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Older Americans Act: Long-Term Care Ombudsman Program

(name redacted)
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Summary

Quality of care in long-term care settings has been, and continues to be, a concern for federal policymakers. The Long-Term Care (LTC) Ombudsman Program is a consumer advocacy program that aims to improve the quality of care, as well as the quality of life, for residents in LTC settings by investigating and resolving complaints made by, or on behalf of, such residents. Established under Title VII of the Older Americans Act (OAA), the Administration on Aging (AoA) within the Administration for Community Living in the Department of Health and Human Services (HHS) administers the nationwide program. As of 2013, there were 53 state LTC Ombudsman Programs operating in all 50 states, the District of Columbia, Guam, and Puerto Rico, and 575 local programs. Title VII programs received about $20.7 million in FY2015. Total 2013 funding for ombudsman activities from all sources combined (federal and nonfederal) was $92.5 million, the most recent year for which data on funding from all sources are available. Of that total, 55.8% ($51.6 million) represented funding from federal sources.

Due to the requirement that ombudsmen investigate and resolve complaints of all residents in residential LTC facilities, the workload of staff and volunteers is substantial. In 2013, ombudsmen reported just over 16,500 nursing facilities and about 53,400 other residential LTC facilities operating nationwide. This translated to a nationwide ratio of one paid ombudsman for every 57 facilities and one paid ombudsman for every 2,400 resident beds. With respect to staffing, the program receives significant support from volunteers. In 2013, over 1,200 paid staff and about 8,300 certified volunteers investigated more than 190,000 resident complaints. Issues regarding residents' rights were the chief complaint in nursing homes, followed by residents' care issues in 2013. Among residents in other LTC facilities, the top complaint categories in 2013 were quality of life and residents' rights.

The OAA Amendments of 2006 (P.L. 109-365) authorized appropriations for the LTC Ombudsman Program through FY2011 (authorizations of appropriations expired on September 30, 2011). Congress has continued to appropriate funding for OAA-authorized activities for FY2012 through FY2015. The 114th Congress may choose to reauthorize the OAA. In doing so, federal policymakers may consider amending or deleting existing authorities under the Act or establishing new authorities, including those under the LTC Ombudsman Program. In addition, Congress will likely consider annual appropriations for LTC Ombudsman Program activities, as well as appropriations for authorities enacted under the Elder Justice Act enacted in the Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended) that support the program.

This report describes the LTC Ombudsman Program, including the program's legislative history, administrative function, other resident advocacy activities, and 2013 funding amounts by source. It also identifies selected issues for federal policymakers, including staffing and resources, in-home care ombudsman, and specialized ombudsman training. The **Appendix** includes a summary of provisions included in S. 192, the Older Americans Reauthorization Act of 2015, that would amend the LTC Ombudsman Program.

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Background

Quality of care in long-term care settings has been, and continues to be, a concern for federal policymakers. The Long-Term Care (LTC) Ombudsman Program is a consumer advocacy program that aims to improve the quality of care and quality of life for residents in nursing facilities and other residential care settings by responding to the needs of those facing problems in such facilities. Among their many functions, ombudsmen provide services to assist residents in protecting their health, safety, welfare, and rights. Ombudsmen help to resolve residents' complaints about the quality of their care and protect resident rights. Ombudsmen provide information, education, and consultation to residents, families, and staff regarding resident interests. Ombudsmen also advocate for systemic changes to improve resident care and quality of life, such as representing residents before governmental agencies or recommending changes to current law or regulation. Ombudsmen are available to help all LTC facility residents, not just those residents in nursing facilities certified by Medicare and Medicaid. This includes residents in assisted living facilities, board and care homes, and other similar adult residential care settings. Resident-focused ombudsman services complement those of federal and state staff who enforce facility-focused quality standards that are required under statute or regulation.

What Is an Ombudsman?

The Old Norse term *ombudsman* essentially means "representative." An *ombudsman* is an individual who investigates and attempts to resolve complaints and problems on behalf of citizens against businesses, institutions, and officials. The modern-day use of the term *ombudsman* began in 19th-century Sweden with the establishment of the Swedish Parliamentary Ombudsman to safeguard citizens' rights by establishing an agency independent of the executive branch.

This report describes the LTC Ombudsman Program authorized under the Older Americans Act (OAA). The OAA Amendments of 2006 (P.L. 109-365) authorized appropriations for OAA-funded activities, including the LTC Ombudsman Program, through FY2011 (authorizations of appropriations expired on September 30, 2011). However, Congress has continued to appropriate funding for OAA-authorized activities for FY2012 through FY2015. The 114th Congress may choose to reauthorize the OAA. In doing so, federal policymakers may consider amending or deleting existing authorities under the Act or establishing new authorities, including those under the LTC Ombudsman Program. In addition, Congress will likely consider annual appropriations for LTC Ombudsman Program activities, as well as appropriations for authorities under the Elder Justice Act enacted in the Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended) that support the LTC Ombudsman Program.

This report briefly describes the LTC Ombudsman Program's legislative history, administrative function and other activities, and funding. The report presents program data related to funding sources and types of facilities funded in 2013, the most recent year for which data are available. The report also provides findings from an Institute of Medicine (IOM) evaluation of the LTC Ombudsman Program and other studies related to the Program. Finally, it identifies further issues for Congress to consider regarding the LTC Ombudsman Program. The **Appendix** summarizes provisions that would amend the LTC Ombudsman Program under the Older Americans Act Reauthorization Act of 2015 (S. 192).

Legislative History

The ombudsman demonstration project was created in 1972 as a Public Health Service (PHS) demonstration project in five states. Authority for administering the project was transferred to the Administration on Aging (AoA) within the Department of Health and Human Services (HHS) in 1973. The results of the demonstration project led to statutory authority for the LTC Ombudsman Program under the Older Americans Act (OAA)[1] in 1978 (P.L. 95-478). In 1987, the program was given a separate authorization of appropriations (P.L. 100-175), and in 1992 it was incorporated into a new Title VII of the OAA authorizing vulnerable elder rights protection activities (P.L. 102-375). Also in 1992, a provision was added to the OAA requiring the AoA to establish a permanent National Ombudsman Resource Center. The most recent amendments to the OAA, in 2006 (P.L. 109-365), made no major changes to the program. Finally, the Elder Justice Act (enacted as part of the ACA) included two elder justice-related activities that would directly assist state LTC Ombudsman Programs.[2] The first aims to improve the capacity of Ombudsman Programs, while the second addresses ombudsman training with respect to elder abuse. Both authorize appropriations to fund these initiatives through 2014. To date, no funding has been provided for these authorized programs.

