TESTIMONY OF
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ON
NURSING HOME QUALITY
BEFORE THE
SENATE FINANCE COMMITTEE
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Chairman Grassley, Senator Baucus, distinguished Committee members, thank you for inviting me to discuss the quality of care provided by nursing homes across the nation. The care of nursing home residents is a high priority for the Bush Administration, the Department of Health and Human Services (HHS), and the Centers for Medicare & Medicaid Services (CMS). In 2003, about 3.5 million elderly and disabled Americans will receive care in our nation's nearly 17,000 Medicare- and Medicaid-certified nursing homes. Just more than half of these are long-term nursing home residents, but nearly as many will utilize nursing homes for rehabilitation care for shorter periods after an acute hospitalization.

The status of the nursing home industry is of no small concern to CMS. The nation is aging, and with an increasing percentage of the baby boom generation entering retirement, the need for high quality nursing home care will grow in the coming years. State and federal governments now pay roughly 60 percent of all long-term care costs, while those needing care and their families pay for 30 percent of costs. A variety of sources, including long-term care coverage, account for the remaining 10 percent. Among the larger nursing home companies, Medicare beneficiaries typically account for 10 percent to 15 percent of the home's population, while Medicaid beneficiaries typically account for 65 to 70 percent of nursing home residents. As the number of older Americans continues to increase, CMS is committed to working with Congress to ensure that America's elderly and disabled receive the high quality care they need.

Mr. Chairman, I would like to take this opportunity to commend you for your leadership on the important issue of nursing home quality. Through your work with CMS, you have highlighted the importance the Administration places on quality, something Secretary Thompson and I have championed since we started with HHS. You also have continually shined a spotlight on areas that need improvement. The GAO reports you have commissioned have served as a tool for evaluating our progress in improving nursing home quality, while at the same time highlighting issues that warrant our attention. Today, I would like to bring to your attention the efforts we are taking to publicly report information about the quality of care available and how that has informed quality improvement efforts in nursing homes nationwide.

GAO NURSING HOME ASSESSMENT

A General Accounting Office report, requested by Chairman Grassley and released today, indicates that the proportion of nursing homes nationwide with serious quality problems has declined "significantly" in recent months. For an 18-month period ending January 2002, actual harm at nursing homes was cited in one-third fewer homes, down to 20 percent from 29 percent in the prior period. In addition, the report found fewer discrepancies between federal and State surveys of the same nursing facilities, indicating that State surveyors are doing a more accurate job and that the drop in the number of serious problems at nursing homes is real. Additionally, the report found that CMS oversight of State survey activities has improved.

The report made several recommendations for how CMS should continue to ensure that nursing homes comply with Medicare and Medicaid quality standards. We are actively addressing the report's recommendations. For example, the report recommended that CMS finalize the development, testing, and implementation of a more rigorous survey methodology to include guidance for surveyors in documenting deficiencies. To this end, we have moved to assist States in improving the effectiveness of the survey process, including contracting to develop surveyor guidance on a series of clinical issues such as pressure sores, hydration and nutrition, accidents, unnecessary medications, and psychosocial harm. The report recommended that the Agency finalize the development of guidance to States for their complaint investigation processes and ensure that the guidance addresses key weaknesses, including the prioritization of complaints for investigation, the handling of facility self-reported incidents and the use of appropriate complaint

investigation practices. Regarding this concern, CMS is developing and implementing the Aspen Complaints Incident Tracking System (ACTS). The ACTS will be a national complaint system that will standardize reported complaints and incidents so that analysis across States can be accomplished. Eventually, we expect to advance complaint improvement efforts that will not only address complaint investigation practices toward improvement, but also the prioritization of complaints.

The GAO report also recommended that CMS further refine annual State performance reviews so they: consistently distinguish between systemic problems and less serious issues regarding State performance; analyze the trends in the proportion of homes that harm residents; assess State compliance with the immediate sanctions policy for homes with a pattern of harming residents; and analyze the predictability of State surveys. CMS has already modified our FY 2003 State performance standards to differentiate between statutory and non-statutory performance standards. We have incorporated the ability to distinguish between systemic problems and less serious issues and will continue to look at homes with varying levels of harm through the work we have done with our Nursing Home Data Compendium, which is widely available to regions, States, Congress, and other stakeholders. Currently, we are working on a data program to ascertain when individual nursing homes have deficiencies that would cause an immediate sanction for instances of actual harm.

