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RESTRICTION CODES

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F.01/03

Outline for OMB Briefing
July 14, 2000, 11:00 a.m.

SUBJECT: Prospective Payment System and Consolidated Billing for
Skilled Nursing Facilities (HCFA-1112-F) (RIN:0938-
AJ593)

PROGRAM DESCRIPTION

The Medicare skilled nursing facility (SNF) prospective payment system (PPS) was implemented for cost reporting periods beginning on or after July 1, 1998. Under the PPS, SNFs are paid a prospective, case-mix adjusted per diem rate applicable to all covered SNF services. These payment rates cover all costs of furnishing covered SNF services (that is, routine, ancillary, and capital-related costs) other than costs associated with operating approved educational activities. Covered SNF services include posthospital SNF services for which benefits are provided under Part A as well as all items and services which, before July 1, 1998, had been paid under Part B (other than physician and certain other services that are specifically excluded) but furnished to SNF residents during a Part A covered stay.

PROVISIONS OF THE FINAL REGULATIONS

This final rule sets forth updates to the payment rates used under the SNF PPS, for fiscal year (FY) 2001. Furthermore, it specifically responds to comments submitted by the public on our April 10, 2000 notice of proposed rulemaking, in connection with implementing provisions of the SNF PPS as amended by the Medicare, Medicaid and State Child Health Insurance Program (SCHIP) Balanced Budget Refinement Act of 1999 (BBRA). Annual updates to the PPS rates are required by statute. The Notice of Proposed Rulemaking (NPRM) had also proposed RUG-III refinements (based on pre-PPS data from the seven demonstration states from which the original RUG-III weights were developed) to account for non-therapy ancillary costs more accurately in the SNF PPS. However, when we completed a validation analysis using a national post-PPS implementation database from 1999, we determined that the new data do not support the proposed structure. The predictive power of the refinement models dropped to approximately 3 percent (R²) using the 1999 data. Thus, as discussed in more detail below, we are

not proceeding with the implementation of the case-mix refinements discussed in the proposed rule.

This final rule also sets forth certain conforming changes to the regulations that are necessary in order to implement amendments made to the Act by section 103 of the BBRA, with respect to additional exclusions from consolidated billing.

As stated in the proposed rule, we were committed to validating the research results before proceeding to final rulemaking on a refinement that would require such a large expansion of the RUG-III classification system and have a significant impact on the delivery of SNF care. Since our latest validation analyses do not confirm the effectiveness of index models in the current (PPS) environment, we are not proceeding with implementation of the RUG refinements discussed in the proposed rule. Therefore, for FY 2001, we will be maintaining the existing 44 group RUG-III configuration. Consequently, we will also maintain the 20 percent add-on to the Federal rates for the 15 selected RUG-III groups in accordance with section 101 of the BBRA.

The fact that we were unable to validate the specific non-therapy ancillary index models described in the proposed rule does not preclude us from further efforts to improve the payment system's ability to allocate payments based on expected ancillary use. However, additional research will be needed to identify variables that will be effective predictors in the PPS environment.

BUDGET IMPLICATIONS

The aggregate increase in payments for FY 2001 associated with this update (including the changes made by the BBRA) is estimated to be ~~\$2.9~~ ^{3.1} billion, an increase of ~~13.8~~ ^{21.8%} percent. Since we are not implementing case-mix refinements in this final rule, the 20 percent increase for certain specified RUG-III groups, specified in section 101 of the BBRA will remain in effect during FY 2001 which accounts for ~~1.5~~ ^{1.5} billion of the increase noted above. Section 101 also includes an across-the-board increase in the adjusted Federal per diem payment rates by 4 percent each year for FYs 2001 and 2002, exclusive of the 20 percent increase.

FEDERALISM

We have reviewed this rule under the threshold criteria of Executive Order 13132. We have determined that it does not significantly affect States' rights, roles, and responsibilities.

EXPECTATIONS

We expect that reaction to this final rule will be mostly favorable. The overwhelming majority of SNFs and Trade Associations supported a delay in implementation. The changes in this final rule are positive for providers and beneficiaries because payments will increase by 12.8 percent. Furthermore, we received numerous comments that had expressed serious reservations about the potential refinements that we had proposed. Based on the comments we received, we expect that the nursing home industry will support this final rule. However, as noted above, the failure to propose case-mix refinements will leave the 20 percent add-on in place and cost ~~\$1 billion~~ 1.5 billion annually. It will also leave in place a perverse incentive created by the BBRA, whereby payments associated with certain less resource-intensive cases are higher than those for more resource-intensive ones. Further, this final rule may complicate the White House give-back strategy, which assumed case-mix refinements would be implemented.

URGENCY

This final rule provides the updates required in section 4432 of the BBA related to Medicare payments for SNF services, as modified by the BBRA. These updates are effective for cost reporting periods beginning on October 1, 2000. Timely publication of this final rule is imperative to meet the requirements of the statute.

Summary

The nation's health care system is in a transition of potentially historic proportions driven by the need for cost-effectiveness under pressures of cost containment and competition, but also made possible by scientific and technological breakthroughs. These forces have led to major changes in the structure, organization, financing, and delivery of health care since the early 1980s.

Managed care organizations have developed rapidly, changing the nature of private health insurance and increasing price competition. These evolving care delivery and payment systems have in turn affected the structure of the health care system by limiting service and directing when and where patients receive care.

Historically the hospital has been at the core of the U.S. health care system, and nursing services are central to the provision of hospital care. However, the changes in payment systems, combined with scientific and technological advances, have permitted shifts from the traditional inpatient care settings to ambulatory, community, home, and nursing home care.¹ Inpatient use of hospitals, length of hospital stay, inpatient days, and the number of beds staffed have all declined. As a consequence, hospitals are changing in ways not considered possible a few years ago. To maintain economic viability, they are rapidly restructuring, merging, and consolidating. They are also redesigning and reconfiguring staffing patterns and, increasingly, moving toward interdisciplinary

¹Throughout the report, the terms "nursing home" and "nursing facility" are used interchangeably.

nary teams of care givers including registered nurses (RN), licensed practical nurses (LPN),² and nurse assistants (NA) and other ancillary nursing personnel.³ They are also downsizing staff to accommodate the reduced volume of inpatient care and to remain economically viable.

The lines between the hospital and the nursing home are beginning to blur. New developments in hospital organization combined with economic and other forces are changing the characteristics of the persons entering nursing homes and are creating new demands for beds and for provision of nursing care in these facilities.

The aging and increasing diversity of the U.S. population and the projected growth of the oldest-old age group will have a major effect on the demand and supply of health services and on the level and type of resources needed to provide those services. These trends are likely to increase inpatient hospital admissions as well as admissions to nursing homes. When combined with the rising severity of illness of patients in both hospitals and nursing homes, these patterns can be expected to exacerbate the long-standing problems in these institutions involving staffing issues, including the paucity of appropriately educated and trained professional nursing personnel.

The implications of these changes in the health care environment for the nursing workforce are profound in terms of numbers, adequate distribution of skills, and educational preparation. Nursing personnel are an integral component of the health care delivery system; therefore, they are affected directly by these changes. It is not surprising that concerns about the fate of patients and health care givers have grown as reported in the media. Within the nursing profession and its supporting organizations there is a high level of uncertainty and concern about what is happening to nursing staff in terms of their physical, psychological, and economic well-being. Individual care givers, professional and trade associations involved in nursing, and unions have expressed concerns that these changes

²In two states, California and Texas, these nurses are called licensed vocational nurses. In all other jurisdictions they are known as licensed practical nurses. In this report, licensed practical and vocational nurses are referred to as licensed practical nurses.

³Ancillary nursing personnel, nursing support personnel, assistive personnel, nurse extenders, unlicensed nursing personnel, multicompetent workers, nurse assistants, or aides are all generic terms used to refer to the various clinical and nonclinical jobs that augment nursing care. This group of employees includes an array of support nursing personnel including certified nurse assistants, orderlies, operating room technicians, home health aides, and others. They assist the licensed nurse by performing routine duties in caring for patients under the supervision of an RN or an LPN. Although Congress defined "nurse" for the purposes of this study to include RN, LPN, and NA, it has not been possible at all times to disaggregate information on NAs from the remaining support personnel because national statistics are often collected and/or tabulated for the group as a whole. For example, the American Hospital Association does not separate information on nurse assistants from that on other "ancillary nursing personnel." Throughout this report, the term ancillary nursing personnel will be used for this group of staff when nurse assistants cannot be disaggregated.

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are endangering the quality of patient care and causing nursing personnel to suffer increased rates of injury, illness, and stress.

In response to these expressed concerns, Congress directed the Secretary of the Department of Health and Human Services (DHHS) to ask the Institute of Medicine (IOM) to undertake a study to determine whether and to what extent there is need for an increase in the number of nurses in hospitals and nursing homes in order to promote the quality of patient care and reduce the incidence among nurses of work-related injuries and stress. For the purposes of this study, Congress defined "nurse" to include RNs, LPNs, and NAs.

To carry out this legislative mandate, in March 1994 the Division of Nursing of the Health Resources and Services Administration requested that the IOM appoint a committee of experts to undertake an independent objective study as stipulated by Congress. In response the study committee explored:

- levels of quality of care in hospitals and nursing homes today;
- the relationship of quality of care (or quality of nursing care, to be more precise) and patient outcomes to nurse staffing levels and mix of different types of nursing personnel;
- the current supply and demand for nurses, including both American- and foreign-trained nurses, and the current and expected levels of workforce participation in that professional group;
- existing ratios of nursing personnel to other measures of demand for health care, such as numbers of patients (in hospitals) or residents (in nursing homes) or numbers of beds, and how those ratios might vary by type of facility, geographic location, or other factors;
- the incidence and prevalence of work-related stress and injuries among nurses in these settings; whether the epidemiology of these problems had been changing in recent years; and whether they differ by type of nursing personnel; undergraduate, graduate, and in-service education and training of different types of nurses; and
- the current and projected patient population of the nation, taking into account the aging of the U.S. population (and the aging of the elderly population itself) and the changing racial and ethnic composition of the population, and the implications of these demographic shifts for the types of health care providers—especially nurses of various kinds—that will be needed in future years.

This report responds to that request. To address its charge in a systematic manner, the committee conducted a complex set of activities. It reviewed and analyzed an extensive body of research and relevant literature, both published and currently under way, and other relevant reports; analyzed published and unpublished data from various sources; heard from a large number of experts; held public hearings and obtained a great deal of written testimony; appointed and convened a liaison panel; conducted several site visits; met with representa-

tives of professional groups, consumer advocacy groups, and trade organizations and others; and commissioned several background papers from experts.

In responding to its charge, the committee decided that although interest in and concern among constituent groups about staffing conditions in hospitals and nursing homes today are intense, the future outlook for the nursing services in the health care system is equally critical for planning and policy formulation. Hence it has attempted to take a long-term view, looking ahead at nurse staffing in the context of a rapidly evolving health care system and an increasingly aging population that will dominate the practice of health care givers at all levels and disciplines as the nation moves into the twenty-first century.

The committee's major findings and conclusions based on this review and its deliberations are summarized below, followed by the text of the recommendations.

FINDINGS AND CONCLUSIONS

Nursing Personnel in a Time of Change

To determine the adequacy of nursing personnel in hospitals and nursing homes, the committee first assessed the overall supply of nursing personnel in the context of the shifting demand for their services and the factors affecting that demand.

More than 3 million health care personnel work in nursing services. Hospitals are the major employers of nursing personnel. RNs are the largest group of health care givers in this country. Their supply in terms of numbers is at an all-time high. In 1992, more than 2.2 million persons held licenses to practice as RNs, and 1.8 million of them were employed in nursing positions. The hospital is the first place of employment for most RNs, where historically two-thirds of them work, and the number of RNs employed by hospitals has continued to grow. This is not the case for LPNs, whose numbers in hospitals have been declining for some time. Many LPNs and NAs also work in nursing homes.

Although the focus of health care is shifting away from nursing at the hospital bedside to nursing at the patient's side in a continuum of care, in absolute terms the largest numbers of nursing personnel are still working in hospital inpatient settings. At the same time, with the emergence of rehabilitative services in nursing homes and the increasingly complex case-mix in these facilities, the need for professional nursing in nursing homes is much greater now than in previous years; and in the years ahead, it will be even greater. Recent data suggest that there might be a small increase of these personnel in nursing homes. Nursing homes accounted for about 7 percent of the RN workforce in 1992, up from 6.6 percent in 1988. The committee concludes that as long as long-term care is almost totally dependent on public and out-of-pocket financing, the current paucity of professional nurses employed in nursing homes will likely con-

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tinue because of fiscal reasons and because of the pay differential between RNs in hospitals and those in nursing homes.

Continuation of current trends toward reduced inpatient hospitalization rates combined with increased acuity of hospitalized patients and the corresponding shift of employment to ambulatory and community care settings could have important implications for the employment of RNs in inpatient hospital settings and for their education and training. In the future, they may be called upon increasingly to fill roles that require increased professional judgment, management of complex systems that span the traditional boundaries of service settings, and greater clinical autonomy.

Likewise, not all nursing homes today are single-focus settings taking care of chronically ill patients who require mostly custodial care. They increasingly are becoming the "hospital" substitute for much of the subacute care that previously was part of a hospital stay. Because of the reduced length of inpatient hospital stays nursing homes are attempting to provide transitional institutional services that in the past would have been provided in the acute care inpatient setting.

All these factors raise important questions about the adequacy of the RN supply in terms of the educational preparation of future RNs. In addressing this issue, several researchers conclude that the aggregate numbers are adequate to meet national needs, at least for the near future, but that the education mix may not be adequate to meet either current or future demands of a rapidly changing health care system. The need to evaluate workforce adequacy for the future in terms both of numbers and of knowledge and skills is clear.

Staffing and Quality of Care in Hospitals

Nursing services are central to the provision of hospital care. Nursing care in hospitals takes on added importance today because the increase in acuity of patients requires intensive nursing care. At the same time, a rapidly changing health care environment, continuing pressures to contain costs, and the rising levels of severity of illness and comorbidity of inpatients all make it imperative for hospitals to explore innovative ways to redesign delivery of care without compromising quality.

Restructuring in the Hospitals

Redesign and reengineering have become principal strategies of the 1990s for many institutions and systems, and increasing numbers of hospitals are restructuring their organization, staffing, and services. Although redesign initiatives are undertaken for a variety of reasons, more than half of the hospital-based efforts are driven by the need to reduce operating costs and have focused on transforming work processes and rethinking roles and jobs. Staff reductions or changes in labor mix are at times implemented without attention to the organiza-

tional changes that might facilitate the possibility of better patient outcomes with fewer, more appropriately trained and used staff. Concurrent with the efforts to restructure hospital services has been the development of total quality management and what is referred to as patient-centered care. These innovative approaches to patient care may also involve case management, the development of critical pathways for managing patients most efficiently during a hospital stay, and other steps that, collectively, lead to restructuring in the hospital. Because of the resource intensity of hospital nursing services, restructuring, work redesign, and cost reduction efforts have a direct impact on the nursing workforce.

Changing Roles and Responsibilities of Nursing Personnel

The challenge today is for care givers and patients to think about the continuum of care needed rather than simply the event of hospitalization. Foremost among these changes is to help RNs and other health care givers to learn how to plan for patient care before the patient is admitted to the hospital, as well as for care needed after discharge from the hospital. It is this challenge, along with the demands for increased efficiency within a standard of good quality of care that, in part, has led many hospitals to implement the concept of patient-centered care teams. As managed care expands, expedient decision making and good judgment will be increasingly more important for all health care providers, and the use of interdisciplinary approaches also will become increasingly the norm in the hospital sector.

This system of organizing care relies on the case manager⁴ to integrate in-depth clinical knowledge, community resources, and financial and organizational requirements with patient needs and with institutional goals of providing high quality, cost-effective care. In acute care settings this role is most often performed by a RN, frequently one who has been prepared with education beyond the basic program of nursing education.

Leading and managing the organizational transformations described above require talents or training that not all RNs now have. For the evolving hospital, the committee believes that it will be imperative for these management, leadership, and supervisory skills to be fostered through various educational programs. The committee believes that more advanced, or more broadly trained, RNs will

⁴"Case management" includes comprehensive oversight of a patient's entire episode of illness incorporating interdisciplinary resource utilization in order to provide high quality, cost effective care. The clinical and financial management of care is coordinated by "case managers" who often span the boundaries of inpatient, ambulatory and community settings (Satinsky, 1995). Some people prefer to use the term "care manager" in lieu of case manager. Care management suggests the provision of direct care and, in some instances a case manager may also be a care manager. For example, registered nurses who coordinate care for groups of hospitalized patients with the same diagnosis may also assume responsibility for giving some of these patients direct care.

the short term, however, these shifts in the way hospitals do business and the way they organize themselves to conduct that business, are causing notable disruptions and misgivings among the nursing staff. From the frequency and intensity of the commentaries that the committee heard during this study, RNs are concerned about the employment ramifications and, more importantly, the professional implications of the organizational changes that are occurring; they believe that these changes may lead to undesirable and unanticipated effects on quality of care. In the committee's view, the harmful and demoralizing effects of these changes on the nursing staff can be mitigated, if not forestalled altogether, with more recognition on the part of the hospital industry that involvement of nursing personnel from the outset in the redesign efforts is critical.

Rapid changes in the health care delivery system and the resultant unstable situation fuel the concern among the nursing community that large decreases in RN staffing in hospitals are both occurring and leading to decrements in patient care and to threats to the health and well-being of nursing personnel. The committee finds that lack of reliable and valid data on the magnitude and distribution of temporary or permanent unemployment, reassignments of existing nursing staff, and similar changes in the structure of nursing employment opportunities greatly hampers efforts at understanding the problem and planning for the future.

Furthermore, answers to such questions are needed for all levels of nursing personnel. Therefore, hospitals should not concentrate their monitoring and evaluation solely on the relationships between RN staffing and quality of care or on work-related illness and injury. Rather, hospitals should focus their efforts in monitoring and evaluating the redesign of staffing on the entire spectrum of their nursing personnel. The committee also supports productive collaboration between federal agencies and private organizations to develop databases containing information that will shed light on workforce issues and on the relationships of staffing, care processes, and patient outcomes.

Measuring Quality of Care in Hospitals

The committee first looked at quality in terms of the overall quality of care received by the patient in the hospital and examined the relationship between structural variables and both processes and outcomes of care. Recent years have seen important advances in measuring quality of patient care at the individual patient and population levels, involving both process and outcome measures. Existing work, however, has not typically focused on isolating the contribution of nursing care to overall hospital quality.

Ensuring the quality of patient care is central to the mission of health care services in hospitals. During the study, the committee heard considerable concern expressed by RNs that increasing numbers of hospitals are restructuring and re-engineering, resulting in smaller proportions of RNs to total nursing personnel and in a probable negative impact on quality of patient care in those hospitals.

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This committee investigated the question of whether the quality of care in hospitals has deteriorated and whether empirical evidence exists of a link between the number and skill mix of nursing personnel and the quality of care.

The committee found that little empirical evidence is available to support the anecdotal and other informal information that hospital quality of care is being adversely affected by hospital restructuring and changes in the staffing patterns of nursing personnel. At the same time, it noted a lack of systematic and ongoing monitoring and evaluating of the effects of organizational redesign and reconfiguration of staffing on patient outcomes. Unfortunately, few recent and objective national data are available that either describe the quality of care in hospitals or that show whether quality has been affected in any way by changes in the system of delivery of care. Indeed, the committee was shocked by the lack of current data relating to the status of hospital quality of care on a national basis, apart from information on indicators such as hospital-specific mortality rates. Because of this lack, the committee is unable to draw any definitive conclusions or inferences about the levels of quality of care across the nation's hospitals today.

The committee does conclude, however, on the basis of the few available studies, that the quality of hospital care in general has not suffered, and may even have improved in some areas, after implementation of the Medicare prospective payment system (PPS). Although quality of hospital care did not suffer after PPS implementation, more patients were discharged too soon and in unstable condition and patients discharged in unstable condition had significantly higher mortality rates. This research suggests that there may be problem areas with the quality of hospital care, but that the extent of these problems today is not known because of the lack of objective current data.

The committee is convinced that investigation of hospital quality of care warrants increasing and immediate attention. Research needs to move beyond hospital mortality as an outcome measure and to focus as well on process-of-care problems that occur during short hospital stays and on outcomes over an episode of care.

Relationship of Nursing Staff to Quality of Care

One of the research challenges in determining the relationship between staffing and quality of care has been the difficulty of isolating the factors (and the relative importance of these factors) that are involved in producing improved patient outcomes. Literature about the effect of RNs on mortality and about variables that affect the retention of RNs is available; differences in mortality rates across hospitals are well documented by several researchers and the literature on RNs' impact on hospital mortality rates is considerable. There is, however, a serious paucity of recent research on the definitive effects of structural measures, such as specific staffing ratios, on the quality of patient care in terms of

outcomes when controlling for all other likely explanatory or confounding variables.

Part of the problem lies in the area of severity of illness and risk adjustment, where patient acuity is a significant factor. Across-the-board staffing ratios tend to assume that in some measure all patients are "alike" and can be cared for with the same level and type of resources. Equally difficult is the task of establishing ratios that will be appropriate for all settings and situations. Staffing levels need to be specific to different types of acute care units and facilities.

RN-rich staffing ratios are sometimes associated with improved patient outcomes, such as lower mortality rates among Medicare patients. Such staffing ratios are essentially proxy measures for other organizational attributes of hospitals that grant nurses autonomy over their own practice and control of the resources necessary to deliver patient care and create good relationships with physicians. That is, when nurses have more autonomy, status, and control, their behaviors on behalf of patients result in better outcomes. Despite this type of information on organizational and related factors, the committee was unable to isolate a number-of-RNs effect.

The committee concludes, therefore, that high priority should be given to obtaining empirical evidence that permits one to draw conclusions about the relationships of quality of inpatient care and staffing levels and mix. Such data should focus on nursing care and quality of care across institutions and within given institutions, and across departments and services. The committee is convinced that more rigorous research on the relationship between nursing variables, broadly defined, and quality of care would have significant payoffs for policy-makers, nursing educators, hospital administrators.

The committee also is concerned about the paucity of objective research on the relationships among restructuring, staffing, and quality. The committee concludes that a clear need exists for some system of monitoring and evaluating the impact of the rapidly changing delivery system on the quality of patient care and the well-being of nursing staff. For this reason, it has advanced several recommendations intended to provide better information on hospital restructuring and to help in delineating those factors that affect patient outcomes. It also calls for the development of a research agenda in this area and for the articulation of reliable, valid, and practical measures of structure, process, and outcome to be used in quality-of-care research as well as quality assurance and improvement programs. A systematic effort is needed at the national level to collect data and develop a research and evaluation agenda so that informed policy development, implementation, and evaluation are undertaken in a timely manner.

A major part of any such research agenda might call for elaboration of the actual variables—in terms of structure, process, and outcome—that warrant high priority attention in studies of the relationship of nursing care, staffing patterns for nursing, to patient outcomes. The American Nurses Association (ANA), for example, has been developing quality indicators that warrant further investiga-

tion. The committee commends the ANA for its exploratory efforts to develop a set of nursing care quality indicators. This research can set an important precedent and standard for the development of meaningful quality standards relating to nursing. This research offers promise for further evolution of external regulatory quality assurance mechanisms (e.g., those of the Joint Commission on Accreditation of Healthcare Organizations [JCAHO]) and for improved public information efforts. Nevertheless, the committee judged that in the future, a broader set of inputs from the nursing community and other affected parties would be desirable. It also believed that efforts based solely in the private sector, with little or no public sector involvement, might be less useful than if federal and state perspectives were taken into account.

The committee supports the current federal requirements and accreditation standards for nursing services in hospitals and emphasizes the need for hospitals to maintain the highest possible standards for nursing care. Moreover, the committee agrees that hospitals should develop improved methods for matching patient needs (severity-of-illness or acuity measures) with the level and type of nurse staffing. The committee endorses efforts to improve systems for planning appropriate nursing care as well as monitoring the outcomes of that care.

