

News Currents

In Brief

User Fees For Revisit Surveys Take Effect

Continuing Resolution Extends Period

The Centers for Medicare & Medicaid Services (CMS) published the final rule of a new program that it claims will “assure greater commitment to compliance for correcting identified quality-of-care problems,” on Sept. 19. The program, which took effect immediately upon its publication, requires nursing facilities to pay a \$2,072 fee for every onsite survey revisit and \$168 for each offsite revisit.

The fees were originally scheduled to expire on Sept. 30, the statutory end of the 2007 fiscal year; however, a continuing resolution signed by President Bush on Sept. 29 extended the fiscal year until mid-November.

Providers should be aware that CMS may notify facilities of the assessment “upon data system reconciliation, which can occur following the closing of the fiscal year,” the rule said. At press time, the rule was expected to be in effect at least until the continuing resolution expires.

In addition, the American Health Care Association (AHCA) reports that it will maintain communication with CMS in an effort to obtain further clarification of the rule as necessary. AHCA also continues to work in opposition to the user fees and their implementation in fiscal year 2008.

What CMS has clarified is that providers and suppliers have the right

to reconsideration if they feel an error of fact has been made in the application of the user fee, such as clerical errors, billing for a fee already paid, or assessment of a fee when there was no revisit scheduled.

However, a request for reconsideration must be received by CMS within 14 calendar days from the date identified on the assessment notice. Providers who are assessed a revisit user fee will receive a notice in the mail, which will include the

amount of the assessed fee, and payment must be received within 30 days or CMS could terminate the facility’s enrollment and participation in the Medicare program.

In response to the rule’s release, AHCA asserted that “it places a greater value on administrative efforts, rather than on continuing to improve the quality of care in America’s nursing homes.”

In its comments to the proposed rule, AHCA warned that the “net effect” of the user fee would be a “reduction in the resources available to care for Medicare beneficiaries.”

Bruce Yarwood, AHCA’s president and chief executive officer, warned that the program will squander scarce resources, especially at a time when “Medicaid is already under funded by more than \$4.5 billion annually.”

At an hourly rate of \$112, one hour

‘Medicaid is already underfunded by more than \$4.5 billion annually.’

Health Care P4P Programs On The Rise Across U.S.

Pay-for-performance (P4P) programs have multiplied dramatically nationwide, by 263 percent over the past four years, according to a recent survey conducted jointly by MedVantage and The Leapfrog Group.

The number of P4P programs in the United States jumped from 39 in 2003 to 148 such programs as of March 2007. The study, which polled 75 purchasers, government agencies, and health plans, yielded the following key findings about its respondents:

- The top reason for implementing P4P is improving clinical outcomes;
- More than 60 percent have now evaluated their programs, and at least half of the evaluated programs find that clinical performance improved significantly;
- About one-third have been able to demonstrate cost savings;
- More than 70 percent are working to expand the scope or number of performance measures they use;
- More than 30 percent posted information publicly on provider performance in their provider directories; and
- Advanced P4P programs are now developing tools to measure improvements in outcomes and eligibility for rewards directly from medical charts.

—Meg LaPorte

of labor for an onsite survey would pay for more than 17 hours of care for one Medicaid patient, he said. On average, Medicaid pays \$6.34 an hour for patient care in nursing facilities, AHCA said. “Resources in our facilities must remain targeted toward meeting the care needs of our patients, and not redirected in an illogical manner,” Yarwood said.

—Meg LaPorte

Medicaid Shortfall To Exceed 2006

Final Report Underscores Danger To Quality Care

States are underfunding the actual cost of providing nursing facility care by at least \$4.4 billion this year alone, according to the final analysis of the Medicaid program by accounting firms BDO Seidman and Eljay.

“The federal government has a moral responsibility to cover at least the overhead costs of caring for those who are most in need,” said Rep. Steve Kagen (D-Wis.) in response to the report, which was released at a recent Capitol Hill briefing.

“The federal government’s practice of passing the buck must come to an end—right here and right now. At stake is the continued existence of high-quality care for our seniors and disabled American citizens.”

According to the report, the average



Kagen (l.) and Hebert at Capitol Hill news briefing.

shortfall in Medicaid daily reimbursement to nursing facilities is projected to be \$13.15 in 2007. This figure represents an increased shortfall of five cents compared to the 2006 figure of \$13.10.

