Testimony of
Anne Henry, Chief Operating Officer
Pennsylvania Health Care Association (PHCA)/Center for Assisted Living Management (CALM)
on
House Bill 1052
before the
House Aging and Older Adult Services Committee
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Chairman Hennessey, Chairman Curry, members of the Committee:

My name is Anne Henry, Chief Operating Officer of the Pennsylvania Health Care Association and the Center for Assisted Living Management (PHCA/CALM). We are a statewide advocacy organization for the commonwealth's elderly and disabled residents and their providers of care. Our mission is to ensure that those who need long-term care receive quality services in the most appropriate and cost-effective setting at each stage of their life.

Our members are based throughout the Commonwealth and include proprietary and non-profit organizations that offer services that range from integrated retirement communities and multi-level care campuses to freestanding nursing homes, assisted living/personal care homes and ancillary care/home care enterprises. PHCA/CALM represents more than 340 long term care and senior service providers that care for nearly 33,000 elderly and disabled individuals on a daily basis across the state.

We appreciate the opportunity to appear before you today to voice our strong support for House Bill 1052 which establishes an independent informal dispute resolution (IIDR) process for nursing homes to dispute deficiencies cited by the Department of Health during survey and certification inspections.

As you know, in Pennsylvania, the Department of Health is the agency designated to survey nursing homes not only for state licensure purposes but also to act as an agent of the federal government to certify nursing homes for Medicare and Medicaid. During these surveys, a nursing home is issued a statement of deficiencies if it is found to be out of compliance with any state or federal regulation. If a nursing home disagrees with one or more of the cited deficiencies, it has the ability to dispute or challenge the deficiency through a process called an Informal Dispute Resolution, or IDR.

The IDR process is required by federal law; however, the law merely establishes minimum standards. States are then given extensive flexibility to determine the manner in which they choose to conduct the IDR process. Because the IDR process provides nursing homes with their ONLY opportunity to resolve disputes in the majority of cases, the method in which the Pennsylvania's Department of Health administers the IDR process is of great importance to nursing homes. The current process is conducted by the Department of Health -- the same agency that surveys facilities -- and PHCA and its members feel that it is critical that nursing

facilities have the ability to choose between seeking an independent process as set forth in House Bill 1052 or utilizing the current process through the Department of Health.

You may ask why an independent IDR process is necessary if the Department of Health is already conducting IDRs. Let me start by talking briefly about the survey process. We know that the Department of Health state surveyors have a job to do and that they strive to do that job to the very best of their ability. However, the current process required by the federal government allows for subjectivity and interpretation by the surveyors when they cite deficiencies. As a result of this – along with simply being human – surveyors bring their own opinions and life experiences to the survey process which can lead to a lack of demonstrated consistency in the way that facilities are surveyed among the commonwealth's nine geographically-designated field offices. Additionally, the survey process, because of its nature and design, is one of punishment rather than collaboration and that sometimes can lead to adversarial relationships between surveyors and nursing facility staff. Yet both parties really only want one thing: quality care for the residents residing in Pennsylvania's nursing homes.

But this doesn't explain why we need an Independent IDR process. While we thank the Department of Health for moving the review of IDRs to the central office in 2010 (previously the IDRs were conducted in the same field office that cited the deficiency), the members of PHCA still believe that it can be difficult for one Department employee to be critical and independent when reviewing a deficiency because they are potentially overturning the work of their colleagues. If one looks at the statistics provided by the Department on the total number of deficiencies challenged and those that were overturned from January 2009 through March 2011, only 12.3% or 32 deficiencies out of 261 were removed. Another 16.5% or 43 were revised but 79% or 206 out of 261 deficiencies were upheld. One might be lead to believe that this statistic shows that the majority of deficiencies issued were absolutely appropriate but nursing homes don't submit an IDR request without serious thought and consideration as to whether or not the statement of deficiencies was accurate.

Let me give you an example of an IDR where the facility and the physician providing care to the nursing home resident absolutely believed the deficiency should have been overturned.

