

Children's Health Bill Would Whack Medicare SNF Payments

Long term care providers are bracing for battle against the House of Representatives' version of a bill that would fund the expansion of health coverage for children in part by cutting \$2.7 billion from Medicare payments to skilled nursing facilities (SNFs). The Senate version of the legislation that passed earlier did not contain the SNF cuts.

The Children's Health and Medicare Protection Act (CHAMP) would reauthorize and broaden the State Children's Health Insurance Program (SCHIP), providing coverage for an additional 5 million uninsured children at a cost of \$47.5 billion over five years. The measure, which passed the House Aug. 1 on a largely party line vote of 225 to 204, also includes \$14.3 billion in Medicare benefit improvements and a \$19.3 billion boost in Medicare physician payments, according to Congressional Budget Office cost estimates.

Most of the bill's hefty price tag would be covered by a 45-cent hike in the cigarette tax, raising \$26.4 billion, and a \$50.4 billion reduction in Medicare Advantage plan payments over five years. Amid a short list of assorted other Medicare payment cuts, however, the \$2.7 billion SNF reduction stands out as the largest. In fiscal year 2008 alone, the cut would wipe out nearly half of the scheduled 3.3 percent SNF payment update, which is collectively worth \$690 million.

"These are the wrong cuts, at the wrong time, directed at the wrong

patient population of highly vulnerable seniors," said Bruce Yarwood, AHCA president and chief executive officer.

"While the broader objectives of the bill are worthwhile, it is irresponsible to finance the expansion of health insurance for our children with major Medicare cuts to our seniors," he said.

Yarwood warned that CHAMP (HR 3162) would be "highly detrimental to the long term care needs of America's 'Greatest Generation' and would ultimately harm the same children targeted by the legislation, who will comprise future generations of elders.

During the August recess, when lawmakers are in their home states, AHCA and its members will mobilize an aggressive advocacy effort to ensure that members of Congress understand that "these cuts could seriously jeopardize the health and well-being of their oldest, sickest constituents," Yarwood said.

Republicans on the House Ways and Means Committee tried to block the SNF cut during the panel's mark-up of the bill in late July. Ranking member Rep. Jim McCrery (R-La.) noted that the economic stability providers need to ensure quality care is increasingly elusive, as facilities rely on Medicare to prop up a deficit-riddled Medicaid program, which under funded services by \$4.6 billion in 2006. Rep. Phil English, (R-Pa.) offered an amendment to eliminate the \$2.7 billion SNF cut, but the measure failed, 17 to 22, along party lines.

The reauthorization of SCHIP has for months been the primary focus of health policy reform on Capitol Hill. President Bush has threatened to veto the legislation, arguing that it would encourage

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LTC Bill Cuts Wide Swath Through Key Issues

Legislation that would address a broad range of long term care regulatory, operational, reimbursement, and financing challenges has been introduced by Sens. Gordon Smith (R-Ore.), Blanche Lincoln (D-Ark.), and Susan Collins (R-Maine).

The Long Term Care Quality and Modernization Act of 2007 (S 1980) "is designed to help sustain quality improvement gains in long term care settings around the country," said a statement from AHCA, which praised the measure for filling critical public policy gaps.

The legislation would "enhance long term care quality by promoting investment in capital improvements and health information technology, encouraging collaboration between providers and surveyors, assisting in the creation of a stable and well-trained workforce, and addressing access and financing concerns," AHCA said.

"When you consider that eight of 10 nursing home residents rely on Medicare and Medicaid for their long term care needs, it is apparent that Congress has a responsibility to improve these programs so they are sustainable for years to come," said Sen. Smith, in a statement

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A Note From The Chair

Jim Collins' keynote address at last fall's convention offered terrific insights about what makes a good business or organization great. In his book, "Good to Great," Collins explains that he finds the best performers across virtually every field possess a single-minded passion for what they do, as well as an unwavering desire for excellence in how they think and work.

From my vantage point as AHCA chair, I know that our membership has that kind of commitment. What we may lack, however, is time.

Often, we are so busy dealing with the day-to-day challenges of caring for frail, elderly, and disabled residents—doing our best to recruit, train, and retain the best staff possible while working to ensure compliance with a multitude of regulations—that we can put off taking the time we need as providers and as business owners to plan for our future needs.