Additionally, the GAO report indicated CMS should require States to review a sample of survey reports below the level of actual harm to assess the appropriateness of the scope and severity rating cited to help reduce instances of understated quality of care problems. Given the importance of this concept, CMS has already incorporated such reviews into Standard 2 of the State Performance Standards, which requires regions to take a sample of Statement deficiencies to evaluate a State's ability to document deficiencies. We will continue to refine this standard to better evaluate the sufficiency of documentation of varying harm levels. Additionally, we have completed a number of data analyses to look nationally, and by State, at the number of deficiency-free facilities and those with above- and below-average numbers of deficiencies. We are working on a data system (Aspen Enforcement Module) so that we can more easily assess these trends in deficiencies.

FOUR-PRONGED EFFORT TO IMPROVE CARE

Apart from actively implementing the GAO recommendations, the Administration has taken a number of steps to improve nursing home quality nationwide, including the Nursing Home Quality Initiative, which Secretary Thompson announced in November 2001. Working with measurement experts, the National Quality Forum, and a broad group of nursing home industry stakeholders – consumer groups, unions, patient groups and nursing homes – CMS adopted a set of improved nursing home quality measures and launched a six-state pilot.

What We Learned From the Pilot Program

CMS decided to launch the national Nursing Home Quality Initiative based on the success of the six-state pilot program. To evaluate the pilot, CMS surveyed nursing home administrators and related stakeholders and studied processes designed to stimulate quality improvement activities in nursing homes and to promote awareness and use of the new quality measures among consumers, including beneficiaries, caregivers, nursing home facilities, and other constituent groups. CMS measured exposure to state and national media and local live events/workshops, tracking CMS website hits and calls to the toll-free number, online satisfaction surveys, and consumer interviews. In addition to the formal evaluation, CMS met with constituent groups throughout the pilot program to solicit feedback, which was used to refine the pilot and to adjust the national implementation.

Our review of the pilot found that the vast majority of nursing homes (88 percent) knew about the quality initiative, and more than half of the nursing homes (52 percent) in the six pilot states requested quality improvement technical assistance from the QIOs. Additionally, more than three-quarters of nursing homes (78 percent) reported making quality improvement changes during the pilot and 77 percent indicated that the quality initiative was partially responsible for their decision to undertake these activities.

We also determined that the quality initiative increased people's search for nursing home quality information. For instance, phone calls to 1-800-MEDICARE concerning nursing home information more than doubled during the pilot rollout, and visits to www.medicare.gov's

nursing home quality information increased tenfold in the six pilot states. Web users indicated the information available was clear, easy to understand, easy to search and valuable. On a scale of "0" to "10," more than 40 percent of web users scored the information a "10" on these dimensions and approximately 70 percent gave the information an "8" or higher. From December 29, 2002, to June 29, 2003, the Nursing Home Compare site has been viewed more than six million times.

Encouraged by the success of the pilot, we expanded the Nursing Home Quality Initiative to all 50 States in November 2002. The quality initiative, which is an important component of CMS' comprehensive strategy to improve the quality of care provided by America's nursing homes, is a four-pronged effort, including: regulation and enforcement efforts conducted by CMS and State survey agencies; continual, community-based quality improvement programs; collaboration and partnership with stakeholders to leverage knowledge and resources; and improved consumer information on the quality of care in nursing homes.

Regulation of State Survey Agencies

The Nursing Home Quality Initiative's approach to regulate State survey agencies is designed to complement CMS' broader survey and certification activities, which are addressed later in this testimony, that ensure that Medicare- and Medicaid-certified nursing homes comply with regulatory requirements for patient health and safety and quality of care. To this end, CMS monitors data that nursing homes report (the Minimum Data Set). In addition, CMS reviews administrative data from the Online Survey, Certification, and Reporting System (OSCAR). These aggregated data sets provide a comprehensive view of the individual receiving care in the nursing home. State Survey and Certification Agencies focus on the quality of care furnished to residents as measured by indicators of medical, nursing and rehabilitative care, dietary and nutrition services, activities and social participation, sanitation, infection control, and the physical environment. Surveys include a review of compliance with residents' rights, written plans of care, and an audit of the residents' assessment.

