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Testimony of
American Association of Homes & Services for the Aging
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Introduction

On behalf of the 5600 mission-driven, not-for-profit members of the American Association of Homes & Services for the Aging (AAHSA), I want to thank the Committee for the opportunity to address the Tri-Committees draft legislation to provide affordable, quality health care for all Americans and reduce the growth in health care spending.

AAHSA members (www.aahsa.org) help millions of individuals and their families every day through mission-driven, not-for-profit organizations dedicated to providing the services that people need, when they need them, in the place they call home. Our member organizations, many of which have served their communities for generations, offer the continuum of aging services: adult day services, home health, community services, senior housing, assisted living residences, continuing care retirement communities and nursing homes. AAHSA's commitment is to create the future of aging services through quality people can trust.

We commend the three committees for their extraordinary collaboration on developing a comprehensive approach to ensuring that all Americans have access to affordable health care coverage. The task is daunting and the committees and their staff are to be commended for the volume of research, deliberation and drafting they have been able to accomplish in such a relatively brief period. The expansion of coverage, the improvements in the insurance marketplace, the proposed solutions to problems with coverage and access which we see in this draft legislation are all elements that must be resolved in any successful reform of our nation's health care system.

There are many provisions in this draft legislation that mirror AAHSA's public policy and that we have urged Congress to adopt for years. We are pleased the committees recognize the value and importance of improving the payment system for nursing homes and address critical workforce issues, access for beneficiaries, quality improvement and transparency. We also appreciate that this legislation is a draft, and will take this opportunity to indicate those areas where we have concerns and recommend alternatives. And of course, we are more than willing to work with the committees to address any recommendations we make.

Health Reform and Long Term Services and Supports

We applaud the committees for addressing very key issues confronting our health care system – issues that affect all of us. Assuring access to affordable and meaningful health insurance, acknowledging a shared responsibility as individuals, employers and government to ensure coverage of essential health benefits,

addressing cost, and investing in our health care workforce are fundamental. These elements affect our members and the people we serve as providers, as employers and as citizens.

While the health reform discussions have focused on the acute care system, we note that the principles that underlie this draft bill resonate in the long term services and supports field and mirror AAHSA's public policy and the policy adopted by well over 100 organizations representing aging services and other providers, consumer groups and persons with disabilities.

The care and services our members provide are an integral part of the health care system. According to a recent poll conducted by the Mellman Group, 85% of Americans believe that long-term services and supports should be included in national health reform and will be surprised if they are not. Instinctively, Americans recognize that there is a critical nexus between the services they need to maintain their health and the medical care itself.

An estimated 10 million Americans currently need long-term services – personal care, assistive technology and other supportive services, and this number will grow. However, we lack a coordinated, national public-private system for adequately, efficiently and humanely delivering high quality services. The elements for such a system mirror the elements in the committees draft legislation:

COVERAGE AND CHOICE: Only 6-7 million Americans have private health insurance coverage for long-term services and supports, and this coverage has been slow to grow for a number of reasons, including affordability, exclusion for health reasons, and the nature of the product. Medicare covers relatively little long-term services and supports. Medicaid has become the default public long-term services and supports program, despite longstanding efforts to restrict eligibility. While Medicaid coverage has broadened in recent years, it still gives beneficiaries few choices of services, providers or settings.

AFFORDABILITY: Nursing home care averages $70,000 per year and can run over $100,000 a year in some areas. Home care costs average $15-20 per hour. These costs are unaffordable for the majority of individuals and increasing reliance on Medicaid for coverage of long-term services and supports is unsustainable for federal and state governments.

SHARED RESPONSIBILITY: Low take-up rates for private long-term care insurance have resulted from underwriting practices that prevent up to 20% of applicants from qualifying for coverage and from the relatively high premiums charged for this coverage. Individuals who finance long-term services and supports on their own can quickly spend down a lifetime of savings. Americans need an accessible and affordable structure to responsibly plan for the cost of their own long-term services and supports.