For me, our annual convention represents the one time each year that I set aside to really focus on the future. This October, I'll be in Boston for AHCA/NCAL/MECF's convention where I will immerse myself in all that AHCA/NCAL has to offer—outstanding educational sessions, critical updates on the ever-changing public policies that directly impact our profession, and the opportunity to meet with vendors and colleagues whose partnership is what makes my business successful today and ready to take on tomorrow. I hope you, too, will invest in your future by joining us in Boston.

For information about the AHCA/NCAL/MECF convention, visit www.ahcaconvention.org.

Angelo S. Rotella, Chair, AHCA

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people to drop private health insurance in favor of a publicly financed plan and steer the nation toward government-run health care.

Created by the Deficit Reduction Act of 1997, SCHIP is a block grant program that now covers 6 million low-income children whose age or family income make them ineligible for Medicaid. Like Medicaid, SCHIP is funded jointly by states and the federal government.

LTC Bill Cuts Wide Swath continued from page 1

introducing the bill. This includes encouraging individuals to take responsibility for long term care planning, Smith said. The legislation would create long term care trust accounts that allow annual contributions up to \$5,000 and provide a refundable 10 percent tax credit for contributions. The funds could be used to purchase long term care insurance or pay directly for services.

In addition, the bill would:

- Establish a two-year, five-state demonstration program for joint surveyor and provider training;
- Reinstate facility-based nurse assistant training programs once providers correct deficiencies that led to their suspension;
- Unbundle certain costs—including "high-cost, low-probability" chemotherapy drugs; ambulance services; and free-standing clinic services—from SNF prospective payment rates, allowing providers of those services to bill Medicare directly. This provision would also require the annual updating of con-

AHCA supports the approach taken in the Senate's more modest bill, which would fund a \$35 billion SCHIP expansion exclusively through a 61-cent cigarette tax hike. The Senate bill, S 1893, passed on Aug. 2 by a veto-proof margin, 68 to 31.

Differences between the House and Senate bills will be worked out in a conference committee when lawmakers return from a month-long August recess.

solidated billing rules to reflect changing medical practices;

- Allow payment for a series of blood glucose testing over a limited period of time, when deemed medically necessary by a physician or nurse practitioner;

- Lift the Nurse Reinvestment Act exclusion on federal loan repayment for nurses working in for-profit health care settings;

- Direct the Department of Health and Human Services to establish and fund a national database that would predict future nursing shortages and assess nursing workforce needs across all health care settings, including long term care;

- Provide a 15-year depreciation schedule for long term care capital projects; and

- Incentivize health information technology adoption with a tax credit, equal to 20 percent of the investment, for qualified long term care systems (computers, related equipment, and software).

Survey

CMS Fine Tunes Oversight Process For Special Focus Facilities

Procedures for dealing with special focus facilities (SFFs) are being refined, pursuant to a draft memorandum from the Centers for Medicare & Medicaid Services (CMS) to state survey agencies.

The changes are aimed at bolstering "the probability that significant improvements in quality of care will be made in the identified nursing homes, and that there are effective and timely alternatives to termination when a facility has failed to make the necessary improvements,"

the memo said. SFFs are deemed by CMS to have a three-year history of "yo-yo" survey performance, marked by repeated serious deficiencies.

SFFs are surveyed twice as frequently as other facilities. After 18 months, or three standard surveys, SFFs that show significant improvement are removed from the list, while those that have not improved are terminated from Medicare and Medicaid.

CMS is enhancing communication

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with SFFs, broadening the initial notification of SFF designation to include administrators, owners, and the board chairperson. Those same parties will receive the results of each SFF survey. In addition, facilities will be informed when they are removed from the SFF list. The memo included a model letter for initial notification to facilities of their SFF status.

CMS is also removing life safety code deficiencies from the SFF formula to ensure that “states can focus more on quality-of-care and quality-of-life concerns in SFFs,” the memo said.

In written comments on the changes, AHCA said it welcomed wider communication with SFFs and suggested broadening the circle to include real estate owners and management companies.

AHCA also urged CMS to enlist the aid of quality improvement organizations in remedying SFF problems and asked for added specificity in the criteria used by the agency for making SFF determinations. The comments sought clarification of terms such as “significant progress” and “persistent pattern of poor quality,” without which facilities would continue to lack definitive guidance, AHCA said.