Provider previously reported in its October 2007 issue that the average daily shortfall was expected to be 8

cents less than the 2006 shortfall, or \$13.02. But that figure was based on preliminary data.

The states with the greatest disparity between the actual cost of providing quality care and Medicaid reimbursement are, in order of severity, Illinois, New Jersey, Wisconsin, Minnesota, Vermont, New Hampshire, Missouri, Delaware, Washington, and Massachusetts, according to the final analysis.

Pointing to his state’s per-patient daily shortfall of \$27.29, Kagen told reporters that “overhead costs are not being paid for by Medicaid or Medicare. We have to recognize that Medicaid must move up.”

David Hebert, senior vice president of policy and government relations for the American Health Care Association, noted that the Medicare Payment Advisory Commission has reported the average margin on Medicare payment to nursing facilities to be 13 percent, while the BDO Seidman/Eljay analysis indicates a 9.2 percent shortfall on Medicaid payment for that year.

“The weighted average 2005 margin from the two government-funded programs combined is a negative 2.5 percent,” Hebert said.

Other factors, such as states’ continued reliability on provider taxes for funding and the shift of Medicaid funding toward home- and community-based services, were also cited as potentially hazardous to long term care. “If state economies downturn,” the report says, “this will put pressure to dampen rate increases to nursing homes and reverse the trend achieved in nursing home funding in the past few years of rate increases, on average, keeping pace with cost increases.”

—Meg LaPorte

Kindred Shopping For Market Opportunities

Kindred Healthcare, Louisville, Ky., ranked No. 2 in *Provider’s* Top 50 Nursing Facility Chains, is exploring opportunities to acquire nursing centers that will complement its “cluster market strategy,” according to a recent earnings call.

The strategy entails identifying strategic acquisitions in markets where Kindred already offers services, with the aim of sharing resources and expertise.

Financing the acquisitions is a \$500 million amendment to Kindred’s credit agreement, with the possibility of a further increase to \$600 million if certain conditions are met, according to company officials.

“These significant changes to our credit agreement provide greater financial flexibility to pursue our strategic development and acquisition plans as we continue our focus

on enhancing shareholder value,” said Kindred President and Chief Executive Officer Paul Diaz, on the call.

One example of Kindred’s cluster market strategy is its recent purchase of a skilled nursing center and assisted living residence. The acquisitions include The Greens Postacute and Rehabilitation Center, a 160-bed skilled nursing center, and The Fountains on the Greens, an assisted living residence with a total of 82 beds, both of which are located in Cleveland.

Kindred currently operates a nursing center in the same market under the name The LakeMed Nursing and Rehabilitation Center and a recently opened free-standing long term acute-care hospital under the name Kindred Hospital-Cleveland.

—Meg LaPorte

NCAL Elects Officers And Board Members

Members of the National Center for Assisted Living (NCAL) Board of Directors were elected and installed at the 58th annual American Health Care Association/NCAL Convention & Exposition, held in Boston last month.

The new executive officers include: NCAL chair, Howie Groff, president of Tealwood Care Centers, Bloomington, Minn.; NCAL vice chair, Nicolette Merino, regional director of Lifestyles, Vancouver, Wash.; and NCAL secretary-treasurer, Michael Shepard, executive director and chief executive officer (CEO) of Davis Nursing Association, Pine Bluff, Ark.

The 2007-2008 term marks the first time NCAL has combined the offices of secretary and treasurer into a single position. The change was made as part of the association's reorganization in 2006, designed to streamline its governance structure.

The 2006 reorganization included the election of 14 at-large board members, with seven serving an initial one-year term to stagger elections and the remaining seven serving two-year terms to provide organizational continuity. The seven at-large members elected this year will serve two-year terms.

The newly elected at-large board members include: Nancy Andrews, director of housing and assisted living for Valley Memorial Homes, Grand Forks, N.D.; Jim Birchem, president and CEO of ElderCare of Minnesota, Bemidji, Minn.; Edie Gerelli, vice president of operations for Chelsea Senior Living, Summit, N.J.; Patricia Giorgio, president and CEO of Evergreen Estates, Cedar Rapids, Iowa; Joe Perkin, regional director for Midwest Health Management, Topeka, Kan.; Dean Solden, president of Solden Development Company, Ann

Arbor, Mich.; and Faun Spencer, owner of Twilight Care, Minnetonka, Minn.

