

February 26, 2008

Mr. Kerry Weems
Acting Administrator
Centers for Medicare & Medicaid Services
314G Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Dear Mr. Weems:

I am writing in regard to the considerable fallout—with policymakers, with the press, and most significantly, with the public—initiated when the Centers for Medicare & Medicaid Services (CMS) posted a list of some 4,000 nursing facilities identified as “targeted for improvement” on the agency’s Web site. I have expressed our concerns to Dr. Barry Straube and Dr. Paul McGann, but want to call your attention to this serious matter.

We appreciate that your agency published this list as part of the bidding process for the Quality Improvement Organizations’ Ninth Scope of Work—and perhaps in response to criticisms leveled in reports issued by the Institute of Medicine (IOM) and Government Accountability Office (GAO). Even so, there is little rationale to explain CMS’ seeming disregard for how this information was disseminated to providers and consumers alike—most of whom remain confused, if not concerned, about the care offered by these 4,000 plus facilities.

The following outlines some of our most serious concerns about which I look forward to speaking with you directly.

AHCA Supports the Quality Improvement Organizations

The American Health Care Association (AHCA) is now—and has been—a strong supporter of the Quality Improvement Organizations (QIOs). We also believe that the Ninth Scope of Work is a positive step toward improving coordination of the QIOs’ work with nursing facilities nationwide.

Certainly, identifying facilities to work with the QIOs is not a bad thing in-and-of-itself—however, the public posting of 4,000 facilities tagged as “targeted for improvement” on the CMS Web site is. CMS did not annotate or otherwise provide appropriate context for policymakers, providers, press, or the public to interpret CMS’ intent in compiling its “list of 4,000.”

Context Critical To Understand What “Targeted for Improvement” Means & Relation to Survey Outcomes

CMS’ Web site does not, in any way, provide context to explain why these facilities are targeted for improvement. Rather, the list appears to have been compiled with total disregard for the kind of specialized services that many of these fine facilities provide. For example, one facility flagged as needing help to reduce restraint use in fact specializes in the care of individuals with Huntington’s Chorea. An accepted—and expected—disease management approach for patients

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with Huntington's Chorea dictates that these patients wear helmets for their safety and protection. As you may know, such helmets are labeled "restraints" according to Survey & Certification standards, which is why this facility was placed on the list. Many facilities targeted for work on high-risk pressure ulcers provide excellent wound care and often are considered the "placement of choice" for individuals who suffer from serious pressure ulcers. Naturally, these facilities have a high prevalence of pressure ulcers – in fact, it is likely the reason a patient has been placed in such a facility to improve the likelihood that his/her pressure ulcer will improve and ultimately heal.

CMS appears to have calculated pressure ulcer rates by dividing the number of persons with the condition by the number of persons at high-risk for the condition, and placed those facilities with high percentages on the list. If so, one must ask if smaller facilities are unfairly "targeted" since the small number of patients could skew the calculation (e.g., if a facility is caring for four patients who are at high-risk for pressure ulcers and one of whom is being treated for a pressure ulcer, then the facility would have a 25% rate in the prevalence of pressure ulcers). While unwarranted placement on such a list is problematic, what is truly troubling is how easily this kind of data could be misinterpreted. A consumer who sees that a facility has a 25% pressure ulcer prevalence rating is much more likely to presume that 1 in 4 patients at that facility requires treatment for a pressure ulcer rather than consider the rating reflects the methodology used to create it.

Corporate or chain-based facilities, on the other hand, could be viewed as "stubborn" or "resistant to assistance" if clinical direction from the QIOs is not readily accepted. This is simply untrue. Clinical policy for these facilities is developed and maintained by experts at the corporate—not facility—level. It is possible that the expertise of corporate-based clinicians does not fully align with the experience of the local QIO. Given that scenario, we would expect that a facility facing a discrepancy in clinical interpretation would follow the corporate policy for clinical issues. In fact, the QIOs tapped into the expertise of corporate clinicians when first working with nursing facilities in the 7th Scope of Work and to the benefit of all of the facilities that were part of the resulting pain collaborative.

CMS has spent considerable time, effort, and resources on the survey process as a means of assessing quality of care in nursing facilities. So, the fact that CMS seems to have ignored how the list of 4,000 would be perceived, especially for the many facilities with excellent surveys—is confounding. Ignoring these factors—specialized facilities and those with excellent survey outcomes—represents a gross disservice to the fine facilities that specialize in caring for some of the most challenging medical conditions, though failing to inform the public of these factors is an even more egregious failing by CMS.

