Improving Quality in Long-term Care Facilities Through Increased Regulations and Enforcement

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This research addresses the origins and motivations that drive long-term-care regulations and enforcement. It outlines the historical development of the US long-term-care system and describes regulations that focus on improving quality of care. Current long-term-care regulations are inadequate and ineffective because of fragmentation and inconsistencies that have resulted in conflicts of interest, inequitable services, underfunded care, low reimbursement, cumbersome and duplicative processes, and inadequate training and compensation for providers. Reforms such as establishing higher standards and modifying enforcement procedures are necessary to bring about increased quality of care for long-term-care consumers. Key words: enforcement of long-term care, long-term care, nursing homes, regulation of long-term care

LONG-TERM CARE (LTC) refers to assistance beyond medical and nursing care that consumers may need in the likelihood of chronic illnesses or disabilities over extended periods. Long-term care may be provided in a nursing home, assisted-living facility, or in one’s own home. Primarily, older adults utilize most LTC services, although young or middle-aged individuals may also require LTC as a result of accidents or debilitating illnesses.

The current US LTC system is made up of a continuum of LTC services. For instance, nursing homes provide room, board, nursing care, and some therapies; assisted-living facilities provide care for residents that need assistance with some aspects of daily living. Other types of LTC include adult day-care centers that provide care and supervision for consumers who cannot be left alone during hours when their primary caregivers are not available, home health care agencies that provide care to LTC consumers in their homes, and hospice care that provides end-of-life care.

The LTC system continues to evolve with the development of additional types of care, providers, and settings to meet the increasing demands of consumers. Long-term-care needs and services are varied and complex, and as the system evolves, cases of abuse, neglect, fraud, and injuries have been reported in these facilities. Therefore, laws and regulations are necessary and must be enforced to better protect consumers’ interests. Despite being one of the most heavily regulated industries, negative outcomes continue to challenge the LTC system. This research identifies the origins of LTC regulations, discusses the motivations that drive LTC regulation, describes the extent to which these regulations are enforced, and recommends that regulations and enforcement are integral to providing higher quality of care and achieving better outcomes for LTC consumers.

CHARACTERISTICS OF LONG-TERM-CARE CONSUMERS

An estimated 10 million Americans needed LTC in 2000. Most but not all persons in need of LTC are elders. More than 60% are persons 65 years or older (6.3 million), and the...
remaining 3.7 million are 64 years or younger. By 2050, the number of individuals using LTC services will more than double. Some of the older population with LTC needs require home- and community-based care (eg, adult day care), whereas others receive institutional-based LTC services (eg, skilled nursing facilities). Furthermore, the level of disability and cognitive impairment among those who receive assistance with daily tasks continue to increase. The prevalence of cognitive impairment among the older population increased over the past decade.

In 2002, the percentage of older persons with moderate or severe memory impairment ranged from about 5% among persons 65 to 69 years to about 32% among persons 85 years or older. Individuals 85 years or older are one of the fastest growing segments of the population. In 2005, there were approximately 5 million people 85 years or older in the United States, and this is expected to increase to 20 million by 2050. Proportionate to this growth is the increase in the number of individuals with severe or moderate memory impairment in 2050, thus leading to tremendous growth in the use of LTC services. Because of this projected sharp rise in LTC use, policies need to be developed to address the increased needs of these consumers while protecting their health and safety and improving overall quality of care.

FINANCING LONG-TERM-CARE SERVICES

Financing LTC services will be especially challenging in the next several decades as baby boomers age and live longer, and many of them will require LTC services. For instance, a person turning 65 years old in 2000 has a 44% chance of entering a nursing home at some point in his life, whereas a 65-year-old woman has a 51% chance of entering a nursing home because women have higher life expectancies. Long-term care is costly, and those costs are growing rapidly. In 2010, the national average annual cost for a private room in a nursing home was $83,585.

Home health care services are also expensive; a home health aide often costs as much as $21 an hour. Because nursing home and home health care are expensive for elderly living on fixed incomes, many older adults expect that they can rely on government entitlement programs to finance their LTC needs. Currently, the major sources of LTC financing are public programs, primarily Medicaid and Medicare, representing 63%. Individuals pay 26% out of pocket, and the remaining 8% is covered by private LTC insurance.