The remaining seven board members serving out the last year of a two-year term are:

Deb Choma, nurse administrator, Shard Villa, Salisbury, Vt.; Vickie Cox, executive director, Heritage at Dover, Dover, Del.; Jeff Hyatt, owner and chief operating officer (COO) of Hyatt Family Facilities, Yakima, Wash.; Christian Mason, chairman and CEO of Vigilant Corp., Woodburn, Ore; Jan Thayer, owner and CEO of Riverside Lodge Retirement Community, Grand Island, Neb.; and J. Michael Williams, vice president and COO of AdCare Health, Springfield, Ohio.

With Michael Shepard's election to secretary-treasurer, the NCAL chair will appoint someone to fill the empty slot for the second year of the term.

—Lisa Gelhaus

Leaders Ponder Emerging 'Age Wave'

Baby Boomers Will Change LTC Dynamic, Conferees Say

With a tidal wave of aging baby boomers looming on the horizon, long term care and seniors housing leaders must come to grips with the challenges that the next 45 years could bring, as the number of Americans aged 65 and older doubles and those 90 and older increases fivefold.

This was the focus of a recent conference in Philadelphia, the Aging Revolution Summit—sponsored by Wesley Enhanced Living of Southampton, Pa.—which examined the impact of the exploding age wave on health care costs and delivery, ethics, and seniors housing and care.

In a session that focused on emerging medical and technological

advances, a panel of physicians and researchers conjectured that improved treatment modalities and the curing of chronic diseases over the next 10 to 20 years will cause a “squaring-the-curve” effect in which individuals will maintain optimum health longer, thereby diminishing the need for long term care.

“From a scientific standpoint, there are technologies being invented today that have the capacity to extend life and extend functionality,” said Jeffrey



Libson, head of the Life Sciences practice at Pepper Hamilton in Philadelphia. He noted, however, that while certain diseases will be eliminated, others such as diabetes will become more prevalent among older adults.

“Individuals born in the United States today have a theoretical life span of nearly 120 years,” said Scott Waldman, MD, director of the Division of Clinical Pharmacology at Philadelphia's Thomas Jefferson ➤

University Hospital. In light of this unprecedented trend, he speculated that the nursing facilities of the future will look more like long-term rehabilitation centers, where patients recover for an extended period of time from hip or joint replacement surgeries before returning back to the community.

“Treatments will be long term and will require appropriate facilities—or ‘bridging facilities,’” Waldman said. “The long term care industry should analyze where technologies are going and how it can best leverage them to accommodate this population.”

Richard McCloskey, MD, vice president of medical technology at Johnson and Johnson Development Corp., predicts that the next 10 years will bring a rise not only in diabetes but also in patients with chronic heart failure. And while such patients will likely be less complex, they will need specialized care teams, he said.

Two key issues that long term care providers should consider as they position themselves for the future are con-

sumerism and the advent of interdisciplinary care teams, said David Nash, MD, professor of health policy and chairman of the Department of Health Policy at Thomas Jefferson University. “Planning for the future will require the building of interdisciplinary care teams and a workforce that is amenable to the idea.”

‘T he baby boom generation will turn the health care system on its head.’

Nash contended that consumers will also play a more prominent role in their own care. “Patients already come to me after doing research on the Internet and know more about their condition than I do,” he said, adding that his department is currently working with a medical education company to develop online, interactive medical

education tools for consumers.

On the downside, the panel acknowledged that while new treatments and cures are likely to enhance the lives of baby boomers and generations beyond, there are some challenges that could impede the squaring of the curve.

In addition to the fact that the cost of health care will not go down, Nash pointed out that the current shortage of physicians could threaten the future of health care delivery.

“We don’t have the complement of caregivers to carry out services if 70 is the new middle age,” he warned. “Medicine is a team sport, and we must change the way we create the teams.”

Nash also expressed concern about inadequate funding for the evaluation of quality care within the long term care spectrum—specifically home care, assisted living, and nursing facility settings. “These measures are not appropriate and are modest compared to those used for hospitals,” he said. “They also need to be completely transparent.”

