S. HRG. 106–852

NURSING HOME BANKRUPTCIES: WHAT CAUSED THEM?

HEARING

BEFORE THE

SPECIAL COMMITTEE ON AGING UNITED STATES SENATE

ONE HUNDRED SIXTH CONGRESS

SECOND SESSION

WASHINGTON, DC

SEPTEMBER 5, 2000

Serial No. 106–35

Printed for the use of the Special Committee on Aging

U.S. GOVERNMENT PRINTING OFFICE

67–641 cc WASHINGTON : 2000

For sale by the U.S. Government Printing Office
Superintendent of Documents, Congressional Sales Office, Washington, DC. 20402

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NURSING HOME BANKRUPTCIES: WHAT CAUSED THEM?

TUESDAY, SEPTEMBER 5, 2000

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Washington, DC.

The Committee met, pursuant to notice, at 2:15 p.m., in room SD–562, Dirksen Senate Office Building, Hon. Chuck Grassley (Chairman of the Committee) presiding.

Present: Senators Grassley, Breaux and Reed.

OPENING STATEMENT OF SENATOR CHARLES GRASSLEY, CHAIRMAN

The CHAIRMAN. I am going to start our meeting. Tuesday is the afternoon, during the lunch hour, that the Republican and Democratic caucuses meet for their weekly meeting, and I left ours early so that I could start this on time. When other members may come, particularly Senator Breaux, if we are in the middle of your testimony, I am going to stop for his opening statement, at least. So, I want to go ahead, but recognize the fact that other members come and participate.

I want to say that all of you are welcome. I am glad so many people are joining us today to learn about the causes of recent nursing home bankruptcies. Over the past year, five of the largest nursing home chains in the country declared bankruptcy. Now, these companies, which operate about 10 percent of the nursing homes in the United States, are reorganizing under Chapter 11.

Although 90 percent of the country's nursing homes are not bankrupt, in some States, many homes are in bankruptcy. Some providers argue that the Balanced Budget Act of 1997 and the administration's implementation of the prospective payment system caused their troubles. Others point to the business practices of the companies in question, and so our goal at this hearing is really quite simple, and that is to clear up any confusion between these two points of view or even other points of view.

The Medicare program accounts for only about 10 percent of the nursing home industry's revenue. Medicaid pays for two-out-of-three nursing home residents and other payers cover the remainder. Throughout the 1990's, however, Medicare costs skyrocketed, growing by an average of almost 30 percent per year. This growth was fueled by an uncontrolled increase in the amount of ancillary services provided to skilled nursing patients.

It did not appear that the number of beneficiaries or the severity of their illnesses could explain the explosive growth. Both the in-

dustry and the Government recognized the need for a system better able to identify the needs of Medicare patients and to pay the facilities to meet those needs. In 1999, Congress and the administration acted, and we did so by mandating a prospective payment system we often refer to as PPS, similar to one under which hospitals have operated since 1985, and to those being established for other categories of Medicare providers.

The prospective payment system has been very controversial. Responding to the concerns of nursing home providers, last year, Congress added more funding to the system. All this did not prevent a rash of bankruptcies. It must be noted that most nursing homes appear to be able to operate under the new system. I will give you examples: (1) Ninety percent of the nursing homes in the United States are not in bankruptcy; (2) HCR/Manor Care and Beverly Enterprises, two of the top five nursing home chains, have not declared bankruptcy; and (3) Most of the long-term care providers that declared bankruptcy showed operating profits for their nursing home business before they declared bankruptcy and continue to show operating profits under PPS.

Our first witness today will represent the General Accounting Office. Last year I asked the General Accounting Office to study the causes of the bankruptcies and the financial situations of nursing home companies. Today, Laura Dummit, Associate Director of Health Financing and Systems Issues at GAO will provide us with an update on that report.

The second witness will be John Ransom, Director of Health Care Research for Raymond James Financial, one of the country's largest financial services firms. He will delve into his nearly 15 years of experience with health care financing and provide us with the Wall Street investors' perspective on what happened to these publicly traded nursing home companies.

Next, we will hear from Dr. Charles H. Roadman. He is President and CEO of the American Health Care Association, which represents more than 12,000 long-term care facilities across the country, including both bankrupt and non-bankrupt nursing home companies. I know that Dr. Roadman made significant adjustments to his schedule to join us today, and we appreciate his efforts.

Our fourth witness will be George Grob, Deputy Inspector General, Department of Health and Human Services. Last year, the Inspector General's Office conducted a study on early effects of the prospective payment system on Medicare beneficiaries' access to skilled nursing facilities. They found modest problems in placing Medicare patients in nursing homes. Today, we will hear the results of their recent work on this issue.

Our final witness is Steve Pelovitz, Director of the Survey and Certification Group of the Health Care Financing Administration. Mr. Pelovitz has worked on the monitoring of financially troubled nursing homes. In addition, he is familiar with the financial situations of the large nursing home chains, due to his involvement with the Department of Justice and the Health and Human Services Office of Inspector General, as they have represented the Medicare program's claims as a creditor of these bankrupt companies. Accompanying Mr. Pelovitz is Laurence Wilson, the Director of the Division of Institutional Post-Acute Care Policy at the Health Care

Financing Administration. Mr. Wilson has served as an expert at congressional staff briefings on issues related to Medicare reimbursement and the nursing home prospective payment system.

We are pleased that you are all here, and, as I indicated, I am going to call on our distinguished ranking member, Senator Breaux of Louisiana.

Senator Breaux. Welcome back.

The CHAIRMAN. Glad to be back. I saw you on television a lot during the Democratic convention, but beyond that, I haven't talked you.

Senator Breaux. You watched our convention?

The CHAIRMAN. I watched your convention. You always keep on top of what——

Senator Breaux. What the other side is doing.

The CHAIRMAN [continuing]. The other side is doing. [Laughter.]

STATEMENT OF SENATOR JOHN BREAUX

Senator BREAUX. Well, thank you very much, Mr. Chairman, and thank all of the panel members. It is certainly a distinguished group of presenters who represent many different facets of this very, very important industry, and I am looking forward to hearing from them.

It is very clear that the nursing home industry plays a very vital and very important role in the care of senior citizens in this country. It has become something that is almost part of most families' daily lives, in dealing with aging parents or grandparents or other close and dear friends.

So, it is an integral part of how we care for this huge, growing senior population in this country. It is therefore clearly in this Nation's interest to have a strong and vital health care provider that provides services like the nursing home industry does. There are some interesting statistics that we are going to hear from GAO, as to the state of the industry from a financial standpoint.

What we do know is that Medicare actually provides only a very small part of the nursing home industry's revenues, approximately, I think about 10 percent. The bulk of it comes from the State and Federal Medicaid program, not the Medicare program. Given that fact, it is also interesting, however, to note the figure of about 30 percent a year are the Medicare cost increase going to nursing homes between 1990 and 1997. Thirty-percent increases on an annual basis is a very large number, and we need to hear more about why that is so, if, in fact, that is correct.

In my own State of Louisiana, we have 38 skilled nursing facilities in bankruptcy. That is a figure that is very frightening. It is not inconsistent with numbers that we have seen in other parts of the country. So, we have an industry that is very important to a very important and rapidly growing segment of our population, of seniors in this country. I think the Chairman is right on target in convening these hearings to try and find out a little more about what is happening, why it is happening and what can be done to change the direction of this very important industry.

The final thing I will mention is that this is just, from my opinion, the continuation of the problem we get into with trying to micromanage the health care industry in this country from Wash-

ington DC. I mean, one year we cut reimbursements to providers; the next year we find we have cut the reimbursements too much. We try to figure out how much we should put back in, and then we begin the cycle of cutting again in the year after we put money back in. I mean, one year, we cut, and the next year, we put it back in, the next year, you know, we cut again and it is a cycle that simply cannot continue if we are to have a modern, 21st-century health care delivery system in this country.

We cannot continue to do what we do with hospitals, with doctors, with home health care, with skilled nursing facilities, and I daresay, if we do the prescription drug ingredient in the wrong way, we will be doing the same thing and having the same problem. So, this is an important hearing and I am glad you convened it, and I look forward to the witnesses' testimony.

The CHAIRMAN. On the last point that the Senator from Louisiana made, his leadership is demonstrated by his work on the Medicare restructuring commission that he chaired, and the statements that he has made in regard to too much micromanagement and ways to change that come as a direct result of that commission's work, his leadership on that, and, more importantly, a very good report that they gave, that has ended up being introduced as legislation, sponsored by Senator Breaux and others.

So, he continues his leadership in a broader area than even this hearing is involved with. But this hearing is a small part of a bigger problem that he has very well described. For each of you, your testimony, as you submit it, plus any supporting documents you want put in the record, will be done that way without your asking. And I ask you now to start, Ms. Dummit, and then we are going to go to Mr. Ransom, Mr. Roadman, and then my left to my right, until we get done, and then we will have questions.

So, would you proceed please?

Ms. DUMMIT. Thank you, Mr. Chairman and Senator Breaux.

The CHAIRMAN. You will have to pull the microphone a little more square between you and me. That is right. Thank you.

STATEMENT OF LAURA A. DUMMIT, ASSOCIATE DIRECTOR, HEALTH FINANCING AND PUBLIC HEALTH ISSUES, U.S. GENERAL ACCOUNTING OFFICE, WASHINGTON, DC.

Ms. DUMMIT. Thank you. I am pleased to be here today to discuss recent bankruptcy filings in the nursing home industry and the changes made to Medicare skilled nursing facility payment policies in the Balanced Budget Act. In the BBA, the Congress required the implementation of a prospective payment system for Medicare skilled nursing facility services. Medicare's historical cost-based reimbursement method, combined with inadequate program oversight, provided few checks on the growth in Medicare spending.

As a result, between 1990 and 1998, Medicare nursing home expenditures rose by an average of 25 percent-a-year. As you can see in this chart, before the BBA changes, Medicare's average payment increased about 12 percent-a-year, to reach $268 per day in 1998, even though the market basket index, which measures the change in prices paid by nursing facilities, rose only about 3 percent-a-year.

To better understand the impact of the BBA changes, we examined financial information submitted to us by seven of the largest nursing home companies, including four of the five that are in bankruptcy. We identified at least three common characteristics of the bankrupt corporations. First, most of the chains in bankruptcy reported higher-than-average nursing home costs, which is detrimental under a PPS because it is based on national average cost.

Second, the companies in bankruptcy were more likely to have high capital costs, often because of substantial investments in nursing home and ancillary service businesses in the years immediately preceding the PPS. Under constrained payments, these debt-laden enterprises are particularly challenged.

Third, most corporations that had filed for bankruptcy had extensive ancillary service businesses to provide these services to their own nursing homes and to others, but under the per-diem PPS payments, nursing homes have become more cost-conscious in purchasing these services, which has reduced both the demand for, and the price of, ancillary services.

Our analysis indicates that the firms in bankruptcy appear to have responded to the financial incentives under Medicare's former payment method more aggressively than others, and therefore their adjustments to the PPS may have to be greater. Furthermore, our analysis indicates that Medicare skilled nursing facility payments are likely to provide sufficient and, in some cases, even generous compensation for services furnished to Medicare beneficiaries, because those payments reflect such high historical spending growth.

Even though Medicare's average payment per day declined between 1998 and 1999, these payment rates incorporate higher-than-warranted historical spending. In addition, the BBA temporarily boosted PPS payments to address concerns about shortcomings in the payment method, which HCFA is now working to resolve. With these and other changes, HCFA estimates that Medicare spending for nursing facility services will go up close to 20 percent between 2000 and 2001. This will boost Medicare spending on nursing facilities by almost $3 billion.

Despite provider claims of inadequate payments, surveys of hospital discharge planners and nursing home administrators indicate that Medicare beneficiaries continue to receive needed nursing facility care. Some patients with extensive needs may need to stay in the hospital longer if they are having difficulty finding a nursing home that can care for them; yet our analysis of hospital lengths of stay shows that patients are not backing up in the hospital.

In conclusion, Mr. Chairman, BBA reforms, as intended, have affected the delivery, cost and use of Medicare nursing facilities services. The changes wrought by the BBA have required providers to adjust both their patterns of care and their business strategies. These adjustments have not been easy for some, and those who have experienced the most difficulty have been quick to attribute their problems to inadequate Medicare payments and call for additional Federal dollars.

Current budget surpluses and reduced Medicare outlays could make it easier to comply with these requests for additional Federal money; yet let me reiterate the Comptroller General's concerns that projected Medicare spending threatens to absorb ever-increasing

shares of the Nation's budgetary and economic resources. Therefore, we will continue to monitor Medicare spending to help the Congress ensure that beneficiary access is protected and that providers are fairly compensated, but also to ensure that taxpayers do not shoulder the burden of funding unnecessary or inefficient spending by nursing homes.

Thank you, and that concludes my formal remarks.

[The prepared statement of Ms. Dummit follows:]

United States General Accounting Office

GAO

Testimony

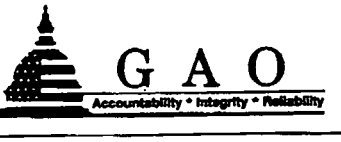
Before the Special Committee on Aging, United States Senate

For Release on Delivery
Expected at 2:15 p.m.
Tuesday, September 5, 2000

NURSING HOMES

Aggregate Medicare Payments Are Adequate Despite Bankruptcies

Statement of Laura A. Dummit, Associate Director
Health Financing and Public Health Issues
Health, Education, and Human Services Division



GAO/T-HEHS-00-192

Mr. Chairman and Members of the Committee:

I am pleased to be here today as you discuss the causes of the bankruptcies of large corporations owning nursing homes, particularly whether recent Medicare payment reforms affected the bankruptcies, and implications for nursing home residents. Those payment reforms, set forth in the Balanced Budget Act of 1997 (BBA), were enacted to control rapid spending growth for Medicare-covered services furnished in nursing homes—spending growth that was neither sustainable nor readily linked to demonstrated changes in beneficiary needs. The reforms altered the financial incentives inherent in the former cost-based payment system to reward providers for delivering care efficiently.

Since the BBA provisions were implemented, five large nursing home chains—comprising almost 1,800 of the nation's 17,000 nursing homes—have filed for bankruptcy protection under Chapter 11 of the U.S. Bankruptcy Code. These bankruptcies and the large reported losses of these companies have received much public attention because of the number of homes involved and because of the fear that residents will be displaced if nursing homes close. Because the distribution of these facilities is concentrated, the potential threat of closure looms much larger for some states than for others. Almost half of the nursing homes in New Mexico and Nevada, for example, are operating in bankruptcy, compared with the national average of about 12 percent. Twelve other states have more than 20 percent of their homes operating in bankruptcy.

Many providers have blamed Medicare policies and the BBA for their financial difficulties and have pressured the Congress to undo some of the act's payment reforms. In response, the Congress has monitored the results of these reforms and made certain modifications in the Balanced Budget Refinement Act of 1999 (BBRA). But many in the industry argue that more changes are needed and are calling for higher payments.

Calls for increased payments come at a time when federal budget surpluses and reduced Medicare outlays could make it easier to consider increases in Medicare payment rates. However, in view of the coming surge in the Medicare-eligible population, the Comptroller General has cautioned repeatedly that projected Medicare spending threatens to absorb ever-increasing shares of the nation's budgetary and economic resources. Without meaningful reform, demographic trends alone will drive Medicare spending to levels that will prove unsustainable for future generations of taxpayers.[1] It is therefore critical to the program's long-term solvency and sustainability that we continue to evaluate provider payments and monitor beneficiary service use to ensure that beneficiaries receive needed services at the same time Medicare receives the best value for its money.

My comments today focus on the adequacy of Medicare's payment rates for skilled nursing services furnished in nursing homes, the relationship between the changes wrought by the BBA and recent nursing home bankruptcies, and what exists to protect

[1] *Medicare Reform: Leading Proposals Lay Groundwork, While Design Decisions Lie Ahead* (GAO/T-HEHS/AIMD-00-103, Feb. 24, 2000).

patients. My remarks are based on our extensive published and ongoing work for this committee.[1]

In brief, our analysis indicates that aggregate Medicare payments for covered nursing home services likely cover the cost of care needed by beneficiaries, although some refinements to the payment system are needed. But Medicare policy changes have required many nursing homes to adjust their operations. The adjustments have been particularly disruptive for homes that took advantage of Medicare's previous payment policies to finance inefficient and unnecessary care delivery and for those companies that invested heavily in the provision of ancillary services (such as rehabilitation therapies) to nursing homes. The problems experienced by some providers of nursing home and ancillary services are therefore the result of business decisions made during a period when Medicare exercised too little control over its payments. Filing for bankruptcy protection under Chapter 11 allows these providers time to restructure their debts and streamline their operations while continuing to care for their nursing home residents. Should any of these providers not emerge from bankruptcy, however, the nursing homes will be sold or the residents may have to find alternative care arrangements.

BACKGROUND

Nursing homes in the United States—numbering about 17,000 nationwide—play an essential role in our health care system. They provide care for 1.6 million elderly and disabled persons who are temporarily or permanently unable to care for themselves but who do not require the level of care furnished in an acute care hospital. Nursing homes furnish a variety of services to residents, including nursing and custodial care; physical, occupational, respiratory, and speech therapy; and medical social services. Medicaid is the largest single source of nursing home revenue. In 1998, Medicaid accounted for 46 percent of total nursing home expenditures, while Medicare, out-of-pocket, and private insurance payments accounted for 12 percent, 33 percent, and 5 percent, respectively. Two-thirds of nursing homes are for-profit entities; and about half are owned or operated by corporations operating multiple facilities known as chains. Many of these chains also operate other lines of business in addition to nursing homes, such as long-term care hospitals, assisted living facilities, pharmacies, and companies that furnish therapy.

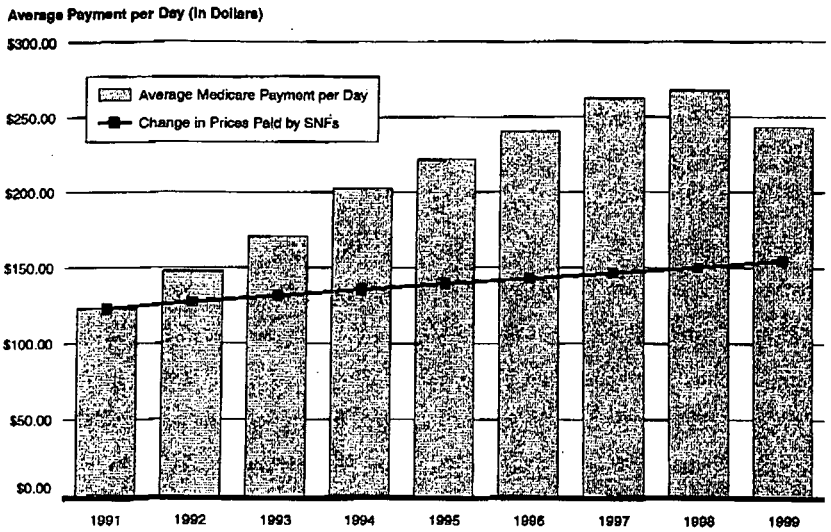
Medicare covers nursing home care for beneficiaries who need skilled nursing or rehabilitative therapy services for conditions related to a hospital stay of at least 3 days occurring within 30 days before admission to a nursing home. All necessary services—including room and board, nursing care, and ancillary services such as drugs, laboratory tests, and physical therapy—are covered for up to 100 days of care per spell of illness. Beginning on the 21st day of care, the beneficiary is responsible for a daily coinsurance payment, which currently is $97.