Administrative Function

There are 53 LTC Ombudsman Programs operating in all 50 states, the District of Columbia, Guam, and Puerto Rico, and 575 local programs as of 2013.[3] The AoA's National Ombudsman Reporting System (NORS) compiles national statistics relating to ombudsman activities. This information includes the number, status, and type of cases reported to state and local Ombudsman Programs; data on staff, volunteers, and funding; and other ombudsman activities.[4]

The OAA requires State Units on Aging (SUAs) to establish an Office of the State LTC Ombudsman (the Office). The functions of the state Ombudsman Programs are mandated by law[5] and include

- identifying, investigating, and resolving resident complaints;
- providing services to assist residents in protecting the health, safety, welfare, and rights of the residents;
- providing information to residents about long-term services and supports;

[1] In 1978, Congress amended the OAA (P.L. 95-478) to include a requirement that each state develop a LTC Ombudsman Program in order to protect the health, safety, welfare, quality of care, and rights of institutionalized residents in nursing facilities, board and care homes, assisted living facilities, and other similar facilities.

[2] Section 6703 of the ACA adds a new subtitle B, Elder Justice, under Title XX of the Social Security Act. For further information on these elder justice provisions, see CRS Report R43707, *The Elder Justice Act: Background and Issues for Congress*, by (name redacted).

[3] National Association of States United for Aging and Disability, *State Long-Term Care Ombudsman Program: A Primer for State Aging Directors and Executive Staff*, July 2013.

[4] National and state program data are publicly available from the National Ombudsman Reporting System (NORS) for 2000 to 2013 at http://www.agid.acl.gov/DataGlance/.

[5] OAA Title VII (P.L. 89-73, as amended); 42 U.S.C. 3058a.

- representing the interests of residents before governmental agencies and seeking administrative, legal, and other remedies to protect residents; and
- analyzing, commenting on, monitoring, and recommending changes in laws and regulations that pertain to the health, safety, welfare, and rights of residents.

Complaints investigated by ombudsmen relate to actions, inactions, or decisions of LTC providers or other agencies that adversely affect the health, safety, welfare, or rights of residents. Among its other responsibilities, the Office is to analyze and monitor federal, state, and local policies that affect residential LTC facilities.

The federal law requires that a full-time ombudsman administer the program at the state level; local ombudsmen may be designated by the state and are considered to be representatives of the Office. According to the AoA, most state Ombudsman Programs (35 states, Puerto Rico, and Guam) are located within SUAs (either independent SUAs or within an SUA that operates under an umbrella government agency). Another four state Ombudsman Programs are located in another government agency outside the SUA, and three states have state Ombudsman Programs that exist inside state governments but operate as independent agencies. Another eight states and the District of Columbia have Ombudsman Programs that are located outside of state government in other organizations, such as a legal services agency or protection and advocacy agency.[6] Variation in the organizational placement of Ombudsman Programs exists partly because the OAA gives each state discretion in determining many aspects of the Ombudsman Program. For example, states can decide

- where Ombudsman Programs may be located organizationally within the state,
- whether enabling legislation should be passed at the state level, and
- whether additional funding will be made available through state and local sources.[7]

These differences mean that the structure, operation, and effectiveness of Ombudsman Programs vary from state to state. Moreover, certain characteristics and features of state LTC Ombudsman Programs, by design, make the program different than other OAA programs and services, such as the Ombudsman Program's independence, strict disclosure requirements, and the responsibility to designate staff and volunteers to serve as representatives. While these unique features and state variation exist, there has been concern among policymakers and other stakeholders that these features have led to inconsistent interpretation of OAA provisions and ultimately issues of compliance.

To provide needed clarification of the responsibilities set forth under the OAA, as well as to address state variation in how OAA statute is interpreted, AoA published a final rule for State LTC Ombudsman Programs on February 11, 2015, after a notice of proposed rulemaking and public comment period.[8] Since placement of the LTC Ombudsman Program under Title VII of the

[6] National Association of States United for Aging and Disability, *State Long-Term Care Ombudsman Program: A Primer for State Aging Directors and Executive Staff*, July 2013.

[7] For further information, see J. Harris-Wehling, J. Feasley, and C. Estes, eds., *Real People Real Problems: An Evaluation of the Long-Term Care Ombudsman Programs of the Older American Act*, Washington, DC: Institute of Medicine (IOM), 1995.

[8] Department of Health and Human Services, "State Long-Term Care Ombudsman Programs; Final Rule," 80 *Federal Register* 7704-7767, February 11, 2015.

Act in 1992, minimal regulations regarding the program's operation existed. In AoA's analysis of and responses to public comments on the rule, the agency noted that it received general support for the rule. Commenters expressing support indicated that the rule addressed a needed gap, in general, with the potential to benefit residents and improve program quality.[9] Specifically, the rule addresses the following areas of program implementation:

- **State Agency Policies**—Requires that the state LTC Ombudsman be responsible for monitoring the files, records, and other information maintained by the program and prohibits the disclosure of identifying information of any complainant or LTC facility resident to individuals outside of the program, except as otherwise provided.
- **Definitions**—Defines the following terms: immediate family; Office of the State LTC Ombudsman; Representatives of the Office of the State LTC Ombudsman; resident representative; State LTC Ombudsman; State LTC Ombudsman Program; and willful interference.
- **Establishment of the Office of the State LTC Ombudsman**—Sets forth requirements in establishing the Office of the State LTC Ombudsman (the Office), including designation of the Office; Ombudsman selection; and development of policies and procedures regarding program administration, procedures for access, disclosure, conflicts of interest, systems advocacy, designation, a grievance process, and determinations of the Office.
- **Functions and Responsibilities of the State LTC Ombudsman**—Sets forth responsibilities of the Ombudsman, including specified functions; determination of local ombudsman entities; training requirements; management and disclosure of program information; fiscal management; annual reporting; state-level coordination with other entities regarding rights of LTC facility residents; and other activities as the Assistant Secretary determines appropriate.
- **State Agency Responsibilities Related to the Ombudsman Program**—Sets forth responsibilities of the state agency in ensuring that the Ombudsman complies with relevant provisions of the Act and this rule, including ensuring sufficient authority and access to facilities; providing training opportunities; providing personnel supervision and management; and providing performance and fiscal program monitoring, among other specified responsibilities.
- **Responsibilities of Agencies Hosting Local Ombudsman Entities**—States that host agencies are responsible for the personnel management, but not programmatic oversight, of representatives of the Office. Host agencies cannot have policies or practices that prohibit representatives of the Office from performing duties and other required activities.
- **Duties of the Representatives of the Office**—Authorizes the Ombudsman to designate local Ombudsman entities and employees or volunteers of the entity as representatives of the Office; also authorizes the designation of an employee or volunteer within the Office. Describes the duties of an individual designated as a representative of the Office and specifies requirements for complaint processing activities.