Many individuals mistakenly believe that Medicare will cover LTC services. Unfortunately, this is not true. Medicare pays only for limited LTC expenses. Specifically, Medicare pays for home health services for elders who need part-time skilled nursing care or therapy services and are under the care of a physician. Medicare pays for up to 100 days for post-acute care services in a skilled nursing facility after the patient has been discharged from a hospital. However, Medicare does not cover services needed by an elderly person who has decreased functional abilities and chronic illnesses.

Medicaid, the joint federal-state health financing program for low-income individuals, continues to be the largest funding source for LTC. Medicaid provides coverage for the medically indigent and for many individuals who have become nearly impoverished by “spending down” their assets to cover the high costs of their LTC. For example, many elderly persons become eligible for Medicaid as a result of depleting their assets to pay for nursing home care that Medicare does not cover. In 2009, Medicaid paid 33% of total LTC expenditures.

States share responsibility with the federal government for Medicaid. To limit states’ Medicaid expenditures, many states have restricted eligibility of nursing home beds, pay nursing home low rates, and provide limited in-home services to those eligible for Medicaid. Moreover, eligibility for Medicaid-covered LTC services varies widely among states. To lower states’ financial burden for LTC services, states set low payment rates. As a result, the quality of services provided is often poor. Therefore, policies should be developed to emphasize and improve quality of care in the LTC system.
HISTORICAL DEVELOPMENT OF THE US LONG-TERM-CARE SYSTEM

The LTC system that exists today has taken longer to develop than other components of the overall health care system. Throughout history, LTC was provided by informal caregivers such as family, friends, religious organizations, and charitable community groups. It was not until the mid-20th century that the formal system of LTC began to develop. Prior to this, almshouses and poor farms primarily cared for those without families. There were few institutional resources in place. In the 1930s, the number of people unable to care for themselves increased significantly because of the Great Depression so that informal caregivers could no longer meet the demands of this growing segment of society. The passage of the 1935 Social Security Act marked the beginning of government involvement in caring for the needy. It also signified the indirect beginning of the nursing home industry and the formation of LTC. Throughout the next few decades, the government became increasingly involved in financing care for the needy. The first major national regulations governing LTC facilities were enacted through the 1950 amendments to the Social Security Act. These amendments mandated that any facility caring for more than 4 unrelated individuals receiving Social Security income had to be licensed by the state in which the facility was located.9

The passage of the Medicare and Medicaid programs in 1965 further extended federal government’s financing and regulation of LTC. Because Medicare and Medicaid are responsible for the largest portion of LTC financing,10 the federal government has a vested interest to protect these programs by regulating quality and cost of care. Thus, comprehensive regulations governing LTC were enacted in order to achieve the government’s 2 primary objectives of quality and cost. Furthermore, regulations were also used to accomplish a third objective: to limit or expand availability of services in defined locations.

In other words, the government determined whether access should be increased in underserved areas and limited in surplus areas. As the LTC system grows, public and private entities are increasingly attempting to control costs while providing consumer protection; thus, these external regulations also seek to balance cost and quality control. Regulatory oversight of LTC facilities begins with state licensure. For instance, a nursing facility must have a license to operate. A license is granted when a facility meets the minimum thresholds for staffing, adequacy of services, building construction specifications, and compliance with fire and safety regulations.11 All facilities must be licensed, but not all facilities are government certified. Certification is a federal function.

The Centers for Medicare & Medicaid Services (CMS) is responsible for certifying nursing facilities. It oversees enforcement of certification standards, but the actual monitoring is undertaken by each state. Although certification is voluntary, nursing facilities must seek federal certification and comply with federal standards to admit Medicare and Medicaid patients.

In addition to licensure and certification, accreditation is a function of private entities. The Joint Commission on Accreditation of Healthcare Organizations accredits hospitals, nursing homes, and other health care organizations and issues its own standards. Unlike the majority of hospitals that are accredited by the Joint Commission on Accreditation of Healthcare Organizations, many nursing facilities are not accredited, because they do not receive the “deemed status” designation that hospitals obtain when an accredited hospital is deemed to have met Medicare conditions of participation.

Studies suggest that achieving accreditation status is correlated with performance on certification surveys. Specifically, accredited nursing facilities perform better on quality measures than do nonaccredited facilities and achieve lower exposures to risk.12 Thus, it would be advantageous for nursing homes to seek accreditation so that they can monitor and continue to improve overall quality as a result of meeting quality standards set by the accrediting agency.