Spending for skilled nursing services furnished in Medicare-certified nursing homes represents a growing share of total Medicare expenditures.[2] Between 1990 and 1998,

[1] *Skilled Nursing Facilities: Medicare Payment Changes Require Provider Adjustments But Maintain Access* (GAO/HEHS-00-23, Dec. 1999).

Medicare expenditures for skilled nursing facility (SNF) services increased, on average, 25 percent annually, reaching $13.6 billion in 1998. This growth was due primarily to a rise in the number of beneficiaries using SNF services and to an increase in the provision of services to each SNF patient. Between 1991 and 1998, the number of beneficiaries receiving SNF care more than doubled, rising from 671,000 to 1.5 million. Over that period, Medicare's average payment per day increased, on average, 12 percent annually, reaching $268 in 1998, although the SNF market basket index, which measures yearly changes in the prices of goods and services purchased by nursing homes, rose only an average of 3 percent per year (see figure 1).

Figure 1. Average Medicare SNF Payments per Day Compared With Changes in Prices Paid by SNFs, 1991-1999



Source: GAO analysis of data from the Health Care Financing Administration, Office of the Actuary, and DRI/McGraw-Hill, Inc.

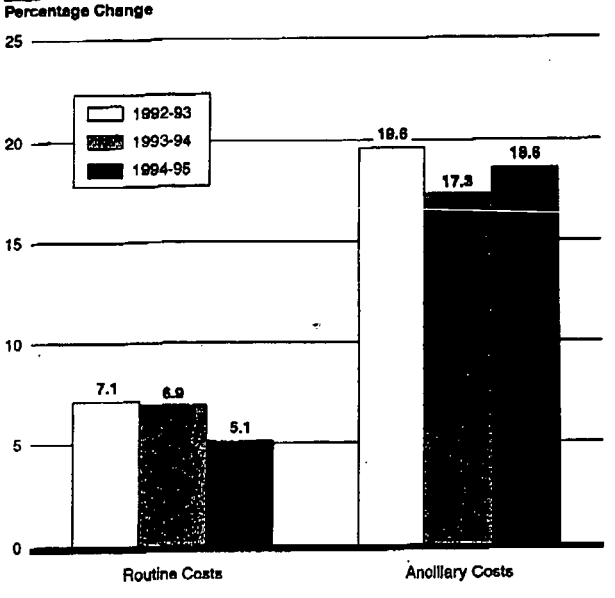
Medicare's cost-based reimbursement method, combined with a lack of appropriate program oversight, provided few checks on the growth in Medicare spending for SNF services. We believe, and the Department of Health and Human Services' Office of Inspector General (OIG) agrees, that the growth in costs for ancillary services, such as rehabilitation therapies, was excessive.[4] Before implementation of the BBA, Medicare

[3]Such facilities are referred to as skilled nursing facilities or SNFs.

[4]See *Medicare Post-Acute Care: Better Information Needed Before Modifying BBA Reforms* (GAO/T-HEHS-99-192, Sept. 15, 1999); Department of Health and Human Services, Office of Inspector General, Office of

paid nursing homes the reasonable costs they incurred in providing Medicare-covered services. Routine services (which include general nursing, room and board, and administrative overhead) were subject to cost limits, but payments for ancillary services and capital-related costs were virtually unlimited. Because higher ancillary service costs triggered higher payments, facilities had no financial incentive to furnish only clinically necessary services and little incentive to deliver them efficiently. Further, high ancillary costs could be used to justify a request for exceptions payments for routine costs over and above the cost limits.[6] Indeed, the growth in Medicare per day expenditures was driven largely by increases in payments for ancillary services. An analysis of SNF costs from 1992 through 1995 found that reported ancillary costs per day rose 19 percent per year, on average, compared to 6 percent per year for routine costs (see fig. 2). This rapid cost growth is not explained by a commensurate increase in Medicare beneficiaries' needs.

Figure 2. Percentage Growth in SNF Routine and Ancillary Costs per Day, 1992-1995



Source: Prospective Payment Assessment Commission

Evaluation and Inspections, *Physical and Occupational Therapy in Nursing Homes: Cost of Improper Billings to Medicare* (OEI-09-97-00122, Aug. 1999); *Medicare: tighter Rules Needed to Curtail Overcharges for Therapy in Nursing Homes* (GAO/HEHS-95-23, Mar. 1995).

[6]Under cost-based reimbursement, providers with reasonable costs that exceeded the routine cost limits could be granted exceptions from the limits if they provided information indicating that they served patients requiring more services than the average.

This was the situation facing the Congress when it mandated in the BBA the implementation of a prospective payment system (PPS) for Medicare-covered SNF care. As required, the Health Care Financing Administration (HCFA) began phasing in the PPS on July 1, 1998. Under the new system, facilities receive a fixed payment for each day of care provided to an eligible Medicare beneficiary. Because not all patients require the same amount of care, payments are adjusted to reflect differences in patient characteristics and service needs. In fiscal year 2001, the payment for those patients expected to be the most costly will be more than three times greater than the payment for those with the lowest expected costs. By establishing fixed payments and including most services under the per diem payment, the PPS attempts to provide incentives for nursing homes to furnish only necessary services and to deliver those services more efficiently. Facilities that can care for beneficiaries for less than the adjusted per diem payment can retain the difference as profit. Those with average costs higher than the per diem payments they receive will incur a loss.

SNF PPS RATES COVER MEDICARE-RELATED COSTS

Nursing home companies that recently have filed for bankruptcy and reported large losses have blamed Medicare payment policies, charging, among other things, that payment rates under the PPS are too low. Before we turn to the causes of the bankruptcies, let us address this issue. We believe that Medicare SNF payments are likely to provide sufficient—and in some cases, even generous—compensation for services furnished to Medicare beneficiaries. The average Medicare payment per day declined about $25 or 9 percent between FY 1998 and FY 1999, reaching about the same average rate as in FY 1996. This is noteworthy, because payments per day in 1996 were thought to be excessive, given that they reflected 6 years of growth of more than 12 percent per year at a time when prices for goods and services purchased by SNFs were rising about 3 percent each year.

Even with the reduction in average payments per day under PPS, we see no evidence that beneficiary access to SNF care has been compromised. Surveys of hospital discharge planners and nursing home administrators conducted by us and the OIG indicate that beneficiaries needing SNF care continue to receive it, even though some patients may have more difficulty finding a nursing home that can care for them. However, hospital lengths of stay for admissions likely to lead to a SNF stay continue to decline, providing no evidence that patients are "backing up" in hospitals.

Although aggregate Medicare payments are adequate to cover the costs of caring for Medicare patients, constraining payments to nursing homes may have created financial difficulties for some providers. Nursing homes with average daily costs that are higher than their payments must modify their treatment patterns and business strategies if they are to operate profitably. In addition, homes that used historically generous Medicare payments to make up for the uncovered costs of other residents may find that their Medicare revenues no longer stretch this far. Some industry representatives and analysts argue that Medicaid payments were often inadequate to cover the costs of Medicaid residents, so Medicare profits were used to make up the difference. But Medicare payments were never intended to finance the costs of these or other non-Medicare residents.

At the same time, the new incentives for efficiency created by the PPS have come at a time when providers are facing other external cost pressures. For example, in our healthy economy, nursing homes may be experiencing increased competition for staff. Competition for workers may have forced nursing homes to increase wages and expand benefits to attract and retain qualified personnel. Nursing homes have also been experiencing slight but steady reductions in occupancy rates over the last few years. Industry representatives contend that competition from assisted living facilities and other residential alternatives has spurred this decline. Still, the median nursing home occupancy rate is 88 percent.

We believe that aggregate payments are adequate, but we are concerned that the system may not adequately identify the most costly patients and distribute payments accordingly. Facilities treating a disproportionate number of high-cost cases may not receive adequate payments for those patients, which could result in access problems or inadequate care for some high-cost beneficiaries. At the same time, nursing homes treating patients with low service needs may be overpaid.[6] HCFA is aware of these distributional problems and is working to refine the system so that payments more accurately reflect differences in patient needs.

In the meantime, the BBRA, which modified some elements of the BBA, included a provision that temporarily boosts payments for certain cases by 20 percent.[7] At the same time, the Act increased payment rates across-the-board by 4 percent for fiscal years 2001 and 2002. These changes will add an estimated $200 million to Medicare SNF spending in fiscal year 2000 and, if allowed to remain in effect for 5 years, will increase total spending by $1.4 billion. To the extent that shortcomings in the payment system created access problems for some patients, the BBRA increase will ease concerns about the distribution of payments across patients. But fiscal prudence and the need for accurate payments to ensure appropriate service provision argues for implementing research-based improvements to the rates as soon as practicable. Such improvements aim to distribute existing payments more appropriately, avoiding the unwarranted expenditure of an additional hundreds of millions of dollars each year.

NURSING HOME PERFORMANCE UNDER PPS IS PRIMARILY A FUNCTION OF PREVIOUS BUSINESS PRACTICES

The nursing home chains that have filed for bankruptcy in recent months have blamed the Medicare PPS for their financial difficulties. Yet our work indicates that the problems experienced by these corporations can be traced to strategic business decisions made during a period when Medicare was exercising too little control over its payments. The former SNF payment system encouraged nursing homes to increase their ancillary and capital costs, because doing so increased their payments. It also created opportunities for other organizations to supply services such as therapy at

[6] *Skilled Nursing Facilities: Medicare Payment Changes Require Provider Adjustments But Maintain Access* (GAO/HEHS-00-23, Dec. 1999).

[7] This BBRA provision is scheduled to expire on October 1, 2000, or when HCFA implements refinements to the payment system, whichever comes later. No refinements are planned for fiscal year 2001.

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inflated prices to nursing homes, which then passed the costs onto the Medicare program. The PPS replaced these incentives with ones that are more closely aligned with Medicare's goals of encouraging provider efficiency and ensuring that payments are adequate for efficient providers to furnish needed services to Medicare beneficiaries. Not surprisingly, providers that most aggressively responded to the incentives in the old payment system have had to make the most adjustments under the new system.

To better understand the issues surrounding the nursing home bankruptcies seen in the past year, we examined financial information submitted to us by seven of the largest nursing home chains, including four of the five corporations that have filed for bankruptcy.[8] We found a number of common elements among the bankrupt corporations. First, most of the chains in bankruptcy reported higher than average nursing home costs, which is detrimental under a payment system based on national average costs. Although Medicare's 1998 average payment per day (which was based on facility costs) was $268, some of the chains reported pre-PPS payments exceeding $300 per day. It is not clear why their costs and resulting payments were higher than average. Their nursing homes may have served patients who needed more intensive care than the average Medicare SNF patient, in which case their PPS payments will likely also be higher than average. Higher costs might also, however, reflect provider inefficiencies, inflated prices, or over-provision of ancillary services.

Since implementation of the PPS, most of the companies we analyzed have cut costs to improve overall performance in their nursing home businesses. Several chains, for example, report that they have decreased costs by reducing the number of ancillary services provided to their nursing home patients and purchasing ancillary services and supplies at lower prices. Some also are opting not to purchase ancillary services from contractors and instead are hiring their own staff to furnish necessary services. At least one chain reports seeking to reduce its costs by admitting patients needing fewer ancillary services.

Some costs, however, are more difficult to reduce in the short term. For two of the bankrupt companies we examined, reported capital-related costs such as depreciation, interest on debt, and rent are substantially higher than the industry average. These companies invested heavily in the nursing home and ancillary service businesses in the years immediately preceding the PPS, both expanding their acquisitions and upgrading facilities to provide more intensive services. Under constrained payments, these debt-laden enterprises are particularly challenged.

A third company now operating in bankruptcy reported a four-fold increase in its rental costs between 1997 and 1999. This increase was due to a business decision to separate the property side of the business from the operating side, with the new real estate company leasing the nursing homes back to the operating company. Under this new

[8]The companies included in our analysis were: Beverly Enterprises, Inc., Extendicare Health Services, Inc., HCR-Manor Care, Inc., Integrated Health Services, Inc., Mariner Post-Acute Care Network, Inc., Sun Healthcare Group, Inc., and Vencor, Inc. Documentary evidence used in analyzing the effect of the BBA included both financial information provided by the companies and their corporate filings from the United States Security and Exchange Commission, which contain material financial and business information on publicly traded companies.

structure, the operating company reported its nursing home rental expenses rose from $42 million in 1997 to $171 million in 1999, without a commensurate decline in other capital costs. As might be expected, this business decision greatly affected the operating company's bottom line. In fact, had the company's capital costs remained at the 1997 level, profits from their nursing home operations would have fallen 9 percent between 1997 and 1999, due primarily to reductions in nursing home revenues. Instead, the company's profits from their nursing home operations fell 78 percent.

The pattern with regard to nursing home revenues is less clear. Almost all of the companies we analyzed, including those not operating in bankruptcy, reported reductions in the proportion of their total nursing home revenues attributable to Medicare. In 1998, the companies we examined had an average Medicare revenue share of 26 percent. In 1999, that average fell to 22 percent.

Declining Medicare revenues resulted in reductions in total nursing home revenues for most of the chains we examined (although one of the companies now operating in bankruptcy saw its total nursing home revenues climb 13 percent between 1998 and 1999). Most of the companies expect total nursing home revenues to be higher in 2000 than in 1999. Moreover, three of the four companies operating in bankruptcy have continued to generate profits in their nursing home operations throughout the transition to the PPS. The remaining company had been operating its nursing homes at a loss even before the implementation of the PPS.

That companies can generate profits in their nursing home operations and at the same time file for bankruptcy can be explained in large part by losses from their ancillary service lines of business. Most corporations that have filed for bankruptcy had invested heavily in the business of furnishing ancillary services to their own nursing homes and others. Two companies attributed about 25 percent of their total corporate revenues in 1998 to their ancillary service lines of business, while one company attributed almost half. But the PPS has made nursing homes, those belonging to these chains as well as others, more cost-conscious in purchasing contracted services, which had the effect of reducing both the demand for and the price of ancillary services. As a result, revenues from ancillary service lines of business have plummeted.

Without the prospect of overly generous, rapidly rising Medicare revenues, these publicly owned corporations were forced to post asset impairment losses on their balance sheets. Accounting principles dictate that such losses be calculated and recognized to inform investors that future expected revenue streams will be lower than anticipated.[9] Companies also have downsized their businesses by selling nursing homes and ancillary service providers, often at a loss. Losses from asset impairment and sales account for much of the bankrupt corporations' reported total shortfalls but reflect business and accounting practices rather than losses from current operations. They are, in effect,

[9]The losses appearing on their income statements reflect the difference between the original value of assets and the revised value, based on the revenue the asset is expected to generate in the future. The American Institute of Certified Public Accountants' Statement of Financial Accounting Standards No. 121 (SFAS No. 121), entitled *Accounting for the Impairment of Long-Lived Assets and for Long-Lived Assets to be Disposed of*, requires such impairment losses to be recognized.

paper losses that do not contribute to the companies' bankruptcy filings, although they do affect calculations of the companies' worth.

OPERATIONS CONTINUE WHILE COMPANIES RESTRUCTURE, BUT SOME FACILITIES MAY BE CLOSED

Given the protections and benefits available under the U.S. Bankruptcy Code (Code), it is unlikely that the bankruptcy filings of the five large nursing home chains will affect the short-term operations of their nursing homes. The five chains have filed for bankruptcy under Chapter 11 of the Code. Filing for bankruptcy protection under this chapter offers a number of benefits to companies. First, Chapter 11 bankruptcy proceedings focus on restructuring a company's debt and reorganizing its business operations with the goal of achieving future profitability and some debt repayment. Protection under Chapter 11 allows a company to cease making debt payments while it renegotiates the terms of those debts, including loan amounts and payment schedules.

A company in Chapter 11 usually retains control of its assets as the "debtor in possession," while a creditor committee is appointed to protect the interests of the creditors. Because Chapter 11 allows the companies to continue to operate as they establish a payment schedule with their creditors, the bankruptcy proceedings should not affect the chains' short-term ability to provide services to their residents. In fact, the Code allows a business to obtain special financing while in bankruptcy to help ensure that it has the funding necessary to operate. All five nursing home chains that have filed petitions under Chapter 11 have obtained such funding. With access to this cash, operations of the nursing homes run by the chains should continue.

Bankruptcy protection under Chapter 11 is designed to allow a company to continue operating, so a nursing home in bankruptcy can continue to care for its residents. However, a nursing home chain that does not emerge from a Chapter 11 proceeding will convert to a proceeding under Chapter 7, in which case residents of the chain's nursing homes would not be protected under federal law, because there are no provisions to do so. In a Chapter 7 bankruptcy, a company is dissolved and its assets are sold to pay its debts. Assets are put under the control of a court-appointed trustee, whose responsibility is primarily to the creditors. Many states have trusteeship (or receivership) laws that allow the state to intercede in a Chapter 7 bankruptcy proceeding involving a health care provider, delaying asset liquidation to protect patients. In such a case, a state court-appointed trustee continues to operate the facility until a buyer is found or until alternative care arrangements can be made for residents. Trusteeship statutes are not present in every state, however, and even if they do exist, implementing them may not be easy. Finding qualified and interested individuals to act as trustees may be problematic, particularly if many are needed, as might be the case in some states if a major nursing home chain files for Chapter 7 bankruptcy. Neither is it clear who would finance the costs of continued operations or the costs of transferring patients to alternative care settings. In some cases, states have argued to the court, generally with little success, that these costs should be charged to the bankrupt company and should receive priority over other debts. Such an arrangement would not be in the interest of

other creditors, since the company's remaining assets may not be enough to retire its debts.

Although industry analysts and government officials expect that most public chains currently operating in bankruptcy will recover, it is important for states to be prepared to address nursing home closures, particularly in states where large numbers of nursing homes are operating in bankruptcy. HCFA has been involved on a limited scale in states' contingency planning processes, by providing guidance to state agencies for the enhanced monitoring of bankrupt facilities and surveying states' contingency planning efforts. Unfortunately, our discussions with HCFA suggest that, in the unlikely event of substantial nursing home closures, some states may not be adequately prepared.

Even if nursing home chains emerge from bankruptcy, some of their facilities may be sold. Given the current climate, corporations may reevaluate their cost structures and decide to get rid of certain facilities based on their profitability or other factors. If no buyers can be found, some facilities may be closed.

The recent bankruptcy filings and the resulting recapitalization or reorganization of nursing homes' debt structures also has had consequences for the industry as a whole. According to market analysts and industry representatives, lenders are now more hesitant to provide capital to nursing homes. Nursing homes that do not have established relationships with lenders may have difficulty obtaining funds for expansions or upgrades to current facilities. This may be problematic for businesses that want to expand or for homes that need improvements. However, prospects for raising capital may improve with recognition of the fact that our aging population will dramatically increase demand for long-term care services.

