



Statement of
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for the
U.S. House Ways & Means Health Subcommittee

“Hearing on Payments to Certain Medicare Fee-for-Service Providers”

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Thank you, Mr. Chairman, and this Committee, for providing the long term care community such a timely and valuable opportunity to discuss the long term care profession’s ongoing commitment to providing quality long term care and services, and your efforts, specifically, to foster a constructive, cooperative environment in which we can continue to work successfully together on behalf of our nation’s most vulnerable population of seniors and disabled citizens.

I am Bruce Yarwood, President and CEO of the American Health Care Association, the nation’s largest long term care advocacy organization. I am honored to be here today to speak on behalf of our nearly 11,000 member facilities nationwide, and the nearly 2 million caring employees who provide critical care and services to 1.5 million frail, elderly and disabled every day.

My 30-years in long term care provide me a unique perspective on the state of the profession, and how to best meet the needs of our patients and residents in the years to come. Over the course of those 30 years, I have been the operator of facilities in northern California; served as a public servant running California’s Medicaid program, MediCal; served as President of the California Association of Health Facilities; and have had the pleasure of working with several of you on this committee here in Washington during my more than 18-year tenure with AHCA.

I have witnessed first-hand and been a part of many significant changes in the long term care profession since I began my career. The nursing home of the early 1970’s and through the 80s and 90s primarily cared for chronically ill residents for long lengths of stay ranging from many months to several years.

Our 21st Century nursing homes are developing to meet the specific needs of today’s aging American, where choice and the need for specialized services is more defined. We’re seeing developments in both brick and mortar and care services to provide increased level of short-term rehabilitative care and services to a more

clinically-complex patient – for an average of 25 days for the Medicare patient. During this time, I have also witnessed a positive shift in which care quality improvement programs – collaborative, successful and ongoing efforts between providers and government – are focused upon delivering the highest quality patient-centered care available.

In the context of today’s discussion, I would like to preface my comments and observations by stating that the long term care profession has made tremendous strides to improve the quality of care and the quality of life of the nearly three million Americans who require critical skilled nursing care and services every year. At no time in the long term care profession’s recent history has the commitment to quality been greater, and I am proud to sit before you today on our profession’s behalf.

Progress has been achieved due to the fact the entire long term care stakeholder community – providers, regulators, lawmakers and consumers – has established a more productive ‘culture of cooperation’ – which is undoubtedly contributing to the rising care quality standards in America’s nursing homes. It is this spirit of a private/public partnership with a collective mission for quality care where we have been able to move the needle on quality.

We must be aggressive in addressing the many quality challenges remaining – and objective in our assessment as to how best to move forward. There’s far more to do, that’s for certain, but we are extremely confident we are heading in the right direction. As we proceed, we must all ensure the entire stakeholder community is prepared to meet the growing complex care needs of the baby-boom retirees – who will inundate our long term care system in the years ahead.

Economic Stability – The Foundation of Quality Care

In order to continue these positive trends and make the necessary investments to prepare for this aging population our shared success, the long term care profession requires a platform of continued financial stability – and will be the primary determinant to meeting our collective quality improvement goals and objectives.

That link between stable funding and quality has been noted time and again – by former Secretary of Health & Human Services Tommy Thompson, former Administrator of the Centers for Medicare and Medicaid Services (CMS), Dr. Mark McClellan, and most recently CMS Acting Administrator Leslie Norwalk, whose article for this month’s edition of *Provider* magazine states,

“Nursing home providers have been on the leading edge of this quality movement. Long before hospitals, doctors, home health providers, pharmacies, dialysis facilities and others came to the table, the nursing home industry was out front with Quality First – a volunteer effort to elevate quality and accountability.... Advancing Excellence in America’s Nursing Homes launched last September... builds on the 2001 Quality First campaign and stresses the essential connection between quality, adequate payment for services and financial stability.”

As Ms. Norwalk pointed out, *Quality First*, was the first nationwide, publicly articulated pledge by a community of health care providers to voluntarily establish and meet quality improvement targets. The

hallmark of our effort has been raising the standards of accountability – and consumers taxpayers, and lawmakers have every reason to expect government resources to be utilized in a manner that supports the provision of high quality long term care for every American. We are proud of our progress thus far – and remain committed to sustained improvement for the future.

This increased focus on resident-centered care, actual care outcomes, increased transparency and public disclosure, enhanced stakeholder collaboration and the dissemination of best practices models of care delivery is paying off.