PREVENTION AND WELLNESS: AAHSA strongly supports efforts to encourage healthier lifestyles to prevent diabetes, heart disease and other conditions that are expensive to treat. Research into more effective treatment and prevention of Alzheimer's disease and other forms of dementia could significantly reduce future spending on long-term services and supports. Nevertheless, the longevity trend which is giving us increasing numbers of centenarians means that more and more Americans will need long-term services and supports in the coming years.

Recommendation:

AAHSA urges the committees to include a national insurance program for long-term services and supports as part of the final health care reform legislation. Insurance is the correct approach, as the need for services is a risk and not a certainty. The inability of the private market to adequately

serve this population, coupled with the increasingly unsustainable burden on Medicaid, points directly to the need for a national insurance program.

The CLASS Act (H.R. 1721), introduced by Rep. Frank Pallone, represents a model that we urge the Committees to adopt in final legislation. It has been included in the health care reform legislation proposed by the Senate Health, Labor, Education and Pensions Committee as Title XXII. The CLASS Act creates a voluntary insurance program specifically for services not covered by traditional health insurance and will provide an affordable product that covers basic needs, provides choices, and helps prevent impoverishment. Including the CLASS Act in health care reform legislation complements and completes the work of the Committees to address the health care needs of all Americans.

The CLASS Act parallels the recommendations AAHSA's own Financing Cabinet made for the reform of the long term services and supports financing system. The cabinet made its recommendations based on a two-year examination of all the issues involved in financing long-term services and supports. As with any form of insurance, the cabinet determined that the more universal the coverage, the more affordable it would be for all participants.

Only a fundamental reform of the long-term services and supports system as proposed in the CLASS Act will achieve the Medicaid savings necessary to prevent Medicaid from imploding under the impending needs of the baby boom generation.

AAHSA will now address specific provisions in the committees draft legislation that affect aging services providers.

Skilled Nursing Facility Payment System (Sec. 1111, 1101)

We commend the committees for incorporating into this legislation the recommendations from the Medicare Payment Advisory Commission (MedPAC) to restructure the payment system for skilled nursing facilities. Restructuring the payment system is needed to more accurately account for caring for medically complex residents. Section 1111 implements a position that AAHSA, as well as MedPAC, has advocated for many years.

Indeed, two years ago AAHSA submitted testimony to the Ways & Means Health Subcommittee urging the committee to revisit this deeply flawed payment system. The current system, which the Tri-Committee draft legislation corrects, is based on Resource Utilization Groups (RUGs) that do not accurately determine acuity of need and do not responsibly calculate cost. This is particularly true for medically complex patients who generally require not only extensive nursing care but also significant amounts of medication, supplies, tests, respiratory care, and other so-called non-therapy ancillaries (NTA). Medicare reimburses skilled nursing facilities for many very expensive patients at considerably lower rates than Medicare pays for patients whose care costs much less. The Inspector General, MedPAC and the GAO have all reported on these inaccuracies.

In February 2009, MedPAC wrote to CMS urging that the system be revised, stating:

> The shortcomings of the current SNF PPS are extensive and create inequities for beneficiaries and providers. The PPS poorly targets payments for nontherapy ancillary services (NTA), such as intravenous medications and respiratory care, so that patients who require these services are harder to place than other patients and the SNFs that treat them are financially disadvantaged. The current design overpays for rehabilitation therapy services and relatively underpays for medically complex

care. In addition, the lack of proportionality between payments and costs for therapy services creates financial incentives to furnish care that may be of marginal benefit to the patient and results in facilities selecting certain patients over others. These design flaws are partly responsible for the widely varying financial performance between nonprofit and for-profit SNFs and between freestanding and hospital-based SNFs. The Commission believes these glaring problems create an urgent need for reform and warrant correction.

Section 1111 directs the Secretary to revise the prospective payment system (PPS) by adding a separate NTA component; replacing the therapy component with one that establishes payments based on predicted patient needs; and adopting an outlier policy. These requirements mirror the recommendations made by MedPAC.