CONCLUSIONS

As anticipated, BBA reforms have had significant effects on the delivery, cost, and use of SNF services. The changes wrought by the BBA have required providers to adjust both their patterns of care and their business strategies. These adjustments have not been easy for some, and those who have experienced the most difficulty have been quick to attribute their problems to inadequate Medicare payments and call for additional federal dollars. However, our analysis indicates that the nursing homes' responses are adaptations to appropriately tightened Medicare payments following a period of unchecked growth.

The SNF PPS needs some refinements, which are under development. In assessing the merits of these refinements, prudence suggests that beneficiary needs and the program's prospects for long-term financial sustainability should be of paramount concern. We will continue to monitor the effects of the BBA to help the Congress ensure that beneficiary access is protected, providers are fairly compensated, and taxpayers do not shoulder the burden of funding unnecessary or inefficient spending by nursing homes.

Mr. Chairman, this concludes my prepared statement. I will be happy to answer any questions you or other Members of the Committee may have.

GAO CONTACT AND ACKNOWLEDGMENTS

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(201088)

The CHAIRMAN. Thank you. Now, Mr. Ransom.

STATEMENT OF JOHN RANSOM, DIRECTOR, HEALTHCARE RESEARCH, RAYMOND JAMES FINANCIAL, ST. PETERSBURG, FL

Mr. RANSOM. Thank you, Mr. Chairman, Senator Breaux. I am not going to read my entire testimony, but I will hit the highlights. I currently am in charge of following about 50 health-care stocks for institutional retail investors; two of those are public nursing home chains, HCR and Beverly. I volunteered to give testimony today. I have no financial stake in this, other than as a concerned citizen, as a somewhat-informed outsider. But I thought my experience, both as an equity analyst and as a former lender to the industry, gave me some perspective on this industry.

First, let me describe the environment in the late 1980's in early 1990's that gave rise to this sector. In the mid-1980's, PPS pricing for hospitals flattened, as Senator Breaux remarked, in one of the episodic fits and starts of increases. As a result of the flattening of this DRG payment system, we created a big demand for post-acute residence in the channel. In a country like ours, whenever there is a demand, supply will be formed to fill that demand. And Integrated Health in 1986 was the first company to formally respond to this, started by Dr. Bob Elkins.

Integrated Health went public in 1991. Forty-one IPOs followed. And, back at that time, investors liked a couple things about this. The first thing they liked was that Medicare payments were indeed rising at 30 percent-a-year, which created a growth business to invest in. The second thing that was attractive was that it was cost-based. It didn't take a lot of skill, frankly, to operate in a cost-based environment. Therefore, capital, both equity and debt, was cheap, and as these companies went public and started to buy Medicaid nursing homes, the story rapidly became: we are going to buy Medicaid beds, we are going to convert them to Medicare beds and we are going to add ancillary services. And we are going to enjoy both absolute and same-store revenue growth.

In the mid–1990's, the industry began to mature and consolidate, and I have outlined in my testimony a half-dozen or so transactions. Genesis Health, in June 1997, bought a company called Multi-Care for $1.4 billion. Extended Care bought Arbor Health for about $500 million in November 1997. InvestCorp purchased Harbor Side in an LBO in April 1998, and Vencor purchased Hillhaven Theratecs Transitional Hospital Corporation for over $2 billion. Mariner Post-Acute bought Grand Care—Living Centers of America and Mariner were brought together to form those companies.

My point is this, two things, No. 1, these transactions, except for the HCR-Manor Care, were done with cash and paid for largely with debt. And, second, these multiples were at fairly high levels in my opinion, at anywhere from nine-to-eleven times EBITDA. We had seen multiples at lower levels in the early 1990's, and, as valuations increased, these valuations began to increase, as well.

What that resulted in is the industry added $5 billion of transactional debt at pretty high multiples. In March 1998, the market value of nursing homes peaked at about $14 billion. However, in the second half of 1998, the storm clouds began to develop for the industry. No. 1, the BBA, as we have remarked upon. What hap-

pened with the BBA, according to our numbers, is that Medicare spending went from growing at 30 percent-a-year to about 20 percent, to about 5 percent, and then, in 1999, actually declined by about 10 percent, so that was quite a dramatic drop-off.

When you look at the public companies, Medicare revenues-per-day declined about 20 percent, from about $365 a day at the peak to $290 a day by May of 2000. Medicaid rates, once the Boren amendment was repealed, also began to lag cost increases. Our numbers, and they are not perfect, would suggest that Medicaid rate increases were less than 4 percent a year, whereas costs were rising at five-to-seven percent a year.

The combination of these factors meant that the average public nursing home company had a 10 percent revenue reduction. At the same time, however, they were only able to reduce their operating expenses by about one-to-three percent, and, at the same time, capital cost began to increase as the risk in the industry was perceived to increase, as well. The result of that, bankruptcy.

The first company to declare bankruptcy was Vencor, and, as you know, I won't go through the litany of the other companies that have declared, but where we are is that Sun, Integrated, Vencor, Genesis and Mariner have all declared bankruptcy. So, where are we now? Where we are now, in my opinion, is that a bunch of lenders own about 12 percent of our Nation's nursing home beds. Lenders are not good long-term owners of these properties because that is not their job.

What they are going to seek to do, like we had in the real estate cycle in the early 1990's, is they are going to seek to liquidate these properties. The other thing that we have going on is we have some other fundamentals in the industry starting to weaken, not just Medicare. This great economy has produced labor shortages in some markets. A couple of other things that are going on include, in Florida, my home State, we have got liability, we have got 40 percent of the country's liability costs, as opposed to 10 percent of the beds, and we have got liability costs that are eight times the national average.

The last thing I will mention is capital flight, and this is what worries me the most, looking forward. Almost nobody will lend against nursing home assets, given that banks have written off hundreds of millions of loans. Equity investors are shying away from providing any capital to this sector, and the assets are somewhat frozen in the hands of people who do not want to be long-term owners. So, with that as a backdrop, I want to just offer a couple of suggestions on where we might go from here.

No. 1, when managed care was active in the long term care business, they had a much simpler system for paying for Medicare. It was based on acuity, but it was only four-to-six levels in the cases we studied. When I study the Government's proposals, with over 50 different rates, I am struck by the fact that for your average mom-and-pop nursing home, this system is too complicated to administer.

We don't have the infrastructure or the systems to administer something this complicated. In the current environment over concern over compliance, everybody's scared to death of an OIG investigation. A couple of other things that would seem on point. In

Florida, we passed a Patient's Bill of Rights that would allow aggressive trial lawyers to sue against vague violations of the Patient's Bill of Rights. This has led to, almost as Ruben King Shaw said in the recent press release, almost a disintegration of the long-term care infrastructure in our State in the last 6 months.

So, it seems like tort reform might be in order. And I don't know why we repealed the Boren amendment, but the Boren amendment, restoration of that might be in order. And, finally, the 3-day hospital stay requirement also is a contributor in my view. So, those are four things that are within the Government's power to do to help this industry. My only goal here today is to begin a dialog to at least restore some private capital back to this sector. If we don't have private capital restored, the infrastructure is going to continue to deteriorate, capacity will shrink, and I do believe access will become a problem.

Thank you.

[The prepared statement of Mr. Ransom follows:]

Introduction:

My name is John Ransom. Thank you for the privilege of speaking today.

I am currently employed by Raymond James & Associates as the Director of Healthcare Research, a firm I joined in June 1996. Formerly, I spent 10 years at First Union National Bank, the last eight of which I spent financing health care companies, including many hospital and nursing home companies.

In my current position, I, along with two other analysts, provide research coverage on publicly held health care service companies for consumption by institutional and retail investors. As part of that effort, we provide research coverage on Beverly and Manor Care, the last two major publicly held nursing home concerns. I estimate that less than 5% of our effort and economics are derived from our efforts in the nursing home sector.

I have volunteered to testify today to give the financial community's perspective on the developments in the industry. I hope the committee will appreciate that I have very little financial stake in the current status of the industry, which, hopefully, will lend some credence to my commentary. I must also add that I am encouraged by the thought process evident in the Breaux-Thomas proposals that the legislative branch appreciates the seriousness of the issues and the need for reform.

Below, I have outlined a condensed "take" on the industry's evolution:

Background: Robust Growth in the Late 1980s to Early 1990s:

• During the late 1980s, hospital DRG price increases flattened dramatically, causing hospitals to become increasingly sophisticated with respect to DRG management. As hospitals shortened average Medicare lengths of stay (which have declined by over 50% since the advent of hospital inpatient PPS), a surge of Medicare enrollees needed care from the emerging "post-acute" care sector, which included SNF, rehab and home health providers.

• There were a number of entrepreneurial responses to the surge in demand for post-acute services. Both hospitals and independent operators rush to capitalize efforts to build out capacity. Integrated Health is the first company to public in April 1991, **the first of 41 IPOs in the 1990s.**

• These entrepreneurial long-term care companies expanded rapidly. The business model: acquire/develop SNFs and open "Medicare" or "sub-acute" units inside of traditional nursing homes. The result: $70-100/day Medicaid patients were replaced with $300-400/day Medicare patients. In addition, other companies established "non-facility" streams of revenue, also reimbursed by Medicare, most notably Pharmacy, Rehab and Home Health units. Another important consideration: SNF care was reputed to be 30-50% "cheaper" than comparable care in a hospital

• From 1991-1995, Medicare SNF payments care grew by more than 30% per annum. Medicare also implemented an exception system in the early 1990s, allowing additional payments for higher acuity patients. Liquidity of all kinds - debt, equity, subordinated debt and REIT financing - was ample. Public companies, especially Genesis Health Ventures, Integrated Health Services, Vencor, and Sun Health rose to prominence.

• Investors were heartened by robust revenue growth (both absolute and "same store"), plus the rising margins associated with the addition of therapy and pharmacy services. Medicare was viewed as a "low-risk" payer, as payments were rising rapidly on an absolute basis and were tied to costs incurred.

• Despite the explosion of Medicare revenues, Medicaid continued to serve as the main revenue contributor, funding over 60% of industry revenues.

The mid-to-late 1990s: A Period of Maturation and Consolidation:

In 1996 there were over 20 public nursing home chains. Investors became confused by many "me too" business models often obscured by complex financing. The stronger management teams began to acquire their public competitors. A sampling of transactions follows:

• In June 1997, Genesis Health purchased Multicare for $1.4 billion (11x EBITDA).

• In November 1997, Extendicare purchased Arbor for $450 million in October 1997 (11x EBITDA).

• In April 1998, Investcorp purchased Harborside (11x EBITDA) for $291 million.

• In 1995-1997, Vencor purchased Hillhaven, TheraTx and Transitional Hospital for cumulative purchase price of over $2 billion.

• From 1997-1998 Mariner Post Acute was created from the mergers of Grancare, Mariner and LCA, three former public companies.

• Integrated Health makes numerous purchases of rehab and home health companies. Larger transactions included the purchase of bankrupt ABC Home Health and RoTech.

• HCR purchased Manor Care in a pooling of interests transaction (i.e., an exchange of equity with no additional debt incurred).

• Against the grain, Beverly begins to shed assets, including its Texas nursing homes and its institutional pharmacy.

As a result, the public companies added over $5 billion in transactional debt at high EBITDA multiples. Market caps peak at $14 billion in March 1998, despite the gathering storm clouds:

• In the fall of 1997, Congress passed the Balanced Budget Act ("BBA"), intended to reduce Medicare spending on skilled nursing by $19.8 billion over 5 years with a new prospective pay system.

• In the early days following the passage of PPS, industry managements believe that "PPS creates a profit opportunity thru efficiency," much like the hospital industry.

• Despite the gathering storm clouds, public market valuations peak on March 31, 1998 at approximately $14 billion.

In the second half of 1998, fundamentals begin to weaken:

• Vencor is the first major nursing home company to experience an earnings shortfall, disappointing Wall Street with a disappointing forecast for the fourth quarter of 1997. It cites concerns that independent nursing homes won't sign long-term therapy contracts in light of PPS uncertainty.

• Beverly announces an extensive investigation into its Medicare billing practices in July 1998.

• Vencor, Sun Healthcare, Beverly, Genesis and NovaCare report 3Q98 EPS numbers indicating severe operating difficulties and weak revenue trends. Confusion about the impact of PPS is rampant, and equity valuations begin to collapse.

1999-Present: the Collapse of Public Valuations and the Spiral into Bankruptcy:

• Fears about Medicare spending are more than realized.The PPS cuts are currently estimated to reduce Medicare spending by almost $40 billion vs. the original $20 billion estimate. After a period of 30% growth, Medicare SNF spending grows in the mid-single digits in 1998 and drops by approximately 10% in 1999.

• Public company Medicare revenues/day peak in 2Q98 at approximately $365/day and decline to approximately $290/day by 4Q99, a 20% decrease. Public company market caps decline from a peak of $14 billion in March 1998 to $1.7 billion in May 2000.

• After the repeal of the Boren Amendment (effective for federal fiscal 1998-2000), Medicaid rate increases (average: < 3.0%) have lagged underlying estimated cost inflation (average: 4-7%).

• The underlying Medicare PPS updates were 1.8% in federal fiscal 1999 and 2.0% in federal fiscal 2000.

• A recent Standard & Poor's credit ratings survey showed marked deterioration from October 1998 to December 1999, with only 2/12 companies having debt rated better than "single B."

• Vencor is first public company to file for Chapter 11 bankruptcy. Filings by Sun, Integrated, Genesis and Mariner soon follow.

• In Florida, entrepreneurial attorneys begin filing claims that nursing homes are violating provisions of the Patient's Bill of Rights. The result: Florida has 10% of the country's nursing home beds but 40% of the liability claims, and 20% of all beds are operated out of bankruptcy. Liability costs are currently running at 8x the national average. A study is under way under the direction of the Lt. Governor.

• Labor shortages, a shortage of nurses (fewer women entering the profession) and a difficult work environment begin to accelerate labor cost trends, especially for nurses and administrators, the most expensive labor.

• Occupancy rates begin to decline, as Medicare lengths of stay are reduced, and competition for private pay patients increases from emerging assisted living companies.

• Banks and REITs write off hundreds of millions of loans, and capital flight is rampant.

Bottom Line - the combination of a 20% reduction in Medicare revenue/day, already low margins, a fixed cost structure, rising debt costs and rising operating costs = Chapter 11. In the interim, lenders and landlords will become the temporary owners of nursing home beds at a cost of a 40-70% reduction in their investment basis.

With 20/20 hindsight, how could one have survived this perfect storm?

- Low Historical Medicare Rates

- Low Leverage

- Low Exposure to Ancillary Revenue Streams

- High Private Pay

Only BEV and HCR managed to produce variations of this business model. Note that some of these tenets were in direct opposition to public company mandate to grow quickly and maximize short-term profits.

So Where are We Now?

- REITS and commercial banks have written off or taken reserves against billions in nursing home investments: Sun, Integrated, Vencor, Genesis, and Mariner account for the lion's share of the exposure.

- Approximately 13% of all industry nursing home beds are operating in bankruptcy.

- Beverly and HCR remain the only viable public companies. Market cap: less than $2 billion vs. a state market value exceeding $10 trillion.

- The industry persists in a state of shock and demoralization with extreme difficulty attracting labor and capital.

Where Should We Go? Some Unsolicited Recommendations from a Wall Street Dilettante:

If nothing changes, we will be faced with rising demand and shrinking capacity. Some suggestions:

- SIMPLIFY PPS (do we need 50+ reimbursement categories?), UPDATE MEDICARE/MEDICAID RATES FOR COST INFLATION and INCREASE PAYMENTS FOR HIGHER ACUITY LEVELS. Nursing homes are not hospitals (smaller/lower margins) and do not have the infrastructure to administer complex payment schemes. Without a workable post-acute network, patients will stay in hospitals "step-down" units at 2x the cost. Hint: some former Florida HMOs make do with 4-6 payment categories.

- ADOPT TORT REFORM but continue state oversight and continue to allow malpractice suits. Uncapped liability vs. vague Patient Bill of Rights standards will enrich the few but has no redeeming social return.

- RESTORE THE BOREN AMENDMENT. Allow nursing homes to argue for higher rates in court. With shrinking welfare roles, a glut of tobacco money and soaring tax receipts, we can afford it.

- ELIMINATE THE 3 DAY HOSPITAL STAY REQUIREMENT but ensure that the MDS confirms "RUGS" diagnosis. Reasons include (1) save $ on the front end, and (2) patient proceeds immediately into a lower cost environment.

Bottom line, capital flight will continue until lenders and other potential investors perceive that the industry has stabilized and that increases in prospective Medicare/Medicaid reimbursement rates will cover increased operating and capital costs.

The CHAIRMAN. Thank you, Mr. Ransom. Now, Dr. Roadman.

STATEMENT OF CHARLES H. ROADMAN, II, M.D., PRESIDENT AND CEO, AMERICAN HEALTH CARE ASSOCIATION, WASHINGTON, D.C.

Dr. ROADMAN. Thank you, Mr. Chairman. This hearing was convened to discuss bankruptcy, and as I have discussed with your staff, I believe that focus is a little too narrow to get to the absolute issues that we need to deal with. I believe that the issue that we have got to address is the issue of economic viability of the skilled nursing profession.

And, if you see the first chart, there is a fairly striking visual with a red pin representing every facility that is currently operating under Chapter 11, and it will tell you that we have a significant problem ahead of us and this is the tip of the iceberg. I believe that the crisis we find ourselves in today is a systemic failure at the Federal and State level of public policies and public resource allocation priorities that we must work on.

Now, I believe there is a squeeze phenomenon that Mr. Ransom started talking about, but I would just like to emphasize again, and that is that the Medicare cuts were much deeper than expected, and that is from an inadequate baseline and a market basket index that is flawed. We have chronically underfunded Medicaid and, with the repeal of the Boren amendment, that has become more difficult, where today we have payments of $4 per hour for care of Medicaid patients, and that is less than we spend for teenage babysitters.

In addition, there has been capital flight from the health-care sector. A recent report stated that 85 percent of lenders do not lend and do not recommend lending to the health-care sector, and that is the fifth quarter in a row. There has been the evaporation of market equity, which Mr. Ransom also talked about, where we have seen an 80-percent reduction of the market equity over the last 2 years, and you know the relationship: no equity, no capital, no future.

We also have a complex PPS system that, does not meet patient needs. We have a subjective, inconsistent survey and enforcement system that has put us in an adversarial role, rather than a partnership. We have a skyrocketing liability insurance premium crisis, primarily, as Mr. Ransom said, in Florida, but that is the bellwether State for what is going to happen nationally. And, last, we have a staffing crisis. So, all of these are contributing, in my estimation, to where we are today.

I really have four key points. Skilled nursing facilities are an essential component of our health-care system. The current economic crisis threatens current and future beneficiary access. Performance expectations must be intimately linked with resources, and market failures are the direct consequence of public policy and implementation decisions to meet beneficiary needs.

From being an essential part of the system, right now, we have about 2 million Medicare beneficiaries that receive care each year. The number is going to be explosively increasing with the entry of the baby boomers into the retirement age. Today, two of three residents are women over 80 years old, without spouses and no con-

stant family caregiver. Our charge, as a health care profession, in the long-term health care profession, not industry, is to improve their health, their quality of life, and return them to home or a home-like setting as quickly as possible, and Medicare is the cornerstone of that mission.