The organization expressed ongoing concern that CMS has not provided “the formula used for computing the SFF candidate list,” pointing out that because the criteria for getting on or off the list are so vague and providers have no recourse for appealing an SFF determination, the selection process “denies providers due process.”

Medicare

Linking Private Insurance And Medicare For Lifetime LTC Coverage

A lifetime of long term care benefits would be available to Medicare beneficiaries under a financing proposal developed by policy experts at Avalere Health and George Washington University (GWU), in Washington, D.C.

The proposal is part of a set of eight working papers, representing a wide range of innovative long term care financing strategies and solutions, solicited by the GWU Long Term Care Financing Project. The paper, “Linking Medicare and Private Health Insurance for Long Term Care,” takes the “pragmatic approach” of shielding beneficiaries from the “catastrophic costs of chronic illness” and at the same time encouraging “better development of the private insurance market,” said Anne Tumlinson, an Avalere consultant and co-author of the report.

Under the financing plan conceived by Tumlinson and her colleague, Jeanne Lambrew, an associate professor of health policy at GWU, Medicare beneficiaries would be given the option of gaining unlimited lifetime Medicare coverage for long term care services in exchange for purchasing a qualified private insurance plan.

Benefits of the private plan must run

out before Medicare coverage kicked in. The offer would be available on a one-time basis, when beneficiaries initially enrolled in Part B.

For those who agreed, Medicare Part B would be reconfigured to exclude home health coverage, which would be provided through private insurance.

The proposal puts a unique twist on income-related benefits. To encourage more lower-income beneficiaries to purchase insurance, the amount of the lifetime benefit that must be provided through the private plan—and that must be exhausted before triggering Medicare coverage—would vary by income. The threshold would rise with beneficiaries’ income, thereby encouraging lower-income participants to buy a modest, more affordable policy.

The paper offered several scenarios of how the program would work. In one example, a Medicare beneficiary is hospitalized and discharged to home health. Medicare Part A pays for 100 visits and expires. The private policy picks up coverage, continuing after the person is admitted to a nursing facility. Eventually, those benefits are exhausted, and the Medicare long term care benefit covers the stay until the beneficiary’s death.

LTC Insurance

Bill Would Spur Purchase Of LTC Insurance

Long term care insurance could be purchased with pre-tax funds from individual retirement accounts (IRAs) and other qualified retirement savings plans under legislation introduced by Sen. John Thune (R-S.D.) and, in the House of Representatives, by Rep. Lee Terry (R-Neb.).

The Long Term Care Act of 2007 (S 1809/HR 3088) would amend the tax code to stipulate that distributions from IRAs, 401(k) plans, section 403(b) contracts, or section 457 plans could be used to pay long term care insurance premiums, without being taxed as gross income.

In a statement, Sen. Thune said the rapid growth of the senior population, particularly those aged 85 and older, calls for health reforms that increase marketplace competition and offer individuals more options for affordable care.

“Long term care insurance allows more individuals to preserve their savings for retirement and ensures that Medicaid dollars are targeted to the neediest recipients,” he said.

In 2005, spending on long term care reached \$207 billion, Thune said. Expansion of the long term care insurance market would “help relieve the burden of long term care planning and give people the flexibility and freedom they need to make the best decisions for their own health care future,” he added.

Bruce Yarwood, AHCA president and chief executive officer, said the measure would boost the ability of Americans “to save for, and ultimately fund, the long term care services most of us will need at some point in our lives.”

The average cost of nursing facility care rose 15 percent between 2004 and 2007, according to Genworth Financial’s “2007 Cost of Care Survey.” “The staggering costs of retirement can quickly overwhelm one’s savings,” Yarwood said in a statement, “so it is important for the 77 million baby boomers who are rapidly approaching retirement age to prepare themselves now for their health care needs when they do retire.”

Bill Would Nix CMS' Competitive Bidding For Clinical Labs

The Centers for Medicare & Medicaid Services-planned Medicare competitive bidding demonstration for clinical laboratory services would be derailed under legislation introduced Aug. 4 by Rep. Nydia Velazquez (D-N.Y.). The bill, HR 3453, would repeal the provision of the Medicare prescription drug statute that mandated the demonstration and create a small business panel to advise CMS on any future plan involving Part B clinical laboratory payments.

