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EVALUATING AND IMPROVING THE NURSING HOME RATINGS SYSTEM

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P R O C E E D I N G S

MR. YARAGHI: Good afternoon. I am Niam Yaraghi, a fellow at the Center for Technology Innovation at Brookings, and I'd like to welcome all of you to our event on evaluating and improving the nursing homes rating system. Nearly two million Americans reside in more than 15,000 nursing homes all around the United States. Medicaid alone spends more than $140 billion on the services provided in these nursing homes. Given that, I think it is very important for patients, their families, and caregivers to have a thorough understanding of the quality of the services provided in the nursing homes. Over the past few years, Centers for Medicare and Medicaid has done a phenomenal job in identifying quality metrics, collecting relevant data, creating aggregate measures, and then reporting them to the public. These efforts has resulted in services such as Nursing Home Compare website, which provides unprecedented data about the performance of the nursing homes in a very easy to understand format of five-star ratings. Like hotels, nursing homes are now being rated between one to five stars, depending on the on-site inspections done independently by CMS auditors and two self-reported domains of quality measures and staffing metrics.

The percentage of the nursing homes who obtained five-star overall rating as a result of their self-reported measures has continuously increased from 11 percent in 2009 to almost 25 percent in 2003 (sic). So in collaboration with Xu Han and Ram Gopal at the University of Connecticut, I conducted a research to see if inflation exists in the self-reported measures. Our research shows that self-reported ratings are neither associated with the on-site inspections in the same year, nor the year after. Moreover, patient reported complaints gathered by independent third parties are not predicted by the overall ratings who could potentially be inflated, but rather are very

precisely predicted by on-site inspections which cannot be predicted.

Overall, we estimate at least six percent of the nursing homes in California, which is the state that we studied, are likely inflating their self-reported measures. Now, I have to say it is a very small percentage. However, given the importance of these ratings, we believe there is still room for improvement. We have a terrific panel of experts here today to discuss the current rating system and the strategies to improve it. But before we start that discussion, I would like to mention that the support for this research was generously provided by National Institute for Health Care Management.

So I'm pleased to introduce Cristina Boccuti, who is an associate director of the program on Medicare Policy at the Kaiser Family Foundation. She conducts a number of projects as a part of the Kaiser project on Medicare Future, which is a major foundation initiative focused on producing timely analysis of Medicare reform proposals and on informing the debate about the future of Medicare program. Joe DeMattos is the president and CEO of Health Facilities Association of Maryland, which is the oldest and largest long-term association in this state representing skilled nursing, sub-acute facilities, assisting living programs, and continuing care retirement communities. He just returned from Hawaii. Toby Edelman is senior policy attorney at Centers for Medicare Advocacy. She has been representing older people in long-term facilities since 1977. She provides training research, policy analysis consultation, and litigation support relating to nursing homes and other long-term facilities. And finally, Edward Mortimore is technical director at Division of Nursing Homes at the Center for Medicare and Medicaid Services. He helped launch Nursing Home Compare in 1998 and has overseen its operation since. He has also led the development of the five-star quality rating system in Nursing Home Compare website. He has worked extensively with academic

researchers, government program evaluators, and the press in developing methods to use CMS data to monitor changes in the U.S. population of nursing home residents, as well as to evaluate the effectiveness of the CMS regulatory oversight of those nursing homes.

So Christina, I would like to begin with you. You, last year published a report that looked at the star ratings in different nursing homes and one of the interesting results that you reported in your research was the fact that the states that have higher proportions of low-income seniors tend to also have higher proportions of lower-rated nursing homes. Why do you think that is?

MS. BOCCUTI: Well, yes we did have that finding. And I think it relates to the geography of the types of nursing homes that are in those states. So we found, for example, that for-profit nursing homes tended to have lower -- larger shares of for-profit nursing homes had lower ratings than the not-for-profit nursing homes, which are -- so the for-profits are more often located in areas where seniors, higher rates of seniors in poverty. Also, smaller nursing homes had higher ratings, tended to have higher ratings than larger nursing homes, and we found that to be the case both for for-profits and not-for-profits. But we have also found that larger nursing homes are more often in areas with lower-income seniors. So those would be some of the findings that relate to the income.

I would also point out that state comparisons, and that's partly what that was. State comparisons have an issue in the methodology of these state ratings in that the health inspection rating -- which is one that is not self-reported, as you've been pointing out -- the state ratings are curved essentially, so that in every state it has to be that I think the bottom -- let's see, I wrote this down -- the top ten percent get five star, the bottom 20 percent get one star, and then the remaining are evenly distributed. So that's

a constant. So comparing state-to-state on just those measures, you'll get the same thing. So what it does highlight is that the differences between states and areas, even if you're -- however it is -- is really a factor of the other two measures that are self-reported.