In that, and in response to public policy decisions, SNFs today, skilled nursing facilities, are vastly different from where they were 10 years ago. The intensity has greatly increased. A study done by Muse recently has shown that 60.8 percent of Medicare patients are aggregated in the high, very high, and ultra-high resource utilization groups, and over 50 percent of the admissions are now Medicare-eligible.

The current economic crisis is threatening access. In August 1999, the OIG report stated that, even in the short-run, 58 percent of discharge planners stated they had difficulty in placing patient needs. Those were people who had extensive care requirements, those that ran out of DRGs before they ran out of hospital days. Those include people that are getting IV feedings, medications, tracheostomies and ventilator support.

Now, Mr. Grob is going to update data today. I have not seen that, new data. That report a year ago showed we had already begun to see changing patterns of admission, changing patterns of access. And, of course, what was said in the report was access is no problem. At that time, my father was going from an acute-care facility to a long-term care facility, and it is no problem unless there is a face on that patient. It is our job, I believe, in advocacy to put a face to that patient.

What I think we see today in access delays, people staying in hospital longer, is nickel ante compared to what we are going to see in the future, as we see increasing requirements and decreasing capacity. The fact that performance expectations must be intimately linked with resources really refer once again to the squeeze. We believe we should have an increasingly efficient system of delivery of care, not a system that underfunds the necessary services to patients. I would give you, just as an example, with my next chart, the market basket index, and you see two lines on this particular chart.

The upper is the increases in cost of providing services. The lower is the inflation rate recognized by HCFA. It doesn't recognize labor increases. It doesn't recognize increased cost in technology. It doesn't recognize increase in pharmacy. And, last, although not designed to do that, it does not identify changes in intensity that we have already described.

In my previous business in the Air Force, where we were flying, what I would describe is—this describes an aircraft in level flight with rising terrain, and I believe we need to fix that. Market failures are the direct consequences of public policy and implementation decisions.

As Mr. Ransom described, what we saw in the development of PPS was a cooperation between the profession and HCFA.

We thought we knew what we were expecting. We were expecting one in six dollars to be removed. What we have seen in the implementation is one in three dollars, and what that really does is it puts us into the oscillatory swings that Senator Breaux dis-

cusses. What was not included in there were the ancillary costs, and what that really meant was that businesses made decisions, strategic decisions on how they would organize, based on what the Government said, vertically oriented, vertically integrated their system and aggressively moved out. But, when one out of three dollars came out, that put the folks who had been most aggressive in a financially untenable position.

What now? Much credit, I believe, needs to go to the long-term care profession. We have operated for several years under tremendous challenges in a difficult environment. I have got with me Karen Shellangovsky from Davenport, IA. She is a head nurse in Davenport, IA. She was an acute-care nurse, shifted to long-term care when her grandmother went into long-term care, and has stayed with that for the love of her patients and with the goal of ensuring quality care.

What we have got to do, Government, providers, patients and families, all come together to begin to define what our future needs to look like—not to win debates, not to point fingers, but to seek solutions that are future-oriented together. And I believe it is a time of great courage.

There are some things that the 106th Congress, I believe, must do. They must adjust the baseline that was used in 1995 to 1998 up by about 13.5 percent. They must revise the market basket index so that it truly reflects the changing environment. We have got to update the SNF benefit, to protect the elderly from excessive co-payments. My assessment, Senator, is that we face a national crisis. It is coming on us quickly and it is going to try the soul of our Nation on how we take care of our young and how we take care of our elderly. It is not a medical problem. It is a public policy problem, and we have got to solve it together.

Thank you.

[The prepared statement of Dr. Roadman follows:]

Testimony of Charles H. Roadman II, M.D.

President and CEO

American Health Care Association

Before

The Senate Select Committee on Aging

September 5, 2000

67-641 2001 - 3

Thank you Chairman Grassley, and thank you Members of this Committee, for the opportunity to testify here today. On behalf of the American Health Care Association (AHCA), I look forward to continuing to work with you and your staff, and with every member of this Committee, to better the lives of America's seniors -- and to ensure those providing care are doing so in a manner that always puts patients and quality care first.

As President and CEO of the American Health Care Association, I represent a non-profit federation of affiliated associations representing more than 12.000 non-profit and for-profit assisted living, skilled nursing and subacute care providers. nationwide.

In addition to my statement today, I would respectfully ask that the charts and documents I'll be referencing be entered into the full record of this hearing.

While the hearing today focuses on the causes and subsequent problems associated with the immediate skilled nursing facility bankruptcy crisis, I believe we cannot examine this crisis isolated from the long-range economic viability of skilled nursing care for our elderly. That's because provider bankruptcies are the end result of a long chain of chronic, systemic failures -- many of which, I contend -- are the result of federal government policies -- however well intended -- that left providers unable to support a long term care or skilled nursing care infrastructure created by good faith business decisions.

I wish to emphasize four key points:

- Skilled Nursing Facilities (SNFs) are an essential component of our health care system – the delivery structure has been shaped in large part by public policy decisions;

- The current economic crisis threatens both current and future beneficiary access -- without adequate reimbursement to meet operating and capital requirements, providers cannot survive;

- Performance expectations must be intimately coupled with resources – public sector demands have not been matched with public sector commitment of resources;

- Market failures are the direct consequences of public policy and implementation decisions; to meet beneficiary needs, the long term care community must partner with the government.

SNFs are providing essential services:

First, let's make it clear why we are all here today: Approximately 2 million Americans need and receive Medicare covered skilled nursing care every year. That

number will increase exponentially as Baby Boomers and their parents age and confront limitations in activities of daily living (ADLs). Two out of three of current residents in skilled nursing facilities are women, aged 80 or older, left without a spouse or constant family caregiver. By anyone's reckoning, these patients are the most vulnerable segment of our population, and most depend on 24 hour skilled nursing care.

It's no overstatement to say that the typical SNF beneficiary puts the overall quality of the rest of his or her life in the hands of our profession. It's our charge to provide quality medical care to improve their health and quality of life, get them back on their feet and back home, or, to a homelike setting within the community. This is a benefit that, over Medicare's many years, has become a true cornerstone of the program.

Mr. Chairman, the rise of skilled nursing facility Medicare utilization during the past decade reflects legitimate clinical efforts by providers to meet beneficiary needs. As envisioned by Congress, skilled nursing facilities have become centers for post-acute rehabilitation and restorative services.

Meeting the needs of higher acuity, post-acute discharge patients have very clearly, whether we like it or not, transformed facility roles, functions and cost structures. The landscape in which skilled nursing facilities operate in the year 2000 is far different, and far more challenging and complex, than just 10 or 20 years ago.

As facilities stepped up and met these new challenges and complexities, the number of patients qualifying for Medicare grew. Today, more than half of all patients admitted to skilled nursing facilities are Medicare qualified.

Certainly, the importance of a viable Medicare system to providers is unmistakable, and some of the problems are painfully evident: A recent analysis from The Lewin Group, an independent public policy research firm, shows, for example, that Medicare reforms in the 1997 Balanced Budget Act were *intended* by Congress to reduce SNF benefit spending over the following seven years by *one out of every six dollars*, and that's how the CBO scored those reforms at the time.

Subsequent 1999 CBO projections have forecast reductions twice as large -- or, *one out of every three dollars*. In the aggregate, between the years 1998 and 2004, federal spending for skilled nursing facility care is now projected by CBO to be $15.8 billion less than Congress anticipated and agreed upon. These figures are based on solid research. A copy is provided attached to our submitted testimony, and I encourage you and/or your staffs to peruse it. We have also included a breakdown of Medicare losses state-by-state.

Although Congress passed the BBRA last year to restore vital Medicare funding for SNF care -- and that was helpful -- Medicare SNF outlays continue spiraling downward. The BBRA budgeted an increase of SNF spending in FY 2000 to $13.3 billion, yet, again, the CBO reports that that SNF spending will actually come in $2 billion below the budget.

Public Policy Failures:

Mr. Chairman, I want to speak directly to recent assertions by the GAO that there is no crisis in long term care, that bankruptcies affecting close to 2,000 skilled nursing facilities is not problematic, and that any difficulties confronting all providers are the direct result of business decisions. It is important for the Committee to understand the sequence of events, and how we got here.

From 1990 through 1997, providers and HCFA participated in demonstration projects to test the details of a prospective payment system. The entire profession, based in large part on its experience with the demonstration project, supported the prospective payment system. With the exception of one important area, providers had a sense of what to expect. That area, non-therapy ancillaries - which includes prescription drugs and ventilator care - was not well accounted for in the system. HCFA gave assurances that the PPS would include a component to account for non-therapy ancillaries when the final rates were published. It did not.

Prior to that, long term care providers made strategic business decisions as to how to phase into the new PPS. They looked at all major aspects of skilled nursing care, including rehabilitation, nursing, and prescription drugs. They made decisions as to how to structure their companies, not alone -- but with the scrutiny of literally hundreds of bankers, credit analysts, and institutional investors based on information provided by HCFA. This information portended a system that would ensure efficiencies in the delivery of skilled care rather than not paying for certain necessary services.

When we sat down with HCFA and Congress in developing this system, it was widely expected that skilled nursing care would experience a $19.8 billion reduction upon implementation of PPS. The reality has been that the PPS has cut more than $35.6 billion from SNF care – $15.8 billion more than originally anticipated.

Attached is a recent analysis completed by KPMG analyzing the adequacy of RUG rates for achieving the nurse staffing standard used by HCFA in developing its rate methodology. Mr. Chairman, I think you will find it astonishing to note that the initial rate structure *was* and *continues to be* grossly inadequate. It can be seen based on HCFA's own information, the overwhelming majority of PPS rates relating to the nursing case mix component is insufficient.

The rates understate nursing by nearly 14%, with the average deficit in rural areas being nearly 17%. In some RUG categories, HCFA's under recognition of nursing costs are in excess of $30 per day. Out of the 44 RUG categories, nursing costs are met in only one of the rural categories, and only three of the urban categories. Obviously, flaws were made in the calculations of the rates.

Mr. Chairman, the implementation of the PPS has penalized those providers that have stepped up to serve Medicare beneficiaries in need of skilled nursing care. Those who invested in the infrastructure to facilitate patients' return to the community for high acuity hospital discharge Medicare beneficiaries are those providers who were most adversely impacted by these cutbacks. These investments included highly skilled staff, on-site therapy services and specialized medical equipment to address the health care needs of patients with complex medical and rehabilitative needs.

Bankruptcies among skilled nursing facilities have reached an alarming figure of approximately 2,000 facilities in the last year alone. But, let me state very, very clearly, on the record, to everyone here today: This is just the tip of the iceberg. Our long term care community is facing a squeeze with the real potential for absolute collapse that will put at risk care for all SNF patients -- We are faced with countless challenges affecting caregivers and patients alike. Among them....

- Medicare cuts, which are *much deeper* than anticipated;
- A grossly underfunded Medicaid system, which pays for two out of every three of our nation's 1.5 million patients -- truly a staggering figure;
- The "capital flight" of the private investment sector is a serious problem; we simply can't improve quality in long term care without having resources to invest in infrastructure;
- The evaporation of nearly all of the profession's market equity support, resulting in a loss of 85% of investment capital;
- A poor patient index classification system;
- An inadequate baseline;
- An overly complex PPS that does not reflect patient needs;
- A subjective and ineffective survey and enforcement system that is not functioning in the best interests of patient care;
- An alarming national trend of skyrocketing liability insurance premiums which is causing a flight of good providers from the state of Florida, with many states soon to follow unless tort reform is implemented;
- And, a staffing crisis, with more than 100% annual staff turnover -- 100%! Employee recruitment and retention in a booming economy at such low wages is a very significant concern.

Consequences of Public Policy Failures:

These factors have had a dramatic impact on SNF viability – and quality and access are next.

Contrary to rumors, access to services has become a problem -- especially in rural areas. And these problems with beneficiary access will become more prevalent in the upcoming months, as the squeeze intensifies.

Looking back at the August 1999 Office of the Inspector General (OIG) report examining the effects of the PPS on access to SNFs, the findings included the following:

- When asked which types of patients have become more difficult to place in nursing homes, the majority of discharge planners -- 58% -- identified patients who require extensive services, according to the OIG. "These types of patients typically require complex direct nursing care and expensive medications. They include patients who require intravenous feedings, intravenous medications, tracheotomy care or ventilator care," the report says.

- One-third of all hospital discharge planners said it was difficult to place Medicare patients in SNFs.

- Approximately 20 % said placement has become more difficult in the past year due to PPS implementation.

- Sixty-five percent of hospitals discharge planners say PPS has had an effect on their ability to place patients.

So, as stated by the federal government's own data, access *IS* a problem.

Equally important has been the impact on the vital fiscal signs of the sector. The attached three graphs detail the severe financial realities we are facing:

- The first, is what I call the "stack of pennies," which shows the division of payment out of each dollar of payment for care -- this is a very labor-intensive sector - - margins have historically been very low; but the economic reality is that most nursing facilities are receiving little or no fiscal return for their efforts.

- The second depicts the market capitalization fall off - - the financial economic crisis was not caused by increased debt, it was caused by decreased revenues. The growth spurt of the early 1990's was fueled by investor confidence -- the changes of the BBA undermined this confidence, and they have left the skilled nursing community without sufficient capital to sustain service capacity.

- And the third shows 1995 -1998 data costs incurred vs. annual inflation update – costs rose 27.4%, reimbursement increased 8.2% – no business can remain viable under such shortfalls.

Meeting Resident Needs:

Credit must be given to the hundreds of thousands of caregivers and providers who, while faced with these tremendous challenges in a very demanding and difficult environment, continue to do right by patients and work tirelessly to maintain a level of quality care. Accompanying me today are a number of those dedicated individuals who provide quality, compassionate care 24-hours a day under very challenging circumstances.

Partnering to Meet Resident Care Needs:

While there are those that want to dwell on what happened and why, our real focus must be on what needs to be done and how quickly. This hearing offers a unique opportunity for all of us to focus on defining real solutions.

As the attached "King/Muse analysis" outlines, we believe certain critical steps can and should be taken immediately. They are:

***First:* Adjust the SNF PPS base to account for the flawed update factor between 1995 and 1998.**

Specifically, we have documented the need for a one-time upward adjustment of 13.5% to the SNF PPS base to account for forecast errors between 1995 and 1998.

***Second:* Develop a process for revising the SNF market basket.**

The current skilled nursing facility market basket index is seriously flawed. It is not a specific measure of skilled nursing cost changes, nor is it an accurate predictor of cost changes in a dynamically changing care environment.

We strongly support a formal process by the Administration to review the SNF market basket to ensure it keeps pace with and fully accounts for the actual increases in costs incurred and reflects changes that will affect costs in the delivery of skilled nursing care.

***Third:* Medicare reforms should include an updating of the SNF benefit.**

We believe Congress must act to protect beneficiaries from excessive co-payments, must act to eliminate outdated controls on access to the benefit and must act to remove barriers to care management.

These steps address only part of the issues. We confront other issues that impact and are unalterably interwoven into the overall big-picture -- specifically, the issues of staffing, the chronic underfunding of Medicaid at the state level, and the survey and enforcement issue.

I would be remiss if I did not briefly discuss the chaotic state of the survey and enforcement system. The shared goal of the long term care community, government and the public is quality care in a safe and secure environment for all nursing facility patients. However; the current survey and certification process doesn't serve that goal. These are my observations and proposed solutions:

- Nursing facilities should have access to a uniform, effective, objective and timely dispute resolution process as a way to appeal survey findings.

- Surveyors' decisions must be based on objective evaluations of actual end results of care, rather than non-specific determinations.

- Surveyors should be prohibited from overriding physicians'orders, or from inspecting areas in which they are not professionally qualified. Where problems do exist, facilities should be given the opportunity to correct problems, *especially when a violation does not cause physical harm to residents.*

- My final point on the survey system: The federally mandated nursing home inspection process should allow inspectors to work with facilities to solve problems. Federal government policy related to nursing home inspections actually prohibits nursing home inspectors from supplying information to caregivers that might help in correcting problems. The government's "no collaboration" policy is an obstacle to ongoing improvements in quality. If our common goal is to correct problems quickly and ultimately improve care, this policy is illogical.

Conclusion:

My assessment is clear -- the government's commitment to fund quality care is wavering -- Medicare funding for nursing facility care has been seriously cut, and Medicaid programs across the country are traditionally and, in some cases, grossly underfunded to the point of paying an average $4 per hour for care in a nursing facility. Sadly, Mr. Chairman. this is less than we pay a teenage babysitter.

Medicaid has become the default payer for people needing nursing facility services as it pays for two out of three residents nationwide. We believe there should be federal oversight of Medicaid payments, and we propose that there must be a minimum Medicaid rate standard, or floor, which will cover basic costs for quality patient care.

Government is demanding higher quality care and staffing while increasing regulations and providing fewer resources to provide it. As you know, Mr. Chairman, the American Health Care Association has taken a strong stance embracing many of the recent recommendations of the HCFA study on nursing home staffing that your committee requested. I have attached a copy of this most recent position paper. We, to believe optimum staffing is related to high-quality care; at the same time, we need your help in making sure that there are adequate resources to recruit and retain nursing staff...and the help of the Congress in creating an environment to stimulate a positive environment for caregivers. It is one thing to establish standards. It is another to help us reach them.

As we continue this important dialogue about the best means by which to address all of the issues discussed today, I want to leave the Committee with this message: We all want the best for our patients, we're always interested in improving the overall skilled nursing system itself, and we seek to work in a positive and constructive manner that *always* puts *patients and quality care first.*

I believe we face a national crisis – coming on quickly – that will try the very soul of this nation...how we care for our young, elderly and disabled in this country.

This is clearly a public policy issue – *NOT* a medical-long term care problem.

So, Mr. Chairman, we need help to accomplish these goals. We look forward to working with you, and this Committee, to accomplish our mutual and positive objectives that, in the end, help the many seniors in our nation who need and deserve not just our care, but our compassion as well.

Thank you.

Attachments: *Position Paper on Optimal Staffing Standards*
National and State-Specific Lewin Studies
KPMG Nurse Care Mix Rates
Capitalization Chart
Bankruptcy list
King/Muse Paper Analysis

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The CHAIRMAN. Thank you, Dr. Roadman. Now, Mr. Grob.

STATEMENT OF GEORGE F. GROB, DEPUTY INSPECTOR GENERAL FOR EVALUATION AND INSPECTION, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, WASHINGTON, DC.

Mr. GROB. Good morning, Mr. Chairman and Senator Breaux. Our office has just completed a study of Medicare beneficiary access to skilled nursing facilities. We are releasing it today. It is an update of the one that we did last year, and I think that you have copies of it already.

This study differs from the one that we presented last year, and which Dr. Roadman had quoted in his testimony. In his testimony, he reflected upon the statistics we gave about the difficulty of placing patients in nursing homes, and indeed the statistics he stated were correctly taken from our report. However, those statistics referred to the difficulty of making the placement, not to the inability to make a placement.

Part of the difficulty that was being experienced at that time was a new system of payment was going into effect and the nursing homes and others were being very careful in how those placements occurred. So, there was an intensity of review of the patients and of the patients' records, to see which patients would be accepted by each nursing home, and that is what accounted for that higher percentage of discharge planners who were saying that they had a difficulty making the placement.