Recommendation:

AAHSA strongly recommends that the final health care reform legislation contain Section 1111. Fixing the RUGS payment system corrects an imbalance that resulted in overpayments for therapy services and underpayments for NTA services. This imbalance had a significant negative impact on not-for-profit SNFs.

Skilled Nursing Facility Payment Update (Sec. 1101)

The Tri-Committee bill freezes skilled nursing facility payments for FY 2010 for a nine-month period effective January 1, 2010. AAHSA was disappointed to see this provision included in the legislation. CMS is already planning to reduce providers' payments by a net 1.2% through a regulatory change, and the failure to implement the update further reduces payments to providers by 3.3% or more.

We urge the Committee to reject this proposal, which would penalize the very health care providers who are making the greatest effort to ensure high quality care for frail older people.

Seventy-six percent of nursing home residents are paid for by Medicaid or Medicare. Very few residents currently have private insurance to cover the cost of their care. The heavy reliance on these two programs makes their payment policies even more critical to nursing facility operations than they are for health care providers that have more varied sources of payment.

The inequity of the current payment system, as described in the discussion of Section 1111, is particularly evident when determining whether the update is warranted. Not-for-profit SNFs have very low Medicare margins; for 2007, MedPAC found that although skilled nursing facilities as a whole achieved 14.5% margins, not-for-profit facilities had Medicare margins of 4.5%. The large margins used by MedPAC to justify eliminating the update are simply non-existent in the not-for-profit sector. The market basket update is essential to smoothing out this disparity and giving facilities caring for the most complex patients the necessary resources.

Adequate Medicare reimbursement makes a major difference to nursing homes' ability to recruit and retain staff, the single greatest determinant of the quality of care facilities are able to provide. Denial of a payment update to facilities that already are struggling to break even on the services they provide to Medicare beneficiaries would run directly counter to the many initiatives we are pursuing to raise nursing home quality.

Because payment policies are so critically tied to adequate staffing, we would add, on a positive note, that we are very supportive of Sec. 1414 (f) in the Tri-Committee bill, which mandates separate reporting of

nurse staffing on Medicare cost reports. This information will give Medicare, MedPAC, and Congress significant information on how Medicare dollars are spent.

Recommendations:

AAHSA urges the Committee not to eliminate the market basket update for FY 2010 as this unfairly penalizes those providers who care for the more medically complex and have higher staffing and therefore have very low margins.

AAHSA strongly supports Sec. 1414(f), cost reporting for nurse staffing, as a critical element for determining appropriate use of Medicare funds.

Post acute care services payment reform (Sec. 1151-1152)

AAHSA supports directing the Secretary to develop an appropriate post-acute care payment system and appreciates the thoughtfulness in approach taken by the Committees. In addition, we support directing the Secretary to develop quality measures to determine the appropriateness of readmissions. We would add that any policy should be coordinated with quality measures for hospitals.

Post-acute services must be better coordinated to prevent the rehospitalizations that are costly to the Medicare program and arduous for beneficiaries. Better transitions among different levels of services are one of AAHSA's big ideas for the future of aging services. The issues to be considered by the Secretary cover many of the concerns AAHSA has noted, including ensuring quality of care and beneficiary choice and addressing corporate and regulatory differences. We believe that in addition to traditional bundling, the Secretary should examine the appropriateness of alternatives such as care transition, medical homes, and house call initiatives.

AAHSA is concerned, however, with the interim policy adopted in Sec. 1151, which essentially creates a non-rebuttable presumption that all readmissions to hospitals within 30 days are the fault of the post-acute care provider. This policy would be much too broad; as an example, a patient who is admitted to a nursing home to recover from hip replacement would have to be rehospitalized if he suffered a heart attack ten days later. The incentive for post-acute providers would then become denying admittance to patients who risk being rehospitalized.

We are also concerned that this approach will exacerbate the problem with placing medically complex patients identified in MedPAC's March 2009 report (p. 167). This policy punishes high quality providers who take very ill patients equally or greater than poor quality providers who have no incentive to accept medically complex patients.