AHCA and other critics of the competitive bidding initiative contend it will cede the marketplace to a few large firms that submit the lowest bids, eliminating from competition many of the 5,200 independent labs that cater to the special needs of certain providers and patient populations, including nursing facilities, and leaving a critical gap in health care services. In a statement, Velazquez warned that independent labs serving “a wide variety of patients, including vulnerable and underserved communities and nursing homes” would lose those relationships under competitive bidding.

“CMS clearly ignored how small firms are able to offer quality and urgent lab service,” she said.

An Aug. 7 letter from Rep. John Dingell (D-Mich.), chairman of the House Energy and Commerce Committee, to Health and Human Services Secretary Michael Leavitt reflected those concerns. Dingell asked CMS to respond to a series of questions, several of which mentioned the impact on nursing facilities, before moving ahead with

AHCA Releases Updated Long Term Care Survey Manual

AHCA has updated its Long Term Care Survey manual to include content changes released from CMS through the end of December 2006.

The manual is now available in a binder format that includes quarterly updates for a one-year period. The softbound version is also available. Product orders may be placed online at www.AHCApublications.org.

implementation of the demonstration. “If laboratories that provide services to vulnerable patients, such as nursing home residents and those served by home health agencies, are not selected for the demonstration, how will CMS ensure the same level of access to care to their patients?” Dingell asked.

Velazquez, who chairs the House Small Business Committee, convened a July 25 hearing on the issue.

Tom Bejgrowicz, a licensed nursing facility administrator and client account manager for East Brunswick, N.J.-based Aculabs, a clinical laboratory specializing in long term care, testified on behalf of AHCA. He warned that Medicare SNF residents, especially those in smaller facilities, would lose access to quality laboratory services “if competitive bidding comes to fruition.”

Independent laboratories routinely produce same-day results, turning around critical tests—such as those that measure how long it takes for blood clotting to occur in a particular patient—in a matter of hours. Furthermore, they often provide “a mobile phlebotomy staff that is available 24 hours a day, 365 days a year” to draw blood, Bejgrowicz said.

Large national labs, in contrast, rely on their network of satellite service centers to collect samples, which are then sent out for testing. Results come back a day or more later—too long for many of the tests that SNF patients need, Bejgrowicz said.

Critics point to major design flaws in the bidding process developed by CMS for the demonstration, including the absence of a guarantee that winners will provide any level of service to SNFs, Bejgrowicz said. Most of the large labs do not service SNFs, preferring more lucrative settings such as physician offices, he said.

In comments on the demonstration submitted last May, AHCA asked CMS to ensure that “quality laboratory services continue to be provided in a demonstration area to SNF patients,” consistent with recommendations from a coalition of labs serving long term care patients.

Baucus, Grassley Team Up On QIO Reform Bill

Legislation that would overhaul the quality improvement organization (QIO) program has been introduced jointly by the chairman and ranking member of the Senate Finance Committee.

At the center of sweeping reforms that comprise the Continuing the Advancement of Quality Improvement Act of 2007, introduced July 31 by Sens. Max Baucus (D-Mont.) and Charles Grassley (R-Iowa), is the restriction of QIO activities to the provision of technical assistance to providers and the transfer of other responsibilities—most notably complaint management—to newly created entities, called Medicare provider review organizations (MPROs).

MPROs would be charged with investigating complaints, reporting their findings to the complainant, and referring the provider to a QIO for technical assistance.

The legislation would also:

- Require QIOs to focus on providers that need help the most, giving priority to those in rural or underserved areas, facilities in financial need, and providers with low performance measures or a high number of beneficiary complaints;
- Promote competition by allowing other types of organizations to serve as QIOs;
- Evaluate QIO performance on uniform measures; and
- Give financial rewards to high-performing QIOs and penalize low performers.

In a statement outlining the proposal and taking QIO performance to task, Grassley said QIOs serve conflicting roles as “regulator and technical assistant” and are failing to perform well in either capacity.

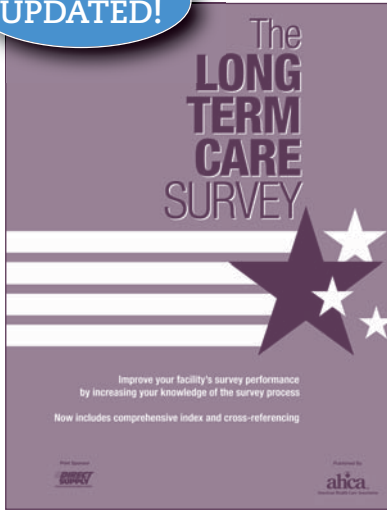
The bill’s sponsors said the proposal was based on the findings and recommendations of several independent reports, including one from the Institute of Medicine.

