

STATEMENT

Of

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On Behalf of



Before the

**U.S. House of Representatives'
Energy and Commerce Committee's Subcommittee on Health**

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Thank you Chairman Pallone, Ranking Member Deal, and the entire Subcommittee. I also commend each member of the Energy and Commerce, Ways and Means, and Education and Labor Committees for working in concert to pursue health care reform in a manner that is cooperative and deliberative, and seeks to achieve President Obama's goals of improving patient care, reducing health care costs, preserving consumer choice, and ensuring access to quality health care – goals that we share. I am Bruce Yarwood, President and CEO of the American Health Care Association and National Center for Assisted Living (AHCA/NCAL). I am grateful for the opportunity to be with you here today to offer our profession's perspective on health care reform and to highlight the crucial role long term and post-acute care fulfills across the spectrum of health services in America.

We agree with the assessment of the Energy and Commerce, Ways and Means, and Education and Labor Committees that the U.S. health care system is in crisis and that rising health care costs affect American families, businesses, and both federal and state health care programs. We applaud the priority placed on reforming our nation's fractured health care delivery system, and the approach taken by the three committees. The discussion draft bill establishes a framework for reform, and I hope that all of us here today can provide insight and input to help shape a final package that serves the best interests of consumers, caregivers, and our nation's commercial infrastructure.

As the largest association of long term and post-acute care providers representing not-for-profit and proprietary facilities, AHCA/NCAL understands the importance and need to address overall health

care reform. We also share your goals of transforming health care through a thoughtful and measured approach that keeps the needs and choices of consumers at the forefront of the discussion. We appreciate the opportunity to contribute to this debate that will ensure, in the final analysis, that the comprehensive health care reform enacted by this Congress will balance the benefits provided to our fellow citizens with the fundamental needs of the professions, industries, and caregivers who provide the foundation for a systemic overhaul of our nation's health care system.

Long term care accounts for 1.1 percent of the Gross Domestic Product (GDP) – \$153.8 billion annually. Our sector contributes to the employment of nearly 4.5 million individuals and supports \$161 billion in labor income nationally - often, with a long term care facility being the largest employer in a town. As a direct employer, long term care provides more jobs than our nation's entire educational services industry and 40 percent more than Wal-Mart, the world's largest employer. With the long term care profession playing such a significant role – as care providers, employers, and revenue generators – the impact that comprehensive health care reform will have on this sector must be addressed prior to implementing major overhauls to the system.

On behalf of the profession responsible for caring for our nation's most vulnerable citizens, I am proud of the advances we have made in delivering high quality long term care services and we remain committed to sustaining these gains in the years and decades ahead – when, as we all know, demand for long term care will by all accounts dramatically increase.

Long Term & Post-Acute Care: A Crucial Element of an Effective Health Care System

Americans are living longer and our nation's aging population is growing – many of whom have medical or cognitive conditions that require care in a nursing facility. Currently, more than three million Americans rely on the care and services delivered in one of the nearly 16,000 nursing facilities each year, and an additional one million individuals receive care and services in assisted living communities nationwide.

The forecast for the future need for nursing facility care is alarming. A March 2008 report from the National Investment Center for the Seniors Housing & Care Industry (NIC) indicates that the demand for long term care services will more than double by 2040. Coupled with the current need and future increased demand for quality long term and post-acute care services, it is imperative that the changing role of care provided by our sector be recognized. The demographics of the individuals cared for in skilled nursing facilities (SNFs) continue to evolve. In fact, at present there are more Medicare covered “short-stay” post-acute patients cared for in a year than there are “long stay” Medicaid residents.

This week marks the ten year anniversary of the U.S. Supreme Court's *Olmstead* decision, which has resulted in a much needed increase in the availability of home- and community-based long term care services (HCBS). The impact that this landmark Supreme Court decision has had on skilled nursing facilities is that the long-stay patient that we care for today is significantly more frail and disabled

than just ten years ago, requiring substantial health care services and assistance with activities of daily living such as bathing and eating. For these individuals, nursing facility care is essential as their chronic care needs cannot be met in the community.

Quality – AHCA/NCAL’s First Priority

Long before “quality” and “transparency” became catch words of the federal government and its oversight of health care, they were truly the compass for AHCA/NCAL and its member facilities.

Our association and our members have been working diligently to change the debate regarding long term and post-acute care to focus on quality – quality of life for patients, residents, and staff; and quality of care for the millions of frail, elderly and disabled individuals who require our services. We have been actively engaged in a broad range of activities that seek to enhance the overall performance excellence of our sector. While keeping patients and their care needs at the center of our collective efforts, we continue challenging ourselves to do better, and to do even more to enhance quality.

Culture of Cooperation – Leading Toward Continuing Quality Improvement

Positive trends related to quality are evidenced by profession-based initiatives, including *Quality First* and *Advancing Excellence in America’s Nursing Homes* – both of which are having a significant impact on the quality of care and quality of life for millions of frail, elderly, and disabled Americans who require long term and post-acute care.