Regulation of hospitals is a long-standing part of government responsibility and can take many forms, including certification, licensure, and accreditation. Under the Social Security Act, one pathway to hospital certification is through accreditation by the JCAHO; this is the route to certification used by most hospitals. Hospitals found to have met the JCAHO accreditation standards are deemed automatically to have met the federal Conditions of Participation for the Medicare program and are in effect considered certified to receive Medicare (and Medicaid) reimbursement. Among the key requirements of JCAHO certification are that: nursing care be provided on a 24-hour-a-day, 7-day-a-week basis; nursing services show evidence that each patient's status is monitored and that nursing care is coordinated with the care provided by other professionals; and specific patient care plans be in place and in use for each patient.

Given the continued reliance of the federal government on JCAHO accreditation for hospital reimbursement by federal health programs, the committee was encouraged by the evolution of JCAHO's methods and standards in the past few years and by the more sophisticated attention being paid to the role of nursing care within those standards. The committee endorses the current federal requirements for hospitals to participate in Medicare, which incorporate the use of voluntary accreditation, to assure the quality of hospital care, and it is particularly supportive of requirements that call for matching nursing resources with patient needs. The committee believes that Congress ought to continue to support this element of assuring the quality of care in hospitals.

Some broader issues of changes in nursing services, such as the enhanced responsibilities of advanced practice nurses and the use of ancillary nursing personnel and their competency, cut across the straightforward issue of the rela-

tionship between nurse staffing and quality of hospital care. In reflecting on the role of nursing personnel in the future, therefore, the committee has also proposed recommendations about these specific types of nursing personnel.

Staffing and Quality of Care in Nursing Homes

The nursing home market is being stressed by an increasing demand for services combined with a constrained growth rate. To gain insights on issues surrounding the relationship of staffing patterns of nursing personnel to quality of resident care, the committee examined statutory requirements and information gathered during site visits and public testimony; it also reviewed an extensive body of research literature and empirical evidence on the relationships between staffing patterns and quality.

Status of Quality of Care in Nursing Homes

Quality of care in nursing homes is a complex concept, and defining it has been a difficult process. Some facilities provide high quality of care even in the face of fiscal constraint, but the quality of care provided in nursing facilities has for years been a matter of great concern to consumers, health care professionals, and policymakers. Since enactment of the Omnibus Budget Reconciliation Act of 1987 (OBRA 87), some improvement has been reported as a result of increased efforts by the federal government to regulate the quality of nursing homes. Many facilities have increasingly focused on reducing negative outcomes and improving the process of care; in many others, however, quality-of-care problems continue to be reported. Several studies have identified negative outcomes in nursing facilities.

Relationships Among Nursing Staff, Management, and Quality of Care

The committee sought to determine if staffing as a measure of quality of care in nursing homes has improved since the implementation of OBRA 87. A slight but noticeable increase in staffing was evident, attributable partly to the requirements of the 1987 legislation and partly to the staffing needs created by the increased complexity of care required for subacute and other special care residents. The committee strongly endorses the intent of OBRA 87 and supports efforts by facilities and states to improve professional nurse staffing in nursing homes consistent with the intent of the statute.

Many factors, both internal and external, influence staff performance and the quality of care provided to residents. Internal factors include staffing and staff characteristics such as education and training levels, patient characteristics such as acuity levels, job satisfaction and turnover of staff, salaries and benefits, and management and organizational climate. External factors include regula-

tions, reimbursement policies, incentives, excess demand for services, and type and ownership of facility. The committee examined all of these factors through review of the research literature, information from administrative databases, information gathered during site visits and from testimony, review of regulatory requirements, and other relevant reports and reached several conclusions.

During site visits the committee heard complaints from some nursing home staff about the paperwork involved in completing the Minimum Data Set (MDS), which is a crucial part of resident assessment procedures. Although the committee is sympathetic about the time-consuming nature of the forms, it strongly endorses the concept of an individualized care plan for each resident, which requires the use of tools such as the MDS. The committee also endorses current efforts by the Health Care Financing Administration (HCFA) to improve the MDS and to require all facilities to computerize MDS data and provide them to state and federal agencies, thus providing a mechanism for a national database.

The research literature generally agrees on the strong relationship among resident characteristics, nurse staffing time requirements, and nursing costs in nursing homes. It shows that facilities need to adjust their staffing levels to take into account the condition of the residents so that they can ensure sufficient staff to provide for residents' basic needs. The preponderance of evidence, from a number of studies using different types of quality measures, shows a positive relationship between nursing staff levels and quality of nursing home care, which in turn indicates a strong need to increase the overall level of nursing staff in nursing homes.

The research literature does not, however, answer questions about what particular ratio of staff to residents is optimal. Varying circumstances among nursing homes, case-mix differentials, and other external factors affect the type and level of staff needed. The committee thus endorses the HCFA staffing standards but is not inclined to recommend a specific minimum staffing ratio across all types of facilities to meet the needs of all types of patients. The committee affirms that nursing facilities should ensure adequate nursing services to meet the acuity needs of their residents.

The committee recognizes the differences in nurse staffing and quality of patient care in nursing homes, on the one hand, and in hospitals, on the other. Hospitals and nursing homes may operate on very different segments of a staffing-quality relationship curve. Hospitals could be operating in the segment of the curve where returns from increases in staffing are low because they already have relatively high staffing levels; by contrast, nursing homes are operating at the low end of the staffing scale where positive returns from increases in staffing are observable.

Extensive research literature exists on the effect on quality of care of the presence of professional nursing (RNs) to provide hands-on training and guidance to NAs. Given the level of NAs' direct care responsibilities and the minimal training for resident care required of them, professional nurse oversight and

tions, reimbursement policies, incentives, excess demand for services, and type and ownership of facility. The committee examined all of these factors through review of the research literature, information from administrative databases, information gathered during site visits and from testimony, review of regulatory requirements, and other relevant reports and reached several conclusions.

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availability for close supervision of NAs and LPNs is critical—more so today than in previous years because of the changing characteristics of the residents. Based on the empirical evidence amassed, the committee concludes that a strong relationship between RN-to-resident staffing in nursing facilities and various dimensions of quality, especially resident outcomes, has been established. The committee, therefore, underscores the need to increase the presence of professional nurses in nursing homes on all shifts. Given the findings on the beneficial effects of continuous RN presence on various dimensions of quality, especially resident outcomes, the committee recommends an RN presence on all shifts in nursing homes as an enhancement of the currently required 8-hour RN presence.

The committee of course recognizes that issues of staffing enhancement in nursing facilities cannot be viewed separately from costs. Ultimately, the committee was of the opinion that the public interest and the need for acceptable quality of care must be considered in addition to cost if we as a society are going to maintain a sense of values and responsibility for the care of the elderly, disabled, and disadvantaged. The committee, however, is reluctant to impose uncompensated costs on nursing facilities, and it concludes, therefore, that Medicaid and Medicare payment levels need to be adjusted accordingly. The committee further believes that waivers to this requirement could be granted by states only under exceptional circumstances. All but one of the committee members were in agreement with these positions.

Based on its review of a number of studies, the committee concludes that there is sufficient evidence to show that the presence of geriatric nurse specialists and practitioners enhances quality of care in nursing homes. Moreover, research has shown that cost savings in the long run accrue, particularly due to reduced rehospitalizations and visits to emergency rooms.

Nurse assistants constitute 70 to 90 percent of the nursing staff in nursing facilities. They provide most of the direct care and spend the most time with residents, but as stated earlier, they are the least trained. On the basis of experience and information gathered from the testimonies received, the committee came to the view that the organization, use, and education of NA staff make a substantial difference in the humane care, comfort, and health of nursing home residents and in the job satisfaction and health of the staff. The committee concludes that the training received by NAs should be enriched and that research is needed on the relationship of NA and LPN staff levels and training to quality of care.

The changing focus of services and the increasingly complex nature of the care provided in nursing facilities create new demands for skill, judgment, supervision, and the management of nursing services. Most directors of nursing (DON) in nursing facilities are not academically prepared for their positions. Furthermore, turnover among DONs is high, their salaries are low in comparison with hospitals, and they have limited opportunities for advancement. None of these factors is conducive to strong leadership. In view of the number of employees,

budgets, and complexity of care in nursing facilities today, strong leadership from DONs is required if high quality, cost-effective care is to be provided. The committee concludes that nursing facilities should place greater weight on educational preparation when employing new DONs.

In the area of reimbursement policies, the committee notes the existence of several experiments designed to look at outcome-based incentives for improved quality of care. The committee concludes that additional research and demonstration projects on the use of financial and other incentives are needed to improve the quality of care and outcomes in nursing homes.

Staffing and Work-Related Injuries and Stress

Nursing is a hazardous occupation. Whereas the injury and illness rate in private industry as a whole has been stable or declining slightly since 1980, the rates for hospitals and nursing homes during the same period have increased by about 52 percent and 62 percent, respectively. Recent statistics and other information suggest that these institutions are becoming increasingly hazardous places to work, exposing workers to a wide range of risks.

The committee reviewed the literature on work-related injuries, in particular back injuries and needlestick puncture wounds, that affect nursing personnel in hospitals and nursing homes. It also reviewed available research to assess the factors that contribute to work-related stress. The committee was struck by the high rate of injuries to nursing personnel in both hospitals and nursing homes, but except for back injuries the committee is unable to substantiate conclusively any linkages among staffing numbers, skill mix, and work-related problems. The committee is impressed, however, with the apparent effects of leadership from management, good employee training, and existing technologies on reducing the probabilities of injuries among nursing personnel.

The committee concludes that considerable levels of injuries and risk of injury may exist at the level of NAs and other ancillary personnel, especially in long-term-care facilities, who may be subject to great stress and probability of injury (especially back injury) and who may be newly employed and comparatively thinly trained. The committee thus found an important need, especially among new employees, for more aggressive training related to the use of lifting devices, lifting teams, and ergonomic training in lifting techniques to prevent back injuries. The committee concludes that all personnel giving direct care (especially in nursing homes) should receive annual training in lifting and transferring patients. Such efforts would improve the quality of life for health care workers and could represent a significant savings to the health care industry. The committee also concludes that hospitals and nursing homes should develop effective programs to reduce work-related injuries.

Violence toward health care workers appears to be on the rise. Increased violence in the general population, greater use of mind-altering drugs and alcohol

abuse, and easier availability of weapons may all contribute to the problem of violence in health care settings. In examining available information on violence and abuse, the committee realized the intricate problems of work situations and of violence and abuse directed at patients, especially residents in nursing homes. Clearly many NAs are not abusive. A certain proportion, however, do verbally or physically abuse, steal from, or otherwise take advantage of nursing home residents. Unfortunately, even a small proportion of abusive staff can affect the health, quality of care, and peace of mind of thousands of nursing home residents. In the committee's view, therefore, nursing facilities should be required to ensure a safe and protective environment for residents by employing personnel who protect and care for residents and do not abuse and steal from them.

The committee believes that much of the incidence of violence in hospitals and nursing homes are preventable and that prevention is a shared responsibility among employers and employees. The committee concludes, therefore, that health care institutions should implement a variety of strategies to prevent assaults against workers and residents and that they should screen applicants for patient care positions for past histories of abuse. Abuse prevention measures should ultimately apply to all who work in nursing homes and, for that matter, in all health care institutions.

RECOMMENDATIONS

On the basis of its findings and conclusions the committee has provided three categories of recommendations: (1) the level and staffing patterns of nursing personnel to promote quality of care in hospitals; (2) the level and skill mix of nursing personnel in nursing homes to promote quality of care in these facilities; and (3) strategies to reduce work-related injuries and stress. The text of the panel's recommendations, grouped according to these categories, follows, keyed to the chapter in which they appear in the body of the report. The sequence in which the recommendations are presented does not reflect a priority order.

RECOMMENDATIONS ON STAFFING AND QUALITY IN HOSPITALS

Recommendation 5-1: The committee recommends that hospitals expand the use of registered nurses with advance practice preparation and skills to provide clinical leadership and cost-effective patient care, particularly for patients with complex management problems.

Recommendation 5-2: The committee recommends that hospitals have documented evidence that ancillary nursing personnel are competent and that such personnel are tested and certified by an appropriate entity for this competence. The committee further recommends that the training for ancillary nursing personnel working in hospitals be structured and enriched by including training of the following types: appropriate clinical care of the aged and disabled; occupational health and safety measures; culturally sensitive care; and appropriate management of conflict.

Recommendation 5-3: The committee recommends that hospital leaders involve nursing personnel (RNs, LPNs, and NAs) who are directly affected by organizational redesign and staffing reconfiguration in the process of planning and implementing such changes.

Recommendation 5-4: The committee recommends that hospital management monitor and evaluate the effects of changes in organizational redesign and reconfiguration of nursing personnel on patient outcomes, on patient satisfaction, and on nursing personnel themselves.

Recommendation 5-5: The committee recommends that the National Institute of Nursing Research (NINR) and other appropriate agencies fund scientifically sound research on the relationships between quality of care and nurse staffing levels and mix, taking into account organizational variables. The committee further recommends that NINR, along with the Agency for Health Care Policy and Research (AHCPR) and private organizations, develop a research agenda on quality of care.

Recommendation 5-6: The committee recommends that an interdisciplinary public-private partnership be organized to develop performance and outcome measures that are sensitive to nursing interventions and care, with uniform definitions that are measurable in a uniform manner across all hospitals.

RECOMMENDATIONS ON STAFFING AND QUALITY IN NURSING HOMES

Recommendation 6-1: The committee recommends that Congress require by the year 2000 a 24-hour presence of registered nurse coverage in nursing facilities as an enhancement of the current 8-hour requirement specified under OBRA '87. It further recommends that payment levels for Medicare and Medicaid be adjusted to enable such staffing to be achieved.

Recommendation 6-2: The committee recommends that nursing facilities use geriatric nurse specialists and geriatric nurse practitioners in both leadership and direct care positions.

Recommendation 6-3: The committee recommends that the training for nurse assistants in nursing homes be structured and enriched by including training of the following types: appropriate clinical care of the aged and disabled; occupational health and safety measures; culturally sensitive care; and appropriate management of conflict.

Recommendation 6-4: The committee recommends that research efforts on staffing levels and skill mix specifically address the relationship of licensed practical nurses and nurse assistants to quality of care.

Recommendation 6-5: The committee recommends that, in view of the increasing case-mix acuity of residents and the consequent complexity of the care provided, nursing facilities place greater weight on educational preparation in the employment of new directors of nursing.

Recommendation 6-6: The committee recommends that the Secretary of Health and Human Services fund additional research and demonstration projects on the use of financial and other incentives to improve quality of care and outcomes in nursing homes.

RECOMMENDATIONS ON WORK-RELATED INJURY AND STRESS

Recommendation 7-1: The committee recommends that hospitals and nursing homes develop effective programs to reduce work-related injuries by providing strong leadership, instituting effective training programs for new and continuing workers, and ensuring appropriate use of existing and emerging technology including lifting and moving devices and needleless medication delivery systems.

Recommendation 7-2: The committee recommends that all hospitals and nursing homes screen applicants for patient care positions filled by nurse assistants for past history of abuse of patients and residents, and criminal records.

STAFFING LEVELS

Background

There is agreement that there is a strong relationship between resident characteristics, nurse staffing time requirements, and nursing costs in nursing homes. Numerous studies have examined these relationships and it is this relationship which serves as the basis for the casemix reimbursement systems used in some states (Fries and Cooney, 1985; Schneider et al., 1988; Fries et al., 1989; 1994).

Not surprisingly, higher staffing levels in nursing homes have been associated with higher quality of care. One of the early studies which documented this relationship found that homes with more RN hours per patients were associated with patients being alive, having improved physically, and being discharged to home (Linn et al., 1977). Fottler, Smith and James (1981) also found nursing hours to be a positive indicator of quality. Nyman (1988b) found that higher nursing hours per resident were significantly and positively associated with three of eight quality measures in Iowa nursing homes. Spector and Takada (1991) examined nursing homes in Rhode Island and found that low staffing in homes with very dependent residents was associated with reduced likelihood of improvement. Cohen and Spector (in press) also had similar findings about the importance of RN staffing.

The evidence from these studies recently led the Institute of Medicine Committee

on Nurse Staff in Hospitals and Nursing Homes (1996) to conclude that the preponderance of evidence from a number of studies with different types of quality measures shows a positive relationship between nursing staffing and quality of nursing home care. Because of the low staffing levels and poor quality of care in some facilities, the IOM Committee (1996) recommended that higher staffing levels are needed in nursing facilities.

The level of registered nurse staffing is a growing concern for quality of care because of controls on Medicaid reimbursement and prospective payment for hospitals and subsequent reductions in staffing levels (Kanda and Mezey, 1991; Swan et al., 1997).

Nursing personnel in nursing facilities were of particular interest for this report. Nursing personnel included: registered nurses (RNs); licensed practical/vocational nurses (LPN/LVNs), and nursing aides/orderlies/ assistants (NAs). Staffing hours (including full-time, part-time, and contract staff) are reported by facilities as total hours worked in a fourteen day period. Nursing personnel hours are examined for each of the above three categories separately, for all licensed nursing personnel (RNs and LPN/LVNs combined), and for total nursing personnel (RNs, LPN/LVNs, and NAs). The staff time includes all administrative and direct care time.

To compute the staffing ratios for this report, the total number of staffing payroll hours reported in a two week period was divided by the total number of residents and by the 14 days in the reporting period. In examining the staffing data, there were some facilities that reported very high or low levels of staffing. In order to minimize the number of facilities which may have reported erroneous data, we developed standard rules to remove these facilities from the data set. A conservative approach was taken by eliminating the lower one percent of facilities and the upper 2 percent after eliminating facilities with extreme outliers. For the details of the data cleaning process, see the technical notes in the appendix.

Nursing facilities are required by regulation to meet minimum nursing standards. Facilities must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of residents. Facilities must also provide sufficient numbers of licensed nursing personnel to provide care on a 24 hour basis to all residents in accordance with resident care plans.

Facilities must also use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week, except when they have been given a waiver. A Medicare only skilled nursing facility may have a waiver if it is located in a rural area and has one registered nurse who is on duty 40 hours a week.

Waivers may be granted under certain conditions where there is a shortage of appropriate personnel and where the

health and safety of individuals is not jeopardized. A total of 518 waivers were granted to Medicaid only facilities by state agencies in 1993. Of these, 66 were for the 24 hour licensed nursing coverage and 490 were for the 8 hours of RN coverage. Sixteen waivers were given to Title 18 and to Title 18/19 certified facilities (HCFA, 1994).

For this report, the total hours of staffing per resident day were examined separately for Medicaid only (Title 19) and/or dually certified facilities (Title 18/19) and for Medicare only facilities (Title 18). The two types of facilities are examined separately because Title 18 facilities have traditionally had higher staffing ratios. Many Title 18 certified facilities are located in hospitals and have residents with higher acuity levels and such facilities usually have more RNs to provide care.

It should be noted that the reported staffing ratios reflect payroll hours per resident day and not the actual hours of care delivered directly to residents. These data are reported by each facility for the two weeks prior to the facility survey. Also note a correction was made in the data reports 1994 through 1996.

Facilities with Medicaid Only and Medicare and/or Medicaid Beds (Title 19 and Title 18/19)

Tables 25 and 26 show the total facilities with Medicaid-only and Medicare/Medicaid beds in the U.S. for the 1992 through 1998 period. The number of facilities varied by year and category because of some missing or erroneous data which were cleaned, using consistent procedures over the time period. There were 12,445 facilities with beds in this category for RNs in 1998.

Registered Nursing Hours

The average RN hours per resident day are shown in Table 25. The average hours was 0.3 in 1992 and 0.6 in 1998. This converts to 36 minutes per resident day or about 12 minutes per 8 hour shift in the 1998 period. The average ratio of RNs hours varied across states from 0.2 hours (in Arkansas and Louisiana) to 1.2 hours (in Alaska) in 1998. This includes nurses who are in administrative positions.

LPN/LVN Nursing Hours

The average LPN/LVN hours per resident day are shown in Table 25. There was an average of 0.6 hours (36 minutes) per resident day (or 12 minutes per shift) in 1992-1998. These data showed no change over the period.

Nursing Aide/Assistant Hours

The average NA hours per resident day are shown in Table 25. The average was 1.9 to 2.0 hours (114 to 120 minutes) in the 1992-1998 period. This is about 38 to 40 minutes per 8 hour shift.

Avg. Nursing Hours Per Resident Day for Facilities with Medicaid and Medicare/Medicaid Beds

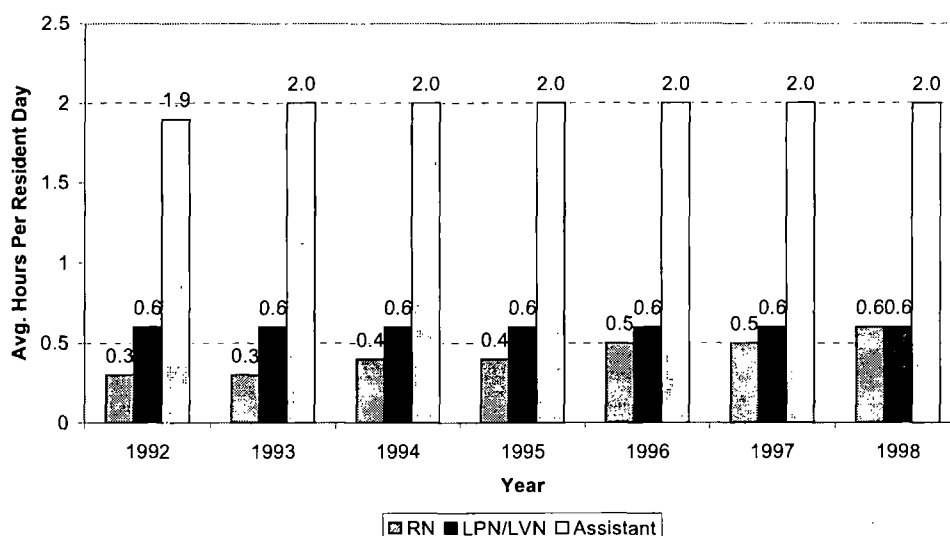


TABLE 25
AVERAGE RN, LPN/LVN, AND ASSISTANT HOURS PER RESIDENT DAY
IN FACILITIES WITH MEDICAID AND WITH MEDICARE/MEDICAID BEDS (TITLE 19 AND TITLE 18/19)

