



TRENDS IN NURSING HOME OWNERSHIP AND QUALITY

HEARING OF THE SUBCOMMITTEE ON HEALTH HOUSE COMMITTEE ON WAYS AND MEANS

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STATEMENT OF THE CENTER FOR MEDICARE ADVOCACY

The recent investigative report in *The New York Times* describing the new phenomenon of private equity firms' taking over multi-state nursing home chains and the declining quality of care for residents that results¹ has brought to the public's attention two important issues – the nursing home industry's use of public reimbursement for private gain, rather than to provide high quality care to residents, and the poor quality care experienced by residents of many nursing homes.

The separation of nursing home management from nursing home property is highlighted by the phenomenon of private equity's recent interest in the nursing home industry, but the issue is not unique to private equity firms. The mechanism has been actively promoted as a way for nursing home companies to avoid liability from public regulatory agencies as well as from private litigants.² Over the years, chains other than private equity firms have used multiple corporations to hide assets and avoid creditors and have used public reimbursement to purchase unrelated businesses.

In a three-day series published November 18-20, 2007, the *Hartford Courant* reported that Haven Healthcare, a Connecticut-based chain caring for nearly 2000 residents in Connecticut, provided seriously inadequate care at 10 of its 15 facilities in the state.³ The chain failed to pay multiple creditors and the owner is accused of diverting reimbursement to fund his investment in a country music recording company in Nashville, Tennessee and personal real estate. On the third day of the series, the chain and its 44 related entities filed for bankruptcy.⁴

¹ Charles Duhigg, "More Profit and Less Nursing at Many Homes," *The New York Times* (Sep. 23, 2007), http://www.nytimes.com/2007/09/23/business/23nursing.html?_r=1&oref=slogin. As the *Wall Street Journal* observed, Manor Care was a desirable take-over target for the Carlyle Group because it owns most of its real estate and because 73% of its revenues come from Medicare and private-pay residents, compared to 53% for some of its competitors. Theo Francis, "Real Estate Is Driver Of Manor Care Buyout Deal; Nursing-Home Firms, Attractive at Moment, Are Acquisition Targets," *The Wall Street Journal* (July 3, 2007). An editorial in *McKnight's Long Term Care* expressed the concern that if the Carlyle Group acts like "a typical private equity firm, . . . we can expect to see aggressive cost-cutting including layoffs." John O'Connor, "Opinion – The Big Picture: Manor Care and the future," *McKnight's LongTerm Care* (Aug. 8, 2007), [http://www.mcknightsonline.com/content/index.php?id=24&tx_ttnews\[swords\]=Manor%20Care&tx_ttnews\[pointer\]=1&tx_ttnews\[tt_news\]=4040&tx_ttnews\[backPid\]=25&cHash=2184780248](http://www.mcknightsonline.com/content/index.php?id=24&tx_ttnews[swords]=Manor%20Care&tx_ttnews[pointer]=1&tx_ttnews[tt_news]=4040&tx_ttnews[backPid]=25&cHash=2184780248).

² Joseph E. Casson and Julia McMillen, "Protecting Nursing Home Companies: Limiting Liability through Corporate Restructuring," *Journal of Health Law*, Vol. 36, No. 4, page 577 (Fall 2003), http://www.proskauer.com/news_publications/published_articles/content/2003_12_02.

³ Lisa Chedekel and Lynne Tuohy, "No Haven for the Elderly; Nursing Home Troubles Show Flaws in State Oversight," *Hartford Courant* (Nov. 18, 2007), http://www.courant.com/news/custom/topnews/hc-haven1.artnov18,0,1229473.story?coll=hc_tab01_layout.