Quality First, which was established in 2002, set forth seven core principles that reflect long term care providers’ commitment to continuous quality improvement, leadership, and transparency. This profession-based initiative led not only to improvements in care and processes, but to the development of the National Commission for Quality Long-Term Care, co-chaired by your former colleagues The Honorable Bob Kerry and Newt Gingrich. *Quality First* and other initiatives have been recognized by former Secretary of Health & Human Services Tommy Thompson, by former Administrator of the Centers for Medicare & Medicaid Services (CMS) Dr. Mark McClellan, and by former CMS Acting Administrator Leslie Norwalk, who wrote in 2007, “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...Quality measurement has worked in nursing homes...Collaborating to measure quality of long-term care, report it, support it, and improve it – that’s the best path to a high-quality, patient-centered, provider-friendly system that everyone can afford.”

AHCA is a founding partner of *Advancing Excellence in America’s Nursing Homes* – a coordinated initiative among providers, caregivers, consumers, government, and other stakeholders that promote quality. Focusing on eight measurable goals, this effort takes previous initiatives a step further—not only measuring outcomes, but establishing numerical targets and benchmarks. *Advancing Excellence*

also promotes best practices and evidence-based processes that have been proven to enhance patient care and quality of life.

This voluntary initiative is working – and outcomes and processes have improved in the nearly 7,500 participating facilities since its launch in September 2006. Data indicates that there have been demonstrable care quality improvements with reduced incidence of pressure ulcers, reduced use of physical restraints, and improved pain management for long-term and short-stay post-acute nursing home residents. In an April 2009 press release, Mary Jane Koren, M.D., M.P.H., who serves as chair of the *Advancing Excellence* coalition, stated, “We estimate that in the course of the Campaign, there were 1.8 million fewer days where a resident at high risk for developing a pressure sore was suffering from one. Also, during this time, we estimate there were 8.5 million fewer days where a nursing home resident used a physical restraint.”

In total, the increased focus on person-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. AHCA/NCAL remains committed to our long-standing practices and programs, which seek to improve the quality of care for our nation’s most frail, elderly, and disabled and to enhance the quality of life for patients and caregivers alike.

Funding Stability Is Critical for Profession to Sustain Quality Gains

It is important to recognize that the nursing home of the 21st Century is far different from its predecessors. We are proud to note that patients are returning home more quickly, but remain concerned about threatened cuts to Medicare funding and what such cuts could mean to the care of older, sicker, and more medically complex patients.

While the U.S. House of Representatives “Tri-Committee” discussion draft considers many revisions to the four components of Medicare (Parts A, B, C & D), we have limited this testimony to those provisions that would have the greatest impact on the care and services delivered in our nation’s long term and post-acute care facilities.

Medicare Part A – Cuts Could Jeopardize Patient Care & Jobs

AHCA/NCAL appreciate that reforming health care now means that we must address many of the toughest issues, which – if done well – 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.

With our profession’s quality agenda as both a backdrop and a desirable ongoing public policy priority, the matter at hand is relatively simple. When Medicare funding for skilled nursing services is stable, quality of care and services improve. When Medicare funding is inconsistent and unstable –

especially in the face of growing demand – our nation’s long term care infrastructure deteriorates to the detriment of every senior today and every retiree tomorrow.

We are very concerned that one of the provisions of the draft would codify in statute what CMS has historically attempted to accomplish through formal rulemaking. Earlier this year, CMS proposed to cut Medicare funding for SNFs by 3.3 percent in FY 2010 to correct a projection error made by the agency in 2005 when it radically changed the SNF patient classification and payment systems through a Notice of Proposed Rule Making (NPRM). The FY 2010 CMS proposed rule (which in effect, has been included in the House legislative proposal) once again seeks to accommodate for a projection error related to the adoption of new patient classification categories four years ago, and would cut SNF Medicare reimbursements by \$1.05 billion in FY 2010 alone. Some projections estimate that this proposal would eliminate \$18 billion from quality skilled nursing care over the next ten years.

In 2005, CMS revised and expanded the Medicare patient classification system – called Resource Utilization Groups (RUGs) – that is used to set Medicare Part A daily payment rates for seniors needing SNF care. CMS’ flawed assumptions failed to account for the increasingly complex patients that seek and receive nursing and rehabilitative care in our nation’s nursing homes. The agency’s attempt to recoup Medicare funds through implementation of the SNF proposed rule is incongruous with CMS’ own policy efforts to encourage certain high-acuity Medicare beneficiaries to receive care in the cost-efficient, quality SNF setting.