It was a Sunday afternoon; a resident who was recently admitted to the facility with a dementia diagnosis became aggressive and started to hit the nursing home staff who were trying to care for him. The staff, in conjunction with the resident's physician, tried multiple behavior interventions but nothing was working. The staff was frightened by the resident's behavior. Other residents were frightened by the resident's behavior – would he begin to try to hit them too?

Anyone who has worked with dementia patients knows that an individual who was meek and mild before contracting the disease can become quite aggressive and combative. Even a 90-pound weakling can seem to have super human power because of this horrific disease. This was the type of situation that was occurring in this particular facility on a Sunday afternoon.

The physician and the administrator of the facility were so alarmed that they came into the facility and after consultation – when there was seemingly nothing left to do as they had exhausted all behavior modification methods that they could safely use – the doctor prescribed a

drug to calm the resident. The staff and physician made sure to diligently document all that occurred and yet the facility was cited, with the Department saying that unnecessary drugs were prescribed. To say that the doctor and staff of the facility were upset by this deficiency is putting it mildly, but they felt they had a good chance of having the deficiency overturned with the current IDR process.

Of course I wouldn't be telling this story if that deficiency or many others similar to it had been overturned. While this story might seem to be specific – it's not – it mimics other examples provided to us by our members In any event, would the outcome of this story be different if the Independent IDR process as outlined in House Bill 1052 been in place? We will never know but I believe if an independent set of eyes had looked at this situation to determine if the doctor and the facility had used their best clinical judgment when deciding to give the drug to that particular resident, they may have come to a different conclusion.

In addition to allowing facilities an independent review of deficiencies, House Bill 1052 allows the Quality Improvements Organization (QIO), if it finds in its review that the deficiency is indeed correct, to not only state its rationale for the decision but to also provide the facility with actions that it can take to achieve compliance.

For those of you that are not familiar with QIOs – let me briefly explain what they are and the role they play in the health care spectrum. CMS contracts with an organization in each state to serve as the state's QIO. QIOs are staffed by professionals, mostly doctors and other health care professionals, who are trained to review medical care. The mission of QIOs is to improve quality of care for patients and ensure that Medicare pays only for goods and services that are reasonable and necessary. Because of the role QIOs play regarding quality of care, they are very familiar with the federal and state regulatory requirements and have the expertise to conduct the IDR process. More importantly, the QIO can provide a more impartial perspective and assure consistency and continuity in the IDR review process.

We understand from a number of states including Michigan, Indiana and Illinois, that quality of care can be enhanced by the ability of the QIO to share this kind of collaborative information when responding to an IIDR. Unfortunately, because of some of the constraints put on the Department of Health by its contract with the federal government as the agency that conducts Medicare and Medicaid surveys and certifications, its ability to share this type of collaborative information is severely limited.

In this day and age of tight fiscal constraints, as members of our General Assembly, you may be worried about the cost of adding an IIDR program in Pennsylvania. In House Bill 1052, as in many states that have implemented this type of process, the nursing facility that chooses the IIDR process instead of the federally mandated IDR process conducted by the Department of Health is required to pay the QIO for the review. While we can't predict the outcome, we heard from informal discussions with the QIO from Michigan that the cost to the state of their IDR program was slightly decreased as a result of the addition of an IIDR process.

Additionally, you may be concerned about the Department of Health relinquishing some of the control that it has over the licensing, survey and certification process for nursing homes. This is

absolutely not the case as federal law requires that the state agency have final decision making over any and all dispute resolution processes.

Finally, House Bill 1052 requires data collection so that the results of IDRS and IIDRS can be monitored. The collection of this data will help to evaluate the success of the program and whether changes should be made to improve on its efficiency and or effectiveness.

In closing, let me again say that PHCA is strongly supportive of House Bill 1052. We believe that the IIDR process will give nursing facilities comfort in knowing that disputed deficiencies can be reviewed by an independent reviewer. We also believe that this may help to reduce some of the tension that can occur between surveyors and facilities in what can sometimes be an adversarial process. Finally and most importantly, we believe that facilities that have deficiencies that are not overturned through the IIDR process can be given additional information by the QIO in order to both "fix" their deficiency and enhance the quality of care that they are providing to their residents. And that's a win for everyone.

I thank you for your time and attention and am happy to answer any questions you may have at this time.