Out-of-Date Data & Information

The published list of 4,000 relies, in some cases, on old data. In fact, some of the facilities that appear on the list have closed, while others are located in a different state than what is reported on CMS' Web site. Such basic information should be captured by CMS, and reporting inaccurate, out-of-date data is irresponsible and unreasonable for a public agency.

Potential for Misuse of Publicly Reported Information in the Legal Arena

Less than 48 hours after CMS publicly posted the list of 4,000, personal injury lawyers began promoting their services to consumers by highlighting that care received in these facilities is "substandard" and even encouraged consumers to review this list of "bad facilities." Clearly, we do not believe that CMS intended such blatant misuse of this information; however, we know that the longer the list remains posted on CMS' Web site, the more problems such as this are likely to arise.

Federal Acquisition Regulation

Dr. Straube has repeatedly stated that CMS is required by law to make publicly available all information related to contract solicitation, and release all of that information at the same time. He also has noted that no information may be provided prior to the public announcement to ensure that no entity is given unfair advantage. We have reviewed the *Federal Acquisitions Regulation (FAR)*, as codified in Title 48 of the *Code of Federal Regulations*, and found Dr. Straube's interpretation to be correct, although nothing in the *FAR* requires that CMS post this information to its own Web site. In fact, the *FAR* mandates that the entire contract solicitation must be published publicly at <http://www.fedbizopps.gov>. Presuming that CMS publicly posted this list in order to comply with the *Federal Acquisitions Regulation*—something nursing facilities certainly understand—then there should be no reason that the agency could not remove the list of 4,000 nursing facilities from CMS' Web site, as we have requested of both Dr. Straube and Dr. McGann. Of course, the list would need to remain posted publicly as part of the entire contract solicitation at www.fedbizopps.gov.

Continuing A “Culture of Cooperation” To Advance Excellence

As we discussed last Friday, AHCA has diligently pursued greater transparency and a “culture of cooperation” among long term care stakeholders, including providers, CMS, and patient/consumer advocates. We have championed working in coalitions and are especially proud of the shared success that *Advancing Excellence in America's Nursing Homes* has brought to our collective table. I believe that all of us who sit around that table and beyond are encouraged by the progress we are making together. Now, many of the facilities that AHCA and other *Advancing Excellence* members have encouraged to work on goals of improving pressure ulcers and reducing use of restraints, and many that were willing to publicly report their progress on those measures also appear on CMS' “list of 4,000.” We are concerned that we will lose facilities from the *Advancing Excellence* voluntary initiative altogether.

Again, I am confident that CMS did not intend such an outcome from publicly posting the list. Still, I remain perplexed that we together could not foresee the impact that releasing this list would have in the wake of the media attention garnered by the release of an “abbreviated list” of Special Focus Facilities (SFF) a while ago. Even with an unblemished record in the court of public opinion, there is little chance that the media and the American public would not mistake a nursing facility on the list of 4,000 for a Special Focus Facility. I think that we owe the public better information and appreciate your willingness to set the record straight—with the media, with facilities, and with their communities and customers.

Next Steps

Addressing these problems and clarifying the misperceptions created for providers and consumers alike demands that we work together. We believe that our best, and our first step should be removing the “list of 4,000” from CMS' Web site. Doing so will immediately begin to alleviate some of the problems that these providers are experiencing.

Second, let's insure the list is correct.

Next, we ask that you issue a letter of explanation about what this list is and what it isn't, that can be sent to patients' families, referral sources, and other relevant entities that may be confused. Such a letter should serve to repair some of the damage to these facilities' reputations and highlight the fact that the list was compiled as a management tool for the QIOs rather than a mechanism for identifying nursing facilities that provided substandard care.

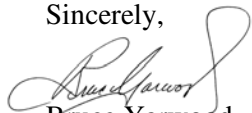
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Lastly, we request that CMS hold a joint press conference with AHCA and other long term care provider representatives. This briefing would help to counterbalance the briefing that you had with Senator Kohl to announce that CMS was posting the "list of 4,000." In addition to setting the record straight, such a briefing would provide CMS a forum to highlight the significant quality improvements that we are making through providers' own efforts and in conjunction with *Advancing Excellence in America's Nursing Homes*.

Thank you for your time and consideration of our concerns and suggestions for how we might proceed toward our shared goal of ensuring that all Americans continue to have access to quality long term care and services when needed. I know that using a cooperative approach like we discussed last week with our colleagues regarding *Advancing Excellence* will be a successful and rewarding one for all of us.

Look forward to seeing you soon.

Sincerely,



Bruce Yarwood
President & CEO

cc: Herb Kuhn
Thomas Hamilton
Barry Straube, MD
Paul McGann, MD
The Honorable Charles Grassley
The Honorable Herb Kohl