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TRENDS IN NURSING HOME OWNERSHIP AND QUALITY

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED TENTH CONGRESS

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TRENDS IN NURSING HOME OWNERSHIP AND QUALITY

THURSDAY, NOVEMBER 15, 2007

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, DC.

The Subcommittee met, pursuant to notice, at 10:13 a.m., in Room 1100, Longworth House Office Building, Hon. Fortney Pete Stark (Chairman of the Subcommittee), presiding.

[The advisory announcing the hearing follows:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE
November 08, 2007
HL–18

CONTACT: (202) 225–3943

Stark Announces Hearing on Trends in Nursing Home Ownership and Quality

House Ways and Means Health Subcommittee Chairman Pete Stark (D–CA) announced today that the Subcommittee will hold a hearing to examine the effect of nursing home ownership trends on nursing home quality and accountability. **The hearing will take place at 10:00 a.m. on Thursday, November 15, 2007, in Room 1100, Longworth House Office Building.**

In view of the limited time available to hear witnesses, oral testimony at this hearing will be from invited witnesses only. However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Subcommittee and for inclusion in the printed record of the hearing.

BACKGROUND:

Medicare covers care in skilled nursing facilities (SNFs) for beneficiaries who need short-term skilled nursing care or rehabilitation services on a daily basis in an inpatient setting. In 2005, Medicare covered 2.5 million SNF admissions, and nearly 70 million SNF days.

The Congressional Budget Office projects Medicare SNF spending of $21.1 billion for fiscal year 2008, with spending growing at an annual average rate of 6.0 percent through 2017. Medicare and Medicaid pay for the majority of nursing home care in the United States.

According to the Medicare Payment Advisory Commission, Medicare margins for SNFs reached 12.9 percent in 2005. For-profit SNFs, which constitute 68 percent of facilities, had margins of 15.5 percent, as compared to nonprofit homes, with margins of 4.5 percent. For 2007, MedPAC projects Medicare SNF margins of 11 percent.

Nursing home chains constitute slightly more than half of the industry. In recent years, several major nursing home chains have restructured or reorganized as a result of mergers, bankruptcies, and acquisitions. HCR ManorCare, one of the largest chains, will soon be purchased by the Carlyle Group in a $6.3 billion acquisition described in both companies' press releases as one that will convert ManorCare from a publicly-traded company to a private, equity-owned company.

Acquisitions and related increases in debt have often been accompanied by changes in ownership and management, cost controls, and corporate restructuring, including the sale of assets and real estate and the establishment of limited liability companies. As a major purchaser of nursing home services, the implications of these changes on quality and accountability of care are of great importance to the Medicare program. *The New York Times* recently investigated the effect of private investment in certain nursing homes, reporting that the heightened focus on cost controls led to staffing cuts and concurrent declines in quality care. *The New York Times* also reported that corporate restructuring created difficulties for State regulators and beneficiaries in identifying accountability and liability for quality of care.

"It's been far too long since Congress has focused on nursing home quality issues," stated Chairman Stark in announcing the hearing. **"I am concerned**

about quality issues and lack of accountability, particularly as more and more beneficiaries are now living in private equity-owned homes. While we must not prejudge anything, these changes provide ample reason for us to reinitiate close oversight of this industry to make sure that interests of beneficiaries are protected."

FOCUS OF THE HEARING:

The hearing will focus on trends in nursing home ownership and quality of, and accountability for, patient care, including the effect of the relatively new trend of private equity ownership.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Please Note: Any person(s) and/or organization(s) wishing to submit for the hearing record must follow the appropriate link on the hearing page of the Committee website and complete the informational forms. From the Committee homepage, *http://waysandmeans.house.gov*, select "*110th Congress*" from the menu entitled, "*Committee Hearings*" (*http://waysandmeans.house.gov/Hearings.asp?congress=18*). Select the hearing for which you would like to submit, and click on the link entitled, "*Click here to provide a submission for the record*." Once you have followed the online instructions, completing all informational forms and clicking "submit" on the final page, an email will be sent to the address which you supply confirming your interest in providing a submission for the record. You ***MUST REPLY*** to the email and ***ATTACH*** your submission as a Word or WordPerfect document, in compliance with the formatting requirements listed below, by close of business **Thursday, November 29, 2007**. **Finally**, please note that due to the change in House mail policy, the U.S. Capitol Police will refuse sealed-package deliveries to all House Office Buildings. For questions, or if you encounter technical problems, please call (202) 225–1721.

FORMATTING REQUIREMENTS:

The Committee relies on electronic submissions for printing the official hearing record. As always, submissions will be included in the record according to the discretion of the Committee. The Committee will not alter the content of your submission, but we reserve the right to format it according to our guidelines. Any submission provided to the Committee by a witness, any supplementary materials submitted for the printed record, and any written comments in response to a request for written comments must conform to the guidelines listed below. Any submission or supplementary item not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All submissions and supplementary materials must be provided in Word or WordPerfect format and MUST NOT exceed a total of 10 pages, including attachments. Witnesses and submitters are advised that the Committee relies on electronic submissions for printing the official hearing record.

2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.

3. All submissions must include a list of all clients, persons, and/or organizations on whose behalf the witness appears. A supplemental sheet must accompany each submission listing the name, company, address, and telephone and fax numbers of each witness.

Note: All Committee advisories and news releases are available on the World Wide Web at *http://waysandmeans.house.gov*.

NOTE The Committee seeks to make its facilities accessible to persons with disabilities. If you are in need of special accommodations, please call 202–225–1721 or 202–226–3411 TTD/TTY in advance of the event (four business days notice is requested). Questions with regard to special accommodation needs in general (including availability of Committee materials in alternative formats) may be directed to the Committee as noted above.

Mr. STARK. With an apology to my colleagues and our guests for the late start, I would like to begin our hearing on the issue of nursing home quality. Thank you for joining us in the first of a series of hearings on nursing home quality issues. It has been 20 years since the passage of the Nursing Home Reform Act, and I guess over a decade since we have held any hearings on nursing home issues on the Committee on Ways and Means. Despite improvements in areas of quality, there is still much to be done. I think our return to this issue is long overdue.

I don't want to prejudge any segment of the industry or anyone in the industry, but I am concerned about a trend that is underway. In recent years, several nursing home chains have changed their corporate structure in ways that may obfuscate the real ownership and management of the individual facilities. I will talk more just for a second at the conclusion of my remarks about that by itself. It seems that—I will talk more about that in a minute.

Without this transparency and accountability, it is hard to hold chains accountable for the quality of care of an individual unit. I worry that this move to more large private equity firm ownership will exacerbate that trend. It has been suggested that there is a negative effect on quality that may result from these corporate structures. I was alarmed to read *The New York Times* article earlier this year that suggested the decline in quality among private equity-owned nursing homes. I guess in a nutshell, they are suggesting that the private equity firms spin off the real estate to leverage the value of the real estate to pay for the acquisition, and in so doing either increase the interest payments needed by the individual units to support the increased mortgages or increase, if they spin it off into a REIT, for instance, they increase the rent to the individual units to sustain their purchase obligations.

I have no quarrel with that if it doesn't result in their reducing the funds they spend for the needed facilities and needed employment to maintain quality of care. I don't intend to question what they do as a business practice. But I do worry that the end result could create an incentive to cut costs, as we like to say. The only costs that I know that they can cut are either in nursing care or food or tender loving care. I don't know how you legislate tender loving care. This industry operates largely on the government's dime. Sixty percent of the spending on nursing homes annually comes from the government, and the remainder is out-of-pocket or from private insurance. At any time nearly 80 percent of the residents in nursing homes are supported by public funds.

The same nursing home industry is enjoying very healthy Medicare—and I have to underline Medicare because there is a distinct difference here between Medicare and Medicaid throughout the industry. But with margins of nearly 13 percent at the last reportable period, and we hear indirectly they are close to that even in the most recent figures that are available, the for-profit nursing homes are doing even better, with Medicare margins north of 15 percent. For those of you who follow the hospital margins, we are used to dealing with acute care hospitals in the neighborhood of somewhere between zero and far out would be 5 percent margins. The industry is publicly supported, and therefore must be held accountable to the public for the care it provides. The nursing home

chains should be striving to improve care and not cut corners to increase profits at the expense of the seniors and people with disabilities. I plan to continue looking into the issue of nursing home quality and accountability. We have already received some policy recommendations from a coalition of consumer groups. I would like to review those.

I would like to enter into the record a letter from the National Consumer Voice for Quality Long-Term Care, a letter addressed to Mr. Camp and myself. Without objection I would make that part of today's record.

[The information follows:]

NCCNHR The national consumer voice for quality long-term care

1828 L Street, NW, Suite 801
Washington, DC 20036
202 332-2275 Fax 202 332-2949
www.nccnhr.org

Alison Hirschel, President
Alice H. Hedt, Executive Director

November 9, 2007

The Honorable Fortney H. "Pete" Stark
Chair, Subcommittee on Health
House Committee on Ways and Means
1135 Longworth House Office Building
Washington, DC 20515

The Honorable Dave Camp
Ranking Member, Subcommittee on Health
House Committee on Ways and Means
1135 Longworth House Office Building
Washington, DC 20515

Dear Chairman Stark and Ranking Member Camp:

Twenty years after Congress passed landmark nursing home reform legislation, progress ensuring resident quality of care is threatened by the takeover of nursing home chains by private equity investors who are maximizing profits while isolating themselves from accountability to residents, workers, or regulators. A *New York Times* investigation, "At Many Homes, More Profits and Less Nursing," September 23, 2007, found that the typical private investor-owned facility scores worse on most quality indicators than other types of facilities; has 19 percent more serious health deficiencies than the national average; and ranks 35 percent below the national average in registered nurses. Unfortunately, staffing levels and quality of care at many for-profit, chain-operated facilities are already below acceptable standards.

The nursing home industry receives approximately $75 billion a year in federal Medicare and Medicaid funding. As organizations that represent nursing home residents, their families, and nursing home workers, we urge you to use the Medicare legislation currently under consideration to take initial steps to improve transparency, accountability and staffing throughout the entire nursing home industry. These include the following recommendations, which can be implemented at minimal cost:

Increasing the transparency and accountability of corporate ownership

- Require full disclosure to the Centers for Medicare & Medicaid Services (CMS) of all affiliated entities with a direct or indirect financial interest in the facility and their parent companies, and the owners (including owners of the real estate), operators, and management of each facility; and require that all these entities be parties to the Medicare provider agreement and listed on Nursing Home Compare. CMS should maintain an ownership database and monitor the quality of care provided by the companies. Severe penalties, including exclusion from Medicare, should be established for hiding ownership or affiliated relationships.
- Many nursing home chains have created complex corporate structures that make compensating residents who have been harmed and recovering penalties from entities that actually have assets very difficult. As early as 1979, a GAO report, *Problems in Auditing Medicaid Nursing Home Chains*, HRD-78-158 (Jan. 9, 1979), http://archive.gao.gov/f0302/108331.pdf, identified complex transactions and relationships in chains and recommended better auditing practices. CMS should address this lack of transparency and the related problem of "judgment proof" or bankrupt entities that commit wrongdoing, such as violations of regulations or fraud, by requiring a surety bond. The provider agreement should be amended to require that providers including purchasers of an existing facility or company, deposit assets in a surety bond with the amount (to be determined) proportional to the number of beds in the facility. The bond would cover

fines, civil monetary penalties, expenses associated with receiverships and temporary management arrangements imposed by state agencies, operational costs where residents are abandoned or workers are not paid, and attorneys' fees, litigation costs and damages awarded to plaintiffs in civil damage actions.

