

## **Statement of Dr. Charles Roadman**

Thank you Chairman Grassley, and thank you Members of this Committee, for the opportunity to testify here today. On behalf of the American Health Care Association (AHCA), I look forward to continuing to work with you and your staff, and with every member of this Committee, to better the lives of America's seniors -- and to ensure those providing care are doing so in a manner that always puts patients and quality care first.

As President and CEO of the American Health Care Association, I represent a non-profit federation of affiliated associations representing more than 12,000 non-profit and for-profit assisted living, skilled nursing and subacute care providers, nationwide.

In addition to my statement today, I would respectfully ask that the charts and documents I'll be referencing be entered into the full record of this hearing.

While the hearing today focuses on the causes and subsequent problems associated with the immediate skilled nursing facility bankruptcy crisis, I believe we cannot examine this crisis isolated from the long-range economic viability of skilled nursing care for our elderly. That's because provider bankruptcies are the end result of a long chain of chronic, systemic failures -- many of which, I contend -- are the result of federal government policies -- however well intended -- that left providers unable to support a long term care or skilled nursing care infrastructure created by good faith business decisions.

I wish to emphasize four key points:

- Skilled Nursing Facilities (SNFs) are an essential component of our health care system - the delivery structure has been shaped in large part by public policy decisions;
- The current economic crisis threatens both current and future beneficiary access -- without adequate reimbursement to meet operating and capital requirements, providers cannot survive;
- Performance expectations must be intimately coupled with resources - public sector demands have not been matched with public sector commitment of resources;
- Market failures are the direct consequences of public policy and implementation decisions; to meet beneficiary needs, the long term care community must partner with the government.

### **SNFs are providing essential services:**

First, let's make it clear why we are all here today: Approximately 2 million Americans need and receive Medicare covered skilled nursing care every year. That number will increase exponentially as Baby Boomers and their parents age and confront limitations in activities of daily living (ADLs). Two out of three of current residents in skilled nursing facilities are women, aged 80 or older, left without a spouse or constant family caregiver. By anyone's reckoning, these patients are the most vulnerable segment of our population, and most depend on 24 hour skilled nursing care.

It's no overstatement to say that the typical SNF beneficiary puts the overall quality of the rest of his or her life in the hands of our profession. It's our charge to provide quality medical care to improve their health and quality of life, get them back on their feet and back home, or, to a homelike setting within the community. This is a benefit that, over Medicare's many years, has become a true cornerstone of the program.

Mr. Chairman, the rise of skilled nursing facility Medicare utilization during the past decade reflects legitimate clinical efforts by providers to meet beneficiary needs. As envisioned by Congress, skilled nursing facilities have become centers for post-acute rehabilitation and restorative services.

Meeting the needs of higher acuity, post-acute discharge patients have very clearly, whether we like it or not, transformed facility roles, functions and cost structures. The landscape in which skilled nursing facilities operate in the year 2000 is far different, and far more challenging and complex, than just 10 or 20 years ago.

As facilities stepped up and met these new challenges and complexities, the number of patients qualifying for Medicare grew. Today, more than half of all patients admitted to skilled nursing facilities are Medicare qualified.

Certainly, the importance of a viable Medicare system to providers is unmistakable, and some of the problems are painfully evident: A recent analysis from The Lewin Group, an independent public policy research firm, shows, for example, that Medicare reforms in the 1997 Balanced Budget Act were *intended* by Congress to reduce SNF benefit spending over the following seven years by *one out of every six dollars*, and that's how the CBO scored those reforms at the time.

Subsequent 1999 CBO projections have forecast reductions twice as large -- or, *one out of every three dollars*. In the aggregate, between the years 1998 and 2004, federal spending for skilled nursing facility care is now projected by CBO to be \$15.8 billion less than Congress anticipated and agreed upon. These figures are based on solid research. A copy is provided attached to our submitted testimony, and I encourage you and/or your staffs to peruse it. We have also included a breakdown of Medicare losses state-by-state.

Although Congress passed the BBRA last year to restore vital Medicare funding for SNF care -- and that was helpful -- Medicare SNF outlays continue spiraling downward. The BBRA budgeted an increase of SNF spending in FY 2000 to \$13.3 billion, yet, again, the CBO reports that that SNF spending will actually come in \$2 billion below the budget.

### **Public Policy Failures:**

Mr. Chairman, I want to speak directly to recent assertions by the GAO that there is no crisis in long term care, that bankruptcies affecting close to 2,000 skilled nursing facilities is not problematic, and that any difficulties confronting all providers are the direct result of business decisions. It is important for the Committee to understand the sequence of events, and how we got here.

From 1990 through 1997, providers and HCFA participated in demonstration projects to test the details of a prospective payment system. The entire profession, based in large part on its experience with the demonstration project, supported the prospective payment system. With the exception of one important area, providers had a sense of what to expect. That area, non-therapy ancillaries - which includes prescription drugs and ventilator care - was not well accounted for in the system. HCFA gave assurances that the PPS would include a component to account for non-therapy ancillaries when the final rates were published. It did not.