[9] Ibid., 7705.

- **Conflicts of Interest**—Requires the state agency and the Ombudsman to identify organizational and individual conflicts of interest and, if identified, remove and remedy such conflicts.

AoA expects that some states may need to update policies in order to operate programs that are consistent with the final rule. As a result, the effective date for the final rule is July 1, 2016. Accordingly, AoA indicates that the agency intends to provide technical assistance and training to states prior to the rule's effective date to allow states time to make adjustments to state laws, regulations, guidance, and other related policy.[10]

Other Activities

In addition to resolving resident complaints, providing education and information, and engaging in advocacy activities, Ombudsman Programs participate in a number of other federal initiatives. These activities range from involvement with quality improvement initiatives to informing nursing home residents and family members about various LTC options to having an expanded role in home care services. For example, the Centers for Medicare & Medicaid Services (CMS) encourages ombudsmen to communicate and work collaboratively with Quality Improvement Organizations (QIOs).[11] Ombudsmen may assist QIOs in identifying and working with facilities on quality assessment and improvement efforts. They may assist residents and family members with the use of quality measures in selecting a nursing home, or they may work to improve resident assessment instruments used for care planning.[12]

Ombudsmen may also assist residents transitioning from nursing homes to private homes or other residential care facilities. In doing so, ombudsmen may refer residents and family members to community resources or monitor the discharge planning process. Some Ombudsman Programs are actively involved in federal nursing home transition initiatives such as the CMS Money Follows the Person Rebalancing Demonstration program. Ombudsman Programs may participate in state level coalitions and advisory committees that oversee these initiatives.[13] In some states, ombudsmen have received training about such initiatives in order to better assist residents with transitions. In addition, some states that are piloting integrated Medicare and Medicaid service models (Duals Demonstrations) have expanded their LTC Ombudsman services to include assistance to individuals receiving services through the demonstration. Through a CMS funding

[10] Ibid., 7704.

[11] Sections 1152-1154 of the Social Security Act require the Secretary of HHS to establish Quality Improvement Organizations (QIOs). According to CMS, QIOs are private, mostly not-for-profit organizations staffed by doctors and other health care professionals who are trained to review medical care, help beneficiaries with complaints about the quality of care, and implement quality improvements. CMS contracts with one organization in each state, the District of Columbia, Puerto Rico, and the U.S. Virgin Islands to serve as the QIO contractor. For more information on QIOs, see http://www.cms.gov/qualityimprovementorgs/.

[12] Centers for Medicare and Medicaid Services, Nursing Home Quality Initiative: Relationship of Quality Improvement Organizations and State Offices of the Long-Term Care Ombudsman, https://www.cms.gov/NursingHomeQualityInits/downloads/NHQIombudqio472a200512.pdf; The National Long-Term Care Ombudsman Resource Center, MDS 3.0, at http://ltcombudsman.org/issues/mds-3.0.

[13] For more information on CMS's Money Follows the Person Rebalancing Demonstration, see CRS Report R43328, *Medicaid Coverage of Long-Term Services and Supports*, by (name redacted); additional information is available on CMS's website, at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Balancing/Money-Follows-the-Person.html.

opportunity, Duals Ombudsman Programs provide services to support beneficiaries, complaint investigation and resolution, and systems-level analysis and recommendations.[14]

Some states have also expanded their state LTC Ombudsman Programs to address LTC provided in home settings. However, one limitation in statute is that states cannot use federal funding designated for the LTC Ombudsman Program under OAA to serve individuals receiving home and community-based services (HCBS) in their own homes. As of 2013, twelve states and the District of Columbia had expanded their LTC Ombudsman Programs into HCBS through state laws or other provisions.[15] These programs use grant funding, additional state funding, and other non-OAA federal funding to extend the program's jurisdiction. However, the role and function of home care ombudsmen varies, and no standardized best practices for home care ombudsman exist. State-based home care ombudsman programs cover complaints across a range of services, including home care services that may be privately funded, state funded, or funded through the OAA, home health agency services, adult day services, and hospice.[16]

Medicaid Administrative Funding for Ombudsman Activities

Ombudsman program activities may also directly benefit the Medicaid program and in doing so may qualify for Medicaid administrative funding to the extent these expenditures can be allocated properly to state's Medicaid programs. In guidance issued by CMS, Medicaid administrative funds may support certain LTC Ombudsman Program activities, subject to the requirements for Medicaid administrative claiming.[17] The following provides examples of activities that may be eligible for Medicaid administrative funding:

- Identifying and referring individuals who may be eligible for Medicaid services, as well as education and consultation to potential Medicaid enrollees on facilitating the enrollment process.
- Tracking and reporting to the state Medicaid enrollee requests for assistance in obtaining covered Medicaid services.
- Consultation and advocacy in transitioning individuals from Medicare Part A coverage into the Medicaid nursing facility benefit, or from private pay status into a Medicaid funded nursing facility or other services, such as home and community-based services.

[14] Department of Health and Human Services, *FY2013 Report to Congress: Older Americans Act,* prepared by the Administration on Aging, Administration for Community Living, 2013.

[15] State LTC Ombudsman Programs with home care responsibilities are available in Alaska; Washington, DC; Idaho; Indiana; Maine; Minnesota; Ohio; Pennsylvania; Rhode Island; Vermont; Virginia; Wisconsin; and Wyoming. Centers for Medicare & Medicaid Services*, Best Practices for Home and Community-Based Ombudsman*, prepared by the Research and Training Center at the University of Minnesota and The Lewin Group, January 2013.