⁴ Lynne Tuohy and Lisa Chedekel, "Nursing Home Takeover Sought; After Haven Files for Bankruptcy, Blumenthal Wants Trustee to Control Facilities," *Hartford Courant* (Nov. 22, 2007), <http://www.courant.com/news/custom/topnews/hc-haven1122.artnov22,0,5263895.story>; Lisa Chedekel and Lynne Tuohy, "Haven Debt Woes," *Hartford Courant* (Nov. 20, 2007), http://www.courant.com/news/custom/topnews/hc-haven3.artnov20,0,2146972.story?coll=hc_tab01_layout. Haven Healthcare's bankruptcy filing is at <http://www.courant.com/media/acrobat/2007-11/33896687.pdf>.

The private equity takeover of nursing home chains has led to many calls for more “transparency” in ownership of nursing homes. Requiring full and comprehensive disclosure of ownership information is a useful, but not sufficient, step to improving quality of care and quality of life for residents. More specific substantive changes are also required to ensure that residents receive the care they need.

There is no single answer to problems of poor quality of care and poor quality of life in nursing homes; multiple efforts are needed. Many solutions have already been identified. Congress should

1. Enact meaningful nurse staffing ratios. Congress needs to enact specific staffing ratios to ensure that facilities employ sufficient numbers of professional and paraprofessional nurses to provide care to residents.

Nurse staffing is the single best predictor of good quality of care. Residents need to be cared for by professional nurses and by sufficient numbers of well-trained, well-supervised, and well-supported paraprofessional workers.

The current standard in federal law is “sufficient” staff to meet residents’ needs, including one registered nurse eight consecutive hours per day seven days per week.⁵ This standard, enacted in 1987 as part of the Nursing Home Reform Law, has not worked to ensure that facilities have sufficient numbers of well-qualified and well-trained staff.

In 2001, the Centers for Medicare & Medicaid Services (CMS) submitted a report to Congress documenting that more than 91% of facilities fail to have sufficient staff to prevent avoidable harm and that 97% of facilities do not have sufficient staff to meet the comprehensive requirements of the Nursing Home Reform Law.⁶

Raising reimbursement rates in the hope that facilities will increase their staffing levels as a result does not improve staffing. Congress increased Medicare reimbursement rates in 2000, specifically for nurse staffing.⁷ The Government Accountability Office (GAO) found that staffing levels remained stagnant and that staffing increased only when states mandated explicit staffing ratios or made other policy changes specifically directed at increasing nurse staffing.⁸

⁵ 42 U.S.C. §§ 1395i-3(b)(4)(C)(i), 1396r(b)(4)(C)(i)(1), Medicare and Medicaid, respectively.

⁶ CMS, *Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes, Phase II Final Report*, pages 1-6, 1-7 (Dec. 2001), http://www.cms.hhs.gov/CertificationandCompliance/12_NHs.asp (scroll down to Phase II report) [hereafter CMS 2001 Nurse Staffing Report].

⁷ Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, Pub.L. 106-554, App. F, §312(a), 114 Stat. 2763, 2763A-498.

⁸ GAO, *Available Data Show Average Nursing Staff Time Changes Little after Medicare Payment Increase*, GAO-03-176, page 3 (Nov. 2002), <http://www.gao.gov/new.items/d03176.pdf>. Nurse staffing time increased by 1.9 minutes per day; registered nurse time decreased and licensed practical nurse and aide time increased.

The staffing ratios that CMS and other experts identified nearly a decade ago need to be mandated and implemented.⁹

2. Require accountability for public reimbursement. Congress needs to ensure that public reimbursement through Medicare and Medicaid funding is spent, as Congress intends, on the care of people who live in nursing homes. In testimony before this Subcommittee, Professor Charlene Harrington described the concern: Medicare reimbursement is based on specific amounts for various components of care, such as nurse staffing, but once a facility receives Medicare reimbursement, it can spend the money in whatever way it chooses. Professor Harrington called for cost centers and for rules prohibiting facilities from shifting reimbursement from one cost center to another (e.g., from staffing to administration). The Center for Medicare Advocacy supports Professor Harrington's recommendation that Congress ensure that public funds are used for their intended purpose.