Prior to that, long term care providers made strategic business decisions as to how to phase into the new PPS. They looked at all major aspects of skilled nursing care, including rehabilitation, nursing, and prescription drugs. They made decisions as to how to structure their companies, not alone -- but with the scrutiny of literally hundreds of bankers, credit analysts, and institutional investors based on information

provided by HCFA. This information portended a system that would ensure efficiencies in the delivery of skilled care rather than not paying for certain necessary services.

When we sat down with HCFA and Congress in developing this system, it was widely expected that skilled nursing care would experience a \$19.8 billion reduction upon implementation of PPS. The reality has been that the PPS has cut more than \$35.6 billion from SNF care - \$15.8 billion more than originally anticipated.

Attached is a recent analysis completed by KPMG analyzing the adequacy of RUG rates for achieving the nurse staffing standard used by HCFA in developing its rate methodology. Mr. Chairman, I think you will find it astonishing to note that the initial rate structure *was* and *continues to be* grossly inadequate. It can be seen based on HCFA's own information, the overwhelming majority of PPS rates relating to the nursing case mix component is insufficient.

The rates understate nursing by nearly 14%, with the average deficit in rural areas being nearly 17%. In some RUG categories, HCFA's under recognition of nursing costs are in excess of \$30 per day. Out of the 44 RUG categories, nursing costs are met in only one of the rural categories, and only three of the urban categories. Obviously, flaws were made in the calculations of the rates.

Mr. Chairman, the implementation of the PPS has penalized those providers that have stepped up to serve Medicare beneficiaries in need of skilled nursing care. Those who invested in the infrastructure to facilitate patients' return to the community for high acuity hospital discharge Medicare beneficiaries are those providers who were most adversely impacted by these cutbacks. These investments included highly skilled staff, on-site therapy services and specialized medical equipment to address the health care needs of patients with complex medical and rehabilitative needs.

Bankruptcies among skilled nursing facilities have reached an alarming figure of approximately 2,000 facilities in the last year alone. But, let me state very, very clearly, on the record, to everyone here today: This is just the tip of the iceberg. Our long term care community is facing a squeeze with the real potential for absolute collapse that will put at risk care for all SNF patients -- We are faced with countless challenges affecting caregivers and patients alike. Among them....

- Medicare cuts, which are *much deeper* than anticipated;
- A grossly underfunded Medicaid system, which pays for two out of every three of our nation's 1.5 million patients -- truly a staggering figure;
- The "capital flight" of the private investment sector is a serious problem; we simply can't improve quality in long term care without having resources to invest in infrastructure;
- The evaporation of nearly all of the profession's market equity support, resulting in a loss of 85% of investment capital;
- A poor patient index classification system;
- An inadequate baseline;
- An overly complex PPS that does not reflect patient needs;
- A subjective and ineffective survey and enforcement system that is not functioning in the best

interests of patient care;

- An alarming national trend of skyrocketing liability insurance premiums which is causing a flight of good providers from the state of Florida, with many states soon to follow unless tort reform is implemented;
- And, a staffing crisis, with more than 100% annual staff turnover -- 100%! Employee recruitment and retention in a booming economy at such low wages is a very significant concern.

### **Consequences of Public Policy Failures:**

These factors have had a dramatic impact on SNF viability - and quality and access are next.

Contrary to rumors, access to services has become a problem -- especially in rural areas. And these problems with beneficiary access will become more prevalent in the upcoming months, as the squeeze intensifies.

Looking back at the August 1999 Office of the Inspector General (OIG) report examining the effects of the PPS on access to SNFs, the findings included the following:

When asked which types of patients have become more difficult to place in nursing homes, the majority of discharge planners -- 58% -- identified patients who require extensive services, according to the OIG. "These types of patients typically require complex direct nursing care and expensive medications. They include patients who require intravenous feedings, intravenous medications, tracheotomy care or ventilator care," the report says.

- One-third of all hospital discharge planners said it was difficult to place Medicare patients in SNFs.
- Approximately 20 % said placement has become more difficult in the past year due to PPS implementation.
- Sixty-five percent of hospitals discharge planners say PPS has had an effect on their ability to place patients.

So, as stated by the federal government's own data, access *IS* a problem.

Equally important has been the impact on the vital fiscal signs of the sector. The attached three graphs detail the severe financial realities we are facing:

- The first, is what I call the "stack of pennies," which shows the division of payment out of each dollar of payment for care -- this is a very labor-intensive sector - - margins have historically been very low; but the economic reality is that most nursing facilities are receiving little or no fiscal return for their efforts.
- The second depicts the market capitalization fall off - - the financial economic crisis was not caused by increased debt, it was caused by decreased revenues. The growth spurt of the early 1990's was fueled by investor confidence -- the changes of the BBA undermined this confidence, and they have left the skilled nursing community without sufficient capital to sustain service capacity.

