month in Medicaid funds for home health services).

One recommendation that went unheeded was the commission’s emphatic plea for the creation of a centralized office for the investigation of nursing homes under the proposed Office of the Inspector General in the Ohio Department of Health. This specific recommendation was bypassed, though ODH did coordinate, consolidate and upgrade some inspection procedures.

Of special importance, the commission’s recommendations - noting that nursing home residents “are among the most powerless individuals in our society” - also called for the establishment of a bill of rights for Ohio nursing home residents. The commission additionally recommended placing the state’s nursing home ombudsman’s office in charge of ensuring those rights, formalizing the office within the Ohio Commission on
Aging (which was elevated to cabinet-level status and became the Ohio Department of Aging under Gov. Richard Celeste in 1983). This legislation, along with the 1978 reauthorization of the Older Americans’ Act, led the state nursing home ombudsman to expand regional ombudsmen programs to the state’s 12 area offices on aging, offering financial and technical assistance at the state level to do so.

The commission was so adamantly supportive of this bill of rights that a bill specifying 30 such rights (Am. Sub. H.B. 600) was enacted in 1979, nearly a year before the commission released its final report in November of that year. These rights (see addendum) - which centered on areas of privacy, dignity and autonomy, with a legal provision for civil action - and the expanded ombudsman program overseen by the Ohio Commission Aging (OCA) - became a model for many states developing ombudsmen programs and residents’ rights in the years to come. The 30 specified rights (now 32) proved especially useful to ombudsmen in negotiating a higher quality environment of care for older persons in Ohio nursing homes (Hornbostel, 2006).

Additionally, H.B. 600 provided for a small civil investigative unit within the OCA (later the Ohio Dept. of Aging), known as the Ohio Nursing Home Investigative Unit, that had broader enforcement powers than the Ombudsman’s Office. The unit was effective in turning around poor conditions at the Ohio Veteran’s Home in Sandusky, but - with just three investigators - it took a back seat to the ombudsman’s office (and its 12 regional offices) in terms of its ability to bring about widespread change in the state’s nursing homes (Hornbostel, 2006). The criminal investigative unit within ODA was disbanded in 1991.

In another step to help curb rising nursing home expenditures, the commission, citing Ohio’s 1978 Certificate of Need Legislation (Am. Sub. Bill 349, in line with federal “1122” law regulating the need for and building of health care facilities), recommended that health care reviewers also take a long look at sales of nursing homes and the ownership changes involved.

Revised Funding Formula

Finally, especially significant was the commission’s recommendation for a revised funding formula, which was acted upon, resulting in the implementation of H.B.
176 in 1980 (Snodgrass, 2006). Assuming, that the prospective/flat-fee system of Medicaid reimbursement for nursing homes provided little incentive for conscientious care and was at least tangentially connected to the poor quality of so many of the state’s facilities - though it allowed for a profit factor of 26 percent on net equity (Final Report of the Ohio Commission on Nursing Home Reform, 1979, p. 151) - Ohio turned to a “retrospective case-mix” system of reimbursement based on “reasonable and adequate” costs as determined largely by the nursing homes themselves.

In return for this increase in Medicaid reimbursement, the new formula, as noted previously, contained inducements to get more nursing homes to accept Medicaid residents. (At the time, nearly half of Ohio’s nursing home residents - and the nation’s - were covered by Medicaid.) The commission found that Ohio risked being defined as a two-tiered system of nursing home care, separate and unequal, in that the care and conditions provided for private-pay residents were generally much better than for Medicaid residents, whose reimbursements to nursing homes under Medicaid were comparatively so low that homes - at a time when nursing home beds were in high demand - often would not accept Medicaid residents. H.B. 176 basically made taking Medicaid residents an all-or-nothing proposition, meaning that for-profit homes could no longer refuse to take Medicaid residents if they wished to continue being reimbursed for those they already had and those they would take on in the future (Hornbostel, 2006).

This 1980 system, which, as the name implied, relied on a complex case mix of approximately 18 classified acuity levels among patients, made moot the old classification concept of intermediate and skilled nursing services, and created more subtle distinctions in levels of care. This system, which also took into account economic differences based upon rural and urban regions, was based upon similar funding formulas already in place in Washington, West Virginia and, interestingly, as noted in the commission’s report, received “a strong endorsement by a CPA (Jerry Rhoads) working for the American health Care Association” Wisconsin (“Final Report of the Ohio Nursing Home Commission,” 1979, p. 174).

Ohio’s newly devised case-mix/retrospective formula was adjusted quarterly for reimbursement in accordance with patients' acuity and care levels. These acuity and care levels were reviewed by a staff of ODH field nurses using that same quarterly timeframe.
in the early 1980s, until the department found such reviews too time-consuming and costly and made their review process less meticulous in the mid-1980s (Snodgrass, 2006).

The state’s 1980 funding formula, as recommended by the commission, also allowed for nursing homes to be reimbursed for capital expenses, depreciation, interest, utilities, payroll taxes, fringe benefits to employees in the interest of reducing turnover rates, workers’ compensation premiums and property usage costs. Ohio, along with North Dakota, is one of two states that have specifics of their nursing home regulations as acts of legislation, making the funding formula much harder to alter and fine-tune without consent of the state’s General Assembly (Recommendations from the Ohio Commission to Reform Medicaid, 2005, p. 15).

*The Boren Amendment*

As changes were occurring in Ohio, the nursing home industry continued to grow nationally through the remainder of the 1970s. By 1981, nearly 18,000 nursing homes were serving approximately 1.4 million older Americans. Of course, government expenditures rose right along with these numbers, approximately tripling from the mid-seventies to almost $14 billion a year in 1981 (Hawes, 1986).

These rising costs and questionable care in nursing homes across the country led to the implementation of the Boren Amendment in that same year, 1981. The Boren Amendment - Section 1902(a)(13) of the Social Security Act - gave states wider latitude in their reimbursement formulas for nursing homes, but at the same time stipulated that Medicaid reimbursement rates had to be “reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable state and federal laws, regulations, and quality and safety standards.”

The law had the odd aim of trying to reduce Medicaid nursing home reimbursement costs while at the same time demanding that government payments to providers be large enough to ensure proper care of nursing home residents under the broad definition of “reasonable and adequate.” A broad result was that many states were tied up for years by lawsuits from nursing home providers citing the Boren amendments language regarding “reasonable and adequate” funding for quality care. (Despite
protestations from the nursing home industry, this amendment was repealed as part of the federal Balanced Budget Act of 1997, giving states more discretion in reimbursing Medicaid nursing home providers so long as funding “methodologies underlying the rates, and justifications, are published subject to public review and comment prior to becoming final” Giacalone, 2001, p. 124). Given how little has been written about the Boren Amendment, outside of its repeal, and in light of reports on increasing nursing home costs and abuses in the years that followed its passage, the act seems to have done little, if anything, to improve conditions in nursing homes or to have cut down on government reimbursement expenses.

1986 Institute of Medicine Report
Perhaps no single document in the history of American nursing homes has drawn a more immediate or significant response than the 1986 U.S. Institute of Medicine's report on “Improving the Quality of Care in Nursing Homes” in this country. The report’s finding of “seriously inadequate quality of care and quality of life” (p. 21) in nursing homes in all 50 states, despite 10 years of extensive government regulations (stemming from Moss’s Subcommittee on Aging and the abuses documented in “Tender, Loving Greed,”), led directly to the passage of the U. S. Nursing Home Reform Act, part of the federal Omnibus Budget Reconciliation Act (OBRA) of 1987. This sweeping piece of federal legislation contained the broadest set of nursing home reforms yet seen in the United States.

The report originated with the federal Health Care Financing Administrations (now the Centers for Medicare and Medicaid Services) request that the U.S. Institute of Medicine (IOM) study nursing home regulations. HCFA was considering changes in regulatory policy (related to then-President Ronald Reagan’s push to deregulate a number of American industries) that nursing home resident advocates strongly feared would further weaken what was already viewed by many as an ineffective policy that did not effectively address fundamental issues of nursing home care. The IOM undertook the study in 1983, with a stated purpose to “recommend changes in regulatory policies and procedures to enhance the ability of the regulatory system to assure that nursing home residents receive satisfactory care” (IOM, 1986, p. 1).
The essence of the report resides in its seven major conclusions, all of which were followed up by lengthy sets of detailed recommendations. Those conclusions were:

1. **Quality of care and quality of life in many nursing homes are not satisfactory.**
2. **More effective government regulation can substantially improve quality in nursing homes. A stronger federal role is essential.**
3. **Specific improvements are needed in the regulatory system (focusing on the care residents receive and the effect of that care on their well-being).**
4. **There are opportunities to improve quality of care in nursing homes that are independent of changes in the Medicaid payment policies or bed supply. (Related recommendation: that HCFA study the relation between nursing home funding and quality of care for residents).**
5. **Regulation is necessary but not sufficient for high-quality care.**
6. **A system to obtain standardized data on residents is essential.**
7. **The regulatory system should be dynamic and evolutionary in outlook (i.e., specific standards should be modified to reflect change in the “art of long-term-care” and the technique of assessing outcomes more objectively).**

**Omnibus Budget Reconciliation Act of 1987 (Public Law 100-203, Nursing Home Reform Act)**

This law, better known as OBRA, contained regulations addressing all seven IOM conclusions (and related recommendations) to ensure that nursing homes provided residents with care that would help them maintain or improve upon their physical, mental, and social well-being, stating that:

“a skilled nursing facility must provide, directly or under arrangements (or, with respect to dental services, under agreements) with others for provision of nursing services and specialized rehabilitative services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.”
While the preceding language is as vague as it is lofty, OBRA did specify that residents were entitled to social services, rehabilitation services, pharmaceutical services, dental and dietary services that would help them maintain that same “highest practicable” well-being. The act also called for nursing homes to conduct initial and periodic assessments for each resident, particularly after significant changes in the resident’s condition, as well as develop comprehensive care plans, and demanded that facilities with more than 120 beds to provide the services of a full-time social worker.