[16] Ibid.

[17] Centers for Medicare & Medicaid Services, *Medicaid Administrative Claiming for Activities Performed by State Long-Term Care Ombudsman Programs*, at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Financing-and-Reimbursement/LTC-Ombudsman-Programs.html.

- Consultation and advocacy to assist individuals participating in Medicaid home and community-based waiver programs.
- Identifying Medicaid-eligible residents who want to transition out of nursing facilities and connecting them with the appropriate entities to assist them in returning to the community.
- Identifying and reporting suspected instances of Medicaid fraud, waste, and abuse to federal and state agencies for further investigation and action.
- Other LTC Ombudsman Program activities that are necessary for the proper and efficient administration of the Medicaid state plan as determined by the HHS Secretary.

LTC Ombudsman Program activities for which Medicaid administrative funding is not available include activities to assist individuals with gaining access to or coordination of non-Medicaid benefits or services, such as social, educational, vocational, legal, and advocacy services. State Medicaid agencies must have an interagency agreement or contractual arrangement with the state agency or other entity that administers the state LTC Ombudsman Program for expenditures to be claimable under Medicaid. The state Medicaid agency is the only entity that may submit claims to receive federal matching assistance. LTC Ombudsman Program activities receive a 50% federal matching rate similar to other general administration activities.[18]

Authorization and Funding

The OAA Amendments of 2006 (P.L. 109-365) authorized appropriations for the LTC Ombudsman Program through 2011(authorizations of appropriations expired on September 30, 2011). However, Congress has continued to appropriate funding for Ombudsman Program activities in subsequent fiscal years through FY2015. Ombudsman activities are authorized under two separate titles of the OAA:

- Title III—Grants for States and Community Programs on Aging, and
- Title VII—Vulnerable Elder Rights Protection Activities.

Title III authorizes grants to states for supportive services and senior centers that provide for a wide range of social services, including ombudsman activities.[19] Title VII authorizes grants to states for Chapter 2 (the LTC Ombudsman Program) and Chapter 3 (the Elder Abuse Prevention Program). Under Chapter 3, some states choose to perform elder abuse prevention activities through the LTC Ombudsman Program.

Title VII programs received $20.7 million of federal funding in 2015.[20] While the majority of federal funding for ombudsman activities comes from appropriations for Titles III and VII of the

[18] For more information, see CRS Report R43847, *Medicaid's Federal Medical Assistance Percentage (FMAP), FY2016*, by (name redacted).

[19] For more information on how funding under Title VII is allocated to states, see CRS Report RS22549, *Older Americans Act: Funding Formulas*, by (name redacted); state allocation tables are at AoA, Funding Allocations to States and Tribal Organizations, http://www.aoa.gov/AoARoot/AoA_Programs/OAA/Aging_Network/State_Allocations/index.aspx.

[20] HHS, ACL, *Fiscal Year 2016 Justification of Estimates for Appropriations Committees*.

OAA, the program also receives substantial nonfederal support. **Table 1** shows total support for ombudsman activities in 2013, the most recent year for which data on funding from all sources are available. Total 2013 funding for ombudsman activities from all sources combined (federal and nonfederal) was $92.5 million. Of that total, 55.8% represented funding from federal sources, with 30.0% from Title III funds, 21.3% from Title VII funds, and 6.7% from other federal funds. In 2013, nonfederal funding represented 44.2% of total support (37.3% state funding and 6.9% local funding).

Table 1. Long-Term Care Ombudsman Program 2013 Funding, by Source

(in millions)

Funding Sources	2013 Funding	% of Total
Total	**$92.5**	**100%**
Federal funds	**$51.6**	**55.8%**
• OAA Title III (non-add)	*$28.6*	*31.0%*
• OAA Title VII, Chapter 2: Ombudsman program (non-add)	*$16.0*	*17.3%*
• OAA Title VII, Chapter 3: Elder abuse prevention (non-add)	*$2.1*	*2.2%*
• Other federal funds (non-add)	*$4.9*	*5.3%*
State funds	**$34.5**	**37.3%**
Local funds	**$6.4**	**6.9%**

Source: CRS analysis based on AoA, *2013 National Ombudsman Reporting System Data Tables*: Table A-9 Long-Term Care Ombudsman Program Funding.

Note: Data may not sum to totals due to rounding.

In 2003, the share of federal funding for LTC Ombudsman Program activities was 63%, while the proportion of funding at the state and local level was 28% and 9%, respectively. Since then, the share of federal funding has decreased to 56% in 2013, its lowest share over the past decade. The proportion of program funding from state governments increased to 37%, its highest share over the past decade, with a slight decrease in the proportion of funding from local governments (7%). Total funding for LTC Ombudsman Program activities in 2003 (nominal dollars) was $68.0 million (which was comprised of $42.9 million in federal funding, $19.1 million in state funding, and $6.1 million in local funding).[21]

Staffing

In 2013, there were 1,233 paid staff (full-time equivalents) in state LTC Ombudsman Programs, an increase of 7% since 2003.[22] Despite this increase, the program still relies heavily on volunteers to carry out program responsibilities. Nine out of every 10 ombudsman staff are volunteers. In 2013, there were just under 12,300 total volunteers; two-thirds (67%) were certified

[21] Sums do not add to total due to rounding.

[22] For further information, see the AoA's AGing Integrated Database (AGID), which includes data for the National Ombudsman Reporting System (NORS), at http://www.agidnet.org/.

to investigate complaints, representing a decrease in the proportion of certified volunteers in the past five consecutive fiscal years. Over the past decade, the total number of volunteers has ranged from about 11,400 to over 13,800, with an average of 12,300 volunteers in a given year. In 2013, ombudsman programs in 48 states and the District of Columbia reported at least one certified volunteer. Two states (South Dakota and Wyoming) and Puerto Rico reported no volunteer activity during this period.

The 1995 IOM evaluation, along with a study done by the Office of Inspector General (OIG) in HHS in 1991, acknowledged the importance of volunteers as a contributing factor to high complaint resolution rates in this program.[23] However, the IOM evaluation advised that adequate methods for recruiting, training, and supervising volunteers are essential to utilizing Ombudsman Program volunteers. State programs have different procedures for certifying volunteers, varying from required classroom training to tests for certification.