So I think that's an important thing to think about, but it also means that the differences could be much wider if you look across the states. Because, say for instance, you have one state where, let's just say, all the nursing homes are fantastic, but they still have to show that the bottom, you know, the bottom two, the bottom 40 percent, are only going to have one or two stars, even if they're all very good. And so that kind of opens up the door to, well, what really is happening when you look nationally. And so sometimes, I think it might be interesting if we saw both. You know, like the state, how they are relative to others in the state, because there are reasons why it's just there are state-relative norms and that that's what you're looking for. People aren't comparing, mostly, whether they're going to go to a nursing home in Alabama or Vermont. They're looking in their area, so you look at a relative in their area. But we don't know about it nationally very well. And so I always, I think about what else we could learn if we looked at it both ways. So that gets to that geographic issue. And I think I'll stop there. Of course I have several more points to make, but maybe that'll come as we continue.

MR. YARAGHI: All right. Thank you. Joe, I've heard that the CMS on-site inspections are like the like Super Bowl for nursing homes. So could you please provide the perspective of the nursing homes about their ratings and the importance of the ratings for the nursing homes?

MR. DeMATTOS: I guess the first thing I would say is that the CMS rating system has been incredibly valuable to both consumers and people working in partnership in the health care continuum. So consumers in Maryland, and all across the country, go to Nursing Home Compare and they look at those rating systems, and they

compare skilled nursing and rehab centers. And when hospitals on the one end of the continuum, or home health care, decide with whom to partner with in a local community, like in Baltimore, they put value in those five-star ratings systems. So I think having the system is a major step forward. Generally speaking, in terms of any rating system, of course none of them are perfect, and that's true of this one as well. One of the challenges is that it is an inherently curved system -- that the percentages of one star versus five stars are statistically allocated, so that's sort of just a necessary design flaw.

Annual inspections and complaint-driven inspections are a big deal in skilled nursing and rehab centers. They're not prevalent in other settings. In most other settings, all of the quality measures are self-reported. They're not based on annual inspections, whereas a physician's office or a medical center. So annual inspections are a big deal in skilled nursing and rehab centers.

A couple of points I think that are interesting about Maryland specific, when we talk about not the 1,600 skilled nursing and rehab centers that were part of this study, but the nearly 16,000 across the country, and you compare them with Maryland as a snapshot. So interestingly, Maryland has a very, very diverse skilled nursing and rehab community. About 233 centers, everything from Genesis HealthCare, which is the largest provider in the United States, which has almost 40 centers in Maryland, down to second, third generation women-owned, they own one center.

And what's interesting in Maryland is that the number one largest center in terms of number of beds, number of days served, in all of Maryland, is the Charles E. Smith Living Community, just a little bit down the road here in Montgomery County. And it's a non-for-profit that very, very much operates and sustains itself as running as a for-profit in terms of its business enterprise. And the number two largest skilled nursing and rehab center in Maryland is Stella Maris in Towson, a non-for-profit owned by the Sisters

of Mercy. Then finally, what's the case in Maryland with regard to skilled nursing and rehab centers is it's a very diverse group of providers, and what you'll find is that whether they're for-profit or nonprofit that they really are a safety net for folks on Medicaid. Relative to the paper, a couple of observations. First it was great to read.

MR. YARAGHI: Thank you.

MR. DeMATTOS: And it's an incredible step forward. And anything that can push the pause button and get us thinking on how we can improve the rating system is a very, very good thing. It's interesting that there's this distinction in the paper between self-reported data versus the survey. The reality is you probably need both in an ideal system going forward, and here's why: the survey, you can have a fantastic center, a five-star, fantastic, great center. And they could have one place where they really drop the ball out of one resident out of 300 residents. And they don't even have to have dropped the ball on that one resident in a catastrophic, damaging sort of way. It could be a number of minor things that happen with that one resident. And as a result of that, a survey can massively impact a center. And it's based, of course, on that, that inspection, and on that one individual, potentially.

I'll give you an example of that in Maryland. We have a -- recently, up until recently, we have a center that was amongst the best in Maryland by both state and federal rating systems. It's a five-star center. They received 26 inconsequential no life harms, very low-level deficiencies in their annual inspection, 26 of them -- four of the deficiencies were for a single malfunctioning wheelchair. As a result of that survey, that center went from a five-star center to a one-star center, and it's now a two-star center, right. But it's amongst the best in Maryland.

So again, you know, the survey can be valuable and it can be powerful. Now, it's interesting, if I'm a consumer, I think the survey is valuable for the reasons that

I've just said, but again, it can go either way based on the results of one consumer. The self-reported data, with regard to quality or staffing -- staffing is a little bit less of an issue now that CMS is requiring a payroll journal reporting where they have to report actual payroll data. But if I'm a consumer or a hospital partner, I want to have survey data, I want to have payroll data, and I want to have quality data. And the value of the quality data and the payroll data is that unlike the survey, it's not swayed by one consumer experience. It's cumulative for, you know, for the entire center.