A critical element of these reforms was the requirement that nurse’s aides, who provide the overwhelming amount of the hands-on care for nursing home residents, undergo at least 75 hours of training and pass a competency test.

Perhaps most importantly, the act supplied nursing home residents with their first formalized federal bill of rights:

* The right to freedom from abuse, mistreatment, and neglect;
* The right to freedom from physical restraints;
* The right to privacy;
* The right to accommodation of medical, physical, psychological, and social needs;
* The right to participate in resident and family groups;
* The right to be treated with dignity;
* The right to exercise self-determination;
* The right to communicate freely;
* The right to participate in the review of one's care plan, and to be fully informed in advance about any changes in care, treatment, or change of status in the facility; and
* The right to voice grievances without discrimination or reprisal.

States maintained the right to apply and expand their own individualized nursing home bill of rights, so long as these rights are at least as comprehensive and protective as the federal government’s. As noted previously, Ohio, for example - under ORC 3721,13 -
had already instituted a bill of resident’s rights even more comprehensive and specific than federal regulations, including 32 separately listed rights as of 2006.

To make sure nursing homes followed requirements of the act, and that residents’ rights were being fully protected, the law also established a certification process requiring states to conduct comprehensive, unannounced surveys of nursing homes. The surveys were designed to focus more on quality-of-care and quality-of-life criteria and featured interviews with residents and their families. This was a large a step up from the prior system, in which inspections took place largely on paper and “a surveyor could conceivably inspect a nursing home and never see a resident” (Hawes, 1997, p.3). The act also contained provisions for stricter state enforcement of regulations and included provisions for monetary penalties, denials of payment and termination from Medicaid/Medicare provider agreements.

In 1989, Ohio passed what is known as “ombudsmen enabling” legislation in the form of HB 359 (effective June, 12, 1990), which created uniform standards for state ombudsman practice; gave ombudsmen greater access to nursing home and resident records; and provided additional funding for its regional ombudsmen programs through a line-item in the state budget as well as a nursing-home bed fee. Interestingly enough, the state agreed to reimburse Medicaid nursing homes for part of this fee (currently $6 per-bed, per-day). Regardless, Ohio’s nursing home ombudsman program - with the state’s strong bill of 32 Residents’ Rights - was viewed as a model for other states and cited by the U.S. Government Accounting Office in 1989 as tops in the country (Hornbostel, 2006).
Chapter 9

Soaring Costs Result in Ohio’s Revised Medicaid Funding of Nursing Homes

Medicaid Money Matters

With tighter staffing ratios (minimum of one aide per 15 residents) and other upgrades brought about by national and state ombudsmen laws, Ohio’s nursing homes improved. But, the Medicaid reimbursement costs were increasingly putting pressure on the state budget.

As with the rest of the country, Ohio’s nursing home costs had soared throughout the 1970s and 1980s, from approximately $5,000 per-resident (per-year) in 1970, to $23,000 per-resident in 1985, to almost $30,000 per-resident in 1990 (Giacalone, 2001) - and to $60,000 in 2005. A state budget report to Ohio’s (1993) Legislative Committee on Long-Term Care Reimbursement indicated that nursing home expenses represented about 44 percent of the state’s Medicaid budget. At that time, reflecting national figures, about two-thirds of Ohio’s nursing home expenses were covered by Medicaid (Giacalone, 2001, p. 88) The budget report also specified that government nursing home costs had grown at a rate doubling those of hospital costs from 1990 to 1991 (by 12 percent compared to hospital payment growth at 6 percent). Facing what he termed a crisis in Medicaid funding, Gov. George Voinovich called for a freeze on nursing home reimbursement in 1991 while he waited for a committee report on how to more economically fund the state’s roughly 1,000 nursing homes, approximately two-thirds of whose 92,000 beds were covered by Medicaid (Scripps Gerontology Center, 2003). Gov. Voinovich imposed an interim funding formula designed to stem the flow of state

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5 Interestingly, as noted in a July 20, 1992, Akron Beacon Journal article. Gov. Voinovich, who collected more than six figures in campaign contributions from the Ohio nursing home industry, “stood by in silence while the Medicaid formula review committee was stacked with industry representatives and their allies in the legislature” (Zajac, 1992).
dollars to Medicaid and called for a temporary moratorium on the issuance of certificates of need (CONs) for the licensing of new nursing home beds.

In 1993, Gov. Voinovich made his CON moratorium on new nursing home beds permanent (though homes could sell existing bed licenses within their home counties) and began phasing in a new funding formula geared toward slowing down the rise in Ohio’s nursing home expenditures and making them more predictable. (To this day, according to Roland Hornbostel, Ohio has not issued a new CON for nursing home beds since the inception of the moratorium, as occupancy rates have plummeted steadily from 92 percent to about 83 percent today, Scripps Gerontology Center, 2003.)

The new formula, effective on July 1, 1993, was based on a prospective system of payments - projected from prior cost history, trends, patient acuity levels and adjusted for inflation - which most other states had adopted 10 years earlier in attempts to keep their costs more manageable and easier to budget for (Giacalone, 2001). Payments would be related to the previous year’s cost reports, but adjusted quarterly for case mix resident acuity levels. Like almost all other states at the time, Ohio’s new formula was termed “prospective, facility-specific.” And, as did about half of the other states, Ohio used case mix data (based on resource utilization groups, known as RUGs) for reimbursement. (AHCA, 1998). The state’s formula also featured a system of reimbursing nursing homes for Medicaid residents through four major cost centers, or categories:

1. Direct care - Payroll (doctors, nurses, aides, therapists), activities, quality assurance.

2. Indirect Care - Administration, food, medical supplies, housekeeping, laundry, bookkeeping, transportation, license and other fees, public relations, maintenance, security, property insurance, legal expenses, employee benefits, workers’ compensation.

3. Capital (aka “Protected”) Costs - Ownership and renovation, including depreciation, and interest on capital assets; amortization and interest on land, improvements and financing costs; lease and rentals.
4. Other protected costs - Real estate, franchise and property taxes; utilities, sewage, trash and hazardous medical waste collection; miscellaneous costs not covered in other sections.

Direct Care

Direct care cost reimbursement was set up to discourage cutting corners regarding the kinds of care of care deemed most essential to residents’ well-being. Reimbursement rates were set along acuity levels of residents and the corresponding amount of care each needed, with adjustments made for the location and type of facility. Categories known as “peer groups” were established to make financial allowances for rural versus urban facilities and set up four geographic regions (peer groups) within Ohio in attempts to ensure economic equality in areas where wages and other economic conditions might vary greatly from those of other parts of the state. Reimbursement rates in Cuyahoga County, for example, might be higher than those in Vinton County.

Acuity levels of residents were recorded in a new system of classification called “Resource Utilization Groups” (RUGS), which denoted resources used in caring for certain types of residents, with more weight being given to residents with higher acuity levels, naturally, calling for more costly levels of care. RUGs, based on minimum data sets of patient information that Medicaid first required in hospitals, rendered a case-mix score upon which Medicaid based its direct care reimbursement to the nursing homes.

In efforts to keep a lid on costs, Ohio placed a ceiling on direct care reimbursement, capping it at the peculiar, intricate amount of “23.78 percent above the cost per case mix unit of the median nursing facility in the peer group” (which was also known as the 85th percentile). In other words, Ohio would not reimburse nursing homes for direct care expenses beyond that needed by approximately 85 percent of other facilities with similar resident acuity levels in similar locations. This was implemented to encourage cost efficiency among providers.

Indirect Care

The 1993 formula allowed for profit in the area of indirect care, particularly in areas where nursing homes were able to cut administrative and operational costs not
related to direct care. Given that intent, it is - at first glance, anyway - odd to find food and medical supplies in this category as opposed to the category of direct care. An Ohio Jobs and Family Services synopsis of the 1993 formula (“Overview of Nursing Facility Reimbursement”) states that food and incontinence supplies were included in the indirect cost center “so that (nursing facilities) have some flexibility in determining where to cut costs.”

Efficiency incentives were spread over eight peer groups (a blend of geography and facility type), and could be as high as $5.42 per-resident, per-day. Ceiling rates for indirect costs involved dividing total allowable expenses by the greater of a facility’s total number of resident days or an imputed 85 percent occupancy rate and adjusting for differences among eight peer groups. (This and other imputed occupancy rates were carried over from the state’s previous reimbursement formula, according to ODJFS officials.)

**Capital Costs**

While the capital cost section of the formula agreed to pay nursing home owners for the cost, interest and depreciation of their investments - allowing for a profitable return on their equity - it also encouraged nursing homes to be efficient regarding these expenditures.

