

STATEMENT

OF



RESPONSE TO THE SENATE FINANCE COMMITTEE'S POLICY OPTIONS PAPER

ON

**TRANSFORMING THE HEALTH CARE DELIVERY SYSTEM:
PROPOSALS TO IMPROVE PATIENT CARE AND REDUCE HEALTH CARE COSTS**

MAY 15, 2009

The American Health Care Association and National Center for Assisted Living (AHCA/ NCAL), which represents nearly 11,000 dedicated long term care providers, commend Chairman Max Baucus (D-MT) and Ranking Member Charles Grassley (R-IA) for pursuing a thoughtful, deliberative, inclusive approach in seeking to transform our health care delivery system. AHCA/NCAL shares the Committee's goals of improving patient care and reducing health care costs, and offers these comments and our assistance in achieving much-needed health care reform in 2009.

The Senate Finance Committee's *Transforming the Health Care Delivery System: Proposals to Improve Patient Care and Reduce Health Care Costs* policy options document contains a variety of important initiatives designed to lead to more effective care coordination and better alignment of payment incentives with quality outcomes. AHCA/NCAL believes that many of the post-acute care, value-based purchasing, chronic care management, and transitional care options outlined in the Senate paper would complement and sustain ongoing governmental and profession-wide initiatives that are already making a positive difference in the lives of America's seniors and people with disabilities.

Since the Senate Finance Committee has an exhaustive list of policy options to review, we have focused our comments only on those provisions that pertain most to long term care, and include a reference to both the topic and section as outlined in the Committee's policy options paper, *Transforming the Health Care Delivery System: Proposals to Improve Patient Care and Reduce Health Care Costs*.

AHCA/NCAL supports the Committee's efforts to achieve significant savings by reforming health care now and recognizes that addressing many of the toughest issues – like rehospitalization – will not only help to contain costs and achieve savings, but also will affect quality. In fact, quality of care is inextricably linked to stable funding – stability that cannot be achieved over the long term without both containing health care costs and making strategic investments in health information technology and other approaches that will yield cost-savings in the future.

Section I Payment Reform

Options to Improve the Quality & Integrity of Medicare Payment Systems

Linking Payment to Quality Outcomes,

Medicare Home Health Agency & Skilled Nursing Facility Value-based Purchasing Implementation Plans

The concept behind value-based purchasing (VBP) is to encourage care delivery patterns that are not only high quality, but also cost-efficient. The Centers for Medicare & Medicaid Services (CMS) considers value-based purchasing a core element for improving the quality and value of health care delivered in the United States. In fact, VBP programs figure prominently in CMS' plans as the agency shifts away from paying Medicare providers based solely on the volume of services in favor of paying for quality and value of care.

Value-based purchasing must be based on standardized, accurate and appropriate quality measures; rely on accurate, reliable, and relevant patient information; and consider resource-use measures that can evaluate health care performance that allows for comparisons to be made regarding the efficiency with which health care is delivered.

AHCA supports the concept of value-based purchasing. We also would welcome a well-designed demonstration of a skilled nursing facility VBP model. CMS is currently moving forward with a nursing home VBP demonstration in four states. The demonstration, which is expected to begin on July 1, 2009, is based on the model developed by Abt that AHCA believes to be flawed on a number of levels. We have detailed our concerns regarding the viability of this VBP model to CMS. Much of our critique of this proposed demonstration centers on the use of minimum staffing requirements that are inconsistent with patient-centered care initiatives, and that do not take into account variations in patient acuity levels nor variations in state mandated staffing levels and interpretation of direct care work. For example, Florida's mandated staffing level does not recognize a clinician as a direct caregiver, even when the clinician is assessing a patient as required under the Minimum Data Set (MDS). We also question CMS' intent to use state quality surveys in evaluating a facility's performance given the considerable discrepancies with survey consistency and fairness. In addition, this model uses the MDS 2.0, which CMS has acknowledged is inadequate, flawed, and scheduled for replacement with MDS 3.0 next year.

This experience regarding this VBP demonstration makes the Senate Finance Committee's directive that stakeholders be consulted and existing programs considered all the more valuable. We are eager to offer our expertise in the continuing development and implementation of a national VBP program for skilled nursing facilities. We also encourage the examination of the various Medicaid value based purchasing programs across the country to identify effective incentives such as bonus differential reimbursement for improving quality. By tapping into what has worked and not worked at the state level – especially the nursing facility VBP programs in Georgia, Iowa, Kansas, Minnesota, Ohio, and Oklahoma – CMS can gain valuable information for refining a national VBP program.

Section I Payment Reform
Options to Improve the Quality & Integrity of Medicare Payment Systems
Primary Care,
Payment for Transitional Care Activities

AHCA/NCAL believes that integrated, transitional care management is an important component for the successful movement of chronically ill patients within and across the spectrum of care. We commend the Senate Finance Committee for including transitional care activities among its policy options, and suggest that the Committee consider expanding this policy to include care management activities performed by non-physician professionals, and also beneficiaries with high-cost, chronic illness who are at highest risk for hospitalization, including those transitions from hospitals and nursing facilities alike. While all beneficiaries with high-cost, chronic illness who are at high risk for hospitalizations might benefit from certain care management activities, “transitional care activities” should be limited to those in transition.

Section II Long-Term Payment Reforms
Options to Foster Care Coordination & Provider Collaboration
Chronic Care Management,
CMS Chronic Care Management Innovation Center

AHCA/NCAL applauds the Committee’s consideration to establish a Chronic Care Management Innovation Center (CMIC) within the Centers for Medicare & Medicaid Services (CMS). We believe that it is a worthy enterprise to create such a center to test and disseminate payment innovations fostering patient-centered care coordination for high-cost chronically ill Medicare beneficiaries. We concur that this center could help to streamline or coordinate some of the demonstrations currently in existence, as well as encourage new, innovative programs, though we have reservations regarding the scale of such a project. We agree that CMS should have permanent authority to test care coordination models. By design and definition, testing may prove some models unsuccessful, so we would recommend against “broadly testing” or “wide-scale testing” of pilot projects. Certainly, the Secretary of Health & Human Services could be given authority to expand the scope of projects once quality of care is determined to remain high and costs remain reasonable.

Section II Long-Term Payment Reforms

Options to Foster Care Coordination & Provider Collaboration

Hospital Readmissions & Bundling

AHCA agrees that bundling of Medicare payments has the potential to address cost containment issues, especially those related to rehospitalization. Despite the success reported by some limited demonstrations, the Medicare Payment Advisory Commission's (MedPAC's) June 2008 Report to the Congress, *Reforming the Delivery System*, has made us keenly aware that such sweeping changes demand thoughtful consideration and thorough evaluation to avoid unintended, unwelcome consequences as a result of implementing any such major system redesign. We encourage this Committee to consider MedPAC's recommendation that advised caution and encouraged an incremental approach that focused on reducing readmissions as a first step.