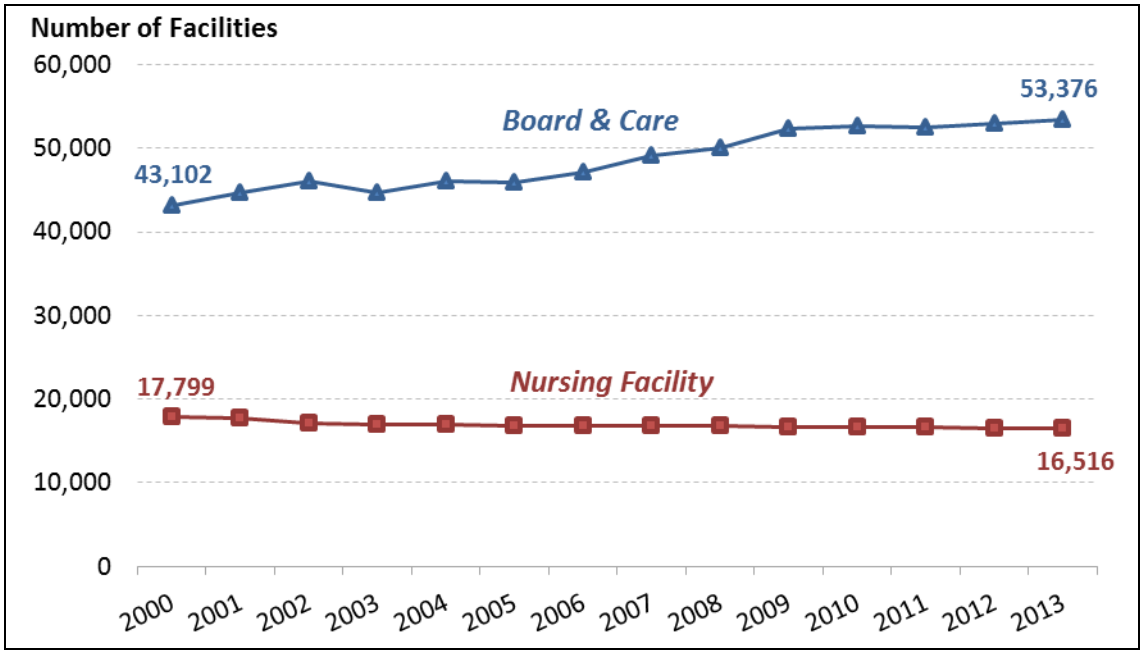
In 2013, ombudsmen reported over 16,500 nursing facilities and about 53,400 other residential LTC facilities operating nationwide.[24] Since 2000, the total number of regulated facilities has increased 15% from about 61,000 to almost 70,000 in 2013 (see **Figure 1**). This change is due to an increase in assisted living facilities, board and care homes, and other similar facilities, which more than offset the decrease in nursing homes over this time period.

[23] For further information, see Office of Inspector General (OIG) Report OEI-02-90-02120, *Successful Ombudsman Programs*; OEI-02-90-02121, *Ombudsman Output Measures*; and OEI-02-90-02122, *Effective Ombudsman Programs: Six Case Studies;* J. Harris-Wehling, J. Feasley, and C. Estes, eds., *Real People Real Problems: An Evaluation of the Long-Term Care Ombudsman Programs of the Older American Act*, Washington, DC: Institute of Medicine (IOM), 1995.

[24] Other residential LTC facilities include board and care homes and similar facilities, such as residential care facilities, adult congregate living facilities, assisted living facilities, foster care homes, and other adult care homes similar to a nursing facility or board and care home that provides room, board, and personal care services to a primarily older residential population.

Figure 1. Number of Long-Term Care Facilities, by Facility Type

2000 to 2013



Source: CRS analysis based on AoA, *2013 National Ombudsman Reporting System Data Tables*: Table A-6-A Long-Term Care Ombudsman Program Funding.

Notes: The number of nursing facilities and board and care homes and similar facilities includes those regulated (licensed or registered) in the state. Under the OAA, the ombudsman program covers all such facilities, whether regulated or unregulated by the state; however, according to the OMB instructions for completing the Long Term Care Ombudsman Program Reporting Form for NORS, it would not be possible for the program to provide the total number of unregulated facilities and beds. Therefore, the actual number of these facilities may be higher. The number of nursing homes may be slightly higher than estimates by the Centers for Medicare and Medicaid Services (CMS), which include only nursing homes certified to participate in Medicare and/or Medicaid.

Workload

Due to the requirement that ombudsmen investigate and resolve the complaints of all residents in residential LTC facilities, the workload of staff and volunteers is substantial, as shown by the reported ratio of staff to facilities and beds. The nationwide ratio of paid ombudsman to facilities was one ombudsman to every 56 facilities in 2013, a somewhat higher ratio than reported in 2003 (one ombudsman to every 53 facilities). Nationwide, there were a reported 2.99 million facility beds under the program's jurisdiction (almost 1.72 million nursing home beds and just over 1.27 million beds in other LTC facilities) in 2013. The nationwide ratio of full-time paid ombudsman to facility beds was about one ombudsman per 2,400 beds, a smaller ratio than reported in 2000 (one ombudsman per 2,800 beds). However, it is important to note that these ratios are nationwide, and each state has a unique ratio of paid ombudsman staff per facility bed.[25] The 1995 IOM study recommended a standard staffing ratio of one paid full-time equivalent staff per 2,000 LTC facility beds.

[25] For further information, see *2010 National Ombudsman Reporting System Data Tables*, at http://www.aoa.gov/AoARoot/AoA_Programs/Elder_Rights/Ombudsman/National_State_Data/2010/Index.aspx.

Despite the high number of facilities to be covered by each ombudsman, ombudsman staff and volunteers visited 70% of nursing homes on a regular basis (defined as at least quarterly) in 2013. These visits were not in response to a complaint. The percentage of nursing homes visited regularly by ombudsman staff was greater than visits by staff to other residential LTC facilities. The proportion of regular visits to assisted living and other LTC facilities was 29% in 2013. Over the past decade, the proportion of regular visits in both settings has declined from more than half of LTC facilities receiving at least a quarterly visit in 2003 (54%) to 39% in 2013.