Key quality indicators tracked by the joint federal-provider Nursing Home Quality Initiative (NHQI) have improved since we stood with HHS and CMS officials to launch this pioneering program five years ago. Since that time, we have experienced improved pain management, reduced use of restraints, decreased number of patients with depression, and improvements in physical conditions such as incidents of pressure ulcers.

In addition, Mr. Chairman, satisfaction of patients and family members are a critical measure of quality. Just last week, *My Innerview, Inc.* released the second annual report based on an independent survey of nursing home patients and their families. The report, *2006 National Survey of Resident and Family Satisfaction in Nursing Facilities*, indicates that a vast majority (82%) of consumers nationwide are very satisfied with the care provided at our nation's nursing homes – and would rate the care as either excellent or good.

We have been able to achieve these positive advances due to our collective commitment to quality – and the government's recognition of how critical economic stability is for our sector has enabled us to continue these trends.

Annual cost of living increases are integral to maintaining economic stability, and essential to the continued provision of quality care. Skilled nursing facilities have the lowest overall operating margins of all major health care providers, and we are operating in an environment of dramatic cost increases in terms of the key building blocks of labor, energy, liability and technology.

The Administration's recent budget proposal to freeze the SNF market basket update in the coming fiscal year, create a prescriptive annual decrease of the market basket, and totally eliminate reimbursement for Medicare bad debt, not only infringe on Congress's authority to determine funding levels for the Medicare program, but would also siphon off more than \$10 billion in funds over the next five years – the very funds utilized to sustain our quality improvement efforts.

Further, Mr. Chairman, to continue focusing solely upon Medicare margins in the nursing home sector does a disservice to those frail, elderly and vulnerable individuals who receive care and services in those facilities. Nearly 70 percent of our nation's nursing home patients rely on Medicaid to fund the 'around-the-clock' long term care and services required, a program that pays, on average, less than \$6 an hour for critical around-the-clock care and services.

But Congress cannot accurately assess the long term care marketplace and patients' growing needs without considering the rampant Medicaid underfunding crisis. America's nursing homes lose an average of approximately \$13 per Medicaid patient per day. This annual \$4.5 billion loss translated into a negative

Medicaid operating margin of 7.06% in 2006 – an unfortunate situation that is expected to continue throughout 2007.

Cost-Efficient, Clinically-Appropriate Post Acute Care

In regard to the so-called Medicare “75% rule,” Mr. Chairman, we state our unequivocal support for your recent efforts to continue moving towards full implementation. It is the right policy at the right time, being implemented for all of the right reasons.

Skilled nursing facilities (SNFs) are clinically appropriate, cost-effective settings providing the highest quality care and rehabilitative services. It is essential to note that since implementation of the 75% Rule was re-initiated in 2004, no Medicare beneficiary has been denied access to care – and the Federal Government has saved hundreds of millions in taxpayer dollars.

Recently-introduced legislation to suspend implementation of the 75% Rule is contrary to the interests not only for patients, but also to U.S. taxpayers – who deserve to see Medicare resources spent in the most efficient, cost-effective manner possible. Suspending implementation also runs contrary to the recent changes in the SNF patient classification system (RUGs 53), which provides incentives for SNFs to more accurately assess, and provide quality care to the patients requiring higher intensity rehabilitation services – at significantly lower cost (more than \$500 per day) than those same patients who receive care in inpatient rehabilitation facilities.

The Rule differentiates the truly high acuity patients who need the most intensive rehabilitation services provided in a hospital setting from those who could be cared for in other settings, like SNFs, at the same high level and quality – and at a significantly lower cost to the Medicare program. With these policies in place, it is illogical in the context of both care quality and fiscal prudence for either Congress or the Administration to take action which delays full implementation of the 75% Rule.

Therapy Caps – Cost Containment Not in The Interest of Patient Rehabilitation

After a Medicare beneficiary has exhausted their 100-day Part A coverage for rehabilitation and post acute care services, they may require additional clinically necessary therapy services – including physical or occupational therapies or speech, language pathology – which is covered by a Part B benefit.

Unfortunately, current policy places arbitrary limits – or a cap – on the amount of the vital therapy services that are covered under Part B – an annual cap of \$1,780. Practically since the inception of the cap, Congress has seen the error in this policy and for that past two years has directed CMS to develop an exceptions process for patients requiring rehabilitation in excess of the cap. Though this exceptions process is in place, it is not intended to be a long term solution to this illogical payment ceiling.

In order to move away from an arbitrary “therapy cap” scenario, we have proposed and are working with Congress and the Administration to develop a permanent, condition-based payment system for Part B covered therapy services. Such a system should be crafted to ensure appropriate rehabilitation services are available to the frail and elderly receiving care in our nation’s nursing facilities when they are required.