The data supports the fact that most of the increase in SNF expenditures was a result of CMS’ own Medicare policies and would effectively “take back” payments from providers that are a result of an increase in acuity and real case-mix change. Policies including the *75% Rule* (now set at 60% by Congress) were crafted to ensure that Medicare beneficiaries receive rehabilitative care in the most appropriate and cost-efficient setting for their needs. In testimony before the House Ways and Means Health Subcommittee in May 2007, CMS officials explained that the rule was working as expected, and specified that, “As enforcement of the *75% Rule* gradually phases in from July 1, 2004 through July 1, 2008, Medicare claims data have demonstrated that patients who might have been treated in an [Inpatient Rehabilitation Facility] IRF (but who have clinical conditions appropriate for care outside of an IRF) – are now getting needed care in other more appropriate and less costly settings.”

CMS’ dismissal of this increase in SNF acuity and real case-mix change puts providers at risk. The agency’s approach is fundamentally flawed and inconsistent with the basic premise of a prospective payment system. CMS has developed methodologies in other settings for identifying real case-mix change and there is ample precedent for CMS to pay for real change in acuity and medical practice. CMS should and must continue to pay providers for real case-mix change.

We are also concerned that the discussion draft proposes eliminating the much needed Medicare annual update for SNFs for the final nine months of FY 2010. This would have the unfortunate effect of granting the Market Basket Update – calculated to account for increases in costs – for only

three months, and then eliminating the increase for the remaining nine months of FY 2010. Currently, the annual market basket update for skilled nursing facilities is intended to reflect an increase in the cost to provide quality care. However, the increases in nursing facility costs from 2001 – 2007 exceeded the increases in the market basket updates each year (FY 2002 to FY 2009). It is clear that a full market basket increase is critical to enable nursing homes and Medicare to continue to move forward in providing quality services for our nation’s most vulnerable citizens.

Further complicating the issue, CMS has included within this same proposed rule major revisions to its current RUGs system to be implemented in FY 2011 – with only a 60-day comment period ending June 30, 2009. The proposed RUG-IV system has the potential to destabilize and redefine the provision of skilled nursing care.

Essentially, massive Medicare cuts to account for projection errors on the part of CMS, coupled with proposals to significantly reduce a crucial annual update means this profession is facing the potential of a “double barrel shotgun” in funding cuts that could jeopardize the health of the entire sector. We respectfully urge all three committees to reconsider these proposals and suggest their elimination in future iterations of this legislation.

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. While we are proud of our gains in enhancing quality, that trend cannot continue if at the same time, funding is drastically reduced.

Medicare & Medicaid Are Inextricably Linked

We are concerned that coupling the proposal to eliminate most of the market basket update for SNFs, with efforts to significantly cut Medicare funding by codifying CMS’s “projection error”, and with the unfortunate reality of Medicaid underfunding for skilled nursing care, the long term care sector could be destabilized and many jobs could be placed in jeopardy. Taking the “projection error” correction by itself, it is estimated that the \$1.05 billion reduction in Medicare nursing facility expenditures on a nationwide level has a substantial impact on the local, state, and national economies – with a reduction of \$1.1 billion in labor income, and a loss of more than 30,000 jobs.

Given the prevalence of Medicaid patients in our nation’s nursing facilities, special consideration of the relationship between Medicare and Medicaid seems particularly relevant to nursing facility care.

Proposed Medicare cuts are exacerbated by the chronic underfunding by Medicaid for care and services provided in our nation’s nursing facilities. A recent *BDO Seidman/Eljay, LLC*, study projected that states cumulatively underfunded the actual cost of providing quality nursing facility care by \$4.4 billion in 2007. The analysis further showed the average shortfall in Medicaid nursing home reimbursement was \$13.15 per patient day in 2007 - a 45 percent increase from 1999.

Further complicating the chronic Medicaid underfunding of long term care is the reality that, according to recent analysis, in response to the recession 46 percent of states are freezing or cutting nursing home rates, and 75 percent are not keeping up with inflation.

And while financial stability is an essential component of delivering high quality long term care services, it is just as critical for the profession to maintain a stable workforce. Nearly 70 percent of skilled nursing operating costs are labor-related. Ongoing funding shortfalls have a major impact on the front lines of care and negatively influence staffing, jeopardize intra-facility quality improvement efforts, and may cost the jobs of the very staff that make a key difference in the quality of care and quality outcomes.

So we ask you, Mr. Chairman, how can dedicated providers of skilled nursing care meet the ongoing demands of the federal government for increased staffing levels and sustained quality improvements with reduced funding?

As the *American Recovery and Reinvestment Act of 2009* (ARRA) included approximately \$87 billion in enhanced Medicaid funding to states, AHCA commends this Subcommittee and its colleagues for directing these critical funds to states at crucial time. In ARRA, Congress made a conscious decision to tell states that these *Federal Medical Assistance Percentage* (FMAP) funds would be watched by establishing oversight provisions that direct states to refrain from depositing these enhanced funds into rainy day accounts, and further stated that these dollars are meant to be used now.