- Require CMS to certify the provider agreements annually to ensure that they are consistent with the current ownership structure and affiliated entities.
- Require CMS to post enforcement actions against facilities and maintain actual CMS Form 2567 survey reports on Nursing Home Compare.

Promoting improved staffing

- Require CMS to collect electronically submitted data from facility payroll records and temporary agency contracts on a quarterly basis, including data on turnover and retention; and require CMS to report that information on Nursing Home Compare as quality measures that include a ratio of direct care nursing staff (RNs, LPNs, and CNAs) to residents and turnover and retention rates. CMS should monitor the reported staffing levels on a quarterly basis and direct that a survey be conducted at facilities where staffing appears to be low and/or declining. CMS has already developed a system to collect and report this staffing information. The National Quality Forum has also recommended that CMS establish a nurse staffing quality measure.
- Require that information on cost reports for Medicare be reported based on five cost centers: (1) direct care nursing services; (2) other direct care services (e.g., activities, therapies); (3) indirect care (e.g., housekeeping, dietary); (4) capital costs (e.g., building, equipment and land costs); and (5) administrative costs. The cost reports should be reported electronically to CMS and summary data should be made available on Nursing Home Compare. In 2004, MedPAC recommended requiring nursing facilities and skilled nursing facilities to publish nursing costs separately from other costs on cost reports. This recommendation was reiterated in a June 2007 MedPAC report (www.medpac.gov/Chapters/Jun07_Ch08.pdf).
- Require CMS to conduct audits of nurse staffing data reports and cost reports at least every three years to ensure the accuracy of the data reported and to prevent fraud. Severe penalties should be established for filing false reports or failing to file timely cost reports.

It is imperative that Congress take immediate action to prevent the further deterioration of care.

Please contact Janet Wells, NCCNHR Director of Public Policy, 202/332-2275, or Michelle Nawar, SEIU Assistant Director of Legislation, 202-730-7232, if you have questions.

Sincerely,
NCCNHR: The National Consumer Voice for Quality Long-Term Care
Alliance for Retired Americans
American Federation of State, County, and Municipal Employees
B'nai B'rith International
Center for Medicare Advocacy
Consumers Union
National Senior Citizens Law Center
OWL – The Voice of Midlife and Older Women
Service Employees International Union

cc: All Members, Subcommittee on Health, House Committee on Ways and Means

Mr. STARK. Mr. Camp and I would also like to see if we could initiate further professional investigations into this issue. I think we will do that today. Let me just return for a moment to this issue, and that is, as I said, there may be a lot of business reasons for large corporations or chains who acquire hundreds of nursing home entities to separate each one of those entities into a separate corporation or separate them into different corporations in different States. That is their business. They may do it for tax reasons, which is perfectly, as long as they pay their legal taxes that they owe, that is okay, too. But to the extent that either intentionally or as a result it limits both financial liability and/or professional liability by shielding small units, say a 50-bed hospital out of a chain that may have thousands of beds so that either the State enforcement agency or a court in a tort liability—in a liability suit can't get at assets either to pay the fine or to assess penalties for behavior that is originated at the owning level, but not—you can't get to them because of corporate shields, to that extent I might suggest that they can go ahead and to that, but then each major chain would have to provide a bond, for example, for each unit in the chain equal to somewhere north of the total equity of that institution.

So, that for whatever reason, if they want a separate corporate entity that doesn't own any real estate that you could get after, doesn't have any assets against which you can levy a fine or a court judgment, they would have to bond themselves up to the many millions of dollars of equity that their corporate parent might have. So, we could probably accommodate both issues, the business reasons that the multiple chain corporations would like to have and also what the State regulators would like to have, and what the people who would like to use the courts as a way to see that people provide good care.

So, I think that there are a lot of ways that we can work together to do this, and I think everybody, the industry, who, by the way, were invited. The industry's advocates and many of the large corporations were invited to be here today, and they chose not to. HCA had submitted written testimony, which is in the record. I yield now for any comments he would like to make to my Ranking Member, Mr. Camp.

Mr. CAMP. Thank you, Mr. Chairman. Like you, I was troubled by the recent articles in *The New York Times*, and particularly the one entitled "At Many More Homes More Profit and Less Nursing," which really does paint a disturbing picture of the care being delivered at two Florida nursing homes. The author makes the argument that private equity homes are purchasing nursing homes, slashing their budgets, firing their staff, and leaving residents with substandard care all in order to increase profits.

In addition to this preference for profit over quality care, the article suggests private equity firms reorganize the corporate structure of nursing homes to shield owners and their assets from liability in suits arising from patients receiving inadequate care. While this is an important story for us to hear, I am concerned that it is not the whole story. In response to the article, the Florida Agency for Health Care Administration recently issued an investigative report that examined these issues. This detailed report found that,

and I quote, "there is no evidence to support that the quality of nursing home care suffers when a facility is owned by a private equity firm or an investment entity."

Instead, this report found that other factors, like the percentage of Medicaid patients and the age and location of the facility were more likely to have an impact on nursing home quality. I am disappointed that story will not be examined at today's hearing. I am especially frustrated that the American Healthcare Association and the Alliance For Quality Nursing Home Care, who are supposed to represent the nursing home industry, both declined our offers to testify today. This failure does a disservice to the entire nursing home industry and the Members of this Committee who will now not be able to hear their side of this important issue. I would just like to ask unanimous consent to admit into the record a statement. This is the eighth hearing on nursing home issues since 2003, including a hearing in May of '07, which the president of the American Healthcare Association did testify before this Committee. So, I would ask unanimous consent that that memo be placed in the record.

[The information follows:]

Haven't had a nursing home hearing in 12 years?

This is the 8th hearing since 2003 where a witness has testified before the Subcommittee on nursing home issues.

1. 5-15-2007
   Hearing on Payments to Certain Medicare Fee-for-Service Providers
   Bruce Yarwood, President, American Health Care Association

2. 3-1-2006
   Hearing on MedPAC's March Report on Medicare Payment Policies
   Stephen L. Guillard, EVP, HCR-ManorCare

3. 6-16-2005
   Hearing on Post-Acute Care
   Mary Ousley, R.N., Executive Vice President, SunBridge Healthcare

4. 4-19-2005
   Hearing on Long Term Care
   David M. Gehm, President and CEO, Lutheran Homes of Michigan

5. 3-18-2004
   Hearing on New Frontiers in Quality Initiatives
   Sarah G. Burger, Consultant, National Citizens' Coalition for Nursing Home Reform

6. 3-6-2003
   Hearing on the MedPAC Report on Medicare Payment Policies
   Mary K. Ousley, Chairman, American Health Care Association

7. 2-13-2003
   Hearing on Medicare Regulatory and Contracting Reform
   Judith A. Ryan, Ph.D., President and CEO, Evangelical Lutheran Good Samaritan Society

Mr. CAMP. While it is extremely important to have transparency of ownership and clear patient protections, I am concerned that it is simply attacking private equity ownership, or for that matter making it easier for care givers to be unionized, and ignores the root problem and will do little, if anything, to improve the quality of nursing home care or lower health care costs. Given our narrow focus today, I fear this hearing is more about political payback than the patients suffering from inadequate care.

I hope that the Chairman will work with me in attempting to get to the bottom of this larger issue. It certainly deserves our attention. As a first step I would ask that he join me in drafting a joint letter to the GAO, asking them to explore nursing home quality as it relates to ownership and other factors. With that I yield back the balance of my time.

Mr. STARK. Thank you. The gentleman as usual is correct, we have had hearings on nursing homes, but they have been entirely focused on payment issues, which are important, and not necessarily on the quality or quality regulations or the results of various studies. I would like to introduce our panel.

Mr. THOMPSON. Mr. Chairman?

Mr. STARK. Mr. Thompson?

Mr. THOMPSON. Thank you, Mr. Chairman. I want to thank you for holding today's hearing. I think quality of care in nursing homes is something that is important to all of us. But I just want to state for the record, and would like to hear from you, Mr. Chairman, if you would, I just think it is very important that this Committee recognize that we share jurisdiction with another Committee on this issue. One of the big—you can't divorce the two issues of quality and the issues of pay in this discussion. The reality is we look at one side of it.

The Commerce Committee has the Medicaid side of it. I think this Committee needs to do everything we possibly can to make sure that we encourage our colleagues on the Commerce Committee to do a better job with the Medicaid component. That is a big problem in this whole debate. As long as there is going to be a need for these care homes, and believe me there is going to be as long as we all keep getting older and there are no other—not you, Mr. Chairman—and there are not other alternatives, this is a very, very important industry in our community and in our families. We need to have a more holistic, I think, approach in how we deal with this.

So, I would like to encourage you, Mr. Chairman, and Mr. Camp, the Ranking Member, to please use the power and force of this Committee and all of its memberships to get our colleagues in the Commerce Committee to address this other side of the financial equation.

Mr. STARK. Well, the gentleman's remarks are well taken. I have great fear of taking on the entire Michigan delegation, much less the Ranking Member or the Chair of the Energy and Commerce Committee, all in one term of Congress. But I have been encouraging Energy and Commerce to do a better job for over 35 years, and I will continue to do that. You are correct that we have a joint jurisdiction, and our reimbursement part is very small. But our concern, I think, that is shared equally with Energy and Com-

merce right now is the quality issue and what we can do there. If it is indeed overall payment, I don't think, although we are called on often to pay for other Committees' legislative mandates—I will address the issue as long as you raise it—that we can have Medicare in the position of bailing out lower Medicaid payments.

I just would give you an example. I don't know how many States anybody can think of where Medicaid pays a physician more than Medicare. There may be a State, but I haven't heard of it lately. Now if we were going to suddenly have to raise Medicare physician reimbursement to cover low payments by States we could break the Medicare system in short order. So, while that jurisdictional problem will come up, and I think we should all be cognizant of it, I think we just have to go ahead based on our role for those Medicare beneficiaries who need these services. I agree.

Okay. I am supposed to agree with him. I am following pretty well. He says I should listen to my staff. Now let me introduce our witnesses and see if I can get through that one without a correction. I am going to call on the witnesses in the order on which they appear on our list. The first one is Ms. Charlene Harrington, who is a professor of sociology and nursing at the Department of Social and Behavioral Sciences at the University of California in San Francisco. Dr. Harrington will provide an overview of ownership and quality trends. Professor John Schnelle, did I pronounce that correctly.

Mr. SCHNELLE. Close.

Mr. STARK. Close. Okay. Professor of medicine and director of the Vanderbilt Center for Quality Aging at Vanderbilt University in Nashville, Tennessee. Mr. Scott Johnson, a Special Assistant Attorney General from the State of Mississippi. He will explain how companies have moved to more complex corporate structures and what it presents to a regulator in trying to build quality care. Mr. Arvid Muller, the assistant director of research for the SEIU are, more affectionately known as the Service Employees International Union. He will report and discuss the effects of corporate structure on care in the nursing home industry. We are going to ask each of the witnesses to summarize in about 5 minutes, if they can. Without objection, their entire prepared testimony will appear in the record. We can get more of the issues that are of interest to you as we inquire after your testimony. Professor, or Dr. Harrington, as you prefer, would you like to lead off?