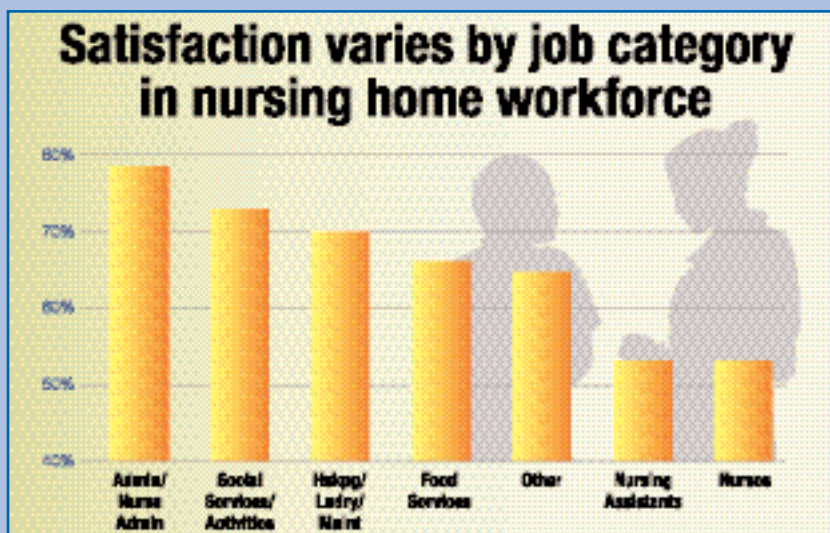
Exacerbating the problem is the cost of moving pharmaceuticals and biologics from conception to the patient, panelists agreed. “While it varies, the average cost of bringing a biologic to market is roughly \$1 billion,” McCloskey said.

No matter what the squaring of the curve might look like, the panelists all expressed certainty that the baby boom generation will turn the health care system on its head. Waldman suggested that such a demand means that “long term care providers will need to go from a continuing care retirement community model to a country club retirement model.”

“The way baby boomers approach health care and their expectations as customers means you will need to be more consumer oriented,” said Lipson. “You will need to create an environment that people want to be part of.”

—Meg LaPorte

By The Numbers



Based on the percent of total weighted nursing home employee satisfaction survey respondents who rated their overall satisfaction as “Excellent” or “Good” in each job category.

Source: 2006 National Survey of Nursing Home Workforce Satisfaction by My InnerView Inc.

Equity Firm Ownership Raises Questions

Lawmakers Request GAO Review Based On *Times* Article

In response to a recent article in *The New York Times* that looked at private-equity ownership of nursing facilities, Sen. Charles Grassley (R-Iowa) announced his intentions to speak with providers, equity firms, and the Centers for Medicare & Medicaid Services (CMS) in an effort to “closely examine” the impact of such ownership on quality of care.

Grassley’s declaration came just days after publication of the *Times* article and was followed by a statement from Sen. Hillary Clinton (D-N.Y.), who said she was “deeply concerned that these new ownership structures may allow private investment firms to effectively control, and profit from, the operations of nursing homes without taking a formal ownership or management stake in the nursing home itself.”

The senators issued simultaneous letters to the Government Accountability Office (GAO), calling for an investigation of the issue.

In her letter, Clinton asked the agency to perform “an assessment of the ownership structures of the 63 nursing homes that GAO identified in March 2007 as having a history of serious deficiencies in care” and asked for recommendations on any needed changes to CMS regulations or other federal laws “to bring greater transparency and accountability to federally funded nursing homes.”

In his letter to GAO, Grassley asked for the following information to be included in the investigation:

- Total number of nursing facilities purchased by private investment groups each year for the past five years;
- Percentage of total nursing facilities that are owned by private investment groups, including percentages by state, each year for the past five years;

- Condition of nursing facilities at the time of purchase by a private investment group;

- Names of the investment groups that have purchased nursing facilities over the past five years, as well as the number of facilities purchased per year;

- Condition and status of nursing facilities in the years following purchase by a private investment group;

- Number and types of complaints against investor-owned nursing facilities compared with other facilities;

- Number and types of health and/or safety deficiencies and violations cited at investor-owned nursing facilities by state and federal regulators in each calendar year over the past five years, compared with other facilities;

- Role of CMS in the oversight of investor-owned nursing facilities; and
- Recommendations or policy options as appropriate to help improve the oversight and accountability of investor-owned nursing facilities.