Congress delivered these enhanced federal Medicaid funds to avoid dramatic cutbacks that would threaten the health care safety net during our current strained economic reality. AHCA/NCAL argued then, and continues to contend, that those funds should have come with a strong maintenance of effort (MOE) requirements regarding funding. We are concerned that the overwhelming majority of these enhanced funds were redirected to programs outside of long term care. As providers of essential care services to our nation's frail, elderly and disabled, we request that these enhanced funds reach the providers of these services, as we believe Congress intended – by adding maintenance of effort for provider payments. By doing so we believe you will act to secure critical funds to a stressed industry.

While we are extremely concerned that these critical funds get to those who provide services to our nation's frail elderly and disabled, it is also crucially important that we plan according for the future when this enhanced funding would be eliminated. On January 1, 2011, this enhanced funding runs out creating a cliff in funding leaving states in an impossible position of cutting a safety net program of which we are a part. As a profession, we depend heavily on the Medicaid system, which funds the care of roughly two-thirds of nursing home patients and 12 percent of assisted living residents. Unfortunately, as I have stated, Medicaid has historically paid less than the cost of care. I pledge to work with this Subcommittee and all the other Congressional Committees of jurisdiction to ensure that there is no reduction in care or services for our nation's most vulnerable individuals. We urge this Subcommittee to explore sustained relief to states as ask that any relief include a strong maintenance of effort to ensure funds are allocated properly.

We ask that Congress help intervene with CMS to urge HHS and the agency to lessen the impact of the NPRM with its drastic Medicare cuts. We also request that the Committees be mindful of the impact that reducing the Market Basket Update will have on many skilled nursing facilities – particularly independently owned and rural facilities.

Medicare Part B – Therapy Caps Exceptions Process in the Best Interest of Patient Care

On behalf of the millions of American’s receiving Medicare Part B therapies (occupational, physical and speech/language therapies) in settings including skilled nursing facilities, we applaud this Subcommittee and the three Committees of jurisdiction in proposing to extend the “therapy caps exceptions process.” Since 1999, Congress has placed a moratorium on imposing very restrictive therapy caps that are not in the best interest of patient care and later created an exceptions process to permit seniors to receive medically necessary therapy services above the cap. According to estimates in 2008, an estimated 700,000 Medicare beneficiaries would have exceeded the limit on their Medicare Part B therapy benefit that year. As the majority of these beneficiaries reside in skilled nursing facilities, we are pleased with this Subcommittees determination to extend the exceptions process for those who require the most extensive therapy services for an additional two years – until December 31, 2011. This extension will effectively protect essential rehabilitative care services for millions and millions of Medicare beneficiaries.

Medicare Parts A & B – Rehospitalization & Bundling

As nursing facilities are the dominant provider of post-acute services in the Medicare program, receiving about 55 percent of all hospital discharges into a post-acute setting of care, the areas of rehospitalization and the development of a post-acute care service payment reform plan will have significant impact on skilled nursing facility providers.

We agree that as a nation, we must address reducing unnecessary rehospitalizations as a step to improving care services and care coordination between acute and post-acute care providers. However, as written the discussion draft refers not to inappropriate rehospitalization, but to excess readmission to a hospital. When a hospital readmission within 30 days of discharge is clinically appropriate and medically necessary, we believe that reducing funding for both the hospital and the post-acute care provider is unwarranted and bad public policy.

In regard to developing a post-acute bundled payment system, we applaud the Tri-Committee discussion draft which takes a thoughtful and measured approach to this complex and nuanced issue. We are pleased with the direction to pursue a demonstration project that will take into consideration important areas that must not be overlooked, including the nature of payments, the interaction of the acute and post-acute care providers, the development of appropriate quality measures, and programmatic policies such as eliminating the three-day hospital stay.

In an effort to achieve greater budgetary savings, we encourage the Committee to consider the development of a new prospective payment system (PPS) for Medicare post-acute care services to enhance care coordination by basing payments primarily on patient need rather than the setting in which services are delivered. Estimates by Avalere Health LLC, indicate that such a site-neutral payment system could generate as much as \$81 billion in savings over a ten year implementation period. We look forward to providing specific legislative language to this Committee to further your consideration of this alternative model.

At a time when our nation's healthcare requires stability and efficiency, we believe that proposals to eliminate most of the SNF market basket update for FY 2010, recoup billion of dollars due to projection errors by CMS, implement funding reductions for rehospitalization – whether appropriate or not – and create post-acute bundled payments, could have dangerous repercussions – jeopardizing quality care and eliminating much needed jobs.

Medicare Part D – Elimination of Part D Co-Pays for Some Dual Eligible Beneficiaries

We would like to commend the Committees for including a much needed improvement to the Medicare Part D drug program in the legislation. Eliminating the Part D cost sharing (co-payments) for full-benefit dual eligible beneficiaries – those eligible for both Medicare and Medicaid covered services – receiving services under Sec. 1915 or 1115 waivers is a crucial improvement for hundreds of thousands of elderly, disabled Americans whose extremely low incomes now make it difficult for them to afford Part D co-payments. This improvement also creates parity with dual eligibles living in nursing homes and other institutions that already have no cost sharing under the Medicare Part D program.