- And the third shows 1995 -1998 data costs incurred vs. annual inflation update -- costs rose 27.4%, reimbursement increased 8.2% -- no business can remain viable under such shortfalls.

### **Meeting Resident Needs:**

Credit must be given to the hundreds of thousands of caregivers and providers who, while faced with these tremendous challenges in a very demanding and difficult environment, continue to do right by patients and work tirelessly to maintain a level of quality care. Accompanying me today are a number of those dedicated individuals who provide quality, compassionate care 24-hours a day under very challenging circumstances.

### **Partnering to Meet Resident Care Needs:**

While there are those that want to dwell on what happened and why, our real focus must be on what needs to be done and how quickly. This hearing offers a unique opportunity for all of us to focus on defining real solutions.

As the attached "King/Muse analysis" outlines, we believe certain critical steps can and should be taken immediately. They are:

#### ***First: Adjust the SNF PPS base to account for the flawed update factor between 1995 and 1998.***

*Specifically, we have documented the need for a one-time upward adjustment of 13.5% to the SNF PPS base to account for forecast errors between 1995 and 1998.*

#### ***Second: Develop a process for revising the SNF market basket.***

*The current skilled nursing facility market basket index is seriously flawed. It is not a specific measure of skilled nursing cost changes, nor is it an accurate predictor of cost changes in a dynamically changing care environment.*

*We strongly support a formal process by the Administration to review the SNF market basket to ensure it keeps pace with and fully accounts for the actual increases in costs incurred and reflects changes that will affect costs in the delivery of skilled nursing care.*

#### ***Third: Medicare reforms should include an updating of the SNF benefit.***

*We believe Congress must act to protect beneficiaries from excessive co-payments, must act to eliminate outdated controls on access to the benefit and must act to remove barriers to care management.*

These steps address only part of the issues. We confront other issues that impact and are unalterably interwoven into the overall big-picture -- specifically, the issues of staffing, the chronic underfunding of Medicaid at the state level, and the survey and enforcement issue.

I would be remiss if I did not briefly discuss the chaotic state of the survey and enforcement system. The shared goal of the long term care community, government and the public is quality care in a safe and secure environment for all nursing facility patients. However; the current survey and certification process doesn't serve that goal. These are my observations and proposed solutions:

- Nursing facilities should have access to a uniform, effective, objective and timely dispute

resolution process as a way to appeal survey findings.

- Surveyors' decisions must be based on objective evaluations of actual end results of care, rather than non-specific determinations.
- Surveyors should be prohibited from overriding physicians' orders, or from inspecting areas in which they are not professionally qualified. Where problems do exist, facilities should be given the opportunity to correct problems, *especially when a violation does not cause physical harm to residents.*
- My final point on the survey system: The federally mandated nursing home inspection process should allow inspectors to work with facilities to solve problems. Federal government policy related to nursing home inspections actually prohibits nursing home inspectors from supplying information to caregivers that might help in correcting problems. The government's "no collaboration" policy is an obstacle to ongoing improvements in quality. If our common goal is to correct problems quickly and ultimately improve care, this policy is illogical.

### **Conclusion:**

My assessment is clear -- the government's commitment to fund quality care is wavering -- Medicare funding for nursing facility care has been seriously cut, and Medicaid programs across the country are traditionally and, in some cases, grossly underfunded to the point of paying an average \$4 per hour for care in a nursing facility. Sadly, Mr. Chairman, this is less than we pay a teenage babysitter.

Medicaid has become the default payer for people needing nursing facility services as it pays for two out of three residents nationwide. We believe there should be federal oversight of Medicaid payments, and we propose that there must be a minimum Medicaid rate standard, or floor, which will cover basic costs for quality patient care.

Government is demanding higher quality care and staffing while increasing regulations and providing fewer resources to provide it. As you know, Mr. Chairman, the American Health Care Association has taken a strong stance embracing many of the recent recommendations of the HCFA study on nursing home staffing that your committee requested. I have attached a copy of this most recent position paper. We, to believe optimum staffing is related to high-quality care; at the same time, we need your help in making sure that there are adequate resources to recruit and retain nursing staff...and the help of the Congress in creating an environment to stimulate a positive environment for caregivers. It is one thing to establish standards. It is another to help us reach them.

As we continue this important dialogue about the best means by which to address all of the issues discussed today, I want to leave the Committee with this message: We all want the best for our patients, we're always interested in improving the overall skilled nursing system itself, and we seek to work in a positive and constructive manner that *always puts patients and quality care first.*

I believe we face a national crisis - coming on quickly - that will try the very soul of this nation...how we care for our young, elderly and disabled in this country.

This is clearly a public policy issue - *NOT* a medical-long term care problem.

So, Mr. Chairman, we need help to accomplish these goals. We look forward to working with you, and this Committee, to accomplish our mutual and positive objectives that, in the end, help the many seniors

in our nation who need and deserve not just our care, but our compassion as well.

Thank you.