—Meg LaPorte

New LTC Nurse Organization Launched

A new association known as the American Association for Long Term Care Nursing (AALTCN) claims to be the only organization that promotes the importance of the entire nursing department of long term care facilities, according to a statement from the Glen Arm, Md.-based association.

In the statement, AALTCN officials say the organization will attempt to remove “fragmenting silos to promote working relationships that support a caring culture” by addressing issues that affect the entire team and promoting measures to foster unity in meeting shared goals.

“The intent is not to replicate or compete with the associations that represent individual categories of long term care nursing employees,” says Charlotte Eliopoulos, AALTCN executive director, “but rather to provide unique educational resources, advocacy, and a voice for the specialty of long term care nursing.”

The AALTCN statement claims that its mission will be accomplished by:

- Uniting various categories of long

term care nursing staff in common goals and needs;

- Providing relevant educational resources that bridge current best practices with bedside practice;

- Bringing visibility and respect to long term care nursing caregivers;

- Advocating for long term care nursing caregivers; and
- Supporting and promoting excellence in care for consumers of long term care.

The association, which provides memberships to long term care nursing departments for one single membership fee—as opposed to individual memberships—offers “a cost-

effective means for a facility to support staff membership in a professional association,” says Ron Romano, AALTCN director of professional services.

Among the services to be offered by AALTCN are educational resources, certificate programs, conferences, train the trainer programs, and a journal. AALTCN can be found at www.LTCNursing.org.

—Meg LaPorte



Jump In Age-Qualified Housing Reported

NIC Predicts Continued Growth In Sector

New data from the National Investment Center for the Seniors Housing and Care Industry (NIC) show that the number of seniors living in age-qualified housing has jumped dramatically since 1998, while financial indicators show little evidence that the seniors housing market has softened.

According to the survey, titled “National Housing Survey of Adults Age 55+,” 12 percent of households age 60-plus indicated that they lived in housing “planned specifically for people at least 55 years of age” in 2007, compared with 7 percent of respondents in 1998.

The data further indicate that among households 75 years and older, 19 percent were living in an age-qualified community in 2007. In this study, age-qualified housing refers to active

adult communities, independent living assisted living, continuing care retirement communities, 55-plus apartments, and rent-subsidized housing.

Thirty-seven percent of age 60-plus households in the 2007 study said they preferred or were willing to consider age-qualified housing—up from 18 percent of such households in 1998.

“As a whole, these are positive findings for the [industry], as they suggest that the demand for age-qualified housing is strong and will continue to be so for the near future,” said NIC President Robert Kramer.

NIC also released its second-quarter 2007 Key Financial Indicators, which showed a 31 percent drop in the amount of loans placed, compared with the first quarter.

Despite sluggish loan originations, the number of outstanding loans rose

slightly, by 2.4 percent, in second quarter 2007, from \$18.5 billion in the first quarter to \$18.9 billion.

Performing loans painted a more positive picture in second quarter 2007, as they stayed near the highest-ever recorded, at 99.35 percent. This figure represents a slight increase, from 99.25 percent, in second quarter 2006.

Nursing facilities saw a decline in mean occupancy rates—from 87 percent in the first quarter of 2007 to 85.5 percent in the second quarter—while assisted living occupancy dipped slightly to 87.5 percent, from 88 percent in the first quarter.

Independent living occupancy inched up to 91.5 percent in this year’s second quarter, from 91 percent in the first quarter.