However, we do not believe that this proposal is complete as it does not eliminate cost sharing for dual eligibles in home- and community-based settings that are covered directly under state Medicaid plans. In order to best serve the poor and elderly who receive care and services through home and community based services, we encourage this Subcommittee to expand the elimination of co-pays for Part D covered prescriptions to all dual eligible beneficiaries.

AHCA Has Led Efforts in Transparency in Health Care – But Transparency Can't Come at the Expense of Patient Care

For many years, the long term care profession has been at the forefront of health care providers pursuing transparency, enhanced quality care, and publicly available information as to our performance. We have and continue to be active and willing partners with CMS and HHS in disclosing information that we hope is and will be helpful to consumers when facing the difficult decision of choosing a nursing facility. For the last eighteen months, AHCA and other representatives of the long term and post-acute care profession have been in active discussions with legislators and their staff regarding proposals to address increased transparency for nursing homes. At the outset, it is important to understand that we support the concept and direction of the

Committee and we are optimistic that by continuing to work together the final legislation will be supported by the profession and will achieve its laudable goals.

We agree with the goal of improving consumer-oriented data to help facilitate selecting the most appropriate care setting for a loved one, but as the discussion draft serves as a road map for change we believe it is appropriate to revise some of specific provisions. As “Nursing Home Transparency” comprises nearly 100-pages of the discussion draft, I wish to take this opportunity to address a few significant areas.

I would first like to address disclosure. While we have long supported public reporting and transparency, new calls for increased disclosure on details such as minimal ownership of a nursing facility will not contribute to this effort to help consumers, nor drive improvement of care or services in facilities nationwide. The disclosure of more information, rather than the right information simply for disclosure sake will only add confusion and greater misunderstanding of the quality and services available.

In fact, disclosure of confusing, inaccurate and/or conflicting data will not only lead to misunderstanding but worse, the possible selection and placement of patients in facilities that are not right for them and will not meet their needs and expectations. Rather than promoting disclosure for disclosure’s sake, we must ensure that available reported data is in the best interest of consumer needs and fair to those facilities dedicated to meeting their needs. The culture of cooperation should be engaged to ensure that the data reported is the correct – most useful – and accurate information available for consumers to make an informed decision as to the right quality nursing facility.

Rather than the current construct of reportable data and the newly proposed data elements to be disclosed, we believe that data revealing family and patient satisfaction, staff turnover, patient outcome trends, and patient acuity and the facility’s specialty areas should be under discussion and consideration. Above all else, we must continue to work together to ensure such data is accurate, up to date and presented in a fashion that is easily understandable and useful to consumers. Any significant, disclosed data should motivate and empower those individuals, including facility operators and administrators, who make decisions which impact the care and services delivered on a daily basis.

Over the last year and a half, prior to the introduction of any “transparency” legislation, AHCA has consistently been working with both the House and Senate authors to improve transparency of information regarding nursing facilities. AHCA supports the goal of promoting transparency, but requiring the disclosure of excessive and, at times, redundant information is not in the best interest of informing consumers, encouraging provider competition in the delivering of quality care and services, nor enhancing government oversight. We also need to be cognizant of the increased costs and administrative burden for providing duplicative information that will in the end not serve to identify nor improve the quality of long term care quality and services.

AHCA and its members have been actively engaged in a broad range of activities which seek to enhance the overall transparency of long term care provider performance. As the long term care profession was the first among health care providers to subscribe to true transparency and publicly available information as to our performance, we were willing partners with CMS and HHS in disclosing more information that we hoped would be helpful to consumers when facing a difficult decision for choosing a nursing facility. We believe that certain transparency provisions for long term care in this bill are redundant and some may actually be harmful rather than helpful in ensuring continued quality improvement and improved patient placement. For example:

- In the area of financial transparency, information such as organizational structure and relationship with affiliated facilities is already reported to the Centers for Medicare and Medicaid (Form 855) and the licensing division of each state. The Medicare cost report also requires disclosure of all related party services on Schedule A-8-1.
 - Under this bill, the disclosure of an entity that provides financial or cash management services to the facility, or accounting or financial services to the facility, would be publicly disclosed. We believe that such disclosure of arms-length financial transactions may have a chilling affect on reducing already limited lending opportunities for nursing homes for necessary upgrades.
 - Further, we believe that definitions contained in this bill should conform to definitions that are currently provided in existing law. For example, the definition of “managing employee” in existing law (Section 1126(b) of the SSA) does not extend to anyone who indirectly manages, advises, or supervises any element of the practices, finances, or operations of the facility. By altering definitions in the *Social Security Act*, employees who have no responsibility for ensuring the quality or provision of patient care will be considered part of management staff and would be required to be disclosed as such.
- In the area of staffing transparency, beginning in January 2003 nursing facilities are required to post daily, for each shift, the number of licensed and unlicensed nursing staff directly responsible for resident care in the facility. State Survey Agencies are responsible for ensuring that the appropriate staff information is posted.
 - Under this reform bill, facilities would be required to post on the public website staffing data and tenure information. We contend that staffing data information is not an accurate reflection of the quality of care provided at a facility. The posting of staffing data does nothing to improve or address the root cause of staffing shortages in facilities. We fully believe one cannot look at staffing data in a silo – one must recognize that this is a national nursing workforce shortage that is being felt across all areas of health care hence any shortage that may be present in long term care is simply a reflection of the state of the shortage not a reflection on the facility.
 - New proposals would require facilities to post various staffing data, as well as certain tenure information on the public website. In the face of a well documented and publicized national nursing workforce shortage being felt across all areas of health care, we simply want to ensure that reported staffing information is reflective of the long term care industry’s efforts to fill the gaps created by the shortage. When reporting staffing