STATEMENT OF CHARLENE HARRINGTON, Ph.D., PROFESSOR OF SOCIOLOGY AND NURSING, DEPARTMENT OF SOCIAL AND BEHAVIORAL SCIENCES, UNIVERSITY OF CALIFORNIA

Ms. HARRINGTON. Yes. Thank you very much. I am pleased to be here to testify today as an individual researcher who is concerned that the recent purchase of nursing home chains by private equity companies will have a negative effect on the quality of care for nursing home residents. Today I will present trends in nursing home quality and ownership, and discuss three areas. One, adequate nurse staffing levels and electronic staff reporting; two, transparency and responsibility in ownership; and three, financial accountability for government funding.

Over 16,000 nursing homes, with over 1.8 million beds, will take in about $132 billion in revenues this year. Sixty-two percent of that is paid by Medicare and Medicaid and government, which covers 78 percent of all the residents. In spite of the high cost of care, literally dozens of studies have documented the persistent quality problems in many nursing homes. The poor care is related to low staffing levels and the 25 percent drop in RN staffing since the year 2000. Nursing homes are not required to provide the level of staffing paid for by Medicare rates, and few nursing homes in the United States meet the staffing levels recommended by experts. For-profit companies are 66 percent of nursing homes and for-profit chains now operate 52 percent of the beds. For-profit chains have lower nurse staffing than for-profit independent facilities and nonprofit chains. In fact, for-profit chains provide only 57 percent of the RN hours and 78 percent of the total hours that nonprofit facilities provide in the United States. In 2006, the 50 largest nursing home chains operated 30 percent of the Nation's facilities.

By 2007, six of the 10 largest chains were either purchased or in the process of being purchased by private equity companies. These companies used strategies similar to those used by the publicly-traded chains to enhance profits. Many own a range of related companies, and they target Medicare and private payers to increase their revenues, while they control their staffing levels and expenditures. Private equity companies may have a negative impact on staffing and quality.

We examined 105 nursing facilities purchased by one private equity company in 2006. The average RN staffing dropped by 8 percent, and the total nurse staffing dropped by 7 percent after purchase. After the sale, the average RN staffing was only 75 percent, and total staffing was 85 percent of the national average.

At the same time, total deficiencies increased from over 500 to over 1,000 deficiencies. Serious deficiencies increased by 80 percent after the purchase. These findings raise two concerns. First, the private equity firms do not have the expertise and experience to manage complex nursing home organizations. Second, these firms are likely to cut staffing to increase profits, which can harm residents. Another troubling and dramatic trend is the conversion of individual facilities into limited liability companies, which protect the parent companies from litigation. Many nursing home chains have dropped their liability coverage entirely to discourage litigation.

Some chains have moved facility assets into separate real estate investment trusts, or REITs, and REIT profits are largely hidden by the lease arrangements, and the REIT protects the assets from litigation. Medicare prospective payment does not limit the nursing home profit margins, and the GAO reported that the 10 largest for-profit chains had margins of 25 percent in the year 2000. Our research shows that nursing homes with profit levels of 9 percent or more have significantly more total deficiencies and more serious deficiencies.

So, private equity firms seek high profits, and they are under no obligation to report the profits because they don't report to the SEC. Private equity companies have multiple investors and holding companies and multiple levels of companies. This complexity makes

it difficult to know who the owners are, who is responsible for the management and the operation of the nursing homes, and who is responsible for the property and the assets. Moreover, CMS has no ownership tracking, monitoring, and reporting system for nursing homes.

The following five areas need to be addressed by Congress: Establish minimum Federal standards for nursing homes recommended by researchers and experts.

Two, require nursing homes to report all types of nurse staffing by shift from payroll records. These should be electronically submitted on a quarterly basis so that CMS can monitor staffing levels.

Three, require ownership reporting for all nursing homes, including the private equity investors and all the related companies and REITs. CMS needs to develop an accurate and timely database for ownership reporting, tracking, and oversight.

Four, a surety bond could be posted by each nursing facility to ensure that the funds are available to pay for civil money penalties, temporary managers, litigation, and other costs.

Finally, establish four cost centers for Medicare nursing home reporting, one for direct care, for indirect care, for capital, and for administrative costs. Nursing homes should be prevented from shifting funds from direct and indirect services to pay for administrative costs, capital, and profits. Audits should be conducted.

In summary, the growth of nursing homes home chains, and now the purchase of chains by private equity companies represents a substantial threat to the quality of care for residents. Congress needs to take action to protect the residents. Thank you.

Mr. STARK. Thank you very much, Professor Harrington.

[The prepared statement of Ms. Harrington follows:]

Prepared Statement of Charlene Harrington, Ph.D., Professor of Sociology and Nursing, Department of Social and Behavioral Sciences, University of California, San Francisco, California

I am pleased to be asked to testify today as an individual researcher who is concerned about the poor quality of care in many nursing homes in the U.S. and about the potential negative impact that the recent purchase of nursing homes by private equity companies may have on nursing home residents. First, I would like to discuss some of the trends in the quality of nursing home care and ownership. Second, there are three areas that need to be addressed to ensure high quality nursing home care, including: (1) adequate nurse staffing levels in nursing homes and electronic reporting of staffing data; (2) transparency and responsibility in ownership, and (3) increased financial accountability for government funding of nursing homes.

TRENDS IN NURSING HOME FACILITIES, BEDS, AND OWNERSHIP

U.S. nursing homes have grown dramatically from a cottage industry of local 'mom and pop' providers prior to 1965 to large corporations, fueled by the 1987 expansion of the Medicare nursing home benefit and its cost-based reimbursement system. In 2006, there were 16,269 nursing home facilities with over 1,760,000 certified and 52,000 uncertified beds in the U.S.[1] Although the total number of nursing home beds has shown little growth over the past decade, there has been a sharp decline in the number of hospital-based nursing home beds (from 13 percent of all beds in 1995 to only 9 percent in 2006).[2,3]

Occupancy rates for certified nursing home beds were only about 85 percent in 2006, having dropped from 90 percent in 1995 in spite of the growth in the aged population.[2,3] This shows that there is excess capacity and increased competition among nursing homes to attract and retain residents. The decline in demand for nursing home care is related to the growth in residential care and assisted living facilities and the expansion of home and community based services that serve as alternatives to nursing home care.

TRENDS IN QUALITY OF CARE AND STAFFING

Literally dozens of studies by researchers, the U.S. Government Accountability Office, the U.S. Inspector General for Health and Human Services, and others have documented persistent quality problems in a sizable subset of the nation's nursing homes since the U.S. Senate Committee on Aging first began holding hearings on nursing homes in the early 1970s.[4–7] A recent GAO (2007) report found, for example, that many nursing homes have serious deficiencies and sanctions, but that states tend to under report quality problems because of weaknesses in the survey and enforcement system.[8] Often quality problems are not detected and when they are, the scope and severity of problems are underrated. Nursing homes with serious quality problems continued to cycle in and out of compliance, causing harm and sometimes death to residents.[8]

In spite of recent efforts to increase nurse staffing levels in nursing homes, the total average staffing has remained flat, at 3.6 to 3.7 hours per resident day (hprd) since 1997, and some homes have dangerously low staffing levels.[2,3] The shocking situation is that the RN staffing hours per resident day (0.6 hprd) in U.S. nursing homes have declined by 25 percent since 2000,[2,3] and this in turn has led to a reduction in nursing home quality.[9,10] The decline in staffing levels is directly related to the implementation of the Medicare prospective payment system (PPS) for nursing homes. Although Medicare rates are based on each facility's resident needs for nursing and therapy services, nursing homes are not required to provide the level of care paid for by the Medicare rates. The declining RN levels in nursing homes and chronic quality of care problems show the need for establishing higher minimum Federal staffing standards than are currently required.

Research has shown that higher staffing hours per resident, particularly Registered Nursing (RN) hours, have been positively and significantly associated with overall quality of care,[11–14] lower worker injury rates, and less litigation actions. An important study conducted by Abt Associates for CMS (2001) reported that a minimum of 4.1 hours per resident day were needed to prevent harm to residents with long stays (90 days or more) in nursing homes.[13] Of the 4.1 hprd total, 0.75 RN hours per resident day and 0.55 LVN hours per resident day are needed to protect residents from substantial harm and jeopardy.[13] At the time of the study, 97 percent of U.S. nursing homes did not meet this standard.[13] There is compelling evidence that staffing levels are a better measure of quality than the clinical quality measures that are commonly used by CMS (e.g. pressure sores).[14] Nursing homes often do not report quality measures accurately and some facilities manipulate their quality measures to increase their Medicare and Medicaid payments and/or to show higher quality scores on the Medicare public reporting system.

TRENDS IN NURSING HOMES OWNERSHIP

For-profit companies have owned the majority of the nation's nursing homes for many years and operate 66 percent of facilities compared to non-profit (28 percent) and government-owned facilities (6 percent) in 2006. Many studies have shown that for-profit nursing homes operate with lower costs and staffing, compared to non-profit facilities, which provide higher staffing, higher quality care, and have more trustworthy governance.[15–18]

Chains. For-profit corporate chains emerged as a dominant organizational form in the nursing home field during the 1990s. Chains were promoted with the idea that they would have lower operating costs than independent facilities, because they could pursue goals including efficiency and access to capital through the stock market. The proportion of chain-owned facilities increased from 39 percent in the 1990s to 51 percent of the nation's nursing homes in 1995.[19] In 1997, most chains were for-profit and relatively small (2–10 homes), operating in one or just a few states. Nursing home chains were established primarily through acquisitions and mergers of individual facilities or other chains (not new construction), and they have exerted considerable influence over the industry.[19] Chains increased to 56 percent of the total in 2001 and then declined to 52.5 percent (i.e., 8,700 facilities) of all nursing homes in 2006.[2,3]

In the late 1990s, as the nursing home industry received widespread criticism for intractable quality problems and low staffing, several large chains entered into large settlement agreements with the Federal Government for fraud and others had corporate compliance 'monitors' imposed by the Department of Justice.[20] Two common managerial practices among large nursing home chains in the 1990s were to acquire facilities with the goal of converting Medicaid beds into higher-revenue generating Medicare beds, and to adopt 'creative' financing sources including the establishment of real estate investment trusts (REITS) that own the land and/or buildings.[21]

In 2000, five of the nation's largest chains elected to operate under bankruptcy protection, involving 1,800 nursing homes.[22–25] Although it is acknowledged that

large chains suffered financially from the 1997 introduction of Medicare prospective payment system (PPS), the General Accounting Office (U.S. GAO) argued that Medicare PPS rates were 'adequate,' and that the large chains' bankruptcies stemmed from 'poor' business strategies including rapid expansion and sizeable transactions with third parties.[25,26]

For-profit nursing home chains have had lower staffing than for-profit independent facilities and non-profit chains. In 2006, U.S. for-profit nursing home chains had an average of .62 RN hrpd and total hours of 3.77. This compares to 0.60 RN hprd in for-profit independent nursing facilities and 1.08 RN hrpd in non-profit facilities in the U.S. For-profit independent nursing facilities had a total of 3.85 hrpd and non-profit facilities had a total of 4.8 hrpd. This shows that for-profit chains have 57 percent of the RN hours that non-profits provide and 78 percent of the total hours that non-profit facilities provide.[1]

Publicly-Traded Chains. The largest nursing home chains have been publicly-traded companies. My colleagues and I conducted an historical (1995–2005) case study of one of the nation's largest publicly-traded nursing home chains and we found that shareholder value was pursued by using three inter-linked strategies at the expense of quality.