The heart of the nursing home survey process is a four-to-five day onsite inspection to see that a nursing home is meeting federal health and safety requirements. Standard surveys take a

"snapshot" of the care beneficiaries receive at the time of the survey. These surveys are unannounced and, by law, must take place based on a statewide average of once every 12 months, but no longer than once every 15 months. The survey process requires States to conduct surveys within prescribed time frames any time a serious problem is alleged. Survey results and complaint data are available on the Nursing Home Compare Web site.

Community-based Quality Improvement Programs

Based on past experience, CMS has found that targeted quality improvement initiatives improve the quality of care. Medicare Quality Improvement Organizations (QIOs), formerly known as Peer Review Organizations (PROs), have been leaders in this type of improvement work. The QIOs have worked with providers, hospitals and others on improvement activities in the past, and have seen providers achieve a 10 to 20 percent relative improvement in performance simply by focusing on identified quality problem areas. As part of the Nursing Home Quality Initiative, QIOs are working with nursing homes to improve performance on the published measures and to develop and implement quality improvement projects. For example, QIOs are available to assist in interpreting and communicating data to nursing homes, which can motivate homes to improve quality. When mistakes or errors occur, QIOs help the nursing home determine what problems exist and implement systems to prevent recurrence, such as certain patient care protocols and standing orders. The QIOs work with community, health care, and business organizations, and with the local media. Together they provide quality information to the public and encourage nursing homes to use the information to improve care.

Facilitated Collaboration

During the pilot phase of the initiative, CMS learned the importance of collaboration and partnerships to improving quality of care in skilled nursing facilities. The quality initiative is designed to foster and improve communication among all parties – including Federal and State agencies, quality improvement organizations, independent health quality organizations, consumer advocates, and nursing home providers – to positively impact quality of care. By creating partnerships to expand our knowledge and resources, we can achieve greater and more immediate improvements in the quality of nursing home care.

While developing the Quality Initiative, CMS worked with the National Quality Forum (NQF) to identify areas of care for the public reporting pilot. NQF's nursing home steering committee included providers, State government representatives, consumer advocates, and others who reviewed the available measures. CMS adopted 10 new quality measures for the Initiative, and subsequently made minor revisions to the list of existing measures, such as dropping the resident weight loss measure. The new quality measures used in the initiative differ for long-stay and short-stay residents.

There are six measures for long-stay residents:

- Percentage of residents with loss of ability in basic daily tasks
- Percentage of residents with infections
- Percentage of residents with pain
- Percentage of residents with pressure sores
- Percentage of residents with pressure sores (with facility-level risk adjustment)
- Percentage of residents in physical restraints

The initiative includes four measures for short-stay residents:

- Percentage of short-stay residents with delirium
- Percentage of short-stay residents with delirium (with facility-level risk adjustment)
- Percentage of short-stay residents who walk as well or better (with facility-level risk adjustment)
- Percentage of short-stay residents with pain

These quality measures are reliable, valid and risk-adjusted so that consumers can use them to assess ways in which facilities differ from one another. The nursing home quality measures come from resident assessment data that nursing homes routinely collect on the residents at specified intervals during their stay (the Minimum Data Set). These measures assess the resident's physical and clinical conditions and abilities, as well as preferences and life care wishes. These assessment data have been converted to develop the 10 quality measures, giving consumers another source of information that shows how well nursing homes are caring for their

residents' physical and clinical needs. We are committed to enhancing these quality measures to better risk adjust and measure quality.

Improved Consumer Information and Outreach

As part of the Nursing Home Quality Initiative, CMS is promoting the use of the aforementioned quality measures through an integrated communications campaign, including paid advertising and publicity, as well as grassroots outreach through Medicare's Quality Improvement Organizations (QIOs) and other health care intermediaries. As part of the rollout of the Initiative, CMS worked closely with physicians and nurses, discharge planners, community organizations and the media. The campaign has cultivated an environment, in cooperation with nursing home industry leadership, to promote improvement in the quality of care. English- and Spanish-language advertisements ran in 71 major daily newspapers on November 13, 2002, to help raise awareness of the quality initiative throughout the country. The advertising highlighted the availability of the nursing home quality measures and illustrated to consumers how to obtain that information. In addition, consumers can call 1-800-MEDICARE or visit www.medicare.gov to review the quality measures, or to obtain a copy of Medicare's Guide to Selecting a Nursing Home as additional information sources.