Recent reports about the purchase of Manor Care by the Carlyle Group indicate that when the sale is completed, Manor Care's CEO Paul Ormond, whose compensation was \$18,800,000 last year, may receive between \$118,000,000 and \$186,000,000 through the exercise of stock options.¹⁰

3. Increase and stabilize funding for survey and certification activities. The budget for survey and certification activities needs to be increased at the state and federal levels to allow for sufficient numbers of well-trained, multi-disciplinary staff to conduct annual, revisit, and complaint surveys. At present, the federal government spends less than ½ of 1% monitoring care in nursing homes, compared with the amount spent on the care itself.¹¹

⁹ Using empirical data, the 2001 CMS staffing report identified 3.55 – 4.1 hours per resident day as the number of nurse staffing hours needed to prevent avoidable harm to residents. In the simulation component of the staffing study, CMS identified, as appropriate ratios of certified nurse assistants to residents to meet the requirements of federal law, 8:1 on the day shift, 10:1 on the evening shift, and 20:1 on the night shift. CMS, *2001 Nurse Staffing Report*, *supra* note 8. These ratios are similar to those identified by an expert panel convened by the John A. Hartford Institute for Geriatric Nursing, Division of Nursing, at New York University: 4.13 hours per resident day for direct nursing care staff (ratios for direct care staff, 5:1 on the day shift; 10:1 on the evening shift; and 15:1 on the night shift). Charlene Harrington, Christine Kovner, Mathy Mezey, Jeanie Kayser-Jones, Sarah Burger, Martha Mohler, Robert Burke, and David Zimmerman, "Experts Recommend Minimum Nurse Staffing Standards for Nursing Facilities in the United States," *The Gerontologist*, Vol. 40, No. 1, 2000, 5-16.

¹⁰ Homer Brickey, "Manor Care sale would enrich execs; Toledo firm's officials may receive more than \$200 million for stock," *The Toledo Blade* (July 6, 2007), <http://toledoblade.com/apps/pbcs.dll/article?AID=/20070706/BUSINESS03/707060449/-1/BUSINESS>.

¹¹ National spending on nursing home care in 2005 was \$80.6 billion (\$21.6 billion for Medicare; \$59.0 billion for Medicaid). Georgetown University Long-Term Care Financing Project, "National Spending for Long-Term Care" (Fact Sheet, Feb. 2007), <http://ltc.georgetown.edu/pdfs/natspendfeb07.pdf>. The federal survey budget for states for all survey activities is \$293 million for fiscal year 2008. Budget of the United States Government, Fiscal Year 2008, Appendix (Department of Health and Human Services), page 23, <http://www.whitehouse.gov/omb/budget/fy2008/pdf/appendix/hhs.pdf>. In general, more than three-quarters of state survey agency time is focused on nursing homes.

Limited survey budgets lead to insufficient numbers of survey staff. Without a strong survey system to detect deficiencies, and the enforcement actions that may be imposed for documented deficiencies, many facilities will not provide care to residents in compliance with federal standards.¹²

4. Strengthen the enforcement system. Congress needs to ensure that enforcement is swift, certain, comprehensive, and meaningful. In the 1987 Nursing Home Reform Law, Congress required the Secretary and states to take a stronger enforcement approach to deficiencies: it required that the Secretary and states have a comprehensive strategy for enforcement; enact and use a full range of intermediate sanctions; impose more significant sanctions for deficiencies that are repeated or uncorrected; and shorten the time between identifying the problem and imposing remedies. The federal regulations did not implement this statutory mandate and have failed to ensure compliance with federal standards of care.

In its most recent nursing home report,¹³ the GAO reiterated once again, as it has consistently and repeatedly reported since 1998, that the enforcement system is too lax and too tolerant of poor care for residents and that it allows most facilities to avoid meaningful consequences for their deficiencies.