First, the company began with a few facilities and grew to become one of the top five largest nursing home chains in 1998. This rapid growth was accomplished primarily by debt-financed mergers which placed a burden on the facilities to pay of their debts.[27] Second, the chain used labor cost constraint through low nurse staffing levels to increase its net income, which caused quality problems.[27] California data showed that even as the poor quality of care in the company's facilities was sanctioned by Federal corporate compliance agreements and legal actions by the state attorney general, the company maintained low nurse staffing levels, which in many cases were below the minimum level required by state law. They also had high staff turnover rates and poor quality, which was indicated by multiple deficiencies and fines for harm and jeopardy.[27] The low staffing level was a particular problem because the chain focused on admitting Medicare residents with high acuity, so that their facilities needed to have higher than average staffing levels to provide quality care, but they did not adjust staffing to reflect resident acuity.

The third managerial practice used by the company was to treat regulatory sanctions as normal costs of business.[27] The company had regulatory actions imposed by a number of states for poor quality of care as evidenced by regulatory violations (including many that jeopardized the health and safety of residents), and despite this, the facilities did not address their quality problems. Additionally, the corporate governance of the company was sanctioned through governmental actions for fraud and improper billing and shareholder legal actions were taken for misrepresentation of its financial status and lack of disclosure. These findings show the need for extended oversight of the corporate governance structure and performance of large nursing home chains.[27]

PRIVATE EQUITY PURCHASES OF NURSING HOME CHAINS

In 2006, of the 50 largest nursing home companies, 12 were publicly traded, 31 were private and 7 were nonprofit. These companies had about 30 percent of the nation's nursing home residents.[28] In 2006, the top 10 nursing home chains had 218,729 beds. Only one chain was a non-profit organization, 3 were privately-held companies and 6 were publicly-traded companies.[28] By 2007, private equity companies had purchased 6 of the largest chains (including Mariner Health Care, Beverly Enterprises, Genesis HealthCare, and ManorCare), which represented about 9 percent of the nation's nursing home beds.[29]

Private equity investment firms are those that issue and invest in securities. The companies invest the money they receive on a collective basis and investors share in the profits and losses in proportion to their investment, with no oversight by the Securities and Exchange Commission. There is no Federal requirement to report information to CMS on whether the licensee of a nursing home is owned by an investment company or by a more traditional company.

Private equity companies use strategies similar to those used by publicly-traded nursing home chains to enhance profits. Like other large nursing home chains, these companies have diversified with a range of related companies offering hospice care, residential care, rehabilitation, Alzheimer's units, outpatient therapy, home health services and other services and facilities.[28] These related companies have complex relationships with the nursing homes and the inter-relationships allow for self-referrals to related companies as a way to enhance revenues and profits.

These companies target Medicare and private payers to increase their revenues (over Medicaid with its lower rates) while they control their expenditures. With Medicare, patient acuity is higher so staffing should be higher for these residents,

and yet private equity companies, like publicly held nursing home chains, are likely to keep their staffing below the national average and to keep other costs low to enhance profits.

QUALITY AND STAFFING IN NURSING HOMES OWNED BY PRIVATE EQUITY FIRMS

The purchase of nursing homes by private equity companies raises serious questions about the staffing and quality of these facilities. To examine the staffing and quality in one chain purchased by a private equity firm in 2006, we examined 105 nursing facilities owned by the company in the 18-month period prior to its purchase compared with the period after its purchase (from 2006 through June 2007).[1] After its purchase, average RN staffing dropped by 8 percent, LVN staffing dropped by 6.5 percent, nursing assistant staffing dropped by 7.5 percent, and total nurse staffing dropped by 7 percent. After the purchase, the average RN staffing hours in the company's facilities were only 75 percent of the national average staffing hours (0.6 hrpd) and 60 percent of the minimum level recommended by experts for (.75 hrpd) for RN staffing. Total staffing hours were only 85 percent of the national average (3.7 hprd) and only 77 percent of the level recommended by experts (4.1 hrpd).[1] These facilities were substituting nursing assistants with little training for registered nurses in order to lower costs. Extensive research shows this can result in harm and jeopardy to residents.

At the same time, total deficiencies for those 105 facilities increased from over 500 to over 1,000 deficiencies after the purchase by the private equity firm. Deficiencies that caused more than minimal harm, harm, or immediate jeopardy increased by 80 percent after the purchase by the private equity firm.

Before this large publicly-traded nursing home company was purchased by a private equity company, it had a long history of quality problems as well as fraud and abuse. It was investigated and charged by the U.S. Department of Justice (DOJ) for fraud and abuse allegations and currently remains under a DOJ Corporate Integrity Agreement (CIA), because of poor quality in its nursing homes. In addition, the company had a history of poor labor relations and work place safety and has been investigated by both the National Labor Relations Board and the Occupational Safety and Health Administration (OSHA). The company has also been involved in cases of resident neglect, and entered into settlement agreements in two states and has been under investigations in five other states. This company has had some of the largest litigation awards in the U.S. by many patients for poor quality. In California, the company was sued by the CA attorney general and entered into one the largest settlements in CA history. During the past 5 years, the company's facilities have been subject to continual monitoring by California officials because of court compliance orders. It has also had a long history of providing inadequate staffing levels throughout the country and, in particular, in California. It is far from clear that the new private equity company has the necessary expertise and experience to provide oversight and to improve the quality delivered to residents by this chain.

These findings raise several concerns about the purchase of nursing homes by private equity firms. First, private equity firms do not have the expertise and experience to manage complex nursing home organizations caring for frail and seriously ill residents, and they are reliant upon the management of the nursing homes for the management of quality that was not demonstrated prior to the purchase of the chain. Second, these firms appear likely to cut staffing to increase their profits. Cutting staffing, supplies, equipment and other needed services can result in serious problems to residents and even deaths, such as in the Florida investor-owned nursing home where 15 resident deaths occurred in three years as a result of poor care.[1]

LIMITED LIABILITY CORPORATIONS

Another troubling and dramatic trend is the conversion of corporations, especially chains, into limited liability companies (LLCs). Limited liability companies (LLCs) and partnerships (LLPs) have structures similar to corporations but owners have limited personal liability for the debts and actions of the LLC. These companies are designed to limit personal liability for breaches of contracts or torts, and especially have been established in some states where litigation has been common. For example, in Florida most nursing homes are LLCs in 2007 (349 LLCs/LLPs compared with 292 nursing home corporations and 31 other types of nursing homes).[30] Separate LLCs for each nursing facility in chains that are publicly-traded or owned by private equity companies protect the parent companies from liability and limit litigation by residents and families who seek redress for poor and negligent quality of care. Another troubling new practice by nursing home chains has been to drop their liability coverage as a way to prevent or discourage litigation.

Real Estate Investment Trusts

Some private equity-owned chains and publicly-traded chains have established separate real estate investment trusts (REITS) by moving facility assets (buildings and land) into the trusts. Although some of these have been in place for a number of years, this trend appears to be accelerating with the purchase of nursing homes by private equity companies. In situations where the assets are owned by a separate entity other than the operating company, the rent or lease is fixed by a lease payment with an annual escalator. In other cases, some of the landlords have a participating rent feature that requires the tenant (lessee) to pay a portion of the increased cash flow from the business as an additional part of the rent payment. If the cash flow after payment of all facility-based expenses exceeds a certain amount, then it is shared on some basis between the group that owns the asset and the group that operates the business. These arrangements divert funds from direct care.

REITS are a concern for several reasons. The REIT may encourage an operator to cut back on staffing, food, or other expenses as a means of increasing profitability to the REIT. Second, in these arrangements, profits acquired by the REITs are largely hidden by the lease arrangements. Third, the REIT maintains the assets and thereby protects the assets from litigation actions that might be taken against the operator.

Excess Profits

Medicare PPS does not limit the profit margins that nursing homes can make. A GAO study of Medicare profit margins found that the median margins for free-standing SNFs were 8.4 percent in 1999 and increased to 18.9 percent in 2000. The 10 largest for-profit chains had margins of 18.2 percent in 1999 and 25.2 percent in 2000.[25,26] These high profit levels direct funds away from direct resident care.

For-profit nursing homes in California have significantly lower quality of care than non-profit homes based on the number of deficiencies and the number of serious deficiencies that may result in serious harm or jeopardy to residents. Our research found that nursing homes with profit levels or 9 percent or more (in the top 14 percent of homes in terms of profits) had significantly more total deficiencies and more serious deficiencies, but this relationship was not found in non-profit facilities.[16] Excess profit-taking has a dangerous negative effect on nursing home quality. Profit taking at 19–25 percent levels, reported by chains,[25,26] raises serious concerns about the dangers to residents and shows the need to monitor and limit profit levels for certified nursing homes.

Private equity firms are under no obligation to publicly report the profits they achieve from their investments, and are unlikely to report, which makes monitoring excess profit-taking difficult. Moreover, the buying and selling of pre-existing commitments to private equity (secondary market) can also occur that can make the nursing homes less financially stable. One concern is that some private investors may enter into the nursing home business for a short time period in order to extract profits and then sell, leaving the companies with fewer resources to carry out their operations, which will later compromise care.

CONFUSING OWNERSHIP AND LACK OF RESPONSIBILITY

Shielded by private equity companies, the ownership of nursing homes has now become so complex that it is increasingly difficult to identify the owners of nursing homes. For example, a review of the corporate filings to states for changes in ownership showed multiple investors, holding companies, and multiple levels of companies involved in the ownership of the nursing homes for a single chain. Many of these companies have converted the facilities to LLCs and moved the property to separate LLC property companies (i.e., REITs). This level of complexity makes it difficult to know who the owners are, who is responsible for the management and operation of the nursing homes and responsible for the management of the property and assets. The lack of transparency in the ownership responsibilities makes regulation and oversight by state survey and certification agencies problematic. It is difficult for individuals to determine who is ultimately responsible for taking care of their family members in a nursing home.

Moreover, CMS has no ownership tracking, monitoring, and reporting system for nursing homes. The CMS OSCAR report which has the licensee listed is inaccurate and incomplete. (In one case, OSCAR showed only ⅓ of the facilities that were owned by a chain compared to the chain's own website). Thus, it is extremely difficult for CMS and state survey and certification agencies to monitor the actions of chains, to track changes in ownership, and to conduct evaluations of companies applying for certification as new owners. CMS and state evaluations of the appropriateness of new ownership applications are even more difficult with private equity companies which have no prior track record in providing nursing home care.

AREAS FOR OVERSIGHT

Three major areas need to be addressed by Congress: (1) adequate nurse staffing levels in nursing homes and electronic reporting of staffing data; (2) transparency and responsibility in ownership, and (3) increased financial accountability for government funding of nursing homes.

STAFFING

Staffing Standards. Unfortunately, the Centers for Medicare and Medicaid Services has not established minimum federal staffing standards that would ensure that nursing homes meet the 4.1 hours per resident day (hprd) recommended by researchers and experts,[13,14,31] mostly because of the potential costs. Considering that most nursing homes are for-profit and have significantly lower staffing and poorer quality of care than non-profits, these facilities are unlikely to voluntarily meet a reasonable level of staffing. If staffing levels are to improve, minimum federal staffing standards are needed.

Accurate Quarterly Electronic Staffing Reports. The current CMS reporting system, which only requires nursing homes to report on 2 weeks of nurse staffing at the time of the annual survey, is inadequate and sometimes inaccurate.[13] These reports are not audited and are collected during annual state surveys when nursing homes often temporarily increase their staffing. Nursing homes should be required to make complete reports of staffing hours for all types of staff and for total staff for each shift on a daily basis from **payroll records** to ensure accuracy. These should be required to be submitted to CMS by nursing homes on a **quarterly** basis, using a standard **electronic** reporting format. Nursing homes should certify the accuracy of their reports under penalty of serious fines. Staff turnover and retention rates are also important indicators of quality which should also be extracted and reported from payroll data of nursing homes. CMS has developed the capacity to collect and report this data so Congress should mandate the reporting.

