



May 15, 2009

The Honorable Max Baucus, Chair
The Honorable Charles E. Grassley, Ranking Member
Senate Finance Committee
Washington, DC 20510

Dear Senator Baucus, Senator Grassley and Members of the Finance Committee:

The American Association of Homes & Services for the Aging (AAHSA) appreciates this opportunity to comment on the policy options proposed by the Senate Finance Committee (April 29, 2009) on transforming the health care delivery system (hereafter, "Report"). We commend the Committee on the thoroughness of its approach to the very diverse issues affecting efficiency and quality in our health care system.

AAHSA members 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 5,800 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.

While the focus of the April 21 Roundtable was acute care, long term services and supports – the services provided to help individuals maintain their functional abilities – is integral to the health care delivery system. The average person simply does not distinguish between acute care and health care services and long-term care and services. Most people believe their health insurance, or their Medicare benefits, already covers things like a caregiver to help one get better after getting out of the hospital. Roundtable participants and the Committee obviously understand there is a relationship between acute care and post-acute care. However, we hope the discussion on delivery systems will expand to incorporate other elements of long-term services and supports (LTSS), so we can make long-lasting changes in the way people access and manage their health care.

We will now respond to specific policy options:

Medicare Home Health Agency and Skilled Nursing Facility Value-based Purchasing Implementation Plans (p. 5)

AAHSA has supported legislation calling for payment incentives to improve quality since at least 2004. The current Medicare payment system for skilled nursing and for home health lacks

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incentives to promote quality. By paying providers identical rates, exemplary performance goes unrecognized and poor outcomes are reimbursed at a high cost to Medicare and the tax payer. We support creation of a more effective reimbursement system for long term care that is efficient, equitable and sustainable and improves the quality of health care provided in nursing facilities and by home health agencies.

The Report has recommended the Secretary complete Medicare value-based purchasing implementation plans for skilled nursing facilities by 2012 and home health agencies by 2011. To issues (1) and (2) we would add the following points to those identified and recommended by the Committee:

- (1) “[D]evelopment, selection and modification process of measures of quality and efficiency.” Quality indicators appropriate for payment purposes do not currently exist in the nursing home sector, as acknowledged by MedPAC and others. The measures developed by the Secretary must be suitable for use in a payment system. We appreciate that the Committee requires the Secretary to consult with relevant stakeholders, and AAHSA is very willing to engage in this process.
- (2) “[R]eporting, collection and validation of quality data.” One key area to include is reporting dollars spent on nurse staffing through the Medicare cost report. This is included in the Nursing Home Transparency section of this Report at page 31, but we wanted to highlight it here, as it is directly related to performance and is essential to ensuring that payment goes for nurse staffing, thus increasing the potential for quality outcomes.

Payment for Transitional Care Activities (pp. 10-11)

We strongly support integrated, transitional care management for persons with chronic conditions, and we commend the Committee for addressing this issue. The Report recommends reimbursing physicians for care management activities relating to certain conditions (congestive heart failure, COPD, etc.).

The Committee asked if this policy should be expanded to include care coordination payments for beneficiaries at highest risk for hospitalization, and we would support that. However, we believe long term services and supports should be included in developing models for transitional care. Transitional care is one of the key areas where the acute care and long term care worlds can either collide or work together. Nursing home, home health, and adult day providers spend more time with the older adult with chronic disease than the physician, as do family caregivers. LTSS has been shown to improve disease prevention and promote healthy lifestyles, as well as help persons

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with disabilities and chronic health needs navigate the system, manage their care, and remain independent. The LTSS support system and the acute care system need to be integrated. AAHSA would be pleased to work with the Secretary to determine the most effective ways to accomplish this goal.

CMS Chronic Care Management Innovation Center (pp. 11-12)

For the reasons discussed above, we urge the Secretary to include long term services and supports in its demonstration projects, and AAHSA and its members, all of whom are not-for-profit and many of whom have independent research institutes, are ready to work with the Secretary to develop appropriate pilots to identify LTSS models as discussed on page 12 in “Proposed Options”.

Hospital Readmissions and Bundling (pp. 13-16)

The Report recommends bundling Medicare payments for hospital and post-acute care as a means of preventing rehospitalizations and ensuring beneficiaries’ well-being as they transition among different levels of care. Our members include the broad spectrum of post-acute care providers that would be affected by bundling – nursing homes, home health agencies, home and community based services. It is difficult to address the recommendations in the Report because they lack detail and so much work needs to be done to develop a bundling proposal that addresses the Committee’s concerns. Issues such as beneficiaries’ ability to choose the settings in which they receive services, to return to a nursing facility or retirement community they consider to be their home, and to have their post-acute care providers determined on the basis of quality as well as cost must be examined and resolved before this proposal is implemented. Criteria such as whether the hospital has implemented quality improvement measures and patient safety protocols as described in the various Institute of Medicine studies on preventable error should also be considered, as well as training and expertise in dementia (see testimony of Mary Naylor at the Committee hearing). Since hospital and post-acute corporate entities have different (Medicare) payment structures and regulatory obligations, another key issue to be addressed and resolved is how to integrate these payment structures and determine a rate setting that is fair, reasonable and transparent.