Ohio placed a ceiling on nursing homes’ reimbursement for capital expenses by dividing “the greater of the total number of resident days or 95 percent of the total bed days.” (According to a 2003 Scripps report, *A Ten-Year Retrospective Look at Ohio’s Long-Term care System*, the average occupancy in Ohio nursing homes at the time was about 91 percent; and about 83 percent currently.) While Ohio capped strict net equity profits at 50 cents per-resident, per-day, the limit on total reimbursements under capital expenses was set at $17.88 per-resident, per-day.

**Other Protected Costs**

These costs - water, heat, electricity, waste collection, franchise fees (a few dollars per-bed, per-day) - were computed in relation to actual resident days, not using imputed occupancy. No ceiling was established in this area since the costs were deemed
outside of the nursing home owner’s control. (It is interesting to observe, however, that nursing homes were reimbursed for the franchise fee and part of the ombudsman bed fee collected by the government, meaning that the government was/is paying the state’s Medicaid portion of its own fee).

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\text{\textbf{Costs Kept Down - Temporarily}}
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The new formula, as seen in relation to per-diem costs for Medicaid residents in nursing homes, was effective for a short while, particularly in its first year of implementation. Scripps data (Scripps, 2003) show that Ohio’s per-diem Medicaid reimbursement costs for nursing home residents actually fell between 1993 and 1994 - from an average of $90 to $88 per-resident, per-day. In 1995, that figure crept up to $94; to $97 in 1996, and to $98 in 1997, not far from general consumer price index inflation at the time. This slow growth was somewhat in accordance with national health care trends (Giacalone, 2001 p. 30) But, in 1998, Ohio Medicaid nursing home costs jumped up by over 15 percent, to $113.

Though the sudden jump in 1998 remains curious, the overall increase in per-diem rates in the 1990s to $147 in 2001 is more understandable. The increase can be explained by inflation and in some part by the fact that (according to several Scripps studies) acuity levels of nursing home residents were increasing while Ohio’s nursing home resident occupancy rate was falling, from 92 percent in 1992 to 85 percent in 1998 and 82 percent in 2000. These lower occupancy rates reflexively resulted in higher per-diem costs as the funding formula, along with its imputed occupancy rates, was set up to help nursing homes recover property costs, utilities, taxes, etc. In short, the formula was naturally geared to pay higher per-diem rates for residents as actual occupancy declined.

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\text{\textbf{In-Home Services}}
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The lower occupancy rates seem counterintuitive given the increase in older persons throughout the 1990s and beyond. Nationally, the 65 and older population, about 12.5 percent of the overall population, grew from 31.2 million to 34.7 million, with Ohio experiencing its proportionate share of this growth. In the same period, persons age 85
and older, those most likely to enter nursing homes, increased from 3.1 million to 4.3 million (Giacalone, 2001).

But, in this same timeframe - almost 15 years after the Ohio Nursing Home Commission’s Final Report lamented that 25 to 40 percent of older Ohioans were going to nursing homes “unnecessarily” because of long waiting lists for in-home services - Gov. Voinovich and Ohio were making a markedly stronger effort to significantly increase home and community services for Medicaid-eligible Ohioans qualifying for a nursing home level of care. Also, senior-service levies in various counties across Ohio and other sources of funding were making various home and community services available to thousands more older Ohioans. Additionally, privately funded assisted living communities began to take hold in Ohio and nationwide.

As part of his initiative to reduce Medicaid costs related to nursing homes, Gov. Voinovich had positioned the state’s PASSPORT program, which provided less costly home services to those seeking alternatives to nursing home care, in charge of the pre-admission screening of potential nursing home residents. At the same time, the governor provided a big boost in PASSPORT funding.

PASSPORT had begun in the Ohio Dept. of Aging as a demonstration project with just a few hundred participants in 1984. When Gov. Voinovich took office, the program was serving approximately 3,000 clients. When he left office 8 years later, close to 15,000 - five times as many - older Ohioans were receiving in-home nursing service through PASSPORT.

And they were receiving these services progressively cheaper. A Scripps’ report records PASSPORT per-diem Medicaid costs as $30 in 1992 (compared to $85 for nursing homes) and just $31 almost a decade later in 2001 (compared to $147) for nursing homes (Scripps Gerontology Center, 2003).

PASSPORT, assisted living and various home and community service programs around the state were obviously diverting some older Ohioans from nursing homes, but it is also important to realize that, as an additional result of PASSPORT, nursing homes were taking on residents with more severe impairments, meaning higher acuity levels resulting in more costly types of care.
A Close Call for OBRA

While Ohio was having some success keeping its nursing home Medicaid reimbursement rates from soaring, Congress was considering dismantling a good portion of 1987 OBRA reforms. This happened despite the fact that OBRA was already widely known for having cut nursing home use of physical and chemical restraints in half (Hawes, 1997) as well as making at least modest improvements in residents’ quality of life.

During 1995-1996 budget debates, “in a version that passed in the House, the OBRA reforms were essentially gutted” (Hawes, 1997, p. 4). It was at this time, according to Hawes, that the Senate Finance Committee refused pleas from consumer advocates wanting to testify on behalf of nursing home residents, and a conference committee version of the budget bill was noted as basically “taking the exact language offered by one of the nursing home trade associations” (Hawes, 1997, p. 5). Hawes also found it somewhat surprising, but certainly noteworthy, that the National Governors Association was an early supporter of the dilution of OBRA, which “despite having no empirical evidence, ... argued that federal (OBRA) regulation had failed ... and should be largely abandoned in the realm of nursing home care.” The suspicion was that the governors were working toward a tacit agreement with the nursing home industry that would offer deregulation in exchange for reductions in reimbursement rates.

But, OBRA survived intact, thanks in no small part to widespread public protest generated by major newspapers, broadcast networks and avid supporters of OBRA, such as the AARP, national and local Alzheimer’s Associations and grassroots organizations like the National Citizen’s Coalition for Nursing Home Reform (launched in 1975 when nursing home advocates working with Ralph Nader and the Gray Panthers joined arms).

Olmstead Act

In 1999, the U.S. Supreme Court decided (6-3) against the state of Georgia in *Olmstead vs. L.C. and E.W.*, ruling that persons with mental disabilities (as well as other disabilities), including older Americans, were entitled to be cared for "in the most integrated setting appropriate to the needs of qualified individuals with disabilities,” in accordance with Title II of the Americans With Disabilities Act.
The case involved a lawsuit filed on behalf of two women who were kept in a Georgia mental institution after two state agency professionals treating the women recommended they be transferred to care outside of the institution in the community.

Delivering the court’s opinion, Justice Ruth Bader Ginsburg, wrote: "States are required to place persons with mental disabilities in community settings rather than in institutions when the state’s treatment professionals have determined that community placement is appropriate, the transfer from institutional care to a less restrictive setting is not opposed by the affected individual, and the placement can be reasonably accommodated, taking into account the resources available to the State and the needs of others with mental disabilities " (accessiblesociety.org, 2006).

Though this ruling pertained specifically to those with mental disabilities, it reinforced the mandate for other areas of disability and had, at least potentially, wide application for Ohio, where more than 60 percent of nursing home residents were assessed as having some cognitive impairment (Scripps, 2003).
Chapter 10

Nursing Home Medicaid Costs Increasingly Pinch the State Budget

Same Old Song

In 2003, a little more than a decade after George Voinovich warned that nursing home Medicaid expenditures were impeding the state’s ability to fund other vital programs, Ohio’s 87th governor, Bob Taft, made an identical observation and took action to freeze and cap reimbursement rates while two special task forces, the Ohio Commission to Reform Medicaid and the Ohio Nursing Facility Reimbursement Study Council prepared reports and recommendations on funding Ohio’s nursing homes.

Nursing Facility Reimbursement Study Council

The NFRSC, chaired by Shawn Webster (R-Hamilton) and composed of other legislators and various representatives from state government and nursing homes, met 13 times from July 2003 to June 2004. The council recommended, among various items, flexibility in monitoring that allowed more oversight of homes with a history of non-compliance and less oversight of homes with good records of resident care; a reduction of excess Medicaid nursing home beds; and the establishment of forgiveness periods, in relation to nursing home employees, for certain criminal convictions.

Regarding funding, however, the council concluded its report by conceding that “significant differences in philosophy and funding levels remain” between government and the nursing home industry. It issued no formal recommendations for funding in its July 2004 report. The council did however, make progress in some areas, coming to a tentative agreement that the general cost-based, case-mix system should be preserved, but that direct care costs should be divided into two components: one a case-mix including nursing and therapists wages; and another, non-case mixed, called “ancillary,” that would include routine medical supplies and dietary expenses. This informal recommendation would be adopted and put into the state’s new funding formula (including a new category for ancillary services), which became effective on July 1, 2006.
Ohio Commission to Reform Medicaid

This commission, chaired by Dr. Bernadine Healy, was comprised of medical experts, business representatives, community leaders and a representative of the AARP. Unlike the reimbursement study council, there were no representatives of for-profit nursing homes on the commission.

The commission opened its January 2005 report warning that “the rate of growth in Medicaid spending is unsustainable” (OCRM 2005, p.7). It noted that despite various aggressive containment efforts in Ohio that Medicaid (including federal matching funds), at $10.5 billion, annually, represented 40 percent of the state’s entire budget. The largest share of that sum goes to nursing home funding. “Decades of ‘reform’ have failed and attempts to reform will continue to fail until we finally get the right kind of competition and structural change,” the report declared (OCRM, 2005, p.8).

