

Testimony of Steven Pelovitz
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on
Nursing Home Bankruptcies
before the
Senate Special Committee on Aging
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Chairman Grassley, Senator Breaux, distinguished Committee members, thank you for inviting me to discuss the financial difficulties of some nursing homes and our efforts to ensure that residents continue to receive the high quality care they deserve. This has been a top priority for us, and I know it is a priority for you as well. We appreciate your interest in this area, and look forward to continuing our work together to ensure beneficiary access to critical nursing home services.

We have monitored closely the effects on nursing homes of the Balanced Budget Act of 1997 (BBA), the Balanced Budget Refinement Act of 1999 (BBRA), and our Nursing Home Initiative to improve oversight and quality. These efforts were essential to control unsustainable growth in nursing home spending, establish proper payment rates, and protect vulnerable nursing home residents. Overall, beneficiary access and quality of care have not been adversely impacted, but significant concerns remain.

As you know, the owners and operators of a number of facilities, including five of the 10 largest nursing home chains, have faced financial difficulties in the past few years. Approximately 1,600 nursing homes across the country now operate under Chapter 11 bankruptcy protection. This means that the organizations in their entirety are continuing to operate nursing homes, as well as other lines of business, while restructuring financial components of the company.

Financial news reports indicate that most of the troubled businesses share a number of common features, and their financial difficulties appear to stem largely from specific business decisions.

These chains generally had aggressively acquired new facilities and expanded rapidly for several years prior to our Nursing Home Initiative and changes in payment structures. They leveraged themselves heavily, paying top dollar for their acquisitions and allowing their debt-to-equity ratios to spiral precipitously.

Meanwhile, other chains have adjusted successfully to the different payment structure and the increased oversight stemming from our Nursing Home Initiative. Additionally, in a December 1999 report, "Skilled Nursing Facilities: Medicare Payment Changes Require Provider Adjustments but Maintain Access," the GAO indicated that nursing homes continue to enjoy adequate profit margins, and that Medicare payment levels are appropriate for the services they provide. Working with the State agencies, we have monitored this situation very closely and have had to relocate only a very small number of residents. To date, there has generally been minimal impact on beneficiary access to care and the quality of care in financially troubled institutions.

Nonetheless, we are concerned about the potential for financial difficulties to impact access and quality. And we appreciate the challenge providers face in adapting to new payment systems. Under our latest baseline, FY 2001 payments to nursing homes will increase by \$2.6 billion, nearly 20 percent above the FY 2000 level. In addition, the President is proposing to increase Medicare nursing home payments by about \$1 billion over the next five years, and we look forward to working with you to enact these changes.

BACKGROUND

Protecting nursing home residents is a priority for this Administration and our Agency. Some 1.6 million elderly and disabled Americans receive care in approximately 17,000 nursing homes across the United States. The Medicaid program, in which States set reimbursement levels, pays for the care of about two-thirds of nursing home residents and is responsible for about half of nursing home revenues. The Medicare program pays for care of about 10 percent of residents, accounting for 12 percent of nursing home revenues.

Medicaid, which is administered by the States, covers close to two-thirds of nursing home residents and accounts for about half of nursing home revenues. The federal government also provides funding to the States to conduct on-site inspections of nursing homes participating in Medicare and Medicaid and to recommend sanctions against those homes that violate health and safety rules.

In July 1995, the Clinton Administration implemented the toughest nursing home regulations ever. However, both we and the GAO found that many nursing homes were not meeting the requirements, and that State enforcement efforts were uneven and often inadequate. Therefore, in July 1998, President Clinton announced a broad and aggressive initiative to improve State inspections and enforcement, and crack down on problem providers. To strengthen enforcement, we have:

- ▶ instructed States that they have the ability to look at an entire corporation's performance when serious problems are identified in any facility in that corporate chain, worked with States in developing more detailed guidelines for chains with performance problems, and required States to develop and submit State contingency plans for chains with financial problems. Furthermore, we are working to refine our instructions in the State Operations Manual, a draft of which is currently available for public comment;
- ▶ expanded the definition of facilities subject to immediate enforcement action without an opportunity to correct problems before sanctions are imposed;
- ▶ identified facilities with the worst compliance records in each State, and each State has chosen two of these as "special focus facilities" for closer scrutiny;
- ▶ provided comprehensive training and guidance to States on enforcement, use of quality indicators in surveys, medication review during surveys, and prevention of pressure sores, dehydration, weight loss, and abuse;
- ▶ instructed States to stagger surveys and conduct a set amount on weekends, early mornings and evenings, when quality and safety and staffing problems often occur, so facilities can no longer predict inspections;
- ▶ required State surveyors to revisit facilities to confirm in person that violations have been

- corrected before lifting sanctions;
- ▶ instructed State surveyors to investigate consumer complaints within 10 days;
 - ▶ developed new regulations to enable States to impose civil money penalties for each serious incident;
 - ▶ met with the Department's Departmental Appeals Board to discuss increased workload due to the Nursing Home Initiative;
 - ▶ established a set of State Survey Agency performance standards to ensure that the Agencies are executing their duties in accordance with our contract terms. These standards are scheduled for implementation on October 1, 2000; and
 - ▶ issued a prioritized list of tasks to State Survey Agencies, laying out which duties should be completed with the highest level of urgency.

We also are now using quality indicators in conjunction with the Minimum Data Set that facilities maintain for each resident. These quality indicators furnish continuous data about the quality of care in each facility. They allow State surveyors to focus on possible problems during inspections, and will help nursing homes identify areas that need improvement.

In addition, we have been working to help facilities improve quality, including:

- ▶ posting best practice guidelines at hcfa.gov/medicaid/siq/siqhmpg.htm on how to care for residents at risk of weight loss and dehydration;
- ▶ testing a wide range of initiatives to detect and prevent dehydration and malnutrition;
- ▶ working with the American Dietetic Association, clinicians, consumers and nursing homes to share best practices for preventing these dehydration and malnutrition; and
- ▶ beginning a national campaign to educate consumers and nursing home staff about the risks of malnutrition and dehydration and nursing home residents' rights to quality care.

We also are continuing to develop and expand our consumer information efforts to increase awareness regarding nursing home issues. We now are conducting a national consumer education campaign on preventing and detecting abuse.

And we are working to educate residents, families, nursing homes, and the public at large about the risks of malnutrition and dehydration, nursing home residents' rights to quality care, and the prevention of resident abuse and neglect. These efforts include our *Nursing Home Compare* Internet site at *medicare.gov*, which allows consumers to search by zip code or by name for information on each of the 17,000 nursing homes participating in Medicare and Medicaid. The site is recording 500,000 page views each month and is by far the most popular section of our website.

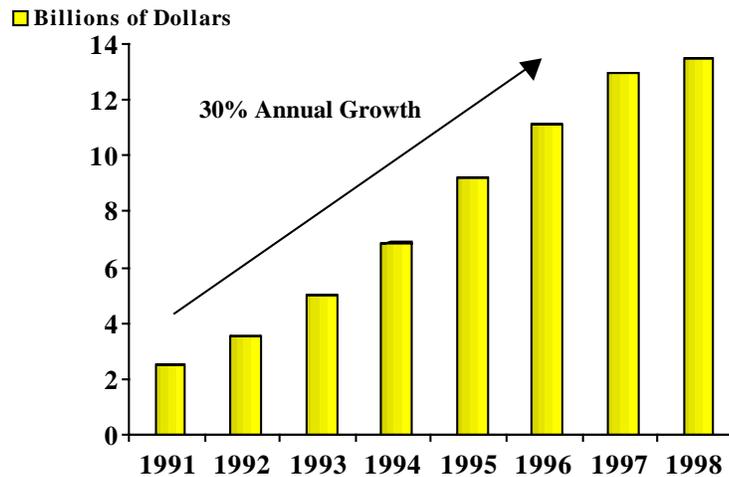
Nursing Home Payments

As mentioned above, the Medicare program pays for the care of only about 10 percent of the nursing home residents. Approximately two-thirds of residents are covered by State-administered Medicaid programs, to which the federal government adds matching dollars. The remaining residents pay out-of-pocket or are covered by long term care or other private insurance. In 1997, the BBA required a new process for States to determine Medicaid payment rates for nursing home services, one that eliminates Federal review of State rates, thus giving States greater flexibility; but which requires public comment on the adequacy of payment levels.