MedPAC identified reducing "readmission rates to acute care hospitals" as a key metric for measuring the effectiveness of the bundling concept. Currently, Medicare does not reward hospital-based initiatives that successfully avert many readmissions since payments are based solely on the patient's diagnosis—regardless of whether the patient is admitted for an initial stay or readmitted either for the same or a related condition. We believe that directing the Secretary of Health & Human Services to reduce payments to hospitals with relatively high readmission rates for select conditions would encourage greater collaboration among providers – physicians, hospitals, long term care, and others – and better coordination of patient care.

Again, long term care must be part of health care reform and as such we have a role to play in solving the issues around rehospitalization. We offer this suggestion, in part, because research has demonstrated that rehospitalizations frequently occur within the first two or three days after discharge from a hospital to a long term care facility. We recognize that avoidable rehospitalization is an issue for hospitals and skilled nursing facilities alike. While there are any numbers of fundamental clinical reasons that could result in rehospitalization of a patient, we believe that studying, quantifying, and addressing the reasons for such a spike is imperative and that greater collaboration and coordination of patient care can only help to ameliorate this need.

AHCA/NCAL recommends that the many existing pilot and demonstration projects seeking both coordination and integration of care and quality improvement, as well as evaluating value-based purchasing and potential cost savings, should also be completed before tackling the complex issues that a bundling proposal would present. We also respectfully request – among the other approaches Congress considers – that this Committee review our financing reform proposal and consider the merits of a new, site-neutral payment system for long term and post-acute care within the context of the overall health care reform that our nation needs.

Americans spend more than \$250 billion annually on long term and post-acute care. Most exhaust their own resources before receiving any government support, causing many to struggle to bridge the growing gap between need and service—valued at an additional \$350 billion each year. These funding inadequacies shift costs to Medicare and put increased strain on the already under-funded Medicaid system. This enormous strain is felt by America's seniors, their families, and taxpayers alike. Our proposal affords consumers with greater choice and access to high-quality, streamlined

affordable care and ensures care coordination across care settings for more effective, integrated care. If enacted, we believe that our proposal would create a sustainable post-acute care payment system using a single, unified method that relies on evidence-based care practices where payment is driven by the individual's care needs, not the care setting. According to Avalere Health, which worked with AHCA/NCAL and the Alliance for Quality Nursing Home Care in developing this proposal, these changes would result in real savings in federal expenditures and save taxpayers \$81 billion over 10 years – offsetting the \$46 billion it would cost to launch a new federal long term care program that would address Americans' long term care needs and return an overall 10-year savings of \$35 billion.

It is interesting to note that one of the instances cited by MedPAC where bundling achieved desirable results is the Geisinger Health System, which created bundled payment for physicians and hospitals for certain open heart surgeries. Bundling in this instance was successful—resulting in a reduction in both the length-of-stay and readmission rates. Since the bundling involved Geisinger-owned acute care hospitals and Geisinger-employed physicians working collaboratively to establish standardized protocols for patients requiring open heart surgery, such success may not easily be replicable.

This observation points to one of myriad thorny issues around implementation of this compelling concept of bundling Medicare payments and raises the specter of how perverse incentives could reward physicians who initiate more admissions, furnish lower levels of service, or cherry-pick patients—a particular concern in long term care as two-thirds of nursing home patients rely on Medicaid to pay for the care and services they need.

Such a shift in payment structure would force a shift in the marketplace. We believe that changing how physicians, hospitals, and post-acute care providers interact would require a seismic shift in cooperative agreements and shared risk among providers.

As much as health care is a service industry, we must recognize that the business of providing health care requires marketplace consideration of legal, financial, and workplace issues. We especially wish to call the Committee's attention to dramatic changes that could diminish the role of independent nursing home owners—nursing facilities that are run by small business owner-operators.

Larger organizations are more apt to have resources to handle increased administrative duties, whereas, independent facilities would be disadvantaged in trying to handle additional contract negotiations or collection of payments from multiple payors if this policy option were to be implemented. These independent facilities would be forced to significantly increase their administrative costs without a corresponding contribution to quality of care. Ironically, it is quality of care that many consumers rely on these often family-run facilities in caring for their loved ones. And according to AHCA members, family members often express that there is a level of comfort in knowing that there is additional accountability that comes from caring for your neighbors and those you grew up with, whose family members you might encounter in the local grocery store.

As the Committee considers these policy options, AHCA/NCAL asks that Congress consider care quality in tandem with the goal of enhanced cost-efficiency.

Section III Health Care Infrastructure Investments Section Tools to Support Delivery System Reform

*Workforce,
TANF Health Professions Competitive Grants &
Proposal on Development of a National Workforce Strategy*

AHCA/NCAL is pleased that the Committee seeks to address some critical workforce issues in *Transforming the Health Care Delivery System: Proposals to Improve Patient Care and Reduce Health Care Costs*. Caregivers are the heart and soul of long term care and essential to providing high-quality long term care and services. No amount of technology – no matter how advanced or how simple – will ever replace the role of our dedicated nursing staff, which care for some of our nations’ most vulnerable citizens each day.

Yet, our nation is facing a critical nursing shortage. The *National Commission for Quality Long-term Care* highlighted this critical shortage in its report, which states, “even if we set the somewhat conservative goal to maintain the current ratio of paid long-term care workers to the current population of 85-year-olds, the long-term care workforce would have to grow by two percent a year — to the tune of 4 million new workers — by 2050.”

AHCA’s 2007 vacancy and turnover survey of skilled nursing facilities found close to 110,000 job vacancies in America’s close to 16,000 nursing homes waiting to be filled by registered nurses, licensed professional nurses, and certified nurse assistants. Based on initial feedback from AHCA membership, we anticipate that the downturn in the economy has attracted qualified applicants to fill these vacancies, which has resulted in a reduction in open positions—but considerable long term care vacancies remain. The *National Commission on Nursing Workforce for Long-Term Care* noted, “efforts to recruit and train new nursing staff are estimated to cost nursing facilities over \$4 billion each year – more than \$250,000 annually for each nursing home in the nation.

Even with these vacancies, long term care, which represents 1.1 percent of the Gross Domestic Product, employs approximately 3 million Americans and created 44,000 jobs in 2008.

AHCA/NCAL strongly support the Committee’s proposal for competitive grants that furnish disadvantaged parents with the necessary education and training to obtain employment in high-demand, well-paying health care fields. The high demand for long term care workers has been well-documented; a recent study by the Department of Health & Human Services (HHS) and Department of Labor (DOL) estimates the U.S. will need between 5.7 million to 6.5 million nurses, nurse aides, and home health and personal care workers by 2050 to care for the 27 million Americans who will require long term care – up more than 100 percent from the 13 million requiring long term care in 2000. While some may hold the misconception that long term care workers are compensated at or very close to the minimum wage, the data proves otherwise. In 2008 the national median hourly wage for nurse aides was \$10.65, \$18.74 for licensed practical nurses, and \$25.00 for registered nurses according a recent report.