Just one last point before I hand it off and we get further into the discussion. The notion that we could, as a nation, rely more on survey data and less on self-reported data, as we extend the findings of this study and look deeper across the country, which I think we need to do, could be problematic. Because as you go from state to state, the variability on state survey capacity and the correlation between inspection surveys and ratings could be incredibly more, you know, problematic. So with that, I too have more to add, but let's open it up and take it down the panel.

MR. YARAGHI: Thank you very much. Toby, you've been doing research in nursing homes since before I was even born.

MR. DeMATTOS: That's a compliment, I think. (Laughter)

MS. EDELMAN: Not the best opening.

MR. DeMATTOS: He meant it in a positive way.

MR. YARAGHI: It's actually the thing she said to me when we had a telephone conversation before, so I know she knows I'm meaning it as a compliment.

MS. EDELMAN: It's fine.

MR. YARAGHI: You have written extensively on special focus facilities and the fact that their ratings are generally lower than the others. When it comes to special focus facilities, is there any challenges in the rating systems, and what do you

think should be done about them?

MS. EDELMAN: OK. Well, thank you. As an advocate for residents for 40 years, almost, I was really pleased to read this paper documenting the inflation of the self-reported domains on Nursing Home Compare, staffing and quality measures. The paper confirmed what a number of us have found and documented in our own work over the years: that facilities boost their overall ratings by reporting information on staffing and assessment, and as a result, they get very high star ratings, high scores. Because CMS doesn't audit the information that it places on Nursing Home Compare, it just reports what is self-reported by facilities, facilities I think make themselves look better than they actually are.

There's often very little correlation between what the surveyors document in their unannounced public surveys and complaint investigations, and what facilities self-report. So we have been thinking about this on an anecdotal, ad hoc basis, and I decided to look a little bit more systematically. So in December 2011, five years ago, I looked at the special focus facilities. These are a very small subset of the one-star facilities, the one star in survey. They are chosen by states and CMS working together, and there maybe is one, possibly two in a state. So these are really very selected, very poor, by definition, among the most poorly performing facilities in the country. In 2011, I looked at 47 facilities, 47 of them, 46 of course, received one star in survey -- that's what you would expect. But 25 of the 46, more than half, had four or five stars in staffing. And 17 of them, more than a third, had four or five stars in the quality measures. Even more significant, I think, the high scores on the self-reported data boosted facilities overall star ratings. So 18 of them, 38 percent, had overall scores of two stars. And one even had a score of three stars because it self-reported good information on staffing and quality measures.

In January 2013, I redid this work and got similar results. More than a third of the facilities had four or five stars in staffing and quality. Public attention really came to this issue in August 2014. There was a front page article in The New York Times called "Medicare Star Ratings Allow Nursing Homes to Game the System," and Katie Thomas reported that nearly two-thirds of the 50 nursing homes on the special focus facility list reported staffing and quality measures of four and five stars, same thing that we had found in our work.

CMS and the White House immediately announced changes that they would reduce the reliance in the rating system on self-reported information and make additional improvements. And they did, but the problems have continued. When the Clinton Administration first started Nursing Home Compare in 1998, and in those early years, the information apparently didn't influence people who were looking for nursing homes for a placement for a relative. But this fall, I read a research article that indicated that once the five-star rating system went in eight years ago, that seemed to influence placement decisions. And it found that admission to one-star facilities had declined by eight percent and admissions to five-star facilities had increased by six percent.

So in October, I did a third analysis of special focus facilities. And this time, I looked at 42 of them, 16 that were newly added and 26 that hadn't improved. Nearly 45 percent of them, 19 of the 42 facilities, reported overall scores of two. In other words, they had boosted themselves out of the one-star category that people try to avoid when looking for a facility, and got two stars. They had gotten these two stars because of staffing and quality measures. At the same time I was doing this work, I read an article in the trade press indicating that 96 percent of the facilities that had five stars for their overall rating in the seven years that they looked at, all seven years, 96 percent of them had their high scores because of self-reported measures, not because of the surveys.

So the facilities at the top of the scale were able to get themselves a five-star rating, which is where people who are looking for facilities presumably increasing their admissions by reporting this data. So, I think we are very concerned about the self-reported nature of the staffing and quality measures, especially when CMS has known for years that these data are pretty inaccurate.

MR. YARAGHI: Thank you.

MS. EDELMAN: So I'll have some recommendations too for later, but I'll wait.