	RN Hours							LPN/LVN Hours							Assistant Hours						
State	1992	1993	1994	1995	1996	1997	1998	1992	1993	1994	1995	1996	1997	1998	1992	1993	1994	1995	1996	1997	1998
AK	0.6	0.7	0.9	0.9	1.1	1.1	1.2	0.9	0.7	0.8	0.7	0.6	0.6	0.6	2.6	2.6	2.9	3.0	3.0	2.8	2.8
AL	0.2	0.2	0.3	0.3	0.3	0.4	0.4	0.8	0.8	0.9	0.9	0.9	0.9	0.9	2.5	2.5	2.4	2.4	2.5	2.4	2.5
AR	0.1	0.1	0.2	0.2	0.2	0.2	0.2	0.5	0.6	0.6	0.6	0.6	0.7	0.7	1.7	1.9	1.9	1.9	1.9	1.9	1.9
AZ	0.3	0.5	0.5	0.6	0.6	0.6	0.7	0.6	0.8	0.7	0.6	0.7	0.7	0.7	1.0	2.0	2.1	2.0	2.0	2.0	2.0
CA	0.3	0.3	0.4	0.5	0.5	0.6	0.6	0.6	0.6	0.6	0.6	0.6	0.6	0.6	2.0	2.0	2.1	2.0	2.1	2.1	2.1
CO	0.4	0.4	0.6	0.6	0.6	0.7	0.7	0.6	0.6	0.6	0.6	0.6	0.6	0.6	1.8	1.9	1.9	1.9	1.9	2.0	2.0
CT	0.6	0.5	0.6	0.6	0.7	0.7	0.7	0.4	0.4	0.4	0.4	0.4	0.5	0.5	1.9	1.8	1.9	1.8	2.0	2.0	2.1
DC	0.7	0.5	0.6	0.5	0.8	0.8	0.6	0.6	0.7	0.8	0.7	0.7	0.8	0.9	2.4	2.1	2.4	2.4	2.4	2.4	2.5
DE	0.4	0.5	0.7	0.8	0.8	0.9	0.8	0.5	0.6	0.6	0.6	0.6	0.6	0.5	2.0	2.2	2.1	2.2	2.2	2.0	2.3
FL	0.3	0.3	0.4	0.4	0.5	0.5	0.6	0.7	0.7	0.7	0.7	0.7	0.7	0.7	2.0	2.0	1.9	2.0	2.0	2.0	1.9
GA	0.2	0.2	0.3	0.3	0.3	0.3	0.3	0.7	0.7	0.7	0.7	0.8	0.8	0.8	2.1	2.0	2.0	2.0	2.0	2.0	2.0
HI	0.6	0.7	0.7	0.7	0.7	0.7	0.9	0.6	0.5	0.6	0.6	0.5	0.6	0.5	2.1	2.2	2.5	2.4	2.2	2.4	2.2
IA	0.3	0.3	0.4	0.4	0.5	0.5	0.6	0.4	0.4	0.4	0.4	0.5	0.4	0.5	1.6	1.8	1.8	1.8	1.8	1.8	1.7
ID	0.3	0.4	0.6	0.6	0.6	0.7	0.7	0.5	0.7	0.6	0.6	0.7	0.7	0.6	1.8	2.5	2.5	2.5	2.5	2.4	2.3
IL	0.3	0.3	0.4	0.4	0.5	0.5	0.6	0.5	0.5	0.5	0.4	0.4	0.4	0.4	1.7	1.7	1.7	1.7	1.6	1.6	1.6
IN	0.3	0.2	0.3	0.4	0.4	0.5	0.5	0.6	0.7	0.7	0.7	0.7	0.8	0.8	1.9	1.9	1.7	1.7	1.7	1.6	1.6
KS	0.3	0.3	0.4	0.4	0.4	0.5	0.5	0.4	0.4	0.5	0.5	0.5	0.5	0.5	1.9	1.8	1.8	1.8	1.9	1.9	1.9
KY	0.3	0.3	0.4	0.4	0.4	0.5	0.5	0.6	0.6	0.7	0.7	0.6	0.7	0.7	2.2	2.3	2.2	2.1	2.2	2.2	2.3
LA	0.1	0.1	0.2	0.1	0.2	0.2	0.2	0.6	0.6	0.6	0.6	0.6	0.6	0.7	1.9	1.9	1.5	1.4	1.9	1.9	1.9
MA	0.4	0.4	0.5	0.6	0.7	0.7	0.8	0.5	0.5	0.6	0.6	0.6	0.5	0.6	2.0	2.0	2.1	2.1	2.2	2.1	2.2
MD	0.3	0.3	0.4	0.5	0.5	0.6	0.7	0.5	0.5	0.6	0.5	0.5	0.5	0.6	2.1	2.0	2.1	2.0	2.1	2.0	2.2
ME	0.4	0.4	0.6	0.7	0.8	0.8	0.9	0.5	0.5	0.4	0.5	0.4	0.4	0.4	2.4	2.5	2.5	2.7	2.6	2.7	2.7
MI	0.3	0.3	0.4	0.4	0.5	0.6	0.6	0.6	0.6	0.6	0.6	0.6	0.6	0.6	2.3	2.2	2.2	2.2	2.2	2.2	2.2
MN	0.3	0.3	0.4	0.4	0.5	0.5	0.6	0.5	0.6	0.6	0.6	0.6	0.6	0.6	1.8	1.9	1.9	1.9	1.9	2.0	1.9
MO	0.2	0.2	0.3	0.3	0.3	0.4	0.4	0.5	0.5	0.6	0.6	0.6	0.6	0.6	2.1	2.1	2.0	2.1	2.1	2.1	2.1
MS	0.2	0.2	0.3	0.3	0.3	0.4	0.4	0.7	0.7	0.7	0.7	0.7	0.7	0.8	1.9	1.9	2.0	2.0	2.0	2.0	2.0
MT	0.5	0.5	0.6	0.6	0.7	0.7	0.7	0.5	0.5	0.5	0.5	0.5	0.5	0.5	2.2	2.2	2.2	2.2	2.2	2.2	2.3
NC	0.4	0.4	0.5	0.5	0.6	0.6	0.6	0.7	0.7	0.7	0.7	0.7	0.7	0.7	2.3	2.3	2.2	2.2	2.2	2.2	2.2
ND	0.3	0.3	0.4	0.4	0.5	0.5	0.6	0.5	0.5	0.5	0.5	0.5	0.5	0.5	2.1	2.0	2.2	2.2	2.3	2.3	2.3
NE	0.3	0.3	0.4	0.4	0.5	0.6	0.6	0.5	0.6	0.6	0.6	0.6	0.6	0.6	1.7	1.9	1.8	1.9	1.8	1.9	1.9
NH	0.6	0.5	0.7	0.7	0.7	0.8	0.8	0.5	0.5	0.5	0.5	0.5	0.5	0.5	2.2	2.1	2.3	2.3	2.1	2.2	2.1
NJ	0.5	0.4	0.6	0.6	0.6	0.7	0.7	0.5	0.5	0.5	0.5	0.5	0.5	0.5	2.0	2.0	2.1	2.1	2.0	2.1	2.1
NM	0.3	0.3	0.4	0.4	0.5	0.6	0.6	0.6	0.6	0.5	0.5	0.5	0.5	0.5	2.0	2.0	2.0	2.1	2.1	1.9	2.1
NV	0.6	0.8	1.0	0.8	0.9	0.9	1.0	0.8	0.9	0.9	0.9	0.9	0.8	0.6	1.8	2.3	2.0	2.1	2.2	2.4	2.2
NY	0.5	0.4	0.5	0.5	0.5	0.5	0.6	0.6	0.6	0.6	0.6	0.6	0.6	0.6	2.1	2.0	2.0	2.0	2.0	2.0	2.0
OH	0.3	0.3	0.4	0.5	0.6	0.6	0.6	0.7	0.7	0.7	0.7	0.7	0.7	0.7	2.1	2.1	2.1	2.0	2.1	2.1	2.1
OK	0.1	0.1	0.2	0.2	0.2	0.2	0.3	0.5	0.5	0.5	0.5	0.5	0.5	0.5	1.7	1.8	1.8	1.9	2.0	2.0	2.0
OR	0.4	0.5	0.6	0.6	0.7	0.8	0.7	0.4	0.4	0.4	0.4	0.4	0.4	0.4	2.0	2.2	2.3	2.2	2.3	2.3	2.3
PA	0.4	0.4	0.6	0.6	0.6	0.7	0.7	0.5	0.6	0.6	0.6	0.6	0.6	0.7	1.7	2.0	2.0	2.0	2.0	2.0	2.1
RI	0.5	0.5	0.5	0.5	0.6	0.7	0.7	0.4	0.4	0.3	0.3	0.3	0.3	0.3	1.9	1.9	2.0	2.0	2.0	2.1	2.0
SC	0.3	0.3	0.3	0.3	0.4	0.4	0.4	0.7	0.7	0.8	0.7	0.8	0.8	0.7	2.1	2.1	2.2	2.1	2.1	2.1	2.0
SD	0.4	0.4	0.6	0.6	0.6	0.7	0.7	0.4	0.3	0.3	0.3	0.3	0.3	0.3	1.9	1.8	1.9	1.9	2.0	2.0	2.0
TN	0.2	0.2	0.2	0.3	0.3	0.3	0.4	0.6	0.6	0.7	0.7	0.7	0.7	0.7	1.7	1.8	1.8	1.8	1.8	1.9	1.8
TX	0.1	0.1	0.2	0.2	0.3	0.3	0.3	0.6	0.7	0.7	0.7	0.6	0.7	0.7	1.8	1.8	1.9	1.9	1.9	1.9	1.9
UT	0.2	0.2	0.3	0.4	0.5	0.6	0.4	0.6	0.6	0.6	0.5	0.6	0.5	0.5	1.8	1.8	1.8	1.7	1.8	1.6	2.0
VA	0.2	0.3	0.4	0.4	0.5	0.5	0.5	0.5	0.7	0.7	0.7	0.7	0.7	0.7	1.6	1.9	2.0	1.9	1.9	2.0	1.9
VT	0.3	0.4	0.5	0.4	0.5	0.6	0.6	0.6	0.7	0.8	0.6	0.6	0.6	0.7	1.8	2.1	1.9	1.9	2.1	2.1	2.3
WA	0.5	0.5	0.7	0.7	0.8	0.9	0.9	0.5	0.5	0.5	0.5	0.5	0.6	0.6	2.1	2.2	2.2	2.2	2.3	2.4	2.4
WI	0.4	0.4	0.6	0.6	0.6	0.7	0.7	0.4	0.4	0.4	0.4	0.4	0.4	0.4	2.0	2.1	2.1	2.1	2.1	2.2	2.1
WV	0.3	0.2	0.3	0.4	0.4	0.4	0.4	0.7	0.7	0.7	0.7	0.7	0.7	0.7	2.2	2.0	2.2	2.2	2.1	2.1	2.1
WY	0.4	0.4	0.6	0.6	0.7	0.7	0.8	0.6	0.5	0.5	0.5	0.4	0.5	0.5	2.0	2.1	2.1	2.1	2.2	2.2	2.2
US	0.3	0.3	0.4	0.4	0.5	0.5	0.6	0.6	0.6	0.6	0.6	0.6	0.6	0.6	1.9	2.0	2.0	2.0	2.0	2.0	2.0
Facilities	####	####	####	####	####	####	####	####	####	####	####	####	####	####	####	####	####	####	####	####	####

Licensed Nursing Hours

Table 26 shows the average licensed nursing hours (RNs and LPN/LVNs) per resident day was 0.9 to 1.2 hours in 1992-1998. This was about 72 minutes per resident day or 24 minutes per 8 hour shift in 1998.

Total Nursing Hours

The total nursing hours (RNs, LPN/LVNs, and NAs) per resident day was 2.8 to 3.2 in 1992-1998 (See Table 26). The total nursing hours varied across states from 2.6 in Illinois to 4.6 in Alaska in 1998.

**Total Nursing Hours Per Resident Day
in Facilities with Medicaid and Medicare/Medicaid
Beds**

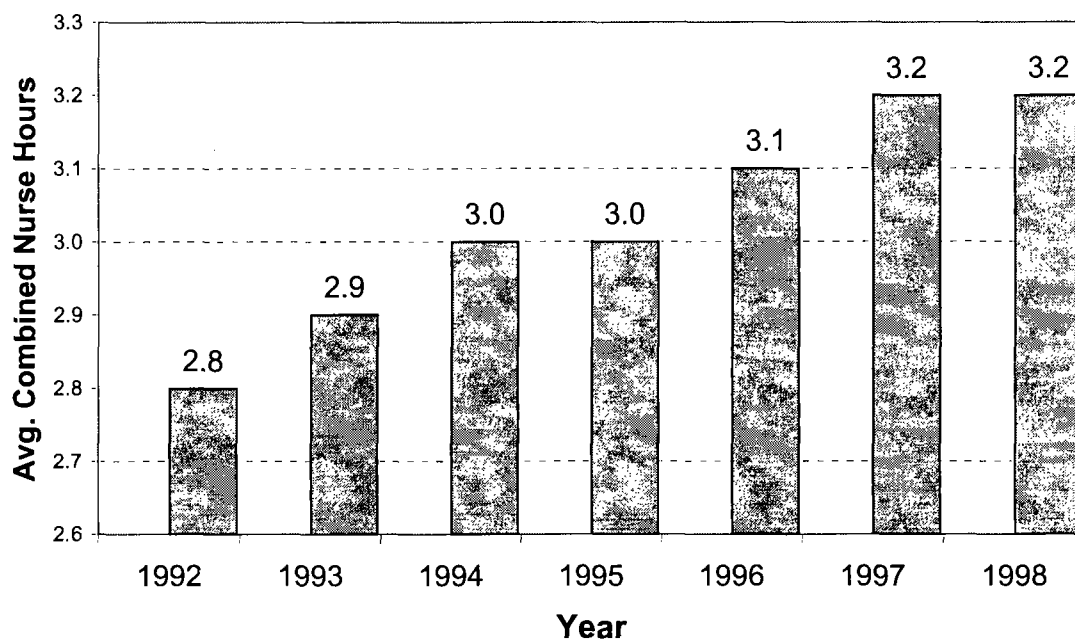


TABLE 26
AVERAGE LICENSED AND COMBINED NURSE HOURS PER RESIDENT DAY
ACILITIES WITH MEDICAID AND MEDICARE/MEDICAID BEDS (TITLE 19 AND TITLE 18/1)

State	Licensed Nurses							Total Nursing Staff						
	1992	1993	1994	1995	1996	1997	1998	1992	1993	1994	1995	1996	1997	1998
AK	1.4	1.6	1.7	1.7	1.8	1.7	1.9	3.8	4.5	4.6	4.7	4.6	4.5	4.6
AL	1.0	1.0	1.2	1.2	1.2	1.3	1.3	3.5	3.5	3.7	3.5	3.7	3.8	3.9
AR	0.6	0.7	0.8	0.8	0.8	0.9	0.9	2.3	2.6	2.7	2.7	2.7	2.8	2.9
AZ	0.8	1.4	1.2	1.2	1.2	1.3	1.4	1.5	3.4	3.4	3.3	3.3	3.3	3.4
CA	0.9	0.9	1.0	1.0	1.1	1.2	1.2	2.9	3.0	3.1	3.1	3.2	3.3	3.3
CO	1.0	1.0	1.2	1.2	1.2	1.3	1.3	2.8	2.9	3.1	3.1	3.1	3.2	3.3
CT	1.0	1.0	1.1	1.0	1.1	1.2	1.2	2.9	2.8	3.0	2.9	3.1	3.3	3.3
DC	1.3	1.2	1.4	1.2	1.5	1.6	1.5	3.7	3.5	3.9	3.5	3.9	3.8	3.8
DE	0.9	1.1	1.3	1.4	1.3	1.5	1.4	2.9	3.3	3.4	3.5	3.4	3.4	3.7
FL	1.0	1.0	1.1	1.1	1.2	1.2	1.3	3.0	3.0	3.1	3.1	3.2	3.2	3.2
GA	0.9	0.9	1.0	1.0	1.0	1.1	1.1	2.9	2.9	3.0	3.0	3.1	3.1	3.1
HI	1.1	1.1	1.2	1.1	1.2	1.3	1.4	3.4	3.3	3.6	3.5	3.6	3.7	3.8
IA	0.7	0.7	0.8	0.9	0.9	1.0	1.0	2.4	2.5	2.6	2.6	2.7	2.7	2.8
ID	0.8	1.1	1.2	1.2	1.3	1.4	1.4	2.7	3.6	3.7	3.7	3.8	3.8	3.9
IL	0.8	0.8	0.9	0.9	0.9	1.0	1.0	2.4	2.5	2.5	2.5	2.6	2.6	2.6
IN	0.9	0.9	1.1	1.1	1.2	1.2	1.2	2.8	2.8	2.7	2.8	2.8	2.9	2.9
KS	0.7	0.7	0.8	0.8	0.9	1.0	1.0	2.5	2.5	2.6	2.7	2.8	2.8	2.9
KY	0.8	0.9	1.0	1.0	1.0	1.1	1.1	3.0	3.2	3.2	3.1	3.2	3.4	3.4
LA	0.7	0.7	0.8	0.8	0.8	0.9	0.9	2.6	2.6	2.5	2.4	2.7	2.8	2.8
MA	1.0	1.0	1.1	1.1	1.2	1.3	1.4	3.0	3.0	3.2	3.2	3.4	3.4	3.5
MD	0.9	0.8	1.0	1.0	1.1	1.1	1.3	3.0	2.9	3.1	3.1	3.3	3.2	3.4
ME	0.9	0.9	1.0	1.2	1.1	1.2	1.3	3.3	3.5	3.6	3.9	3.7	3.9	4.0
MI	0.9	0.9	1.0	1.0	1.1	1.1	1.2	3.2	3.1	3.3	3.3	3.4	3.4	3.4
MN	0.8	0.9	1.0	1.1	1.1	1.2	1.2	2.6	2.9	3.0	3.0	3.1	3.2	3.1
MO	0.7	0.7	0.9	0.9	0.9	1.0	1.0	2.8	2.8	2.9	2.9	3.0	3.1	3.1
MS	0.9	0.9	1.0	1.0	1.0	1.1	1.2	2.8	2.8	3.0	2.9	3.0	3.2	3.3
MT	0.9	1.0	1.1	1.1	1.2	1.3	1.3	3.1	3.2	3.4	3.3	3.4	3.5	3.6
NC	1.1	1.1	1.2	1.2	1.3	1.3	1.4	3.3	3.3	3.5	3.4	3.4	3.5	3.6
ND	0.8	0.8	0.9	0.9	1.0	1.0	1.1	2.9	3.0	3.2	3.2	3.3	3.4	3.4
NE	0.8	0.8	1.0	1.0	1.1	1.1	1.2	2.4	2.7	2.8	2.9	2.9	3.0	3.1
NH	1.1	1.0	1.2	1.2	1.2	1.3	1.3	3.3	3.1	3.5	3.4	3.2	3.5	3.4
NJ	1.0	1.0	1.1	1.1	1.1	1.2	1.2	3.0	3.0	3.1	3.1	3.2	3.3	3.3
NM	0.8	0.8	0.9	0.9	0.9	1.0	1.1	2.8	2.9	2.9	2.8	3.0	3.0	3.2
NV	1.5	1.6	1.6	1.6	1.7	1.6	1.6	3.6	3.9	3.5	3.6	3.8	4.1	3.8
NY	~~1.1~~	~~1.1~~	~~1.1~~	~~1.1~~	~~1.1~~	~~1.2~~	~~1.2~~	~~3.2~~	~~3.1~~	~~3.1~~	~~3.0~~	~~3.1~~	~~3.2~~	~~3.3~~
OH	1.0	1.0	1.2	1.2	1.3	1.3	1.4	3.1	3.1	3.2	3.2	3.4	3.4	3.4
OK	0.6	0.6	0.7	0.7	0.7	0.8	0.8	2.3	2.5	2.5	2.6	2.8	2.8	2.8
OR	0.8	0.9	1.0	1.0	1.0	1.1	1.1	2.7	3.1	3.3	3.2	3.4	3.4	3.4
PA	0.9	1.0	1.2	1.2	1.2	1.3	1.3	2.6	3.1	3.2	3.2	3.3	3.4	3.4
RI	0.9	0.9	0.9	0.9	1.0	1.0	1.0	2.8	2.9	2.9	2.9	3.0	3.1	3.0
SC	1.0	1.0	1.1	1.1	1.1	1.2	1.2	3.1	3.1	3.3	3.2	3.2	3.3	3.3
SD	0.8	0.7	0.9	0.9	1.0	1.0	1.1	2.7	2.6	2.8	2.8	3.0	3.1	3.1
TN	0.8	0.8	0.9	0.9	1.0	1.0	1.1	2.5	2.6	2.8	2.8	2.9	2.9	2.9
TX	0.8	0.8	0.8	0.9	0.9	1.0	1.0	2.6	2.6	2.7	2.8	2.8	2.9	3.0
UT	0.8	0.9	0.9	1.0	1.1	1.0	1.0	2.6	2.7	2.7	2.7	2.9	2.7	3.1
VA	0.8	1.0	1.1	1.1	1.2	1.2	1.2	2.5	3.0	3.1	3.0	3.1	3.2	3.2
VT	1.0	1.0	1.3	1.1	1.2	1.2	1.4	2.8	3.1	3.4	3.2	3.3	3.4	3.7
WA	1.0	1.1	1.2	1.3	1.3	1.4	1.5	3.1	3.3	3.5	3.6	3.7	3.9	3.9
WI	0.9	0.9	1.0	1.0	1.0	1.1	1.1	2.9	3.0	3.1	3.1	3.2	3.2	3.2
WV	0.9	0.9	1.0	1.1	1.1	1.1	1.1	3.1	2.9	3.2	3.3	3.2	3.2	3.2
WY	0.9	0.9	1.1	1.2	1.1	1.2	1.2	2.9	3.0	3.2	3.3	3.2	3.5	3.4
US	0.9	0.9	1.0	1.0	1.1	1.1	1.2	2.8	2.9	3.0	3.0	3.1	3.2	3.2

Facilities #####

Facilities With Medicare Only Certified Beds (Title 18)

Tables 27 and 28 show the certified facilities with Medicare only beds. In 1998 there were a total of 1,757 such facilities which had RN staffing data available. Medicare only certified facilities represented only about 3 percent of the total nursing homes.

Registered Nursing Hours

The average RN hours per resident day are shown in Table 27. The average RN hours was 1.2 in 1992. The ratio increased up to 2.2 hours per resident (or 132 minutes) in 1998. The ratio of RNs hours varied across states.

LPN/LVN Nursing Hours

The average LPN/LVN hours per resident day are shown in Table 27. There was an average of 1.4 hours per resident day in 1992 and this decreased to 1.3 in 1998. This was about 78 minutes per resident day or 26 minutes per shift in 1998.

Nursing Aide/Assistant Hours

The average NA hours per resident day are shown in Table 27. The average was 2.5 hours in 1992 and in 1998.