AHCA/NCAL is especially pleased that this policy option will leverage previous efforts funded through the DOL’s ongoing High Growth Job Training Initiative. In 2007, six grants were targeted

for the preparation of workers for careers in long term care. Fostering additional grants will build upon a previous effort funded by the DOL, a manual for addressing nursing workforce development entitled, *Developing State Partnerships and Initiatives to Address Long Term Care Nursing Workforce Challenges*, a collaborative project between AHCA/NCAL and the Wertlieb Institute for Long-term Care at George Washington University.

AHCA/NCAL also endorses the Committee's proposal to facilitate the development of a comprehensive, coordinated nationwide health care workforce development strategy, which encompasses supply, retention, and training elements. We have long advocated for legislative, policy, and other changes to address existing fragmentation in the responsibility and oversight of numerous federal workforce development initiatives from the Centers for Medicare & Medicaid Services, the Health Resources & Services Administration (HRSA), the Department of Labor, and the Department of Veterans Affairs.

Much of the legwork regarding these issues has already been accomplished by the National Commission on Nursing Workforce for Long Term Care, which AHCA/NCAL supported. Recommendations in the Commission's final report, *Act Now For Your Tomorrow*, call for the creation of a broad long term care workforce group comprised of all committed stakeholders, including national long term care organizations, nursing and professional caregiver groups, colleges and universities, nurse educators, and state and federal policy makers to support and encourage development of national policies and programs specifically addressing the long term caregiver shortage.

The Eldercare Workforce Alliance – which is comprised of 28 national organizations, consumer groups, family caregivers, direct-care providers, and health care professionals – also seeks to advance workforce development approaches that also would improve care quality. This Alliance is focused on the challenges and recommendations described in the Institute of Medicine report, *Retooling for an Aging America: Building the Health Care Workforce*, which calls for immediate attention to and investment in care of older Americans.

We applaud the efforts to date and recognize the need for continuing synchronization at the federal level, including additional data collection and analysis by HRSA that can provide the necessary foundation to complete a comprehensive, national workforce development strategy.

Additional Provisions for Consideration in the Reform Package Legislative Proposal on Workforce

As the Senate Finance Committee evaluates myriad policy options in the context of overall health care reform, AHCA/NCAL asks that the Committee also consider policy remedies that can address the critical nursing shortage that we face in America today. AHCA/NCAL offers the following policy options designed to address the education, recruitment and retention needs for a well-qualified long term care workforce. We know that sound public policy that strengthens our nation's long term care workforce also will extend quality improvement, and help to ease the burden that so many American families face in caring for aging parents and grandparents.

AHCA/NCAL would be pleased to discuss any of the following options and to share draft legislative language should the members of this Committee wish to have greater detail.

- Reinstating the ability for registered nurses (RNs) employed by proprietary long term care facilities to be eligible for federal loan repayment under Section 846(a) of Title VIII of the *Public Health Service Act (PHSA)*, which expired in FY 2008. This provision would improve recruitment.
- Establish a national health care workforce database within the U.S. Department of Health & Human Services, tracking the areas of practice for all health care professionals and paraprofessionals so that future supply and demand trends may be established and analyzed. This provision would address supply.
- Create and implement a consistent reporting requirement for Nursing Workforce Development Program grantees under Title VIII of the *PHSA*, so that outcomes and efficacy of the programs across all practice settings may be tracked and evaluated. This provision would improve education, recruitment, and retention.
- Create and implement a consistent reporting requirement for Health Professions Workforce Development Programs grantees under Title VII of the *PHSA*, so that outcomes and efficacy of the programs across all practice settings may be tracked and evaluated. This provision would improve education, recruitment, and retention.
- Re-establish federal capitation grants for Institutions of Higher Learning to enhance existing nursing education programs in order to facilitate increases in faculty creation and retention as well as student enrollment. This provision would improve education, recruitment, and retention.
- Establish a loan repayment program under Title VIII of the *PHSA* for those RNs who pursue graduate degrees in nursing with the intention of becoming faculty. This provision would address education and supply.
- Create incentives for RNs to practice in long term care, by adding this setting to the list of practice and retention priority areas contained in Title VIII of the *PHSA*. This provision would improve recruitment and retention.

- Provide financial support for long term care residencies for new nurses just entering practice in addition nurses with no long term care experience through Title VII of the *PHSA*. This provision would address education and supply.
- Require the General Accountability Office (GAO) to examine the effect of government funding (e.g., Medicare and Medicaid) on efforts by the long term care profession to recruit, retain, and educate direct care staff. This provision would improve education, recruitment, retention, and supply.
- Increase staffing by alter existing Medicare and Medicaid requirements over time so that nursing facilities are required to have a registered nurse on site 24 hours a day, 7 days per week, retaining the existing exemptions for extenuating circumstances. This provision would improve recruitment, retention, and quality.
- Implement matching grants to fund Administrators-in-Training (AIT) to provide support for those who plan to practice in long term care settings. This provision would improve recruitment and retention.

Section III Health Care Infrastructure Investments Section

Tools to Support Delivery System Reform

Health IT,

Encouraging Health Information Technology Use & Adoption in Support of Delivery System Reform Goals
Improving Quality Measurement

Health information technology (HIT) has a crucial role to play in improving health outcomes and reducing costs as well as improving patient safety and quality of life. AHCA/NCAL encourages the Committee to finish the job that the *American Recovery & Reinvestment Act of 2009 (ARRA)* started in ensuring that all patients have electronic health records (EHRs). To achieve the potential improvement in outcomes, as well as cost savings, these need to be universally deployed and fully interoperable.

AHCA/NCAL strongly encourages the Committee to move forward with the option under consideration to provide “additional health IT incentives to other health care providers, such as those offering post-acute services, that were not included in the Medicare and Medicaid incentives included in *ARRA*.”

Medicare and Medicaid beneficiaries access health care in a variety of care settings (e.g., from ambulatory care to acute care to post-acute care and beyond), which requires the smooth flow of reliable, timely, and necessary clinical, diagnostic, and financial information from one provider to the next. It is difficult to see the logic in offering financial incentives to some providers for adopting 21st Century health information technologies, without offering similar incentives across the health care spectrum.

The Committee was correct in suggesting that “additional health IT incentives within Medicare are warranted to help support the care coordination and quality improvement goals and activities related to various proposals included in this document...” We would call special attention to the problems of unplanned, presumably unnecessary, returns to acute care hospitals within 30 days of discharge.

Many post-acute care providers are of the opinion that a substantial portion of rehospitalizations are a result of poor, fragmented, and inadequate transmission of information between the discharging hospital and the post-acute provider. Incentives to both acute and post-acute providers to adopt interoperable, compatible electronic information sharing and exchange systems seem a cost-effective approach to reducing if not eliminating problematic re-admissions to acute care.