MR. YARAGHI: Yes, I'll ask about it. And Edward, you are the architect of the system that we are talking about, and you've been involved in it since the very beginning. We're going to have very major changes in the overall health care policy in the United States going forward, so I would like to know how this nursing home rating system changed since its inception to date, and how it's going to change as we go forward.

MR. MORTIMORE: Great. Thank you, Niam, and thank you for having me here, and thank you for the paper that you so carefully put together that I think offers a very helpful and critical analysis of some important dimensions. So, Nursing Home Compare certainly evolved a lot since we put it together, really as a simple information system to help people find nursing homes in their area. That really was its origin, it was pretty simple. And then we started adding more and more information to it to be even more helpful. It eventually got so, frankly, so cumbersome that we were asked to create a rating system to help, essentially, synthesize the information on the site.

And I think that's been very helpful. But certainly the needs of the site, the demands placed on the site, have evolved, frankly, probably a little bit faster than we anticipated. What we designed as a way to synthesize a vast amount of very

complicated information to help consumers in their search. And it is, I think it's important to remember, we've designed it, and we still consider it to be, first and foremost, a consumer information site. But we recognize that it's evolved, and whether we intended it to be that way or not, it's used as a report card. We know that managed care organizations, accountable care organizations, banks, insurance companies, HUD, all use the rating system in different ways, and frankly, in different levels of involvement, I guess I should say, to make their decisions about who gets what contracts, who gets what loans, and who can get a mortgage guarantee, for example.

So, I mean, those are some of the issues, and I think that's probably the major issue we're facing going forward is how to develop the system to be responsive to those uses that have really freighted it with consequences that we didn't intend. That creates a feedback loop, and I think we've all heard examples and your paper amply demonstrates that we've -- the incentives for high scores are out there, and I think that has a direct impact on reporting. I don't think there's any question about that. We've seen it, we've recognized that.

I should point out, we're doing a number of things -- we have done a number of things, and more things are planned, to try to address that. And in fairness, partly in response to the Katie Thomas article in The Times, we were able to implement some things we had been planning for a while, and that was to bring in quality measures that were not explicitly self-reported. And I think this is helpful for everybody, for providers and consumers alike, because what it did was add a lot of new information, particularly addressing areas of care that, frankly, we were a little bit short on, particularly rehab short-stay outcomes of care. So we added several measures that were not based on self-report, but rather based on claims data, so things like hospital readmissions, emergency department visits, successful discharge. I think there's a consensus that

those are important outcomes of care and they have the advantage of not being self-reported, and frankly, also not burdening providers as well since we're building those from claims that have already been submitted.

We're also, we've moved, as I think many of you know, we've recently implemented a payroll-based -- I think Joe mentioned that -- a payroll-based staffing system. That's something that had been planned, and actually, CMS had developed a number of years ago, but in the fall of 2014, received funding from Congress to implement. And that's a system that allows nursing homes to directly report staffing levels at the staff-person level for each day. That will open up a realm of opportunities for better measures, measures that I think will be helpful to providers. We'll be able to look at daily staffing; we'll be able to look at things like turnover. We'll have it at the person level. We're not identifying the names of people, we don't know how much they make, but we do know -- we can distinguish the individuals by ID, so we can look at turnover and tenure; we can look at staffing by day. And our intention is to provide those reports back to providers and to consumers to help both understand the dynamics of staffing and resident census and resident care needs, and their intermix. So we're hopeful. That is -- and that will be subject to audit, so we're actually developing an audit process right now with an accounting firm and an actuarial firm. So those will -- the payroll-based staffing program, the data collection piece is in place now, and nursing homes are reporting. And I think we have about 94 percent of nursing homes reporting data through that already in the first quarter.

We still have to evaluate the quality of the data. There is a learning curve. It's a significant effort for nursing homes to report that data, we acknowledge. But the audit process will be in place probably within the next year, so we think that's a significant step forward.

MR. YARAGHI: Thank you very much. My next question is to all of the members of the panel, and I would like to know, each one of you, from your own perspective, what do you think is the most important challenge when it comes to the current rating system and overall evaluation of the nursing homes, and what do you think should be done in near- and long-term future to address those challenges? So any one of you.

MR. DeMATTOS: Yes, I'll jump in on that. So first, just a couple of quick observations. So in terms of, I'm actually not surprised by Toby's data with regard to special focus facilities, right. So special focus facilities, these one or two skilled nursing and rehab centers in each state across the country, these are centers that are identified by state and federal regulators. They're not even going to make it holding the number one. These are substandard centers, and there's an intervention put in place. And so when you look at that intervention that's put in place, I don't think -- and I've been in one of these centers, like three weeks ago I was in one of these centers -- I don't think it's unrealistic to self-report much higher staffing levels and much higher quality measures in those centers because they're basically responding to a triage critical event of the center. The center may not survive, it may no longer be a federally certified center, unless appropriate resources are brought to bear and raise it -- and raise it up -- so I'm actually not surprised by that.