In June, the Government Accountability Office (GAO) released a report, requested by Grassley, which examined

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CHAMP Advances Limited Part D Co-Pay Relief For Dual Eligibles

About two-thirds of dual-eligible residents in assisted living and residential care communities would be relieved of Medicare prescription drug cost sharing under a provision of the children's health bill, which passed the House of Representatives Aug. 1 (*see related story, page 1*).

The Children's Health and Medicare Protection Act (CHAMP) would eliminate the Part D cost sharing for individuals who qualify for Medicare and Medicaid (dual eligibles), receive community-based services—including assisted living—under a 1915 or 1115 waiver program, and would otherwise require the level of care provided in a nursing facility or other institutional setting.

This section of CHAMP would cover an estimated two-thirds of the 121,000 dual eligibles in assisted living and residential care facilities, says Karl Polzer, senior director of policy for the National Center for Assisted Living (NCAL).

The Congressional Budget Office estimates that eliminating cost sharing for this population would cost \$200 million over five years.

NCAL supports the measure, while continuing to advocate for wider coverage that would apply to all dually eligible assisted living residents.

It's unclear whether the CHAMP provision will survive the conference committee, where differences in the House and Senate versions of the children's health bill will be reconciled. That process won't begin until lawmakers return from a month-long August recess.

In the meantime, NCAL/AHCA continues to advocate for the broader relief that would be provided by the Medicare Prescription Drug Savings for Our Seniors Act of 2007 (HR 3025), introduced by Rep. Lloyd Doggett (D-Texas).

The bill, which encompasses many Part D changes, would end cost sharing for all dually eligible assisted living residents. An

identical exemption exists in a freestanding Senate bill, S 1107, the Home and Community Services Copayment Equity Act of 2007, introduced last April by Sen. Gordon Smith (R-Ore.), which has drawn bipartisan support from 13 co-sponsors.

"Like nursing home residents on Medicaid, the 121,000 dual eligibles in assisted living and residential care facilities have very limited financial resources, often just a few dollars a month from a personal needs allowance," said an Aug. 8 letter from NCAL and 38 other organizations, thanking Doggett for his support on this issue.

Assisted living residents use a similar number of prescriptions as nursing facility residents, about 8 to 10 a month, the letter said.

As a result, even small Part D copayments of \$1 to \$5.35 per prescription "can present financial hardships" for dually eligible residents.

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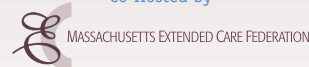
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QIO work with nursing facilities that had volunteered for intensive assistance on targeted quality measures. GAO found that QIOs seldom selected poor-performing facilities to work with and recommended that the Centers for Medicare & Medicaid Services increase the extent to which QIOs direct intensive assistance to this segment of providers.

While the overall impact of QIOs on nursing facility quality could not be isolated, most of the facilities contacted by GAO “attributed some improvements in the quality of resident care to their work with QIOs,” the report said.

David Schulke, executive vice president of the Washington, D.C.-based American

Health Quality Association (AHQA), which represents QIOs, said some provisions of the bill “would impose a more radical and costly solution than is necessary to solve the problems that have been documented,” in a statement. AHQA agreed with the objective of reporting complaint investigation results to beneficiaries, but rejected the need for MPROs to fulfill that function. Instead, Schulke said, regulators should rewrite the rule that currently bars QIOs from disclosing those results over a physician’s objection.

“It’s both costly and unnecessary to create a new national infrastructure of contractors to solve that problem,” Schulke said.

Tort

Bill Would Fund State Tort Reform Demonstrations

Legislation that would provide \$5 million to fund 10 state demonstration projects offering alternatives to the traditional medical tort litigation system has been introduced by Sen. Max Baucus (D-Mont.) and Sen. Mike Enzi (R-Wyo.).

The grants would fund the “development, implementation, and evaluation” of alternatives to dispute resolution involving medical injuries, the senators said.

Eligible states would be required to allow patient safety and health care quality organizations to collect and analyze dispute-related data that would help reduce medical errors.