Training

State ombudsman programs are responsible for training new and existing staff. The OAA contains only basic requirements for training and stipulates that the AoA is to develop model standards for training LTC ombudsmen, both paid and unpaid volunteers. Furthermore, the law stipulates that the state LTC Ombudsman is responsible for establishing procedures for training representatives of the local ombudsman program based on the AoA standards and that training is to be developed in consultation with representatives of citizen groups, LTC providers, and ombudsmen. In the absence of specific federal training requirements and/or required training materials, many states have developed their own standards. Several states provide the training directly through an individual responsible for conducting all of the training, while some states require local ombudsman programs to conduct training. State LTC Ombudsman Programs have received assistance in developing training programs from the National Long-Term Care Ombudsman Resource Center.[26]

Program Data and Resident Complaints

As advocates for residents' rights in LTC facilities, ombudsmen work to resolve resident complaints. In 2013, AoA data show that ombudsmen opened about 125,000 new cases of resident complaints and closed almost 124,000 cases in all types of facilities.[27] Compared to FY2012, the number of complaints decreased by less than 2%, from 194,000 to about 191,000 complaints. Over the past decade, the number of resident complaints has decreased overall by one-third (33%), from 286,000 complaints in 2003.

The top five resident complaint categories in nursing homes for 2013 were

1. problems with discharge planning or eviction notification and procedures;
2. unheeded requests for assistance;

[26] The National Long-Term Care Ombudsman Resource Center provides support, technical assistance and training to state LTC Ombudsman Programs and their statewide networks of local programs. The Center is operated by the National Consumer Voice for Quality Long-Term Care with funding from AoA. For further information on training materials to assist states, see the National Ombudsman Resource Center website at http://www.ltcombudsman.org/.

[27] According to the National Ombudsman Reporting System (NORS) Reporting Requirements Form (OMB No. 0985-0005), a complaint is a concern brought to, or initiated by, the ombudsman for investigation and action by or on behalf of one or more residents of a LTC facility relating to health, safety, welfare, or rights of a resident. Each inquiry involving one or more complaints constitutes an "opened" case, which then requires ombudsman investigation, a strategy for resolution, and follow-up. A case is reported "closed" when none of the complaints within the case require any further action on the part of the ombudsman and every complaint has been assigned the appropriate disposition code.

3. lack of dignity or respect for residents by staff;
4. resident conflict, including roommate conflict; and
5. problems with organization or administration of medications.

These top five complaints have generally remained among the top 10 resident complaints in nursing homes over the past decade.

Similarly, the top five resident complaint categories in other LTC facilities for 2013 have remained the same over the past decade:

1. lack of quantity, quality, variety, and choice in food;
2. problems with medication administration or organization;
3. inadequate discharge or eviction notice or procedure;
4. lack of dignity or respect for residents by staff; and
5. poor equipment or building conditions.

In 2013, the top five resident complaints in nursing homes and other LTC facilities accounted for over one-fifth of all complaints for each facility type.

Program Evaluation

The most recent national evaluation of the Ombudsman Program was conducted in 1995 by the IOM. Since then, various studies have examined factors associated with program effectiveness. Given the growth in the number of long-term care facilities over this time period and potential for increased demand in long-term services and supports with the aging of the baby-boom generation, findings and recommendations from these studies may still be relevant to the program implementation today. For example, the 1995 IOM study concluded that the program plays an important role in improving long-term services and supports but is understaffed and underfunded to carry out its broad and complex responsibilities.[28] In March 1999, HHS's OIG recommended that AoA work with states to strengthen the program by

- developing guidelines for a minimum level of program visibility that include criteria for the frequency and length of regular visits, as well as the ratio of ombudsman program staff to LTC beds;
- further developing strategies for recruiting, training, and supervising more volunteers; and
- establishing ways in which ombudsman programs can enhance collaboration with the state nursing home survey and certification agencies, which are responsible for oversight of nursing home care quality.[29]

[28] J. Harris-Wehling, J. Feasley, and C. Estes, eds., *Real People Real Problems: An Evaluation of the Long-Term Care Ombudsman Programs of the Older American Act*, Washington, DC: Institute of Medicine (IOM), 1995.

[29] OIG Report OEI-02-98-00351, *Long-Term Care Ombudsman Program: Overall Capacity.*

A 2000 study of state ombudsman programs reaffirmed the importance of several factors identified in the IOM evaluation as key to program effectiveness, including sufficient funding, staff, and volunteers; autonomy of the ombudsman program in terms of organizational placement within the state; a supportive political or social environment; and strong interorganizational relationships.[30] A study of local ombudsman programs conducted in two states, California and New York, in 2004, found wide variation both across and within each state's program in terms of program location (area agency on aging versus nonprofit organization) and the number of paid staff versus volunteers. Despite reporting that their program budgets were inadequate to support their mandated requirements, program coordinators in both states perceived their programs as effective, more so in the nursing home setting than in board and care facilities. Program coordinators in both states similarly identified staffing, resident care, and residents' rights as the most pressing issues.[31]

A 2010 study of factors associated with the effectiveness of local LTC Ombudsman Programs in California and New York across five activities mandated by the OAA found that no single factor was associated with effective performance of local programs. However, researchers found patterns among categories they proposed were relevant to program effectiveness.[32] The five mandated activities studied were complaint investigation, resident/family education, community education, monitoring laws, and policy advocacy. For example, perceived quality of training and organizational autonomy was associated with effectiveness for several mandated activities in both states. However, program size was associated with effectiveness in different ways across the two states, suggesting there may be a minimum amount of staffing and resources needed for effectiveness, but above which further gains are not uniformly achieved.