The commission calculated that Ohio’s Medicaid costs had risen by 78 percent during the past six years (over twice the rate of overall state spending) and would likely eat up more than half of the entire state budget if current growth rates continued through 2009. But, it emphasized that Ohio was not alone in this regard and that, in fact, Medicaid increases nationally were even higher, rising at roughly 10 percent each year.

The commission urged that Medicaid consume no larger proportion of the state budget in future years than the current approximate state share of 18 percent and that Ohio should:

1. Eliminate its Medicaid nursing home reimbursement rates from state statute in order to facilitate wider negotiation for competitive prices.
2. Phase out the CON program, because of its interference with the free market.
3. Ensure that older Ohioans have access to a wide array of in-home and community-based services as alternatives to nursing home care.
4. Offer assisted living programs as a Medicaid option.
5. Implement short-term provider rate reductions or freezes.
The commission was especially firm on its perception of Ohio’s institutional bias regarding long-term care services, that is, the favoring of nursing homes and other forms of institutional care over the provision of home services. Of course, Nixon and Moss brought up that same point some 30 years previous, as did the Ohio Nursing Home Commission in 1978.

The net effect of this institutional bias, the commission explained, is that Ohio - with the ninth highest number of nursing home beds per-1,000 age 65 and older in the country, “spends more per capita on long-term care than most states, and spends a high proportion of those resources on nursing facility care” (OCRF, 2005, p.14). That is despite the fact that home and community services are generally less than half as costly and are overwhelmingly preferred by those given the choice.

The report went on to note that only eight states had lower nursing home occupancy rates than Ohio (75%, p. 13, though that figure is out of line with figures from the Scripps 2003 report). It further emphasized that even though the state’s nursing home population had declined by 4,600 over the past nine years, Medicaid spending on nursing homes had still increased by 90 percent. Ultimately, the commission concluded, Ohio’s special statutory protection of the nursing home industry “gives nursing facilities an unfair advantage when it comes to being the first at the table for the distribution of long-term care resources. Nursing facility industry representatives have taken advantage of this special relationship to block or control the development of other alternatives” (OCRF, 2005, p. 15).

Ohio House Ignores Commission Recommendations

One could not ask for a better example of that special relationship than the Ohio House of Representatives eschewing the commission’s recommendations, as well as Gov. Taft’s pleas, for taking the state’s nursing home funding formula out of statute and tightening reimbursements. Instead, the House went in the opposite direction in the spring of 2005, proposing changes in the state’s fiscal years 2006-2007 budget that would actually increase Ohio reimbursements to Medicaid nursing homes, adding $826 million in funding to them by 2008 (Cleveland Plain Dealer, 2005). The Plain Dealer article noted that the nursing home industry, rated by Ohio Citizens Action and a number of
state officials as among the top three most influential political lobbying organizations in the state (and country), had donated more than $2 million to Ohio’s legislative candidates over the past four years, the largest specific portion of that going to Ohio House Speaker John Husted (R-Dayton).

_Senate Turnaround_

But the Ohio House’s legislative largesse toward nursing homes was quickly derailed in the Senate. Apparently, the senate’s stark realization that the state’s Medicaid costs (particularly regarding nursing homes) were becoming increasingly unsustainable, given the state’s overall fiscal crunch, helped moved budget discussions back along a more frugal track.

When Ohio’s 2006-2007 budget bill, H.B. 66, was finally passed in June 2005, Ohio’s nursing home funding formula remained, against the governor’s hope, in statute, but it contained a revised formula containing many of the commission’s - and some of the council’s - recommendations for controlling costs while attempting to improve efficiency and care.

The Ohio Dept. of Jobs and Family Services had much to do with the final crafting of the formula, which caused immediate controversy with what some insiders considered potential incentives for cutting corners on care of residents as well as cuts in capital reimbursements that some saw as unreasonable and unfair to those who had undertaken building and renovation projects under assumptions of higher reimbursement rates

_New Funding Formula_

Ohio’s new funding formula for reimbursement of Medicaid nursing homes essentially issued state rates for fiscal year 2006 at the same rates, adjusted for inflation, as those frozen between 2003 and 2005 (with an additional $1.95 added to the per-diem bed tax (now $6.25), which the state, in turn, reimburses most nursing homes for anyway).

The new funding formula becomes effective state fiscal year 2007, which runs from July 1, 2006 to June 30, 2007. To ensure a solid measure of financial continuity for
both the state and its nursing homes, the new formula has capped changes in funding to nursing homes at a variation rate of 2 percent: i.e., in 2007, nursing homes (assuming additional beds are not added or subtracted), regardless of actual costs, will be reimbursed at no more than 102 percent of their reimbursement for 2006; and the homes will be reimbursed at no less than 98 percent of their reimbursement rate for 2006. This continuity is assured during subsequent phase-in years with gradually increasing gain/loss caps in 2008 (5 percent), 2009 (7 percent), and 2010 (10 percent) before the revised formula goes to a full pricing system in 2011.

Major revisions in the revised funding formula, which ODJFS officials describe as more of a “fee-for-service” as opposed to the prior “cost-based” formula, center around the condensing of the four cost centers (Capital Costs, Direct Care Costs, Indirect Care Costs and Protected Costs) into three cost centers: Capital, Direct Care and a new category (basically a blend of the former Indirect Care and Protected with a few additions from Direct Care), Ancillary and Support Costs.

The new formula also condensed Ohio’s four previous geographic peer groups (rural, metropolitan, Cleveland metropolitan and Cincinnati metropolitan) into three groups, lumping Cleveland into the general metropolitan group. (Cincinnati is classified in a peer class of its own because, ODJFS officials say, it has traditionally had higher costs for services than in other areas of the state.)

While the new funding formula retained the weighted case mix (and slightly revised geographic peer group) concept, as well as much of the cost center framework, it applied critical revisions in funding of resident care that some academics and others taking in-depth looks at Ohio’s nursing home industry construe as possibly - though unintentionally and indirectly - offering incentives for nursing homes to cut back on the most important aspect of nursing home care: staffing and staff-related care of residents.

**Direct Care Reimbursement**

The first and foremost concern in this regard pertains to the new formula’s change in funding of direct care. The old formula reimbursed nursing home providers for direct care (mainly payroll for nurses, nurses aides, therapists, staff development and medical supplies) at a rate which put a ceiling on Medicaid payments at the 85th percentile of a
nursing facility’s case-mix peer group, providing incentives for nursing homes to keep costs in line, but still allowing for costs to go well beyond the median.

The new formula provides much stronger incentives for nursing homes to operate efficiently in the area of direct costs, apparently encouraging them to operate at costs below the median. The new formula sets a ceiling on cost per-case-mix peer groups at just 7 percent above the peer group rate paid to nursing homes operating at the 25th percentile - or bottom quarter - in terms of cost per-case-mix.

The new formula also uses the same 25th percentile basis for reimbursement of ancillary and support costs (formerly known as “indirect care” and “other protected costs,” e.g., social services, pharmacy consults, medical records, food, dietary supplies, laundry, human resources, communications, insurance, workers’ compensation, employee benefits, license fees, and “all reasonable costs incurred by a nursing facility that are not direct care or capital costs,” according to Ohio’s Legislative Services Commission). But, the ceiling in this area is placed at just 3 percent above the reimbursement of the 25th percentile in the applicable case-mix and geographic peer group. ODJFS officials observe that it is the ancillary and support services that nursing homes have the most discretion and leeway to cut down on expenses and increase overall revenues.

Quality Incentives

In attempts to ensure that Ohio’s Medicaid-reimbursed nursing homes have incentives to provide quality care and adhere to regulations, the new formula provides monetary inducements for nursing homes in the top three of four percentiles according to a set of accountability measures. Nursing homes finishing in the top 25th percentile of their respective peer groups receive the highest bonus payment; with those in the next 25th percentile receiving the second highest bonus; and those in the following 25th percentile receiving the third highest bonus. Nursing homes finishing in the bottom 25th percentile, or quarter, receive no bonus payment.

The bonus payment will be arrived at through a complex formula involving case-mix peer groups and resident days. The state’s Legislative Services Commission surmises that the mean bonus payment will be 2 percent above the standard payment based on case-mix and geographic peer groups.
There are a total of nine accountability measures, and nursing homes will receive one quality point for each measure met, with nine points being the maximum reached by any one nursing home. The accountability measures are:

1. Having no health deficiencies on the facility's most recent standard survey;
2. Having no health deficiencies with a scope and severity level greater than E, as determined under nursing facility certification standards for the Medicaid program, on the facility’s most recent standard survey;
3. Having resident satisfaction above the statewide average;
4. Having family satisfaction above the statewide average;
5. Having a number of hours of employing nurses that is above the statewide average;
6. Having an employee retention rate that is above the average for the facility’s direct care peer group;
7. Having an occupancy rate that is above the statewide average;
8. Having a Medicaid utilization rate that is above the statewide average;
9. Having a case-mix score for direct care that is above the statewide average.