Now, because that phrase, the difficulty of placing patients, came up in other policy deliberations, we decided that this year we would be more precise in the way that we did our report. So, this year, we are distinguishing between the concepts of whether or not nursing homes are actually able to make the placement, or whether they are incurring delays, or whether they are having other difficulties in making the placements. And I hope this new, more refined information will be helpful in the policy deliberation process.

First of all, our study is based on interviews with a nationally representative, random sample of hospital discharge planners and our own analysis of Medicare program data. With regard to access to care, almost all discharge planners report that they are able to place Medicare beneficiaries in nursing facilities. In fact, 80 percent say they could place all their Medicare patients. Another 14 percent estimate they can place all but one-to-five percent.

One reason that they say they are successful is that there are an adequate number of beds available in their area, often including at their own facility. Our analysis of Medicare data confirmed this. From 1997 to 1999, the number of Medicare-certified beds increased by 23 percent, and the largest part of that percent occurred last year.

To see if all kinds of patients were being placed, we examined diagnoses of patients discharged to skilled nursing facilities. We found little change in the proportion of diagnoses, indicating that overall there are not severe placement problems, even for patients with medically difficult conditions.

With regard to delays, while patients are generally being placed, we did find some discharge planners experiencing delays in making

placements. In fact, more than half experienced such delays. However, the data about delays is somewhat mixed. For example, 62 percent say that these delays are about the same as before the prospective payment system. Only 28 percent say that the delays are more frequent than since the prospective payment system. Also, two-thirds of our discharge planners had to contact the same number of nursing homes as before PPS, about three; and 23 percent said they had to contact fewer. Only 9 percent said they had to contact more.

When we looked at the Medicare data, we found that the average length of stay in hospitals before Medicare patients are discharged to nursing homes, actually decreased slightly. When delays do occur, they tend to be for patients with particular medical needs, such as intravenous or expensive drug users and medically complex patients. Needless to say, these patients receive care in the hospital until they reach the nursing home.

With regard to placement practices, this year's report is similar to last year's in that hospital discharge planners report that nursing homes have altered their admission processes since the advent of the prospective payment system, requesting more detailed information about patients before deciding whether to admit them. About one-third also report that there are other reasons for delays, especially for patients and their families being more selective about which nursing home they wish to use.

Our conclusion then is this, that overall, while the study reveals some practice adjustments, there do not appear to be major service-access disruptions as a result of the prospective payment system.

Thank you.

[The prepared statement of Mr. Grob follows:]

ACCESS TO SKILLED NURSING FACILITIES UNDER PROSPECTIVE PAYMENT

Testimony of
George F. Grob
Deputy Inspector General
for Evaluation and Inspections

Hearing Before:
Special Committee on Aging
United States Senate

September 5, 2000

Office of Inspector General
Department of Health and Human Services
June Gibbs Brown, Inspector General

Testimony of
GEORGE GROB
Deputy Inspector General
for Evaluation and Inspections
Department of Health and Human Services

Good afternoon, Mr. Chairman and members of the committee. I am George Grob, Deputy Inspector General for Evaluation and Inspections within the Department of Health and Human Services. I am pleased to be here today to discuss the results of our study on Medicare beneficiary access to skilled nursing facilities (SNFs). Based on our interviews with hospital discharge planners and analysis of Health Care Financing Administration (HCFA) data, Medicare patients are not generally being denied access as a result of implementing the prospective payment system. To the extent that there are access problems, they appear to be localized.

INTRODUCTION

The Balanced Budget Act of 1997 changed Medicare skilled nursing facility to a prospective payment system in order to control Medicare program costs. Concerns have been raised by the health care industry, patient advocates, and Congress that the new payment system may adversely affect Medicare patients' ability to obtain needed care. The Balanced Budget Refinement Act of 1999 increased funding for skilled nursing facilities. Both the Administration and Congress are considering doing so again.

In the summer of 1999, we issued a report based on interviews with discharge planners. In *Early Effects of the Prospective Payment System on Access to Skilled Nursing Facilities, OEI-02-99-00400*, we reported that there were no serious problems with Medicare patients' access to SNF care, but that nursing homes were changing their admission practices. We recently repeated the inspection. It is based on interviews with a random sample of 202 discharge planners and an analysis of HCFA data related to the availability of nursing home beds, hospital lengths of stay, and the diagnoses of nursing home patients.

FINDINGS

Access to Care
We found that almost all discharge planners report that they are able to place Medicare beneficiaries in skilled nursing facilities (SNFs). In fact, about 80 percent of discharge planners state that they could place all of the Medicare patients. Another 14 percent estimate that between 1 and 5 percent of patients cannot be placed, while the remaining 5 percent put the estimate at over 5 percent. Most discharge planners indicate there are enough beds available in their particular area to accommodate Medicare patients. Many volunteer that they have flexibility because their own hospital beds are certified by the Medicare program to be used as

SNF beds when needed. Discharge planners also indicate that patients whom they are unable to place remain in the hospital or eventually go home with or without home health care.

Further, Medicare data support the views of discharge planners that there are adequate skilled nursing home beds available for Medicare patients. From 1997 to 1999, the number of Medicare certified beds has increased by 23 percent. This increase is largely due to the increase in dual certified beds which are available for either a Medicare or Medicaid patient.

We also looked at pre- and post-PPS data for patients with diagnostic related groups (DRGs) from the first three months of years 1996 to 2000 to see if the proportion of patients with certain medical conditions is decreasing which would possibly indicate that certain patient types are experiencing a reduction in access to SNFs. We did not find any large decreases. Three DRGs had decreases over 1 percent: specific cerebrovascular disorder (-1.6 percent), respiratory infections and inflammations (-1.1 percent), and hip and femur procedures except major joint (-1.0 percent). Four DRGs had decreases of less than 1 percentage point. Three DRGs showed an increase of less than 1 percent in the proportion of patients being discharged to SNFs. The largest increase was for simple pneumonia at 2 percent. (See Appendix B)

Some Delays

We found that some discharge planners experience delays in placing patients. For purposes of discharge planning, a delay occurs when a patient is medically cleared by a doctor for discharge, but no SNF bed has been secured. When specifically asked how often they experience delays in placing Medicare patients in SNFs, 43 percent rarely or never experience delays while 44 percent of discharge planners report that they sometimes experience delays. Twelve percent of discharge planners say they always or usually confront delays in placing patients. While 62 percent of discharge planners experience the same percentage of delays as prior to PPS implementation, 28 percent state that they have a higher percentage of delays since PPS implementation.

However, despite the reported delays, hospital lengths of stay are shorter. Medicare data from the first three months of 1996 through 2000 show a decrease in the average length of hospital stays for Medicare patients prior to a SNF admission. The average lengths of stay for the top 10 DRGs of patients discharged to SNFs show that the length of hospital stays decreased ranging from 1.8 days (specific cerebrovascular disorders) to 0 .2 days (septicemia). These data suggest that Medicare patients do not have extended lengths of stay while waiting for a bed in a nursing home.

On average discharge planners state that they have to contact about three nursing homes to place a Medicare patient in a SNF. Sixty-six percent of discharge planners had to contact approximately the same number of nursing homes prior to the implementation of PPS. Twenty-three percent respond that they had to contact fewer nursing homes since PPS implementation, and 9 percent respond that they contact more nursing homes.

Factors Affecting Placement Process

Medical Needs: Eighty percent of hospital discharge planners who report delays in placing Medicare patients in SNFs state that patients with particular medical conditions or service needs are more likely to experience delays before being placed in skilled nursing facilities. Discharge planners most often note that patients requiring intravenous or expensive drugs experience delays, with 44 percent reporting delays. They say that medically complex patients are also more likely to experience delays, with 34 percent reporting delays. These patients typically require extensive services by the nursing home staff to adequately care for their medical needs. Discharge planners point to similar medical conditions or service needs when asked which patients they are never able to place in nursing homes.

Prospective Payment System: Sixty-nine percent of discharge planners who mention delays in placement for medical conditions or service needs attribute these delays to PPS. The remaining discharge planners note that they experienced delays for these particular medical conditions or services prior to the implementation of PPS.

About 63 percent of discharge planners volunteer that nursing homes have altered their admission process for Medicare patients since the implementation of PPS. For example, discharge planners report that nursing homes request additional patient information and on-site visits to evaluate the patient. A few discharge planners add that nursing homes analyze the reimbursement rates of the individual patients before they accept patients and that the routine screening and admission process takes longer. Most discharge planners respond that the reimbursement levels for these patients are too low to cover the expenses of the nursing homes.

On the other hand, about a third of discharge planners also state that patients requiring rehabilitation services (physical, speech, or occupational therapy) are experiencing fewer delays because of PPS. They indicate that higher reimbursement levels for these patients makes it advantageous for nursing homes to accept these patients. They also mention that rehabilitation patients are often short-term with foreseeable discharge dates and that their service needs are easily administered.

Other Factors: In addition to medical conditions and PPS, discharge planners note other reasons that Medicare beneficiaries experience delays before being placed in a SNF. The decision making process by patients and their family members is mentioned most often as a source of delays. The patient and the family may be considering placement options or waiting for a bed to become available in their nursing home of choice. Lack of nursing home beds in the area is also mentioned by the discharge planners. In addition, discharge planners also note that secondary payor issues cause delays. They explain that Medicare patients applying for Medicaid may experience delays waiting for approval.

Access for Dialysis Patients

In our previous report (*Effects of Prospective Payment System on Access to Skilled Nursing Facilities for Patients with End-Stage Renal Disease OEI-02-99-00402, 10/99*), we found that discharge planners most often listed end stage renal disease (ESRD) as the clinical condition that had become the hardest to place since the implementation of PPS. Discharge planners noted that

the transportation to dialysis facilities for ESRD residents was not covered in the per diem rate. Although discharge planners continue to report delays for dialysis patients, we found in this report that dialysis patient delays dropped to the fifth most commonly cited delay. This is probably due to the fact that the Balanced Budget Refinement Act of 1999, which became effective April 1, 2000, extended pass-through payments to ambulance services to renal dialysis so that nursing homes no longer have to absorb these costs.

CONCLUSION

The findings in this follow-up study are consistent with those in the original report. While the study reveals some practice adjustments, there do not appear to be any major disruptions as a result of implementing the prospective payment system.

Mr. Chairman, I hope my comments this afternoon have been useful for you and the committee. I can assure you that the OIG will continue to monitor access to care and oversight of the quality of services for Medicare nursing home residents. I would be happy to answer any questions that you or the other committee members might have.

The CHAIRMAN. Thank you, Mr. Grob. Now, Mr. Pelovitz.

STATEMENT OF STEVE PELOVITZ, DIRECTOR, SURVEY AND CERTIFICATION GROUP, HEALTH CARE FINANCING ADMINISTRATION, BALTIMORE, MD; ACCOMPANIED BY LAURENCE WILSON, DIRECTOR, DIVISION OF INSTITUTIONAL POST-ACUTE CARE POLICY, HEALTH CARE FINANCING ADMINISTRATION, BALTIMORE, MD

Mr. PELOVITZ. Chairman Grassley, distinguished Committee members, thank you for inviting me today to discuss the financial difficulties being experienced by some of the Nation's nursing homes. Our priority is to ensure that residents continue to receive quality care during this period of time, and I know that is a priority for you, as well. We have been working with States to ensure that residents who are in those financially troubled facilities get the care they deserve.

State survey agencies use a protocol that we specifically developed for monitoring these facilities. We have also taken steps to ensure that States have contingency plans for safeguarding residents in case nursing homes actually close. Generally, the State agencies have not reported significant disruptions to residents or any systemic quality problems created within those chains operating under the protections of Chapter 11 of the bankruptcy code.

We continue to work with the facilities and the chains to avoid patient relocation. We are closely monitoring the impact throughout the nursing home industry of our initiative to improve the oversight and quality of care and of the payment changes included in the Balanced Budget Act and BBRA. These efforts were essential to protect vulnerable nursing home residents, establish proper payment rates, and control unsuitable growth in nursing home spending.

Medicare payments to nursing homes have been growing at an average rate of 30 percent each year prior to BBA. The BBA required a new prospective payment system, based on the actual cost of providing care, and with incentives to provide care efficiently. Adjusting to any new payment system is a challenge for providers, but overall beneficiary access and quality of care have not been adversely impacted.

We do, however, have significant concerns about the financially troubled facilities. Financial news reports indicate that most of the troubled businesses share a number of common features, and their financial difficulties appear to stem largely from specific business decisions. These chains generally had aggressively acquired new facilities and expanded rapidly prior to the nursing home initiative and changes in the payment structures. They leveraged themselves heavily, often paying top dollar for acquisitions and allowing debt-to-equity ratios to spiral downward.

Changes in Medicare payments, which cover only about 10 percent of nursing home residents, are not a primary reason for the problems these chains are facing. As the GAO has indicated, Medicare payment levels are appropriate. In fact, other chains have adjusted successfully to the new payment structure and are posting profits. Nonetheless, we remain concerned about the potential for financial difficulties to impact both access and quality of care in

homes, and we appreciate the challenge providers face in adapting to the new payment systems.

To help providers adjust and to ensure that quality is maintained, payments to nursing homes for the next fiscal year will increase by $2.6 billion. The President is proposing further increases of $1 billion over the next 5 years.

We look forward to working with you to enact these changes. We greatly appreciate the support you have provided in our efforts to improve quality of care in nursing homes. I appreciate the opportunity to be here today to discuss these issues with you, and I will be happy to answer any questions.

[The prepared statement of Mr. Pelovitz follows:]

Testimony of Steven Pelovitz
Director, Survey and Certification Group
Health Care Financing Administration
on
Nursing Home Bankruptcies
before the
Senate Special Committee on Aging
September 5, 2000

Chairman Grassley, Senator Breaux, distinguished Committee members, thank you for inviting me to discuss the financial difficulties of some nursing homes and our efforts to ensure that residents continue to receive the high quality care they deserve. This has been a top priority for us, and I know it is a priority for you as well. We appreciate your interest in this area, and look forward to continuing our work together to ensure beneficiary access to critical nursing home services.

We have monitored closely the effects on nursing homes of the Balanced Budget Act of 1997 (BBA), the Balanced Budget Refinement Act of 1999 (BBRA), and our Nursing Home Initiative to improve oversight and quality. These efforts were essential to control unsustainable growth in nursing home spending, establish proper payment rates, and protect vulnerable nursing home residents. Overall, beneficiary access and quality of care have not been adversely impacted, but significant concerns remain.

As you know, the owners and operators of a number of facilities, including five of the 10 largest nursing home chains, have faced financial difficulties in the past few years. Approximately 1,600 nursing homes across the country now operate under Chapter 11 bankruptcy protection. This means that the organizations in their entirety are continuing to operate nursing homes, as well as other lines of business, while restructuring financial components of the company.

Financial news reports indicate that most of the troubled businesses share a number of common features, and their financial difficulties appear to stem largely from specific business decisions.

These chains generally had aggressively acquired new facilities and expanded rapidly for several years prior to our Nursing Home Initiative and changes in payment structures. They leveraged themselves heavily, paying top dollar for their acquisitions and allowing their debt-to-equity ratios to spiral precipitously.

Meanwhile, other chains have adjusted successfully to the different payment structure and the increased oversight stemming from our Nursing Home Initiative. Additionally, in a December 1999 report, "Skilled Nursing Facilities: Medicare Payment Changes Require Provider Adjustments but Maintain Access," the GAO indicated that nursing homes continue to enjoy adequate profit margins, and that Medicare payment levels are appropriate for the services they provide. Working with the State agencies, we have monitored this situation very closely and have had to relocate only a very small number of residents. To date, there has generally been minimal impact on beneficiary access to care and the quality of care in financially troubled institutions.

Nonetheless, we are concerned about the potential for financial difficulties to impact access and quality. And we appreciate the challenge providers face in adapting to new payment systems. Under our latest baseline, FY 2001 payments to nursing homes will increase by $2.6 billion, nearly 20 percent above the FY 2000 level. In addition, the President is proposing to increase Medicare nursing home payments by about $1 billion over the next five years, and we look forward to working with you to enact these changes.

BACKGROUND

Protecting nursing home residents is a priority for this Administration and our Agency. Some 1.6 million elderly and disabled Americans receive care in approximately 17,000 nursing homes across the United States. The Medicaid program, in which States set reimbursement levels, pays for the care of about two-thirds of nursing home residents and is responsible for about half of nursing home revenues. The Medicare program pays for care of about 10 percent of residents, accounting for 12 percent of nursing home revenues.

Medicaid, which is administered by the States, covers close to two-thirds of nursing home residents and accounts for about half of nursing home revenues. The federal government also provides funding to the States to conduct on-site inspections of nursing homes participating in Medicare and Medicaid and to recommend sanctions against those homes that violate health and safety rules.

In July 1995, the Clinton Administration implemented the toughest nursing home regulations ever. However, both we and the GAO found that many nursing homes were not meeting the requirements, and that State enforcement efforts were uneven and often inadequate. Therefore, in July 1998, President Clinton announced a broad and aggressive initiative to improve State inspections and enforcement, and crack down on problem providers. To strengthen enforcement, we have:

- instructed States that they have the ability to look at an entire corporation's performance when serious problems are identified in any facility in that corporate chain, worked with States in developing more detailed guidelines for chains with performance problems, and required States to develop and submit State contingency plans for chains with financial problems. Furthermore, we are working to refine our instructions in the State Operations Manual, a draft of which is currently available for public comment;
- expanded the definition of facilities subject to immediate enforcement action without an opportunity to correct problems before sanctions are imposed;
- identified facilities with the worst compliance records in each State, and each State has chosen two of these as "special focus facilities" for closer scrutiny;
- provided comprehensive training and guidance to States on enforcement, use of quality indicators in surveys, medication review during surveys, and prevention of pressure sores, dehydration, weight loss, and abuse;
- instructed States to stagger surveys and conduct a set amount on weekends, early mornings and evenings, when quality and safety and staffing problems often occur, so facilities can no longer predict inspections;
- required State surveyors to revisit facilities to confirm in person that violations have been

corrected before lifting sanctions;

- instructed State surveyors to investigate consumer complaints within 10 days;
- developed new regulations to enable States to impose civil money penalties for each serious incident;
- met with the Department's Departmental Appeals Board to discuss increased workload due to the Nursing Home Initiative;
- established a set of State Survey Agency performance standards to ensure that the Agencies are executing their duties in accordance with our contract terms. These standards are scheduled for implementation on October 1, 2000; and
- issued a prioritized list of tasks to State Survey Agencies, laying out which duties should be completed with the highest level of urgency.

We also are now using quality indicators in conjunction with the Minimum Data Set that facilities maintain for each resident. These quality indicators furnish continuous data about the quality of care in each facility. They allow State surveyors to focus on possible problems during inspections, and will help nursing homes identify areas that need improvement.

In addition, we have been working to help facilities improve quality, including:

- posting best practice guidelines at *hcfa.gov/medicaid/siq/siqhmpg.htm* on how to care for residents at risk of weight loss and dehydration;
- testing a wide range of initiatives to detect and prevent dehydration and malnutrition;
- working with the American Dietetic Association, clinicians, consumers and nursing homes to share best practices for preventing these dehydration and malnutrition; and
- beginning a national campaign to educate consumers and nursing home staff about the risks of malnutrition and dehydration and nursing home residents' rights to quality care.