In 2011, AoA awarded a contract to NORC at the University of Chicago to develop an evaluation study design to assess the effectiveness of LTC Ombudsman Programs. In collaboration with the ACL and a Technical Advisory Group created to guide and inform research objectives and design, NORC issued a report that describes an evidence-based approach and recommendations for a comprehensive study design that consists of process and outcomes evaluation activities. NORC states that proposed evaluation activities are adaptable and scalable depending on resource needs.[33]

Issues for Congress

As the nation prepares for an increase in the number of older individuals and an increase in demand for long-term services and supports among the frail elderly, ensuring quality of care in LTC facilities will likely remain a key issue for federal policymakers. The role of the LTC Ombudsman Program in providing resident and systems advocacy to improve quality of care may be a focus for the 114th Congress. Specifically, Congress may want to consider efforts to

[30] C. Estes, et al., *State Long Term Care Ombudsman Programs: Factors Associated with Perceived Effectiveness*, The Gerontologist, vol. 44(1), pp.104-115, 2004.

[31] C. Estes, *Enhancing the Performance of Local Long Term Care Ombudsman in New York State and California: Chartbook*, University of California, San Francisco, 2006.

[32] C. Estes, et al., *Factors Associated with Perceived Effectiveness of Local Long-Term Care Ombudsman Programs in New York and California*, Journal of Aging and Health, vol. 22(6), pp. 772-803, 2010.

[33] NORC at the University of Chicago, *Final Report: Evaluation Study Design for Long-Term Care Ombudsman Program under the Older Americans Act: Research Design Options*, January 31, 2013.

understand resource adequacy, the role of the LTC Ombudsman Program in home and community-based service expansion, furthering efforts with respect to LTC Ombudsman training and prevention of elder abuse, and the reauthorization of the Older Americans Act.

Resource Adequacy

The increasing number of residential care facilities has placed pressure on state LTC Ombudsman Programs to monitor quality of care in these settings. Ombudsmen indicated that regular visitation to these facilities was often limited and in some cases nonexistent.[34] In addition, federal funding appropriated for state LTC Ombudsman Programs in the annual Labor-HHS-Ed appropriations bill, unadjusted for inflation, has remained relatively flat over the past decade ($20.1 million in FY2006, compared to $20.7 million in FY2015). At the same time, the total number of facilities ombudsmen oversee has increased 9% in 10 years (by more than 6,000 facilities). That increase is entirely driven by the growth in residential care settings, which increased almost 12% over that time period, while nursing facilities decreased by more than 1%. In a study of LTC Ombudsman Programs in three states, coordinators reported a lack of resources (e.g., time, funding, and personnel), as well as the need to prioritize certain mandates over others (e.g., prioritizing complaint investigation over systems advocacy).[35] Policymakers may choose to address greater ombudsman program oversight of residential care facilities through additional staffing and resources for ombudsman programs and specialized training on the needs of residents in these settings.

Expansion of Home and Community-Based Services

The growth in home and community-based services, and the increase in demand for such services, has also drawn attention to potential problems with quality of care in home-based settings. Stakeholders have identified a perceived need for an in-home care ombudsman program to address quality of care issues among these LTC recipients.[36] Policymakers may choose to consider extending ombudsman activities to older persons receiving LTC in their own home. These activities are not among those financed by the Older Americans Act. However, without additional staff or resources to expand ombudsman activities to home settings, federal expansion of the program may overwhelm an already strained system. Moreover, the number of additional staff and amount of resources needed to provide adequate ombudsman services to home care recipients is not known.

Training

Expanding the role of ombudsmen in quality improvement efforts, as well as assisting in transitions from nursing homes, emphasizes the need for a well-trained and informed ombudsman staff. However, most ombudsmen are volunteers, and ombudsman training procedures and

[34] Carol V. O'Shaughnessy, *The Role of the Ombudsman in Assuring Quality of Residents of Long-Term Care Facilities: Straining to Make Ends Meet,* National Health Policy Forum, Background Paper No. 71, December 2, 2009.

[35] B. Hollister and C. Estes, *Local Long-Term Care Ombudsman Program Effectiveness and the Measurement of Program Resources*, Journal of Applied Gerontology, vol. 32(6), pp. 708-728, 2012.

[36] National Association of State Units on Aging, *Charting the Long-Term Care Ombudsman Program's Role in a Modernized Long-Term Care System*, January, 2008.

standards vary by state. In order for the LTC Ombudsman Program to serve as a valued resource for outreach and referral to community services, the ombudsmen must be educated and informed about the financing and delivery of long-term services and supports (LTSS). Ombudsmen must also have well-developed communication and critical thinking skills in order to help resolve resident complaints. Policymakers may consider establishing federal training requirements or providing technical assistance for training, such as national or regional training institutes.

Elder Abuse

The LTC Ombudsman Program plays a key role in identifying and investigating complaints regarding resident abuse and neglect. A study of national trends in reporting of abuse and neglect in nursing facilities from 2006 to 2013 using NORS data found that physical abuse by a nonresident was the most frequent complaint in each year reported.[37] The same study found that over this time period, the total number of abuse and neglect complaints in nursing facilities decreased. Complaint reductions were observed for all types of abuse and neglect complaints, with the exception of financial exploitation. Overall, from 2006 to 2013 the number of total complaints, including those identified as abuse and neglect, in both nursing and other residential care facilities declined by one-third. These national trends point to a need for further understanding and research; enhancements to national data, such as NORS, that could examine reasons for a decline in reporting overall; and reporting among specific categories and within settings. Provisions enacted under the Elder Justice Act, if funded, could also provide additional resources to assist the LTC Ombudsman Program address elder abuse.

Older Americans Act Reauthorization

On January 20, 2015, the Senate introduced a bipartisan bill to reauthorize the Older Americans Act for a three-year period. The Older Americans Act Reauthorization Act of 2015 (S. 192) would authorize appropriations for most OAA programs through FY2018. It also would make various amendments to existing OAA authorities, including proposed changes to the LTC Ombudsman Program. On January 28, 2015, the Senate Health, Education, Labor, and Pensions (HELP) Committee ordered S. 192 reported favorably. On July 17, 2015 the bill was passed by voice vote in the Senate and subsequently received in the House and referred to the House Education and Workforce Committee. Key LTC Ombudsman Program provisions under S. 192 address state organization, procedures for access and disclosure, and conflicts of interest (see the **Appendix** for a summary of these provisions). To date, legislation to reauthorize OAA has not been introduced in the House.

[37] Elizabeth M. Bloeman et al., "Trends in Reporting of Abuse and Neglect to Long-Term Care Ombudsman: Data from the National Ombudsman Reporting System from 2006 to 2013," *Geriatric Nursing*, April 30, 2015.