data, the data should include all hands-on staff time devoted to patients at the bedside. For example, staff reporting should be indicative of the availability of advanced care practitioners, occupational and physical therapy staff, social workers, dieticians and perhaps even educational staff that serve to enhance not only care-giver time but the level and quality of that care giving. More inclusive publicly disclosed staffing information would more fairly and accurately reflect the facilities commitment to care delivery at levels that assure the consumer his or her needs and expectations can and will be met.

In the area of providing more access to standardized complaint reporting by both patients and staff, it should be noted that nursing facilities are already mandated by federal regulation under the residents right's requirements at 42 CFR 483.10 to "inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing residents conduct and responsibilities." This regulation also gives residents the right to voice grievances without discrimination or reprisal and requires prompt efforts by nursing home staff to resolve grievances. Additionally, nursing homes are already required by federal regulation to post the names, addresses, and telephone numbers of all pertinent state client advocacy groups such as the state survey and certification agency, the state licensure office, the state ombudsman program, the protection and advocacy network and the Medicaid fraud control unit (483.10(b) (7) (iii)), this list could also include the state Attorney General as also required by state law. Under (483.10(b)(7) (iv)), nursing homes must also inform residents upon admission that they may file a complaint with the state survey and certification agency concerning resident abuse, neglect, misappropriation of resident property in the facility and on compliance with the advance directives requirements.

While we support a new standardized complaint form and process available to both consumers and employees, we simply urge any new forms and processes be integrated with current requirements to eliminate duplication that will add administrative cost and more importantly confusion for those filing complaints. We are, however, very concerned that some of the staff-specific whistleblower provisions of this bill will restrict employers' ability to appropriately supervise, manage and discipline employees when appropriate and necessary. We believe that the overly broad whistleblower protections in this bill will have the unintended consequence of making it incredibly difficult for an employer to not only discipline an employee, but could actually impact the reporting or filing of a complaint against a worker to appropriate State professional disciplinary agencies once that worker has filed a "quality of care or other issue" complaint against the facility. Without some qualifying language, we are concerned that this provision could protect unscrupulous employees from disciplinary action because they will be able to preempt discipline with a complaint against the facility, legitimate or not. We also have some concern about the whistleblower provisions effect on current employer/employee contractual mediation and arbitration dispute agreement.

Further, compliance programs crafted by this bill should require that the size of the organization be taken into account. We suggest that the HHS Secretary develop specific elements of a compliance program that consider the size of the organizations, including allowing organizations with fewer than 5 facilities to have more streamlined compliance programs. This is consistent with the Office of

Inspector General's Supplemental Compliance Program Guidance for Nursing Facilities, 73 Fed. Reg. 56834 (Sept. 30, 2008).

We are encouraged to see that a portion of the funds collected from civil money penalties (CMP) may be used for facility improvement initiatives such as joint training of staff and surveyors and technical assistance for facilities under quality assurance programs. However we oppose the increase of CMPs as unnecessary, punitive and not a motivation for improving facility behavior. Increasing monetary fines drains the facility of resources available for patient care.

Imposition of CMPs takes resources away from facilities thus decreasing available resources used to care for other residents. There already exists in law an ability to penalize the facility and for the family to be compensated.

While we agree that facilities that harm patients should be held accountable for their actions and that those who violate patients rights should be punished, there is no clear evidence to suggest that increasing civil penalties will deter those facilities from these behaviors. According to a 2007 GAO study requested by Senator Grassley, CMS hesitates to impose some CMPs that are higher than \$200 per day because that could bankrupt some nursing homes.

These CMP provision also provide no practical incentive for providers to self-report. There is little, if any, incentive for providers to self-report. The issues surrounding self-disclosure are complex. Properly determining what to disclose (i.e., what actually constitutes a violation of applicable law), when to report it and to whom to report requires careful consideration and a working knowledge of the fraud and abuse laws. If facilities invite the OIG to come in, the OIG and or surveyors will cite the facility for that self-reported deficiency and look for other deficiencies to cite. This is not a motivator to self-report.