**Capital Costs**

Ohio’s new funding formula also seeks to cut government expenditures in regard to reimbursement of nursing homes’ capital costs for building and renovations. The old capital cost formula reimbursed nursing homes more in regard to documented costs for building and renovations. The new formula puts a ceiling on reimbursements for capital expenses at the median rate of reimbursement of the facility’s capital peer group. In other words, a nursing home incurring $10 million in expenses for building a 50-bed facility in an area where others built a similar 50-bed facility for an average of $8 million, would still be reimbursed for only $8 million and have to swallow the $2 million extra that it spent in building expenses. Also, the new formula no longer includes reimbursement for interest and depreciation on extensive renovations, i.e., renovations over $500; nor will the new formula continue to reimburse providers for Certificates of Need (CONs), the
costs of acquiring the rights to nursing home beds, which, in some locations, can cost upwards of $25,000 each.

**AOPHA Unhappy with New Formula**

Although the new funding formula includes monetary incentives for quality care, academics and insiders believe that these incentives may be negated, if not overridden, by the monetary incentives to provide resident care more efficiently, which may leave nursing homes that provide more than average staff-to-resident ratios at a disadvantage.

That is apparently the case with the Association of Ohio Philanthropic Homes for the Aged (AOPHA), which represents close to 300 non-profit nursing homes and service providers for the elderly in Ohio. AOPHA continues to oppose the new funding formula most particularly in regard to the reimbursement of direct care with a ceiling of 107 percent of the costs of the lowest 25th percentile in that cost center’s peer group.

In efforts to stir opposition to the new funding formula, AOPHA President John Alfano wrote in an open letter to the association’s members: “Ohio should never, by inadequately funding nursing home care, turn back the clock to an era when our seniors and disabled citizens could not count on quality. ... AOPHA believes the pricing system as passed last year in House Bill 66, state budget legislation, does not ensure quality services for Ohio’s elderly and disabled. House Bill 66 also adversely affects not-for-profit nursing homes in that they have historically staffed and continue to staff at higher levels than their for-profit counterparts.”

In a carefully delineated critique of the new formula’s direct care funding plan, Alfano’s first three points were as follows:

1. *The current price for direct care services set at 107 percent of the peer groups’ 25th percentile does not provide adequate staffing levels currently provided in the ‘average’ nursing home.*

2. *Under a price for direct care, providers are encouraged to maximize profits without regard to staffing and benefit levels.*

3. *Setting a price for direct care services discourages providers to care for high acuity Medicaid patients.*
Among other aspects of the funding formula opposed by AOPHA was the change in capital reimbursements. Alfano’s three primary points in relation to the new capital formula were that:

1. Pricing all providers at the peer group median for capital is not an appropriate reimbursement methodology.

2. Median-based pricing ignores expenditures providers have made in the past to improve the working and living environments in their facilities and creates a disincentive for future improvements.

3. The pricing system for capital going forward should recognize differences in the age and condition of facilities throughout Ohio.

**OHCA Files Suit**

Although the Ohio Health Care Association stood behind most of the new funding formula, and did not make reference to alterations in direct care reimbursements, the organization filed suit against the state’s formula (OHCA, et. al. v. Barbara Riley, ODJFS Director, et. al.) on July 20, 2005, charging that the new formula for capital expenditures was unfair and unlawfully excluded OHCA member input.

In a press release attached to the lawsuit, OHCA President Pete Van Runkle (a lawyer who became familiar with the nursing home industry as a former assistant chief legal counsel for the Ohio Dept. of Health) declared: “The new price-based system does not take adequate account of capital expenditures that providers need to make so residents can have safe, pleasant living environments and to comply with ever-increasing building regulations. ... The way the pricing system deals with capital costs is not best for Ohio’s seniors and should be changed.”

In the lawsuit and in the press release, OHCA also challenged provisions of the new funding formula that would fail to reimburse some providers for higher rates in place when renovations and capital expenses were undertaken under the old formula. “These people made long-term financial commitments in good faith, based on a set of rules that
have been in place for many years. The rug has been pulled out from under them, and that needs to be fixed,” Van Runkle observed.

The Future

It remains to be seen whether Ohio’s new nursing home reimbursement funding formula will accomplish its primary goal - reining in long-term care Medicaid expenditures (now 40 percent of overall state Medicaid expenditures), while at the same time providing adequate care to nursing home residents.

Most who have even casually studied the nursing home industry - in Ohio and/or nationally - will not be inclined to hold their collective breath regarding cost control. A major narrative in the past 40 years of nursing home history has been that of government trying - and failing - to contain Medicaid expenditures.

In Ohio, per-diem costs for nursing home residents have gone up steadily since Medicaid was launched, from roughly $12 a day in 1966 (Hornbostel, 2005) to $155 a day in 2006, which amounts to an increase that outpaces general inflation. Moreover, despite Gov. Voinovich’s pointed efforts to stem the flow of Medicaid dollars to nursing homes in the early 1990s (and despite a declining number of nursing home residents in Ohio), the state’s per-diem, per-resident Medicaid costs for nursing homes more than doubled from approximately $75 to about $155 in 2006 (from roughly $27,000 to $57,000 per individual, annually).

Efforts to improve the quality of care in nursing homes have been slightly more fruitful, but not nearly as much as advocacy groups like NCCNHR and most individuals would like, especially given OBRA reforms and other measures taken over the past three decades in the quest for more conscientious, humane care for the 1.4 million Americans in nursing homes (AHCA). By most accounts, the quality of life in America’s nursing homes has not substantially improved over the years.

In its 2001 report, “Improving the Quality of Long-Term Care,” a follow-up to its 1986 report that spawned OBRA, the Institute of Medicine gives an approving nod to a general decline in the use of physical and chemical restraints in nursing homes, but concludes, ultimately, that “grave neglect and problems in care persist in some nursing homes and few - despite some examples to the contrary - have physical environments or
policies that promote the quality of life most people desire regardless of their functional limitations or settings in which they receive care” (IOM, 2001, p. 252). Moreover, the report stresses in its closing remarks, notoriously low quality nursing homes too often remain in operation. “Particularly worrisome,” the report states, “is the continued participation in Medicare and Medicaid of persistently poor-performing providers, especially those who have been repeatedly dropped from the program and reinstated (IOM, 2001, p. 251).

As government funds for nursing home reimbursement tighten, some - including the IOM - worry about quality of care of the residents. In its conclusion on nursing home reimbursement, the IOM report warns against cutting nursing home costs at the more intangible expense of resident care, urging that “states and the federal government should be cautious in their quest for Medicare and Medicaid savings. Because many of the recommendations proposed in this report will likely mean additional costs for providers (e.g., for additional staff), the withdrawal of substantial resources from long-term care providers is a matter of concern” (IOM, 2001, p.247).

Though research (as well as common sense) indicates that higher staffing ratios would improve care and quality of life in nursing homes, the nursing home industry continues to stave off serious reforms in this area, pointing to what it considers excessive costs in relation to government funding. After consumers and nursing home staff members complained to Ohio Department of Health officials about insufficient staff levels in 2001, state officials and other interested parties met with providers in 2001 to redraft state regulations on staffing levels. ODH, with support from NCCNHR and the U.S. Center for Medicare and Medicaid Services, recommended nurse/nurse’s aide staffing ratios that would provide a minimum 4.0 hours of daily direct care to residents. The nursing home industry, pleading such ratios were financially impractical, managed to get the standard down to 2.75 hours of daily direct care, according to a U.S. Dept. of Health and Human Services 2003 report: “State Experiences with Minimum Nursing Staff Ratios for Nursing Facilities: Findings from Case Studies of Eight States.”

Beyond perceived inadequacies of staffing regulations is the continuing problem of turnover among nurses and nurse’s aides in the nursing home industry. These are people performing very personal, often intimate, work with residents, and it's natural to
presume that continuity of such personnel is extremely important to residents receiving such care.

In a Cleveland Plain Dealer article, “High Turnover Rates Among Nurse Aides Threaten Quality Care,” reporter Diane Solov explored the negative aspects of nurse aide turnover, especially as related to the large number of nursing home residents with cognitive impairments. Solov quotes Dr. Mark Sager, director of the Alzheimer’s Institute at the University of Wisconsin-Madison medical School, who said: “One thing a demented person relies upon is structure; if the caregivers are constantly changing, the quality of care has got to be very low.” The article notes that temporary workers are often used to fill in for nursing home staff shortages, and that in 1998 one-third of Cuyahoga County nursing homes were cited by the state for excessive reliance on temporary workers. Observed one longtime nurse’s aide, “Agencies are there to fill in, but some of them just don’t have that caring part of taking care of a person. Some of them wash (the residents), dress them, put them in a chair and say, ‘next’” (Solov, 2000).

Continuity in nursing home personnel is alarmingly rare across the country. A 2002 AHCA “Survey of Nursing Staff Vacancy and Turnover in Nursing Homes reveals a 49 percent yearly turnover rate for both registered and licensed nurses and a 71 percent turnover rate for nurses’ aides. Ohio’s turnover rate for nurses was similar to national figures, but the turnover rate for nurses’ aides in Ohio nursing homes in that same report was 85 percent, notably above the 71 percent average.

In that same year, 2002, a U.S. Dept. of Health and Human Services survey found that “more than 90 percent of the nation’s nursing homes have too few workers to take proper care of patients” (Pear, 2002). Interestingly, the report concluded that achieving staff ratios conducive to better care - a recommended 4.1 hours of direct care, daily - would result in an 8 percent increase in overall nursing home funding, costing the government an additional $7.6 billion a year - an amount the report termed “not currently feasible.” The report recommended raising the average hourly wage of nurse’s aides from $8.60 an hour to nearly $1 or $2 more an hour, depending on regional economies.