We strongly agree that reducing or eliminating avoidable re-hospitalization is an important goal not just financially but also as a consumer issue and a quality issue. We recognize that post-acute care providers have an equal responsibility with hospitals to prevent rehospitalizations whenever possible. However, we urge the Committees to eliminate this specific provision and instead make sure that the Secretary moves quickly to determine what is an "avoidable hospitalization" and appropriate incentives and penalties.

Recommendations:

AAHSA supports the provisions in Sec. 1152, but requests that the committees not adopt Sec. 1151. AAHSA would be happy to work with the committees as to develop alternative interim policies.

Reducing Health Disparities (Sections 1221-1224)

AAHSA supports the provisions in these Sections and is very pleased that the committees recognize the importance of addressing cultural competence generally and language specifically. We encourage including aging services providers in these studies; many of our members have multi-lingual campuses, and of course that includes residents from many backgrounds as well as staff. The Better Jobs Better Care research and demonstration program (www.bjbc.org), funded by the Robert Wood Johnson Foundation and Atlantic Philanthropies, and the AAHSA Commission on Ethics in Aging Services have produced tool-kits and other resources to assist providers develop and maintain workplaces that respect diversity of staff and residents.
http://www.aahsa.org/uploadedFiles/resources/Governance/Legal_and_Ethical_Policies/Ethics_Whitepaper_WEB.pdf

Recommendation:

AAHSA strongly supports these provisions and encourages inclusion of aging services providers in studies and demonstrations.

Extension of therapy caps exceptions process (Section 1231)

AAHSA has long advocated for a reasonable payment system for outpatient therapy services. We appreciate continuation of the exceptions process, but ultimately the question of how to pay for outpatient therapy needs to be addressed, either by repealing the arbitrary cap structure entirely or by developing another system for payment.

Medicare currently covers physical, occupational and speech therapy, but limits or "caps" the amount of therapy an individual can receive in a given year.

Therapy needs have increased as the population ages and people live longer. Limiting the therapy that one can receive in a particular year often hinders an individual's ability to regain physical strength and daily living skills that are required to live independently. In addition, an individual may exhaust his or her permitted therapy early in the year and have a new need for therapy later in the year as a result of a new medical setback (surgery, injury from a fall, heart attack, etc.)

Caps on therapy coverage first were imposed by the Balanced Budget Act of 1997, but soon afterward Congress imposed a series of moratoriums on the caps because of their potential impact on beneficiaries with serious injuries and health conditions.

The last moratorium expired at the end of 2005. Instead of renewing it, Congress created an exceptions process under the Deficit Reduction Act, which is continued each year.

Recommendations:

Optimally, Congress should simply repeal the caps. Although repeal scores as an increase in federal spending, the caps have been in full effect for only a few weeks in the last twelve years. They have not effectively reduced federal spending.

Alternatively, the provision in the Tri-Committee bill should be adopted. We suggest that the Secretary be directed to create a permanent process for determining appropriate payment for therapy treatment. The legislation should specifically direct the Secretary to design and implement

a new system that (among other things) includes an outlier process and conforms to the Data Quality Act. The Secretary should also be directed to convene a Technical Advisory group to assist in the design of this new system, which would include relevant consumer and provider groups and scientists.

Nursing Home Transparency (Title IV, Subtitle B)

AAHSA supports these provisions, with the exception of Section 1421, which we will address separately.

This bill will increase transparency and promote accountability by requiring all nursing homes to disclose their ownership. We share the Tri-Committees' view that the public must have complete information about the individuals and corporate entities who may effectively be held accountable for the quality of services provided in a nursing facility.

Recognizing that consumers need adequate and more easily accessible information, the bill also improves the information available to consumers on Nursing Home Compare, and directs that improvements be made to make the site more user-friendly for the public.

It is difficult for consumers to obtain adequate and useful information on nursing homes so that they can make an informed decision for themselves or a loved one. The information that is available is not written for the lay person and does not contain critical information to assess the quality of life and care provided by the home. This lack of good information is particularly disturbing because consumers seldom have the time or capacity to research homes.