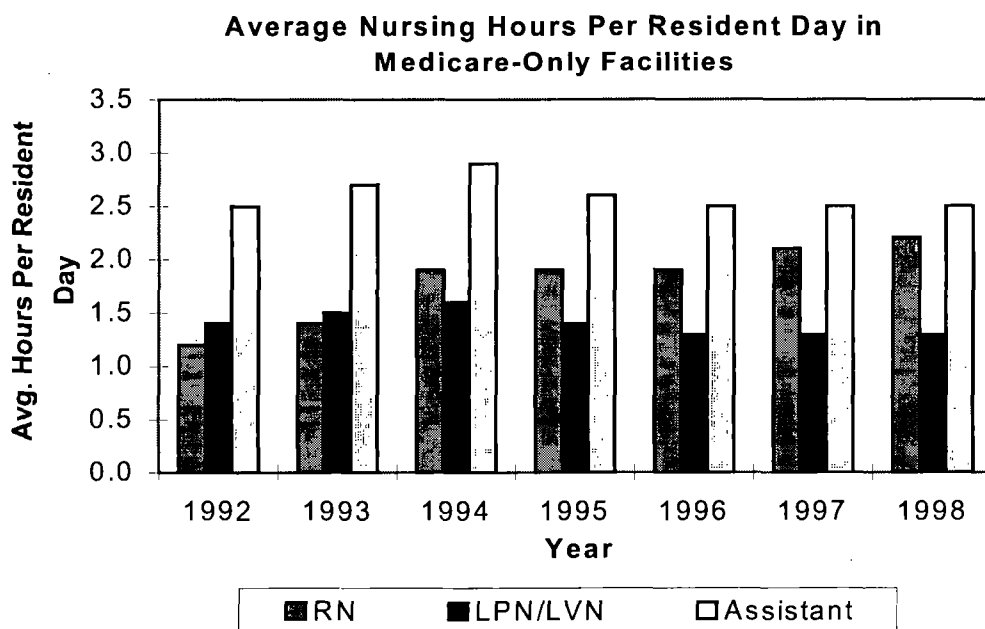


TABLE 27
AVERAGE RN, LPN/LVN, AND ASSISTANT HOURS PER RESIDENT DAY
IN FACILITIES WITH MEDICARE ONLY BEDS (TITLE 18)

	RN Hours								LPN/LVN Hours								Assistant Hours							
State	1992	1993	1994	1995	1996	1997	1998	1992	1993	1994	1995	1996	1997	1998	1992	1993	1994	1995	1996	1997	1998			
AK	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	3.1	0.0	0.0	0.0	0.0	0.0	0.0	3.4	0.0			
AL	1.3	0.7	2.2	1.5	1.3	1.8	1.6	2.3	1.5	1.8	1.8	1.3	1.2	1.8	3.2	2.9	3.2	3.0	2.4	2.7	3.1			
AR	2.5	2.0	2.4	2.3	1.7	2.0	1.8	3.0	2.5	2.1	1.8	1.5	1.9	1.5	2.3	2.6	2.4	2.0	2.2	2.2	2.5			
AZ	0.5	0.8	2.4	1.1	2.1	2.8	2.4	0.6	0.8	2.1	1.1	0.9	1.0	0.8	2.0	2.4	3.8	2.6	1.7	2.6	3.3			
CA	0.8	1.1	1.8	2.0	1.7	2.1	2.1	0.9	0.9	1.0	1.1	0.9	1.0	1.0	2.4	2.6	3.1	2.9	2.6	2.7	2.8			
CO	1.3	1.8	3.3	1.9	1.9	2.9	2.2	0.8	2.1	2.2	1.1	1.1	1.1	1.0	2.8	2.8	3.6	2.2	2.2	2.2	2.2			
CT	1.1	0.9	1.0	1.2	1.4	1.1	1.1	0.2	0.5	0.5	0.5	1.1	0.4	0.4	2.6	2.4	2.6	2.5	2.2	2.3	2.5			
DC	0.0	0.0	0.6	0.0	0.4	0.6	0.5	0.0	0.0	0.6	0.0	0.7	0.8	0.9	0.0	0.0	2.8	0.0	2.1	2.2	2.4			
DE	0.8	0.8	0.7	0.8	1.3	1.6	1.4	0.5	0.6	0.6	0.6	0.6	0.7	0.6	2.3	2.3	2.1	2.4	2.1	1.9	2.7			
FL	0.7	0.8	1.1	1.4	1.6	1.6	1.7	1.0	1.0	1.1	1.1	1.2	1.0	1.1	2.3	2.2	2.3	2.4	2.3	2.2	2.2			
GA	1.9	2.1	2.7	2.6	2.3	2.2	3.8	1.3	1.2	0.8	2.6	1.0	1.4	1.5	3.4	3.0	2.9	2.1	3.0	2.2	2.4			
HI	6.0	0.7	0.5	0.8	0.4	0.9	0.8	2.3	0.6	0.2	0.3	0.3	0.3	0.3	3.1	2.5	1.0	2.1	2.0	2.1	2.1			
IA	2.3	1.4	2.6	1.8	3.0	3.7	3.5	2.0	1.9	1.4	1.1	1.0	1.3	1.4	1.8	1.7	2.4	1.9	1.8	2.5	2.0			
ID	0.0	1.4	1.8	1.6	1.9	2.4	1.6	0.0	0.5	3.8	1.2	1.4	1.7	0.9	0.0	1.9	3.7	2.9	3.3	3.1	2.5			
IL	1.5	1.7	2.5	2.2	2.4	2.6	2.5	1.1	1.0	1.1	0.8	1.0	1.0	0.9	2.7	2.8	2.9	2.6	2.7	2.6	2.6			
IN	1.5	1.7	1.4	1.7	1.5	1.7	2.0	1.6	1.4	1.6	1.2	1.2	1.3	1.2	3.7	3.6	2.8	2.7	2.2	2.4	2.3			
KS	1.8	3.3	2.9	2.4	3.2	3.5	3.9	1.8	2.5	2.1	1.6	1.7	1.8	1.4	2.6	3.0	3.5	2.7	3.9	3.1	2.8			
KY	1.2	1.3	1.6	1.8	1.8	2.0	2.0	1.2	2.4	1.6	2.0	1.6	1.5	1.4	3.2	4.0	2.8	2.8	2.5	2.7	2.4			
LA	2.5	1.9	3.2	2.6	2.1	2.3	2.4	3.2	3.3	3.5	2.7	2.2	2.0	2.0	2.5	3.0	3.4	2.8	2.6	2.3	2.4			
MA	0.8	0.8	1.0	2.1	1.1	2.9	2.5	1.1	1.2	1.1	0.7	1.2	1.2	0.9	2.0	2.3	2.1	3.4	2.5	3.1	2.3			
MD	1.1	1.0	0.7	1.2	0.9	0.9	1.0	0.5	0.6	0.5	0.4	0.5	0.7	0.8	2.1	2.4	2.5	2.7	2.5	2.5	2.9			
ME	0.5	0.4	0.6	0.6	0.8	1.0	1.3	0.5	0.6	0.4	0.5	0.5	0.5	0.6	2.7	2.6	2.6	2.7	3.0	2.9	3.4			
MI	0.3	0.3	0.4	0.5	0.7	1.3	1.2	0.7	0.9	1.0	0.9	0.8	0.8	0.9	2.4	2.4	2.7	2.5	2.4	3.1	2.6			
MN	0.7	0.6	1.1	0.8	1.1	1.1	1.1	0.7	0.7	0.7	0.7	1.0	0.9	0.9	1.8	2.3	1.7	1.9	1.9	2.3	2.4			
MO	2.4	2.2	2.7	2.6	2.3	2.6	2.7	2.8	2.3	2.2	2.0	1.7	1.7	1.6	3.7	3.5	3.3	3.0	2.8	2.9	2.7			
MS	1.5	1.7	4.7	4.4	2.8	3.1	4.0	5.2	4.2	6.0	3.7	1.7	1.8	2.2	3.1	3.2	5.2	3.5	2.8	2.6	2.9			
MT	1.1	1.2	1.1	1.5	3.0	3.7	2.0	1.3	1.8	1.4	2.3	1.1	1.4	1.8	2.2	2.6	2.3	3.6	2.5	2.1	2.3			
NC	0.7	1.4	0.8	0.8	1.0	0.9	1.2	0.8	1.4	0.9	0.9	0.9	0.8	1.0	2.7	3.9	2.9	2.8	3.0	2.7	2.4			
ND	0.0	3.8	3.5	4.0	2.3	2.3	3.9	0.0	7.4	3.1	2.5	1.7	1.8	2.7	0.0	3.8	4.4	2.2	2.4	1.9	1.9			
NE	2.1	1.3	1.0	1.4	1.5	2.0	2.0	1.1	1.0	1.0	1.0	0.9	1.1	0.7	2.0	2.2	2.1	1.9	2.3	2.2	2.3			
NH	0.0	1.1	2.5	1.5	1.9	1.8	1.6	12.7	0.6	0.7	0.6	0.5	0.6	0.7	0.0	2.6	2.6	2.5	2.2	2.8	4.0			
NJ	1.6	0.8	1.0	0.7	0.9	1.6	3.2	1.7	0.8	0.6	0.6	0.6	0.6	1.3	2.4	2.1	2.7	2.3	2.5	2.3	3.2			
NM	4.0	0.0	3.8	1.6	1.7	2.1	1.5	2.6	0.0	3.2	1.1	0.3	0.6	0.6	3.0	0.0	3.7	2.2	2.6	2.7	2.7			
NV	0.6	0.5	1.4	0.9	1.2	1.9	1.4	0.8	0.9	1.3	0.9	0.8	1.1	0.6	1.6	2.1	2.3	1.8	2.1	2.1	1.8			
NY	0.2	0.0	0.0	0.0	0.4	0.0	0.0	0.6	0.0	0.0	0.0	0.7	0.0	0.0	2.7	0.0	0.0	0.0	2.8	0.0	0.0			
OH	1.3	2.8	2.6	2.5	2.5	2.8	2.6	1.1	1.5	2.0	1.8	1.3	1.4	1.2	2.4	2.9	2.9	2.7	2.3	2.3	2.1			
OK	1.9	1.6	2.7	2.3	2.0	2.7	2.6	2.6	2.0	2.4	2.7	1.8	2.4	2.2	2.7	2.7	2.5	2.7	2.3	2.4	2.7			
OR	0.7	0.5	0.7	0.7	0.6	1.5	0.9	0.5	0.4	0.3	0.4	0.4	0.6	0.5	2.2	2.6	2.2	2.3	2.5	2.9	2.4			
PA	1.1	1.5	2.8	2.4	2.4	2.6	2.8	0.8	1.1	1.7	1.6	1.1	1.2	1.3	1.9	2.3	3.1	2.4	2.7	2.5	2.4			
RI	0.3	0.0	0.0	0.0	0.0	0.0	0.5	0.3	0.3	0.0	0.0	0.0	0.0	0.2	1.5	1.0	0.0	0.0	0.0	0.0	0.9			
SC	0.6	1.0	1.1	1.2	1.7	1.8	1.6	1.1	1.5	1.5	1.6	1.3	1.1	1.0	2.7	3.2	3.2	2.8	2.8	2.8	2.3			
SD	0.7	0.6	0.8	0.8	0.8	1.0	1.0	0.4	0.4	0.3	0.3	0.3	0.2	0.2	1.8	1.9	2.2	2.2	2.2	2.5	2.1			
TN	0.9	0.9	3.6	2.8	2.6	2.3	2.2	1.3	1.9	2.4	2.3	1.9	1.7	1.6	2.4	1.9	2.9	2.8	2.4	2.6	2.2			
TX	1.9	2.2	2.6	2.6	2.5	2.4	2.2	2.7	3.0	2.5	2.0	1.8	1.6	1.6	3.2	3.2	3.2	2.7	2.6	2.6	2.5			
UT	1.3	1.0	1.0	1.0	0.8	1.1	1.2	0.8	0.8	0.6	0.6	0.6	0.6	0.7	2.4	2.6	2.4	2.2	2.1	2.3	2.5			
VA	1.2	0.6	0.9	0.9	1.3	1.1	1.0	1.4	1.1	0.9	0.9	1.0	1.1	1.3	3.1	2.5	2.3	2.2	2.4	2.4	2.3			
VT	0.6	0.0	0.0	0.0	0.0	0.0	0.7	0.4	0.0	0.0	0.0	0.0	0.0	0.7	2.3	0.0	0.0	0.0	0.0	0.0	2.2			
WA	0.8	1.0	1.4	1.7	1.6	2.3	2.6	0.6	0.7	0.6	0.7	0.7	0.8	0.7	1.8	2.6	2.6	2.9	2.7	2.7	3.2			
WI	2.1	0.9	1.5	2.4	2.1	2.5	2.4	1.3	0.5	0.9	1.5	0.6	0.7	0.6	3.7	2.7	2.3	4.2	2.9	2.2	2.1			
WV	3.1	1.3	2.0	3.4	1.9	1.7	3.0	3.7	1.7	2.1	2.9	1.6	1.7	1.2	2.3	2.7	4.1	3.6	2.1	2.5	2.6			
WY	4.7	3.2	3.1	3.1	4.9	4.7	4.4	1.6	2.8	2.8	2.8	2.6	2.7	1.8	3.1	2.0	2.1	2.1	1.2	0.9	1.5			
US	1.2	1.4	1.9	1.9	1.9	2.1	2.2	1.4	1.5	1.6	1.4	1.3	1.3	1.3	2.5	2.7	2.9	2.6	2.5	2.5	2.5			
Facilities	1,110	1,234	1,384	1,470	1,594	1,761	1,757	1,108	1,240	1,406	1,487	1,612	1,772	1,773	1,106	1,230	1,392	1,475	1,609	1,769	1,760			

Licensed Nursing Hours

Table 28 shows that the average licensed nursing hours (RNs and LPN/LVNs) per resident day was 2.5 in 1992 and 3.3 in 1998. The ratio varied across states.

Total Nursing Hours

Table 28 shows that the total nursing hours (RNs, LPN/LVNs, and NAs) per resident day was 4.8 in 1992 and 5.8 in 1998. The total hours varied across states.

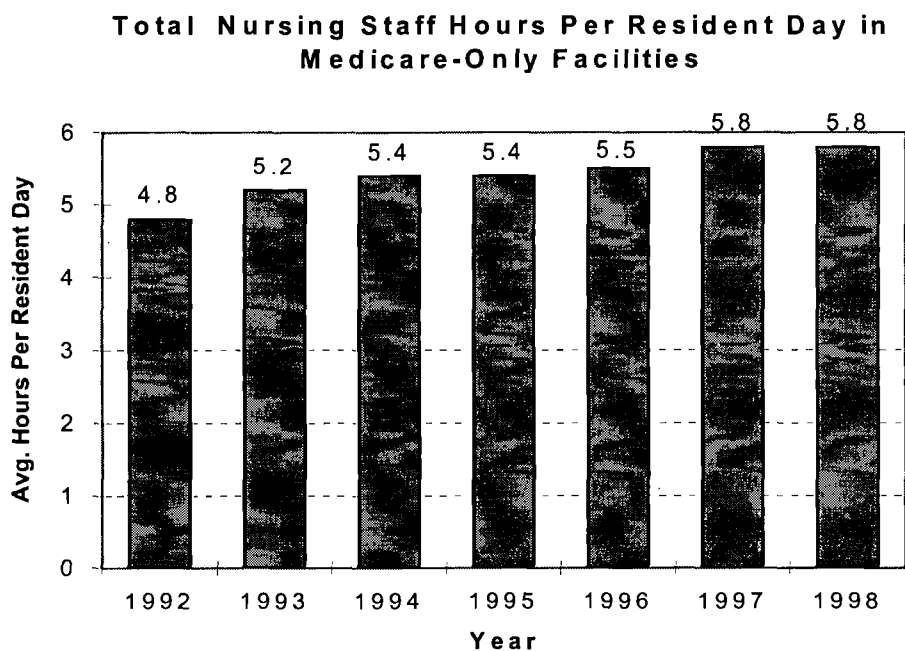


TABLE 28
AVERAGE LICENSED AND COMBINED NURSE HOURS PER RESIDENT DAY
IN FACILITIES WITH MEDICARE ONLY BEDS (TITLE 18)

State	Licensed Nurse Hours							Total Nursing Staff						
	1992	1993	1994	1995	1996	1997	1998	1992	1993	1994	1995	1996	1997	1998
AK	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
AL	3.7	2.2	2.8	3.3	2.5	2.7	3.4	5.9	5.1	4.4	6.3	4.9	5.3	6.5
AR	4.5	3.9	3.6	3.5	3.1	3.6	3.3	6.3	7.1	5.3	5.7	5.1	5.8	5.8
AZ	1.2	1.6	2.0	2.2	3.5	3.8	3.3	3.2	3.8	4.4	4.8	5.5	6.5	6.1
CA	1.5	1.9	2.5	3.1	2.7	3.1	3.1	3.9	4.4	5.2	5.4	5.3	5.7	5.5
CO	2.0	3.9	3.3	3.1	3.0	3.8	3.2	3.9	5.1	5.9	5.3	5.5	5.8	5.4
CT	1.3	1.4	1.6	1.7	2.5	1.4	1.4	3.9	3.8	4.1	4.2	3.5	3.7	4.0
DC	0.0	0.0	1.2	0.0	1.1	1.3	1.4	0.0	0.0	3.9	0.0	3.2	3.5	3.8
DE	1.3	1.4	1.4	1.5	1.9	1.6	2.2	3.6	3.7	3.5	4.2	4.0	3.7	5.3
FL	1.7	1.9	2.0	2.4	2.6	2.5	2.8	3.8	4.1	4.1	4.6	4.9	4.7	5.0
GA	3.2	3.3	4.6	6.0	2.8	3.0	4.1	6.7	6.3	8.5	8.5	4.8	5.2	6.4
HI	8.3	1.3	1.4	1.1	0.8	1.2	1.1	2.9	3.8	3.4	3.2	2.8	3.3	3.1
IA	4.4	3.4	4.4	3.1	4.0	5.0	4.9	6.1	5.1	7.0	5.1	5.9	7.6	6.9
ID	0.0	1.8	3.3	3.2	3.3	4.0	2.7	0.0	3.7	4.6	6.4	6.6	6.4	5.4
IL	2.6	2.7	3.1	3.0	3.5	3.6	3.5	5.1	5.6	5.8	5.4	6.0	6.1	6.1
IN	2.4	2.6	2.2	2.9	2.5	2.7	3.1	5.7	5.7	4.8	4.7	4.7	5.0	5.6
KS	3.7	5.2	5.2	3.9	4.7	4.9	5.3	6.4	7.9	9.0	6.7	7.8	7.8	8.0
KY	2.6	3.7	2.8	3.6	3.4	3.4	3.2	5.3	6.7	5.4	5.7	5.7	6.2	5.6
LA	5.2	5.4	5.4	5.0	4.2	4.5	4.4	7.4	7.6	8.5	7.6	6.5	7.1	6.7
MA	1.9	2.0	2.1	2.9	2.2	4.1	3.5	3.8	4.3	4.3	6.2	4.7	7.2	5.8
MD	1.6	1.6	1.2	1.6	1.4	1.6	1.8	3.7	4.0	3.7	4.3	4.2	4.0	4.6
ME	1.0	1.0	1.0	1.1	1.3	1.6	1.9	3.7	3.7	3.6	3.8	4.3	4.5	5.3
MI	1.1	1.2	1.4	1.4	1.4	2.1	2.2	3.4	3.6	4.1	3.8	3.9	5.1	4.4
MN	1.4	1.3	1.8	1.7	2.3	2.0	2.0	3.2	3.6	3.5	4.2	4.4	4.3	4.3
MO	4.7	3.9	4.4	4.4	4.0	4.3	4.2	7.5	6.8	6.9	6.9	6.7	6.8	6.7
MS	6.7	5.9	5.6	5.5	4.2	4.9	5.8	9.8	9.9	8.2	6.5	7.0	7.8	8.4
MT	2.5	3.0	2.5	3.7	4.1	5.1	3.7	4.7	5.6	4.8	7.3	6.6	6.4	6.1
NC	1.5	2.1	1.7	1.7	1.9	1.7	2.1	4.2	5.6	4.5	4.5	4.4	4.3	4.5
ND	0.0	11.3	6.6	6.5	4.0	4.1	6.6	0.0	15.1	5.3	8.7	6.4	6.0	8.5
NE	3.2	2.2	2.0	2.4	2.3	3.1	2.7	5.1	4.4	4.1	4.3	4.9	5.3	5.0
NH	0.0	1.8	3.3	2.1	2.4	2.4	2.4	0.0	4.4	5.9	4.7	4.6	5.2	6.4
NJ	1.2	1.5	1.6	1.3	1.5	1.5	3.9	3.2	3.6	4.3	3.6	4.0	3.7	6.8
NM	6.6	0.0	2.8	2.7	1.9	2.7	2.1	4.8	0.0	5.3	4.9	4.6	5.4	3.9
NV	1.5	1.1	1.7	1.8	2.1	3.1	2.0	3.3	3.0	3.9	3.7	4.2	4.1	3.8
NY	0.8	0.0	0.0	0.0	1.1	0.0	0.0	3.5	0.0	0.0	0.0	3.8	0.0	0.0
OH	2.5	3.7	3.8	4.0	3.4	4.1	3.6	4.9	6.7	6.7	6.6	6.0	6.3	5.9
OK	4.0	3.4	3.8	4.4	3.5	4.8	4.6	6.3	5.3	5.9	5.9	5.8	7.2	6.6
OR	1.2	0.9	1.0	1.0	1.0	2.1	1.4	3.4	3.5	3.3	3.4	3.5	5.0	3.8
PA	1.8	2.6	3.2	3.4	3.6	3.8	4.0	3.9	5.0	5.7	5.5	5.7	6.1	6.3
RI	1.1	0.0	0.0	0.0	0.0	0.0	1.0	4.2	1.3	0.0	0.0	0.0	0.0	1.6
SC	1.7	2.5	2.0	2.6	3.0	2.9	2.9	4.4	4.9	4.8	5.4	5.6	5.6	5.5
SD	1.1	1.0	1.1	1.1	1.1	1.2	1.2	2.9	2.8	3.3	3.4	3.3	3.7	3.3
TN	2.3	3.3	4.6	5.3	4.2	3.9	4.0	4.7	5.4	6.0	6.6	6.7	6.5	6.3
TX	4.4	5.0	4.1	4.3	4.2	3.9	3.7	7.2	7.5	7.0	6.6	6.5	6.4	6.1
UT	1.8	1.4	1.6	1.5	1.4	1.8	1.9	4.3	3.9	3.7	3.7	3.4	4.0	4.3
VA	2.8	1.7	1.9	1.9	2.3	2.2	2.3	4.3	4.2	4.2	4.0	4.7	4.6	4.6
VT	1.0	0.0	0.0	0.0	0.0	0.0	1.4	3.4	0.0	0.0	0.0	0.0	0.0	3.6
WA	1.6	1.8	2.0	2.5	2.2	3.1	3.3	3.6	4.3	4.6	5.3	4.9	5.8	6.5
WI	3.4	1.3	2.4	4.3	2.7	3.2	3.5	3.8	4.0	4.7	8.5	5.6	5.6	6.0
WV	4.4	3.0	4.1	6.3	3.5	3.4	4.0	7.1	6.1	7.1	9.8	5.6	5.9	6.7
WY	6.3	6.0	5.9	5.9	8.5	7.4	6.2	9.4	8.0	8.0	8.0	10.9	8.4	7.7
US	2.5	2.7	2.9	3.1	3.1	3.3	3.3	4.8	5.2	5.4	5.4	5.5	5.8	5.8
Facilities	1,070	1,194	1,304	1,427	1,550	1,718	1,714	1,056	1,173	1,301	1,402	1,535	1,700	1,697

Total Certified Facilities (Title 19, Title 18/19, and Title 18)

Table 29 and 30 shows a combined total of about 14,000 facilities (with Title 19, Title 18/19, and Title 18 only beds) which had useable staffing data for the staffing analysis in 1997.

Registered Nursing Hours

The average RN hours per resident day are shown in Table 29. The average hours was 0.4 in 1992. The ratio of RNs hours increased to 0.8 in 1998. This was 48 minutes per resident day or 16 minutes per 8 hour shift.

LPN/LVN Nursing Hours

The average LPN/LVN hours per resident day are shown in Table 29. There was an average of 0.6 hours per resident day in 1992 and this increased to 0.7 in 1993-1998. This was 42 minutes per resident day or 14 minutes per 8 hour shift.

Nursing Aide/Assistant Hours

The average NA hours per resident day are shown in Table 29. The average was 2.0 hours in 1992 and 2.1 hours in 1998. This was 126 minutes per resident day or 42 minutes per 8 hour shift.

Average Nursing Hours Per Resident Day in All Facilities

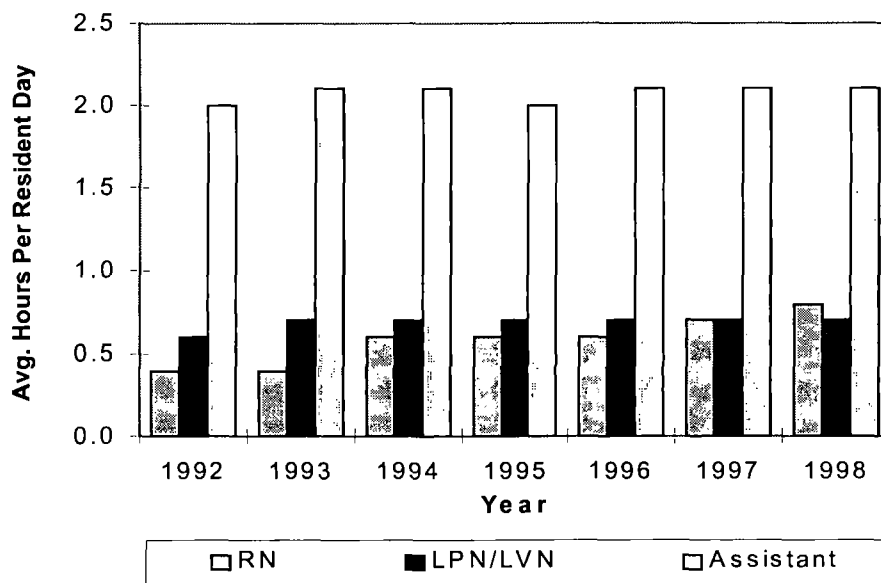


TABLE 29
AVERAGE RN, LPN/LVN, & ASSISTANT HOURS PER RESIDENT DAY
IN ALL CERTIFIED NURSING FACILITIES IN THE U.S.