The Centers for Medicare and Medicaid Services currently is researching the potential impact of bundling on Medicare beneficiaries. While the Report identifies steps for CMS to take to develop post-acute care bundling, we strongly believe the current research should be completed first so mechanisms that must be in place to protect quality of care are identified. In addition, we support

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the recommendations made by MedPAC to begin with a voluntary pilot program, “to allow CMS to resolve ... design and implementation issues, while allowing providers who are ready the chance to start receiving a bundled payment”. (MedPAC roundtable statement to Committee, April 21, 2009, p. 12).

In addition, the Report suggests non-profit entities other than hospitals may be more appropriate to manage the bundled payment. Community-based organizations with expertise in caring for persons with chronic conditions, the elderly and persons with disabilities may very well be better positioned to manage post-acute care than hospitals. This approach has been shown to work extremely well in the PACE program and other fully integrated systems that take advantage of the knowledge of specialized physicians and providers who have valuable expertise in managing patients with multiple chronic conditions and in providing the kinds of services with which hospitals may have limited experience. We recommend the Secretary be directed to include all high-performing stakeholders in the process both to determine overall criteria for bundling so there is consistency and transparency, and when evaluating bundling for specific geographic areas or communities. As noted above, AAHSA and its members are pleased to work with the Secretary on all these issues.

Nursing Home Transparency (pp. 29-33)

AAHSA supports the recommendations to improve nursing home transparency as outlined in this Report. These provisions will increase transparency and promote accountability by requiring all nursing homes to disclose their ownership. We share the Committee’s view that the public must have complete information on the individuals who may effectively be held accountable for the quality of services provided in a nursing facility. In addition, as noted above, the recommendation 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.

We have two suggestions we hope the Committee will consider. First, on the independent monitor pilot program, we assume the purpose is to address systemic problems in large nursing home systems or chains, rather than problems in individual homes. It would be helpful to include in the direction to the Secretary more specific criteria for the Secretary to address in determining whether this concept is feasible and the criteria for involuntary inclusion in a permanent plan.

Secondly, we agree that the training and education programs for direct care workers and supervisors should be re-evaluated. We would add administrators and other high-level employees to the study. For additional information, we refer the Committee to our comments on the workforce section, following technology, below.

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Encouraging Health Information Technology Use and Adoption in Support of Delivery System Reform Goals (pp. 19-21)

We strongly support expanding incentives to other health care providers, including long-term care providers. The HITECH provisions in the American Recovery and Reinvestment Act recognized that nursing homes, home health, and other long-term care providers are an integral part of the health care system. We believe that HIT infrastructure and EHR systems which are interoperable across provider settings ensure the continuity of information, and thus continuity of care, and can lead to fewer medical errors and duplicative procedures and expenditures, while improving care quality, especially for the aging population.

The development of interoperable electronic health record and personal health records is critical to the success of technology implementation. We support the national initiatives to develop EHRs and encourage work on PHRs. These activities form the foundation for the future vision of how networked healthcare systems will operate between older adults, caregivers, family members and healthcare providers.

Seniors usually have multiple chronic conditions and complex co-morbidities. They receive care from a multitude of providers and transition frequently between acute and long-term care settings. They would benefit the most from networked healthcare systems. Key to maximizing the benefits of a networked healthcare system is the inclusion of long-term care settings, such as assisted living, skilled nursing, home health, home care and specialty services providers in the network. Standards for such electronic record systems should take into account the functional assessment data and patient summaries required by long-term care providers, to allow the electronic exchange of critical health information among all care providers. Lack of interoperability is one of the important barriers to the adoption of these technologies.

Although analysis of the 2004 National Nursing Home Survey revealed use of electronic information systems in NH patient care functions is considerably greater than previously thought and actually exceeds the adoption rate of physician offices, there remains considerable room for improvement; this study clearly points out the role of federal policy in driving some features of electronic information systems utilization in nursing homes, such as billing and MDS reporting.

It is critically important not to allow the long-term side of the health care system to languish while the acute-care side is built up. We need to build both sides at the same time, if we are to ensure patients are not lost in the process. We therefore strongly support including long-term care providers in the incentive program so as to enable them to prepare their information and communications infrastructure and deploy new technologies, including HIT and interoperable

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EHR systems, as well as other technologies for care documentation by direct care workers which improve the quality of care.