Appendix. The Older Americans Act Reauthorization Act of 2015 (S. 192): Long-Term Care Ombudsman Provisions

The Older Americans Act Reauthorization Act of 2015 (S. 192) was introduced January 20, 2015, and would authorize appropriations for most OAA programs, including the LTC Ombudsman Program, through FY2018. Provisions that would amend the program under Section 8 of the bill (as reported to the Senate on February 3, 2015) are summarized below.[38]

Ombudsman Definitions

The bill would amend the definition of the term "resident" to mean "an individual" who resides in a LTC facility instead of (as currently) an "older individual." Thus, it would eliminate explicit reference to "older" individuals, which would allow residents of any age who reside in LTC facilities to receive Ombudsman Program services, including investigating and resolving complaints.

Ombudsman Programs

The bill would require the state long-term care (LTC) Ombudsman to be responsible for the management, including the fiscal management, of the Office of the State LTC Ombudsman (hereinafter referred to as the "Office"). It would amend the functions of the Ombudsman to add language stating that the Ombudsman's functions include identifying, investigating, and resolving complaints that are made by, or on behalf of, residents with limited or no decision making capacity and who have no known legal representative. It would further specify that if such a resident is unable to communicate consent for an Ombudsman to work on a complaint involving the resident, the Ombudsman would be required to seek evidence to indicate what outcome the resident would have communicated and work to accomplish that outcome. It would also amend the duties of designated local ombudsman entities and representatives to identify, investigate, and resolve complaints made by or on behalf of residents with limited decision making capacity in similar circumstances.

In addition to residents having regular and timely access to the Ombudsman's services, the bill would require that the Ombudsman ensure that residents have private and unimpeded access to such services. In providing technical support for the development of resident and family councils, the bill would require the Ombudsman to actively encourage and assist in the development of such councils. Similarly, it would also amend the duties of designated local ombudsman entities and representatives to actively encourage and assist in the development of such councils. It would further add that the Ombudsman, when feasible, continue to carry out specified functions on behalf of residents transitioning from a LTC facility to a home care setting.

[38] For a section-by-section summary of key provisions in S. 192, see CRS Report R43414, *Older Americans Act: Background and Overview*, by (name redacted) and (name redacted).

Procedures for Access

The bill would amend the requirement that a state ensure representatives of the Office have "access" to LTC facilities and residents to specify that representatives have "private and unimpeded access." It would also amend the current law provision that requires representatives to have appropriate access to the medical and social records of a resident, subject to certain conditions, to provide that representatives have appropriate access to "all files, records, and other information" concerning a resident rather than (as currently) "files." It would amend current law to clarify that representatives must have appropriate access to review such information when a resident is "unable to communicate consent" to the review and has no legal representative, rather than (as currently) "unable to consent." Similarly, it would expand the requirement that representatives have access to the "records" as is necessary to investigate a complaint, to specify that representatives have access to the "files, records, and information" necessary.

It would add that the Ombudsman and representatives of the Office would be considered a "health oversight agency" for purposes of Section 246(c) of the Health Insurance Portability and Accountability Act of 1996 (HIPAA, P.L. 104-191), including regulations issued under that section. Thus, the release of residents' individually identifiable health information to the Ombudsman could not be prevented from occurring under certain specified circumstances.

Disclosure

Current law requires the state agency to establish procedures for the disclosure of files maintained by the program by the Ombudsman or other ombudsman entities. The bill would strike the language "files and records" and replace it with "files, records, and other information" in each place the term appears under disclosure requirements. It would amend disclosure requirements pertaining to the identity of the complainant or resident to ensure that the Ombudsman may disclose information as needed in order to best serve residents with limited or no decision making capacity who have no known legal representative and are unable to communicate consent, in order for the Ombudsman to carry out functions and duties as described.

Conflict of Interest

The bill would replace the subsection on conflict of interest with a new subsection that separately describes individual and organizational conflict of interest.

Individual Conflict of Interest

The bill would require the state agency to ensure that no individual, or member of an immediate family of an individual, involved in the designation of the Ombudsman, or the designation of a local ombudsman entity or representative, is subject to a conflict of interest. Furthermore, the state agency would be required to ensure that no officer or employee of the Office, representative of a local Ombudsman entity, or member of the immediate family of the office, employee, or representative, be subject to a conflict of interest. The bill would also require the state agency to ensure that the Ombudsman

- does not have direct involvement in the licensing or certification of a LTC facility or provider of a LTC service;

- does not have an ownership or investment interest in a LTC facility or service;
- is not employed by, or participating in the management of, a LTC facility or a related organization, and has not been employed by such a facility or organization within one year before the date of the determination involved;
- does not receive, or have the right to receive, directly or indirectly, remuneration under a compensation arrangement with an owner or operator of a LTC facility;
- does not have management responsibility for, or operate under the supervision of an individual with management responsibility for adult protective services (APS); and
- does not serve as a guardian or in another fiduciary capacity for residents of LTC facilities in an official capacity.

Organizational Conflict of Interest

The bill would require the state agency to comply with specified requirements in a case where the Office poses an organizational conflict of interest, including a situation in which the Office is placed in an organization that is responsible for licensing, certifying, or surveying LTC services in the state; is an association of LTC facilities or any other residential facilities for older individuals; provides LTC services including those carried out under certain Medicaid waiver and other authorities; provides LTC case management; sets rates for LTC services; provides APS; is responsible for Medicaid eligibility determinations; conducts preadmission screenings for placement in LTC facilities; or makes decisions regarding admission or discharge of individuals to or from such facilities.

The state agency would not be authorized to operate the Office or carry out the program, directly or by contract or other arrangement, in a case in which there is an organizational conflict of interest unless such conflict of interest has been identified by the state agency, disclosed by the state agency to the Assistant Secretary in writing, and remedied in accordance with certain requirements. In a case where potential or actual organizational conflict of interest involving the Office is disclosed or reported to the Assistant Secretary by any person or entity, the Assistant Secretary would require the state agency to remove the conflict or submit and obtain the approval of the Assistant Secretary for an adequate remedial plan that indicates how the Ombudsman will be unencumbered in fulfilling specified functions.

Author Contact Information

(name redacted)
Specialist in Health and Aging Policy
/redacted/@crs.loc.gov, 7-....

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