The Bush administration issued a response, saying wages should ideally be straightened out by the forces of a free marketplace and that “we do not think there is sufficient information upon which to base a federal (hours of daily care) requirement for
all certified nursing homes.” Direct care requirements in nursing homes are left up to the states.

A revealing anecdotal account of what is bred by small wages and high turnover in nursing homes is found in Barbara Ehrenreich’s “Nickeled and Dimed - On Not Getting By in America” (2001). Ehrenreich, a social scientist, took a number of low-paying jobs to get a better idea of what it’s like trying to survive on near-minimum wages. She was quickly hired as a $7 an hour dietary aide in a Maine nursing home and after a few days on the job, due to a staff shortage, found herself in the position of feeding an entire Alzheimer’s ward by herself. Her observation: “What is this business of letting someone in off the street to run a nursing home, or at least a vital chunk of a nursing home, for a day?” (Ehrenreich, 2001, p. 105).

Perhaps the most direct answer to the new funding formula’s chances for success at containing costs while offering adequate care comes from Bernadine Healy, chair of the Ohio Commission to Reform Medicaid, who observed in a commission press release that: “Decades of reform have failed and attempts to reform will continue to fail until we change the system. If Ohio does not root out inefficiencies in the Medicaid program and institute marketplace competition based on quality, access and price, then the needed transformation will not occur.” Suffice it to say that Ohio’s new funding formula does not change the system; it simply tinkers with it, as decades of reformers have done beforehand.

Still, many social researchers and nursing home observers forecast an impending paradigm shift ushered in by aging baby boomers and their offspring who will demand more home and community based services as well as more consumer-oriented, humanely operated nursing homes. Ohio’s PASSPORT program, now serving about 26,000 Medicaid-eligible older persons, has surely diverted a portion of that number from nursing homes. And the state’s newly created Assisted Living program for 1,800 Medicaid waiver older persons will likely help do the same.

These community-based and home-service programs continue to downsize the state’s nursing home population even as the state’s older population increases. Occupancy rates for Ohio’s 94,231 nursing home beds have gone down steadily from 92% in 1992 to approximately 83% today (Mehdizadeh and Applebaum, 2003).
This is an indication that more and more people are seeking alternatives to nursing homes and that the nursing home industry may well be entering a long awaited period in which its services and treatment of residents will be regulated by caring family members and traditional market forces, not the relative indifference of the government. As Mendelson sharply stated more than 30 years ago, “You do not need to be a professional to know the difference between kindness and cruelty, cleanliness and filth, food and slop. ... We must look instead to the relatives of nursing home patients for any lasting improvement” (Mendelson, 1975, xv).

Slowly and incrementally, with changing demographics, expanding social consciousness and an increasing awareness of, and disillusion with, the collusion of special interests and government, we appear to be headed in that direction. Perhaps we will get there in time so that our children’s generation will not fear nursing homes, as those before them did - as we still do now - more than death.
Summary & Conclusions

The introductory question posed by this critical inquiry - “How did we end up here?” - tempts a stream of reflexive, one-word answers: greed, indifference, capitalism, corruption and callousness, to name a few. If only the conclusions were that short and that simple.

We wound up here, in our Ohio nursing homes today, for complex reasons that do not lend themselves to brevity; for reasons related to a subtle, long-steeped blend of societal norms, values and priorities with the forces of capitalism, government and history. We wound up here, in our state’s nursing homes, for reasons that are most immediately summed up as follows:

1. government has a tradition of providing institutional assistance designed to discourage those who may need to avail themselves of it.
2. society, as a whole, still marginally accepts that tradition.
3. a segment of society finds nursing homes profitable enough to wish to sustain them in something close to their current form;
4. that certain segment of society has unified its aims and takes in enough profit to rechannel a significant portion of that capital to government representatives in positions to pass laws favorable to their enterprise;
5. nursing home residents, their family, friends and advocacy groups, such as the National Citizen’s Coalition for Nursing Home Reform, have not yet united and/or gained enough power (i.e., money and public relations machinery) to influence government to the extent that the nursing home industry does.
6. government representatives, by and large, have not found it politically advantageous - or morally compelling - enough to pass and enforce laws implementing more meaningful reform.

An intricate blend of the above has produced nearly a century’s worth of legislation and regulations - and the lack of them - apparently designed to ease our
conscience as a society while easing our wallets as taxpayers. The result, it seems, has pleased nobody, with the possible exception of the nursing home industry, for-profit and non-profit alike, which has a history of hiding its pleasure to allay suspicions that its members might have things a little too good.

But, when casting about for broader, deeper causes, can one really blame a business person for trying to increase profits, especially if the means are legal? And, can one fault a politician for trying to win votes? Would we not sooner get to the real point by contemplating society as a whole? By taking our democracy to task for failing to demand something better? By looking deeper into ourselves? As Mendelson stressed in the closing sentences of Tender Loving Greed, despite her scathing attack on the nursing home industry and government, “there is no one to answer - except us.”

This critical inquiry began long ago, partially in musing on Senator Bobby Kennedy’s visionary declaration (by way of George Bernard Shaw): "Some men see things as they are and ask 'why?' I dream things that never were and ask, 'why not?'"

Why not a society that honors its elders, honors life itself, to the point that we strive to ensure that the final days of those that go before us (and, eventually, ourselves) are made as pleasant, dignified and endurable as humanly possible. Why not public nursing homes that provide private rooms, daily massages and enough personal attention to ensure that a great deal of lunch doesn’t end up in our laps? Why don’t we exalt the positions of those who provide some of the more saintly aspects of personal care to our elders and pay them accordingly? Or at least enough to keep their cars running.

Certainly, profit and politics do provide some cheap answers, but a cursory glance at history tells us that those two driving forces represent only the tip of the iceberg, the visible, oily machinery of a much less tangible, but infinitely more powerful, commodity - culture. It was not so much power, politics and profit that spawned much in our past that seems horribly unjust, antiquated and unacceptable in retrospect - e.g., slavery; women not having the right to vote; and the hanging of children for picking pockets - as the cultural norms that not only tolerated those practices but sometimes promoted them. Think of those who were willing to kill and die to preserve the right to enslave others; men who laughed at the idea of women’s equality; and the spectators that once gathered for amusement at public executions.
Our laws are much more an extension of culture, of shifting values, priorities and societal mores, than our culture is an extension of law. This is a view succinctly summed up by 18th-century philosopher Thomas Paine in *Common Sense* (cited earlier in this inquiry) that: “Time makes more converts than reason.” In other words, the law (and the collective sense of fairness it is derived from), in all of its supposedly infinite wisdom, tends to drag its feet behind the evolving values of society. As follows, we cannot count on our politicians, our government, to lead us. It will likely be the other way around.

Paine’s perspective on time and reason is as good and broad a viewpoint as any from which to observe and explain America’s nursing homes. They are products of their times. Times that, in the vast scheme of human history, have been relatively short. The 700 years or so covered in this paper represent but a few days on history’s calendar; which is why such a great deal of our past is found in the present regarding our nursing homes today: now has not yet disentangled itself from then, and the law, as often is the case, is lagging behind the values of the people it is supposed to serve.

In “Five Hundred Years of English Poor Laws,” cited extensively in the early part of this work, author William Quigley quotes an unnamed observer speaking about English almshouses nearly 300 years ago: “And the houses were the scene of great cruelty by the contractors to whom they were farmed out and who underpaid those who worked for them” (Quigley, 1996). Though obviously unintended, the application to today’s nursing homes remains all too clear. The cruelty may not be as overt or as intentional as in the past, but the fate of a great many Americans who spend their final days in nursing homes now still conjures up the word “cruel.” And an industry with annual turnover rates average over 70 percent might consider significantly upping its wages.

In a broad sense, the history of our nursing homes - how we ended up here - is foremost a centuries-old saga of repetition, compromise and incremental improvement that has never been enough: a segment of society grows gradually ashamed and sickened by what its government has wrought, followed by government tinkering, followed by more scandal and more social outcry, followed by more minor adjustments and more money to providers and more public criticism and more slight alterations and more money to providers and still more criticism.
It’s a history of discouraging the poor from seeking assistance by making the assistance minimal, punitive and shameful; of 18th century English politics and poorhouse cruelties being passed on to 19th century American almshouses (“Designed and overseen, often by those benefiting from political patronage with little care for the comfort, dignity or health of their occupants,” Vladeck, 1980. p. 33); in turn, passed on to early 20th-century almshouses described as including “the composite horrors of poverty, disgrace, loneliness, humiliation, abandonment, and degradation” (Evans 1926); of supposedly “improved” 1940s nursing homes that were frequently “dilapidated and frequently unsafe” places with minimal medical and nursing services (Vladeck, 1980, p. 38); of 1950s and ‘60s nursing homes that were under-regulated fire hazards housing often abused and financially exploited residents (“shameful places where we warehouse those who are old and sick” (Mendelson, 74, XV); of the “profoundly disturbing” conditions found in Ohio nursing homes in the 1970s (Ohio Nursing Home Commission, 1979); of the “seriously inadequate quality of care and quality of life” in nursing homes in all 50 states called to national attention by the report of the U.S. Institute of Medicine in 1986 (p.21); and of the subsequent 2001 IOM report that documented “grave neglect” and persistent problems wherein “few (nursing homes) have physical environments or policies that promote the quality of life most people desire regardless of their functional limitations or settings in which they receive care.”