Staffing data can be used for two purposes. First, it is needed to monitor staffing levels and to investigate facilities that have lower staffing or that show substantial declines in staffing. This allows for better oversight of facilities that may cut staffing and then develop quality problems. Second, it will improve the accuracy of the staffing that is publicly reported on *www.Medicare/NHcompare.gov*. Providing consumers with information about quality of care is an important way to give consumers more power in making informed decisions about nursing home care.

Detailed Deficiency Reports. Low staffing and high turnover results in poor quality. CMS should be reporting the detailed survey agency deficiency reports (Form 2567) on its Medicare nursing home compare website. These reports provide clearer information on the types of violations and the quality of care for residents than the summary information currently reported by CMS on Medicare nursing home compare website.

OWNERSHIP TRANSPARENCY AND RESPONSIBILITY

The complex new ownership relationships, particularly those established by private equity firms, need to be taken into account to increase the transparency and responsibility of facilities for the quality of care and the financial liabilities of the facilities. All owners including all private equity companies and investors should be annually reported to CMS for certification by Medicare and Medicaid. All related parties with direct and indirect financial interests in a nursing facility should be identified to CMS and disclosed to the public on the Medicare nursing home compare website. The parent companies, the operators of nursing homes, and all the multiple companies including the real estate investment trusts that have an interest in the nursing home should be responsible for nursing home care. One approach is to require these parties to sign the Medicare/Medicaid provider agreements, which should be renewed annually. CMS should refuse to sign the annual provider agreements where nursing facilities and their parent companies have been involved in causing harm or jeopardy to residents or found to be involved in fraud and abuse.

CMS needs to establish an accurate and timely ownership tracking, monitoring, and reporting system for nursing homes, which should include all parties involved in the operation of each nursing home and their owners including private equity companies and REITs. CMS and state survey and certification agencies need to monitor the actions of nursing homes, to track changes in ownership, and to conduct evaluations of companies applying for certification as new owners.

Another option is to require a surety bond to be posted by each nursing facility operator. The bond would ensure that facilities pay for civil monetary penalties, fines, temporary managers or receivers, attorney fees, litigation judgments and damage awards. This would also address the increasing problem of nursing facilities that do not carry liability insurance.

FINANCIAL ACCOUNTABILITY

The National Health Statistics Group at the Centers for Medicare and Medicaid Services (CMS) estimated that the U.S. will spend $132 billion on nursing home care in 2007 (excluding counting care in hospital based facilities).[32] Of the total nursing home expenditures in 2005, 16 percent was paid by Medicare and 46 percent was paid by Medicaid and other public programs.[33] Moreover, government is paying for 78 percent of all residents at any given point in time.[2] Because government is paying an increasingly large proportion of the total nursing home costs, it is important that nursing homes be more fully accountable for the public funds they receive.

Medicare developed a complex and elaborate system for establishing its PPS nursing home payment rates, but requires little financial accountability. As noted above, under Medicare PPS, nursing homes do not need to ensure that the amount of staff and therapy time is equal to the amount that is allocated under the Medicare rates. Moreover, nursing homes are not required to spend a specific proportion of their funds on direct and indirect care to assure quality. This is also the case in many states under Medicaid payment rules. Since the adoption of Medicare PPS, RN staffing levels have declined by 25 percent and quality of nursing home care has declined.[2,3] Because Medicare does not limit nursing home profit margins, facilities have an incentive to cut staffing and expenses to increase profits.

Cost Centers. One approach to make nursing homes more financially accountable under Medicare PPS systems is to establish cost centers. Four general cost centers could be established for reporting purposes: (1) direct care services (e.g. nursing, activities, therapy services), (2) indirect care (including housekeeping, dietary, and other services), (3) capital costs (e.g. building and land costs), and (4) administrative costs. Medicare should determine prospectively the amount of funds allocated for each of these costs centers. Nursing homes should be required to report by cost center and they should be prevented from shifting Medicare funds from direct and indirect services to pay for administrative costs, capital costs, or profits. Reports on profits from all parts of the nursing facility's operation should be disclosed, including profits on the real estate and buildings (REITs) and other related parties.

Audits. To ensure that the reimbursement rates are used for the intended purposes, retrospective audits should be conducted to collect Medicare and Medicaid funds not expended on direct and indirect care. Penalties should be issued for diverting funds from direct and indirect services.

Summary

In summary, the growth in nursing home chains and the purchase of chains by private equity companies represents a substantial threat to quality of care in nursing homes. Current nurse staffing levels are not adequate to ensure high quality and private equity companies may cut staffing further to increase profits. In nursing homes, the decline in registered nurses and the failure to improve staffing shows the need for greater regulatory standards and incentive systems. As ownership has become more complex with private equity companies that do not have the same reporting requirements as publicly-held companies, steps must be take to assure ownership transparency and responsibility. Finally, greater financial accountability is needed to ensure that Medicare and Medicaid funds are spent on direct and indirect care and not diverted to paying for real estate, administration, and profits. We must ensure that nursing homes deliver high quality of care for our family members, friends and ourselves when we need such care.

References

1. Harrington, C. and Carrillo, H. 2007. Analysis of On-Line Survey Certification and Reporting data from the Centers for Medicare and Medicaid Services. San Francisco, CA: University of California, November.

2. Harrington, C., Carrillo, H., and Woleslagle, B. 2007. *Nursing Facilities, Staffing, Residents, and Facility Deficiencies, 2000–06.* San Francisco, CA: University of California. **www.nccnhr.org.**

3. Harrington, C., Carrillo, H., Wellin, V. and Shemirani, B.B. 2002. *Nursing Facilities, Staffing, Residents, and Facility Deficiencies, 1995 Through 2001.* San Francisco, CA: University of California. **www.nccnhr.org.**

4. U.S. Senate Special Committee on Aging. 1973–74. Special Hearings on Nursing Homes. Washington, DC: U.S. Senate.

5. U.S. General Accounting Office (GAO). 1987. Report to the Chairman, Subcommittee on Health and Long-Term Care, Select Committee on Aging, House of Representatives. *Medicare and Medicaid: Stronger Enforcement of Nursing Home Requirements Needed.* Washington, DC: U.S. GAO.

6. U.S. General Accounting Office. 2000. *Nursing Homes: Sustained Efforts Are Essential to Realize Potential of the Quality Initiatives—Report to the Special Committee on Aging, U.S. Senate. GAO/HEHS–00–197*. Washington, DC: General Accounting Office.

7. U.S. General Accounting Office. 2003. *Nursing Homes Quality: Prevalence of Serious Problems, While Declining, Reinforces Importance of Enhanced Oversight—Report to Congressional Requesters GAO–03–561*. Washington, D.C.: General Accounting Office.

8. U.S. Government Accountability Office. 2007. *Nursing Homes: Efforts to Strengthen Federal Enforcement Have Not Deterred Some Homes from Repeatedly Harming Residents.* GAO–07–241. Washington, D.C.: GAO.

9. Konetzka, R.T., Yi, D., Norton, E.C., and Kilpatrick, K.E. 2004. Effects of Medicare Payment Changes on Nursing Home Staffing and Deficiencies. *Health Services Research.* 39 (3):463–487.

10. Konetzka, R.T., Norton, E.C., Sloane, P.D., Kilpatrick, K.E. and Stearns, S.C. 2006. Medicare Prospective Payment and Quality of Care for Long-stay Nursing Facility Residents. *Medical Care.* 44 (3):270–6.

11. Institute of Medicine (IOM), Wunderlich, G.S. and Kohler, P., Eds. 2001. *Improving the Quality of Long-Term Care.* Washington, DC: National Academy of Sciences, IOM.

12. Institute of Medicine. 2003. *Keeping Patients Safe: Transforming the Work Environment of Nurses.* Washington, DC: National Academy Press.

13. U.S. Centers for Medicare and Medicaid Services, Prepared by Abt Associates Inc. *2001. Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes. Report to Congress: Phase II Final.* Volumes I–III. Baltimore, MD: CMS.

14. Schnelle, J.F., Simmons S.F., Harrington, C., Cadogan, M., Garcia, E., and Bates-Jensen, B. 2004. Relationship of Nursing Home Staffing to Quality of Care? *Health Services Research.* 39 (2):225–250.

15. Harrington, C., Woolhandler, S., Mullan, J., Carrillo, H., & Himmelstein, D. 2001. Does Investor-Ownership of Nursing Homes Compromise the Quality of Care? *American Journal of Public Health.* 91, 1452–1455.

16. O'Neill, C., Harrington, C., Kitchener, M., & Saliba, D. 2003. Quality of Care in Nursing Homes: An Analysis of the Relationships Among Profit, Quality, and Ownership. *Medical Care*, 41, 1318–1330.

17. Schlesinger, M. and B.H. Gray. 2005. *Why Nonprofits Matter in American Medicine: A Policy Brief.* Washington DC: Aspen Institute.

18. Harrington, C., Zimmerman, D., Karon, S.L., Robinson, J., and Beutel, P. 2000. Nursing Home Staffing and Its Relationship to Deficiencies. *The Journal of Gerontology: Social Sciences.* 55B (5):S278–286.

19. Banaszak-Holl, J., W.B. Berta, D. Bowman, J.A.C. Baum, and W. Mitchell. 2002. The Rise of Human Service Chains: Antecedents to Acquisitions and Their Effects on the Quality of Care in U.S. Nursing Homes, 1991–1997. *Managerial and Decision Economics.* 23:261–282.

20. Kitchener, M., and C. Harrington. 2004. U.S. Long-term Care: A Dialectic Analysis of Institutional Dynamics. *Journal of Health and Social Behavior* 45 (Extra issue): 87–101.

21. Lehman Brothers. 2004. *2004 Health Care Facilities: Long-Term Care Industry Guidebook.* January 29. New York: Lehman Brothers.

22. Kitchener, M., O'Neill, C. and Harrington, C. 2005. Chain Reaction: An Exploratory Study of Nursing Home Bankruptcy in California. *Journal of Aging and Social Policy.* 17 (4):19–35.

23. American HealthCare Association (AHCA). 2002. *Facts and Trends: The Nursing Facility Sourcebook*. Washington DC: AHCA.

24. U.S. Centers for Medicare and Medicaid Services, Scully, T. 2003. *Health Care Industry Market Update. Nursing Facilities.* Washington, DC: CMS, May 20.

25. U.S. General Accounting Office. 2000. *Nursing Homes: Aggregate Medicare Payments Are Adequate Despite Bankruptcies.* Testimony Before the Special Committee on Aging, U.S. Senate. GAO/T–HEHS–00–192. Washington, DC: U.S. General Accounting Office, September 5.

26. U.S. General Accounting Office. 2002. *Skilled Nursing Facilities: Medicare Payments Exceed Costs for Most but Not All Facilities.* Report to Congressional Requestors. GAO/HEHS–03–183. Washington, DC: General Accounting Office, December.

27. Kitchener, M., O'Meara, J., Brody, A., Lee, H.Y., Harrington, C. 2007. Shareholder Value and the Performance of a Large Nursing Home Chain. *Health Services Research.* In press.

28. LaPorte, M. 2007. ManorCare Soars Above the Pack by 18,000 Beds. Top 50 Nursing Facility Chains 2006. *Provider.* 33–41.