REGULATION OF LONG-TERM-CARE FACILITIES

Regulations generally fall into 2 categories, those pertaining to quality of care and those...
that deal with reimbursement. Consumers have the right to receive high quality of care, and payers need to be assured that the services for which money was expended are of high quality. Because LTC facilities provide care to some of the most vulnerable members of our society, there is more regulation in this area of health care. Furthermore, this can also be attributed to the fact that the government is the single largest payer of LTC services.

The regulatory functions of government are administratively complex. Regulations in LTC usually originate in the same ways as regulations in other industries. An issue arises that necessitates a legislative body to enact a law, and the administrative agency that oversees the particular industry enacts regulations to implement that law. For the LTC industry, the administrative agency is the CMS, which falls under a much larger administrative agency, the US Department of Health and Human Services.

The CMS is responsible for producing and maintaining federal regulations with which LTC facilities that wish to participate in Medicare and Medicaid must conform. For instance, in skilled nursing facilities, the state survey, licensing, and certification agencies are responsible for surveying or inspecting nursing homes to verify their compliance with regulations, investigating complaints, and reporting results to the CMS.

When deficiencies are identified, state agencies and the CMS regional offices share responsibility for taking enforcement action to make sure that nursing homes deal with problems and are in compliance. The CMS funds most of the costs of Medicare/Medicaid certification and oversees the performance of state survey agencies to ensure that federal regulations are implemented appropriately. States also have their own licensing requirements, with which all nursing homes (not just those participating in Medicare and Medicaid) must conform. State regulations may parallel or exceed federal requirements and generally have separate provisions for licensing nursing homes, undertaking surveys or inspections, investigating complaints, identifying deficiencies, and taking enforcement action. The regulations themselves are usually not enacted without some type of hearing taking place to allow interested parties to present their views and concerns, as well as any evidence concerning the proposed regulation to the administering agency. These regulations can also be reviewed in court when issues of the constitutional rights of individuals or groups may be violated by the proposed regulation.

**Regulations in nursing facilities**

As described above, nursing facilities are highly regulated at all levels of the government to ensure that the care received by consumers is accessible, safe, of high quality, and obtained at the lowest cost. Regulations are very complex and sometimes are in conflict. The 1987 Omnibus Budget Reconciliation Act (OBRA), also known as the Nursing Home Reform Act, mandated higher standards for resident care. It increased staffing requirements and established residents’ rights. In addition to OBRA, Medicare and Medicaid and state licensing regulations prescribe the level and types of care given, the types and numbers of professional staff needed, the conditions of the facility and how that care should be provided.

**Regulations in subacute care facilities**

Subacute care refers to comprehensive inpatient care provided to patients who have had an acute event resulting from injury, illness, or exacerbation of a disease process. Subacute care patients do not require intensive procedures or acute levels of care but have a course of treatment including diagnostics or invasive procedures. Subacute care has grown in response to managed care, cost savings strategies, and demand by consumers for more choice. Regulations for subacute care are complex and inconsistent from hospitals and nursing facilities because it is a relatively new entity. It is neither hospital care nor nursing facility care, but is rather treated as a hybrid. For instance, administrators in nursing facilities must be licensed, whereas administrators of hospitals are not, so one area of debate is whether administrators of subacute care facilities should be licensed like nursing homes or not like hospitals. Therefore, regulations must be developed specifically for subacute care.
Furthermore, conflicting regulations exist in Medicare certification requirements that govern staffing, length of stay, and patients' rights depending on the type of subacute care provider. For example, OBRA regulations governing facility design, staffing patterns, care plans, and services are applicable to subacute care.

If subacute care is provided in nursing facilities, then nursing facilities are required to meet OBRA standards; however, hospital units that provide subacute care find it very restrictive to comply with OBRA regulations. As a result of these existing inconsistent regulations, states are looking at developing regulations geared for subacute care facilities, because this is a newly created type and level of care in the LTC industry.

Regulations in assisted-living facilities

Regulations in assisted-living facilities are continuing to proliferate. Many states have developed licensing regulations specifically designed for the “assisted living” category. Assisted-living facilities refer to consumer-centered services, apartment settings, residential environment, and additional services to support aging-in-place. These differ significantly from nursing facilities that provide medical care. Thus, advocates for assisted-living facilities insist that regulations should be different from nursing facilities. They believe that the focus of regulations in assisted-living facilities should primarily target quality of care and customer satisfaction especially in areas that need improvement in nursing facilities. In addition, assisted-living facilities follow the same regulations as other provider organizations, such as the Occupational Safety and Health Act and Life Safety Code.