It’s a history of government holding tighter relations with the powerful than the people at large; an ongoing legacy of laws being written for (and sometimes by) the lords, as was the case with the Statute of Laborers in the 1300s and the Poor Laws of 1601; of the American Medical Association and the insurance establishment prompting government to compromise its national health care plan out of the Social Security Act in 1935; of the AMA, the American Hospital Association and the nursing home industry getting Congress to funnel Medicare and Medicaid money to its members in a loosely regulated way, allowing them to call many of their own shots and virtually name their own prices; of government programs that “became a guarantee of excess profits (to the nursing home industry) with no benefit to the patient”; of a great society policy that, in Mendelson’s words, said: ‘Let us give you the money, and we won’t look too closely at how it’s spent’ (Mendelson, 1975, p. 37); of nursing home lobbyist Harold G. Smith
writing and diluting the regulations to the Moss-Kennedy amendments in the late 1960s; of states’ reluctance to enforce laws protecting nursing home residents throughout the 1970s; of nursing home lobbyists stacked into Ohio’s nursing home funding committee in the early ‘90s; of nursing home lobbyists writing Congressional committee reports that came close to undoing OBRA in 1996 (Hawes, 1996-97); of the Ohio nursing home industry’s chief lobbyist writing the report of the Nursing Facility Reimbursement Council for the state representative that chaired it; of slightly improving conditions while significantly increasing payments to providers; of delaying the provision of services where people most want them - in their own homes - despite 40 years of repeated calls for non-institutional care settings.

In an even bigger sweep of things, the history of our nursing homes is a history of incremental civilization - a history of a very gradually growing tide of decency in caring for those no longer able to care for themselves beating against society’s slowly shifting shores. It is the usual history of humans, circling forward through time, waiting for reason - and its most forceful byproduct, government - to catch up.
Appendix

Timeline
for the Evolution of Public Aid to the Infirm & Destitute Elderly
and the Development of American
and Ohio Nursing Homes

1349: English Statute of Laborers forbidding begging by able-bodied persons is enacted. Notably, the statute also prohibits giving to able-bodied beggars.

1531: Acts of Parliament set up system of poor relief for the blind, elderly and others precluded from labor that required government documents as a qualification for receiving alms.

1601: Elizabethan Poor Law enacted to authorize parishes to collect taxes to aid the infirm and destitute. Filial requirements of the law mandate that parish (public) responsibility for the infirm and destitute begins only when family members of the infirm and destitute are not able to provide for them.

1662: Act of Settlement restricts begging by infirm and destitute to parish of origin as large numbers of poor leave farmlands and flock to London and other large urban areas.

1722: Poor Act of 1722 authorizes the use of taxes for the building of almshouses and workhouses, and mandates that the frail and destitute must live (and, if able, work) in the almshouses as a prerequisite for receiving government assistance.

Late 1700s: Almshouses (aka poorhouses) are increasingly erected in American colonies as places to indiscriminately house frail, disabled and destitute persons of all ages and backgrounds (e.g., blind, mentally retarded, insane, elderly).
**Early 1800s:** Private nursing homes, often known as “widows homes” for the care of mostly upper class widows, spinsters and widowers begin cropping up in the United States. Most have ethnic and/or religious affiliations and many are segregated according to race, religion and ethnicity.

**1817:** One of the country’s earliest private nursing homes was the “Indigent Widows and Single Women’s Society,” was founded in Philadelphia.

**1920:** About 50,000 mostly older Americans reside in almshouses; roughly the same number as those in private nursing homes.

**1923:** Creation of special facilities for the blind, orphans and other special populations in the past half century leaves older Americans as the dominant population in almshouses. In 1880, older persons made up about one-third of almshouse residents. By 1923, two out of three almshouse residents were older persons.

**1925:** U.S. Dept. of Labor conducts national study of almshouses and reports that “dilapidation, inadequacy, and even indecency are the outstanding physical features of many of our small almshouses.” Most are criticized as undesirable and unhealthy places.

**1935:** Widespread desire to rid nation of almshouses leads to a special provision in the Social Security Act prohibiting old age pensions and other government assistance to be used s payments for almshouses or other public homes. Government institutes old age assistance so older persons in need of assistance would be able to select their own private board and care facilities.

**1937:** “Association of Ohio Philanthropic Homes for the Aging” is initiated in to represent growing number of non-profit nursing homes in Ohio.
**Late 1930s/Early 1940s:** With issuance of old age assistance and first social security checks in 1940, almshouses (though some reconstitute themselves as private homes), begin gradually disappearing across the country as small board and care homes increasingly accommodate older persons in need of some assistance. The rise of the for-profit nursing home begins, with very little in the way of regulations, licensing requirements and forethought related to the health care of the older citizens that it oversaw.

**1940s:** As products of reaction rather than initiative, many private, for-profit nursing homes offer minimal health services leading to widespread dissatisfaction. Services offered described as “vague and variable.” Shortage of nursing homes keeps government from requiring more in the way of licensure and regulations.

**1941:** Ohio’s Dept. of Public Welfare placed in charge of Ohio’s nursing home regulations.

**Mid-1940s:** Increasing hospital shortage and hospital emphasis on providing acute care results in placement of more older, chronic patients into residential and nursing facilities.

**1946:** Nationwide hospital shortage results in passage of Hill-Burton Act (aka Public Law 79-725, the Hospital Survey and Construction Act), which resulted in government funding for the construction of some 6,000 hospitals (350,000 beds) in the United States over the next 30 years. Amendments to Hill-Burton would pave the way for nursing home construction.

**1949:** What is now the American Association of Nursing Homes, a national lobbying group representing for-profit nursing homes, is formed.

**1950:** The 1950 U.S. Bureau of the Census shows America’s age 65-plus population had grown from 3 million in 1900 to 12 million in 1950, and had increased from 4 to 8
percent of the total population. Thirty-five percent of older Americans live in poverty, with two-thirds of those 65-plus having yearly incomes of less than $1,000; and only one of eight having health insurance.

1950: Social Security amendments reverse the original act and lift the government ban on social security payments to older persons residing in public institutions due to the government’s waning confidence in private nursing homes (usually small board-and-care facilities) to adequately care for their elderly residents, combined with the need for more facilities. The amendments also allowed for social security funds to be used as federal matching payments (linked to those of state and local agencies) made, in some cases, directly to providers of health-care services (i.e., nursing facilities) rather than sending checks to the beneficiaries themselves. This had the effect of eliminating the middleman and paved the way for the direct government-to-provider system we have today via Medicaid. It also gave the newly evolving nursing home lobby, the American Nursing Home Association, a consolidated target (i.e., government) to take aim at in negotiating rates and regulations for those it represents. On a more positive note, the amendments marked the first federal attempt to impose licensure standards on the states. Additionally the 1950 amendments were crucial to the expansion and development of the American nursing home industry: in 1950 only 35 percent of older Americans not living in their own or family members’ homes lived in nursing facilities. By 1960 that figure would jump to 50 percent, and in 1970 to 72 percent (Johnson, 1985).

1954: Hill-Burton Amendments provide $10 million, annually in federal construction grants to public and private non-profit nursing homes and long-term care facilities, stipulating that such newly constructed homes and facilities be affiliated (and operated in conjunction) with a hospital. The amendments further specified that these facilities adhere to licensing standards, staffing requirements, health planning and other medically oriented regulations as a condition of receiving Hill-Burton grants. As a result, nursing homes became more medically oriented than merely custodial and took on the appearance of hospitals that is still widely observable today.
1954: Hill-Burton amendments also require the U.S. Public Health Service to conduct the nation’s first comprehensive survey of the country’s nursing homes. The survey identified 9,000 nursing homes providing 260,000 beds.

1956: Congress authorizes the Small Business Administration to make participatory loans to for-profit nursing homes.

1959: Congress directs the Federal Housing Administration to offer loan guarantees to for-profit nursing homes for amounts up to 90 percent of their construction expenses.

1959: Oversight of Ohio’s nursing homes is transferred from the Ohio Dept. of Public Welfare to the Ohio Dept. of Health.

1960: U.S. nursing home population doubles from about 200,000 to 400,000, while U.S. nursing home expenditures more than double - from $187 million in 1950 (of which government paid only (10%) to over $500 million in total nursing home costs in 1960 (of which government now paid 22 percent. OAA payments to health-care providers surged from $36 million in 1950 to $280 million by the end of the decade (www.elderweb.com/history).

1960: Kerr-Mills Act, a forerunner to Medicaid also known as Medical Assistance for the Aged, is passed. The act calls for federal matching funds to states offering financial assistance to older persons who either did not qualify for Old Age Assistance or did not receive enough from that fund to cover medical expenses. The act extends leeway to states in determining benefits in two key areas that would carry over and become part of Medicaid law: it let states define medical indigency apart from the federal government’s OAA standards; and it set no maximum amount for federal matching funds, meaning the states could spend as much, or as little, as each desired.

1961: The “American Association of Homes for the Aging,” an advocacy group representing non-profit nursing homes and service providers nationwide, is launched.
This group will become the “American Association of Homes and Services for the Aging” in 1994.

1963: November 23 fire kills 63 residents of the Golden Age Nursing Home in Fitchville, Ohio.

1965: Government payments for indigents in nursing homes increase almost 10 times over between 1960 to 1965; from about $50 million to roughly $450 million in that timeframe. By 1965, about half of all U.S. nursing home residents (300,000 of the 600,000 total) were covered by Kerr-Mills (MAA) payments.