	RN Hours							LPN/LVN Hours							Assistant Hours						
State	1992	1993	1994	1995	1996	1997	1998	1992	1993	1994	1995	1996	1997	1998	1992	1993	1994	1995	1996	1997	1998
AK	0.6	0.7	0.9	0.9	1.1	1.1	1.2	0.9	0.7	0.8	0.7	0.6	0.8	0.6	2.6	2.6	2.9	3.0	3.0	2.9	2.8
AL	0.3	0.2	0.4	0.4	0.4	0.5	0.5	0.8	0.8	0.9	0.9	0.9	0.9	1.0	2.5	2.5	2.5	2.4	2.5	2.4	2.5
AR	0.3	0.3	0.4	0.4	0.4	0.5	0.5	0.7	0.8	0.8	0.8	0.8	0.9	0.8	1.7	1.9	2.0	1.9	1.9	2.0	2.0
AZ	0.5	0.8	0.8	0.6	0.7	0.9	0.9	0.6	0.8	0.9	0.7	0.7	0.7	0.7	1.9	2.3	2.4	2.1	2.0	2.1	2.1
CA	0.4	0.4	0.6	0.6	0.6	0.8	0.7	0.6	0.6	0.6	0.6	0.6	0.6	0.6	2.1	2.1	2.2	2.1	2.1	2.2	2.1
CO	0.5	0.6	1.0	0.8	0.8	1.0	1.0	0.6	0.7	0.9	0.7	0.7	0.7	0.7	1.8	2.0	2.2	1.9	1.9	2.0	2.0
CT	0.6	0.6	0.7	0.6	0.7	0.7	0.8	0.4	0.4	0.4	0.4	0.5	0.5	0.5	1.9	1.9	1.9	1.9	2.0	2.0	2.1
DC	0.7	0.5	0.6	0.5	0.8	0.8	0.6	0.6	0.7	0.8	0.7	0.7	0.8	0.9	2.4	2.1	2.4	2.4	2.4	2.4	2.5
DE	0.5	0.6	0.7	0.8	0.9	1.2	1.1	0.5	0.6	0.6	0.6	0.6	0.6	0.5	2.1	2.3	2.1	2.3	2.1	2.0	2.4
FL	0.4	0.4	0.5	0.6	0.8	0.8	0.9	0.7	0.8	0.8	0.8	0.8	0.8	0.8	2.0	2.0	2.0	2.1	2.0	2.0	2.0
GA	0.2	0.2	0.3	0.3	0.3	0.3	0.4	0.7	0.7	0.7	0.8	0.8	0.8	0.8	2.1	2.0	2.0	2.0	2.0	2.0	2.0
HI	1.0	0.7	0.7	0.7	0.7	0.8	0.9	0.7	0.5	0.5	0.5	0.5	0.5	0.5	2.2	2.2	2.3	2.4	2.2	2.3	2.2
IA	0.3	0.3	0.5	0.5	0.6	0.6	0.7	0.4	0.4	0.5	0.5	0.5	0.5	0.5	1.6	1.8	1.8	1.8	1.8	1.8	1.8
ID	0.3	0.4	0.7	0.7	0.8	1.1	0.9	0.5	0.7	1.0	0.7	0.8	0.9	0.7	1.8	2.4	2.6	2.5	2.6	2.6	2.4
IL	0.4	0.4	0.6	0.6	0.7	0.8	0.8	0.5	0.5	0.5	0.5	0.5	0.5	0.5	1.8	1.8	1.8	1.8	1.7	1.8	1.7
IN	0.3	0.3	0.5	0.5	0.6	0.7	0.7	0.7	0.7	0.8	0.8	0.8	0.9	0.8	2.0	2.0	1.8	1.8	1.8	1.8	1.7
KS	0.3	0.4	0.5	0.5	0.6	0.7	0.7	0.5	0.6	0.6	0.6	0.6	0.6	0.6	1.9	1.9	1.9	1.9	2.0	2.0	1.9
KY	0.4	0.4	0.6	0.6	0.7	0.8	0.9	0.6	0.8	0.8	0.9	0.8	0.9	0.9	2.3	2.5	2.3	2.3	2.3	2.4	2.3
LA	0.4	0.3	0.6	0.5	0.5	0.6	0.6	0.9	0.9	1.0	0.9	0.9	0.9	0.9	2.0	2.1	1.7	1.6	2.0	1.9	2.0
MA	0.4	0.4	0.5	0.6	0.7	0.8	0.8	0.5	0.5	0.6	0.6	0.6	0.6	0.6	2.0	2.0	2.1	2.1	2.2	2.2	2.2
MD	0.4	0.3	0.4	0.5	0.6	0.6	0.7	0.5	0.5	0.6	0.5	0.5	0.5	0.6	2.1	2.1	2.1	2.1	2.1	2.1	2.2
ME	0.4	0.4	0.6	0.6	0.8	0.9	1.0	0.5	0.6	0.4	0.5	0.5	0.5	0.5	2.5	2.6	2.6	2.7	2.8	2.8	2.9
MI	0.3	0.3	0.4	0.4	0.5	0.6	0.6	0.6	0.6	0.6	0.6	0.6	0.6	0.6	2.3	2.2	2.2	2.2	2.2	2.3	2.2
MN	0.3	0.3	0.4	0.4	0.5	0.6	0.6	0.5	0.6	0.6	0.6	0.6	0.6	0.7	1.8	1.9	1.9	1.9	1.9	2.0	1.9
MO	0.4	0.5	0.6	0.6	0.6	0.7	0.7	0.8	0.8	0.8	0.8	0.7	0.7	0.8	2.3	2.3	2.2	2.2	2.2	2.2	2.2
MS	0.2	0.2	0.4	0.6	0.7	0.9	1.0	0.7	0.8	0.9	1.0	0.9	0.9	1.0	1.9	1.9	2.1	2.1	2.1	2.2	2.2
MT	0.5	0.5	0.6	0.6	0.8	1.0	0.8	0.5	0.6	0.5	0.6	0.6	0.6	0.6	2.2	2.2	2.2	2.2	2.3	2.2	2.3
NC	0.4	0.4	0.6	0.5	0.6	0.6	0.7	0.7	0.8	0.7	0.7	0.7	0.7	0.8	2.3	2.4	2.3	2.3	2.3	2.3	2.2
ND	0.3	0.4	0.5	0.7	0.6	0.7	0.7	0.5	0.5	0.6	0.6	0.6	0.6	0.6	2.1	2.0	2.3	2.2	2.3	2.3	2.3
NE	0.3	0.3	0.5	0.5	0.5	0.6	0.6	0.5	0.6	0.6	0.6	0.6	0.6	0.6	1.7	1.9	1.8	1.9	1.9	1.9	1.9
NH	0.6	0.5	0.8	0.7	0.8	0.8	0.9	0.7	0.5	0.5	0.5	0.5	0.5	0.5	2.2	2.1	2.3	2.3	2.1	2.3	2.2
NJ	0.5	0.5	0.6	0.6	0.6	0.7	0.9	0.5	0.5	0.5	0.5	0.5	0.5	0.6	2.0	2.0	2.1	2.1	2.1	2.1	2.2
NM	0.4	0.3	0.7	0.5	0.6	0.9	0.8	0.7	0.6	0.7	0.6	0.5	0.5	0.5	2.1	2.0	2.1	2.1	2.2	2.1	2.2
NV	0.6	0.6	1.3	0.9	1.2	1.7	1.3	0.8	0.9	1.2	0.9	0.8	1.1	0.6	1.7	2.1	2.3	1.9	2.1	2.2	1.9
NY	0.5	0.4	0.5	0.5	0.5	0.5	0.6	0.6	0.6	0.6	0.6	0.6	0.6	0.6	2.1	2.0	2.0	2.0	2.0	2.0	2.0
OH	0.4	0.5	0.6	0.6	0.7	0.8	0.8	0.7	0.8	0.8	0.8	0.8	0.8	0.8	2.1	2.1	2.1	2.1	2.1	2.1	2.1
OK	0.3	0.3	0.4	0.3	0.4	0.5	0.6	0.7	0.7	0.7	0.7	0.6	0.8	0.8	1.8	1.9	1.9	1.9	2.1	2.1	2.0
OR	0.4	0.5	0.7	0.6	0.7	0.8	0.7	0.4	0.4	0.4	0.4	0.4	0.4	0.4	2.0	2.3	2.3	2.2	2.3	2.3	2.3
PA	0.4	0.5	0.8	0.8	0.8	1.0	1.1	0.5	0.7	0.7	0.7	0.7	0.7	0.8	1.7	2.1	2.2	2.1	2.1	2.1	2.1
RI	0.5	0.5	0.5	0.5	0.6	0.7	0.7	0.4	0.4	0.3	0.3	0.3	0.3	0.3	1.9	1.9	2.0	2.0	2.0	2.1	2.0
SC	0.3	0.4	0.5	0.5	0.6	0.7	0.7	0.8	0.8	0.9	0.9	0.9	0.9	0.8	2.2	2.3	2.3	2.2	2.2	2.3	2.1
SD	0.4	0.4	0.6	0.6	0.6	0.7	0.7	0.4	0.3	0.3	0.3	0.3	0.3	0.3	1.9	1.8	1.9	1.9	2.0	2.0	2.0
TN	0.2	0.2	0.5	0.5	0.5	0.6	0.6	0.6	0.7	0.8	0.8	0.8	0.8	0.8	1.8	1.8	1.9	1.9	1.9	2.0	1.9
TX	0.3	0.4	0.6	0.7	0.8	0.8	0.8	0.9	1.0	1.0	0.9	0.9	0.9	0.9	1.9	2.0	2.1	2.0	2.1	2.1	2.1
UT	0.7	0.8	0.9	0.8	0.7	1.0	1.0	0.7	0.8	0.6	0.6	0.6	0.6	0.6	2.1	2.3	2.2	2.1	2.0	2.1	2.3
VA	0.3	0.3	0.4	0.4	0.5	0.6	0.6	0.6	0.7	0.7	0.7	0.7	0.8	0.8	1.7	2.0	2.0	2.0	1.9	2.0	1.9
VT	0.4	0.4	0.5	0.4	0.5	0.6	0.6	0.6	0.7	0.8	0.6	0.6	0.6	0.7	1.8	2.1	1.9	1.9	2.1	2.1	2.3
WA	0.5	0.6	0.7	0.7	0.8	0.9	0.9	0.5	0.5	0.5	0.6	0.5	0.6	0.6	2.1	2.3	2.2	2.3	2.3	2.4	2.4
WI	0.4	0.4	0.6	0.6	0.6	0.7	0.7	0.4	0.4	0.4	0.4	0.4	0.4	0.4	2.0	2.1	2.1	2.1	2.1	2.2	2.1
WV	0.5	0.3	0.4	0.6	0.6	0.6	1.0	0.9	0.7	0.8	0.9	0.8	0.9	0.8	2.2	2.0	2.3	2.3	2.1	2.1	2.2
WY	0.5	0.6	0.7	0.7	0.8	1.0	1.0	0.6	0.7	0.6	0.6	0.6	0.6	0.6	2.0	2.1	2.1	2.1	2.1	2.1	2.1
US	0.4	0.4	0.6	0.6	0.6	0.7	0.8	0.6	0.7	0.7	0.7	0.7	0.7	0.7	2.0	2.1	2.1	2.0	2.1	2.1	2.1
Facilities	13573	13366	14108	14093	14446	14462	14202	13526	13345	14136	14118	14487	14507	14237	13526	13313	14100	14087	14462	14477	14208

Licensed Nursing Hours

Table 30 shows the average licensed nursing hours (RNs and LPN/LVNs) per resident day was 1.0 in 1992 and 1.4 in 1998.

Total Nursing Hours

Table 30 shows the total nursing hours (RNs, LPN/LVNs, and NAs) per resident day was 3.0 to 3.5 hours per resident day over the 1991-98 period. In 1998, this was about 210 minutes per resident day or 70 minutes per 8 hour shift.

Total Nursing Hours Per Resident Day in All Facilities

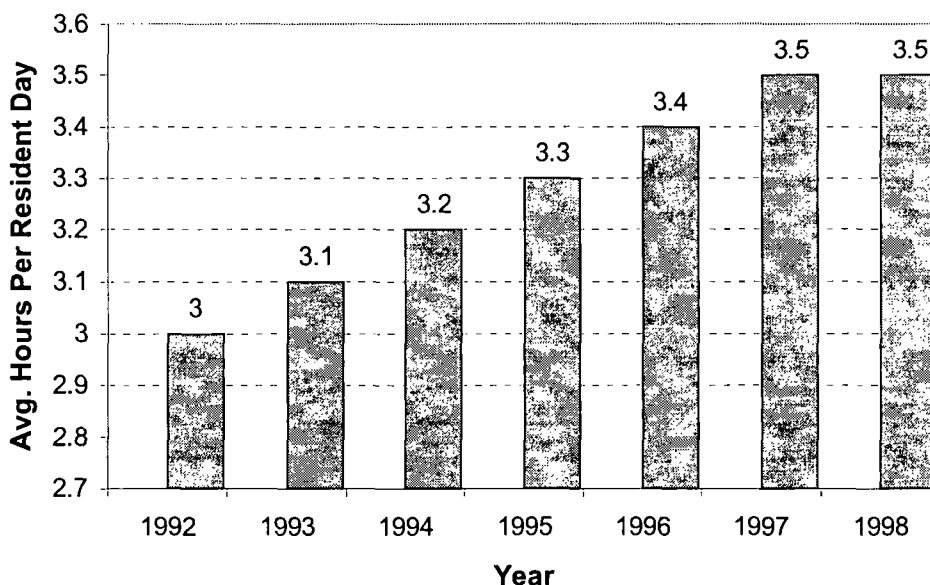


TABLE 30														
AVERAGE LICENSED AND COMBINED NURSE HOURS PER RESIDENT DAY														
IN ALL CERTIFIED NURSING FACILITIES COMBINED														
	Licensed Nurse Hours							Total Nursing Staff Hours						
State	1992	1993	1994	1995	1996	1997	1998	1992	1993	1994	1995	1996	1997	1998
AK	1.4	1.6	1.7	1.7	1.8	1.7	1.9	3.8	4.5	4.6	4.7	4.6	4.5	4.6
AL	1.1	1.1	1.3	1.3	1.3	1.4	1.4	3.6	3.6	3.7	3.7	3.8	3.8	4.0
AR	0.9	1.0	1.2	1.1	1.2	1.3	1.4	2.6	3.0	3.0	3.1	3.1	3.3	3.4
AZ	1.2	1.6	1.4	1.4	1.5	1.6	1.6	3.0	3.7	3.6	3.5	3.5	3.7	3.7
CA	1.0	1.1	1.2	1.2	1.2	1.4	1.4	3.1	3.1	3.3	3.3	3.4	3.5	3.5
CO	1.0	1.3	1.4	1.5	1.4	1.7	1.7	2.8	3.1	3.5	3.4	3.4	3.7	3.7
CT	1.0	1.0	1.1	1.1	1.1	1.2	1.2	2.9	2.8	3.0	3.0	3.1	3.3	3.3
DC	1.3	1.2	1.4	1.2	1.5	1.6	1.5	3.7	3.5	3.9	3.5	3.8	3.8	3.8
DE	1.0	1.2	1.3	1.4	1.5	1.6	1.7	3.1	3.4	3.4	3.7	3.6	3.5	4.2
FL	1.1	1.2	1.3	1.4	1.6	1.6	1.7	3.1	3.3	3.3	3.4	3.6	3.6	3.7
GA	0.9	0.9	1.0	1.1	1.1	1.1	1.2	3.0	3.0	3.1	3.1	3.1	3.1	3.2
HI	1.7	1.1	1.2	1.1	1.2	1.3	1.3	3.3	3.4	3.6	3.5	3.5	3.7	3.7
IA	0.7	0.8	0.9	0.9	1.0	1.1	1.2	2.5	2.6	2.7	2.7	2.8	2.9	2.9
ID	0.8	1.1	1.4	1.4	1.5	1.9	1.6	2.7	3.6	3.8	4.0	4.1	4.3	4.2
IL	0.9	0.9	1.2	1.1	1.2	1.3	1.3	2.6	2.8	2.9	2.9	3.0	3.1	3.1
IN	1.0	1.0	1.3	1.3	1.4	1.5	1.5	3.0	3.0	3.0	3.0	3.2	3.3	3.3
KS	0.8	0.9	1.1	1.0	1.1	1.2	1.3	2.7	2.8	3.0	2.9	3.1	3.2	3.2
KY	1.0	1.2	1.3	1.5	1.5	1.6	1.6	3.2	3.6	3.6	3.6	3.8	4.0	3.9
LA	1.2	1.3	1.5	1.4	1.3	1.5	1.6	3.2	3.2	3.4	3.2	3.3	3.5	3.5
MA	1.0	1.0	1.1	1.2	1.3	1.4	1.4	3.0	3.0	3.2	3.3	3.4	3.5	3.6
MD	0.9	0.9	1.0	1.0	1.1	1.1	1.3	3.1	3.0	3.1	3.1	3.3	3.3	3.5
ME	0.9	1.0	1.0	1.1	1.2	1.4	1.5	3.3	3.6	3.6	3.8	4.0	4.1	4.4
MI	0.9	0.9	1.0	1.0	1.1	1.2	1.2	3.2	3.2	3.3	3.3	3.4	3.5	3.4
MN	0.8	0.9	1.1	1.1	1.2	1.2	1.2	2.6	2.9	3.0	3.0	3.1	3.2	3.2
MO	1.1	1.2	1.4	1.3	1.4	1.4	1.5	3.3	3.3	3.4	3.4	3.6	3.6	3.7
MS	1.0	1.0	1.1	1.4	1.5	1.8	1.9	2.9	2.9	3.1	3.2	3.6	4.0	4.0
MT	1.0	1.1	1.1	1.2	1.4	1.6	1.4	3.1	3.2	3.4	3.5	3.6	3.7	3.7
NC	1.1	1.1	1.3	1.3	1.4	1.4	1.5	3.4	3.4	3.6	3.5	3.6	3.6	3.7
ND	0.8	1.0	1.2	1.3	1.2	1.3	1.3	2.9	3.1	3.2	3.6	3.5	3.6	3.7
NE	0.8	0.8	1.0	1.1	1.2	1.2	1.2	2.5	2.7	2.9	2.9	3.0	3.2	3.2
NH	1.1	1.1	1.3	1.2	1.2	1.4	1.3	3.3	3.2	3.5	3.5	3.3	3.6	3.5
NJ	1.0	1.0	1.1	1.1	1.1	1.2	1.4	3.0	3.0	3.2	3.2	3.2	3.3	3.6
NM	1.0	0.8	1.0	1.1	1.1	1.3	1.3	2.9	2.9	3.1	3.1	3.2	3.4	3.3
NV	1.5	1.3	1.7	1.8	2.0	2.8	1.9	3.4	3.2	3.8	3.7	4.1	4.1	3.8
NY	1.1	1.1	1.1	1.1	1.1	1.2	1.2	3.2	3.1	3.1	3.0	3.1	3.2	3.3
OH	1.1	1.2	1.4	1.4	1.5	1.6	1.6	3.2	3.4	3.5	3.5	3.6	3.6	3.6
OK	0.9	0.9	1.0	1.0	1.0	1.3	1.3	2.7	2.7	2.8	2.8	3.1	3.4	3.3
OR	0.8	0.9	1.0	1.0	1.0	1.2	1.1	2.8	3.1	3.3	3.2	3.4	3.5	3.4
PA	1.0	1.2	1.4	1.4	1.5	1.7	1.8	2.7	3.3	3.5	3.5	3.6	3.8	4.0
RI	0.9	0.9	0.9	0.9	1.0	1.0	1.0	2.8	2.9	2.9	2.9	3.0	3.1	3.0
SC	1.1	1.3	1.4	1.4	1.5	1.5	1.6	3.3	3.4	3.5	3.7	3.7	3.8	3.8
SD	0.8	0.8	0.9	0.9	1.0	1.1	1.1	2.7	2.6	2.8	2.8	3.0	3.1	3.1
TN	0.8	0.9	1.2	1.2	1.3	1.4	1.4	2.6	2.8	3.0	3.0	3.2	3.3	3.4
TX	1.2	1.4	1.4	1.6	1.6	1.6	1.7	3.1	3.3	3.4	3.5	3.6	3.7	3.7
UT	1.3	1.3	1.5	1.4	1.3	1.6	1.6	3.4	3.5	3.5	3.5	3.3	3.8	3.9
VA	0.9	1.0	1.2	1.1	1.2	1.3	1.4	2.6	3.0	3.2	3.1	3.2	3.3	3.4
VT	0.9	1.0	1.3	1.1	1.2	1.2	1.4	2.8	3.1	3.4	3.2	3.3	3.4	3.6
WA	1.0	1.1	1.3	1.3	1.3	1.5	1.5	3.1	3.4	3.5	3.6	3.7	3.9	4.0
WI	0.9	0.9	1.0	1.0	1.1	1.2	1.2	2.9	3.0	3.1	3.2	3.2	3.3	3.3
WV	1.2	1.0	1.3	1.4	1.4	1.5	1.7	3.3	3.1	3.5	3.6	3.5	3.7	3.9
WY	1.1	1.3	1.3	1.3	1.3	1.6	1.6	3.2	3.5	3.4	3.4	3.5	3.8	3.7
US	1.0	1.1	1.2	1.2	1.3	1.4	1.4	3.0	3.1	3.2	3.3	3.4	3.5	3.5
Facilities	13,296	13,059	13,768	13,744	14,089	14,121	13,856	13,133	12,913	13,600	13,574	13,930	13,943	13,693

August 3, 2000

OPTION FOR IMPROVING STAFFING LEVELS IN NURSING HOMES

The following is a list of options that could form the basis of responding to Sen. Grassley's request for technical assistance as well as possible additions to the Administration's give-back proposals. Sen. Grassley has requested assistance in developing a proposal that would provide additional funding to nursing homes and that funds would be tied to improvement in nurse staffing levels.

This document is a working draft. Staff from OL, CHPP and CMSO have had preliminary discussions of these proposals. Any recommendations are preliminary and would be used only for internal purposes and would not be shared with Hill staff.

Option 1 -- Modifications to Exist Proposals

Enhanced Reporting Requirements -- As a Condition of Participation for Medicaid or Medicare, nursing homes (or certified portions) would be required to provide detailed reports to HCFA on all nursing staff, including the total number of hours, the coverage per shift, whether the staff were CNAs, LPNs or RNs, and the average wage rate for each class of employees. Nursing homes would also be required to classify all residents in certified facilities into Medicare RUGs. Nursing homes would not be paid directly for the costs of this new requirement, rather this would be included as part of the proposal to provide SNFs the full market basket update. (Provision similar to Stark Bill)

In addition, this information could be used in conjunction with other options discussed below.

Concerns/Issues: This option would not directly increase funding to nursing homes but would provide the base information need to assure that increases in staffing levels actually occur. If we paid for this directly it would contradict general policies related to other new CoPs for hospital etc.

Staff Recommendation: This proposal should be included as a modification to existing give-back proposal.

Option 2 -- Establish Staffing Levels

Establish a minimum staffing level -- As a Condition of Participation for Medicare and Medicaid, nursing homes would be required to maintain a certified nurses aide (CNA) to patient ratio that provides at a minimum 2 hours per day of CNA staff to each resident. (No minimums

for RNs or LPNs at this time.) Enhanced reporting requirements from Option 1 would be included. Nursing homes would be paid for the costs of this new requirement through appropriate changes to both Medicare and Medicaid payment rates as follows.

Medicaid

Enhanced Matching Rates -- States would have the option to increase Medicaid payment rates. As an incentive to States, the FMAP would be increased by xx percentage points (calibrated to only spend \$1 billion over 5 years) for all costs reported as nursing facilities services. States would provide HCFA with a written assurance that they were using the additional Federal funds to increase support of nurse staffing in nursing homes. Federal reviews/audits would be made to verify the State assurance.

Medicare [Only if necessary]

Increase the staffing component of the SNF PPS -- The nurse staffing component of the Medicare SNF PPS rate would be increased xx percent. SNFs would be required to provide HCFA with written assurances that the increased payment would be used to increase so that nursing homes would be able to increase either the rate of pay for CNAs or the overall number of CNAs in the facilities. Note: The component of the rate related to "nurse staffing" (not simply "staffing") addresses approximately 25 percent of the rate depending on RUG-- other components of the rate capture different staffing costs (e.g., rehab therapy, administrative).

Concerns/Issues: The 2-hour standards has not been validated as of yet. We will have much more confidence in this approach after Phase 2 of the staffing study is complete later this year. The cost to the nursing homes/facilities is not yet determined, OACT is investigating this and hopes to have an estimate in two weeks. Medicare payments are probably adequate already and increasing them just to allow for cross subsidization may be inappropriate at this time given concerns about UPL. CHPP is investigating the staffing levels inherent in the existing RUGs-based PPS payment system.

Staff Recommendation: Low priority. Although this proposal is probably the right thing to do, it is premature given the status of the Phase 2 report. Once the Phase 2 report is available we will be in a much stronger position to move this type of proposal forward.

Option 3 -- Encourage States to Increase Medicaid payment rates

The following are several options designed to encourage States to increase payments to nursing facilities tied to nursing staff needs.