With regard to Nursing Home Compare, and in 1998 versus now, you have to remember that in 1998, we were still living in a time when people were often admitted to a skilled nursing and rehab center in relatively good health and driven there by a family member, all right. It was a totally different era in terms of the patient mix of skilled nursing and rehab center. The vast majority of people admitted both for short term care, for rehab, a congestive heart failure event, kidneys, an orthopedic event, or for long

term care, they're admitted by a hospital partner, right. They're driven there by ambulance.

And so many, many of the services that 25 years ago were provided only in hospitals across the country are now, both in terms of long term care and in rehabilitative care, provided for and in the skilled nursing and rehab centers, and that's why, as you mentioned, that the five-star rating system is so important, because many people are using it as a proxy. Hospitals are using it as a proxy. Should I send my long-term care patient to skilled nursing rehab center A, with a three-star rating, versus B versus a five-star rating?

One more point before we get to the challenge, because the challenge is related. On all of these issues of staffing, these are all issues that come up during the inspection and the annual surveys, so if there is a disconnect between self-reported staffing and then staffing as part of the survey process, this is something that is inspected during the annual inspection in the survey process and we can look at this disconnect. Again, moving forward, because the payroll journal and because it's an auditable issue, this will be less of an issue.

Finally, on self-reporting, you know, they are 75 MDS measures of quality, each with 16 subcategories. In order for an entity to intentionally manipulate that reporting, in order to raise the five-star numbers, you know, as an intentional measure, would certainly set off a lot of different alarms at various OIGs, both state and federal, if it were an issue. So, I mean, it would require an incredible level of sophistication.

Now all of that connected to the big challenge going forward. I think probably the biggest challenge going forward, working with our CMS partners and others, is recognizing what skilled nursing rehab centers are today. They are folks that are providing services, teams that are providing services that 25 years ago were largely

provided for in hospitals, right. And so they have very, very high acuity patients. And figuring out how the rating system can go forward and recognize the difference between, and the connections between, acuity and Medicaid versus Medicare, right. Because that center that I talked about in Baltimore a few moments ago that went from a five-star to a one-star, in order for that center to continue to be viable, they have to be able to partner with their other partners across the continuum. They're going to want a three-star rating. But in order for that building to be a resource for Marylanders in need in Baltimore, they're going to have to continue to take elders that are incredibly challenging, clinically challenging, and on Medicaid.

And so going forward, in a best possible world with a CMS five-star rating system, maybe some, maybe some evolution on the recognition that we really are serving sort of different systems on Medicaid/Medicare to ensure that those systems are still in place for people in need in those systems. So that would be my wish going forward on the rating system.

MR. YARAGHI: Thank you.

MS. EDELMAN: Well, I have concerns about putting all of our hopes and dreams on the five-star rating system because this is pretty much a market-based approach. We're going to give people information and let them choose facilities, and I don't think that's sufficient. I think we need to improve and strengthen the public regulatory enforcement system to make sure that facilities are actually meeting standards. And as Joe said, a lot of residents look very different today from the way they looked in 1998. But what we just missed the boat, I think, with CMS on the revised requirements of participation for nursing homes first big revision in 25 years is that we didn't change the staffing standard. We still have the same standard we had in 1998, which is a registered nurse on the day shift, licensed nurses around the clock, and

otherwise sufficient staff to meet residents' needs.

And very few, even though we have a report from CMS from 2001 that the whole world relies on saying that 90 percent of facilities don't have enough staffing, the regulatory system almost never cites staffing as a deficiency because the standard is too vague. And so I think we need to both increase the staffing in nursing homes dramatically. There was legislation that Congresswoman Jan Schakowsky had for many years: put a nurse in a nursing home, like there really need to be registered nurses in nursing homes around the clock. That hasn't passed, and it doesn't seem likely to pass in the immediate future.

But we need better staffing and I think better enforcement. And then the rating system is an important tool, but it can't be the only thing we're relying on to get better care for people. Because many people really don't have any family. There's nobody that they have who can advocate for them, and so the public purpose and what the Nursing Home Reform Law says from '87 is that the secretary has to assure that the standards and their enforcement are adequate to protect residents' health, safety, welfare and rights. There's a very important public role that the regulatory system has to play.