Regulations in home- and community-based care

Home- and community-based services include care provided in the consumer's home and other locations in the community such as adult day care and hospice care. Home care provides a wide range of health care and supportive services including professional nursing care; physical, occupational, respiratory, and speech therapies; social work; nutritional care; diagnostics; and supplies and medical equipment. Hospice care, aimed at easing the pain for the terminally ill, may be provided in the home or in the hospital.

Adult day care includes social day care and health day care. Social day care is provided to adults who have some minor limitations in the activities of daily living. Health day care is provided to those who need more medical care or require medication assistance. Regulations affecting these community-based services include Medicare certification, licensure of provider organizations, and licensure of professional staff in these organizations. Because home health care and hospice care are covered by Medicare, they require Medicare certification, whereas adult day-care centers do not. Licensure also differs for community-based services. Whereas almost all states require hospices to be licensed, not all home health care agencies are licensed. Furthermore, regulations of adult day-care centers vary considerably, depending on the state. In general, states that accept Medicaid reimbursement for adult day-care centers have more regulations than those that do not. Because of these inconsistencies in regulations among states and among the various types of community-based care organizations, more regulations need to be developed and enforced at the state and national levels.

LONG-TERM-CARE REGULATIONS THAT FOCUS ON IMPROVING QUALITY OF CARE

Some policy makers wish to enact regulations that focus on protecting the consumer, whereas others emphasize maintaining low costs. Still others wish to consolidate both. Because the LTC industry serves individuals who may be unable to speak for themselves and are unable to judge the quality of care they are receiving, it becomes a societal concern and responsibility to protect the interests of these vulnerable consumers through increased regulations that focus on quality.

Quality of care is defined as “a judgment about the goodness of both technical care and the management of the interpersonal
exchanges between client and practitioner. Using that definition of quality, care can then be broken down into 5 interrelated domains that should be measured to establish overall quality of care: consumer satisfaction, employee satisfaction, workforce stability, clinical outcomes, and regulatory performance. These domains cover both clinical and nonclinical measurement areas and address an organization’s primary stakeholders: residents (and their families), staff, and external regulators. Because one of the domains of quality focuses on regulatory performance, this is the domain that will be discussed in reference to LTC facilities.

Historically, quality in nursing facilities is defined by standards established for participation in the Medicare and Medicaid programs. Nursing home inspections were used to ascertain nursing home compliance with certification standards. However, compliance was equated with quality. In 1975, the federal Office of Nursing Home Affairs determined that meeting certification standards and being in compliance did not necessarily mean quality of care, and serious deficiencies in quality of care were found in nursing homes. This prompted Congress in 1984 to request the Institute of Medicine to investigate the issue and recommend reforms.

The Institute of Medicine conducted an intensive investigation and in 1986 published an influential report that gave detailed recommendations for reforming the regulation of nursing homes in order to improve nursing homes’ quality of care. Those recommendations were largely accepted by Congress and enacted through the 1987 OBRA and have since been gradually implemented by the CMS. As part of this act, new standards were set for operating nursing facilities. This comprehensive set of regulations enacted “new standards for nursing homes that were to make them more focused on quality of care, more detailed and comprehensive in their coverage, and more explicit about the rights of residents.”

Through OBRA, the state survey or inspection process used to verify compliance with the standards was also reformed to make it less oriented toward paper records and structures and more focused on direct observation of care and communication with residents. A much broader range of enforcement mechanisms was introduced, including financial penalties, blocks on payment for new admissions for residents, provisions to take over the management of failing homes, and ultimately termination of participation in Medicare/Medicaid.

Regulations that address quality of care originate primarily at the federal level and are most often contained in legislation that appropriates funds for LTC reimbursement. Because Medicare and Medicaid are the largest sources of LTC funding, they also account for a large proportion of regulations dealing with quality of care. Detailed and comprehensive requirements are necessary for providers to meet in order to qualify for reimbursement. With the passage of OBRA, additional patients’ rights regarding freedom from resident abuse, neglect, and misappropriation of resident property were mandated.