We encourage Congress to require CMS to engage in a condition-based therapy reimbursement pilot program for one full year, and then fully implement a similar system nationwide while maintaining the current exceptions process to protect Medicare beneficiaries.

Moving to a Diagnostic-Based Post Acute Payment System

At present, there is an excessively fragmented and irrational health care services payment structure. When it comes to post-acute care, for example, we now have it backwards: our post-acute payment structure is tied to the institutional setting in which patients are placed – not to the patient and the services required.

CMS requires different patient assessment instruments for three of the four post-acute care provider categories, and requires each provider to be certified under separate criteria. CMS ensures patient safety and quality in each of these settings through vastly different regulatory structures. In addition, the physical settings in which patients receive care greatly differ – ranging from a patient's home to a nursing home to a hospital.

Most post-acute care providers, physicians and others involved in patient care believe in a hierarchy of acuity among the different settings, and assume patients with the highest acuity clinical needs will receive care in the highest acuity setting. Research as well as provider experience shows that different post-acute care settings sometimes serve similar patients. This overlap in patient populations can occur for legitimate non-clinical reasons or clinical reasons that are not measurable by research. Regardless, the overlap is sometimes inappropriate, and results in Medicare overpayment.

For certain diagnostic conditions, inpatient rehabilitation facility (IRF) and long term care hospital (LTCH) reimbursements are much higher than SNF payments. Some of this is clearly due to variations in severity of illness. Yet, because there are no common patient assessment tools or outcome measures across all settings, it is not possible to ascertain whether patients are being treated in the most appropriate setting – and whether resources are being allocated efficiently and appropriately.

AHCA strongly supported language in the *Deficit Reduction Act of 2005 (DRA)* that served as a first step in reforming the post-acute care payment system. As is currently being developed, we believe it is essential for CMS to develop a patient centered uniform screening and assessment tool for post acute care patients, and a uniform integrated payment system based on this comprehensive assessment tool focused not on the site where services are provided but, rather, on the needs of the patient.

But until CMS can finalize and apply a uniform system, it can do a better job of placing post acute patients in the most appropriate care settings. For example, AHCA supports the use of hospital discharge planning as a starting point to standardize post acute assessment tools.

For patients with prior hospital stays, CMS should continue to apply hospital discharge planning that is already required by law and regulations. AHCA also supports continued Quality Improvement Organization (QIO) review of the appropriateness of patient placement.

Conclusion

Mr. Chairman, at a time when the Administration and Congress are considering budget cuts in many essential health care programs, the first priority must be to ensure we spend existing resources wisely and efficiently – and in a manner that best serves our seniors, our taxpayers and our citizens at large.

With the imminent wave of long term care patients before us, I reiterate that we must work together cooperatively to establish a health care system – particularly for post acute and long term care – which is patient centered, not site-centered.

For the reasons I have outlined, Mr. Chairman, it is imperative for Congress to take action to address the many existing payment and regulatory inconsistencies for skilled nursing facilities to ensure that we are able to effectively meet the needs of our aging population and continue the positive quality trends we are seeing. The *Long Term Care Quality and Modernization Act of 2006 (HR 6199)*, which was introduced in the 109th Congress, represents an important step toward establishing and nurturing a culture of cooperation – a legislative step we enthusiastically embrace and endorse. This legislation would encourage investment in capital improvements and health information technology, support the sustainability of a stable and well-trained workforce, require joint training and education of surveyors and providers, and implement facility-based training for new surveyors.

The bill would also enhance the role of nurse practitioners in the nation’s nursing homes and amend current law to allow nursing facilities to resume their nurse aide training program when deficiencies that resulted in the prohibition of the training have been corrected, and compliance has been demonstrated.

On the front lines of care, Mr. Chairman, these proposals are significant, and they merit strong support.

And from the standpoint of common sense, what is best for our patients and, indeed, what is ultimately best for the future of our nation’s health care policy, these proposals should be implemented as quickly as possible.

Each of us here today seeks precisely the same objective – which is to improve the quality of care received by every long term care patient in America, and to do so in a manner that helps us best measure both progress as well as shortcomings.

As I have noted, Mr. Chairman, improving care quality is a continuous, dynamic, ongoing enterprise. While we are enormously proud and pleased by our care quality successes, we acknowledge there is far more to accomplish. And from our profession’s standpoint, there has never been a broader recognition of the importance of quality, or a broader commitment to ensure it continues to improve by working together.

Thank You.