Nursing home deaths: the safety net unravels

Bruce C. Vladeck

The tragic and — at least in hindsight — partially preventable calamity of more than 31,000 COVID-19-related deaths in U.S. nursing homes has come as little surprise to the very few people outside the nursing-home industry itself who pay it much attention. Nursing homes have long been the disfavored stepchildren of health care policy, a status that has only been reinforced in recent decades by the policy consensus that care of the frailest elderly and disabled Americans should be moved out of such institutions altogether, in favor of home and community-based services (HCBS).

Indeed, the figures are dramatic: the number of long-stay nursing home residents in the United States — about one million — has hardly increased since the 1980s, and today there are more than twice as many individuals receiving publicly-financed HCBS, along with millions more receiving it with private financing.

Home and community-based care is the overwhelming preference of individuals and their families, but we know substantially less about what is actually happening to patients in HCBS settings than we do about those in nursing homes. We do know that regulatory oversight of HCBS is substantially weaker and less systematic than the inadequate system of overseeing nursing homes, that the dynamics of supply and demand have meant that expanding HCBS instead of nursing-home care has not saved public financing programs any money, and that some proportion of the individuals who have died in hospitals or at home from COVID-related causes were clients of HCBS programs — although it will take years of research, if it's ever performed, to establish even a rough quantitative estimate.

In short, care of the frailest elderly and disabled members of our society is — with some laudable exceptions — one of the weakest links in a badly fraying social safety net. Some of the problems arise from the inherent difficulty of taking care of adults with such complex needs, but more arise from increasingly generic problems of social insurance in contemporary America. Three of those problems must be called out.

THE STATE OF THE STATES

Although their role is often ignored in Washington-centric policy discussions, state governments are central to the administration of the safety net of social insurance and related programs. Medicaid is, of course, by far the largest and most obvious such program, but state governments still play the central role in administering Workers' Compensation, Unemployment Insurance, disability insurance, and what's left of direct cash assistance through Temporary Assistance for Needy Families (TANF) and Supplemental Security Income (SSI). But state governments, all but one of which must operate under constitutional

BRUCE C. VLADECK *currently serves as a Senior Advisor to the Greater New York Hospital Association and to LiveOnNY, an Organ Procurement Organization, and consults for several other health care organizations. He also chairs the board of the Medicare Rights Center and serves on the boards of Penn Medicine and the Mary Imogene Bassett Hospital. He has served as President of the United Hospital Fund; administrator of the Health Care Financing Administration (now the Centers for Medicare and Medicaid Services); and Senior Vice President of Mount Sinai Medical Center, among other senior positions. He is the author of* Unloving Care: The Nursing Home Tragedy, *the standard reference on nursing home policy in the United States. A Founding Member of the Academy, he received the Robert M. Ball Award in 2005.*

balanced-budget requirements, suffered an enormous blow from the 2008 recession, from which many have not fully recovered. The impact of public-sector job losses, combined with the success of well-organized right-wing efforts to take control of state legislatures, has been widely recognized in discussions of public education and higher education, but its effects on human services have been no less dramatic.

For long-term care, the erosion in states' capacity to govern has created a triple whammy. First, state governments have the primary responsibility for enforcing quality standards in health services, even for those paid by Medicare or private insurers, and the state agencies responsible for those activities have almost uniformly lost staff and have cut back on the frequency and thoroughness of basic inspections. Second, the capacity of state Medicaid agencies to actually manage the care delivery and clinical operations in their programs has also eroded dramatically. They have responded by largely contracting out program administration to what the late Congressman John Dingell used to describe as "the tender ministrations of private insurance companies." Despite many bumps along the road, Medicaid managed care has worked reasonably well for moms and kids, but long-term care is a much more complex service and administrative challenge — and no one really knows how it's working because the data collected on HCBS quality is so limited and unreliable. Third, and most basically, while the relationship between expenditure levels and quality of care is problematic and far from linear, squeezing budgets through intermediary private corporations in the absence of strong quality measurement and enforcement all but guarantees that the most costly patients will be underserved.

"...in an environment of constrained Medicaid payment rates, failure to meet even ludicrously minimal staffing standards became pervasive in the nursing-home industry, and also led to significant service cuts in long-term at-home managed care. Staffing shortages contributed directly to the extraordinary COVID-related death rates in nursing homes; they almost certainly have in HCBS as well."

WORKFORCE ISSUES

Both in nursing homes and HCBS, the overwhelming proportion of actual patient care is provided by aides, disproportionately women of color, paid at minimum wage or below, usually without health benefits or paid time off, with minimal or no training and few opportunities for advancement. Under the circumstances, the fact that most aides provide care as well as they do is a remarkable tribute to their compassion, commitment, and fundamental decency. As labor markets tightened in recent years, however, and as many states raised the minimum wage for both institutional and in-home nursing aides in an environment of constrained Medicaid payment rates, failure to meet even ludicrously minimal staffing standards became pervasive in the nursing-home industry, and also led to significant service cuts in long-term at-home managed care. Staffing shortages contributed directly to the extraordinary COVID-related death rates in nursing homes; they almost certainly have in HCBS as well.

FACING REALITY

Most basically, Medicaid is fundamentally an inadequate vehicle for financing high-quality long-term care, whether in nursing homes or

beneficiaries' homes. Private long-term care insurance has repeatedly failed to deliver on its promises or to catch on with consumers, and the future outlook is even more bleak, given that the next generation of long-term care patients will have even less money and assets than those currently in the system. On the other hand, a stable, long-term financing and regulatory system for long-term care is not a particularly difficult conceptual or intellectual challenge.

Such a system, though, like those in place in most of the civilized industrial nations of the world, would necessarily require a new source of government revenues and possibly new administrative structures. It might also disadvantage or even eliminate private firms that are now flourishing financially under the status quo. As such, it appears to fall outside the realm of currently permissible political discourse in contemporary America, just as other hallmarks of modern civilization such as universal health care or child care or paid time off for employees receive serious consideration in only a few very blue jurisdictions. It's perhaps too soon to tell whether Americans will respond to the coronavirus crisis by demanding substantive changes. Until the current political logjam breaks, however, tens of thousands of our frailest citizens will suffer, and thousands will continue to die unnecessarily.