The BBA also acted to address unsustainable growth in Medicare nursing home spending. Since 1986, Medicare payments for nursing home services had been surging upward at an average rate of 30 percent each year, climbing from \$578 million to over \$13 billion. And the Medicare Payment Advisory Commission has reported that, although routine costs were paid on a set per diem rate, payments for ancillary services were growing at a pace five times that of service usage.

By reimbursing based on whatever nursing homes reported as costs, Medicare had little control over potential over-utilization of services. In fact, according to the GAO and Health and Human Services Inspector General (IG), under cost-based reimbursement beneficiaries often were subjected to unnecessary or excessive therapy.

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The BBA therefore required Medicare to implement a new prospective payment system (PPS) for nursing homes, similar to the payment system used for hospitals since the early 1980s. Prospective payment systems are based on patient need and episodes of care, and create incentives to provide care efficiently.

The PPS is designed to “pay right,” allowing Medicare to pay for care provided based on national data, weighted by case mix and geographic area for individual facilities. The PPS rates were developed using actual cost data representing the cost level necessary for the efficient delivery of health services. Using this actual cost data, payment rates are established under the PPS which provide appropriate payments for nursing home services. These payment rates are updated to

reflect changes in the acuity level of the Medicare beneficiaries served by the facility, geographic wage variation, inflation, and Metropolitan Statistical Area.

The Medicare nursing home PPS established more appropriate payment levels for Medicare nursing home services. This and other BBA fiscal discipline, along with our success in fighting fraud, waste, and abuse have helped to greatly improved the status of the Medicare Trust Fund. It is now projected to remain solvent until 2025, 26 years beyond where it was just 8 years ago. The prospective payment systems mandated by the BBA are particularly important because they create incentives to provide care efficiently. However, these new payment systems mark a substantial departure from cost- and charge-based reimbursement, and the transition can be challenging for providers.

The new PPS for nursing homes went into effect in 1998. This new system contributed to changes in the nursing home market. Recent GAO and HHS Inspector General (IG) studies have found that some nursing homes have been more cautious about admitting high-cost cases. One study found that 58 percent of hospital discharge planners reported that Medicare patients requiring extensive services such as intravenous medications have become more difficult to place in nursing homes. The IG is today reporting that 80 percent of hospital discharge planners report no problems in placing beneficiaries in skilled nursing facilities.

Additionally, several large private nursing home chains have experienced financial problems. Approximately 1,600 nursing homes now operate under Chapter 11 bankruptcy protection. Financial news reports conclude that most of the troubled facilities are in chains that generally had aggressively acquired new facilities and expanded rapidly for several years prior to our Nursing Home Initiative and changes in payment structures. They leveraged themselves heavily, paying top dollar for their acquisitions and allowing their debt-to-equity ratios to spiral precipitously.

More for-profit organizations that operate nursing homes currently are operating under Chapter

11 bankruptcy protection than non-profits. This is consistent with the fact that approximately 65 percent of nursing homes are owned by for-profit companies nationally. Publicly held, for-profit companies that are operating in bankruptcy own about nine percent of nursing homes nationally, constituting the bulk of nursing homes operating in bankruptcy. In part, for-profit companies, particularly publicly held companies, had broader access to greater amounts of capital than non-profit companies. This provided the basis for the aggressive acquisition strategies and accumulation of high levels of debt that, in turn, have been cited as reasons for the financial difficulties some of these companies are experiencing.