Extending HIT incentives to post-acute caregivers will greatly expedite progress toward the ultimate goal of electronically linking all the major groups of providers across the health care delivery spectrum and avoid many of the difficulties experienced when the Medicare Part D benefit was introduced. What we learned from those experiences is that interoperability of HIT systems is critical – especially for long term care patients and residents who require, on average, nine prescription drug medications per day.

Ensuring the interoperability of HIT, including EHRs, will benefit all health care consumers, including America’s seniors living in long term care settings, who have multiple acute and chronic

care needs and who receive care from a variety of providers. EHRs for these patients would lead to significant improvement in coordination of care for these medically complex patients, as well as cost savings resulting from greater care coordination.

About 1.5 million Americans receive long term and post acute care in nursing facilities on any given day. Another one million live in assisted living communities, where they receive assistance with activities of daily living and taking medications, so it is also important to find ways to provide support for HIT in assisted living facilities. For example, about 40 percent of assisted living facility patients suffer from dementia and may not be able to share information with their health care providers themselves. The improved coordination of care provided by EHRs would be particularly beneficial to these patients.

About 115,000 assisted living residents have their long term care services paid by the Medicaid program, which does not reimburse these facilities for the cost of housing and other capital costs. Given the low rate of Medicaid payment and fact that Medicaid pays for services only in assisted living, facilities caring for these patients have limited ways to meet capital costs such as HIT even though they are an important part of the health care system that monitoring patients after stays in the hospital. At the very least, AHCA/NCAL believes that assisted living facilities caring for Medicaid recipients should be eligible for financial incentives for the development of HIT capacity.

AHCA/NCAL recommends that the Committee make nursing facilities and assisted living facilities eligible for Medicare and Medicaid HIT payments. AHCA/NCA also recommends that the “meaningful use” criteria for incentive payments for physicians and hospitals be expanded to include post acute and long term care providers who are certified as meeting the standards of interoperability, clinical functionality, and security as developed for and approved by the Secretary of Health & Human Services.

Section III Health Care Infrastructure Investments Section

Tools to Support Delivery System Reform

Nursing Home Transparency

Because we support greater transparency and accountability, we are pleased that the Committee has included provisions that would ensure more meaningful information is reported by providers and more useful information is made available to the public. AHCA/NCAL has been working with Committee staff on many of these issues, especially regarding increased transparency and accountability provisions and initiatives to continue to sustain and improve quality care. We look forward to continuing that dialogue.

We believe that several of the provisions being considered by the Committee regarding increased transparency merit more in-depth evaluation. To be clear, our concern is not with a mandate of disclosing “who owns what,” but rather, the additional regulatory and administrative burdens that accompany the current provisions related to transparency. Nursing facilities already must comply with more than 180 federal regulations along with innumerable state regulations. We respectfully request that Congress be cognizant of this fact and not require additional, unnecessary, or redundant reports. Instead, we ask that Congress require nursing homes to provide the state and federal government – and, more importantly, the consumer – with the information necessary to make informed health care decisions while eliminating the paperwork that diverts facility staffs’ attention from focusing on quality of care for frail, elderly, and disabled Americans.

We have outlined some of the modifications that we believe will help us to more effectively reach the goals that we share around transparency and accountability.

Required Disclosure of Ownership

We agree with the goals around requiring substantial disclosure of ownership of skilled nursing facilities (SNFs) and nursing facilities (NFs), and those related to, or affiliated with these SNFs and NFs. Disclosing ownership of nursing homes, which is already provided to the states and to Medicare by virtue of provider licenses and agreements, is perfectly appropriate. It is the methods by which this information is sought and the kinds of specific information that may prove problematic in some instances.

Related Party Disclosure

The provisions in this section of the Senate Finance policy options paper would require disclosure of those parties affiliated with a SNF or NF, including consultants, contracted therapists, realtors, bankers, landscapers, laundry contractors, and others. More importantly, this provision would require SNF/NFs to certify to the Secretary of Health & Human Services as to the accuracy of this information, which would have implications for receiving reimbursement.

We have specific concerns about including financial entities as related parties—not because nursing homes have problems with disclosure, but due to the administrative burden and the unintended effects. For example, the provisions require that nursing homes report the names of directors, officers, and shareholders of additional disclosable parties as well as an organizational chart. While this information may be available from a community bank, acquiring it from Bank of America or

Citigroup or their shareholders (including in effect the U.S. Treasury Department) or the Department of Housing & Urban Development (HUD) will prove to be extremely difficult at best.

There are also unintended consequences which should be considered. Will the mandatory disclosure of lenders create a chilling effect on lending? Will banks and mortgage companies or other financial guarantors be reluctant to provide loans due to concerns about liability? Would this in turn adversely affect nursing homes which want to improve their buildings and operations in order to increase quality of care? These are issues which should be fully considered.

SNF/NFs may ask disclosable parties for information, but the entity is not obligated to provide it. SNF/NFs could jeopardize their certification if an incomplete or inaccurate report – although submitted in good faith – because a related party did not provide accurate information or because the disclosable party did not make available the information in a timely fashion. In effect, the provision requires the SNF – which may be a small independent operator in small town America – to put its ability to receive Medicare reimbursement on the line based upon information provided by a third party, which may be incomplete or faulty.

Finally, policymakers should consider the administrative burden imposed by these provisions. Perhaps many, if not most of the large nursing home chains already maintain compliance departments that would attempt collection of the information. However, smaller facility owners do not readily have the staffing capability and this could prove burdensome.

Accountability Requirements

These provisions would mandate that nursing facilities initiate compliance and ethics programs. Again, we agree with the goal of this section, but the details of the requirements are very important. Most of the larger facility chains already have compliance departments that could readily initiate these programs, if they have not done so already—most likely have. However, so-called “Mom and Pop” facility owners may be financially unable to finance the creation of their own “compliance department.” Where the language in the provision states that the Secretary *may* vary the program based upon the size of the organization, we believe that the Secretary *should* be required to create a simple and streamlined compliance program. In the comments provided by the Office of Inspector General (OIG) Supplemental Compliance Program Guidance for Nursing Facilities, in 2008, it appears that the OIG appreciates the distinction.

“Given the diversity of the nursing facility industry, there is no single ‘best’ nursing facility compliance program. OIG recognizes the complexities of the nursing facility industry and the differences among facilities. Some nursing facilities are small and may have limited resources to devote to compliance measures; others are affiliated with well-established, large, multi-facility organizations with a widely dispersed work force and significant resources to devote to compliance. Accordingly, OIG does not intend this supplemental CPG to be a ‘one-size-fits all’ guidance. OIG strongly encourages nursing facilities to identify and focus their compliance efforts on those areas of potential concern or risk that are most relevant to their organizations. A nursing facility should tailor its compliance measures to address identified risk areas and to fit the unique environment of the facility (including its structure, operations, resources, the needs of its resident population, and prior enforcement experience). In short, OIG recommends that each nursing facility adapt the objectives

and principles underlying this guidance to its own particular circumstances” (73 *Federal Register*, 56834, No. 190, Tuesday, September 30, 2008).