- Deficiencies are not cited. The GAO¹⁴ and State Auditors¹⁵ repeatedly report that surveyors fail to identify and cite many deficiencies.
- Deficiencies are described as less serious than they actually are. Many deficiencies are identified as causing no harm to residents when, in fact, they cause harm.¹⁶

¹² Helena Louwe, Carla Perry, Andrew Kramer (Health Care Policy and Research, University of Colorado Health Sciences Center), *Improving Nursing Home Enforcement: Findings from Enforcement Case Studies* page 44 (March 22, 2007), http://www.medicareadvocacy.org/SNF_FinalEnforcementReport.03.07.pdf (“Although ‘the case studies revealed that enforcement actions, if executed, have only a limited positive effect . . . it must be recognized that nursing home behavior changes seldom occurred without a formal citation.’ [hereafter University of Colorado, *Improving Nursing Home Enforcement*]).

¹³ GAO, *Efforts to Strengthen Federal Enforcement Have Not Deterred Some Homes from Repeatedly Harming Residents*, GAO-07-241 (March 2007), <http://www.gao.gov/new.items/d07241.pdf> [hereafter GAO 2007 Report]. The GAO has issued more than a dozen reports on nursing home survey and certification issues since 1998. These reports are listed at pages 92-93 of the 2007 report.

¹⁴ See, e.g., GAO, *Nursing Home Deaths: Arkansas Coroner Referrals Confirm Weaknesses in State and Federal Oversight of Quality of Care*, GAO-05-78 (Nov. 2004), <http://www.gao.gov/new.items/d07241.pdf>. See also University of Colorado, *Improving Nursing Home Enforcement*, *supra* note 12.

¹⁵ See, e.g., California State Auditor, *Department of Health Services: Its Licensing and Certification Division Is Struggling to Meet State and Federal Oversight Requirements for Skilled Nursing Facilities*, 2006-106 (April 2007), <http://www.bsa.ca.gov/pdfs/reports/2006-106.pdf> [hereafter California Auditor 2007]; Colorado State Auditor, *Nursing Facility Quality of Care: Department of Public Health and Environment, Department of Health Care Policy and Financing (Performance Audit)* (Feb. 2007), [http://www.leg.state.co.us/OSA/coauditor1.nsf/All/D2FC96140165870D8725728400745D8C/\\$FILE/1767%20NurseHomePerf%20Feb%202007.pdf](http://www.leg.state.co.us/OSA/coauditor1.nsf/All/D2FC96140165870D8725728400745D8C/$FILE/1767%20NurseHomePerf%20Feb%202007.pdf) [hereafter Colorado Auditor 2007].

- Deficiencies that are cited do not lead to sanctions or lead to only minimal sanctions. Remedies that are discretionary are imposed infrequently; per day and per instance civil money penalties are often imposed at the lower ends of the allowable range; and temporary management is almost unknown. The Secretary does not impose denial of payment for all Medicare and Medicaid beneficiaries, as authorized by law.¹⁷

While CMS could use additional enforcement tools, such as the state remedy of denial of all admissions, the GAO has repeatedly shown that CMS and state survey agencies do not use the full range of remedies they currently have.

Despite these serious shortcomings, recent research demonstrates that the survey and enforcement system is essential to securing compliance by nursing facilities. Without the system, facilities do not make necessary changes.¹⁸

The nursing home industry advocates for weakened enforcement and calls for alternative, ineffectual, “voluntary” collaboration between survey agencies and nursing homes

The nursing home industry opposed the comprehensive enforcement provisions of the Nursing Home Reform Law as the law was being enacted in 1987 and it has continued its opposition ever since, often trying to weaken the law or undermine it, or both. For example, the American Health Care Association unsuccessfully challenged the per instance civil money penalty regulation that the Health Care Financing Administration promulgated in 1999.¹⁹ Over the years, the industry has also developed a series of voluntary “quality initiatives” – *Quest for Quality*, *Quality First*, *Advancing Excellence in America’s Nursing Homes* – that promise a commitment to high quality care, but that undermine the regulatory system by establishing alternative criteria for evaluating nursing facilities. In contrast to the criteria established by the regulatory system, these industry criteria reflect secret goals and targets for improvement that are voluntary, self-reported and unaudited, and lack public accountability.²⁰