MS. BOCCUTI: And in fact, I'll add that I mean that a third of the counties in the U.S., we found had three or lower stars. So that sort of highlights what is the federal role when you have these minimum standards. How can we boost the lower ones? You know, it's like trying to get into the five-star. Well, what about those that aren't trying because they don't even have competitors that are in the five-star, you know. So they're at the one- to three-star ratings in a third of the U.S. counties. So I think there is something about the federal role and how there is an opportunity to boost up the quality for really, I think we have to recognize, you talked about the acuity level, but even 30 years ago, these are the most frail, vulnerable populations that we have now. And so

standards, and you brought up the standard of staffing, and that was something that I wanted to bring up because I was kind of shocked to learn that it's a one registered nurse for eight hours. This is just the minimum, one registered nurse for eight hours daily, regardless of the size of the nursing home. Now, many states are requiring more, so the states have taken it on to say that that's not really require. But the federal Medicare and Medicaid certification requirements do not require more than that. So there is something I think that a challenge beyond the star ratings has to do with what is being done for the low, not just the focus ones that you bring up.

MS. EDELMAN: Right. All of them.

MS. BOCCUTI: But the two-star nursing homes, and the people that don't have any choice. And in fact, there could be a five-star nursing home, but they can't get into it, right. It's full, it's the only one in the county, they can't get into it. Where are we with the people that are looking that are looking for the other ones. And also, people can't move a lot of times. You're in one, you find out it's whatever, you know, do they have family that can pack them up, how disruptive it is to move to another nursing home?

MR. YARAGHI: I think all of these points are really good points. We cannot expect a free market to operate as long as we do not have choice. And when it comes to the residents of the nursing homes, as was mentioned in the panel, many of them really neither have information, nor choice. Therefore, I think it's more important to think about the role of government in increasing the quality and basically advocating for those people who don't have a voice. Well, I think we have some time to get some questions from the audience, and there will be a microphone coming to you. Please.

SPEAKER: I don't know if this is -- am I coming through on the mic?

MR. YARAGHI: Yes.

SPEAKER: OK. I don't know if this is just a crank issue, and if it is, feel free to pass it by. Last January, I had an accident. I went to work and I couldn't come home, wound up in the hospital, had three surgeries, was in rehab for orthopedic stuff. And one of the things that made me absolutely crazy was that on weekends, certain types of staff weren't available. When you're in a rehab facility, when you're in a skilled nursing facility, there are no Saturdays and Sundays, except maybe for the menu when they're trying to impress the visitors, and that's another issue. But I was shocked that there were so many things that I had to pay for out of pocket because they weren't provided on a regular basis. I needed a physician to come in and see me on a Saturday because I had surgery on a Friday, and it took six hours to get a doctor there and it cost me $400 out of pocket. So are there any regulations about consistency? Also, when they change shifts, you can't get any medication when they change shifts for about two hours in rehab facilities. So maybe this is just a crank issues, but it's, for the person who has been in a rehab facility, the unavailability of staff, the inconstancy of the availability of staff, is a major issue.

MR. YARAGHI: Thank you.

MR. DeMATTOS: So, no, I don't think it's a crank. I think it's a fair comment. I'm glad you're better, glad you're well. That's the most important thing. You know, we've had, I've had family in skilled nursing and rehab centers as recently as a few months ago, and there's no doubt that staffing is not the same in a skilled nursing and rehab center on a weekend as it is in a hospital. There's just no doubt, especially if you're there for, you know, an intense orthopedic rehab. The good news is that we do have, in Maryland and across the country, skilled nursing and rehab centers that do intense rehab more intensely, more focused than in other settings, and get folks in and out of those centers, you know, quicker than we used to.

The average length of stay for a Medicare resident in Maryland is 28 days. It's about the same as the national average. So that's the good part of the equation. It sounds like you were on a Medicare-qualified stay.

SPEAKER: I was on private insurance.

MR. DeMATTOS: Or private insurance, so either through Medicare, a Medicare-qualified stay, or private insurance, the doctor's visit counts as an out of office visit. So there's a co-pay for that visit and that's one of the things that's challenging for Americans all across the country. And so in Maryland, we actually have a law that says that you have to inform a patient, when they are going to a skilled nursing and rehab center, of their status -- which we helped to advocate for in Maryland -- so that the patient knows that if they're on private insurance or on their three-day qualifying hospital stay, that all of those visits, they're all individual co-pays, and they're going to be paying for that eventually.

On the subject of staffing, you know, every state, thank goodness, has higher standards than -- most states, not all states, Maryland does -- has much higher standards in terms or RN staffing than as the federal minimum. And in terms of physicians, I think there's a trend across the country -- and I've been very fortunate to visit a number of skilled nursing and rehab centers across the country -- I think there is a trend for these centers to hire and employ their own physicians. Genesis HealthCare, the largest company I mentioned earlier, they have 500 directly employed physicians. FutureCare Health care of Maryland, own company, has their own hired, directly hired physicians. And I think there's also a trend to hire, at a minimum level, RNs, and to hire more nurse practitioners. So I think that's a trend as well.