Therefore, by default, the primary source of information for consumers is Nursing Home Compare, the website established and maintained by CMS. Nursing Home Compare contains the results of the latest surveys for each Medicare and Medicaid-certified nursing home, quality measures based on the information collected for the Minimum Data Set (MDS) Repository, and some general information regarding each nursing home. Although an effort has been made to explain each reported measure and deficiency citation, the site never actually explains the process and the meaning of the results, how surveys are conducted, what they mean and don't mean. How should the consumer assess the meaning of a deficiency that ranks as a "2" and affects a "few" residents? Consumers cannot even determine if cited deficiencies relate to many incidents or one incident. Nor is there any lay explanation of the facts underlying the deficiency so that a consumer can understand the meaning of the deficiency. What is the actual impact on "quality"? How should the consumer use this data? Other issues that have been raised about the information provided on Nursing Home Compare relate to the reliability of the data1, as well as understanding that compliance with regulations is not the same thing as quality. None of these questions is answered, even though understanding how to interpret survey data and integrate this data into one's analysis of any particular nursing home seems like fairly basic information.

Furthermore, Nursing Home Compare measures and reports only compliance with minimum standards of care. It does not identify nursing homes that consistently achieve outstanding quality of services, and unfortunately, there really is no other data source for identifying which nursing homes have high quality. As a result, everyone from CMS to consumer groups to nursing homes ourselves urge prospective residents or their decision makers to visit the nursing homes they are considering if at all possible. The time to visit prospective homes and the tools to analyze the information obtained from Nursing Home Compare and their visits are critical to the ability of consumers to make thoughtful and intelligent decisions.

Other important provisions included in this bill relate to workforce. As noted earlier in our testimony, the bill corrects a long-standing omission on Medicare cost reports by requiring information on dollars spent for nursing – nursing costs are a critical element in assessing quality. Breaking out these costs separately on Medicare cost reports will enable policymakers, regulatory agencies and consumers to easily determine which facilities are using the resources provided by Medicare to maximize their quality of care.

The bill also includes provisions adding dementia management and abuse prevention to direct care worker training programs. Finally, the bill addresses concerns about the scope and length of training for certified nursing assistants, and calls for a study on the content of training programs for staff and whether the minimum hours should be increased. We strongly support a study of these issues. One of the key findings from the Better Jobs Better Care research and demonstration program was that there simply does not exist a definition of core competencies for staff in long-term care settings. As a result, existing programs may not be sufficient and more importantly fail to provide optimal education, training and advancement. A study of education and training in this field is long overdue.

Finally, AAHSA urges the Tri-Committees to remove the provisions in Sec. 1421 that increase civil money penalties. AAHSA believes that the provisions increasing penalties for deficiencies are unnecessary and unduly punitive. Extensive remedies currently exist to address inadequate performance by nursing homes, through fines, denial of payment for new admissions, exclusion from Medicare, and imposition of temporary management (in addition to the national independent monitor program created in the bill). We believe based on our work on the Advancing Excellence Campaign with CMS, AARP and other consumer groups, and the other provider organizations that education, training, support and positive reinforcement of nursing homes that engage in continual quality improvement are the building blocks for improving quality in our nursing homes, protecting residents, and leading to the time when there will be only two types of nursing homes – the excellent and the non-existent.

Recommendations:

AAHSA supports the Nursing Home Transparency subtitle; it addresses critical areas that will strengthen transparency for consumers, improve quality, and improve the workforce. However, AAHSA urges the Tri-Committees to remove the provisions in Sec. 1421 increasing penalties, and, rather, encourage CMS to utilize fully the remedies that already exist to address quality concerns.

Conclusion

We appreciate the committees' efforts. Comprehensive health care reform is a truly monumental task. AAHSA is pleased to be a resource in this effort and we assure the committees that we are more than willing to be a resource on each of the recommendations we have made and on health reform generally.

Thank you.