Quality Assurance & Performance Improvement (QAPI)

This provision mandates the Secretary to create regulations on quality assurance and performance improvement (QAPI) plans. It requires SNF and nursing homes to implement QAPI plans and submit them to the Secretary. Further it states that the Secretary be required to provide technical assistance to facilities on their development of “best practices” in order to meet QAPI standards. SNFs already have provisions in law regarding quality assurance and improvement. Section 1819 (b)(1)(B) of the *Social Security Act* and §483.75 (o) of the nursing home regulations clearly delineate the expectations for quality assessment and assurance in a facility:

A facility must maintain quality assessment and assurance committee consisting of the director of nursing services, a physician designated by the facility, and at least 3 other members of the facility’s staff. The committee must meet at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.

The law and regulations further state:

A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this subparagraph; and

Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.

The QAPI provision appears to be duplicative to existing SNF regulation with regard to quality assessment and assurance. Even though 483.75 does not specifically state Performance Improvement Program, it is implied it in existing regulation.

The QAPI calls for the establishment of standards related to quality assurance and performance improvement to such facilities and provide technical assistance. 483.75 (o) already establishes the standards. The Quality Improvement Organizations currently provide the technical assistance. Given this, the intent of QAPI is unclear.

Nursing Home Compare

We agree that providing consumers with information they need to make informed choices on selecting a nursing facility is very important.

It is important to note that currently, each nursing facility must post its most current survey statement (or CMS form 2567) and this is available to all individuals who enter the facility. The provision in the proposal requires states to link to Form 2567 inspection reports; to facility plans of correction; and to information that guides consumers in interpreting and understanding these reports. While we believe that it is important to provide accurate information to consumers about nursing facilities, we maintain that the 2567 is not “consumer friendly” and will benefit very few consumers who come to the website for information to help them select a nursing home for a loved

one. The 2567 is a technical, raw document written in “F-tag” language that is not easily read by most consumers. The benefit to consumers is unclear and the information from the 2567 does not arm the consumer with understandable information to make the decisions they need to make. Most importantly, the 2567 provides no information about the type of care and services offered by a particular facility. The 2567 is designed to determine compliance with law and regulation. The document is a result of subjective assessment by surveyors, and numerous government studies have stressed the inconsistency of interpretation among surveyors nationally.

Even if the information is made available through links on *Nursing Home Compare*, CMS has admitted there are challenges in placing information on the web site and the GAO has criticized CMS saying they are not timely. There is no indication that when facilities “fix” the problem that the website will accurately depict the corrected problem and post it in a timely fashion, thereby leaving consumers with incomplete information. On the positive side, we are pleased to see that the transparency provisions require that a “Plan of Correction” along with the 2567 that the facility writes in response to the deficiencies, be posted. We are also supportive of the requirement that would mandate timeliness of information reported on *Nursing Home Compare*, and have it updated at least quarterly.

While providers continue to support transparency and public reporting of data, CMS has not successfully translated regulatory jargon, clinical descriptions, and data, into useful, accessible, and easily understandable information that consumers can use to make informed health care choices. This failing undermines the current value of *Nursing Home Compare*. While *Nursing Home Compare* has the potential to become a valuable resource, it presently does not empower consumers.

Staffing on Nursing Home Compare

We agree with the provisions requiring staffing data based on payroll data which is inclusive of agency and contract nurses and other direct care workers may be a better report on staffing than what is currently available. We understand that the intent of this provision to allow an apples to apples comparison of staffing among nursing homes. This would assume that all nursing homes staff identically and provide identical services. Facilities serve various levels of acuity and specialties and staff according to patient mix, practice of the company and various other reasons. One facility may have lower acuity residents and possibly require fewer staff. Another facility may specialize in complicated wound care and may have a higher staffing ratio. We are not sure that a snapshot of the number of nurses on staff will give the consumer the information they need to make an informed decision. Mandating that all Medicare and Medicaid facilities post and report staffing information to include the category of work, whether a registered nurse (RN), licensed practical nurse (LPN), or certified nurse aide (CNA), resident census data, turnover, retention, and the hours of care provided by each category of employee specified will require significant resources by the facility to comply. Once again, we urge you to consider the effect on nursing homes in small town America.

A critical group of staff which is not currently reflected on *Nursing Home Compare*, are therapy staff. This is critical information for the potential resident/patient requiring rehabilitation services.

Our 2007 vacancy and turnover survey of skilled nursing facilities found that nationally, 16 percent of registered nurse (RN), 11 percent of licensed practical nurse (LPN), and more than 9 percent of certified nurse aide (CNA) positions account for nearly 110,000 vacancies overall. Based on more recent initial feedback from AHCA membership, we anticipate that the downturn in the economy

has attracted qualified applicants to fill these vacancies, which has resulted in a reduction in open positions—but considerable long term care vacancies remain. Still, the current long term caregiver shortage is only projected to get progressively worse over the next decade. Attracting, training, and retaining quality long term care staff remains a particular challenge for long term care providers. Posting this data may serve transparency but it does nothing to help alleviate the caregiver shortage.

Standardized Complaint Form

This provision requires the Secretary to develop a uniform complaint form for use by residents when they file a complaint with the state survey agency and the ombudsman. The state must establish a complaint resolution process. Federal law and regulation currently directs facilities to resolve complaints, directs the state survey agency to promptly review the results of all complaint investigations and determine if a facility has violated any requirements and provides for enforcement of compliance for long term care facilities. Enforcement remedies available to the state to impose on facilities for non-compliance with regulations governing complaints include directed plan of correction, imposition of temporary management, denial of payment, civil monetary penalties (CMPs), state monitoring, transfer of residents, closure of facility, etc. (42CFR 488.406).

Residents have long held the right to voice grievances without discrimination or reprisal and regulation requires prompt efforts by nursing home staff to resolve grievances. Residents are informed of their rights upon admission which is included in a list of federal and state rights provided to resident and family. Residents have flexibility whether to submit a complaint in writing, provide it verbally, call a phone number, inform the ombudsman when he or she is there, or advise a nursing home administrator or other employee. Nursing homes are currently required by federal regulation to post the names, addresses and telephone numbers of all pertinent state client advocacy groups such the state survey and certification agency, the state licensure office and the state ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit while some states also add the Attorney General to that list.

Requiring states to now establish a new process on top of a system and structure that is already in place is redundant. There are already systems and structures in place to take in, record and resolve complaints. If this system is broken in certain areas, then we should identify and address it within the current structure.