We also are continuing to develop and expand our consumer information efforts to increase awareness regarding nursing home issues. We now are conducting a national consumer education campaign on preventing and detecting abuse.

And we are working to educate residents, families, nursing homes, and the public at large about the risks of malnutrition and dehydration, nursing home residents' rights to quality care, and the prevention of resident abuse and neglect. These efforts include our *Nursing Home Compare* Internet site at *medicare.gov*, which allows consumers to search by zip code or by name for information on each of the 17,000 nursing homes participating in Medicare and Medicaid. The site is recording 500,000 page views each month and is by far the most popular section of our website.

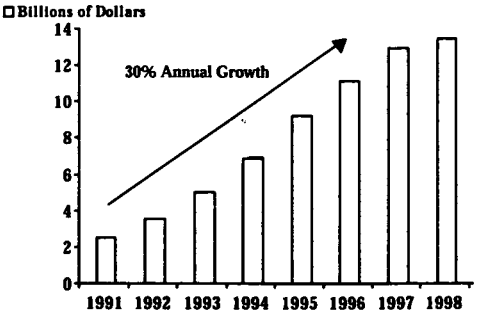
Nursing Home Payments

As mentioned above, the Medicare program pays for the care of only about 10 percent of the nursing home residents. Approximately two-thirds of residents are covered by State-administered Medicaid programs, to which the federal government adds matching dollars. The remaining residents pay out-of-pocket or are covered by long term care or other private insurance. In 1997, the BBA required a new process for States to determine Medicaid payment rates for nursing home services, one that eliminates Federal review of State rates, thus giving States greater flexibility; but which requires public comment on the adequacy of payment levels.

The BBA also acted to address unsustainable growth in Medicare nursing home spending. Since 1986, Medicare payments for nursing home services had been surging upward at an average rate of 30 percent each year, climbing from $578 million to over $13 billion. And the Medicare Payment Advisory Commission has reported that, although routine costs were paid on a set per diem rate, payments for ancillary services were growing at a pace five times that of service usage.

By reimbursing based on whatever nursing homes reported as costs, Medicare had little control over potential over-utilization of services. In fact, according to the GAO and Health and Human Services Inspector General (IG), under cost-based reimbursement beneficiaries often were subjected to unnecessary or excessive therapy.

Medicare SNF Payment Growth



The BBA therefore required Medicare to implement a new prospective payment system (PPS) for nursing homes, similar to the payment system used for hospitals since the early 1980s. Prospective payment systems are based on patient need and episodes of care, and create incentives to provide care efficiently.

The PPS is designed to "pay right," allowing Medicare to pay for care provided based on national data, weighted by case mix and geographic area for individual facilities. The PPS rates were developed using actual cost data representing the cost level necessary for the efficient delivery of health services. Using this actual cost data, payment rates are established under the PPS which provide appropriate payments for nursing home services. These payment rates are updated to

reflect changes in the acuity level of the Medicare beneficiaries served by the facility, geographic wage variation, inflation, and Metropolitan Statistical Area.

The Medicare nursing home PPS established more appropriate payment levels for Medicare nursing home services. This and other BBA fiscal discipline, along with our success in fighting fraud, waste, and abuse have helped to greatly improved the status of the Medicare Trust Fund. It is now projected to remain solvent until 2025, 26 years beyond where it was just 8 years ago. The prospective payment systems mandated by the BBA are particularly important because they create incentives to provide care efficiently. However, these new payment systems mark a substantial departure from cost- and charge-based reimbursement, and the transition can be challenging for providers.

The new PPS for nursing homes went into effect in 1998. This new system contributed to changes in the nursing home market. Recent GAO and HHS Inspector General (IG) studies have found that some nursing homes have been more cautious about admitting high-cost cases. One study found that 58 percent of hospital discharge planners reported that Medicare patients requiring extensive services such as intravenous medications have become more difficult to place in nursing homes. The IG is today reporting that 80 percent of hospital discharge planners report no problems in placing beneficiaries in skilled nursing facilities.

Additionally, several large private nursing home chains have experienced financial problems. Approximately 1,600 nursing homes now operate under Chapter 11 bankruptcy protection. Financial news reports conclude that most of the troubled facilities are in chains that generally had aggressively acquired new facilities and expanded rapidly for several years prior to our Nursing Home Initiative and changes in payment structures. They leveraged themselves heavily, paying top dollar for their acquisitions and allowing their debt-to-equity ratios to spiral precipitously.

More for-profit organizations that operate nursing homes currently are operating under Chapter

11 bankruptcy protection than non-profits. This is consistent with the fact that approximately 65 percent of nursing homes are owned by for-profit companies nationally. Publicly held, for-profit companies that are operating in bankruptcy own about nine percent of nursing homes nationally, constituting the bulk of nursing homes operating in bankruptcy. In part, for-profit companies, particularly publicly held companies, had broader access to greater amounts of capital than non-profit companies. This provided the basis for the aggressive acquisition strategies and accumulation of high levels of debt that, in turn, have been cited as reasons for the financial difficulties some of these companies are experiencing.

While these difficulties are due primarily to business practices unrelated to Medicare, changes in Medicare payment systems and improved oversight may have exacerbated the impact of some businesses' aggressive growth strategies.

The BBRA made a number of changes to the PPS to facilitate nursing homes' transition to the new payment methodology. These included a temporary increase of 20 percent for 15 categories of residents, as well as a four percent increase for all beneficiaries in fiscal years 2000 and 2001. For the most part, our implementation of these increases has gone smoothly. Although computer system changes prevented us from implementing the temporary 20 percent increase for certain beneficiaries immediately, nursing homes now are receiving the increased payments, and we are paying these retroactively to April 1, 2000, the intended start date. Additionally, the BBRA allowed certain high cost items, such as certain prosthetics and some chemotherapy-related codes, to be paid outside of the PPS, increasing payment for some medically complex care. Today, the Medicare baseline for nursing homes shows about eight percent growth.

Protecting Beneficiaries

Although Medicaid programs pay for the majority of nursing home services, we have a responsibility to ensure adequate access to care for both Medicaid and Medicare beneficiaries. In light of public reports of financial troubles at some nursing home chains, we have been working with the States since early 1999 to ensure that residents continue to get the kind of care that they

deserve and that federal and State regulations require. We have taken steps to ensure that States develop and refine contingency plans for safeguarding residents.

We also instructed States to monitor conditions in financially troubled nursing homes. Within four weeks after a nursing home chain has filed for bankruptcy, the State Survey Agency conducts onsite monitoring to the affected facilities in their State. The State Survey Agencies use a protocol specifically designed for monitoring these facilities, and we maintain contact with State Agencies regarding these situations. Following the initial visit, the State Survey Agencies exercise their discretion to determine whether or not a facility requires additional monitoring.

Generally, the State Survey Agencies have not reported any significant disruptions in these financially troubled facilities; and we work with the facilities to avoid patient relocation whenever possible. The State Survey Agencies monitor the residents in these troubled facilities on an ongoing basis, and provide the HCFA Regional Offices with updates. While there have been isolated cases where residents have been impacted, we have had to relocate only a small number of these residents. For example, in one case in Texas, three homes were closed and the residents were forced to move. In each case, representatives of the State Survey Agency and our Regional Office were on-hand to assist with the resident transfers, and all were relocated successfully to other facilities. Such individual cases illustrate how we have made every effort to minimize disruptions to the nursing home residents when relocation was the only reasonable alternative.

In addition to meeting with States, we have had regular monthly meetings with the Department of Justice and the IG to discuss nursing home issues and the bankruptcy proceedings. We also have met repeatedly with the management of major chains, both before and after they filed for Chapter 11 bankruptcy protection. Furthermore, the IG has developed corporate integrity agreements with several large nursing home chains in order to focus on ensuring quality care for residents even while the chains face financial difficulties.

President's Proposals

Under our latest baseline, payments to nursing homes will increase by $2.6 billion for next year, exceeding the FY 2000 level by almost 20 percent. In addition, the President's FY 2001 budget proposes changes that would increase Medicare nursing home payments by about $1 billion over the next five years.

The President's plan would:

- delay for an additional year (until FY 2002) the application of the therapy caps providing additional time for development of policies;
- replace the BBA's nursing home update of market basket minus 1 percentage point with a full market basket update for FY 2001; and
- eliminate the proposed reduction in Medicare reimbursement for bad debt.

The President proposed delaying the application of the therapy caps because we are concerned about the yearly payments for Part B physical/speech therapy and occupational therapy, which the BBA limited to $1,500 each per beneficiary. Under this provision, some therapy patients exceeded the payment limits and either had to pay for the care out-of-pocket or discontinue the medically necessary service. The BBRA put a two-year moratorium on the limits while a study is conducted to determine appropriate payment methodologies that reflect the differing therapy needs of patients. However, the moratorium may not be long enough to complete this complicated work, and so the President proposed another delay in the application of the therapy caps.

We are continuing to work to refine the payment classification system in a budget neutral way to ensure adequate payment for medically complex residents, and particularly to account more specifically for the cost of drugs and other "non-therapy ancillary" services. Using the best data available at the time we initiated the research, we developed two payment classification models we believed would ensure adequate payment for complex residents. The data was limited to the experience of facilities in six States in the years immediately before the PPS was implemented.

We issued a proposed rule in April 2000 which included refinements based on these models and solicited public comments. In addition, we contracted with outside experts to validate the models using more recent data. When we tested the models with nationwide data following the implementation of the PPS, we found that the models were no longer statistically significant in identifying high-cost beneficiaries with complex care needs and the ancillary services they use.

Proceeding with implementation of the proposed refinements based on these models could have changed payment levels without any assurance that we were distributing funds more equitably, creating incentives for efficient care, or minimizing the risk of negative financial consequences. We therefore are deferring the implementation of the refinements.

Shortly, we will begin consulting with outside researchers and experts to begin further analysis using the 1999 national data aimed at determining the feasibility of developing case-mix refinements that reflect current practice. Our goal is to propose such refinements as soon as possible. However, until a feasibility study is completed, we will be unable to accurately forecast the potential and timing of such refinements.

In the meantime, the temporary 20 percent increase in payments included in the BBRA will remain in place until refinements of the system can be implemented, which will be in fiscal 2002 at the earliest. And as I noted, in addition to the temporary 20 percent increase, the BBRA also provided a 4 percent increase in payments for all nursing home beneficiaries.

Ongoing research to quantify the staffing ratios necessary for quality care is another essential step in our efforts to improve the quality of life and care for nursing home residents. The research was mandated by Congress in 1990, with a report due in 1992. This proved to be much more challenging than anticipated. Our report on the initial phase of this research establishes for the first time in a statistically valid way that there is, in fact, a strong association between staffing levels and quality of care. Many had long suspected as much, but this had never before been documented. The findings from the three States examined demonstrate that there are

significantly more problems in facilities with less than 12 minutes of registered nursing care, less than 45 minutes of total licensed staff care, and less than 2 hours of nursing aide care per resident per day. Numerous facilities in the study do not meet these levels of care, and the results suggest that many facilities may need to increase staffing levels. While these findings are troubling, and represent a major step forward in understanding the relationship between staffing levels and quality of care, they are preliminary. We now are working to address remaining issues.

The second phase of this research initiative involves:

- evaluating staff levels and quality of care in additional States with more current data;
- validating the findings through case studies and examining other issues that may affect quality, such as turnover rates, staff training, and management of staff resources;
- refining case mix adjustment methods to ensure that any minimum staffing requirements properly account for the specific care needs of residents in a given facility;
- determining the costs and feasibility of implementing minimum staffing requirements and the impact on providers and payers, including Medicare and Medicaid.

In the meantime, we want to work with Congress, States, industry, labor, and consumer advocates to evaluate ways to ensure that all nursing home residents receive the quality care they deserve. These strategies include improving staffing levels, improving training, increasing dissemination of performance data, strengthening enforcement, and enhancing intensity of survey and certification practices.

CONCLUSION

It is essential that we ensure Medicare and Medicaid beneficiaries continue to have access to the high quality care they deserve. Chairman Grassley, you and this Committee have made great contributions to these efforts, and we greatly appreciate the work you have done. Over the past few years, we have worked hard and made progress in ensuring that nursing home residents receive quality care and that we pay appropriately for this care. We continue to work on a number of fronts to protect nursing home residents and ensure beneficiary access to nursing

home services as some businesses reorganize under Chapter 11 protection. We greatly appreciate your interest in this matter. And we look forward to continuing our work with you to make sure beneficiaries receive the care and quality they deserve. I thank you for holding this hearing, and I am happy to answer your questions.

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The CHAIRMAN. Before I ask questions, do either one of my colleagues have time—well, even beyond what you thought I was going to say, any time constraints, because I was going to suggest, if we could have 10 minute turns. Is that going to be OK?

Senator Reed. That is fine.

The CHAIRMAN. Now, some of my questions might be repetitious of testimony we just had, but I want to nail down with some definiteness the points that have been made. I would start with our key concern, whether or not Medicare beneficiaries are getting services they need, even if some nursing facilities are in bankruptcy. So, Mr. Grob, you and Ms. Dummit spoke of studies by the General Accounting Office and the Inspector General that continue to show Medicare beneficiaries do have access to needed nursing services after the prospective payment system went into effect; but you also said that nursing homes are being more selective in the types of patients they accept for admission.

Have you found any evidence that this selectivity results in harm to patients, and what about, specifically, access to therapy services? Let's start with you.

Ms. DUMMIT. Senator, I would reiterate the information that Mr. Grob presented, which is consistent with what we had found with an earlier survey, which is hospital discharge planners were telling us that they were indeed requiring more information, to provide more information to nursing homes, before the nursing home would accept the patient for placement. But, often these were the same kinds of patients who had always taken more time and effort for the hospitals to be able to place in a nursing home, people who needed specific types of services or had extensive care needs. These were always difficult patients to place.

But let me remind you that even if there are difficulties in finding a nursing home for a patient, that patient is remaining in the hospital; that patient is receiving the necessary services. Furthermore, consistent with the information Mr. Grob presented, this increased scrutiny of patients, if you will, before their being admitted to nursing homes, must not be very widespread, because we have not seen any increases in hospital lengths of stay; that is, patients are not backing up in hospitals, waiting to get into nursing homes.

The CHAIRMAN. Mr. Grob.

Mr. GROB. I would say we do not have any direct evidence that patients are not getting the care they need, because they are being selected out through the process. I do think that the nursing homes are being very selective and are being very careful in their admissions. If I were to step back from it, there is a good chance that we might say that this care that everyone is taking is probably very good for the patients. I think they are trying to find the right place for the patient.

As I said in our testimony, this year we are seeing that the families are also expressing some interest in wanting to get placed in the nursing home of their choice. Now, as far as the therapy is concerned, last year at this time we issued some studies which showed that a lot of the physical and occupational therapy that was being rendered at that time was not medically necessary. In fact, 13 percent of all the therapy in those categories was found to be not medically necessary, worth about $1 billion.

In addition to that, there was another $300 million-plus that was not properly documented, and then another $300 million or so for which the therapy companies had obtained considerable markups. Nursing homes got considerable markups on the therapy they were buying for their patients.

So, that led me to believe that there was some margin in there, of service that was being paid for that did not need to be paid for, and some room, if you will, therefore, for some reductions in payments to be made in that base. Since that time, of course, therapy has been included in prospective payment, for about three-quarters of it. One-quarter of it is still paid for outside the nursing home payment and is undergoing scrutiny because of policies related to a cap that was later postponed.

Our interviewees this year told us, about one-third of them, that they actually seek out the therapy patients because they believe that the reimbursement levels for those patients are adequate and it is very much worth their while in getting these patients. So, that is what we have on that subject as of now.

The CHAIRMAN. I will go to Mr. Pelovitz next. First of all, thank you for describing what is being done to make sure that nursing home residents in financially troubled situations are protected. Do you feel confident that there has been no deterioration of quality of care due to bankruptcies?

Mr. PELOVITZ. Yes, Senator, we do. Back at the end of last summer, we put in place a set of protocols with the State survey agencies to monitor the quality of care when the first of the chains went into Chapter 11, because one of our primary concerns was to make sure that the care did not deteriorate. There have been, as was the case before the Chapter 11 filing, individual homes within chains that have had quality problems that we have addressed with those homes, but we have not seen any systemic problems created by the homes actually operating within Chapter 11.

The CHAIRMAN. I might add that I have an amendment included in that bankruptcy reform legislation that would establish the appointment of a patient's ombudsman in the cases of facilities that have gone into bankruptcy, so that the care of the patients would be always on the mind of the bankruptcy court.

Mr. Ransom, I would like to clarify what prompted bankruptcies. You described, if I am correct, the heavy debt incurred as bankrupt chains expanded by mergers and acquisitions during the 1980's and the 1990's. Three questions: For what purpose was this debt incurred?

Mr. RANSOM. The simple answer, Senator, is that sellers wanted cash and the buyers wanted to expand.

The CHAIRMAN. OK. Explain why the debt was financially destabilizing.

Mr. RANSOM. Well, let's compare a public nursing home chain with a mom-and-pop for a minute. When two public companies combine, not only is all the debt taken on that was necessary to build out the infrastructure, but there is a certain amount of what I described in my testimony as transactional debt, in other words, debt to pay for the current enterprise value of that entity being acquired.

A mom-and-pop nursing home, on the other hand, has debt only to build out the infrastructure to provide care. So, when two public companies come together, they can do it two ways. One is pooling. The other is purchase accounting. Pooling would involve no increase in pro forma debt. Purchase accounting would involve cash going into the sellers—the seller's ownership, and then assets being transferred into the buyer's at a net increase in debt to the two entities. The nursing home consolidations of the mid–1990's were largely—not all—but largely debt financed with some pocket of equity.

The CHAIRMAN. And the extent to which this debt was a factor in the nursing home companies' declaring bankruptcy?

Mr. RANSOM. I think there are three primary factors behind the nursing home bankruptcies. One of those is transactional debt. The other is, I think, the change in Medicare reimbursement was more abrupt than anybody thought. We traveled with a lot of the management teams to see investors in the late 1997, early 1998 era, and no one at that time foresaw an actual decline in Medicare. They thought they might see something on the order of a five-to-percent reduction in Medicare rate per day. So, the change was much higher than expected.

And, third, Senator, this industry, once you have taken on a certain level of debt, this industry is largely a fixed-cost industry. So, when abrupt changes in revenue occur, it is difficult—actually it is impossible for facilities to make requisite changes in expenses.

The CHAIRMAN. Dr. Roadman, do you think that there was any way that these companies could have avoided acquiring debt? To put it another way, did they choose to acquire that debt as one of the options for financing their business or was it about the only way they could finance skilled nursing services?

Dr. ROADMAN. Well, Senator, I think there is not a yes-no answer to that, obviously. I believe that, in fact, as the PPS was developed, there was a reasonable understanding of what that environment would look like, and that the strategies and the structuring of companies was based on what was described by the Government that would occur. What was not included in the PPS, but was said to be an add-on that would be there when it was published were the non-therapy ancillaries.

When it was actually published, those non-therapy ancillaries were not in the reimbursement program, and that, in fact, accounted for about $47 on the average per day for a Medicare patient. So, the answer is, I believe they incurred debt seeing an environment as described by the Government, and what was finally published did not manifest itself that way. And so a good business decision in an environment that did not reflect itself that way comes out to be not so.