Workforce (pp. 33-37)

We support the policy options presented in this section. We are concerned, however, about the lack of focus given to the special health care needs of elders and the scarcity of health care professionals at all levels who are educated and trained to care for this population.

Elders use health care in greater numbers and in greater proportion than do younger people, and yet they are one of the least well-served cohorts under our present system. Last year's report by the Institute of Medicine, *Retooling for an Aging America: Building the Health Care Workforce*, pointed out the nation is not ready to meet the social and health care needs of a rapidly aging population. The report noted the sheer number of baby boomers aging into needing help with chronic health conditions and the diversity of this population in terms of education, dispersal of families, longevity, and racial and ethnic differences. The report also emphasized the shortage of health care workers, especially in the long-term services and supports field, and the inadequate training all levels of the healthcare workforce receive in caring for older adults.

We urge the Committee to include the following provisions in health care reform or related legislation:

- **Research into core competencies:** Effective education and training standards require identification of the knowledge and skills needed across all settings for all categories of long-term care professionals, including administrators, nurses, medical directors, social workers, and direct service workers. Only when a determination has been made as to what knowledge and skills are necessary to various positions in the aging services field can effective standards be set for education and training.
- **Incentives under state and federal payment systems for appropriate spending on direct care:** Currently, the Medicare prospective payment system allows nursing homes to profit by cutting spending on both staffing and other, indirect care costs. The Medicare and state Medicaid programs should adopt strategies such as modified pricing that create appropriate incentives for spending on direct care. A modified pricing payment system has been adopted by a number of states, and features a component tying payment to direct care (e.g., nurse staffing). Profit potential on this direct care component is minimized, and incentives to reduce spending are focused on other aspects of nursing home costs such as administration.

- **Full funding of federal healthcare recruitment, retention, and education programs and increased focus on geriatrics:** Programs under Titles VII and VIII of the Public Health Service Act are essential to attract and retain more people into the health care professions and the long-term services and supports field. Important initiatives funded under these programs include continuing education for nurses in aging services and management. Loans also are available to increase the number of qualified faculty at nursing schools, which have had to turn away thousands of applicants for nursing education due to faculty shortages. The field also needs increased focus on geriatric training under federal healthcare workforce programs to ensure all healthcare professionals have the special skills and knowledge necessary to care for seniors.

Finally, to summarize our recommendations (by section):

Medicare Home Health Agency and Skilled Nursing Facility Value-based Purchasing Implementation Plans:

- Quality indicators appropriate for payment purposes do not currently exist in the nursing home sector, therefore the measures developed by the Secretary must be suitable for use in a payment system. We appreciate that the Committee requires the Secretary to consult with relevant stakeholders, and AAHSA is very willing to engage in this process.
- Include reporting dollars spent on nurse staffing through the Medicare cost report. This is directly related to performance and is essential to ensuring payment goes for nurse staffing, thus increasing the potential for quality outcomes.

Payment for Transitional Care Activities (pp. 10-11); CMS Chronic Care Management Innovation Center (pp. 11-12)

- Include long term services and supports when developing models for transitional care.

Hospital Readmissions and Bundling (pp. 13-16)

- Complete CMS research before adopting bundling so mechanisms that must be in place to protect quality of care are identified and addressed.
- Include all high-performing stakeholders in the process both to determine overall criteria for bundling so there is consistency and transparency, and when evaluating bundling for specific geographic areas or communities.

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Nursing Home Transparency (pp. 29-33)

- Include in the direction to the Secretary more specific criteria for the Secretary to address in determining how to implement the independent monitoring program and the criteria for involuntary inclusion in a permanent plan.
- Include administrators and other supervisory staff in enhanced education and training, and integrate with workforce improvements.

Encouraging Health Information Technology Use and Adoption in Support of Delivery System Reform Goals (pp. 19-21)

- Include long-term care providers in the incentive program so as to enable long-term providers to prepare their information and communications infrastructure and deploy new technologies, including HIT and interoperable EHR systems, as well as other technologies including technologies for care documentation by direct care workers that improve the quality of care.

Workforce (pp. 33-37)

- Conduct research into core competencies for long-term care.
- Provide incentives for appropriate spending on staffing in long-term care.
- Fully fund federal healthcare recruitment, retention, and education programs and increase the focus on geriatrics.

In conclusion, we thank you for this opportunity to comment, and offer our members' commitment to working with the Congress and the Administration on these critical issues.

Sincerely,



William L. Minnix, Jr.
President and CEO