Reporting of Expenditures/Ensuring Staffing Accountability

Both of these provisions mandate the SNF and nursing homes report expenditures for wages and benefits for direct care staff on facility cost reports. In addition, it requires that the Secretary create a process to require SNF and nursing facilities to regularly report staffing data, including agency and contract staff, by staff position categories (based on payroll and other verifiable and auditable data).

We have no problem reporting this information so long as contract staff is included, as stated, in the final provisions of the legislation. We would only question the extent to which these provisions (“reporting of expenditures” and “ensuring staffing accountability”) are duplicative in their mandates.

Moreover, we suggest that instead of creating a new system of reporting, that cost reports include the information on staffing desired.

Civil Monetary Penalties

We start with the basic philosophic belief that the imposition of civil monetary penalties (CMPs) will not, in and of themselves, create improvement in nursing homes. The survey system itself is flawed and subjective, and cannot be compared from state to state. We have consistently called upon both the Centers for Medicare & Medicaid Services (CMS) to overhaul the survey system but we have met with little success. The previous program was created over twenty years ago and a new survey system is long over due.

With respect to the provision on CMPs, we appreciate that facilities would have an opportunity for participation in an independent informal dispute resolution process within 30 days of the imposition of the penalty. The provision states further that where deficiencies cited at the level of actual harm or immediate jeopardy, the Secretary would have the authority to place CMPs in an escrow account following completion of the IDR or the date that is 90 days after the imposition of the CMP, whichever is earlier.

Related to the informal dispute resolution process, we would like to ensure that the Secretary monitors these processes in each state, and assures that the state entity responsible for conducting the informal dispute resolution process is different than the state survey agency. This permits a truly objective review and a balanced approach to both the perspective of the surveyor and the perspective of the provider.

This provision should specifically state that CMPs not cited at the actual harm or immediate jeopardy level *will not* be collected until the conclusion of all appeal rights that afforded the facility in current law and regulation.

We appreciate that the provision permits the Secretary to be authorized to use a portion of collected penalties to fund activities that benefit residents, including those which can be used to fund joint training of staff and surveyors, as well as technical assistance for facilities implementing quality assurance programs, among others. This is a positive and worthwhile use of CMPs.

National Independent Monitor Pilot Program

This provision requires the Secretary to develop, test, and implement a two-year pilot for an independent monitor program to oversee large interstate and intrastate nursing home chains. We believe that this should be a demonstration program as opposed to a pilot program. The Office of Inspector General (OIG) should report to Congress as to the benefits of the program following its completion. Then Congress should in turn, evaluate its merits and determine whether it should be made permanent.

Notification of Facility Closure

This provision mandates that SNF and nursing homes be required to modify in a timely fashion state, federal, and stakeholder officials, as well as residents and their representatives, other responsible parties, the State and long term ombudsmen program that a facility is preparing to close. It further requires that 60 days notice be given by the Administrator prior to closure and that the facility ensure safe transfer of residents to another facility or alternative setting.

We have no problem with the notification requirement, but suggest that the number of organizations or entities to be notified be fairly designated so that the facility can comply as quickly possible without unnecessary administrative burdens.

Demonstration Projects To Culture Change & Use Of Information Technology In Nursing Homes

We support this provision.

Dementia & Abuse Training

We support this provision.

Study & Report On Training Required For Certified Nurse Aides & Supervisory Staff

We support this provision.

Summary on Transparency Provisions

We agree with the Committee's goal that nursing homes should provide transparency of ownership. There is already significant information in the public domain. Our concern is not with a mandate of disclosing "who owns what," but rather, the additional regulatory and administrative burdens.

Nursing facilities already have enormous numbers of state and federal regulations with which they must comply. We respectfully request that Congress be cognizant of that and not require additional reports which are unnecessary or redundant. Let's provide the state and federal government, and most importantly the consumer, with the information they need to make informed decisions without additional mounds of paperwork, which divert staff attention from focusing on quality of care for America's seniors and disabled.

AHCA along with Senate and House staff have engaged in a constructive and meaningful dialogue over the past several months in order to successfully reach a conclusion on many of the issues discussed above. We are confident that in the final analysis, we will be able to work out the details of these provisions which will be both satisfactory to the Congress and workable to the nursing home community.

Additional Provisions for Consideration in the Reform Package

Legislative Proposal on Survey Reform

The purposes of the nursing home reform provisions in the *Omnibus Budget Reconciliation Act of 1987* are twofold: (1) to improve the consistency of quality care in nursing homes nationwide; and (2) to improve the consistency of national oversight. Consistency in quality and oversight should recognize the diversity of nursing home providers and residents. As implemented, the Nursing Home Survey System assumes a one size fits all approach; fails to provide national consistency in quality and in oversight; and fails to provide incentives to encourage better performance by nursing homes. In addition, the variation within the survey process of oversight makes it extremely difficult to provide information that would allow for meaningful comparisons of individual homes within and across states. When all of this is considered in the context of a confluence of shrinking resources, increased availability of quality data and a public demand for more useful, timely and reliable data, there is the opportunity to streamline and improve the current survey system.

Legislative Proposal

The legislative changes that we are proposing would provide for a quarterly offsite review of a set of quality markers across all nursing homes and provide an incentive for the top tier of performing nursing homes to have a full onsite survey every 36 months, with a half-day onsite survey during the two intervening years. Other homes would continue with the annual full onsite survey. This would free up additional time for surveyors to provide more oversight for homes which are showing the poorest performance. The changes also call for the development of acuity adjusters to incorporate differences in populations being served across homes. The Secretary of Health & Human Services would also be required to take steps to improve the consistency of the conduct and documentation of individual surveys in order to allow for the public to compare the performance of homes when making a choice for themselves or their loved ones. It is important that this consistency be within and across states since families often are spread across the country and may need to compare homes in several states. The Secretary would be required to post this data and update same on a quarterly basis.

To facilitate the national adoption of the Quality Indicator Survey System, which aims to improve consistency of quality and oversight, we also propose that states may request the return of Federal Civil Monetary Penalties to meet the federal funding requirements to implement this survey system.

In order to improve consistent understanding and interpretation of regulations, surveyor guidance, and agency policies, the Secretary will also implement a program of joint training for federal and state surveyors and providers.

The proposal also directs the Secretary to conduct an evaluation of the implementation of the *Nursing Home Reform Act of 1987* and the implementing regulations to assess the degree to which the law and regulations have been adhered to, particularly in the area of consistency in oversight.

These proposed changes would also require the Secretary to report to Congress on an annual basis on progress in achieving these goals. There are also a number of other minor conforming changes.