I have one chart, which is a stack-of-pennies chart, which I would really like to show you. What we have done is we have taken over 300 facilities with a resident mix of about 10-percent Medicare, about 65-percent Medicaid and about 25-percent private. What we have seen is that revenue dropped, cost increased and margins disappeared. We went from about a blended per diem rate of 156 prior to PPS to a post-PPS of 150. The primary cause of this reduction was Medicare, SNF, PPS.

The slide compares the expenditures of pre-and post-BBA. This gets to the fixed-cost issue that Mr. Ransom discussed. With labor costs increasing and revenues decreasing post-BBA, about 85 percent of every dollar is spent on facility operations. As you know, pre-BBA was about 80 cents. Add to these costs debt service, receivable financing and administrative support, which, again, Mr. Ransom described, pre-BBA, 99 cents of every dollar was spent on the business of providing care with a one-cent margin. Post-BBA, $1.04 is spent out of one dollar on providing care.

So, I think that you see that, in these facilities that we have looked at, is that the margin has decreased and what we expected in the post-PPS environment did not manifest itself, and so with that carrying of debt, you get to a nonviable organization.

The CHAIRMAN. Before I go to the Senator from Louisiana, I should ask either Ms. Dummit or Mr. Ransom to respond to that, if you have a response based upon what Dr. Roadman said, and my question was whether or not this was the only option to finance skilled nursing services as a reason for the debt.

Ms. DUMMIT. Actually, one component of Dr. Roadman's statement that I would like to comment on has to do with the non-therapy ancillary costs and whether those were included in the skilled nursing facility payments; and, indeed, we have done an analysis of the non-therapy ancillary costs, and I would be glad to submit our report to the members.

In our analysis, we found that, indeed, those non-therapy ancillary cost are included in Medicare's payment rates. The problem, however, is that the case-mix system used to distribute payments across different types of patients does not include those. What that means is that to the extent that non-therapy ancillary costs, primarily prescription drugs and other things, vary across different types of patients, Medicare's payments are not going to be sensitive enough to those costs, so that, in essence, Medicare rates are underpaying for patients that have high non-therapy ancillary costs, but conversely it is overpaying for those patients who have low costs.

So, the money is in the system to the extent it was in the 1995 base year. It is just there is a problem with distributing those payments. HCFA knows about this and is working to correct that problem.

The CHAIRMAN. Mr. Ransom.

Mr. RANSOM. Debt, obviously, is a component of any reasonable capital structure. If you look at the hospital industry, average debt-to-capital is anywhere from about 40-to-about-60 percent in the for-profit sector, maybe a little higher in a not-for-profit sector.

There are two things in the nursing home industry that are, not unusual, but I guess a component of a Government—sort of—driven process. No. 1, certificate-of-need laws in most States largely inhibit the construction of new nursing home infrastructure. You have to go through a lengthy, expensive process to petition the State to build new nursing homes, and sometimes you are successful, and sometimes you are not.

If you cannot build new nursing home beds through that process, the only choice is to acquire those beds. And the capital structure and the price that is paid is largely a function of the marketplace

at that time. In the mid-1990's, there was a sentiment in the financial community, wrongly, as it turned out, that generous financing from the Government would continue, even under a cost-based system. And, you know, those companies that continued with 50-to-70 percent debt-to-capital did not look that unreasonable at the time.

I will draw one distinction, though, as I conclude on that point. The hospital industry makes a double-digit margin on inpatient DRG reimbursement, and they have largely done that, in my opinion, by reducing lengths-of-stay. Lengths-of-stay have dropped over 50 percent in your hospitals. The PPS system for nursing homes is a per diem system, and what we have seen is we have seen the same sort of rapid drop in lengths-of-stay in nursing homes. However, since they are paid on a per diem, the churn factor in caring for those patients has gone up, as have the costs.

So, ironically, if the system were on a revenue-per-admission versus a revenue-per-day, I believe some of the efficiencies that the hospital industry has been able to derive and some of the margin probably would be there for the industry, but because it is a per-day system and the fixed-cost nature of the business, I think the industry is in somewhat of a squeeze.

Dr. ROADMAN. Mr. Chairman, may I just—MedPAC, Congress and HCFA have all said that non-therapy ancillaries are not accounted for in RUGS Three. So, there is a disagreement, Ms. Dummit, on that. And, in fact, that was one of the efforts and the reasons for BBRA to do the add-on 20 percent, and it really is an issue of central control on cost.

The CHAIRMAN. Mr. Wilson, could you clear that up for us, please?

Mr. WILSON. I would be happy to, Senator. There are two components of the prospective payment system. You can think about it in terms of the pool of dollars and the system used for distributing those dollars. The pool of dollars contains all the dollars associated with non-therapy ancillaries, every single cent. The system that we used to distribute those dollars, RUGS Three, as Dr. Roadman correctly points out, and Ms. Dummit correctly points out, is the system used to distribute those dollars. That is an area where we have tried to improve, refine the system to better distribute the dollars for non-therapy ancillaries. So, the dollars are there. Yes, we do need to make some improvements on how we distribute those dollars.

The CHAIRMAN. Senator Breaux.

Senator BREAUX. Well, I thank all the panel members. All of this just drives me crazy. I mean, this is the only thing we do as a Government where we have to micromanage down to how many dollars an industry that provides health care to 40 million seniors is going to be reimbursed. Is it going to be $2 billion? No, it is going to be $2.1 billion or $2.2 billion. And we sit in these rooms and behind these committee hearings and decide whether we are going to give a .75-percent increase or a .78-percent increase to nursing homes, home health care, doctors and hospitals, and we wonder why we have got a problem with this system, because we are micromanaging it down to the ninth degree, and we are incapable of continuing to do that in this fashion.

This makes no sense. I mean, I am glad you all have had to present this testimony to us. There is no question why we are in a problem like this, trying to come up with formulas and market baskets and prospective payments, and we cut the BBA one year and we put it back the next year, and we are going to cut it the next year. We are going to continue doing this until we change the system. We don't buy airplanes or guns or tanks or anything else the Government buys by determining what the price is going to be before we buy it, but we do it with health care.

Is it any wonder we have got 11 percent of the nursing homes in the country in bankruptcy, and some States much higher than that? Because those of us in Washington are trying to figure out whether you are going to get paid X-amount for therapy, X-amount for ancillary services, and it is just not working. I mean, this is great evidence of the fact that it is not working. We cannot continue to do this. I mean, this service is too important to the Nation's seniors and to health care in general for this country, to continue to manage it on a 1965 model. And that is what we are doing and that is why we have got the problem.

The GAO, I guess, Mr. Roadman, tells us that you had a 25-percent average increase in Medicare payments annually between 1990 and 1998. Most people out there, maybe not in this audience, because you probably all have an interest in this, but most people say, "My God, how can an industry not make it with a 25-percent increase every year in payments from the Federal Government?" What is your answer? Mr. Roadman.

Dr. ROADMAN. I am sorry, Senator. As you pointed out earlier, this is a blended issue that we are dealing with, and as I described the squeeze phenomenon, if we look at Medicare alone, we are once again micromanaging a complex, interactive system, because we have funding flows taking care of the elderly of our Nation from Medicaid, Medicare and private-pay.

Now, Medicare actually is about 9 percent of the patient days and 17 percent of the revenue stream. But it is followed by a grossly underfunded Medicaid program. Now, I am not saying that the Federal system should be subsidizing the State responsibility for delivery of care, but I am saying that if we look at only one component of it, it leads us off to an answer that, in fact, we won't be able to live with.

Senator BREAUX. Maybe that is part of the problem, and the only thing we can deal with in this Committee and in this Congress is the Medicare component of it. We cannot dictate to the States how much they are going to put up for their citizens who are in nursing homes. So, the basic question is we have increased annually since 1990 Medicare funding for nursing homes 25 percent a year.

Dr. ROADMAN. Yes, we have.

Senator BREAUX. And the question is why can't you make it?

Dr. ROADMAN. But we need to put a denominator under there, under utilization, and in 1990, there were 750,000 beneficiaries using Medicare; and today, or in 1999, there are two million. So, as you put a denominator under that and look at the utilization rate, then you have to back out what that increase in—increased cost——

Senator BREAUX. How much would the increase be financially as a net, counting the increase in the number of patients served?

Dr. ROADMAN. I will have to get that answer for you.

Senator BREAUX. Ms. Dummit, do you have that? I mean, what is an approximate increase if you could factor in the number—dealing with more patients than you did before?

Ms. DUMMIT. Our evidence indicates that there have been, since 1990, 12-percent annual increases in payments per day, so that takes out all of the utilization effect, so payments have increased 12 percent every year.

Senator BREAUX. I think most people would like to have 12 percent more salary every year, and businesses making 12 percent profit more per year over a 10-year period. It would be pretty good, Mr. Ransom, wouldn't it be?

Mr. RANSOM. Yes.

Senator BREAUX. So, you know, I have done this so many times, it drives me nuts, but is the market basket wrong? I mean, the market basket shows a 3-percent increase. The average price we have been increasing your reimbursement is 12 percent. What is wrong with the market basket? Is it not an accurate denominator of what the actual costs are?

Dr. ROADMAN. Senator, the market basket uses 1992 labor statistics as the index. That is the most recent from the Bureau of Labor Statistics. It does not recognize intensity of care. And so, as we look at that 750,000 versus the 2 million users, recognizing the intensity is also increasing, and that causes increased resource utilization, but the market basket, in fact, does not recognize labor adequately. It does not recognize technology, and that has changed since 1990. It does not reflect increase in pharmacy cost. That has increased since 1990. So, the advances in medical science are also reflected in long-term care, the same way they are in acute care.

Senator BREAUX. Mr. Wilson, Mr. Pelovitz, or anybody with the Government, does it take an act of Congress to change the market basket?

Mr. WILSON. I would like to address that issue in two ways, first analytically. The market basket does use certain data from 1992, because that is the frequency with which data is available from certain Government statistical reporting agencies, that is true. But it also uses the latest available numbers for other things, like the factors that we use to update prices of certain services that are components of the market basket and of SNF per diem cost. For example, pharmacy—the market basket looks at an annual sample every year to bring in the latest additions to drugs, the newest drugs, into the market basket. So, it does do things on an ongoing basis to update and provide the most accurate, reliable forecast of prices.

Senator BREAUX. Well, Mr. Roadman strongly disagrees with that. He says you are still using some things from 1990 and 1992. I mean, do we annually update the market basket or is it done every couple of years or how often is it updated to be more accurately reflective of the real cost?

Mr. WILSON. Well, as Dr. Roadman stated——

Senator BREAUX. Is this something that helps over here? I don't know if this chart just appearing from the left there might be something that is important.

Mr. WILSON. I am not sure it is germane.

Senator BREAUX. That is not your chart?

Mr. WILSON. It is not my chart, sir.

Dr. ROADMAN. Well, Laurence, go ahead and talk about it. It will be fine.

Senator BREAUX. Must be Mr. Roadman's chart.

Dr. ROADMAN. It is.

Mr. WILSON. As Dr. Roadman said, yes, we do—and I stated, yes, we do use some information from 1992. That is just one component of the market basket. As I stated, we use additional information, like the price inflators for the different services, which is much more recent, ongoing, updated information. In fact, some of it is updated quarterly, and when we update the market basket for our annual updates, we use the latest available updates.

Senator BREAUX. Mr. Roadman, do you have a comment on that?

Dr. ROADMAN. I do, Senator. The question you asked, does it take an act of Congress, and the answer is no, it does not. The administration has the capability of changing the market basket, has the statutory authority to do that. The fact of the matter is it has not been changed, and I once again want to emphasize this chart. As we go from 1995 to 1998, there has been about a 27-percent increase in cost, and that recognition is about 8.2 percent recognition inflation in the market basket by the Health Care Financing Administration.

The problem with that, also, however, is that that is the inflator that is used on an inadequate baseline. And when that baseline is contracted and inadequately—I want to use the term deflated, because, in fact, that is a deflation—as you do that, as our providers work, the harder they work, the further behind they get.

Senator BREAUX. Well, it just points out how difficult, Mr. Chairman, this problem is. I mean, we are actually going to sit down sometime before the end of this year and decide exactly how much a nursing home is going to get more than they got last year if there is going to be an increase. I mean, the President's proposal is $2 billion for this year, $2.0 billion. We are going to sit in a room somewhere and figure out whether that is the right number, and I daresay there are not going to be a lot of us that are going to know whether that is the right number or not, yet we are spending billions of dollars for an industry that deals with 40 million Americans. And I am not very optimistic of us getting it right, that is the unfortunate thing. But I think this panel has been very helpful, and I thank them for that.

The CHAIRMAN. Well, we will get it right when your changes that you have suggested go through.

Senator Reed.

Senator REED. Thank you, Mr. Chairman. Let me thank the panel for their very insightful testimony. I am struck by the different ways that the nursing home system has reacted to the PPS. It seems from the general testimony that independent nursing homes seemed to have fared better financially than some of the larger chains. For example, in my State, we have 102 nursing

homes. There are only six in bankruptcy—that is 5.88 percent—and we do not have a very large profile of chain nursing homes in our State.

That suggests several possible answers. One is that the independent homes are able to manage better under PPS or somehow they do not have the debt structure that brings down the chains or they are suffering the same, but there are less incentives to declare bankruptcy. Ms. Dummit or Mr. Ransom, would you please comment on that point? Why is there this difference between the independent nursing homes and the chains?

Mr. RANSOM. Corporations, when they merge and increase the combined debt of both entities, have to amortize both corporate overhead and transactional debt. A mom-and-pop nursing home with a more modest profile of services, less corporate overhead and no transactional debt often has a lower cost structure. I don't recall the exact numbers, but mom-and-pop nursing homes also have a much lower Medicare revenue percentage than the chains do. I don't know the exact numbers, but it is a fairly high differential.

Senator REED. So, in some respects, perhaps the number of bankruptcies is not really indicative of the problem, that it represents the way large corporate chains react to the same problems that smaller independents are also experiencing to.

Mr. RANSOM. Well, I think there are two types of investors. There is guy who owns the mom-and-pop, is probably content with an annuity revenue stream on his investment. A public investor is probably looking for an investment that is going to grow 15-plus percent a year, and the public chains reacted to the incentives of both the equity marketplace and the Government. The Government, frankly, had an easy vehicle to achieve that kind of growth, and on top of that, through acquisition and consolidation, you could often increase that already very generous growth rate.

So, I think the public investor has a different expectation than the private investor, and that did lead to some of the transactions in the mid–1990's that I mentioned. Also, the second point, the public companies again were more entrepreneurial. The reason they attracted capital to begin with largely was to build a vehicle that could deliver these Medicare services, and debt was incurred, equity was raised, to buildup this infrastructure; whereas a lot of the mom-and-pops, the facilities looked to more Medicaid, more private-pay, more of an annuity base, lower turnover, lower degree of service.

I am sure Dr. Roadman can speak to this much more substantively and eloquently than I can, but that is the difference, different in two investor mindsets and differences in the business model.

Senator REED. Without simplifying a very complex situation, you are looking at public investors in large-scale companies, who had expectations of significant profits in a very short time period versus independent operators, who did not have the same expectation of profit and certainly had a longer view in terms of realizing the profits coming out.

Mr. RANSOM. Right. And, also, I will mention the tax code. As a small business owner, there are a lot of advantages to owning, de-

preciation, write-offs, et cetera. The public investor, they are paid on an after-tax basis, so the tax code is there, as well.

Senator REED. Well, it suggests, that, simply the companies that are declaring bankruptcy is an indication of problems, but it might not be the main problem. The problem is elsewhere, in terms of what they expected to get out, they are not getting it, and they are making a very conscious business decision that bankruptcy is the way to cut their losses.

Let me ask another question. I do not want cutoff Mr. Roadman, but let me ask you another set of questions. That would be, as you look forward, typically in a Chapter 11 bankruptcy, the company would reorganize, settle with their creditors and go forward or sell off assets, et cetera. Is your view that these companies will generally come out of bankruptcy or will sell their assets, so that, in effect, the bottom line is that these nursing home beds will still be there?

Mr. RANSOM. Well, to oversimplify it, if I am a bank and I have made a loan for $10 million to a nursing home company who then declares Chapter 11—not Chapter 7, but Chapter 11 bankruptcy—I am fighting with other folks in the capital structure for what my new basis will be post-reorganization. And, if you look at the market for these bank loans, the loans are trading, in most cases, below 50 cents on the dollar.

So, what the market is saying is the market thinks that these loans, post-bankruptcy, are going to be worth less than half of what they were. So, if the senior lenders are getting 50 cents on the dollar, let's say, 40 or 50 cents on the dollar, what that means is that everybody below them, and that pretty much includes everybody, gets zero to a few pennies. And the thing I am concerned about, I mean, again, just to editorialize, I don't have a stake, but the thing I am concerned about, I don't really think this is ever going to be a growth industry for public investors, probably should not be, frankly. However, I think what needs to happen is at least some stability for a period of time, such that capital can be attracted back to this industry, because I think what needs to happen is—what is going to happen with the larger chains, in my view, is some of these assets are going to be spun back out to smaller operators who have probably more modest ambitions. But they are going to need banks to step up and lend against these assets, and right now, there is so much uncertainty that the assets are essentially frozen.

So, the only reason I am here today is to make a very, very small push, I hope, toward emphasizing that unless the Government wants to fund this like we fund school construction or we fund other things, public housing, if we want private capital in this industry, all that private capital needs on the debt side is just some ability to project out three-to-five years and predict cash-flows. And right now, they cannot do that.

Senator REED. Mr. Roadman, if you have a comment——

Dr. ROADMAN. Well, I did, and as you were discussing the Chapter 11 reorganization, there is a structural difference in the bankruptcy laws between large corporations that can go through restructuring under Chapter 11—now, I have to tell you I feel pretty uncomfortable giving you the obstetrical view of bankruptcy law.

But my understanding is that small facilities, in fact, cannot go through Chapter 11. In other words, when they finally get to the end of the road, they have got to liquidate and close.

So, as you look at smaller facilities, the most difficult thing that we have tried to do is try to define who is in financial trouble. With the large multis, that is fairly easy, because they go through public disclosure and we can look at Chapter 11 reorganization. The smaller facilities, if they said they were in trouble, all of their lenders would try to call their loans, all of their suppliers would try to get payment. And, so, they go through a Chapter 7 issue. So, it is a real structural issue.

Now, when you say you have about 5.8 percent bankruptcy in Rhode Island, the issue is you also have above-average Medicaid rates in your State, and I just do not think that we can solely concentrate on Medicare and say that is the only issue. It is the squeeze of understanding, that you have two cash-flows, and if you have both of them as loss leaders, you are not going to make it.

Senator REED. Well, I agree with you, but then we charge HCFA to come up with what is adequate, fair reimbursement mechanisms, which, for what they are paying for, they might be able to say this is exactly what we are paying for, we have validated it. But if there are not sufficient Medicaid payments, then the bottom line for that home is going to suffer tremendously.

Dr. ROADMAN. Absolutely. But neither of those exist in many States, an adequate Medicare payment system, nor an adequate Medicaid system.