Option 3A Enhanced Matching Rates -- States would be expected to increase Medicaid payment rates independently from any minimum staffing level. As an incentive to States,

the FMAP would be increased by xx percentage points (calibrated to only spend \$1 billion over 5 years) for all costs reported as nursing facilities services only if the States provided nursing facilities increased payment rates specifically tied to increased nursing staff that were in excess of the rate of inflation and normal population growth. States would provide HCFA with a written assurance that they had provided a payment rate increase greater than the rate of CPI plus 1 percent (for population growth) and that the rates were specifically targeted to increasing either the rate of pay for CNAs or the overall number of CNAs in the facilities. Federal reviews/audits would be made to verify the State assurance.

Concerns/Issues: This proposal would be entirely optional and therefore if States did increase rates sufficiently there would be no Federal costs and no impact on staffing levels. This would require addition RO audits of State payments to oversee the State assurances. This might also be perceived as supporting nursing homes over community-based care that might be going in the opposite direction as Olmstead.

Staff Recommendation: Medium priority. Enhanced match rates are controversial and possible institutional bias concerns would need to be addressed.

Option 3B Re-Establish Boren Amendment -- The Boren Amendment would be re-established. This provision that was repealed in 1997 BBA would required States find and makes assurance to HCFA that the payment rates to hospitals, ICFs/MR, and nursing facilities are reasonable and adequate to meet the costs of an efficient and economical facility in conformance with State and Federal laws, quality of care, and reasonable access. (Waxman Bill) This could even be further targeted to refer to "adequate nursing staff to assure quality of care."

Concerns/Issues: This Administration proposed to repeal the Boren Amendment in the first place. It is not clear that States would increase rates. The only incentive to increase rates that this proposal provides would be in the avoidance of possible lawsuits.

Staff Recommendation: Low priority. We should support more direct positive incentives rather than relying on lawsuits to act as a State incentives to raise rates.

Option 3C State Standards -- Either require States to establish nursing staff standards as 11 States do today, or provide an enhance matching rate to those States that agree to set a standard equal to or better than those included in our Summer 2000 report.

Concerns/Issues: This approach could be done either as a mandate or an option with a FMAP incentive. The mandate approach would be at a State-specific staffing level that might be very minimal. Making the proposal as an option with a FMAP increase as an incentive avoids the problems of a "mandate," but creates a problem at what level to set the standard. We wouldn't want to "pay" for a really low standard, so this option proposes giving the incentive only if the State uses the Summer 2000 report levels of 2

hours of CNA and 1 1/2 hours for licensed nurses.

Staff Recommendation: Medium priority for the option that uses incentives and low priority for the option that requires a mandate.

Option 4 -- Medicare

Increase the staffing component of the SNF PPS -- The nurse staffing component of the Medicare SNF PPS rate would be increased xx percent. SNFs would be required to provide HCFA with written assurances that the increased payment would be used to increase so that nursing homes would be able to increase either the rate of pay for CNAs or the overall number of CNAs in the facilities.

Concerns/Issues: Medicare payments are probably adequate already and increasing them just to allow for cross subsidization may be inappropriate at this time given concerns about UPL. CHPP is investigating the staffing levels inherent in the existing RUGs-based PPS payment system.

Staff Recommendation: Low Priority. Since Medicare is not likely to be the problem this has a low priority, however using Medicare PPS may be easier administratively than many of the other options.

Option 5 -- Grants to States

Grants to States -- Incentive grants would be made to States that demonstrate a number of different concepts. The State could have a program that demonstrates that nursing homes have increased nursing staff wages or levels. (Similar to Waxman Bill and Stark Bill) Another idea that is described in the Stark bill, use these grants to establish funding for education and training centers for individuals who furnish direct resident care. These training centers could easily include nursing homes or even limited to nursing homes. In addition, the Waxman bill suggests that the grants to States be used for improving the quality in nursing homes. The funds could be used for nursing homes to hire additional staff or retain existing staff; or to increase nursing staff education, or incentives to increase nursing staff.

Concerns/Issues: The Waxman approach is funded by new sanctions related to the number and level of deficiencies found during the survey. This funding source may not be necessary in the context on a "give-back" Bill

Staff Recommendation: High Priority. This proposal would involve funding and policy decisions separate from either Medicare and Medicaid therefore this proposal would avoid complex implementation issues. States or nursing homes would just get some money if they

meet the award criteria.

Option 6 -- Sanctions/Penalties

Penalties -- Establish new sanctions separate from the current nursing home sanctions to fund Grants to State under option 4.

Option 6A -- The Waxman bill establishes a trust fund that receives to support the grant program described above. Funding comes from a new set of sanctions as follows \$2000 for each deficiency that has the potential for harm, \$10000 for each deficiency that causes actual harm, and \$25000 for immediate jeopardy. This is just an example of new sanctions.

Option 6 B -- Sanctions could also be applied for not reporting data as specified in Option 1.

Option 6 C -- HCFA would require that providers found, as a result of a State or Federal survey, to provide very poor care (this level of care would be defined by HCFA taking into account scope and severity level of deficiencies, and possibly resource issues) would be required, in addition to any other remedy imposed, to submit to the State/Federal survey agency for approval, a plan of correction in which the provider specifies:

1. How CNA, LPN, and RN staffing ratios contributed to deficiencies, how the provider proposes to ensure that sufficient numbers of staff are available to prevent similar deficiencies from reoccurring, and a date by which sufficient staff will be available; and
2. How CNA, LPN, and RN staff training contributed to deficiencies, how the provider proposes to address training needs of new and existing staff, a date by which staff training will be completed, and a schedule for any ongoing training;

Concerns/Issues: The main approach in these options has been incentives not penalties, however oversight and enforcement of new and old requirements is still a very real issue.

Recommendations: Medium Priority. We prefer incentives to penalties, however we need to ensure quality of care.

Executive Summary

This interim report responds to a request from the Senate Appropriations Committee for an evaluation of the effect of the President's 1998 Nursing Home Initiative (NHI) on nursing home quality of care. This report presents initial findings--drawn from the Health Care Financing Administration's (HCFA) survey and certification administrative database, its longitudinal data base of resident assessment information known as the Minimum Data Set (MDS), from surveys of State Survey Agency staff and HCFA regional offices, and from focus groups of consumers. Results of analyses of these data will provide some preliminary information about the implementation and outcomes of the Nursing Home Initiative. HCFA will continue to assess these data and will submit yearly reports to Congress with the results of these studies.

The Nursing Home Initiative

The President initiated a series of actions to:

- Make State inspections more effective by increasing the focus on assessing and preventing bed sores, malnutrition, and abuse in nursing homes by conducting more frequent surveys of selected facilities that have repeated violations, and by starting more surveys in off hours.
- Improve the enforcement of nursing home requirements by instituting immediate sanctions for repeated violations of nursing homes that harm residents, by preventing terminated facilities from immediately being reinstated, and by establishing an additional sanction that will allow for immediate civil money penalties and by conducting complaint investigations of potential harm more quickly.
- Educate the public for making better choices for nursing home care, to increase awareness of potential abuse and how to report it, and to understand the importance of proper nutrition for nursing home residents.

To support implementation of the various initiatives, the survey and certification budget has increased from \$158 million in FY 1997 to \$204 million in FY 2000. Additional funds have been reprogrammed for complaint investigations (\$4 million in FY 1999, \$5 million in FY 2000). There has also been increased HCFA regional office involvement in supporting State survey Agencies and assuring State accountability in a consistent manner. Finally, HCFA has increased training for State survey agency staff as well as trying to increase ongoing communication with State managers.

Nursing Home Initiative Implementation

The findings in this interim report are grouped into three areas. The first group looks at several of the nursing home initiatives to see how completely they were implemented by HCFA and the State agencies. The five initiatives addressed were:

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- 1) the implementation of a staggered schedule (a schedule which includes weekends and evenings) for nursing home recertification surveys;
- 2) removing, from facilities with a history of noncompliance, the opportunity to correct deficiencies before imposition of enforcement remedies;
- 3) allowing reasonable assurance periods before re-admitting terminated nursing homes to the Medicare program;
- 4) increased scrutiny of special focus facilities; and ^{→ define}
- 5) implementation of a streamlined process for investigating complaints in which allegations were raised. This is a subset of the Nursing Home Initiatives: they represent the ones for which data are readily available (e.g. from administrative databases). Data on other Nursing Home Initiatives--such as increasing sample size for residents at risk of dehydration--require the collaboration of multiple parties, and therefore additional time and resources to collect. As a result, they are not reported here.

This report finds that the first four of the studied initiatives have been implemented. Our data show that, since January 1998:

- the number of surveys beginning in the evening or on weekends has increased from less than 1% to more than 8%;
- Over 90% of facilities that HCFA identified as having severe deficiencies were referred to the proper authorities for immediate sanctioning.
- Facilities terminated from the Medicare program now remain out of the program an average of 4 months before being readmitted.
- Through the close scrutiny of Special Focus Facilities, HCFA uncovered serious problems in these facilities. As a result, 10% of these facilities were removed from the Medicare and Medicaid programs or voluntarily withdrew, while 28 (25%) came into consistent compliance.

An evaluation of the fifth initiative--HCFA's guidance to State Agencies in modifying the complaint investigation procedures--suggests that States and HCFA may have had different expectations concerning the levels of instruction and supervision HCFA would provide. However, it does indicate that HCFA took measures to implement the new procedures, but that these measures may not have been adequate to implement the policy change. Nevertheless, more than two-thirds of the States reported that they were investigating complaints of alleged immediate jeopardy within 2 days and complaints of alleged actual harm within 10 days.

Survey Problem Identification

One of the key goals of the NHI was to increase the effectiveness of surveyors in identifying problems in nursing homes. The second section reports on several measures of survey problem identification, such as the mean number of deficiencies found in a survey, and the proportion of surveys that result in determinations of substandard quality of care. The purpose of this section is to assess indirect evidence that suggests that the NHI might have led to changes in surveyors' ability or willingness to detect problems in nursing homes. For several, but not all, of these measures, this report suggests that there has been an increase in findings of problems in nursing homes. The most striking increase (from 6.7% in early 1996 to 14.1% in the latter half of 1999) is in the percentage of nursing homes cited for abuse. There were also increases in the number of facilities cited for any deficiency, the average number of deficiencies found in a facility, and the number of facilities cited for failure to prevent or care for pressure sores (bed sores).

Resident Characteristic Trends

The third set of findings looks at several resident characteristics that reflect, indirectly, interventions of the nursing home initiative. One of these measures, the use of physical restraints, has shown a steady downward trend. Since 1996 restraint rates have dropped from about 18 percent to about 11 percent. There is a possible upward trend in the use of tube feeding, which is consistent with other reports of national increases in the use of tube feeding. There is also a possible slight downward trend in the prevalence of pressure ulcers. However, the prevalence of pressure sores varies greatly by State and may simply reflect changes in reporting practices or an increasing tendency to move residents with pressure ulcers to other care settings.

Conclusion

In conclusion, this report suggests that, of the limited measures looked at, States have generally implemented the NHI. Data also suggest that surveyors are identifying more problems in nursing homes and that more nursing homes are falling into the substandard quality of care category. Data on resident characteristics studied for this report show that physical restraints is the only resident condition that has changed importantly; this decline has continued for more than 5 years.

It is important to note that these are preliminary results to an initiative that is less than 2 years old. Thus there are a number of limitations to these findings. The first is that we employed indirect measures of quality of care and of the implementation of the Nursing Home Initiative, making it difficult to detect changes in either. For example, all of the measures of resident characteristics are prevalence measures (percentage of residents with a characteristic), which are not very satisfactory for understanding when events occurred and what caused those events. The second major limitation with the study design for this report is that it did not attempt to rule out other causes for the observed changes. Now that the impact of the NHI should be beginning to take full effect, HCFA will expand its studies to assess the effect and any changes to the quality of care provided by nursing homes. Over the next year, HCFA will concentrate on assessing outcomes in Nursing Home residents' conditions using the Minimum Data Set database. To the degree possible, the analyses will attempt to isolate the effect of the President's nursing home initiative

~~minimum data set~~
~~database~~
~~that~~
We do not
have enough
data to indicate
whether
quality is
truly declining
or whether
these findings
are the
result of
more
rigorous
surveys

from other important events such as the Medicare skilled nursing facility PPS or increased financial distress of nursing home chains.]

Is this possible for HCFA to do? Later text implies this can't be done.

Introduction

This interim report responds, in a preliminary way, to a request by the Senate Appropriations Committee for an evaluation of the effect of the NHI on quality of care in nursing homes.¹ HCFA's analysis of this question is ongoing. This report provides an update of HCFA's activities and will describe HCFA's strategy for responding to the Congress.

Background

There has been continued public concern about the quality of care in nursing homes and about the ability of HCFA's current system of survey and certification to protect a vulnerable population. Evidence of this concern can be found in recent press reports, in reports from the General Accounting Office (GAO), and in HCFA's July 1998 Report to Congress.

In response to the findings of both HCFA's own July 1998 Report to Congress and the GAO reports, HCFA implemented in the latter half of 1998 and throughout 1999 a number of new survey and enforcement activities. These activities included the selection of a group of nursing homes (the so-called Special Focus Facilities) to receive close scrutiny by State survey agencies; the initiation of a standardized process for handling complaints; new emphasis on conducting surveys outside of normal business hours; and closer scrutiny of potential problems of care related to pressure ulcers, use of physical restraints, dehydration, and nutrition (for a complete list of the Nursing Home Initiatives, see Appendix A). While some of these initiatives have only been recently implemented, it is reasonable to assess the current status of these efforts.

Study Design

It is inherently difficult, perhaps impossible, to give a definitive assessment of the effectiveness of the NHI. Without a randomized study design or even a quasi-experimental design we cannot ultimately separate the effects of the NHI from other changes roughly concurrent with the implementation of the NHI. These include implementation of the Medicare Prospective Payment System (PPS) for Skilled Nursing Facilities, financial difficulties of a number of large nursing home chains and individual facilities, decline in occupancy levels, possible changes in the acuity and functional limitation of the resident population, and changes in practice patterns. In addition, the NHI is not a single intervention, but a package of interventions implemented at varying times and to varying degrees throughout the United States. If determining the collective impact of the NHI is difficult, assessing the effect of a specific intervention is even more difficult.

Finally, the criterion for judging effectiveness is not obvious. In general, improved regulation is regarded by many as a very blunt instrument for improving the quality of care of the nursing home

¹ Page 199 of Senate Report 106-166 (accompanying the FY 2000 Labor, HHS, Education appropriation bill).

population. HCFA's current system of survey and certification, as is normal for all regulatory systems, is designed to ensure adequate minimal standards of care. Hence, while improvement in the survey and certification system might raise the performance of the poorly performing facilities, it may not have any impact on those nursing homes that perform above that minimum.

Interim Report Assessment *mention education efforts like nursing home compare etc. which have the potential to impact better care perform home through competition and full disclosure.*

The above study design difficulties notwithstanding, we believe that an assessment of the NHI can be informative. First, a number of the initiatives had very specific process objectives - e.g., the implementation of staggered surveys and conducting more surveys on weekends. The States are also now required to have established an explicit process for complaint investigation consistent with recent HCFA policies. Evidence can be collected to assess whether these and other initiatives have been implemented.

Second, we can assess whether the evidence on the lack of enforcement that both HCFA and the GAO found in previous studies has changed. Although we had no way to assess the appropriateness of any individual survey, we found it implausible that entire States found no or almost no substandard care deficiencies. As before, although we are unable to separate the impact of other factors (e.g., changes in the quality of care), we can assess whether the prior extreme levels of poor problem identification have persisted.

Third, we can assess possible changes in resident characteristics, particularly in problem areas targeted by the NHI. These areas include resident nutrition and hydration, resident abuse and neglect, and pressure sores. However, for all the reasons noted above, we have to be very cautious in making inferences about the causal impact of the NHI.

These three assessment areas provide the organization of this interim report. The report will summarize findings about the implementation of several of the nursing home initiatives, assess evidence about whether or not States are adequately identifying problems in nursing homes, and present data on changes in important resident characteristics (e.g. prevalence of pressure sores and restraint use) that may be related to quality of care.

Future Assessments

Although this interim report provides a very limited assessment of the NHI, we think future assessments can be more definitive. First, it may be possible to develop measures of the *degree* of implementation of the various parts of the NHI and compare outcome measures for States that are relatively high implementors of the NHI as compared to low-implementation States. Second, we may be able to take advantage of the staggered implementation of the PPS and develop a quasi-experimental design for assessing the impact of the PPS and the NHI. Third, in future reports we may be able to contrast changes in resident characteristics that were targeted by the NHI with

*doesn't
HCFA
have data
to do this?*

other problem areas not targeted. Fourth, conclusions about the effectiveness of the NHI might be arrived at indirectly by eliminating other explanations for changes in apparent quality, such as changes in case mix. Finally, we may conduct some qualitative case studies on the processes implemented by States that appear to have achieved very good outcomes.

Overview of the contents of this report

OSCAR { This study will present preliminary data from the Online Survey, Certification, and Reporting System (OSCAR) and from the Minimum Data Set (MDS). OSCAR is HCFA's administrative database. It includes data reported by the nursing homes, at the time of the annual survey, on resident characteristics, on nursing home staffing, and on resident census. OSCAR also contains information about citations made by the surveyors for regulatory violations uncovered during the survey. The MDS is a longitudinal data set that captures clinical information about nursing home residents in every Medicare- and Medicaid-certified nursing home in the country. It is estimated that these homes represent more than 95% of all nursing homes in the country. HCFA has collected MDS centrally since 1998.

Two { The preliminary data presented in this report are intended to be descriptive. They illustrate broad, but crude, trends in resident characteristics that are potentially affected by the NHI over the last ~~two~~ four years. This report cannot ascribe any cause to these changes. Multiple factors, such as change in the characteristics of nursing home residents over time, changes in nursing home payment methods, changes in staffing characteristics, changes in nursing home ownership and organization, and changes in regulatory practice operate simultaneously to potentially alter the quality of care in nursing homes. Subsequent reports, which will have the benefit of additional sources of data, may be able to provide some evidence of causal association, but it is highly likely that any future conclusions will be highly tentative and will be confined to describing changes in nursing home outcomes that occurred at the same time as the Nursing Home Initiative.

The report findings are grouped into three broad areas. The first presents findings from OSCAR and from the MDS about changes in several resident characteristics. These characteristics were selected because they were most closely tied to the NHI and because they were judged to be the most representative of nursing home quality of care. They include: the prevalence of physical restraint use (from OSCAR and MDS), the prevalence of pressure sores (from OSCAR and MDS), the prevalence of tube feeding (from OSCAR and MDS), the prevalence of dehydration (from MDS), and the prevalence of weight loss (from MDS).

The second group of findings presents data from OSCAR about the results of nursing home inspections. These inspection results include: 1) the number of health deficiencies found; 2) the number of citations made for resident abuse; 2) the number of citations made for improper use of physical restraints; 3) the number of citations made for improper use of tube feeding; 4) the number of citations made for poor quality of care leading to pressure sores; 5) the number of findings made of substandard quality of care; and 6) the number of deficiency-free surveys found.

These results will be compared to earlier published findings about how well the nursing home survey process identified problems in nursing homes (Health Care Financing Administration 1998).

The third group of findings from this study will look at five measures of implementation of the Nursing Home Initiative. These measures include: how consistently States identify and report (to HCFA's Regional Office) facilities that should be given no opportunity to correct deficiencies before enforcement remedies are imposed; how many revisits are conducted after serious deficiencies are found before facilities achieve substantial compliance or receive enforcement remedies; how fully States are implementing changes to the complaint process; and findings about the results of the special focus facility program.

DRAFT June 23, 2000



DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

Washington D.C. 20201 - 0001

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National Health Care Group Supports Creation of New Optimal Staffing Standard For Skilled Nursing Patients

***American Health Care Association Initiates Policy Discussion To Help Solve
Important National Problem***

***Cites Need To Attract 250,000 Certified Nursing Assistants Into Profession By 2002; Seeks Joint Venture
With HCFA To Establish, Monitor Impact Of Standards***

Washington, DC -- The President and CEO of the American Health Care Association (AHCA), Charles H. Roadman II, M.D., today released new guiding principles, recently approved by AHCA's Executive Committee, that, "supports the creation of an aggregate optimal staffing standard," that will be accomplished by, "working with government and consumer advocates to establish this aggregate optimal staffing standard and method."

Said Dr. Roadman: "Achieving a mutually agreed-upon aggregate optimal staffing standard for skilled nursing patients is a key public policy objective. With this declaration, we seek to initiate a national policy debate on how best to implement this important priority of increasing staff to ensure quality patient care."

The AHCA "Staffing Standards in Nursing Facilities" guiding principles also, "calls upon the Clinton Administration and the Congress to join us in a national crusade in establishing a goal of attracting over 250,000 new Certified Nursing Assistants (CNAs) to the profession, as well as 60,000 new Licensed Practical Nurses (LPNs) and Registered Nurses (RNs) to the profession, by January 1, 2002," and notes that, "a national initiative on the order of President Clinton's call for 100,000 new police officers and 100,000 new teachers is in order." These bold numbers were calculated by AHCA from HCFA's proposed "optimal nursing standard" in a recent HCFA study.

The guiding principles specifically state that the creation of an optimal staffing standard must be based on patient's acuity, that, "Any standard enacted by legislation or adopted by regulation must impact all patients regardless of payor source," that, "any staffing standard cannot be 'Medicare specific'," and, that, "States must fully fund any staffing standard in their Medicaid reimbursement methodologies."

"The bottom line," said Dr. Roadman, "is that all parties involved in this matter have an obligation to America's seniors, and to the public at large, to put solutions on the table in order to move forward in a positive and constructive manner."

See Attached AHCA Staffing Standard Guiding Principles (3 Pages Total Document)

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Operations: Staffing

Position of the American Health Care Association on Staffing Standards in Nursing Facilities

Our Position: The American Health Care Association (AHCA) supports the creation of an aggregate optimal staffing standard. Government, consumer advocates and providers must join together to create a fully funded aggregate optimal staffing standard for nursing facility patients. We offer these guiding principles on the creation and maintenance of nursing facility staffing standards:

1. Any standard enacted by legislation or adopted by regulation must impact all patients regardless of payor source. Specifically, for the purpose of the legislative discussions that will take place for the remainder of the 106th Congress, any staffing standard cannot be "Medicare specific". Such a narrowly focused standard would be disastrous for dually certified providers and the patients they serve by inappropriately skewing upward the staffing standard on beds occupied by Medicaid recipients without the concomitant funding to support these standards. The Congress will reexamine the Balanced Budget Act of 1997 and the Balanced Budget Refinement Act of 1999 this Fall. If policy makers conclude that the infusion of additional funding will only be forthcoming to the profession if tied to a staffing standard, such a standard and the funding that follows must apply to both Medicaid and Medicare providers and recipients.

2. States must fully fund any staffing standard in their Medicaid reimbursement methodologies. Any federal legislation enacted or regulation adopted must require the states, in their state plans, to fully fund the standard for their Medicaid nursing facility providers and recipients. HCFA must be vigilant in its oversight and state plan review and approval responsibilities. Furthermore, the federal directive must prohibit states from funding the staffing standard by reducing one or more non-nursing components of the rate. "Robbing Peter to pay Paul" cannot be tolerated.

3. AHCA supports a fully funded aggregate optimal staffing standard to provide quality care for our patients. Government, consumer advocates and providers continue the debate over the "right" staffing number that no one really knows. We support an aggregate optimal staffing standard based on acuity to provide quality care to our patients. We commit to working with government and consumer advocates to establish this aggregate optimal staffing standard and method. We will accept and support the "right" number consistent with a public policy to fully fund this

might hinder concurrent with a public policy to fully fund this quality level to ensure that the long term care profession recruits, retains and rewards qualified people.

4. AHCA calls upon the Clinton Administration and the Congress to join us in a national crusade in establishing a goal of attracting over 250,000 Certified Nursing Assistants (CNA) to the profession by January 1, 2002. Our CNA 's are the long term care profession's critically important first line of safety and service for our patients. Accordingly, a national initiative on the order of President Clinton's call for 100,000 new police officers and 100,000 new teachers is in order. AHCA proposes the following steps to assist in accomplishing this initiative:

a. The Clinton and successor administrations must lead and exhort the public to action. The employment environment in the profession is condition critical. It requires an immediate, aggressive and effective response.

b. Our immigration laws must be liberalized to attract qualified professional and para-professional help to the long term care profession from outside the country.

c. Congress and the Administration must help to reduce the use of a temporary work force for the profession. Nationally, the profession has had to use temporary employees because it has been unable to attract and keep a permanent work force. The use of temporary employees is unnecessarily expensive and, more importantly, destroys the continuity of long term care delivery which is so critical to successful patient outcomes.

d. Funding must be provided for training grants to providers and organizations that represent them so that the profession can keep its qualified people and establish rewarding career paths for them.

e. A national criminal background check registry must be created to ensure the safety of long term care patients and personnel.

f. Medicare and Medicaid funding systems must be fully funded to give the long term care profession the resources to attract and keep qualified people.