Voluntary efforts, such as those used by Quality Improvement Organizations (QIOs), do not improve care for residents. A recent evaluation of the National Nursing Home Improvement Collaborative found that the QIO’s \$1,400,000 project to reduce the

¹⁶ GAO, *Nursing Home Quality: Prevalence of Serious Problems, While Declining, Reinforces Importance of Enhanced Oversight*, GAO-03-561 (2003), <http://www.gao.gov/new.items/d03561.pdf>; California Auditor, *supra* note 15; Colorado Auditor; *supra* note 15.

¹⁷ GAO 2007 Report, *supra* note 13.

¹⁸ University of Colorado, *Improving Nursing Home Enforcement*, *supra* note 14.

¹⁹ *American Health Care Association v. Shalala*, D.D.C., Civil No. 1:99CV01207 (GK) (case dismissed, March 6, 2000), unsuccessfully challenging final regulations published at 64 Fed. Reg. 13,354 (March 18, 1999), 42 C.F.R. §§488.430(a), 488.438(a)(2).

²⁰ Center for Medicare Advocacy, *The “New” Nursing Home Quality Campaign: Déjà vu All Over Again* (Sep. 21, 2006), http://medicareadvocacy.org/AlertPDFs/2006/06_09.21.SNFQualityCampaign.pdf.

incidence and prevalence of pressure ulcers in 35 nursing facilities (all members of multi-state chains) “did not significantly affect the overall rate of [pressure ulcers or PUs],” although it “substantially reduced the rate of Stage III and IV PUs.”²¹ The researchers, who are primarily affiliated with the QIO community, recommend excluding Stage I and II pressure ulcers from publicly-disclosed pressure ulcer rates. They also recommend reporting “process” measures, rather than “outcome” measures of pressure ulcer prevalence and incidence. These changes would make facilities appear to be doing a better job in addressing pressure ulcers – and reported pressure ulcer rates would suddenly fall – but they would not improve actual outcomes for residents. The American Health Care Association applauds nursing homes’ collaborative work with QIOs and “encourages CMS to swiftly adopt the study’s recommended changes for measuring pressure ulcers.”²²

Conclusion

The New York Times identified problems in nursing home care when private equity firms take over nursing homes. These problems extend beyond private equity firms and reflect problems throughout the nursing home industry. Congress needs to act in order to ensure that standards of care, including staffing levels, are high and that they are meaningfully and effectively enforced.

ABOUT THE CENTER FOR MEDICARE ADVOCACY, INC.

The Center for Medicare Advocacy is a non-profit, non-partisan organization that works to obtain fair access to Medicare and necessary health care for older people and people with disabilities. The Center, founded in 1986, provides education, analytical research, advocacy, and legal assistance to help older people and people with disabilities obtain necessary health care. The Center focuses on the needs of Medicare beneficiaries, people with chronic conditions, and those in need of long-term care. The Center provides training on Medicare and health care rights throughout the country and serves as legal counsel in litigation of importance to Medicare beneficiaries nationwide.

²¹ Joanne Lynn, Jeff West, Susan Hausmann, David Gifford, Rachel Nelson, Paul McGann, Nancy Bergstrom, and Judith A. Ryan, “Collaborative Clinical Quality Improvement for Pressure Ulcers in Nursing Homes,” *Journal of American Geriatric Society* 55:1663-1669 (2007) (quoted language at 1668).

²² AHCA, “American Health Care Association Praises Collaborative Efforts with Quality Improvement Organizations to Enhance Patient Outcomes” (News Release, Oct. 22, 2007), http://www.ahcancal.org/News/news_releases/Pages/22Oct2007.aspx.