It is essential to recognize that today's regulatory and oversight construct of long term and post-acute care providers is based upon yesterday's nursing facility and does not account for the shift in the patient mix and the type of care and services being delivered. Independent studies validate the fact that skilled nursing facilities are providing intensive rehabilitation and nursing care to a growing number of short-stay patients who return to their home and community, often within one month. At the same time, an increasing percentage of the nation's nursing facility population has significant cognitive difficulties – including advanced Alzheimer's disease – and more disabilities. Despite changes in patients and care provided, changes to the oversight system have not kept pace.

AHCA believes that achieving a sustained level of quality care will only be fully realized when there is a collaborative effort to recognize and implement improved health care technologies and best clinical practices designed to improve and enhance patient outcomes. This type of culture change is essential to appropriately address the needs of a growing patient population and a shrinking pool of caregivers.

Today, we know far more about promoting quality, and we have better tools with which to measure it than we did twenty years ago. We need to intelligently change the regulatory process to allow and encourage us to use what we have learned – to place quality over process, care over procedure, and most importantly, put patients at the forefront.

Essential Changes Needed to Inappropriate and Misguided 5 Star Rating Index

While not a focus of the discussion draft, we want to use this opportunity to address CMS' misguided and inappropriate nursing facility rating system. On December 18, 2008, during the last days of the Bush Administration, CMS published the *Five Star Quality Rating System* (Five Star) on its Medicare.gov website. While we agree that this system set out to help consumers make informed decisions, regrettably this rating system is terribly misguided and contains a critical methodological flaw that does not validly nor accurately assess or compare nursing homes. Five Star attempts to rank nursing facilities like restaurants giving them a star rating based on set criteria. Placing a loved one in a nursing facility is a complex decision and the information readily available to consumers must accurately address the components that comprise the complexity of the care provided in a facility.

Five Star utilizes a flawed methodology that allocates star ratings in three categories, survey reports, staffing, and quality measures. AHCA has long contended that the survey system is not an accurate measure of quality as it is subjective in nature and results vary from surveyor to surveyor not to mention from state to state. Further, the survey system is punitive in nature and does not reflect any positive aspects of care. A table found on the CMS website allocates stars for health inspections as follows: 5 stars-10%; 4 stars-23.3%; 3 stars-23.3%; 2 stars-23.3%; 1 star-20%. The survey component is the basis and the most heavily-weighted domain of the rating system.

The staffing standard used by the rating system is based on a study released in 2001 that CMS and Congress acknowledged it would never adopt nor fund due to the exorbitant cost. Additionally, the staffing information included in the rating system does not include all direct care staff. For example, therapy staff and physician extenders cannot be counted. If both CMS and Congress admit that this staffing standard is unattainable, how is it acceptable for facilities ratings to be contingent on such a standard?

The quality measures used in the rating system are also in a forced distribution – that is, only 10 percent of the facilities can receive a 5 Star rating (the highest rating) for this domain and 20 percent of the facilities will receive 1 star (the lowest rating). AHCA has also raised concerns that the patient case mix is not taken into account when assessing star ratings- as one can imagine staffing is heavily dependent on the type of patients being cared for in a given facility.

Apart from beginning with the unsubstantiated assumption that 43.3percent of our nation's nursing homes are below average by definition, under Five Star a facility that may be a five star in one state could be a three or four star or worse in another state. In a time when families are separated by state

lines a rating system that is incompatible from one state to another is not helpful when trying to make a decision on where to place a loved one.

The design of this system makes it impossible for all facilities to ever attaining a five star rating; additionally because of the set percentages of star ratings every nursing home's rating is dependent upon the rating of every other nursing home. The net effect of this methodology is that a nursing home's rating could be changed every month based on inspections of other nursing homes without that nursing home having made any changes at all. Conversely a nursing home that might have made significant improvement could find that its rating remains the same, or worse, declines.

Although the intent of the Five Star System was to be useful to consumers, the information is incomplete incompatible and misleading. AHCA asks that CMS remove the Five Star Rating System from the public website, and convene stakeholder groups to develop a more useful rating system. We ask that CMS test the new system and evaluate its usefulness to consumers with the input of providers. AHCA welcomes the opportunity to work with the new Administration, the Department of Health and Human Services and CMS to develop a rating system that will provide useful and accurate information to consumers that can be used to make informed decisions regarding care.

We ask that Congress urge CMS to withdraw the Five Star system until it can be reviewed by an independent, impartial third party, such as the U.S. Government Accountability Office (GAO) or that this Committee conduct hearings on this subject.

A Stable, Well-trained Workforce is the Building Block of Quality Long Term Care

All of us in this profession are acutely aware that human contact is essential to treating long term care patients and residents, and you will never be able to replace the role that people play in providing long term care. AHCA/NCAL has long recognized that the provision of high quality long term care and services is dependent upon a stable, well-trained workforce. However, America's long term care system is currently suffering from a chronic supply and demand problem when it comes to our labor force. Addressing this challenge on both fronts is the only real means to sustain the provision of high quality long term care.

