The National CONSUMER VOICE for Quality Long-Term Care formerly NCCNHR

William Lamb, President
Sarah F. Wells, Executive Director
Ph: 202.332.2275
Fax: 202.332.2949
www.theconsumervoice.org

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Re: Comments on Post Acute Care (PAC) Reform Proposals

Dear Committee Members:

The National Consumer Voice for Quality Long-Term Care (Consumer Voice) welcomes the opportunity to provide feedback on the post-acute care reform proposals detailed in your June 19, 2013 letter to stakeholders. In addition to providing comments on these proposed reforms, we offer further recommendations on ways in which the post-acute care system could be improved without endangering beneficiaries' access to needed care.

Consumer Voice is a national non-profit organization that has over 38 years of experience advocating on behalf of long-term care consumers across care settings. Our membership consists primarily of consumers of long-term care and services, their families, long-term care ombudsmen, individual advocates, and citizen advocacy groups.

As you are aware, individuals that require long-term services and supports often have coinciding needs for post-acute care. Furthermore, a growing amount of post-acute care services are being provided in traditional long-term care settings, such as skilled nursing facilities and home health settings. Given the complex relationship between post-acute and long-term care, our organization urges the committee to approach any potential Medicare funding reductions or structural changes with appropriate caution so as not to limit access to quality care or increase overall out-of-pocket costs for consumers.

Consumer Voice provides the following feedback to the committee on this matter:

Improved Transparency and Oversight of Medicare Payments to SNFs Skilled nursing facilities (SNFs) have become an increasingly common setting in which Medicare beneficiaries receive post-acute care. In fiscal year 2012, SNFs received $32.2 billion in Medicare payments for providing such services to beneficiaries. However, an Office of Inspector General Report (OIG) released in February of this year found that $5.1 billion of these Medicare funds went to stays in which SNFs failed to meet or follow significant care guidelines. Thirty-seven percent (37%) of SNFs did not develop care plans for beneficiaries that met care planning requirements or failed to provide services in accordance with beneficiaries' existing care plans. Thirty-one percent (31%) of SNFs failed to meet discharge planning requirements. In addition, the OIG report cited egregious examples of poor care in SNFs related to wound care, medication management and therapy.[1]

[1] Government Accountability Office, *Skilled Nursing Facilities Often Fail to Meet Care Planning and Dicharge Planning Requirements*, OEI-02-09-00201, (Feb. 2013), https://oig.hhs.gov/oei/reports/oei-02-09-00201.asp

It is critical to ensure that Medicare beneficiaries in SNFs receive the quality of post-acute care to which they are entitled. In order to enhance provider accountability, we recommend that: 1) SNF expenditures broken down by direct care services, including wages and benefits for direct care staff; indirect care; capital assets; and administrative services be made publicly available this year (much of this is already required by the Affordable Care Act); and 2) SNFs be required to allocate a specific portion of their Medicare funding to direct care services. Facilities must be held accountable for providing beneficiaries the services for which Medicare is paying.

Preserving and Enforcing the Nursing Home Reform Law The Nursing Home Reform Law of 1987 established Requirements of Participation for SNFs, regulations that facilities are required to meet in order to begin or continue participating in the Medicare program. These standards have resulted in significantly positive changes in facilities; they elevate the quality that is to be expected in nursing homes and make an enormous difference in the daily lives of nursing home residents. The Consumer Voice opposes any efforts to weaken these regulations since doing so would compromise beneficiary health, safety and well-being.

There is also a critical need for greater enforcement of these requirements, as any regulation is rendered meaningless if it is not adequately enforced. A GAO report published in May 2008 found that enforcement agencies continue to understate serious care problems in SNFs[2]. Improving federal and state oversight of SNFs, as well as strengthening enforcement actions, is essential to ensuring beneficiaries receive quality post-acute care in these facilities.

Denying Deemed Status for PAC Providers Consumer Voice believes that deemed status of any Medicare provider or supplier is poor public policy. Delivery of quality care is the responsibility of the government and should not be transferred to a private non-regulatory entity that is accountable to its clients – health care providers – and not to the public. Currently, the law permits, and the Centers for Medicare and Medicaid Services (CMS) has allowed, a wide range of providers to receive deemed status, with the exception of skilled nursing facilities. Consumer Voice strongly supports the continuation of CMS's policy of refusing to grant deemed status to SNFs and urges Congress to make legislative changes that would prohibit deemed status for any post-acute care provider.

Permitting deemed status for nursing homes that provide post-acute care would cause beneficiaries receiving care in these facilities to lose important rights and protections they are entitled to under the Nursing Home Reform Law. Furthermore, state survey agencies would no longer conduct annual surveys or complaint investigations of SNFs, enforcement would be weakened, and the public would no longer have access to SNF inspection reports. As stated previously, SNFs are already failing to meet basic care requirements for beneficiaries that receive post-acute care services in these settings. Allowing these facilities to qualify for deemed status would only serve to further compromise the health and safety of beneficiaries by eliminating public accountability.