Specifically, abuse is defined as “willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish.” Neglect refers to “failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness.” Misappropriation of resident property is defined as “deliberate misplacement, exploitations, or wrongful, temporary, or permanent use of a resident’s belongings or money without the resident’s consent.” Furthermore, the Patient Self-determination Act of 1990 requires all health care providers to protect and promote patient rights including basic rights to privacy, dignity, and confidentiality and that consumers have the right to determine the amount and type of care received in end-of-life situations and to create advance directives. Another legislation that addresses the delivery and quality of care is the Balanced Budget Act of 1997; it states that Medicare and Medicaid would deny payment to facilities charged with abuse and mistreatment of patients.

In addition, LTC providers must comply with other federal regulations related to quality of care, including the Civil Rights Act and the Americans With Disability Act, both of which relate to quality of care and equal access and...
treatment. Furthermore, state and local governments also have their roles in regulation. At the state level, regulating quality of care is generally designated to the agency that administers federal programs. Each state must have a single agency that is in charge of oversight for Medicare and Medicaid programs. At the local government level, quality of care is usually regulated by local health departments that oversee public health issues, and LTC facilities must comply with their regulations.

CHALLENGES IN LONG-TERM-CARE REGULATIONS

Although some favor more regulation of LTC to better protect consumers and be more cost-effective, others believe that additional regulations would be ineffective. State agencies are responsible for inspecting LTC facilities and also managing the enforcement of any deficiencies, violations, and complaints along with the regional CMS offices. There are numerous enforcement methods such as financial penalties, provisions to take over management, termination of participation in Medicare/Medicaid, and even criminal charges when serious abuse and/or neglect occur. However, the enforcement process is complaint-driven and penalizes violators. If complaints are not made or individuals are scared or hesitant to make complaints, then violations and deficiencies may not be detected. Furthermore, certification standards are based on establishing minimum standards of quality rather than maximizing quality. In addition, the National Commission for Quality Long-term Care argues that regulations are uncoordinated and duplicative.\(^\text{16}\) Regulatory agencies are understaffed to enforce regulations and have little impact on low-performing providers.

For instance, one of the most consistent complaints that comes from LTC providers is the amount of documentation and paperwork that needs to be completed to receive reimbursement. Administrative paperwork is cumbersome and time-consuming, and it detracts from time that could be better spent on caring for residents. This issue can be examined from the point of view of providers as well as from that of regulators. Regulators want to know that adequate levels of care are provided because meeting minimum standards of care is linked to reimbursement to documentation; thus, this motivates providers to complete documentation to be reimbursed for their services.

More often than not, LTC facilities are understaffed because of high rates of turnover and inadequate staffing; consequently, completing a great deal of redundant paperwork makes a difficult job even more burdensome. This causes some providers to make mistakes and even falsify documentation. Thus, ways to facilitate the documentation process for regulators and providers include streamlining the paperwork process and reevaluating the reimbursement process to ensure that proper documentation is not redundant. This would result in higher quality and reduce fraudulent documentation and mistakes. Protecting consumers and maintaining low costs are motivators that can be consolidated, and the best way to accomplish this is to bring all interested parties together to improve quality of care. To reach this goal, LTC facility administrators and employees must develop a vested interest in developing strategies that improve care through coordinated teams. In addition, staffing levels should be reviewed for their capacity to deliver appropriate quality of care. Each team member should be aware of the needs of LTC consumers and proactively monitoring and maintaining quality in these facilities.

Another major difficulty that arises in identifying violations is that guidelines are subject to interpretation by individual inspectors. Inspectors use their own judgment, and that can be influenced by local norms and resource constraints. This is an area of frustration for regulators because this leads to inconsistency.

In addition to variation among citation rates, a comprehensive study of state regulation and enforcement revealed highly variable rates of censures issued by state and federal officials.\(^\text{17}\) For example, 61% of civil monetary penalties were issued in only 16 states; 8 states issued none. In fact, most state regulators did not find monetary penalties to be effective in improving facilities’ responsiveness. Denial of payment for new admissions, another “intermediate
sanction” available to regulators, was instituted by only 32 states.

Finally, decertification or withdrawal of state licensure is applied in exceedingly rare circumstances, although much more frequently for nursing homes located in poor communities and for those serving predominantly Medicaid patients. There is substantial interstate variation in the application of sanctions for apparent infractions of nursing home regulations, but there is still no real evidence that states who take more stringent enforcement action have better-quality nursing homes. In order for citation and enforcement to be effective, it needs be consistent and meaningful, and if current enforcement methods have been proven to be ineffective, then they must be changed.