The legislation also mandates that states would also have to demonstrate how proposed alternatives would enhance the “prompt and fair resolution of disputes;” promote the disclosure of health care errors; improve patient safety by “detecting, analyzing, and reducing medical errors and adverse events;” maintain access to medical liability insurance; and give patients the option of not participating in the program.

The measure is an attempt to shift the debate over tort reform from a long-standing and failed focus on caps for noneconomic damages, Sen. Baucus said in a floor statement on the bill.

Oversight

Senators Seeks To Step Up Nursing Facility Oversight

The Nursing Home Compare Web site could be improved by the creation of a “watch list” that “identifies the worst nursing homes that repeatedly fall out of compliance,” U.S. Sen. Charles Grassley (R-Iowa) asserted in a recent letter to Centers for Medicare & Medicaid Services (CMS) Acting Director Herb Kuhn.

“By listing nursing homes and implemented enforcement actions online, the public would have easy access to this information, and nursing homes would have an extra incentive to meet quality standards,” the former chair of the Senate Finance Committee explained in the letter.

“This list: 1.) should be easily accessible online; 2.) ought to be searchable by location and name; and 3.) should clearly identify the nursing home, the date of the sanction placed against it, and a detailed description of why the sanction was put in place.”

According to a statement from Grassley’s office, the impetus for his request comes from the findings of a Government Accountability Office report that “revealed shortcomings in the federal effort to coordinate regulatory efforts and an enforcement approach that undermined the sanctions available through the law.”

Workforce

Bill Would Create National Background Check Program

AHCA President and Chief Executive Officer Bruce Yarwood called for a “national interstate background check system” as a cornerstone of resident safety, in a statement submitted to the Senate Special Committee on Aging for a “listening session” on the prevention of elder abuse.

Committee Chairman Sen. Herb Kohl (D-Wis.) is sponsoring legislation that would create a nationwide background check program—including fingerprinting and screening by the Federal Bureau of Investigation—for nursing facilities (see July AHCA NOTES). The bill would provide direct federal reimbursement to providers for the cost of the screening.

AHCA has long supported a background check system “that enables long term care providers to conduct effective and fair criminal history background checks on potential nursing home employees,” Yarwood said, noting that AHCA has endorsed Kohl’s legislation, the Patient Safety and Abuse Prevention Act of 2007 (S 1577).

In addition to the need for thorough criminal background checks, long term care providers need the ability to recruit “the highest quality caregivers to provide critical care and services to America’s seniors and people with disabilities,” Yarwood said. “Nursing and assisted living facilities are in dire need of caregiving staff.”

Yarwood urged Kohl to “address this critical issue in the coming months” by reauthorizing and amending the Nurse Reinvestment Act to:

- Permanently remove the exclusion on loan repayment for nurses working in for-profit health care settings;
- Create and fund a national database to forecast future shortages and workforce needs; and
- Ensure that Title VIII grant awards require reporting on the number of nurse educators and nurses produced or hired, the growth in nurse education slots, and the decrease in the number of qualified applicants turned away from nursing programs.

Medical Workforce Model Broken: PwC Report

As the need for health care services ramps up with the aging of the baby boom generation, the majority of physicians and nurses are preparing for retirement along with the rest of the population, creating “a diminishing pipeline” of nurses and primary care physicians, according to a report on the medical workforce from PricewaterhouseCoopers (PwC), a New York-based Big Four accounting and professional services firm.

The federal government predicts a shortage of 1 million nurses and 24,000 physicians by 2020, said the report, “What Works: Healing the Healthcare

Staffing Shortage.” The shortage is exacerbated by a “broken, dysfunctional medical workforce model,” according to the study, which called for an overhaul in the way nurses and physicians are trained and deployed.

A central conclusion of the report is that nursing education—which unlike its medical counterpart is not heavily subsidized by the federal government—must be revamped.

Nursing programs are often money losers for colleges and universities, PwC reported. As a result, they are “stifled by perverse financial incentives” that limit institutional interest in expanding the

programs or raising faculty salaries, said Bill Dracos, a director in PwC’s Health Advisory Practice.

According to the report, the number of “denied applicants for nursing schools is at its highest ever, increasing more than six-fold since 2002.”

Only about 45 percent of nursing school applicants are accepted, only about half of those graduate, and half of new nurses leave their first job after two years, PwC found.

Focusing on the impact on acute care settings, a PwC analysis found that every 1 percent in nurse turnover costs a hospital about \$300,000.

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