Section IV Medicare Advantage

Options to Promote Quality, Efficiency & Care Management

With regard to the Committee's proposed policy reforms for Medicare Advantage (MA), AHCA recognizes that the proposed consumer-driven options to promote quality, efficiency and care management are beneficial. Skilled nursing facility (SNF) providers are willing to partner with MA plans to ensure these goals are achieved. However, notwithstanding these important reforms for patient care and quality, AHCA believes there are additional reforms related to the relationship between nursing facility providers and MA plans that the Committee should consider.

SNF providers are increasingly reporting problems with their relationships with MA plans. Many of these problems are payment and process related issues. A major concern for nursing facility providers relates to the responsibility for cost-sharing for dual eligible enrollees in the MA program. More and more SNF providers care for dual eligibles enrolled in MA plans. These providers are increasingly reporting problems related to a lack of responsibility for payment of enrollees' cost-sharing (i.e., copayments) by either the MA plan or the state. Moreover, there appears to be no remedy available to providers who experience unpaid copayments—they must bear the cost themselves.

In a January 2009 final rule, CMS finalized requirements in which all MA plans with dual eligible enrollees specify in their contracts with providers that such enrollees will not be held liable for Medicare Parts A and B cost-sharing when the state is liable for the cost-sharing. CMS goes on to state that the provider would either accept the MA payment in full or bill the appropriate state source (e.g., Medicaid). The final rule also implements requirements established in the Medicare Improvements for Patients and Providers Act (MIPPA) targeting special needs plans (SNPs). These requirements establish that for full benefit-dual-eligible individuals or qualified Medicare beneficiaries enrolled in a SNP, an MA organization may not impose cost-sharing that exceeds the amount of cost-sharing that would be permitted if the individual were under Medicaid and were not enrolled in a SNP.

Notwithstanding the intent to affirm that dual eligible enrollees are not to be held liable for cost-sharing when the state is liable, the reality for providers is they are, in many cases, absorbing the cost of unpaid cost-sharing for enrollees in SNPs and other MA plans. Moreover, providers are left without any remedies to deal with such a financial loss that can, in some cases, amount to more than \$100 per day per dual eligible enrolled in an MA Plan. This adds up to huge losses for many SNF providers and is on top of losses already suffered due to shortfalls in Medicaid reimbursement to nursing facilities.¹

AHCA agrees that dual eligible enrollees in MA plans should not be held liable for cost-sharing when the state is liable. Neither should the provider be in essence "held liable" by inability to collect the copayment from either the state or the MA plan. Indeed, as CMS knows, even when a state is

¹ According to a report by BDO Seidman and Eljay, the average shortfall in Medicaid reimbursement to nursing facilities was \$13.15 per Medicaid patient day in 2007. This results in a total shortfall in Medicaid nursing facility reimbursement of more than \$4.4 billion.

technically liable, an increasing number of states in effect do not pay the copayment under various cost sharing formulas.

Nearly all of SNF unpaid copayments is for beneficiaries dually eligible for Medicare and Medicaid coverage, whether these beneficiaries are covered under traditional Medicare fee-for-service or under the MA program. Since most dual eligible beneficiaries are also impoverished and rely on Medicaid for their health coverage, Medicaid is responsible for paying the copayment. However, many state Medicaid programs limit (through use of a formula) or exclude coverage of the Medicare deductible and coinsurance amounts owed to SNFs for dual eligible beneficiaries. In fact in 2005, 25 states severely limited Medicaid payments for copayments or paid nothing at all.

Lack of responsibility for payment of enrollees' cost-sharing by either the MA plan or the state is not good public policy. If Congress and CMS believe in the efficacy and integrity of MA plans and their benefit to beneficiaries, then they should immediately correct problems that stand in the way of further development of such plans. Literally punishing a provider for providing care to beneficiaries enrolled in the MA plan does not make sense. The disparity between the treatment of dual eligible copayment under traditional Medicare and Medicare Advantage should be of deep concern to both Congress and CMS. It is a stumbling block for the improvement and growth of managed care.

In previous comments to CMS, AHCA recommended that CMS provide for payment to nursing facilities of copayments owed to providers by MA dual eligible enrollees either through treating such unpaid copayments as bad debt or, alternatively, by requiring that MA plans facilitate these payments as part of their benefit design or requiring the payment of copayments or deductibles by states for those beneficiaries enrolled in MA plans. The latter can be accomplished by SNPs coordinating with state Medicaid programs so that covered benefits and payments are ensured for dual eligibles enrolled in SNPs.

Section V Public Program Integrity

Options to Combat Fraud, Waste & Abuse

Provider Screening

Data Base Creation & Data Matching

Provider Compliance & Penalties

Program Integrity Funding & Reporting Requirements

Provider Screening

The Committee proposes to amend the provider and supplier (hereinafter jointly referred to as “providers”) enrollment process to add prerequisites to enrollment (determined based on a provider risk assessment), such as: 1) fingerprinting, 2) criminal background checks; 3) database inquiries; and 4) unannounced site visits. Providers will pay additional fees to fund this screening process. Providers would not be enrolled until the process is complete. Once complete, “some” providers would be provisional providers with limitations on payment.

We would like to bring to the Committee’s attention to several issues that should be considered in advance of enacting this proposal. As an initial matter, the existing Medicare enrollment process is broken. Enormous resources are spent by providers on enrollment, re-enrollment, “changes of information filings,” and “changes of ownership filings.” Medicare contractors that process these filings are overwhelmed. In many states, our members are reporting that it can take six months or more to process a new enrollment. Until the “tie-in notice” is received from the Medicare contractor, the provider cannot bill for services. Because these rules apply when a provider changes ownership (including corporate reorganizations), companies commonly provide services without payment for six months or more. While these providers eventually are reimbursed, the delay can create financial hardship, especially for smaller and rural providers. Significantly increasing the enrollment requirements while the current system is broken would cause dramatic negative effects.

Moreover, providers are already subject to labyrinthine and burdensome licensure, enrollment and regulatory requirements. Nursing homes enroll in the Medicare program, but also usually enroll in state Medicaid programs. They also are required to meet state licensure requirements and certificate of need laws (when applicable). In addition, nursing homes are subject to Clinical Lab Improvement Act certification, in many cases state controlled substances and, as applicable, pharmacy licensure and registration, and a myriad of other local licensure schemes (from barber shop licenses to FCC licenses to operate communications equipment). Many of these state and local licensure schemes require Medicare enrollment as prerequisite. Stated otherwise, states will not enroll nursing homes in Medicaid or issue a nursing home license unless that entity has applied for and/or enrolled in Medicare. Adding significant screening requirements to Medicare enrollment provisions will only further delay compliance with state and local requirements.

The proposal suggests additional inspections are warranted before enrollment. This is already a prerequisite to nursing home enrollment through the survey and certification process. Other providers are also subject to various forms of survey and certification. The Committee should consider the need to overlay another survey process on the existing program. It should also ask what standards will be utilized? How will they be used and reported?