IMPROVING SURVEY AND CERTIFICATION EFFORTS

As I mentioned earlier, CMS is using the Nursing Home Quality Initiative to support its efforts to improve the survey, certification, and monitoring of Medicare- and Medicaid-certified nursing facilities. CMS also uses Federal Monitoring Surveys (FMS) – or "comparative" surveys. Sections 1819(g)(3) and 1919(g)(3) of the Social Security Act requires the Secretary to conduct federal onsite surveys in each State each year within 2 months of the completion of the State's survey. In October 1998, CMS introduced its current program of overseeing State agency performance, referred to as the federal monitoring survey. As part of the program, called a comparative survey, a team of federal surveyors conducts a complete, independent survey of a long-term care facility after the State has completed its survey of that facility. The results of both surveys are then compared for discrepancies. In addition, the program includes an observational survey in which one or two federal surveyors accompany State surveyors to a long-term care facility, either as part of the facility's annual standard survey, or as part of a revisit or a

complaint investigation. The combination of the comparative survey and the observational survey is used to meet the federal oversight requirement.

OSCAR data from FY 2001 indicate that CMS regional offices conducted a total of 146 comparative surveys on skilled nursing homes and dually participating nursing homes. Consistent with the recommendations in the GAO report mentioned earlier, CMS is moving toward improving the consistency and number of comparative surveys. For example, CMS intends to award a contract to conduct additional comparative surveys. Such a contract would permit CMS to increase the number of Federal comparative surveys being conducted and assist CMS regional offices experiencing constrained human and financial resources to perform additional comparative surveys. As part of this effort, a request for proposals was published June 18, 2003, in Federal Business Opportunities. The deadline for proposals to be submitted is July 18, 2003.

Additionally, CMS is maintaining its nursing home oversight improvement program. This effort includes initiatives to strengthen survey and enforcement activities relating to Medicare- and Medicaid-participating nursing homes. As part of the program, the Agency continues to employ the off-hour survey cycle, which has been incorporated into the set of State performance measures. The Department and CMS are committed to home and community-based service programs, which ensure that people are afforded the opportunity to live independently in their own homes, while receiving quality care and support in a community setting.

It should be noted that the Medicare survey and certification budget is funded through the annual HHS appropriation bill that funds CMS Program Management. The amount earmarked in the FY 2004 budget for State survey agencies decreased one percent from the FY 2003 level. While Medicare State survey and certification nursing home expenses are funded at the federal level, States are responsible for 25 percent of the cost of Medicaid survey and certification programs. State budget crises remain a critical issue for the accomplishment of Medicaid survey and certification workload because State survey agencies must obtain hiring authority from State legislatures each year to maintain staffing levels, to hire new State surveyors, and to fill vacant State surveyor positions. In times of significant budget pressure, States will often initiate State

hiring freezes in certain State departments, severely limiting the staffing levels in certain State departments and agencies. This situation strains the ability of States to accomplish federal workload requirements. Therefore, it is vital for States to receive adequate funding to fulfill their survey and certification commitments and work to ensure high quality care.

FINANCIAL STATUS OF THE NURSING HOME INDUSTRY

Under the prospective payment structure, Medicare pays skilled nursing facilities a case-mix adjusted per diem amount intended to cover the routine, ancillary, and capital-related costs of providing care. Medicare covers such services for beneficiaries who have recently been discharged from an acute care hospital where they received care for at least three days. Given that coverage is limited to 100 days per spell of illness, Medicare does not cover care in a skilled nursing facility on a long-term basis. Most beneficiaries requiring such care must pay out-of-pocket or rely on Medicaid. A small number of beneficiaries have private long-term care insurance to cover these expenses.