Increased Staffing and Transparency The quality of care received by beneficiaries in SNFs is highly contingent upon staffing levels. The current federal requirements - a registered nurse 8 hours a day, licensed nurses 24 hours a day and "sufficient staff" to meet residents needs - are inadequate. The term "sufficient" is unclear, ambiguous and impossible to objectively measure. Its vagueness allows nursing homes to under-staff on a regular basis and owners and operators to

[2] Government Accountability Office, *Nursing Homes: Federal Monitoring Surveys Demonstrate Continued Understatement of Serious Care Problems and CMS Oversight Weaknesses*, GAO-08-517 (May 2008) http://www.gao.gov/new.items/d08517.pdf

keep staffing levels low in order to maximize profit. As a result, staffing levels are not sufficient to enable individuals in SNFs to achieve the highest practicable quality of care. Consumer Voice recommends the enactment of a minimum staffing standard that includes a registered nurse (RN) 24 hours each day. At the very least, individuals receiving care in SNFs should have access to adequate nursing care when needed.

Furthermore, we recommend the full implementation of § 6106 of the Affordable Care Act, which would ensure staffing accountability for SNFs by requiring facilities to report direct care staffing information based on payroll and other variable and auditable data. Unless staffing data for SNFs can be verified via an independent auditing process, the data will remain unreliable. Without this information, we cannot sufficiently address the ongoing problem of understaffing in SNFs and the harm it causes to beneficiaries receiving post-acute care in such settings.

Consumer Rights and Protections We support the continuation and strengthening of consumer rights and protections in current models of post-acute care. Additionally, we strongly recommend that any future post-acute care models include adequate measures to ensure beneficiary safety and choice. Any future models of post-acute care should involve beneficiaries in shaping, implementing and monitoring new systems. Beneficiaries must also be given adequate information and guidance on any new care models prior to their implementation.

Observation Status Our organization strongly recommends that Medicare's observation status policy, in which the Medicare program will only pay for care in a skilled nursing facility after a hospital stay if a beneficiary spends at least three consecutive days in the hospital as an inpatient (not counting the day of discharge), be eliminated. Because of this policy, more and more beneficiaries are being admitted into hospitals under observation status and not as inpatients. While beneficiaries may spend three days or more in the hospital, none of that time counts if they are observation status. These individuals, in turn, do not qualify for Medicare coverage in a skilled nursing facility following their hospital stays and must pay thousands of dollars out of their own pockets or return home without receiving the therapy and nursing services they need to recover. The observation status rule must be eliminated or, at the very least, all the days that a beneficiary spends in a hospital should count to this three day prior hospitalization requirement.

Home Health Copayment Consumer Voice opposes placing a copayment on any home health services received by beneficiaries. Burdening beneficiaries with out-of-pocket costs for home health episodes would only serve to discourage or prevent these individuals from receiving ongoing needed care in their communities. Reducing consumer access to home and community-based services would likely result in worse health outcomes and greater costs to the health care system, as it would force greater numbers of beneficiaries into more expensive care at SNFs and other long-term care facilities.

Reduction of Avoidable Rehospitalizations and Readmissions While we agree with the importance of reducing avoidable hospitalizations and readmissions among Medicare beneficiaries, we believe that the focus of such a goal should not strictly be reducing the number of such events. Instead, attention must be given to ways to improve discharge planning and post-discharge care to prevent such incidents. Post-acute care providers must engage in adequate discharge planning with beneficiaries, which should include consistent follow-up with these individuals following discharge. It is vital to monitor the health conditions of such beneficiaries post-discharge to ensure they are receiving quality care; this, in turn, will aid in reducing rates of avoidable hospitalizations and readmissions. In addition, care coordination and transitions between post-acute settings and home and community settings must be strengthened. Improving

the quality of care beneficiaries receive once they leave post-acute settings and return home is critical to preventing any avoidable rehospitalizations or readmissions.

We also recognize that not all rehospitalization and readmission episodes need to be prevented; it is important to ensure beneficiaries do not lose access to medically necessary care under the greater goal of reducing the frequency of these occurrences. The goal should be the right care in the right setting for each individual.

Value Based Purchasing Consumer Voice recommends that the quality measures included in any Value Based Purchasing model be based on reliable, verifiable – and verified – data. Currently the quality measures for skilled nursing facilities are developed from self-reported and unaudited data, making the results questionable at best.

Therapy Caps We adamantly oppose placing annual caps on the amount of therapy services that beneficiaries may receive in outpatient care settings. Therapy caps place beneficiaries at a distinct disadvantage by forcing them to decide between forgoing necessary care or paying for such care out-of-pocket. Furthermore, individuals that require therapy services are often the oldest and sickest of Medicare beneficiaries, suffering from health conditions such as Parkinson's disease, strokes or osteoporosis, and are living with limited incomes and resources. These beneficiaries should not be denied medically necessary therapy that is integral to their health and recovery, as well as to the maintenance of their abilities.

Site Neutral Payments Consumer Voice is wary of implementing site neutral payments between SNFs and inpatient rehabilitation facilities (IRFs) for certain procedures. Such a policy would undoubtedly shift more beneficiaries into SNF care at a time when SNFs cannot be trusted to meet basic care requirements. Until SNF quality concerns can be adequately addressed, we should not be enacting any policy that would result in beneficiaries receiving poorer care and experiencing slower recoveries.

We thank you for the opportunity to share our organization's feedback on post-acute care reform proposals. Please do not hesitate to contact our Director of Public Policy and Advocacy, Robyn Grant, at 202-332-2275 (ext. 205) or rgrant@theconsumervoice.org, if our organization could be of any assistance to you on these matters.

Sincerely,

Sarah Wells
Executive Director

Robyn Grant
Director of Public Policy & Advocacy