We remain committed to partnering with Congress, the Administration, and other long term care stakeholders to ensure a qualified and well-trained staff is in place to care for our nation's elderly and disabled today – and in the coming years when the current crisis will hit epidemic proportions unless government intervenes.

The high demand for long term care workers is already documented by the federal government. A recent study by the Department of Health and 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.

America's nursing facilities have been facing a chronic direct-care workforce shortage for more than a decade. This shortage continues despite the current recession. In a recent study in *Health Affairs*, "The Recent Surge In Nurse Employment: Causes And Implications," the authors discuss the fact that the current recession is spurring dramatic increases in nurse employment, with as many as 243,000 nurses joining (or re-joining) the workforce in 2007-08. Unfortunately, most of the nurses returning to the workplace are not employed by nursing facilities. In the study, the authors also warn policy makers that despite "The recent increase in employment...[and] improving projections of the future supply of RNs... large shortages are still expected in the next decade. Until nursing education capacity is increased, future imbalances in the nurse labor market will be unavoidable."

Data collected and analyzed by AHCA/NCAL reaffirms the findings of the study reported in *Health Affairs*. AHCA's Vacancy & Turnover Survey released in late 2008 indicated that there were more than 110,000 vacant nursing positions nationwide, including Certified Nurse Assistant (CNA), Registered Nurse (RN) and Licensed Practical Nurse (LPN) positions. Since that report, given the current economic realities, AHCA pursued updated results in order to provide a "snapshot" of the current nursing shortages. Based on a limited number of responses, we have learned that while the 110,000 vacancies previously reported have decreased by approximately 50 percent, skilled nursing facilities still have significant numbers of vacancies—estimated to be approximately 50,000 nationwide. It is critical to note; however, that despite the effects of the recession, and the decrease in staffing vacancies, the easing of the staffing shortage is only temporary, so action must be taken now to prepare.

Vacancies and turnover in the long term care profession compromise sustained quality improvements and increase costs. In fact, a recent report from the *National Commission on Nursing Workforce for Long-Term Care* concluded that "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.

While efforts to recruit and train new qualified long term caregivers are costly, our profession has been aggressively pursuing potential nurses and caregivers. An unfortunate truth exists that nursing education programs are forced to turn away well-qualified applicants for the sole reason that there are not enough nurse educators to train these potential caregivers. In fact, the American Association of Colleges of Nursing found in its annual survey that more than 40,000 qualified applicants were not accepted into nursing programs primarily because of insufficient nurse faculty for the 2007-2008 academic year.

The 2.5 million frail, elderly and disabled patients and residents living in our nation's nursing facilities and assisted living communities deserve an adequate workforce to care for their needs. A strong and capable workforce is essential to meet the needs of those Americans that require nursing care now and in the future. The workforce investments we make now will affect the quality of long term care in the future. A 2008 Institute of Medicine (IOM) report, *Retooling for an Aging America: Building the Health Care Workforce*, called for immediate investments. It stated "The dramatically rising number of older Americans, along with changes in their demographic characteristics, health needs

and settings of care [that] will necessitate transformations related to the education, training, recruitment and retention of the health care workforce serving older adults.”

Therefore, we thank this Subcommittee and the three Committees of jurisdiction for recognizing the scarcity of all health care professionals – in addition to Registered Nurses - including administrators, through the inclusion of the Section 2231 Public Health Workforce Loan Repayment program. We also applaud the Committees for creating the Advisory Committee on Health Workforce Evaluation and Assessment and the National Center for Health Care Workforce Analysis to examine and analyze our Nation’s health workforce priorities, goals, and policies. Finally, we are especially appreciative of efforts in the Tri-Committee draft to address the nursing shortage by establishing the nursing career ladder grant programs, which increase capacity across both nursing education and practice settings. In addition, we respectfully request that further consideration be given to health care workforce development issues as the Tri-Committee draft is refined, and we look forward to working with members of this Subcommittee and the full Energy and Commerce Committee to do so.

Conclusion

We agree that not only do consumers deserve the highest quality care and services across the spectrum of health care settings, but also employees deserve well-paid, positive work environments. As the profession responsible for the care of our nation’s most vulnerable citizens, we are proud of the advances we have made in delivering high quality long term care services and we remain committed to sustaining these gains in the years and decades ahead.

Given the financial implications and care access problems that could be unfortunate and unintended consequences of reforms that do not provide the appropriate consideration of long term care, we believe it is a crucial time for us to work together to ensure that the future of America’s healthcare system continues to meet the skilled nursing and rehabilitative care needs of our nation’s seniors.

Thank you for the opportunity to offer these comments on behalf of millions of professional, compassionate long term caregivers and the millions of frail, elderly, and disabled Americans they serve each day. I look forward to responding to your questions.

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