5. The profession and policy makers must work together to develop dependable and defensible data collection systems to establish appropriate staffing standards and to monitor them. Phase II of the HCFA study creates an excellent opportunity for HCFA and the long term care profession to joint venture an initiative to do the research that is necessary to develop the data collection infrastructure to establish present and future profession staffing standards and to monitor the impact of such standards on long term care costs, quality of and access to care.

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EXECUTIVE SUMMARY

1998 STATE LONG TERM CARE PROGRAM AND MARKET CHARACTERISTICS

INTRODUCTION

This is a summary of findings from a project on state long term care (LTC) program and market characteristics conducted by researchers at the University of California, San Francisco, and Wichita State University under a cooperative agreement with the U.S. Health Care Financing Administration and the U.S. Department of Housing and Urban Development. Descriptive data for 1998 were collected from a survey of state officials in 1999. The data collection effort was designed to build upon a cross-sectional longitudinal data set on long term care program characteristics in the states for the 1978 through 1998 period. Primary data were collected by telephone using structured questionnaires that requested specific data from each state.

STATE DATA BOOK

A state data book has been prepared which has a state by state presentation of statistical data for 1998. Data were collected from three different surveys of: (1) state LTC providers; (2) state certificate-of-need and moratorium programs; and (3) Medicaid reimbursement agencies.

Each part includes data on six types of long term care services: (1) nursing facilities (NF); (2) intermediate care facilities for the mentally retarded (ICF-MR); (3) residential care (or board and care); (4) adult day care; (5) home health agencies; and (6) hospice.

In addition, analytic papers have been prepared which describe special studies that were conducted. These papers include special analyses of data from the 50 states regarding the change in nursing facility beds and the predictors of reimbursement rates. The following is a summary of the most important findings from the 1998 descriptive data and from trends over the 1978-1998 period.

DEMOGRAPHIC TRENDS IN THE STATES

The demand for long-term care services is growing with the increasing numbers of individuals who are aged and chronically ill. In 1998, there were 34.4 million Americans who were age 65 and older. As the population ages and develops chronic illnesses, the need for long term care services, including nursing facility services increase. The average aged population in the U.S. has been increasing rapidly. The aged population (65 and over) was 11 percent of the total population in 1978 but grew to 12.7 percent in 1998. The percentage aged 85 and over increased from 1.0 percent of the total U.S. population in 1978 to 1.5 in

1998. States show a wide range of ratios of aged population. Alaska has the lowest ratio of aged (5.5 percent aged 65 and over in 1998) while Florida had 18.3 percent aged 65 and over. States with the lowest ratios tended to be in the west and states with the highest ratios of aged were in the northeast or central regions. The data on the population came from the U.S. Bureau of the Census.

NURSING FACILITY PROVIDERS

The number of nursing facilities in the nation increased from 14,264 in 1978 to 17,458 in 1998. This represents a 22 percent increase in the 20-year period of 1978-1998 for the U.S. The total number of combined skilled nursing and nursing facility beds in the states increased from 1.31 million to 1.81 million between 1978 and 1998, a 38 percent increase during the 20 year period. Thus, the growth in the number of beds exceeded the growth in the total number of facilities. The U.S. average number of beds per facility increased from 91.8 beds in 1978 to 103.5 beds in 1998 (a 13 percent increase).

There were 53.4 beds per 1,000 population aged 65 and over in the U.S. in 1978 compared with 52.5 in 1998. The average number of beds per 1,000 population aged 85 and over declined from 610.3 to 445.6 between 1978 and 1998 (a 27 percent decline). Between 1997 and 1998, 33 states showed declines in the ratio of nursing facility beds per 1,000 population aged 65 and over.

Data on nursing facility occupancy rates across states are increasingly difficult to obtain from the state agencies. In 1978, the average nursing facility occupancy rate for 25 reporting states was 90.3 percent. The average occupancy rates for the U.S. increased gradually to a high of 92.8 percent in 1984 (46 states reporting), and then gradually declined again to 88.3 percent in 1998 (22 states reporting). Because many states have not collected occupancy data during the last four years, the lower rates may simply be an artifact of these states reporting. Occupancy rates varied from a low of 78.0 percent in Oregon to a high of 95.0 percent in New York in 1998.

COMMUNITY-BASED PROVIDERS

Considerable growth in home care and other community-based long term care services occurred during the 1990s. Thus, those who need long term care services have greater choices and expanded opportunities for public funding for such programs. Although the demand for long-term care services is growing, little is known about the availability of community-based long term care providers.

Intermediate Care Facilities for the Mentally Retarded

In 1998, 6,553 licensed ICF-MR facilities were identified in the states. This was a decrease of 19 facilities since 1997. The largest number was reported in California (989 facilities). New York and Texas also had large numbers of

facilities relative to those reported by other states.

There were 125,909 licensed ICF-MR beds in the states in 1998. This was a decrease of 2.1 percent over the total beds in 1997. Texas had the largest number of beds, but its beds declined by 0.6 percent since 1997.

The average number of beds per facility was 19.2 beds in 1998. Although there was a slight decrease in the U.S. average number of beds per facility in 1998, the average varied considerably across the states. As with nursing facilities, ICF-MR beds per population varied by state. The highest ratio of ICF-MR beds per 1000 population was in the District of Columbia with 1.64. The lowest ratios were in Alaska (0.00), New Hampshire (0.02) and Vermont (0.02). Generally, states were unable to report occupancy rates for ICF-MR facilities. For those states reporting (9 states), the average occupancy rate, was 96.4 percent in 1998.

Other Residential Care

Residential care is reported in two separate categories: facilities for adults/aged, and facilities for the non-aged, which includes individuals with MR/DD, mental illness, substance abuse and AIDS.

There were 51,227 licensed residential care facilities reported for adults/aged in 1998 (a 2.6 percent increase since 1997 and a 45.7 percent increase over the 35,171 facilities serving the elderly in 1990). The state with the largest number of facilities was California (10,652) and the state with the smallest number of facilities was Wyoming (35).

The total number of licensed residential care beds for adults/aged in the U.S. was 878,804 in 1998 (a 6.0 percent increase since 1997 and a 70.7 percent increase over the 514,749 beds serving the elderly reported in 1990). In 1998 California reported 169,184 beds, over twice as many as Pennsylvania and Florida, 4 times as many as New York, and nearly 6 times as many as Texas. The average number of licensed residential care beds per facility was 17.2 beds in 1998.

The ratio of licensed residential care beds serving adults was 25.5 residential care beds per 1000 population age 65 and over in 1998. These ratios also varied widely across states, from 51.8 beds per population in Oregon to 3.7 beds per 1,000 in Louisiana. The data also show that the ratio of licensed residential care beds per aged population has increased over the 1990-1998 period.

In 1998, there were 13,277 'residential care non-aged' facilities in the U.S., an increase of 10.7 percent since 1997. The number of 'residential care non-aged' beds was 102,068 in 1998, an increase of 3.9 percent since 1997.

The increases in residential care for both aged and non-aged populations are, in part, related to more complete reporting on residential care from the states.

Some states have residential care reporting and monitoring located in as many as three agencies, making data collection difficult.

Home Health Care Agencies

There were a total of 13,537 licensed home health care agencies in the U.S. in 1998. The number increased by 326 percent over the 3,175 in 1989. Since many states were unable to report on the number of agencies licensed in earlier years, the large increase in agencies may in part be an artifact. Texas, Florida, California, and New York reported large numbers of agencies in 1998. The average ratio of licensed home health care agencies per 1000 population aged 65 and over was 0.47 in 1998. Texas had the largest ratios of agencies per aged population (1.81), Pennsylvania had the smallest (0.05).

For the first time, a drop in licensed home health care agencies occurred between the years 1997 and 1998. In 1997 there were 14,062 licensed home health care agencies and in 1998 there were 13,537, a decrease in 3.7 percent. This drop appears to be related to changes in Medicare certification under the Balanced Budget Act of 1997.

Ten states did not license agencies but rather used certification of agencies for participation in Medicare and Medicaid. The number of certified home health care agencies increased from 2,905 agencies in 1989 to 9,726 agencies in 1998. This was a 235 percent increase in certified agencies over the 1989-1998 period. The number of certified home health care agencies declined 7.3 percent since 1997.

Adult Day Care Centers

Twenty-seven states reported 3,590 licensed adult day care centers in 1998 in the U.S. Pennsylvania and California reported the largest numbers of day care centers in 1998 (627 and 619, respectively). When the number of centers was compared with population aged 65 and over, the national average ratio per 1,000 aged population was 0.16 in 1998. Louisiana had the highest ratio of day care centers per population (0.56).

Hospice

In 1998, 43 states reported 1,992 licensed hospice organizations. Texas and Michigan had the most organizations in 1998, with 151 and 120 respectively. Colorado and South Dakota had the fewest licensed hospices, with 2 each. The 1,992 licensed hospices reported in 1998 represented an increase of 2.2 percent since 1997. There were 0.07 licensed hospice organizations per 1000 population aged 65 and over in the U.S in 1998. Wyoming had the highest ratio of hospices (0.25) while California, Florida and Iowa, with 0.01 organizations per 1000 population each had the lowest.

The number of certified hospices increased from 2,254 in 1997 to 2,344 in 1998. This was an increase of 4.0 percent since 1997. In 1998, there were 8 states that

did not license hospice organizations, but used certification instead. Louisiana was the only state that licensed but could not report the number of certified hospices in 1998.

In summary, while the total number of nursing facilities, ICF/MR and home health care agencies have decreased since 1997, the total number of residential care, adult day care and hospice programs have continued to increase in the recent time period. The alternatives to nursing home care have been increasing and may reduce the demand for nursing home care over time. The wide variations in the supply of different LTC providers reflect the many historic differences in state programs and utilization patterns.

CERTIFICATE-OF-NEED AND MORATORIA

State certificate of need policies are designed to limit or plan provider supply. Congress passed the National Health Planning and Resources Development Act of 1974 (P.L. 93-641) to establish the certificate-of-need program (CON), which required approval for new beds and services. After the federal requirements for health planning and certificate of need were removed in 1986, there was wide variation in state CON activities.

By 1980, all states had adopted CON programs. In 1982, 44 states had CON only, 6 had CON and moratorium, and only one state, Arizona, had no CON. Between 1997 and 1998, 44 states (including the District of Columbia) continued their CON programs and/or moratorium for nursing facilities.

Some states began adopting moratoria on all nursing bed growth in the early 1980s. Eight states that retained their CON programs also added a moratorium on nursing home beds and services during the 1980s. In 1998, 13 states had both a CON and moratorium, 6 states had only a nursing facility moratorium (with no CON), and 25 states had CON only. This left only 7 states with neither a CON nor a moratorium.

In summary, during 1998, 44 states regulated the growth of new nursing facility beds and/or facilities through either a CON and/or a moratorium. Of the total states, 38 also had a CON and/or moratorium requirement for regulating the conversion of hospital beds to nursing home beds.

Many states that had CON and/or moratorium programs for nursing facilities also used them for other long-term care programs. Intermediate care facilities for the mentally retarded (ICF-MR) were regulated under CON and/or moratorium requirements by a majority of states (35 states in 1998). Of these states, 14 had both a CON and moratorium and 4 had a moratorium only on ICF-MR beds and facilities. Surprisingly, 18 states included residential care facilities under their CON and/or moratorium requirements in 1998, an increase of 8 states since 1997.

Between 1979 and 1981, 28 states had CON programs for home health agencies. Once a state developed CON for home health care, they generally retained the program (only 7 states dropped CON during the 1978-1992 period). In 1998, 18 states used a CON alone for home health and 1 state had both a CON and moratorium.

In summary, in spite of the federal withdrawal of support for the CON program, the majority of states and the District of Columbia retained their CON and/or moratoria for nursing facilities and ICF-MR. A number of states also used CON and/moratorium for other long-term care programs.

MEDICAID REIMBURSEMENT RATES

State Medicaid provider rates can have a critical impact on stimulating or reducing supply and demand for nursing facility services. State Medicaid programs have been making major efforts to control the growth in nursing facility reimbursement rates. States are given a great amount of flexibility in their reimbursement methods and the variation across states is substantial.

NURSING FACILITY REIMBURSEMENT

Reimbursement Methods

Primary data were collected on state Medicaid nursing home reimbursement rates and methods for the 1978-1998 time period. Rates were categorized into five groups: (1) retrospective, (2) prospective class, (3) prospective facility specific, (4) prospective adjusted, and (5) combination of prospective and retrospective. Retrospective reimbursements traditionally have set rates based on the costs of providing care. Prospective methods set rates in advance, by setting a flat rate for groups of facilities (class method) or by setting rates for each facility based on historical costs and other factors (facility-specific). Adjusted methods allow upward adjustments during a period, generally based upon cost information that becomes available. Combinations systems use different approaches, and sometimes these are set for different cost centers. In addition, some states have been adjusting their rates based upon the characteristics of residents (casemix reimbursement). Such methods can be applied to any of the five general rate-setting methods.

None of the states changed their general nursing home reimbursement methods between 1997 and 1998. The number of states using retrospective reimbursement methods declined from 13 in 1979 to only 1 state (Nebraska) in 1996, and remained so through 1998. The number of states using prospective facility-specific methods was 20 in 1998. The states using prospective class methods (4 in 1978 and 3 in 1998) remained relatively stable over the period. Twenty-four states used prospective adjusted methods in 1998 compared with

only 13 in 1979. Combination methods were used in 3 states in 1979 and in 3 states again in 1998. These trends in methods show more complex but flexible rate setting methods.

Casemix Reimbursement

The most striking trend has been the increase in the number of states using casemix reimbursement methods, which pay on the basis of patient care needs, to account for differences in the costs of providing for those needs. By 1998, there were 26 states using casemix reimbursement, an increase over the 19 that used this method in 1992. No changes were made in the use of casemix between 1997 and 1998. The use of casemix reimbursement methods may improve access for heavy care patients, enhance quality of care, increase facility efficiency, and more fairly treat facilities on the basis of patients admitted. Casemix systems, however, can create incentives to increase patient dependence and could have negative effects on quality of care depending upon how the systems are designed and monitored.

Ancillaries

One critical feature of rates is whether or not ancillaries are included and which ones are included. In 1998, 32 states included durable medical equipment, 35 included physical therapy, 32 included occupational therapy, 31 included respiratory therapy, and 10 included physician services. Forty-seven states included non-legend drugs and only 3 states included prescription drugs. Where an ancillary is included in a daily nursing home rate, the rate should be higher, but ancillary costs may be less. There was a greater tendency to include ancillaries in rates by 1998 than there had been in previous years.

Cost Reporting Years

States use cost reports from previous years to set their prospective rates. In 1994, all states except 2 were using cost report data from the 1990s to set current reimbursement rates. In 1998, 33 states used cost reports from 1996, 1997 or 1998 in setting rates.

Capital Component

The methods of reimbursing capital are of special interest. States have different methods of valuating capital. Historic cost and market value approaches may allow less control of changes in rates, by allowing greater inflation in valuation of capital. There was a slight shift away from pure historic cost valuation of capital between 1984 (35 states) and 1989 (30 states). By 1998, 26 states used historic costs methods, while 6 used combination systems, 9 used rental value, and the others used different systems.

Reimbursement Rates

Each state can be characterized by one overall average reimbursement rate for nursing facilities. Depending on payment and rate setting methods, estimating average reimbursement rates by state is variably complex and imprecise. State Medicaid reimbursement rates have increased substantially overtime. In 1980, the weighted average nursing home per diem rate across the states was \$30.36. This increased to \$45.06 in 1985 and by 1992, it was \$73.98. In 1998, the average reimbursement increased to \$95.72 from \$91.45 in 1997. When inflation was taken into account, the rates increased from \$36.84 in 1980 to \$58.72 in 1998. Thus, the average inflation adjusted rate increase for the 19-year period was 59 percent, an average of 3.1 percent annually. The inflation-adjusted rates increased 2.7 percent between 1997 and 1998.

In summary, the variations in nursing facility rates and methods create major differences in revenues by state and regions. Such variations can have a direct impact on the financial viability of LTC facilities and the public and private investments made in LTC facilities.

OTHER MEDICAID LONG TERM CARE REIMBURSEMENT

Intermediate Care for the Mentally Retarded

State ICF-MR reimbursement is established by the Medicaid program. The methodologies vary considerably across states but tend to be similar to the methods for nursing facilities. In 1998, 18 states used prospective facility specific methods, 13 used retrospective reimbursement, 12 used adjustable upward rates, 3 states used prospective class reimbursement, and 5 used combination methods. The Medicaid reimbursement rates varied from \$80.79 per day in Oklahoma to \$517.07 per day in Oregon in 1998. The average Medicaid reimbursement rate was \$222.29 per day in 1998 (all states including the District of Columbia reported).

Home Health Care

States have a variety of ways to reimburse Medicaid home health agencies. States may opt to simply apply Medicare principles, which was used by 12 states out of 51 reporting in 1998 (including Washington DC). Another 9 states used Medicare principles with state alterations. Nineteen states used a fee schedule for payment to home health agencies. One state used Medicaid retrospective reimbursement methods, 5 states used prospective agency-specific reimbursement rates, and 5 used other methods. The average reimbursement rate for Medicaid home health care was \$71.26 per visit in 1998 for those 43 states reporting rates. Rates ranged for registered nursing care from \$ 26.92 in Indiana to \$164.96 in Alaska.

Residential Care

Seventeen states provide Medicaid services to persons in residential care under the Medicaid waiver program. Some rates are tied to specific types of clients while other payment rates are allocated for different types of services or facilities.

Adult Day Care

Forty-one state Medicaid programs provide reimbursement for adult day care services. Reimbursement rates vary by types of day care and by clients. The client groups may include the aged, developmentally disabled, mentally ill, persons with HIV/AIDS, and other groups depending upon the state program.

Sub-acute Care

Fifteen states have Medicaid reimbursement rates for sub-acute care facilities. Reimbursement rates may vary by the types of clients and services approved. These types may include residents receiving ventilator services, complex respirator services, special rehabilitation services, head trauma care, and AIDS/ARC services that are more intense than the traditional nursing facility services but less costly than general hospital services and rates.

Summary

States have wide discretion in setting reimbursement rates for long term care services. As the number of types of services expand, states are developing more complex reimbursement methods and the variation in rates appears to be increasing.

NEW YORK

Demographics

Percentage Population 65 and Over	13.3 % (US 12.7 %)
Percentage Population 85 and Over	1.7 % (US 1.5 %)

Licensed Nursing Facilities

Total Facilities	673
Total Beds	118,885
Beds Per Nursing Facility	176.6 (US 103.5)
Average Occupancy Rate	95
Beds Per 1000 Population:	
Age 65 and Over	49.0 (US 52.5)
Age 85 and Over	395.0 (US 445.6)
Medicaid:	
Recipients Per 1000 Pop, 1997	7.34 (US 6.00)
Expenditures Per 1000 Pop, 1997	\$259,445 (US \$114,494)
Adequacy of Bed Supply*	Not Available

Licensed Intermediate Care Facilities For Mentally Retarded

Total Facilities	825
Total Beds	11,600
Beds Per 1000 Population	0.64 (US 0.47)

Other Licensed Residential Care

Total Facilities for Adult/Aged	1,332
Total Beds for Adult/Aged	41,328
Beds Per 1000 Pop, Age 65 and Over	17.1 (US 25.5)
Total Facilities, Other	9
Total Beds, Other	464

Licensed Adult Day Care

Total Facilities	484
Facilities Per 1000 Pop, Age 65 and Over	0.2 (US 0.16)

Licensed Home Health Care

Total Agencies	963
Agencies Per 1000 Pop, Age 65 and Over	0.4 (US 0.47)
Medicaid:	
Recipients Per 1000 Pop, 1997	23.83 (US 6.95)
Expenditures Per 1000 Pop, 1997	\$224,833 (US \$45,711)

Licensed Hospices

Total Organizations	Not Licensed
Organizations Per 1000 Pop, Age 65 and Over	Not Licensed (US 0.07)

Certificate of Need (CON) or Moratorium

Nursing Facilities	CON Only
ICF/MRs	CON Only
Hospital Bed Conversion	CON Only
Residential Care	No CON or Moratorium
Adult Day Care	CON Only
Home Health Care	CON Only
Hospice Care	CON Only

* Opinion of State Health Planning Officials.

NEW YORK

Reimbursement

Free-Standing Nursing Facilities

Methods

A prospective facility-specific method was used for setting Medicaid reimbursement for nursing facility care. Peer groupings were used for case mix intensity, type of ownership, and number of beds. The basic method was adopted January 1, 1986, based on a calendar year for case-mix adjustments. The 1983 cost report was used for operational costs. The 1996 cost report was used for FY98 capital reimbursement. Inflation based on the CWPI, a New York market basket, and a case-mix were used to trend rates. The minimum occupancy standard was 90%.

Adjustments

Quarterly adjustments to the initial rates were made upward/downward and during/after the rate period, based on case mix. Appeals also affected the rate for all facilities.

Cost Centers

A total of 36 cost centers were used including: 1. direct nursing, limited to 110% of mean below and above the statewide mean; 2. dietary, limited to 7.5% below and 5% above the mean; 3. housekeeping; 4. room and board; 5. indirect, limited to 107.5% above of the mean and 105% below the mean; 6. administration, limited to 7.5% below and 5% above the mean; 7. capital investment/rent (actual rentals only); and 8. equipment including lease hold improvements.

Ancillary Services

Physical therapy, occupational therapy, durable medical equipment, physician services, hearing, dental, podiatry, psychiatric, radiology, lab, electrocardiology and electroencephalography was included in the rate. Some were subject to a ceiling on direct costs. Non-prescription drugs, prescription drugs, medical supplies, patient transportation and speech therapy are all part of the direct component of the rate.

Case-Mix Adjusters

Case-mix was adopted in 1986 using RUGs II factors. Case-mix was set on an overall facility basis, including direct and other patient care. A possible sixteen levels were provided. New client groups were added, such as AIDS, ventilator, brain trauma, behavior intervention, and pediatric (pediatric not case-mixed).

Capital Costs

The value of capital was determined by historic cost and appraisal/reappraisal and actual interest expense. Refinancing (interest and depreciation), refurbishing, and rental costs and leases were allowed as costs, but limited to the owner's cost. Depreciation charges were allowed with straight line and accelerated cost recovery. A sinking fund was required. A return on net equity called a "real property equity" was allowed.

Reimbursement Rate

The FY98 average reimbursement rate was \$158.93, weighted by days of care.

Other Long-Term Care

Hospital-based nursing facilities used a prospective facility-specific methodology completely separated from free-standing nursing facilities. ICF-MR facilities also used a prospective facility-specific method for setting rates which were two and a half times that of free-standing nursing facilities. Home health services used a prospective agency specific method rate with an average rate of \$77.30 for a registered nurse visit and a home health aide hourly visit at \$19.20 per hour. Adult day care used a prospective facility-specific rate held to 65% of the affiliated nursing home. Subacute care was tied to the case-mix system.