Senator REED. One final point is that, again, the discussion of bankruptcy, I think, focuses everyone's attention, obviously. But my sense is that all of our nursing homes, even the 100 or 96 in Rhode Island that are not in bankruptcy, are feeling the pressure, and one major area is in attracting certified nursing assistants, because I don't know how we market and pay for those services but I had an individual who runs a religious nursing home come to my office to speak to me because he is really desperate to find CNAs.

I had just that morning driven near my office, by a Burger King that was advertising starting workers at seven dollars an hour, which is not much less than what he can pay certified nursing assistants. So, we really have some critical issues, regardless of whether the company is in bankruptcy or out of bankruptcy, of compensating fairly for services that are critical.

Again, I think this has been a very useful panel, focusing in on the distress in the industry. I would say it probably goes beyond those that are in bankruptcy and it goes across the board, and we have to look, not only at Medicare, but, as you point out, Doctor, Medicaid and also private payers.

Dr. ROADMAN. I cannot emphasize that enough, I mean, as you have made that description. It is not just what is in bankruptcy. We are talking about the economic viability of this profession, and I think it is at risk.

Senator REED. Anyone else? OK. Thank you.

The CHAIRMAN. Mr. Ransom, you discussed two companies that did not go into bankruptcy, Manor Care and Beverly. Could you give us some reason why they did not go into bankruptcy and

whether or not they did anything different than other large nursing home chains that did go into Chapter 11?

Mr. RANSOM. Yes. A couple of distinctions, No. 1, Manor Care and Beverly, before PPS, Medicare per day was under $300 per day. When PPS was implemented, there was not the dramatic step down, as there was for some of the companies that pursued higher-acuity strategies. The second reason was that the debt-to-operating income levels were lower. So, they had lower debt, they had lower Medicare rates. And, third, when Manor Care came together, the merger of HCR-Manor Care, that transition was done through an exchange of equity, not a purchase accounting, which resulted in no debt increase. So, that debt-to-EBITDA actually decreased when that transaction came through.

And, finally, Beverly, sort of against the grain, sold assets in States where they could not make money. They sold assets in Texas and they also sold their pharmacy business to another public company, both of which raised capital to pay down debt. So, these companies frankly went against the grain of what the public incentives were at the time, and properly, I suppose, anticipated the difficulties in PPS.

I will mention the only other guys who won, the guys who really won, if you will, are the guys who sold out for cash early. Those are the only people that really benefited unequivocally from what happened.

The CHAIRMAN. I want to ask any or all of you about the point that Medicaid is a large share of the income of nursing homes, and the extent to which Medicaid reimbursement levels might have played a role in these nursing home bankruptcies. Just jump in, anybody.

Ms. DUMMIT. The one point I would like to make is that, while the GAO has not examined the adequacy of Medicaid payment rates, we have heard nursing home chains stating that the Medicaid inadequacies were the real problem, not Medicare. But what I would point out is we did look at nursing home chains who were under bankruptcy and those who are not, and it was quite notable that the Medicaid share was much higher for those who are not in bankruptcy.

That is consistent with our other analyses, and what Mr. Ransom has been talking to you about is that those were generally lower-acuity facilities, facilities that did not aggressively pursue Medicare money through Medicare's cost-based reimbursement systems for capital and for ancillary costs.

The CHAIRMAN. OK. Mr. Grob.

Mr. GROB. I would just make a general remark that comes from analyzing programs over a number of years in our department, which is that there are a lot or had been a lot of Federal programs in which adjustments were being made in one program to make up for the deficiencies in another. And, so, we have ended up with programs where the decision as to how much money should be placed into the program or what the formula should be, did not have all to do with how that program was operating, but how well other things were supposed to be operating or weren't operating very well.

And while that may be a way to even the funding out, it makes the policymaking process even more complicated, as Senator Breaux initially indicated. It adds a level of complexity to policymaking, because when you are trying to decide something, you do not have at the table all the information you should be having as to what to do about it. And I think that it would be a big mistake to adjust the Medicare program in order to make up for shortfalls that are either in Medicaid or private insurance or long-term care insurance or all the other things that should go into financing nursing home care.

The CHAIRMAN. Before I go on to another question, anybody want to jump in on this?

Dr. ROADMAN. But they clearly need to be blended so that, in fact, the profession can remain viable. The Medicaid census across the Nation is about 66 percent of the skilled nursing facilities, and only brings in about 55 percent of the revenue. So, as you start to look at, not only volume, but the unit revenue for each of those, they do play a role, and I think we have to look at it across the continuum, recognizing that we incentivized earlier discharges from hospitals.

There was an opportunity there for growth in the skilled nursing facilities. As that expanded to fill that niche, business decisions were then made. Senator Grassley, in Iowa, you have a Medicaid rate of $3.95 per hour. In Louisiana, its $2.81 per hour. But then you would say why then do we have a lower bankruptcy rate in Iowa? And the fact of the matter is you have a much higher private pay, a much lower Medicaid and lower Medicare utilization or source of revenue.

And, so, the interplay of all these payment systems is a critical issue, I believe, for this Committee as we start to take on the policy of how we structure our system for the future, to be able to look at all of those and not just one bucket, if you will.

The CHAIRMAN. Mr. Pelovitz, you have been involved in negotiations between creditors and bankrupt companies. Based on that involvement, is there anything you would like to add to anything other witnesses said or have not said about the causes of bankruptcy?

Mr. PELOVITZ. Well, a couple things, if I might, Senator. First, I would like to thank the five chains who have filed for Chapter 11, because before each of them filed, they did come in and sit down and talk to us. We had been in contact with them. But there have been ongoing discussions between the Department of Justice, the Inspector General and HCFA to try and both ensure the welfare and safety of the residents of the home and, to the extent possible, protect the financial interest of the Government.

So, they have been in. We have been working together to try to move forward.

I guess, as we have listened to folks up here today, there seems to be, at least, some common threads through all of those. I think there were a set of factors that exist out there in the marketplace, in the nursing home enterprise, if you would, that impacted all homes, and I think a full-employment economy had a set of impacts on the homes, the ability to recruit and retain and how much you had to pay for the labor force, the increased attention to oversight

of the homes had an impact on that, and certainly the Balanced Budget Act had an impact.

There is not a way to get around that or to ignore that. I think those are important things, but most important, if you take a look at those chains that are in Chapter 11, and I think this is part of what Senator Reed was sort of remarking on before, the additional piece there was that there were a set of aggressive business decisions made, and aggressive business decisions have both the opportunity for a significant gain, but usually have greater risk, also. And I think that is what we have seen play out here. I think that all of those companies that are in Chapter 11 are working hard to try and manage through that process and to get out the other side, and we will continue to work with them.

The CHAIRMAN. Ms. Dummit, and I would ask maybe Mr. Wilson to comment on this, as well, you described the increased Medicare cost between 1991 and 1998 that could not be explained by an increase in Medicare beneficiaries' needs, and you mentioned a 25-percent annual increase in payment for SNF services and a 12-percent increase for per diems. Would you elaborate on that? And maybe Mr. Wilson, fill in from your expertise.

Ms. DUMMIT. Our and other analyses have indicated that a large portion of that increase in the per-day payment from Medicare to nursing homes was due to higher ancillary costs. Now, certainly if patients entering nursing homes are sicker, require more services, they will need higher ancillary services, and that is one of the reasons why those ancillary costs have increased much greater than what the market basket or a measure of input prices would indicate. But, we are still talking 12-percent-a-year annual increases, and we believe that a large portion of that increase in ancillary cost has to do with Medicare's former cost-based reimbursement system. And, indeed, the nursing homes in bankruptcy tended to invest heavily in ancillary services.

Often, they had their own company that sold ancillary services, both to their own nursing homes and to other nursing homes. That was a profitable line of business because Medicare reimbursed their costs. So, that was a major component of the increase in Medicare per-day spending, and there is no reason to believe that that increase in ancillary cost per day is commensurate with the increase in patient needs.

The CHAIRMAN. Mr. Wilson, anything to add?

Mr. WILSON. I would just reiterate that which Ms. Dummit said, Senator. Under the current retrospective cost reimbursement system in effect prior to the BBA, there were very few controls on both the price of services and the volume of services, and so we did see dramatic growth in ancillary payments, as well as volume. Another factor I would mention is that the nursing home industry and hospital industry responded to the incentives inherent in the inpatient prospective payment system for acute-care hospitals. The incentive to move patients more quickly out from under a per-discharge PPS system in the hospital setting to post-acute settings, such as skilled nursing facilities, that, in effect, added days in the post-acute setting and resulted in essentially patients coming quicker and sicker to these post-acute areas, like skilled nursing facilities.

The CHAIRMAN. Let me follow up with you on another point. Mr. Wilson, you presented a briefing to congressional staff, I have been told, on the intricacies of the Medicare prospective payment system and CBO's projections. So, I would like you and Mr. Pelovitz to respond to concerns about the changes in the CBO's projection of savings to the Medicare program by the PPS that have been raised by the bankrupt companies. So, very simply, could you explain why CBO estimates change from year-to-year?

Mr. WILSON. I can certainly respond to that, Senator, and I will address that in two ways. Of course, I would encourage those interested to talk directly with CBO, who has a much more detailed knowledge of their own assumptions in formulating the baseline. However, what I can say is, again, two issues: The baseline, of course, is an estimate of current and future outlays based on the best available data at any given point. Historically, we have seen it change. In some years, it has been higher. In some years, it has been lower, both the CBO's estimates and our own estimates of baseline expenditures.

And, No. 2, shifts in the baseline for CBO and HCFA reflect a variety of factors, many of them not related at all to one particular payment provision or other factor, economic assumption, demographic factor, et cetera. Some of the things CBO has cited as causing a decline or a decrease in the baseline include the following: Obviously, the Part A prospective payment system implemented under the BBA resulted in a decrease in the baseline. At the time of the BBA, CBO scored that provision at $9.2 billion over 5 years. But that $9.2 billion did not include other BBA provisions which also had an impact on the baseline.

One of these provisions was the post-acute transfer policy implemented under the BBA for hospital payments—were, in fact, pro rated to reflect early discharge for certain DRGs. The effect that that provision had was to decrease the number of certain patients coming into skilled nursing facilities, and therefore had a decreasing effect on payments. So, that provision, other BBA provisions, did have an impact on the baseline and the decrease in the baseline.

Another factor that is totally unrelated to the payment system is the period between service delivery and payment has decreased over time. That has had a downward effect on the baseline. Another thing I would mention are the economic assumptions used in formulating the baseline at any given point. Projected rates of inflation that CBO and we have used over time have decreased since the time of the BBA, and inflation has been quite low.

Beneficiary demographics, another point, things like——

The CHAIRMAN. I think you have given us a good idea of everything that is involved there. So, this is the question I want to get to, in addition. Does this projected increase in savings mean that Medicare payments are not sufficient to meet the needs of Medicare beneficiaries?

Mr. WILSON. I do not believe so at all, Senator. The SNF PPS is designed to make per diem payments which are equitable for SNFs and meet quality of care, support quality of care, quality services. They are not designed to achieve a historical budget tar-

get that is an aggregate budget target, but again, per diem payments which support quality and equitable payments.

The CHAIRMAN. So, kind of a common sense——

Dr. ROADMAN. Senator, could I——

The CHAIRMAN. Just a minute, and then I will let you respond, because I think it's fair to have you respond. But just as kind of a summary here then, common sense would kind of dictate, as we look at the Congressional Budget Office and try to determine the appropriate amount of Medicare funding, that we should base those decisions on whether seniors are getting the access to Medicare services, rather then base those decisions on just certain CBO projections of previous years; would that be fair to say?

Mr. WILSON. That would be fair to say, Senator.

The CHAIRMAN. Dr. Roadman.

Dr. ROADMAN. Well, I think the important thing, as we talk about baselines and baselines not being—or doing the best we can do with baselines. If you take a 1995 baseline and project that to 1998, what you do is you retroactively extract out both the case mix and the changing acuity that we have seen in the post-PPS change in skilled nursing facilities. And, so, that automatically lowers, if you will, the origin of the point, and the slope may stay the same, but the origin is different.

Now, the slope of the line is the issue of what the inflator or deflator is, of cost versus the market basket. Both of those were inadequate. It resulted in one out of three dollars being removed instead of one out of six, on which the business projections were made. And the fact of the matter is that the entire system is not adequate to maintain the care for our patients. The other thing, and I think using Senator——

The CHAIRMAN. I am not going to stop you, but I do want you to point out that aren't you talking about the cost-based share as opposed to the CBO? You are using as your baseline the cost-based share.

Dr. ROADMAN. I believe that that is true, but I will have to get you the answer to that.

The CHAIRMAN. Before you continue, would I be right on that, Mr. Pelovitz or Mr. Wilson? What he is talking about is a cost-based share, as opposed to CBO?

Mr. WILSON. Senator, it sounded to me like he was discussing the base year for the prospective payment system, what we use to establish the rates and how it was updated, not the baseline.

The CHAIRMAN. So, you can continue, but your comment was based on the CBO projections that I asked him about, as opposed to the cost-based share, which I didn't ask about. Now, you can continue.

Dr. ROADMAN. The other thing, and I was going to shift subjects, I think the issue, using Senator Breaux's terms of it drives me crazy, reminds me back of when I wore a white coat most of the time. We talk about over-utilization, but we haven't talked about under-utilization. And I think that really gets to the issue of quality of care. And it harkens me back to when we had the therapy caps. When we forced—because of financing, we forced people to make decisions on consumption of care based on a budget, rather

than the patient requirements. I believe we have got to make sure that we keep a face on it, not just a programmatic approach.

The CHAIRMAN. Well, I agree with you, but when you have an under-utilization, aren't you looking at the professionals that are making a decision, the doctors or the nurses, on the care that a person needs? Those facilities are going to provide that care.

Dr. ROADMAN. Or a bureaucratic constraint stopping the payment for them, and then——

The CHAIRMAN. Well, I agree with you, and we admit that was a terrible mistake. And, hopefully, we are working our way to getting a more reasonable system along that line, and in the meantime, we are not abiding by those caps.

Dr. ROADMAN. Right, but I think we also need to come back to the fact that we, in fact, did, as a profession, take part in the development of PPS, expecting once again that about one-sixth of the dollars would come out, not one-third.

The CHAIRMAN. Mr. Grob, there may be legitimate reasons for changes in CBO's savings estimates. There has been some discussion about the impact of the aggressive effort to eliminate waste, fraud and abuse in Medicare billing, on decreased Medicare revenues, and on the revised savings estimated to be put out by CBO. Do you think that any increase in CBO's savings estimates is attributable to these efforts?

Mr. GROB. I think that we are trying to be very careful to make sure we root out the fraud, waste and abuse wherever it occurs, but I do not think that we are rooting out any inappropriate—that we are rooting out appropriate payments when we do that. And I do think we are seeing here some potential settlements with nursing homes. Recently, we had a compliance agreement with Vencor, for example. At the same time, going back to what Mr. Pelovitz was talking about, every effort is being made to ensure that, in terms of settlements, that patient care is tended to. And special and, I think, innovative and creative steps are being taken to make sure that the patients will be OK.

The CHAIRMAN. And, Mr. Pelovitz, your question will be the last one I ask. Obviously, as we think about replenishment of the 1997 BBA decisions, with some money last year and some money this year, we are concerned about the provider community. And, as someone who has been involved with the settlement negotiations with bankrupt companies, do you expect that these companies have the ability to survive bankruptcy and to continue to provide nursing home services in the future, and is that at all a consideration in the discussions that you have in these environments?

Mr. PELOVITZ. I believe, as we have gone through discussions with each one of the chains, and to their credit, there has been very open and candid discussion with an agreement that those discussions sort of stay within the room, because, in all instances, it is the hope, desire and plan of those organizations to be able to emerge at the other end of the process and come out of Chapter 11 and back as a viable organization.

Each one of them has their own plan that has been shared. We have had multiple parts of the Justice Department in the rooms with us, significant players from the IG in the room with us. We have kept resident care, quality of care, safety, and trying to do

what we could to make sure that there was not the need to do any broad-scale transfers of residents, sort of at the top of our list, as well as trying to protect the overall interest of the Government. I agree with Mr. Grob that I think the structure put in place with Vencor recently and announced around an integrity agreement is a significant step forward in the way we expect to be doing business in the future. So, I think there is a way to balance those things and I just hope that the partnership continues.

The CHAIRMAN. I thought maybe Senator Breaux had something to ask, but I guess he had to go, as well, so I express to him my regrets that I took so long.

Well, first of all, as Senator Breaux has said, we have had a real good discussion of this, and we thank you all for your participation. So, I do thank you all for your hard work, both those from the public sector and the private sector. I think it has become clear that there are many reasons why we have had bankruptcies of large nursing home chains. We have discussed business decisions based on a belief that Medicare would continue to increase without limits, as it has in the past.

We have heard about overuse of therapies and related services at inflated costs, which the old cost-based Medicare system seemed to encourage, and which the PPS discourages. We have heard about heavy debt burdens created by aggressive merger activity; nursing home facilities and others, such as HMOs, negotiating tougher contracts; competition from alternatives, such as assisted living and home care. We did not discuss those here, but it is in some of the testimony—decreased revenues, due to efforts to fight fraud, waste, and abuse in the health care industry, and we sure heard a lot about litigation and related insurance costs, particularly in a few States.

Having heard the testimony, I think it is clear that bankruptcies are not solely due to the Medicare prospective payment system. As we have heard, some of the executives of the companies have—not just the executives, but their investors and bankers—have kind of gambled on the Government's portion and payments to be ever-growing, and obviously that miscalculation hurt when that vision was not based upon reality.

Others took a more cautious approach, and now are well-positioned to operate in a tight Medicare budget situation. And I think as we listen to the pleas of some of the nursing home executives for more Medicare funds, I think we have to keep a complete picture in mind, and that is part of the purpose of the hearing that we are having today.

I think we have accomplished two things; first, the safety and welfare of residents of these nursing homes must be protected. Over a long period of time, I thank the Health Care Financing Administration for working with us to monitor financially troubled nursing homes, to make sure that they are staffed and provided supplies that are needed. Mr. Pelovitz, you reported today that the States have presumably done a good job of increasing their monitoring and that they report no significant reductions in the quality of care due to bankruptcy status.

Also, I have sponsored the legislation that I have referred to for a patient's ombudsman in the bankruptcy bill, and I hope that we

are able to get that bill passed. But, regardless, we will pursue that separate provision in another way. Second, if Congress considers legislation giving the nursing home industry additional funds, it seems to me that we ought to do it not so much because of understanding that it caused the bankruptcies, or because of some of the arguments about changes in the CBO projections. Instead, any such legislation can only be justified if necessary to ensure beneficiaries access to services. That should be the test, as far as I am concerned.

So, the bottom line is taxpayers should pay for appropriate and adequate nursing home care for Medicare beneficiaries. The good news is that the vast majority of nursing homes prepared for the new PPS and have been able to weather the storms of transition, and, obviously, we ought to commend those who have made prudent business decisions, because they serve their patients well.

I would thank all of our witnesses for their valuable insight and their assistance in helping us understand this complex problem. Although the hearing is adjourned, I would be open to further discussions with anybody wants to talk to me about these issues.

Thank you all very much. Meeting adjourned.

[Whereupon, at 4:02 p.m., the Committee was adjourned.]

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