We are also concerned about the discretionary risk assessments in the proposal. What types of providers will be subject to additional screening? We believe that this determination is too important to be delegated to the Secretary when these issues are of significant importance to all providers and should be subject to legislative inquiry and hearing?

Finally, we believe that these significant additional burdens are disproportionate to the ostensible targeted purpose – the prevention of enrollment fraud and specifically the prevention of “fly-by-night” providers that set up shop and immediately begin the submission of thousands of fraudulent claims. Nursing homes, by example, do not physically or literally “fly-by-night.” The establishment of a nursing home is a significant investment of time and resources and includes numerous regulatory hurdles, checks, and hearings on both the federal and state level. Likewise, it is burdensome and unreasonable for any institutional Part A providers to be subject to increased costs and an even lengthier enrollment process than already exists. Surely there are more targeted and appropriate mechanisms to identify fraudulent enrollment. At a minimum, such increased standards should not be applied to nursing homes or other institutional providers.

Data Base Creation and Data Matching

As a general matter, we applaud the creation of focused and coordinated data systems. We are cognizant, however, of the difficulties in implementing such coordination. We are also concerned about the intended use in coordinating systems with specific regulatory purposes. Stated otherwise, the databases cited in the proposal all have specific regulatory purposes or statutory mandates. What standards will govern the use of these data outside intended purposes?²

For example, the proposal provides that certain quality measures be included in the database to assist state licensure agencies. Such data are subject to varied interpretation, especially when aggregated and summarized in a database and viewed by an official not familiar with the collection and utilization of such data. How would a typical state licensure official view quality measures for providers that attend to higher acuity patients, who tend to measure with higher incidences? Currently these data are applied to a certain context and the aggregation of the data potentially removes the context and could subject providers to discrimination. At a minimum, we request that safeguards and remedies for the correction of such data be included in any legislation.

Provider Compliance and Penalties

Nursing facility care is one of the most regulated industries in the United States. As discussed, Medicare providers are subject to numerous standards, regulation, inspection, licensure and investigation. The proposal concisely lists many of the obligations to which Medicare providers are pledged. All providers are subject to conditions of participation/coverage and are subject to sanctions if they fail to meet those conditions. In addition, providers are also subject to a panoply of other civil and criminal laws including: various Civil Money Penalties; the federal *False Claims Act*; state false claims acts; the federal Anti-Kickback Statute; state anti-kickback and all-payor laws; state fee splitting prohibitions; the federal Stark self-referral law; beneficiary inducement prohibitions; state practice of medicine restrictions; state licensure and certificate of need laws; the *Health Insurance*

² E.g., a report published May 6th by the Department of Justice Inspector General questioned data handling by the Federal Bureau of Investigation “no-fly” list. Many individuals were kept on the list for years after underlying investigations were resolved.

Portability & Accountability Act (HIPAA); and many other laws that include financial sanctions and criminal penalties.

Providers are regulated, or oversight is provided by the Centers for Medicare & Medicaid Services (CMS); the Drug Enforcement Administration (DEA); the Environmental Protection Agency (EPA); the Food & Drug Administration (FDA); the Department of Justice (DOJ); the Department of Health & Human Services' Office of the Inspector General (HHS-OIG); the Occupational Safety and Health Administration (OSHA); Postal Inspectors; TRICARE Inspectors; Department of Veterans Affairs (VA); Medicare contractors fraud units; Medicaid contractor fraud units; states attorneys general; the Federal Bureau of Investigation (FBI); state pharmacy boards; state prosecutors; various boards of licensure and oversight and others.

In addition to all these requirements, qualifications, overseers and overseers of overseers, health care providers are subject to termination and/or exclusion from federal health care program participation, essentially a death sentence for a health care company. In spite of these various requirements, the proposal would add yet another standard to the backs of health care companies – the mandatory compliance program.

We support the establishment of voluntary compliance programs. We believe that they can be appropriate tools that benefit all stakeholders in the Medicare program. We at AHCA have provided on-going educational tools to assist our members to develop and implement their own compliance programs tailored to the size and complexity of their organizations. The OIG has expressly recognized that there is no “one-size-fits-all” approach to compliance.³ Mandatory compliance programs, however, have only been imposed on providers in return for a release of permissive exclusion. In other words, providers that have engaged in allegedly improper conduct (*i.e.*, violation of the various standards discussed above) have traded the application of a mandatory compliance program in return for a promise from the OIG not to proceed against the provider in an exclusion proceeding. Now, this proposal would seek to impose the same requirement against providers that have not violated any standard (allegedly or otherwise).

For those providers who have been subject to mandatory compliance programs, known as corporate integrity agreements (“CIAs”), these programs have been expensive, requiring third-party consultants, government monitoring, and significant administration.

How would this new compliance requirement be measured (*i.e.*, compliance with the compliance requirement)? Who will bear the significant costs of this model? While larger and chain providers may have the ability to leverage economies of scale, we are especially concerned about smaller and rural providers, who may not have the leverage to implement such complicated programs successfully. And to what measure is success? Who will monitor failure? CIAs all have stipulated penalties and the expedited risk of exclusion. Would providers be subject to the same standard?

In summary, we believe that there are sufficient laws and regulations governing the participation of providers in the Medicare program and that there are sufficient tools for regulators to enforce compliance with such laws and regulations.

³ See, e.g. OIG Supplemental Compliance Program Guidance for Nursing Facilities, 73, Fed. Reg. 56832, 56834 (Sept. 30, 2008).

Program Integrity Funding and Reporting Requirements

In addition to the recommendations of the proposal, we recommend that Health Care Fraud & Abuse Control (HCFAC) reporting specifically include an accounting of monies recovered from fraud settlements. Stated otherwise, some portion of federal *False Claims Act* settlement monies is paid into HCFAC. We recommend that these amounts be reported as well (instead of the current process of reporting overall settlement amounts).

Conclusion

Next year will mark 30 years since the Bipartisan Commission on Comprehensive Health Care (aka the Pepper Commission) released its report calling on Congress to make long term care reform a priority. It is time to make good on that call to action.

Medicare provides only limited benefits, and overburdened State Medicaid programs cannot sustain being the primary payor of the long term care needs of our aging nation. We urge this Committee to consider more fully how we may refine these options to better rationalize acute and post-acute services. More importantly, if we are to achieve better care coordination that is seamless to the patient and health care consumer – across all care settings – we must ensure that long term care is included in any health care reform initiative offered by Congress or the Administration.

We applaud Chairman Baucus, Ranking Member Grassley, and members of this Committee, who have already contributed to a thoughtful discussion about how to reform our very complex health care system. We commend Chairman Baucus and Ranking Member Grassley for a very extensive list of options to help reform our nation's health care system to achieve person-centered, cost-effective, quality health care for all Americans. AHCA/NCAL stands ready to work shoulder to shoulder with the Senate Finance Committee and others in Congress to achieve meaningful and effective health care reform.