One last point on staffing. There needs to be a federal push and a marketplace push. And the reality is that in Maryland now, because we have such a

competitive environment -- maybe it can be a snapshot for the rest of the country -- the marketplace is demanding more RNs and more nurse practitioners because again, your hospital might prefer to partner with me if I'm directly employing physicians and nurse practitioners, than perhaps you who are employing directly RNs and LPNs, right. So the marketplace is demanding that.

MS. BOCCUTI: Well, I think another reason that nursing homes might start having more registered nurses or nurse practitioners is that there's tremendous concern in public policy about readmissions.

MR. DeMATTOS: Exactly.

MS. BOCCUTI: Readmissions to hospitals, readmissions to nursing homes, and there are certain things based on scope of practice laws that LPNs and certainly nurse aides can't do. So if there's not a registered nurse who is in the nursing home, who is able to handle problems, they have to send people to the hospital because they can't deal with the problems themselves if they are an LPN. So I mean that's--

MR. DeMATTOS: That's a driver. That is absolutely a driver.

MS. BOCCUTI: That's a driver, but we could have put it in federal law.

SPEAKER: If I may interject, I almost got transferred to the hospital on Saturday.

MS. BOCCUTI: Well, that's right.

SPEAKER: Because they were having some (inaudible).

Ms. BOCCUTI: Well, there was an inspector general's report several years ago about adverse events in nursing facilities. They never looked at that before, that was always a hospital concern. And the rate was higher in nursing homes, and what they found in the average of 15.5 days, that's how long it took, there were tremendous medication errors, falls, the nursing staff didn't respond quickly enough or didn't identify

the problems, many rehospitalizations, and many deaths that had not been anticipated because there was just not sufficient staff to provide care. And you know, we know, I understand nursing homes say they don't get enough under Medicaid. Whether they do or not is a debatable point, depends upon the state. But certainly the Medicare rates are extremely high. And so here are the Medicare people in 15 and a half days not getting good care. That's really inexcusable.

MR. YARAGHI: Thank you. Let's get a question from the other side of the room, the gentleman there.

MR. HARDER: Sure, thank you. Ben Harder, I'm with *U.S. News and World Report*. I oversee our public reporting program, including our best nursing homes ratings, which we have used Ed Mortimore's team's data for a number of years on, and our hospital rankings. I appreciated Mr. DeMattos bringing up the question of rehabilitation intensity; I want to develop that theme for a moment. So you all mentioned the very important investigation that *The New York Times* did several years ago. There was another very important investigation led by *The Wall Street Journal* last year that looked at utilization of rehabilitation at the patient level, looking again at claims, as you mentioned. At the patient level, how much rehabilitation was administered to each patient.

And one of the most striking observations that those journalists made was that there are two clinically implausible spikes in utilization of rehabilitation therapy at the points at which reimbursement is maximized for nursing home facilities. And it's supported by a lot of anecdotal evidence and commentary by former employees and current anonymized employees of nursing facilities. There was extreme concern, I would say, about the clinical appropriateness of that care that was being delivered. And following that publication of that investigation, CMS did release -- it has not to my

knowledge been worked into the plans for the nursing home ratings yet -- but did release a facility level data set that identified essentially the percentage of patients who are at these high, very financially valuable junctures in their care for the nursing homes. The national average, and in fact the Maryland state average, is that two-thirds of the patients who receive the highest level of rehabilitation care are treated within a ten-minute window that maximizes the reimbursement. Two out of every three patients in the state.

It's troubling. Clinicians, I think, find that very troubling, and even though CMS hasn't incorporated this into their ratings, we at U.S. News, my colleague Avery Comarow and I, decided we would. And so we have stripped the fifth star from every home that exceeds a certain percentage of patients falling into this narrow bracket of rehabilitation intensity. We took a conservative approach our first year. These are ratings released last month. We will probably ratchet that up over time, and we think it can provide some additional accountability for the industry. So I wonder if Mr. DeMattos would like to respond to that, and also I would be interested in your thoughts Ed, on whether there's any opportunity to include that in your measures going forward.

MR. DeMATTOS: You know, so I think everybody is concerned about therapy getting that close to a cap and it gets everybody's attention. So I'll leave that part of it at that. I think one of the arguments that a skilled nursing and rehab center would make going forward is that what needs to be figured into the equation is: what was the rehospitalization rate of somebody that received the maximum number of rehabilitative care versus the rehospitalization rate of somebody who received maybe a lower end of that care? I think one of the things certainly nationally that skilled nursing rehab centers sort of industry is pushing for is this notion of site neutral bundle payment, where the number of hours really don't matter, just the clinical outcomes matter. You know, give me a lump sum, tell me what I'm expected to do clinically on behalf of this patient, allow me

to partner with, on the one hand the hospital and on the other side the home health agency and let me produce a clinical outcome.