While these difficulties are due primarily to business practices unrelated to Medicare, changes in Medicare payment systems and improved oversight may have exacerbated the impact of some businesses' aggressive growth strategies.

The BBRA made a number of changes to the PPS to facilitate nursing homes' transition to the new payment methodology. These included a temporary increase of 20 percent for 15 categories of residents, as well as a four percent increase for all beneficiaries in fiscal years 2000 and 2001. For the most part, our implementation of these increases has gone smoothly. Although computer system changes prevented us from implementing the temporary 20 percent increase for certain beneficiaries immediately, nursing homes now are receiving the increased payments, and we are paying these retroactively to April 1, 2000, the intended start date. Additionally, the BBRA allowed certain high cost items, such as certain prosthetics and some chemotherapy-related codes, to be paid outside of the PPS, increasing payment for some medically complex care. Today, the Medicare baseline for nursing homes shows about eight percent growth.

Protecting Beneficiaries

Although Medicaid programs pay for the majority of nursing home services, we have a responsibility to ensure adequate access to care for both Medicaid and Medicare beneficiaries. In light of public reports of financial troubles at some nursing home chains, we have been working with the States since early 1999 to ensure that residents continue to get the kind of care that they

deserve and that federal and State regulations require. We have taken steps to ensure that States develop and refine contingency plans for safeguarding residents.

We also instructed States to monitor conditions in financially troubled nursing homes. Within four weeks after a nursing home chain has filed for bankruptcy, the State Survey Agency conducts onsite monitoring to the affected facilities in their State. The State Survey Agencies use a protocol specifically designed for monitoring these facilities, and we maintain contact with State Agencies regarding these situations. Following the initial visit, the State Survey Agencies exercise their discretion to determine whether or not a facility requires additional monitoring.

Generally, the State Survey Agencies have not reported any significant disruptions in these financially troubled facilities; and we work with the facilities to avoid patient relocation whenever possible. The State Survey Agencies monitor the residents in these troubled facilities on an ongoing basis, and provide the HCFA Regional Offices with updates. While there have been isolated cases where residents have been impacted, we have had to relocate only a small number of these residents. For example, in one case in Texas, three homes were closed and the residents were forced to move. In each case, representatives of the State Survey Agency and our Regional Office were on-hand to assist with the resident transfers, and all were relocated successfully to other facilities. Such individual cases illustrate how we have made every effort to minimize disruptions to the nursing home residents when relocation was the only reasonable alternative.

In addition to meeting with States, we have had regular monthly meetings with the Department of Justice and the IG to discuss nursing home issues and the bankruptcy proceedings. We also have met repeatedly with the management of major chains, both before and after they filed for Chapter 11 bankruptcy protection. Furthermore, the IG has developed corporate integrity agreements with several large nursing home chains in order to focus on ensuring quality care for residents even while the chains face financial difficulties.

President's Proposals

Under our latest baseline, payments to nursing homes will increase by \$2.6 billion for next year, exceeding the FY 2000 level by almost 20 percent. In addition, the President's FY 2001 budget proposes changes that would increase Medicare nursing home payments by about \$1 billion over the next five years.

The President's plan would:

- ▶ delay for an additional year (until FY 2002) the application of the therapy caps providing additional time for development of policies;
- ▶ replace the BBA's nursing home update of market basket minus 1 percentage point with a full market basket update for FY 2001; and
- ▶ eliminate the proposed reduction in Medicare reimbursement for bad debt.

The President proposed delaying the application of the therapy caps because we are concerned about the yearly payments for Part B physical/speech therapy and occupational therapy, which the BBA limited to \$1,500 each per beneficiary. Under this provision, some therapy patients exceeded the payment limits and either had to pay for the care out-of-pocket or discontinue the medically necessary service. The BBRA put a two-year moratorium on the limits while a study is conducted to determine appropriate payment methodologies that reflect the differing therapy needs of patients. However, the moratorium may not be long enough to complete this complicated work, and so the President proposed another delay in the application of the therapy caps.