EFFECTIVE ENFORCEMENT OF LONG-TERM-CARE REGULATIONS

According to a Kaiser Family Foundation’s survey, 63% of the general public does not feel there is enough government regulation of nursing homes, and 59% feel that the government does not enforce quality standards in current regulations. This would suggest that the general public supports more stringent regulation of nursing homes and at the very least more adequate enforcement of the existing regulations.

The Government Accountability Office cited a number of continuing problems with the enforcement of nursing home standards. For instance, the Government Accountability Office investigated enforcement of federal nursing home regulations and found more than one-fourth of the facilities had deficiencies that caused actual harm to residents or placed them at risk of death or serious injury, and many others had serious deficiencies. Furthermore, it reported that once the state survey agency identified deficiencies in the quality of care, it was ineffective in achieving the remedial state of consistent compliance with the law. For example, nearly 10% of California nursing homes were cited twice in a row for “actual harm” violations. Between 1995 and 1998, one-third of California nursing homes had serious violations that caused death, seriously jeopardized residents’ health and safety, or were considered to be substandard. Because of these alarming statistics, reforms that result in more and better enforcement of regulations must be made.

The first area that needs to be addressed is funding of LTC services. One of the main problems facing LTC facilities is that reimbursement is decreasing. Facilities are expected to operate with increased occupancy and decreased funding. This can be attributed to LTC consumers depending solely on Medicaid and Medicare to finance their LTC. Because the aging population is the fastest-growing segment of our society, state Medicaid programs and Medicare are quickly approaching insolvency and are operating under increasing deficits. As a result, Medicare and Medicaid are seeking ways to reduce costs, and the primary method to be more cost-effective is to reduce provider reimbursement.

In response to reductions in reimbursement, LTC providers are offering only the bare minimum levels of care and staffing. To change this system, new financing mechanisms must be developed to provide funding for LTC services. These include both private sector and public sector reforms. Employers should provide assistance by offering LTC policies and paying for half of premium costs for employees. These private sector reforms are essential to enable more individuals to purchase LTC insurance. Public reforms are also necessary.

Unfortunately, rising health care cost is a major challenge and barrier to LTC reforms. For example, the 2010 Patient Protection and Affordable Care Act took one step toward reforming the current LTC system that could possibly ease some of the burden on Medicare and Medicaid. The Community Living Assistance Services and Supports (CLASS) program is a national, voluntary insurance program that offers a lifetime cash benefit for those needing LTC services. Under the 2010 Patient Protection and Affordable Care Act, CLASS is voluntary for employed workers. However, on October 14, 2011, the Obama Administration and the US Department of Health and Human Services made a decision not to implement CLASS because of
inadequate funding. This is a major setback for the LTC system. Without integral reforms and action from the federal government, improvements to the LTC system are elusive and unattainable. Nevertheless, we believe that the LTC system can continue to evolve and make improvements based on the joint efforts of individuals and employers. Similar to other health care benefits, LTC insurance should be financed jointly by employers and employees. In this way, more employees would have access to LTC services, thus easing the financial burden on individuals, families, and government.

Another way to reduce the burden on Medicaid and Medicare is for consumers to purchase their own private LTC insurance policy. Currently, very few individuals (10%) purchase LTC insurance on their own. Second, because Medicaid covers LTC, the elderly believe that they can fall back on this option should they need LTC services later on in life. However, Medicaid should serve only as a safety net for low-income aged persons. Thus, the primary burden for LTC needs should be placed on the individual and the family. Therefore, reforms are necessary to encourage more individuals to purchase private LTC insurance. Specifically, public service announcements are necessary to make the general public aware of the urgency in purchasing LTC policies. Delays in making the decision to purchase LTC will result in higher costs. Thus, it is imperative for individuals to purchase their own LTC insurance policies early because younger adults pay lower premiums than older individuals. If consumers purchase this type of policy when they are in their 40s or early 50s and in relatively good health, the policy is not as expensive compared with policies that are purchased later in life.

Consequently, Medicare and Medicaid can then be used as supplementary insurance rather than being the sole payer of LTC services. By increasing the number of payers, the regulatory system will consist of more stakeholders with interests to protect consumers and provide higher-quality and more cost-effective services. The current system relies almost solely on CMS for regulation and enforcement; however, if more individuals and private insurance providers are paying for LTC services, then they have a more vested interest in the quality of care provided.