1965: Medicaid and Medicare are passed, pumping millions of government money into nursing homes with little in the way of strong, uniform regulation. The concept of “substantial compliance” allows many nursing homes not in compliance with regulations to nonetheless receive government money for care of nursing home residents. In the words of Mary Mendelson: “In effect, the sponsors of Medicare and Medicaid said to the industry: ‘Let us give you the money, and we won’t look too closely at how it’s spent.’ That fatal compromise is the root cause of the nursing home industry’s ability to extract excess profits from the government.”

1965: Ohio Legislative Service Commission’s Staff Research Report No. 68, simply titled “Nursing Home Regulation,” is published subsequent to the Fitchville fire. The 44-page pamphlet was devoted mainly to building standards, fire safety codes and regulatory procedures and allowed just over 2 pages for proposed regulations on resident care. According to the report, proposed regulations are diluted and held up in court by the Ohio Federation of Licensed Nursing Homes.

1967: Moss Amendments passed, but by the time they are finally enacted three years later, the amendments were written in such a watered down fashion (by the Dept. of Health Education and Welfare) as to have dispensed altogether of tighter nurse-to-
patient ratios and were, according to Bruce Vladeck, “weaker than those required by Medicaid before the passage of the Moss amendments.”

1969: National Center for Health Statistics and Bureau of the Census data state the number of people in U.S. nursing homes had nearly doubled from 500,000 in 1963 to 973,000 in 1969.

1969: Intermediate Letter 371, calling for a reinterpretation of Medicare/nursing home policy, is issued to Medicare claims examiners as Medicare nursing home costs were rising as much as 10 times that predicted by government analysts. The result was a tightening of eligibility requirements for Medicare reimbursement to nursing homes and a tripling of the percentage of Medicare nursing home claims denied.

1971: Intermediate care facilities, funded at a lower rate than skilled nursing home facilities, became part of Medicaid under Title XIX. Federal standards for the operation of these facilities were issued in the same year. A major consequence was that in many states, nursing home residents were almost immediately reclassified from needing skilled nursing to needing only intermediate care, saving owners of the nursing homes the trouble of trying to pass muster as skilled nursing facilities and indicating that, as one might guess, there was often little, if any, real difference in the care provided in skilled and intermediate facilities.

1972: Average government payments to nursing homes were $14 per-resident for Medicaid and $32 per-resident for Medicare. Social Security amendments permanently tie SSI payments to inflation rate and attempt to strengthen nursing home regulations.

1974: Deinstitutionalization regarding nation’s mental health and criminal treatment adds to U.S. nursing home population. According to the Senate Subcommittee on Long-term Care, the number of persons age 65 and older in America’s state mental hospitals dropped by 44 percent between 1969 and 1974, from about 428,000 to 237,000. (In Ohio, the comparable figure was 16,934 to 9,793.) Additionally, between those same years,
state prisons released some 75,000 persons age 65 and older, cutting the number of older prisoners more than in half, from around 135,000 to 60,000. Countless thousands from both the mental institutions and the prisons went directly into nursing homes.

1975: Publication of Mary Mendelson’s scathing indictment of the nursing home industry, “Tender Loving Greed, lead to government investigations. Disclosures to Utah Senator Frank Moss’s Subcommittee on Long-term Care in 1975 (gathered in a 1975 report titled: “Nursing Home Care in the United States: Failure in Public Policy”) revealed that 21 out of 50 states had never so much as audited a single nursing home since Medicaid first began funding the facilities in 1966. Ohio, despite being the sixth most populous state and having earned an infamously prominent place in Mendelson’s catalog of scandal, had conducted only four nursing home audits as of 1975.

1976: The number of nursing homes in America grew from 9,582 homes with 331,000 beds in 1960 to 23,000 homes with 1.3 million beds by 1976. It is interesting to note that while the number of older persons in nursing homes quadrupled, the costs of caring for them increased more than 20 times over, from $500 million in 1960 to $10.5 billion in 1976, with more than half of it paid for by the government.

1977: The state convenes the Ohio Nursing Home Commission to study the Ohio’s long-term care system and facilities and make recommendations for improvement. It was the most significant and comprehensive attempt at the time to examine Ohio’s nursing homes in regard to regulations, funding and patient care.

1978: Ohio long-term care ombudsmen program becomes fully operational.

1979: In its final report, the Ohio Nursing Home Commission observes that “the central problem of Ohio’s nursing home program is the failure of its regulatory process.” The commission proposes a new cost-based funding formula and warns of a two-tiered system of private-pay and Medicaid-reimbursed nursing homes in the state. The commission also draws attention to the need for home services in Ohio for the elderly, noting that
Ohio spent some $20 million a month in Medicaid nursing home reimbursement, but only $22,000 a month in Medicaid funds for home health services.

1979: As proposed by the Ohio Nursing Home Commission, an Ohio Nursing Home Bill of Rights, specifying 30 such rights (Am. Sub. H.B. 600) was enacted in 1979. This bill would become a model for many states across the nation.

1980: As proposed by the Ohio Nursing Home Commission, Ohio turned to a “retrospective case-mix” system of nursing home reimbursement based on “reasonable and adequate” costs as determined largely by the nursing homes themselves.

1981: The Boren Amendment - Section 1902(a)(13) of the Social Security Act - is passed, giving states wider latitude in their reimbursement formulas for nursing homes, but at the same time stipulating that Medicaid reimbursement rates had to be “reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable state and federal laws, regulations, and quality and safety standards.” A broad result was that many states were tied up for years by lawsuits from nursing home providers citing the Boren amendments language regarding “reasonable and adequate” funding for quality care. This amendment was repealed as part of the federal Balanced Budget Act of 1997, giving states more discretion in reimbursing Medicaid nursing home providers so long as funding “methodologies underlying the rates, and justifications, are published subject to public review and comment prior to becoming final.”

1986: The Institute of Medicine releases its report, “Improving the Quality of Care in Nursing Homes.” The report’s finding of “seriously inadequate quality of care and quality of life” in nursing homes in all 50 states, despite 10 years of extensive government regulations (stemming from Moss’s Subcommittee on Aging and the buses documented in “Tender, Loving Greed,”), led directly to the passage of the U. S. Nursing Home Reform Act, part of the federal Omnibus Reconciliation Act (OBRA) of 1987.
1987: OBRA is passed, mandating that all U.S. nursing homes provide residents with care that would help them maintain or improve upon their physical, mental, and social well-being, stating that: “a skilled nursing facility must provide for provision of nursing services and specialized rehabilitative services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.” This new law provided the first federal nursing home resident bill of rights, called for interviews with residents and their families as part of nursing home inspections, and was especially effective in reducing nursing homes’ use of physical and chemical restraints.

1989: Ohio passes “ombudsmen enabling” legislation in the form of HB 359 (effective June, 12, 1990), which creates uniform standards for state ombudsman practice; gives ombudsmen greater access to nursing home and resident records; and provides additional funding for its regional ombudsmen programs through a line-item in the state budget as well as a nursing-home bed fee.

1990: As with the rest of the country, Ohio’s nursing home costs soared throughout the 1970s and 1980s, from approximately $5,000 per-resident (per-year) in 1970, to $23,000 per-resident in 1985, to almost $30,000 per-resident in 1990.

1991: With nursing home costs constituting over 40 percent of the state’s overall Medicaid expenses, Gov. George Voinovich called for a freeze on Medicaid nursing home reimbursement in 1991 while authorizing a committee report on how to more economically fund the state’s roughly 1,000 nursing homes, approximately two-thirds of whose 92,000 beds were covered by Medicaid.

1993: Gov. Voinovich calls for a moratorium on the issuance of certificates of need (CONs) for the licensing of new nursing home beds (that remains in effect today), and enacts a new nursing home funding formula termed “prospective, facility-specific.” As did about half of the other states, Ohio used case mix data for reimbursement and featured a system based on Resource Utilization Groups and four major cost centers, or categories: direct care; indirect care, capital costs; and other protected costs.
1999: Olmstead Act is passed, stating that persons with mental disabilities (as well as other disabilities), including older Americans, were entitled to be cared for "in the most integrated setting appropriate to the needs of qualified individuals with disabilities," in accordance with Title II of the Americans With Disabilities Act.

2003: Gov. Taft points to soaring Medicaid costs for the state’s nursing homes, despite declining occupancy rates, and calls for a freeze on reimbursement rates. The governor convenes the Nursing Facility Reimbursement Study Council and the Ohio Commission to Reform Medicaid to address the problem.

2005: OCRM finds that despite reductions of Ohio’s nursing home population by 4,600 over the past nine years, Medicaid spending on nursing homes had still increased by 90 percent.

2005: Ohio enacts new nursing home funding formula designed to keep Medicaid costs at no more than 40 percent of overall state budget. The new formula cuts reimbursements for capital costs and renovations, condenses the four cost centers into three cost centers and provides incentives for efficiency and quality. The Ohio Health Care Association files suit over the new funding formula, claiming it was not allowed adequate input on capital reimbursements and that the new formula was not fair to those who had begun construction under the presumption that costs would be reimbursed under the old formula.

2006: The Ohio Association of Philanthropic Homes for the Aging issues policy papers stressing that the new funding formula, despite some bonus incentives for quality outcomes, will hurt non-profit homes as it may reward nursing homes for cutting corners on staffing and conscientious care.
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