I think going forward, we had been hopeful that that would be a more likely federal model. And I think all issues of federal health care policy are, sort of, now at a pause and we don't know what will be the case. So again, I guess the three points that I'll just reiterate is that it is striking any time you look at data that gets that close to a cap and it certainly deserves a close look, so I applaud you looking at that. I think that an industry response would be: "Yeah, we're just, we did that, but we want to look at what we saved the total system in terms of rehospitalization and better clinical outcomes." So I think you always have to look at paired data beyond that event and the total care of the patient and the total clinical outcome for that patient.

And the third point again, we wish would be more relevant but now is a question mark is, I think, as a country we'll be better served by encouraging partnerships that are clinically driven across settings that says: "Your goal is to focus on getting Mary or Joe better, and to partner with somebody else, and there is this much money to do that, go and do that." And then the hours of care under that kind of model become much, much less relevant

MR. HARDER: (inaudible) in hearing whether there's any (inaudible) performance based measure.

MR. MORTIMORE: Yes, so historically and this probablyreflects that Nursing Home Compare grew out of (inaudible) out of a regulatory environment. We've been payer agnostic. So we haven't -- we do minimal reporting of therapy hours on this site. We've really never looked at therapy as a quality measure, particularly Medicare therapy. But it is something worth considering, particularly now with the advent of more detailed payroll-based data where we can look at therapy across all payers. It's

something we'd definitely be interested in taking a look at.

MS. EDELMAN: Niam, can I just say something there quickly?

MR. YARAGHI: Yes, please.

MS. EDELMAN: CMS is very concerned about this reimbursement issue and is trying to develop a new system, because even though there's perspective payment system in Medicare, the way this system has worked because of minutes of therapy determining the rates, most residents, or the facilities are billing at the highest rates. So CMS is actively involved in making a change. There are numerous False Claims Act cases pending against the large corporations that have that issue of billing all of their residents or large portions of their residents at the highest rug categories. And the third concern is something that my office has, The Center for Medicare Advocacy which is the opposite, we had litigation that was settled and approved by the court in January 2014 saying that people are entitled to therapy in nursing homes, also home health and outpatient therapy to maintain function, not just to improve function. If somebody, particularly with a chronic condition, needs therapy to prevent or slow decline or deterioration, they are entitled to therapy, and it's very hard to get that implemented because there's a lot of fear of the False Claims Act cases and the overutilization of therapy. So there is, there's overbilling for therapy, but we're also concerned about the underbilling of people who aren't getting what they need.

SPEAKER: So I appreciate that discussion, as a clinician, actually a physical therapist times 20 years. I want to delve into the side of the measures related to quality and self-report. As a clinician, we've used validated outcomes tools for evidence-based practice, so I'm kind of curious as to why we've been slow, or what the challenge is for using a validated measure for the self-report quality tool.

MR. MORTIMORE: Well there are a few reasons. First of all, I'd say

that the data, I think the quality measures are reasonably well-validated. I think the challenge has been evolving measures that deal with new populations. So many of the measures are essentially 20 years old or more in terms of their construct, so to get back to Joe's point, they tend to deal -- tend to consider the nursing home population as a more homogeneous, so many of them were built, and frankly for years, until really until this summer when we released 16 measures, the vast majority were focused on long-stay residents. So there were things like the prevalence of pressure ulcers, prevalence of physical restraints, and so, I mean, those are important measures, but they're missing key resident populations.

And I think that's one of the challenges, it's one of the big challenges, and this sort of gets to future opportunities. I think we need to recognize that nursing homes themselves, the nursing home residents are a much more heterogeneous population than we've really been able to capture historically in quality measures. So, and there are issues around self-report,but I do want to emphasize that nursing homes, the quality measures are based on Medicare claims and the MDS, the minimum data set, which is the clinical assessment that's legally and medically part of the clinical record. And its primary purpose is for resident assessment and treatment. And so it grows out of stuff, the critical assessments and care planning, that nursing homes do for all of their residents. So these are not aggregated measures reported separately outside of the clinical care process. So and they deal with, you know, physical functioning and just very important clinical outcomes. So I think there are issues with how the ratings have changed over time, there's no question. But I think they are well validated clinically.

There may be challenges in, sort of, how they're used at the nursing home, and I think more importantly, sort of, in the breadth of measures that we're able to offer for the heterogeneity of the population.

MR. YARAGHI: Well, I think we have to take the other questions offline because we are out of time. And I'd like to thank our panelists: Christina, Joe, Toby and Edward.

I appreciate all of you for providing us with your insights, and thank you very much for coming out.

(Applause)

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