Another area that needs to be addressed is provider training and compensation. Most care in skilled nursing facilities is provided by certified nurse assistants (CNAs). This requires a minimum amount of training, and they must be certified by a state agency as having received such training or otherwise being judged competent. Certified nurse assistants in nursing facilities are among the lowest-paid workers in the health care industry. They are often paid only slightly more than the minimum wage, yet they provide care to the most vulnerable consumers. Most CNA training is only 8 weeks and cannot possibly prepare them for the various challenges and meeting the diverse needs of a wide range of LTC consumers.

The burden of providing the majority of care for patients coupled with low wages causes high turnover rates, low morale, and substandard quality of care. In order for CNAs to provide quality services and be able to manage the challenges of a difficult occupation, more skilled training should be provided. Extensive background checks should also be conducted along with mandatory random drug testing throughout employment and not just during the hiring process. A national database of LTC providers and their history needs to be developed in order to ensure that only those individuals with adequate training and a history of high-quality care should be hired. A probationary period should be utilized for all new employees in nursing facilities. Once these additional standards are instituted, compensation for CNAs should also be increased. As CNAs are held to higher standards and quality of care, then, they will be entitled to higher compensation. In addition to CNAs, other employees in LTC facilities should be held to similar high standards of training, certification, licensing, background checks, and random drug tests. Thus, only highly qualified individuals would be employed in LTC facilities, and their compensations should be commensurate with their training.
A third area that needs to be addressed is separating regulation, inspection, and enforcement from the reimbursement process. This means that CMS should not be allowed to regulate, inspect, and enforce LTC services and also serve as the single largest payer of such services. Under the current structure, this creates a conflict of interest and makes it difficult to differentiate whether regulations are being used to increase the quality of care or simply to cut costs and lower reimbursement levels.

A separate agency should be created that is responsible for the regulatory process. This agency should not have ties to CMS and should be completely impartial. The agency should be composed of LTC experts whose sole purpose is to ensure that the highest quality of care is provided at the most reasonable cost. Furthermore, regulation, inspection, and enforcement of LTC providers are inconsistent from state to state, and this creates inconsistencies in the quality of care received depending on where a consumer lives. It would better serve consumers for LTC to be regulated at the national level rather than the state level. This makes it more efficient for large integrated health systems and providers that operate in multiple states to adhere to regulations. The inspectors of LTC facilities should be nationally licensed and trained so that uniform standards can be upheld. Moreover, the enforcement of regulatory violations should actually be enforced. There is no point to the regulatory process if it is not enforced. In order for regulations to work as intended, more funding need to be allocated to a new and separate regulatory agency that will be responsible for enforcement. With stringent regulations and proper enforcement procedures, this would prevent inefficiencies in the LTC system, eliminate deficiencies in facilities, and ultimately result in higher quality of care.

CONCLUSION

The LTC system is growing rapidly as the aging population increases dramatically over the next decades. Reforms are necessary in the LTC system to improve quality of care and provide more cost-effectiveness. Current LTC regulations are inadequate and ineffective because of fragmentation and inconsistencies that result in conflict of interest, inequitable services, underfunded care, low reimbursement, cumbersome and duplicative processes, and inadequate training and compensation for providers. These issues are not easily resolved; however, if all stakeholders in the LTC system take part in reforming the regulatory process, more effectiveness will result. Consumers and their families, LTC providers, and private LTC insurance companies need to be more involved with ensuring that regulations are designed not just to save money but also to improve the quality of care being provided. For instance, adverse events that cause injury or harm and endanger patient safety in LTC facilities occur too often to be ignored. The first step to correct deficiencies in regulating LTC facilities is to identify and enforce violations of current regulations. This provides regulators with evidence to make improvements in specified areas. Nationalizing regulations and enforcement will lead to a more consistent and effective LTC system that is consumer friendly. Finally, creating a new and separate agency that is responsible for the regulation, inspection, and enforcement of violations is necessary to improve quality of care in LTC facilities. Additional regulations and enforcement are necessary to increase quality of care in order to better protect LTC consumers. This requires the participation of all stakeholders to coordinate their efforts to develop strategies that will substantially improve quality of care in LTC facilities.

REFERENCES