—Meg LaPorte

Stock Check

PROVIDERS	Symbol	Where Traded	% Current Price 9/28/07	Adjusted P/E Ratio	Change From 1/1/07	52-Week Range High	52-Week Range Low
Skilled Nursing							
Advocat	AVCA	NASDAQ	\$10.94	7.0	-32%	\$21.03	\$9.25
Kindred Healthcare	KND	NYSE	\$17.91	8.3	-29%	\$28.27	\$17.35
Manor Care	HCR	NYSE	\$64.40	12.2	37%	\$68.86	\$46.07
National HealthCare	NHC	AMEX	\$51.39	8.5	-7%	\$59.00	\$48.73
Skilled Healthcare Group	SKH	NASDAQ	\$15.75	10.0	2%	\$16.95	\$13.02
Sun Healthcare Group	SUNH	NASDAQ	\$16.71	8.9	32%	\$16.13	\$9.79
Developmental Disability Service Companies							
ResCare	RSCR	NASDAQ	\$23.13	N/A	26.5%	\$23.79	\$16.59
Assisted/Independent Living							
Assisted Living Concepts	ALC	NYSE	\$9.14	13.5	-8%	\$13.18	\$7.44
Brookdale Senior Living	BKD	NYSE	\$39.81	15.2	-17%	\$49.94	\$33.53
Capital Senior Living	CSU	NYSE	\$8.42	12.3	-21%	\$12.22	\$7.61
Emeritus Assisted Living	ESC	AMEX	\$27.10	17.0	9%	\$39.40	\$19.99
Five Star Quality Care	FVE	AMEX	\$8.22	10.4	-26%	\$12.46	\$6.07
Sunrise Senior Living	SRZ	NYSE	\$35.37	N/A	15%	\$42.97	\$29.05
REITs							
Care Investment Trust	CRE	NYSE	\$11.98	N/A	-20%	\$14.80	\$9.40
Health Care Property Investors	HCP	NYSE	\$33.17	5.4%	-10%	\$42.11	\$25.11
Health Care REIT	HCN	NYSE	\$44.24	6.0%	3%	\$48.55	\$35.08
Healthcare Realty	HR	NYSE	\$26.66	5.8%	-33%	\$44.19	\$18.00
LTC Properties	LTC	NYSE	\$23.67	6.3%	-13%	\$29.25	\$19.02
National Health Investors	NHI	NYSE	\$30.91	6.5%	-6%	\$35.54	\$27.72
Nationwide Health Properties	NHP	NYSE	\$30.13	5.4%	0%	\$35.01	\$22.63
National Health Realty	NHR	AMEX	\$23.27	5.7%	-3%	\$25.30	\$19.29
Omega Healthcare	OHI	NYSE	\$15.53	7.0%	-12%	\$19.17	\$12.00
Senior Housing Properties Trust	SNH	NYSE	\$22.06	6.2%	-10%	\$26.83	\$16.22
Universal Health Realty	UHT	NYSE	\$35.53	6.5%	-9%	\$42.05	\$28.23
Ventas	VTR	NYSE	\$41.40	4.6%	-2%	\$47.97	\$26.50

(1) Adjusted P/E=(market cap + total debt + capitalized leases = cash)/annualized EBITDAR based on the most recent quarter.

The rate used to capitalize the leases has been changed from 12.5% to 10.0% effective 1/31/06 to better reflect market conditions

Quotes courtesy of www.seniorcareinvestor.com, Norwalk, CT (203) 846-6800

SCHIP Minus Medicare Cuts Draws Presidential Veto

Although President Bush last month vetoed legislation that would have expanded the State Children's Health Insurance Program (SCHIP), the measure, which had passed both chambers of Congress, contained no reductions to Medicare funding to skilled nursing facilities.

The legislation removed the \$2.7 billion in Medicare cuts proposed in the original House version in favor of a measure that more closely resembles the Senate plan, which relied solely on a 61-cent tobacco tax to fund a \$35 billion expansion of SCHIP.

Despite the Bush veto, Congress is expected to keep Medicare cuts out of any final SCHIP measure. At press time, however, a separate Medicare package, which could include funding cuts, was expected to surface before the end of the year.

American Health Care Association President and Chief Executive Officer Bruce Yarwood commended House and Senate leadership for their work on a plan that "does not include Medicare cuts for our most vulnerable seniors, while expanding children's access to health care."

A stop-gap measure has extended 2007 SCHIP spending until mid-November. While House and Senate leaders vowed to fight for SCHIP expansion, only the Senate had enough votes to override the president's veto at press time.

The House, meanwhile, put off an override vote until the week of Oct. 18 as leaders attempted to drum up the necessary two-thirds majority that would be required.

House Speaker Nancy Pelosi (D-Calif.) has vowed to continue working "with a bipartisan majority in Congress and 43 governors from across the country to increase support

for SCHIP in the House so we can override the veto and provide 10 million children the health coverage they need and deserve," she said in a statement.

"The president chose to block a bill with strong bipartisan consensus—

which has so much potential for good—to force Congress to mount a veto override effort. We remain committed to making SCHIP into law, with or without the president's support," Pelosi said.

—Meg LaPorte