29. Duhigg, C. 2007. At Many Homes, More Profit and Less Nursing. *New York Times.* September 23, A1–A20, A21.
30. Florida Agency for Health Care Administration (FAHCA) 2007. Long Term Care Review: Florida Nursing Homes Regulation, Quality, Ownership, and Reimbursement. Tallahassee, FL: AHCA. https://exchange.ucsf.edu/exchange/Charlene.Harrington/Inbox/FW:%20Today%27s%20New%20York%20Times%20Article.EML/1_multipart_xF8FF_4_Florida%20Agency%20White%20Paper%2010-30-07.pdf/C58EA28C-18C0-4a97-9AF2-036E93DDAFB3/Florida%20Agency%20White%20Paper%2010-30-07.pdf?attach=1
31. Harrington, C., Swan, J.H., and Carrillo, H. 2007. Nurse Staffing Levels and Medicaid Reimbursement Rates in Nursing Facilities. *Health Services Research.* 43 (3):1105–1129.
32. Poisal, J.A., Truffer, C., Smith, S. et al and the National Health Expenditure Accounts Team. (2007). Health spending projections through 2016: modest changes obscure Part D's impact. *Health Affairs.* 26 (2):w242–w253.
33. Catlin, A., Cowan, C., Heffler, S., Washington, B. and the National Health Expenditure Accounts Team. (2007). National health spending in 2005: the slowdown continues. *Health Affairs.* 26 (1):142–153.

Mr. STARK. Mr. Schnelle, how is that?

Mr. SCHNELLE. Schnelle, actually.

Mr. STARK. Schnelle. Okay. I am getting pretty close. Professor Schnelle, would you proceed?

STATEMENT OF JOHN SCHNELLE, PROFESSOR OF MEDICINE AND DIRECTOR, VANDERBILT CENTER FOR QUALITY AGING, VANDERBILT UNIVERSITY

Mr. SCHNELLE. Thank you. I am a behavioral psychologist.

Mr. STARK. But you got to punch the button on your microphone.

Mr. SCHNELLE. Excuse me. I am a behavior psychologist at Vanderbilt University with a special interest in nursing home care quality and analyzing the factors that control provider and consumer decisions about care quality. I have worked directly with nursing home residents and staff for over 30 years to document staff labor costs and outcomes when care is provided consistent with regulatory guidelines. This experience, as well as my daily interaction with licensed nurses, and aides have led me to the conclusion that there are not enough staff to provide all the care mandated in regulatory guidelines, and that furthermore incentives exist that prevent realistic solutions to this problem at both the provider and regulatory level.

The major points to be made in my presentation is that the minimum staffing requirements to implement the basic care described in regulatory guidelines is five to six residents per nurse aide during waking hours even if one assumes very high staff productivity.

The acuity level of at least long-term stay residents, how sick they are, do not dramatically change these minimum staffing levels. They do change maximum, but not the minimum. Most nursing homes are staffed significantly below this minimum level to provide the basic care. But here is the important point about incentives. The measures most sensitive to staffing levels in nursing homes are quality of life measures that can only be collected by directly talking to residents and staff or observing care delivery.

Examples of such measures include asking incontinent residents deemed capable of interview how many times someone helps them

to the toilet. The further removed we are as researchers, surveyors or owners have from the daily care being provided within the facility, the more likely we are to underestimate the effects of staffing on resident life quality and staff productivity.

In the case of owners, there may be incentives for facility managers to reduce one of their higher operating costs, which is staffing, under the false premise that this reduction will not impact care quality. This latter point is perhaps the most relevant to the purpose of today's hearing. My original report on the relationship between staffing and quality was published in 2001 by CMS. We used computerized simulation methods that are used in business and industry and the best data available about how much time it takes to actually take somebody to the bathroom and do other basic care.

We used very conservative estimates of productivity—or very liberal estimates of productivity. We assumed very high productivity among the nursing home staff. Despite our evident to be very conservative, we came up with the number that you need five to six residents per aide to provide all the care that is in regulatory guidelines. The typical nursing home is staffed at eight to ten residents per one aide. We projected, there would be very many people who would do without basic care, getting out of bed in the morning, given adequate feeding assistance at those ratios. The worse the ratios, the much worse it became because of efficiency reasons. This study has been validated several times by direct observations. We have gone into nursing homes in California specifically who are staffed high and staffed low. Most of the ones staffed high are either 100 percent private pay or for-profit—or not for profit, and we found that in the higher staffed homes that they do significantly better on 16 out of 18 process measures, like how often patients are talked to, the tender loving care that you were talking about.

However, what they don't do better on necessarily are Minimum Data Set quality indicators that are widely used to measure quality. These indicators are heavily influenced by resident frailty and sickness burden. Nursing home residents, in our experience, get acutely sick about twice a year, can dramatically affect their functioning. Basically, even a well-managed home might not do well on those indicators.

In a recent study by Mukamel and her associates, even the providers who generate the information for the quality indicators rated resident acuity and coding errors as more influential in affecting these quality indicators than the actual care provided by staff. There are controversial arguments about the validity of measures used to monitor nursing home quality, but it is clear to me that important differences in residents' quality of life due to staffing differences would be missed if one relies solely on quality indicators generated by providers or even survey deficiencies. There are numerous important implications from a behavioral point of view relevant to how provider behavior is affected by the fact that staffing is much more related to the care that the residents receive, such as dining and toileting assistance, than MDS quality indicators or deficiency measures.

However, I think the most important incentive that exists is that people who are not in direct contact with the daily life of residents

may make business decisions to reduce staffing based on false data. Arguments could always be made to justify a lower staffing through improvements in work efficiency and good leadership or training, and on site administrators can be easily misled by incentives to make staffing reductions based on these false arguments. These cost control incentives are not inappropriate. Any good business would do them. But any good business has to do them based on accurate data about what their consequences are on care. I don't think there is accurate data about what consequences they have on care. We reported in several reports that data recorded about nursing home daily care activities, how often people are toileted, how much feeding assistance they got are not accurate. They are not accurate because these records are used for compliance purposes rather than improvement purposes, and if you record things for compliance purposes, the goal is to make everything look good. It is not to identify problems for improvement. In defense of nursing homes, I think they are put into an unrealistic state where what their expectations for care exceeds what their resources are for care, and they are more or less forced into the situation where compliance has to be the goal of these records. But the consequence of this is simple to me.

If people who are removed from the daily reality of nursing home care are making the staffing decisions based on these data, they might make decisions to reduce staffing that are wrong from a business and quality perspective, but will not be detected by the measures that currently exist. The possibility of such poor staffing decisions may increase due to the nature of the equity company or organizational structures that are the focus of today's hearing because there may be more people who do not have personal experience with the realities of nursing home care making these financial decisions.

I say "may" because to be quite frank, I have read all this, and I have a very hard time understanding the structure of the equity companies. So, at least there seems to me the potential for that to exist. What is the solution? There are two ways to immediately address the issue, I think, make transparent and accurate nursing home reports of staffing level and costs both at the facility and the chain level, and allow consumers easy access to this data. I think improving the accuracy and objectivity of the survey process and documenting care quality problems at the resident level, how often they are toileted, how often they are talked to, how much time they spend in bed would get at quality measures that currently are being missed and ignored. Thank you.

Mr. STARK. Thank you very much.

[The prepared statement of Mr. Schnelle follows:]

Prepared Statement of John Schnelle, Ph.D., Professor of Medicine and Director of the Vanderbilt Center for Quality Aging, Vanderbilt University, Nashville, Tennessee

I am Dr. John Schnelle, Director of the Center for Quality Aging and Professor of Medicine at Vanderbilt University. I am a behavioral psychologist with special interests in nursing home care quality and analyzing the factors that control provider and consumer decisions about care quality. I particularly appreciate the opportunity to talk about staffing and quality in nursing homes.

I have worked directly with nursing home residents and staff for over 30 years to document the staff labor costs and resident outcomes when care is provided con-

sistent with regulatory guidelines and best practice recommendations. This experience, as well as my daily interaction with licensed nurses, nurse aides and residents, has led me to the conclusion that there are not enough staff to provide all of the care mandated in regulatory guidelines and that incentives exist that prevent realistic solutions to this problem at both the provider and regulatory level.

Both nursing home residents and direct care staff would reiterate this same message about the inadequacy of existing staffing levels if given the opportunity to do so in a non-threatening context. It is my goal today to give voice to their concerns about staffing limitations and how low staffing affects their ability to provide quality care to residents and residents' associated quality of life. The major points to be made in this presentation are the following:

1. The ***minimum*** staffing requirements to implement the basic care described in regulatory guidelines is 5–6 residents per nurse aide during waking hours even if one assumes very high staff productivity.
2. The acuity level of long-stay residents do not dramatically change these minimum staffing requirements; thus, most nursing homes are staffed significantly below the minimum levels to provide basic care for all residents in need.
3. The measures most sensitive to staffing levels are quality of life measures that can only be collected by talking directly to residents and staff or observing care delivery. Examples of such measures include asking incontinent residents deemed capable of interview how many times each day someone helps them to use the toilet or observing feeding assistance care provided during meals for residents at risk for unintentional weight loss. The further removed we are as researchers, surveyors or owners from the daily care being provided within a facility the more likely we are to under estimate the effects of staffing on resident life quality and staff productivity. In the case of owners, there may be incentives for facility managers to reduce one of their highest operating costs, which is staffing, under the false premise that this reduction will not impact care quality. This latter point is perhaps the most relevant to the purpose of today's hearing.

My original report on the relationship between staffing and quality was published in a 2002 report for CMS.[1] In this report, we identified from research studies the time required to implement incontinence care, dining assistance, exercise and repositioning for pressure ulcer prevention to all residents who were rated by nursing home staff as needing such assistance. We used computerized simulation technology to model an unrealistically high productivity work environment and predicted the number of staff needed to consistently provide care in all of these daily care areas at the frequency and intensity necessary to produce positive clinical outcomes (e.g., lower the prevalence of incontinence). We were conservative in our estimates of the time to provide care (e.g. 18 minutes per meal for people who needed dining assistance) and optimistic in our projections of how productive staff could be in a work environment that is characterized by high staff turnover and poor organization in daily work processes. Despite our effort to project staffing needs under the best of circumstances, we determined that from 2.9 direct care (nurse aide) hours per resident per day (in a home with a low number of dependent residents) to 3.1 direct care (nurse aide) hours per resident per day (in a home with a high number of dependent residents) was minimally necessary to provide good care. These numbers translate into a direct care (nurse aide) staffing ratio of about 5–6 residents to one nurse aide. In homes staffed at the average level for the nation's facilities we were also able to project how many residents would not receive care. These findings showed that in homes staffed at a level of 8 residents to one aide (a typical ratio) 20% of residents dependent on staff for eating would not receive assistance at all meals. The number of residents who would not receive assistance in many basic daily care areas increased dramatically as staffing decreased further.

These staffing and care quality projections have been validated in recent studies wherein independent research staff assessed staffing levels and the quality of daily care delivery.[2] These studies compared care quality measures between facilities staffed above the minimum levels (2.9–3.1 hours per resident/day) and facilities staffed below these levels (2.1–2.3 hours per resident/day). Results showed that the higher staffed facilities provided significantly better care based on 13 of 16 care process measures. For example, residents in the higher staffed homes received significantly more dining assistance, exercise, and spent more time out of bed during the day.[3] In addition, residents in higher staffed homes also reported that they received more toileting and mobility assistance and had more choices about meals.