NEW YORK

Free-Standing Nursing Facilities

Method	Prospective Facility-Specific, Adjusted
Average Reimbursement Rate	\$158.93
Percentage Rate Change From Previous Year	4.7%
Peer Groupings	Type of Ownership and Number of Beds
Year of Cost Report to Set Rate	1983/1996
Inflation Adjustment	CWPI NY Market Basket & Case Mix
Minimum Occupancy in Rate-Setting	90%
Case-Mix Adjusters	RUGS II; Direct Nursing & Other Patient Adjusted
Capital Reimbursement Determination	Historic Cost and Appraisal
Ancillary Services Included in Rate ¹	Physical Therapy Occupational Therapy
	Prescription Drug Medical Supplies
	Durable Med. Equip. Patient Transport
	Physician Services Non-Prescription Drug

Hospital-Based Nursing Facilities

Method	Prospective Facility-Specific
Average Reimbursement Rate	\$188.02

ICF-MR

Method	Prospective Facility-Specific
Average Reimbursement Rate	\$379.61
Capital Reimbursement Determination	Historic Cost and Appraisal
Ancillary Services Included in Rate	Does Not Include All Ancillary Services

Home Health

Method	Prospective Agency specific
Average Reimbursement Rate, RN Visit	\$77.30 by visit
Average Reimbursement Rate, HH Aide Visit	\$19.20 per hour

Other Residential Care For Aged

No Medicaid Program

Adult Day Care

Method	Prospective Facility-Specific ²
Reimbursement Program	Not Available ²
Average Reimbursement Rate by Facility Type	
Day Health	65% of affiliated nursing facility ³
Clients covered	Aged, Physically Disabled, Pediatrics & AIDS ²

Sub-Acute Care

No Separate Program

¹ Also included: Electrocardiology, Electroencephalography, Speech Therapy, Hearing, Dental Consultant, Podiatry, Psychiatry, Radiology, and Lab.

² AIDS Program was reimbursed by a prospective flat rate.

³ Jan. 1, 1990 rate trended to the current rate year.

I. The Bankruptcy Code provides no guidance to ensure continuity of nursing home resident care

The proliferation of nursing home bankruptcies raises questions, concerns and issues which are unique and uncharted in the history of bankruptcy jurisprudence in this country. For the first time, to the knowledge of the undersigned, an industry which provides life-sustaining services and care to that section of our populous which stands in the untenable position of being unable to provide such care for themselves, to wit, the elderly, infirm and disabled, has sought to shield itself from the claims of its creditors and residents alike by filing petitions in bankruptcy. These nursing homes are the fiduciaries of each and every nursing home resident, and are charged pursuant to federal and state law with providing, directly or under arrangements with other providers, that level of nursing services, specialized rehabilitation services, medically-related social services, pharmaceutical services necessary for each resident to maintain the highest practicable physical, mental and psychosocial wellbeing of each such resident, in accordance with written plans of care prepared in accordance with each such resident's nursing assessment, and such dietary services as are necessary to meet the daily nutritional and special dietary needs of each such resident. When a nursing home files for bankruptcy protection under Chapter 7, it essentially decides to abruptly terminate nursing home operations, and hands over its keys and financial records and accounts to the United States bankruptcy trustee for an accounting, liquidation and distribution to creditors. If the debtor files a petition under Chapter 11, it continues to operate as a debtor in possession, or the court appoints a bankruptcy trustee to assume the role of the debtor in the operation of its business pending the reorganization of the bankrupt estate. The Bankruptcy Code, as currently drafted and as interpreted by applicable decisional law, provides no guidance as to the provision of adequate and appropriate nursing home care and services, but rather seeks to reorganize the debtor's debts and seeks a plan to fairly and equitably distribute the debtor's assets to estate creditors pursuant to a confirmed plan of reorganization. Nowhere in the Bankruptcy Code has Congress included any provision which could be applied to ensure the prompt and adequate provision of quality nursing care to the very persons to whom the debtors owe fiduciary obligations, and on whose behalf the debtors derive the bulk of their revenue.

Over the past twelve (12) months we have seen the bankruptcy filings of some of the largest nursing home chains in this country, to include Vencor, Inc., Mariner Post Acute, Inc., and Mariner Health Group, Inc., Integrated Health Services, Inc., Lenox Healthcare, Inc., Sun Healthcare Group, Inc., and Genesis Healthcare, Inc., along with dozens of other smaller public and privately owned nursing home enterprises. While these companies are involved in the negotiation of their post-petition financing arrangements, the daily living requirements of the residents of those nursing home debtors are haphazardly provided at the mercy and sometimes the whim of the nursing home debtors, which are admittedly distracted by their financial reorganization activities. The bankruptcy court, at the same time, is largely unsympathetic to the plight of nursing home residents, and in the case of the aforementioned national chains, all of which filed for Chapter 11 bankruptcy protection in the Delaware Bankruptcy Court in the last twelve (12) months, has continually denied nursing home residents relief from the automatic stay to allow such residents to pursue their state law claims for inadequacy of care. In fact, when faced with the complaints of living nursing home residents that nursing homes are understaffed

or are staffed by persons who are incompetent to provide care due to drug problems, lack of qualifications, criminal physical abuse charges or otherwise, the Delaware Bankruptcy Court has refused to consider such allegations, and has suggested that the bankruptcy court is not the proper forum to address such claims. Paradoxically, the nursing home residents are precluded by reason of the automatic stay, 11 U.S.C. §362 (a), from raising or pursuing these claims in any other forum.

The proposed legislative reforms seek to require a bankruptcy court to weigh and consider in reorganization cases, in addition to the financial interests of the creditors, shareholders and the debtor, the very nursing home residents whose care and quality of life hang in the balance of equities facing the bankruptcy court. The interest of the aforementioned groups should be compatible, at least on a long-term basis, since the failure to provide high quality care to nursing home residents will ultimately reduce the revenues which inure to the debtors and possibly result in the withholding of payments, offset or recoupment claims based upon the failure to provide such care. Ultimately, therefore, the failure to provide quality care may well harm creditors as well as residents.

II. Bankruptcy Reform is Necessary to Protect Nursing Home Residents

Mr. Wilkes also discussed with The President the tragic results of nursing home resident dumping, as documented by numerous studies which have shown that due to the peculiarly fragile mental and physical conditions of the nursing home resident population, any abrupt transfer, discharge or relocation of such resident from, or within, a nursing home, can have tragic, and often lethal consequences. Most states have drafted statutes and enacted regulations which require nursing homes to notify the appropriate state regulators far in advance of their intent to close a nursing home, so as to allow the state to monitor and intervene when necessary in the nursing home's transfer and relocation activities, to ensure the reasonable and safe transition of nursing home residents to other facilities or to alternative arrangements. By filing a petition under Chapter 7, the nursing home debtor can bypass these safeguards to the transitioning of nursing home residents, and instead abruptly cease operations, shut its doors, and hand the keys over to the United States Trustee. The bankruptcy court, a court of equity which is charged with administering the financial reorganization of the debtor's estate, and the bankruptcy trustee, generally a bankruptcy law attorney appointed by the bankruptcy court to act as a fiduciary to the debtor's estate and its creditors, are ill-equipped to assume the role of nursing home administrator, and consequently the safety and welfare of nursing home residents of Chapter 7 debtors are placed in serious jeopardy. Accordingly, and at the request of The President, we have attempted to draft reform legislation aimed at providing legislative guidance to bankruptcy courts, bankruptcy trustees and debtors in possession, to facilitate and ensure the continuity of adequate and appropriate resident care during the pendency of the nursing home bankruptcy case.

III. The Proposed Legislation

The enclosed draft legislation protects residents by making it clear in section 109(b) and (d) that a nursing home is not eligible to file a Chapter 7 liquidation case which would result in the appointment of an interim trustee and the continuation of the interim trustee or the election of

a new trustee, neither of whom may have any experience in the operation of nursing homes. Furthermore, under section 721 of the Bankruptcy Code, a Chapter 7 trustee will generally not operate a debtor's business and must indeed seek permission of the court to operate the business for even a limited period of time. Consequently, the proposed amendment to section 109 is designed to prevent the potential chaos triggered by a Chapter 7 filing and the corresponding possibility that services to residents will be interrupted. The provisions of sections 362 of the Bankruptcy Code have also been modified to specifically state that the automatic stay does not prevent a State or local regulatory agency from taking action necessary to protect residents, including the appointment of a receiver.

In a reorganization case, the legislation provides for the mandatory appointment of an "authorized representative" for residents, similar to the "authorized representatives" for retired employees authorized under section 1114. The authorized representatives will normally consist of a committee of residents or their representatives (because of the disability of residents, committee members may include relatives or guardians of, or counsel for, residents). The authorized representative would have the right to retain and employ counsel and professionals whose compensation would be subject to approval by the bankruptcy court in the same fashion as counsel and professionals employed by official committees of creditors appointed by the United States Trustee.

The relationship between the nursing home and the patient is basically contractual in nature, and the legislation contains provisions that preclude the rejection of residents' contracts without the approval of the bankruptcy court. Any effort to reject residents' contracts must be preceded by good faith negotiations and the filing of a motion that would demonstrate the necessity and fairness of the proposed rejection.

The legislation also incorporates various provisions long employed in railroad reorganization cases. These provisions collectively balance residents' needs with the interests of other parties in the reorganization case.

In proposing legislative reform, we enlisted the services of Harley E. Riedel, Esquire of the firm of Stichter, Riedel, Blain & Prosser, P.A., to evaluate current bankruptcy law, identify those sections of the Bankruptcy Code which needed to be amended to provide protection to the residents of nursing home debtors and to add new code sections to address the Chapter 11 reorganization of nursing home debtors, with a view towards maintaining the adequacy and appropriateness of nursing home residents' care. Harley Riedel is an eminent bankruptcy scholar with a national bankruptcy practice, and has served as lead bankruptcy debtor's counsel in numerous Chapter 11 reorganizations. Mr. Riedel is a Fellow of The American College of Bankruptcy and is the principal author of the Chapter 11 Debtor's Section of the Norton Handbook for Trustee Debtors in Possession and Committees (West Publishing Co., 2d ed. 2000). A copy of his *curriculum vitae* will be provided upon request. Harley, Jim and I are available to assist The White House in further revisions or modifications of the enclosed draft legislation at the pleasure of The President.

Mr. Chris Jennings
August 29, 2000
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Please feel free to contact Harley at (813) 229-0144, or Jim Wilkes and me at (813) 873-0026 should you have any questions about the enclosed draft legislation, or if you have further instructions or direction for us.

Respectfully submitted,

A handwritten signature in black ink, appearing to read "Susan B. Morrison". The signature is fluid and cursive, with the first name "Susan" and last name "Morrison" clearly distinguishable.

Susan B. Morrison

SBM/mab

Enclosure

PROPOSED AMENDMENTS TO TITLE 11 OF THE UNITED STATES CODE

amend section 101 to add the following new subsection and renumber the existing subsections which follow:

Section 101. Definitions. In this title -

- (41) "nursing home" means any institution, entity, building, residence, or other place, whether operated for profit or not, which undertakes through its ownership or management to provide 24-hour custodial care, nursing care, pharmaceutical care, medically-related social services, dietary services and personal care ("nursing home services") to persons unrelated to the owner or manager of the nursing home by blood or marriage and who, by reason of illness, physical infirmity, or advanced age require such services; the term nursing home does not include any facility providing care and treatment primarily for the acutely ill or for the treatment of mental diseases; the term nursing home includes
 - (A) skilled nursing facility, as that term is defined in 42 U.S.C. §1395i-3(a)(2000) and 42 C.F.R. §483.5, is an institution, or a distinct part of an institution, which is certified to primarily provide skilled nursing care or rehabilitative care and related services as Medicare covered services to nursing home residents who are injured, disabled or sick, in such a manner as will promote the maintenance or enhancement of such residents' highest practicable physical, mental, and psychosocial well-being in accordance with a written plan of care; and
 - (B) nursing facility, as that term is defined in 42 U.S.C. §1396r(a)(2000) and 42 C.F.R. §483.5, means an institution, or a distinct part of an institution, which is certified to primarily provide skilled nursing care or rehabilitative care and related services as Medicaid covered services to nursing home residents who are injured, disabled or sick, in such a manner as will promote the maintenance or enhancement of such residents' highest practicable physical, mental, and psychosocial well-being in accordance with a written plan of care.

amend section 109 (b) to add a new subparagraph (4) as follows:

Section 109. Who may be a debtor.

- (b) A person may be a debtor under chapter 7 of this title only if such person is not -

* * *

- (4) A nursing home.

amend section 109(d) to add nursing homes as follows (deleted text shall appear as a strikethrough and new text will be underscored):

- (d) Only a person that may be a debtor under chapter 7 of this title, except a stockbroker or a commodity broker, ~~and a railroad,~~ and a nursing home may be a debtor under chapter 11 of this title.

amend section 362(b) to add a new subparagraph (19) as follows:

Section 362. Automatic stay.

(19) under subsection (a) of this section, of any action by a federal or state regulatory agency regarding a nursing home's compliance with all federal and state statutes, regulations, plans of corrections, memoranda of understanding, final agency orders, or other agreements applicable to the operation, management or maintenance of a nursing home, or relating to the nursing home's status as a Medicare or Medicaid provider or state licensee authorized to operate a nursing home, or to any action taken by such agencies to seek appointment of a receiver to ensure the uninterrupted continuity and adequacy of custodial, nursing and personal care for such nursing home's residents, or to take any action to seek an order of any court of competent jurisdiction to protect, preserve and maintain the highest practicable physical, mental and psychosocial well-being of each such nursing home resident, and to protect such residents from abrupt or inappropriate discharge or transfer from the nursing home.

add a new section 1115 as follows:

Section 1115. Marshalling of nursing home residents' benefits to ensure quality of care.

(a) For purposes of this section, the term "nursing home residents' benefits" means the prospective, concurrent or retrospective payment of Medicare, Medicaid or third party funds to a nursing home or its fiscal agent for the purpose of providing 24-hour custodial, nursing and personal care including the provision of pharmaceutical care and ancillary therapies to such nursing home residents, under qualified long term care insurance policies or under any federal, state or private plan, fund or program (through the purchase of insurance or otherwise), wherein the debtor has participated as a provider prior to the filing of a petition commencing a case under this title.

(b) (1) For purposes of this section, the term "authorized representative" means the authorized representative designated pursuant to subsection (c) for persons currently receiving or having received any nursing home services provided by the debtor pursuant to benefits provided by or through Medicare, Medicaid or third party plan, fund or program or subsection (d) in the case of persons receiving nursing home services not covered by such an agreement.

(2) Committees of nursing home residents' authorized representatives appointed by the court pursuant to this section shall have the same rights, powers, and duties as committees appointed under sections 1102 and 1103 of this title for the purpose of carrying out the purposes of sections 1114 and 1129(a)(13) and, as permitted by the court, shall have the power to enforce the rights of persons under this title as they relate to nursing home residents' benefits.

(c) The court, upon a motion by any party in interest, and after notice and a hearing, shall appoint a committee of authorized representatives of nursing home residents if the debtor seeks to utilize Medicaid, Medicare or third party nursing home resident plan or program funds for purposes other than the provision of adequate and appropriate nursing home services or if the court otherwise determines that it is appropriate, to serve as the authorized representative, under this section, of those persons receiving any nursing home residents' benefits not covered by Medicare, Medicaid or other third party plans.

(d) (1) Notwithstanding any other provision of this title, the debtor in possession, or the trustee if one has been appointed under the provisions of this chapter (hereinafter in this section "trustee" shall include a debtor in possession), shall ensure that all such Medicare, Medicaid or private pay funds as are received by the debtor on behalf and for the benefit of nursing home residents shall be used by the debtor first to satisfy all usual and necessary costs of providing adequate and appropriate nursing home care, including the provision of and payment for adequate staffing to meet the needs of each nursing home resident as established by such resident's assessments and care plans, the prompt payment of pharmaceutical care and ancillary care providers, and the prompt payment of liability insurance and professional negligence insurance premiums. Debtors shall not modify or reduce the quality or quantity of any other services, supplies or therapies necessary in the operation of the nursing home to provide adequate and appropriate covered nursing home services to any nursing home resident, except that -

- (A) the court, on motion of the trustee or authorized representative, and after notice and a hearing, may order modification of such nursing home services, or reallocation of such payments pursuant to the provisions of subsections (f) and (g) of this section, or
- (B) the trustee and the authorized representative of the nursing home residents who are the intended recipients of those benefits may agree to modification of such services or, reallocation of such payments, after which the provider and supplier claims for provision of such nursing home services as modified shall continue to be paid by the trustee.

(2) Any payment for nursing home residents' covered services, and any claim by a nursing home resident for damages by reason of the debtor's failure to provide adequate and appropriate nursing home services required to be made before a plan confirmed under section 1129 of this title is effective has the status of an allowed administrative expense as provided in section 503 of this title.

(1) Subsequent to filing a petition and prior to filing an application seeking modification of the provision of, in payment for nursing home residents covered services, the trustee shall:

- (A) make a proposal to the authorized representative of the nursing home residents, based on the most complete and reliable information available at the time of such proposal, which provides for those necessary modifications in the nursing home residents that are necessary to permit the reorganization of the debtor and assures that all creditors, the debtor and all of the affected parties are treated fairly and equitably; and
- (B) provide, subject to subsection (i)(3), the authorized representative of the nursing home residents with such relevant information as is necessary to evaluate the proposal.

(2) During the period beginning on the date of the making of a proposal provided for in paragraph (1), and ending on the date of the hearing provided for in subsection (i)(1), the trustee shall meet, at reasonable times, with the authorized representative to confer in good faith in attempting to reach mutually satisfactory modifications of such nursing home services.

(f) The court shall enter an order providing for modification in the provision of nursing home services or in the use of Medicare, Medicaid and private pay funds for covered nursing home services if the court finds that:

- (1) the trustee has, prior to the hearing, made a proposal that fulfills the requirements of subsection (e);
- (2) the authorized representative of the nursing home residents has refused to accept such proposal without good cause; and
- (3) such modification is necessary to permit the reorganization of the debtor and assures that all creditors, the debtor, and all of the affected parties are treated fairly and equitably, and is clearly favored by the balance of the equities; except that in no case shall the court enter an order providing for such modification of the provisions or payment for nursing home services to a level lower than that minimal level required by federal and state law and as required by each nursing home resident's assessments and care plans or as that proposed by the trustee and as found by the court to have complied with the requirements of this subsection and subsection (e): provided, however, that at any time after an order is entered providing for modification in the provision of or payment for nursing home services, or at any time after an agreement modifying such services or the use of such benefits is made between the trustee and the authorized representative of the recipients of such covered nursing home services, the authorized representative may apply to the court for an order increasing the provision of or payment for such

services, or which order shall be granted if the modification in the provision of nursing home services or the use of nursing home resident benefits sought is consistent with the standard set forth in paragraph (3); provided further, that neither the trustee nor the authorized representative is precluded from making more than one motion for a modification order governed by this subsection.

(g) (1) Prior to a court issuing a final order under subsection (f) of this section, if essential to the continuation of the debtor's business, or in order to avoid irreparable damage to the estate, the court, after notice and a hearing, may authorize the trustee to implement interim modifications in the provision of, or payment for, nursing home services.

(2) Any hearing under this subsection shall be scheduled in accordance with the needs of the trustee.

(3) The implementation of such interim changes does not render the motion for modification moot.

(h) No claims for the provision of, or payment for nursing home services paid between the filing of the petition and the time a plan confirmed under section 1129 of this title becomes effective shall be deducted or offset from the amounts allowed as claims for any claims for nursing home cases which were not provided or the provision of which remain unpaid, or from the amounts to be paid under the plan with respect to such claims for unprovided or unpaid nursing home services, whether such claims are based upon or arise from a right to future unpaid benefits or claims or from any claims not paid as a result of modifications allowed pursuant to this section.

(i) (1) Upon the filing of an application for modification in the provision of, or payment for, nursing home services, the court shall schedule a hearing to be held not later than fourteen days after the date of the filing of such application. All interested parties may appear and be heard at such hearing. Adequate notice shall be provided to such parties at least ten days before the date of such hearing. The court may extend the time for the commencement of such hearing for a period not exceeding seven days where the circumstances of the case, and the interests of justice require such extension, or for additional periods of time to which the trustee and the authorized representative agree.

(2) The court shall rule on such application for modification within ninety days after the date of the commencement of the hearing. In the interests of justice, the court may extend such time for ruling for such additional period as the trustee and the authorized representative may agree to. If the court does not rule on such application within ninety days after the date of the commencement of the hearing, or within such additional time as the trustee and the authorized representative may agree to, the trustee may implement the proposed modifications pending the ruling of the court on such application.

(3) The court may enter such protective orders, consistent with the need of the authorized representative of the nursing home residents to evaluate the trustee's proposal and the application for modification, as may be necessary to prevent disclosure of information provided

to such representative where such disclosure could compromise the position of the debtor with respect to its competitors in the industry in which it is engaged.

add new sections 1181 - 1186 applicable to the reorganization of nursing homes

Section 1181. Right to be heard

In addition to the parties described in section 1109, any federal or state agency having regulatory jurisdiction over the debtor may raise and may appear and be heard on any issue in a case under this chapter, but may not appeal from any judgment, order, or decree entered in the case.

Section 1182. Protection of the interests of nursing home residents and the public interest

In a case under this chapter, the court and the trustee shall consider the interests of nursing home residents and the public interest in addition to the interests of the debtor, creditors, and equity security holders.

Section 1183. Closing of nursing home

- (a) The court, after notice and a hearing, may authorize the closing of a nursing home operated by the trustee if:
 - (1)(A) such closing is in the best interest of the estate; or
 - (B) such closing is essential to the formulation of a plan; and
 - (2) the interests of all residents at such nursing home have been adequately protected and the debtor has submitted a fair and reasonable plan for the discharge, transfer and relocation of such residents to alternative facilities to be accomplished no sooner than sixty (60) days, nor longer than ninety (90) days after entry of an order authorizing such closing, including the payment of any costs of such relocation; and
 - (3)(A) such closing is otherwise consistent with the public interest
- (b) If, except for the pendency of the case under this chapter, such closing would require the approval by any federal or state agency having regulatory jurisdiction over the debtor, the trustee shall initiate an appropriate application for such closing with such federal or state agency. The court may fix a time not less than twenty days within which any such federal or state agency having regulatory jurisdiction over the debtor shall report to the court on such application.
- (c) After the court receives the report of the federal or state agency having regulatory jurisdiction over the debtor, or after the expiration of the time fixed under

- (c) After the court receives the report of the federal or state agency having regulatory jurisdiction over the debtor, or after the expiration of the time fixed under subsection (b) of this section, whichever occurs first, the court, after notice to the following persons and after conducting a hearing on the matter, may authorize the closing of the nursing home. Such notice shall be provided to the trustee, any party in interest that has requested notice, the authorized representative for nursing home residents, any federal or state regulators having jurisdiction over the debtor, and any other entity proscribed by the court.

Section 1184. Priority claims

There shall be paid as an administrative expense any claim of an individual nursing home resident or of the personal representative of a deceased individual nursing home resident against the debtor or the estate, for personal injury to or wrongful death of such resident arising out by the operation of the debtor or the estate of a nursing home, whether such claim arose before or after the commencement of the case.

Section 1185. Contents of plan

- (a) Section 1129(a)(7) shall not apply in nursing home reorganization cases.
- (b) In addition to the provisions required or permitted under section 1123 of this title, a plan –
 - (1) shall specify the extent to and the means by which the debtor's nursing home operations are proposed to be continued and the extent to which any of the debtor's nursing home operations are proposed cease; and
 - (2) may include a provision for –
 - (A) the transfer of any or all of the nursing homes of the debtor to another operator; or
 - (B) the closing of any nursing home in accordance with section 1183 of this title.
- (c) If, except for the pendency of the case under this chapter, the closing of any of the debtor's nursing homes would require the approval by any federal or state agency having regulatory jurisdiction over the debtor, then a plan may not propose such a closing unless the proponent of the plan initiates an appropriate application for such closing in accordance with section 1183 of this title.

Section 1186. Confirmation of plan

- (a) the court shall confirm a plan if –

- (1) the applicable requirements of section 1129 of this title, except section 1129(a)(7), have been met;
 - (2) each creditor or equity security holder will receive or retain under the plan property of a value as of the effective date of the plan, that is not less than the value of property that each such creditor or equity security holder would so receive or retain if all of the nursing homes of the debtor were sold (a) after the closing of such nursing homes and (b) after the relocation of the nursing home residents, and the proceeds of such sale and the property of the estate were distributed under chapter 7 of this title on such date;
 - (3) in light of the debtor's past earnings and the probable prospective earnings of the reorganized debtor, there will be adequate coverage by such prospective earnings (after providing adequate assurance for the appropriate treatment of nursing home residents) of any fixed charges, such as interest on debt, amortization of funding debt, and rent for nursing home facilities, provided for by the plan; and
 - (4) the plan is consistent with the interests of nursing home residents and with the public interest.
- (b) if the requirements of subsection (a) of this section are met with respect to more than one plan, the court shall confirm the plan that most likely to provide adequate assurance of appropriate care for nursing home residents.

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