In response to concerns about the payment system, a series of temporary rate increases were instituted through the Balanced Budget Refinement Act of 1999 and the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 to help the facilities transition from a cost-based to a prospective payment system. This year, CMS proposed a rule to increase Medicare payments to skilled nursing facilities due to inflation for FY 2004 by 2.9 percent. This proposed rule would result in about $400 million more in Medicare payments to the facilities. The comment period for the proposal ended July 7, and the Agency will publish the final rule by August 1 so it can be implemented October 1, 2003, the start of FY 2004.

Medicare's Cross-Subsidization of Medicaid

Medicare covers about 10 to 15 percent of the nursing home population. Medicaid covers about 65 to 70 percent, and generates about 45 percent of revenue for skilled nursing facilities. Medicare payment rates are higher and effectively cross-subsidize lower Medicaid reimbursements. In 2001, Medicare reimbursed $268 per covered day of care, which does not include beneficiaries' coinsurance payments. In FY 2002, the Medicaid State agencies for 48 States and Washington, D.C., reimbursed an average of $124.26 per day (See Attachment 1).

Medicaid projects spending approximately $90 billion (Federal and State) on LTC services in FY 2004, with $49.1 billion spent in nursing home care. The average stay in a nursing home is 2.6 years with the total cost reaching $137,500. Medicaid funds other types of long-term care coverage through the use of home- and community-based waivers.

Fiscal Pressures Compound to Challenge Nursing Homes

The economic outlook for the nursing facility industry has grown more negative over the past year (See Attachment 2). Wall Street nursing home analysts' main concerns are the sunset of certain Medicare add-on payment provisions, potential Medicaid cuts by States, and skyrocketing liability costs. Due to mounting budgetary pressure, analysts have concluded that States will freeze or cut payments to nursing facilities in an effort to balance their budgets. With the end of some of the Medicare payment provisions in the Balanced Budget Refinement Act of 1999 and the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, nursing facilities may be less able to absorb the impact of lower Medicaid payments due to slimmer operating profit margins and declines in investment incomes from endowments and charitable contributions. To control costs, facilities may cut staff, which could adversely impact the quality of care provided to nursing home residents.

In addition, nursing facility margins have declined due to increases in patient care liability cases, average claim sizes, and insurance premium costs. About 28 percent of nursing homes operate under a not-for-profit status. Among these homes, the GAO has found the median total margin for such facilities was 0.6 percent in 1999 and 0.3 percent in 2000, compared to 1.6 percent in 1999 and 2.2 percent in 2000 for for-profit facilities. According to the American Association of Homes and Services for the Aging (AAHSA), the average total margin of a non-for-profit skilled nursing facility was 1.9 percent in tax year 2001. Additionally, AAHSA found that not-for-profit facilities had a negative 4.3 percent operating margin and relied on the sale of assets, principal from endowments, and investment income to cover the operating losses.

FINANCING OF LONG-TERM CARE

The economic outlook of the nursing home industry becomes ever more critical with the aging of the baby boom generation, and the issue of how we pay for long-term care becomes increasingly

pressing. This is an issue of significant concern for beneficiaries, their families, caregivers, providers, and the people that administer the public programs that finance nursing home care; however, the burden on families is significant. Family caregivers provide the vast majority of long-term care, as few families can afford the $50,000 to $100,000 in annual costs of nursing home care or the expenses associated with assisted living and home care alternatives that average more than $20,000 per year. As a result, spending down assets to qualify for Medicaid has been the most viable alternative for many seniors.

Given that reliance on public funding is problematic, exploring the options for expanded financing in the private sector becomes a necessity. One approach to financing long-term care is to encourage consumers to buy long-term care insurance. For example, the President has proposed to expand the four State programs on Long-Term Care Partnerships, as well as two important tax relief measures for caregivers and those who purchase long-term care insurance. In addition, the President's budget includes additional funding to increase the flexibility of health savings accounts.

CONCLUSION

Mr. Chairman, I would like to thank you again for the opportunity to testify this morning on the quality of care in nursing homes and to reiterate my appreciation for your leadership in this area. With our combined efforts and continued vigilance, I am confident we will continue to see improvements in the quality of care delivered in America's nursing homes. I hope that I have been able to express the Administration's dedication to strengthening the quality of our nation's 17,000 Medicare- and Medicaid-certified skilled nursing facilities as well as our commitment to work with you to do so. I look forward to answering your questions.