While these daily care process measures showed significant differences between low and high staffed homes, it is important to note that research also shows there are not large differences in Minimum Data Set defined quality indicators (e.g., prev-

alence of incontinence) between low and high staffed homes. These MDS indicators reflect clinical outcomes for the resident population within a facility and currently are being used to monitor nursing home care quality. Unfortunately, these indicators are heavily influenced by resident frailty and sickness burden and thus relatively insensitive to the quality of care provided by even the best homes. In a recent study by Mukamel and her associates, even the providers who generate the information for the quality indicators rated resident acuity and coding errors as more influential in affecting these quality indicators than the actual care being provided by staff.[4]

There are controversial arguments to be made about the validity of measures used to monitor nursing home care quality, but it is clear that important differences in residents' quality of life due to staffing level differences would be missed if one relied solely on quality indicators generated by providers or even survey deficiencies. Survey deficiencies have been documented in several reports by the GAO and CMS to be inaccurate and inconsistent and one must ask the question why the quality of care problems frequently documented by research teams is frequently not detected in the survey process.[5] A recent study by CMS evaluating the survey process has been conducted to help answer this question and points to directions for improving survey accuracy and consistency. A more objective and realistic survey process would be an important step to both improving the ability of providers to provide better care and the sensitivity of the survey in documenting quality differences between homes. This study is under review and will be released soon.

There are numerous important implications relevant to how provider behavior is affected by the fact that staffing is much more related to the care that residents receive, such as dining and toileting assistance, than to the MDS-defined indicators and deficiency measures widely used to judge nursing home care quality. However, one of the most important implications is that people who are not in direct and frequent contact with residents and staff and who are insulated from their concerns about quality may believe that staffing can be reduced without affecting quality. In fact, staffing reductions from already low levels that exist in most homes may not be reflected by poorer quality indicator scores because many indicators are uniformly poor due to low staffing and it would be difficult to make them worse by reducing staffing even further. The most obvious example of this phenomenon is for incontinence quality indicators. These indicators show that 80 plus percent of residents dependent on staff for toileting assistance are incontinent despite the fact that many could be continent if provided consistent toileting assistance. Residents have been observed to receive an average of only 1 to 2 assists to the toilet per day which is not adequate to maintain continence.[6] Low staffing levels according to both direct care staff interviews and independent observations of care provision explain the low toileting assistance rate and the fact that the number of residents incontinent could not get much worse if staffing were reduced even further. However, further staffing reductions would result in even fewer residents receiving care considered basic for dignity and quality of life.

It would be a logical yet misguided business decision to reduce costs by reducing staffing because quality measures heavily influenced by factors other than the quality of care actually received by residents and which are uniformly poor do not dramatically change. Arguments can always be made to justify lower staffing through "improvements in work efficiency" and "good leadership or training"; and, on-site administrators can be easily misled by incentives to make staffing reductions based on these false arguments. Such cost control incentives are already prevalent in the nursing home industry and they are not necessarily inappropriate. However, we do not know to what extent these incentives are effective or appropriate because we do not have accurate measures of the impact of staffing decisions on the quality of care residents actually receive in daily care practice.

Unfortunately, a strong argument can be made that these accurate measures are not available.[7,8] One consequence of this is that there is a risk that decision makers who are under financial pressure and who are removed from the daily reality of nursing home care will design incentives to induce operators to reduce staffing costs which are wrong from both a business and quality perspective. The possibility of such poor staffing decisions may increase due to the nature of the equity company organizational structures that are the focus of today's hearing because there may be more people who do not have personal experience with the realities of nursing home care making these financial decisions. This can only lead to inappropriate and misguided decisions to reduce costs by reducing staffing and lead to even poorer care quality for many elderly residing in our nation's nursing homes. There are two ways to immediately address this issue:

1. Make transparent and accurate nursing home reports of staffing levels and costs at both the facility and chain level and allow consumers easy access to these data. The preliminary work to allow for such a staff reporting system has been largely done and awaits implementation.
2. Improve the accuracy and objectivity of the survey process in documenting care quality problems, particularly problems created by low staffing levels. The protocols used by survey staff to improve their documentation of the care that residents actually receive also could be used by providers to judge the effects of staffing decisions if these protocols meet basic specificity criteria that would allow for their replication. Some of these protocols have been developed and currently are being evaluated for use by surveyors.

References:

1. Schnelle JF, Simmons SF, Cretin S. Minimum Nurse Aid Staffing Required to Implement Best Practice Care in Nursing Homes. Chapter in Report to Congress: Phase II Final. Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes. Prepared by Abt Associates, Inc. Cambridge, MA. December 2001. Volume I, Chapter 3. p3.1–3.67.

3. Bates-Jensen B, Schnelle J, Alessi CA, Al-Samarrai NR, Levy-Storms L. The Effects of Staffing on In-Bed Times Among Nursing Home Residents. *J Am Geriatr Soc* 2004; 52:931–938.

4. Mukamel D, Spector W, Zinn J, Huang L, Weimer D, Dozier A. Nursing Homes' Response to the Nursing Home Compare Report Card. *Journal of Gerontology* 2007; 62B (4)S218–S225.

5. Louwe H, Parry C, Kramer A, Feuerberg M. Improving Nursing Home Enforcement: Findings From Enforcement Case Studies. UCDHSC, Division of Health Care Policy and Research. CMS Report March 22, 2007.

6. Schnelle JF, Cadogan MP, Yoshii J, Al-Samarrai NR, Osterweil D, Bates-Jensen BM, Simmons SF. The Minimum Data Set Urinary Incontinence Quality Indicators: Do They Reflect Differences in Care Processes Related to Incontinence? *Medical Care* 2003; 41(8):909–922.

7. Schnelle JF, Osterweil D, Simmons SF. Improving the Quality of Nursing Home Care and Medical Record Accuracy with Direct Observational Technologies. *The Gerontologist* 2005; 45(5):576–582.

8. Schnelle JF, Continuous Quality Improvements in Nursing Homes: Public Relations or Reality? *JAMDA.* 2007; 8(1):S2–S5.

Mr. STARK. General Johnson?

Mr. JOHNSON. That was a perfect pronunciation of my name, by the way.

Mr. STARK. All right. Good.

STATEMENT OF SCOTT JOHNSON, SPECIAL ASSISTANT ATTORNEY GENERAL, STATE OF MISSISSIPPI

Mr. JOHNSON. First, let me extend greetings from my boss, the Honorable Jim Hood, Attorney General for the State of Mississippi. I appreciate being here today. I have worked as a Special Assistant Attorney General, especially when I was Director of the Medicaid Fraud Control Unit in our office, closely with our Mississippi State Department of Health. The State Department of Health is the entity in Mississippi which inspects nursing homes and which levies fines for misconduct found, substandard conduct, and also levies penalties for deficiencies until such time as those deficiencies are corrected.

I am here today to testify about the potential dangers associated with undercapitalization of nursing homes, specifically with respect to the growing trend of ownership by private equity firms and the subsequent divestiture of assets. To make that clear to the Subcommittee what that means is that we have a situation or trend going on where the nursing home licensee, the entity who is re-

sponsible for possibly or would be responsible for a fine or a penalty levied by the State regulator, is divesting itself of assets. In other words, it exists in name only because it is selling off its real estate holdings, possibly its equipment, and any other tangible assets that it has to various limited liability companies.

Now what are you left with then when a potential creditor and I say creditor, the State, when it is owed money, is a creditor just like a plaintiff that has got a successful judgment would be a creditor. What are you left with when attempting to collect these fines or penalties? Well, what we have found in Mississippi is there has been a sufficient income stream to date from Medicare and Medicaid payments.

In Mississippi, we have a lag time that is up to 90 days on the time in which from services being rendered to services being paid by Medicare or Medicaid to the providers. Therefore, if we have levied a fine or penalty, we have a hammer of being able to come in and collect that money. We can intercept the money, in other words.

So, we don't have a problem at this point. Where we would have a problem is if there was a situation where there were fines or penalties which exceeded the amount of money which was due from Medicaid or Medicare. In other words, if the fine that was levied or the penalties that were levied exceeded the income stream. Well, then what are we left with to be able to collect the funds from? This is what plaintiffs, this is what plaintiffs who have obtained successful judgments, this is the situation they find themselves in. Our primary concern as a State regulator is to make sure that the nursing homes are operating at at least minimal—or providing at least minimal—standards of care.

So, we come in and we are looking at the baseline. You know, some of the other people at this table, or I guess the other people at this table are, you know, looking above the baseline, trying to improve, as we should as a society because either we are going to die or we are all going to become elderly. We know we ought to look out for the present elderly and look out for ourselves in the future also.

So, as a State regulator, we come in and we look and make sure there is a maintenance of minimal standards. Our then primary concern is if we assess a penalty or a fine, can we collect that penalty or fine? Now, if for whatever reason the income stream is not sufficient to extinguish levied penalties or fines there are some options that could be taken. One would be the assets of the nursing home. This is what we had in the past. You could place a lien on the actual assets of the home. Another option would be that each individual home could be bonded for an amount sufficient to cover any penalties or fines that were levied. A third option would be insurance, which would cover civil or regulatory penalties.

Now the problem with, when I mentioned the first alternative of levying a lien—or placing a lien, I should say, on the assets of a corporation—with the trend that we are seeing, there are no assets of the corporation. You cannot place a lien on something that does not exist. So, in this complex—the other thing that I believe the Subcommittee should consider is with the complex corporate structures that routinely exist—there is no way to follow the assets.

There is a concept in law called piercing the corporate veil. In the paper that I provided I set out—I didn't do a national survey because it was time-prohibitive—but in Mississippi, there are four ways that you can go after assets that have been divested from a corporation.

The only one that would potentially be available in this context, in my opinion, would be if you could show the assets were fraudulently divested, in which you would have to be able to show—the State regulator would have to be able to show, or any other creditor—that the assets were conveyed for a less than fair market value. That is almost impossible to do with nursing homes because nursing homes are not fungible entities. How do you prove the value; how do you prove that the assets were conveyed for less than a fair market value? It would be very tenuous to do so.

One last point I want to make clear is I am here speaking on behalf of State regulators, and not the plaintiffs' bar. The reason that there is an extreme dichotomy between the two is the State regulator, we, our job is to identify misconduct and to attempt to, through remedial action, correct that misconduct, or to identify deficiencies and put the nursing home on notice of those deficiencies. And say for example, you have got a door: Alzheimer's patients are being able to escape out through the door; one is eventually going to get hit by an automobile; fix the door. If you don't, we are going to fine you so much per day. The cost associated with regulatory agencies as levied against nursing homes is a very small fractional amount when you look at it in comparison to what the cost of the potential harm is. For example, if the person escapes from the nursing home because of a problem with the door, we come in and levy a relatively small fine. What happens with the person who has eloped when they do get hit by the automobile? That is an issue that I am not able to address today. I would just point out that comparing what we do as regulators to what people do—what we do in trying to prevent harm, versus the recoupment of payment to make someone whole for having suffered harm is not comparing apples to oranges, it is comparing grapes to watermelons. Thank you.

[The prepared statement of Mr. Johnson follows:]

POINTING THE FINGER AT GHOSTS

Potential Dangers Associated with Undercapitalization of Nursing Homes

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(Note: This paper would not have been possible, but for the time and efforts of Special Assistant Attorney General Lisa Blount and Legal Intern Rita Silin.)