We are continuing to work to refine the payment classification system in a budget neutral way to ensure adequate payment for medically complex residents, and particularly to account more specifically for the cost of drugs and other "non-therapy ancillary" services. Using the best data available at the time we initiated the research, we developed two payment classification models we believed would ensure adequate payment for complex residents. The data was limited to the experience of facilities in six States in the years immediately before the PPS was implemented.

We issued a proposed rule in April 2000 which included refinements based on these models and solicited public comments. In addition, we contracted with outside experts to validate the models using more recent data. When we tested the models with nationwide data following the implementation of the PPS, we found that the models were no longer statistically significant in identifying high-cost beneficiaries with complex care needs and the ancillary services they use.

Proceeding with implementation of the proposed refinements based on these models could have changed payment levels without any assurance that we were distributing funds more equitably, creating incentives for efficient care, or minimizing the risk of negative financial consequences. We therefore are deferring the implementation of the refinements.

Shortly, we will begin consulting with outside researchers and experts to begin further analysis using the 1999 national data aimed at determining the feasibility of developing case-mix refinements that reflect current practice. Our goal is to propose such refinements as soon as possible. However, until a feasibility study is completed, we will be unable to accurately forecast the potential and timing of such refinements.

In the meantime, the temporary 20 percent increase in payments included in the BBRA will remain in place until refinements of the system can be implemented, which will be in fiscal 2002 at the earliest. And as I noted, in addition to the temporary 20 percent increase, the BBRA also provided a 4 percent increase in payments for all nursing home beneficiaries.

Ongoing research to quantify the staffing ratios necessary for quality care is another essential step in our efforts to improve the quality of life and care for nursing home residents. The research was mandated by Congress in 1990, with a report due in 1992. This proved to be much more challenging than anticipated. Our report on the initial phase of this research establishes for the first time in a statistically valid way that there is, in fact, a strong association between staffing levels and quality of care. Many had long suspected as much, but this had never before been documented. The findings from the three States examined demonstrate that there are

significantly more problems in facilities with less than 12 minutes of registered nursing care, less than 45 minutes of total licensed staff care, and less than 2 hours of nursing aide care per resident per day. Numerous facilities in the study do not meet these levels of care, and the results suggest that many facilities may need to increase staffing levels. While these findings are troubling, and represent a major step forward in understanding the relationship between staffing levels and quality of care, they are preliminary. We now are working to address remaining issues.

The second phase of this research initiative involves:

- ▶ evaluating staff levels and quality of care in additional States with more current data;
- ▶ validating the findings through case studies and examining other issues that may affect quality, such as turnover rates, staff training, and management of staff resources;
- ▶ refining case mix adjustment methods to ensure that any minimum staffing requirements properly account for the specific care needs of residents in a given facility;
- ▶ determining the costs and feasibility of implementing minimum staffing requirements and the impact on providers and payers, including Medicare and Medicaid.

In the meantime, we want to work with Congress, States, industry, labor, and consumer advocates to evaluate ways to ensure that all nursing home residents receive the quality care they deserve. These strategies include improving staffing levels, improving training, increasing dissemination of performance data, strengthening enforcement, and enhancing intensity of survey and certification practices.

CONCLUSION

It is essential that we ensure Medicare and Medicaid beneficiaries continue to have access to the high quality care they deserve. Chairman Grassley, you and this Committee have made great contributions to these efforts, and we greatly appreciate the work you have done. Over the past few years, we have worked hard and made progress in ensuring that nursing home residents receive quality care and that we pay appropriately for this care. We continue to work on a number of fronts to protect nursing home residents and ensure beneficiary access to nursing

home services as some businesses reorganize under Chapter 11 protection. We greatly appreciate your interest in this matter. And we look forward to continuing our work with you to make sure beneficiaries receive the care and quality they deserve. I thank you for holding this hearing, and I am happy to answer your questions.

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