My name is Scott A. Johnson, and I have been employed as a Special Assistant Attorney General with the State of Mississippi for over six (6) years. I currently serve as Trial Counsel for the different Divisions and assist in litigation in various contexts. In my tenure at the Attorney General's Office, I have served as Antitrust Counsel, Director of the Medicaid Fraud Control Unit and Director of the Public Integrity Division (of which the Vulnerable Adults Unit is a subdivision). Prior to accepting employment with the Attorney General's Office, I had been engaged in the practice of law in the private sector since September of 1993.

As Director of the Medicaid Fraud Control Unit, I became familiar with the inspection process of nursing homes administered by the Mississippi Department of Health and its ability to levy and collect fines for substandard performance. Nursing homes in rural states comprise only a small fraction of the approximately 17,000 nursing homes currently operating in the United States. For example, Mississippi now has a total of two hundred and one (201) nursing homes, with the majority of its eighty-two (82) counties having only one home. Accordingly, a geographical monopoly of sorts exists with respect to availability of nursing home care within a sixty-plus mile radius. In the absence of vigorous regulatory practices (i.e., the inspection of homes, and the levying and **collection** of fines) such as those employed by the Mississippi Department of Health, family members of a resident could easily be confronted with the choice of leaving a loved one in a conveniently located, but substandard home, versus moving the resident to a superior but distant facility.

Prior to beginning my discussion of the inherent dangers associated with the proliferation of nursing home ownership by private equity firms (in the absence of adequate and available income

streams, as discussed hereafter), I am reminded of a prediction made in the late 1960's by Melvin Belli, one of America's preeminent trial lawyers, that went something like this: With enough research, time and expense, scientists could figure out how to develop a self-contained, mobile telephone and, further, they could also figure out how to make amputated limbs regenerate. Mr. Belli went on to explain, however, that while we could expect the mobile phone within the relatively near future, the regenerative limb would probably remain confined to the realm of science fiction. Why? Because even forty years ago, Mr. Belli realized that almost everyone could benefit from the convenience of a mobile phone and would be willing to pay for it. Whereas, to the contrary, the world only has a finite number of amputees, with limited buying power. **In the absence of premature death, we are all going to get old, and the majority of us will require long-term health care in a residential setting.** It is, therefore, time to look past the horizon to adopt and put into practice any remedial actions which are necessary to protect our elderly loved ones today and ourselves tomorrow.

Example of Common Mississippi Nursing Home Corporate Structure

An example of a nursing home in Mississippi owned by a private equity firm is Trinity Mission Health & Rehab of Holly Springs in Holly Springs, Mississippi. For ease of discussion, I am providing its corporate structure as it existed prior to July of this year. See "Exhibit A," attached hereto. Fortunately, Mississippi Code § 43-13-121(7) (1972, as amended), provides that in order for a nursing home to be enrolled in the State Medicaid Program, the nursing home must provide the identity of all entities owning five percent (5%) or more of the home. In this example, we have two (2) owners which each own thirty-five (35%) and two (2) additional owners which each own fifteen percent (15%). As detailed in the attached exhibit, the ownership of the two larger interest holders

is further subdivided.

In the event of inadequate insurance and the absence of a minimum standards performance bond, where does this corporate structure leave a state regulator attempting to levy a fine or assessment for the provision of substandard care? In this particular case, despite the maze of ownership interest, the assets of the nursing home (e.g., buildings, furniture, equipment, etc.) remain intact and subject to placement of a lien or attachment via the appropriate legal process. This corporate structure is a mere continuation of the company from which it was initially purchased and, as such, is obligated for all liabilities, both existing and contingent, based on its (or "their" may be more appropriate) acquisition of assets. *See Stanley v. Mississippi State Pilots of Gulfport*, 951 So.2d 535 (Miss. 2007). More importantly, from the vantage point of a State regulator, this facility produces an income stream which would be sufficient to cover all conceivable fines or penalties which might be levied by the Mississippi Department of Health. Payments made to this nursing home on behalf of residents covered by Medicare and/or Medicaid tend to lag for weeks after services are rendered. Accordingly, there is no danger of the money being shielded from utilization for payment of any pending fine.

Hypothetical Corporate Structure (Asset Divestiture by Licensee)

Now let us compare the above structure to what is becoming more prevalent nationwide. Nursing Home ABC sells one hundred percent (100%) ownership to Holding Company DEF, LLC. In turn, DEF sells the actual building, furniture, beds, and equipment to GHI, LLC, for an artificially low purchase price. GHI leases the building and other items back to DEF at an artificially high price. Although DEF is now the nursing home licensee and actual operator, it has effectively divested itself of tangible assets, other than accounts receivable. Accordingly, in the absence of insurance, a

performance bond, or a sufficient income stream, such asset divestiture could make it difficult, if not impossible, for a State regulator to collect (as opposed to levy) fines and penalties for substandard performance.

This paper is not meant to be a survey of the law of various states with respect to a creditor's ability to identify and attach divested assets. Accordingly, I will confine my discussion to the prevailing law in Mississippi for discussion purposes. The general rule is that a company which acquires the assets of another company is NOT obligated for the liabilities of the acquired company, unless one of four (4) following exceptions apply: "(1) the successor expressly or impliedly agrees to assume the liabilities of the predecessor; (2) the transaction may be considered a de facto merger; (3) the successor may be considered a 'mere continuation' of the predecessor; or (4) the transaction was fraudulent." *Stanley*, 951 So.2d at 538 (citing *Paradise Corp. v. Amerihost Dev., Inc.*, 848 So.2d 177, 179 (Miss. 2003)(citations omitted)).

Although a unique situation may exist which justifies an argument to the contrary, neither exception (1), (2) or (3) is applicable on its face with respect to the DEF scenario. How about exception (4)? In order for a regulatory agency to attempt to collect a penalty or fine via attachment of the divested assets of the nursing home, that agency would have to show that the sale of those assets was fraudulent. Herein, a large problem lies. First, because nursing homes are not fungible entities (i.e., the same structure and equipment in one location may be worth much less than that in another location because of vastly different local economies, real estate prices, availability and costs associated with attending physicians, etc.), it would be almost impossible to prove that the sale price was significantly below an "acceptable" fair market value. Further, in Mississippi, any such allegation of fraud would have to be proven by clear and convincing evidence, as opposed to the

normal lower civil standard of preponderance of the evidence. Second, in some states (e.g., Oregon), undercapitalization of a business entity, such as example DEF here, can serve as the basis for "piercing the corporate veil," thus rendering the transferred assets fair game for attachment. However, this theory has been expressly rejected by the Mississippi Supreme Court. *Stanley*, 951 So.2d at 542.

In the absence of an adequate income stream, applicable insurance or a performance bond, the State regulator's potential for relief via litigation would be bleak in most cases. Further, the State regulator would be subject to incurring litigation expenses in its efforts to follow the assets. While the law applicable in this regard is certainly going to vary from state to state, Mississippi's law is demonstrative of the obstacles which may be incurred in seeking fines and penalties through attachment of fraudulently divested assets.

In the DEF scenario above, the norm would be for GHI to then lease the building, furnishings and equipment to DEF at artificially high prices (i.e., again, at the very upper limits of an acceptable range so as not to risk a finding of fraud via an adjudication in a Court of proper jurisdiction). Further, DEF is then left with debt in the form of leases and any contracts with GHI. At that point, DEF's only remaining significant asset is its stream of income predominantly, if not totally, from Medicaid/Medicare.

Based on its contractual obligations for rent of building, lease of equipment and management fees, DEF can then adjust its subsequent yearly cost reports to reflect an increase in the overall expense of patient care–thereby likely resulting in an increase in the per diem rate which the nursing home is paid to care for its patients. In other words, the more it costs to provide care, the more Medicaid pays. It is my understanding that this policy is meant as an attempt to keep profit margins

per patient within a reasonable range of deviation among various providers.

To further compound the ABC/DEF situation above, the growing trend is for DEF to hire JKL, LLC, as the "management company." By JKL lowering costs by reducing the number of registered nurses by ratio to patient and/or replacement by licensed practical nurses (significantly less trained) and other cost-cutting measures, then DEF's profits substantially increase allowing significant dividend payments to be paid to its shareholders. The management company is basically "management personnel." Other than possible ownership of some computers and other office equipment, JKL has no assets which could be subject to the placement of liens and/or attachment by State regulators for misconduct as possibly provided by statute in some states.

The ABC/DEF scenario is meant to highlight problems associated with insolvent licensees due to the divestiture of assets, and purposely does not discuss DEF's potential income stream for that reason. Further, as it relates to my capacity as a State regulator, the interests of potential plaintiffs in being able to recover monetary judgments in negligence/malpractice suits is NOT a consideration in my evaluation of the current landscape and trends with respect to the ownership structure of nursing homes.

From a fine or penalty standpoint, the State regulator is not interested in the source of the demanded funds, but as to their existence. Accordingly, if: (1) there is sufficient lag-time between payment being due from a payor (e.g., Medicaid) and a potential fine having to be paid by the nursing home licensee AND (2) the payment due is normally, if not always, greater than the potential fine; then the adverse consequences of undercapitalization subside.

By the same token, if State regulators "hold the line" (such as I have determined to be the norm in Mississippi) on staffing requirements, the quality and nutritional value of food, upkeep of

physical facilities, *et cetera*, by the levying and collection of penalties and fines, then the undercapitalization of the nursing home licensee does not equate to the existence of substandard services, as sometimes associated with ownership by private equity firms.

Potential Remedies to Combination of Undercapitalization and Inadequate Income Stream

As a State regulator, the ability to levy and collect fines and penalties is paramount. In order to insure adherence to minimum standards, the regulator has to be able to get into the licensee's pocketbook, rather than invest its limited capital and personnel resources in attempting to follow the assets in the complex ownership structure evermore prevalent in nursing homes. When comparing potential fines to "owed, but yet to paid" income streams in Mississippi, our nursing home residents appear to be adequately protected (barring the occurrence of such egregious behavior, the scope of which has yet to be encountered)–as well as can be protected by a regulatory scheme. Based on my research to date, I have been unable to locate an example wherein the Mississippi Department of Health levied a fine against a nursing home licensee for substandard conduct, or any type of deficiency or rule violation, which has not been paid in full.

In the absence, however, of an adequate pending income stream to the nursing homes in his or her state in relation to potential fines or penalties, a State regulator would be wise to seek legislation requiring one or more of the three following options:

(1) Minimum capitalization requirements placed on the Licensee for a Certificate of Need (CON) to be granted or for whatever other type of statutory mechanism exists for the opening of a new nursing home (or for a transfer of ownership in an existing facility);

(2) Minimum insurance requirements with respect to fines and/or penalties levied by

State regulatory agencies; and/or

(3) Minimum bonding requirements with respect to fines and/or penalties levied by State regulatory agencies.

Although Alternative 1 would have the dual effect of prohibiting the nursing home licensee from rendering itself totally judgement proof (as seems to be the main animus for asset divestiture and complex corporate structuring), Alternatives 2 and 3 impact would inure solely for the benefit of State regulators, with no collateral benefit to potential Plaintiffs against the licensee. The lingering inquiry then appears to be two-fold:

(1) If an adequate income stream exists by way of payment of Medicaid/Medicare benefits to nursing home licensees so as to insure payment of regulatory fines and penalties, is there a justification for addressing undercapitalization from a regulatory standpoint?

(2) Can the interests of nursing home residents be adequately protected through rigorous enforcement of minimum standards by State regulatory agencies?

Respectfully submitted, this the 13th day of November, 2007.

Scott A. Johnson

Special Assistant Attorney General
State of Mississippi

SALE OF TRINITY MISSION HEALTH & REHAB OF HOLLY SPRINGS
HOLLY SPRINGS, MISSISSIPPI

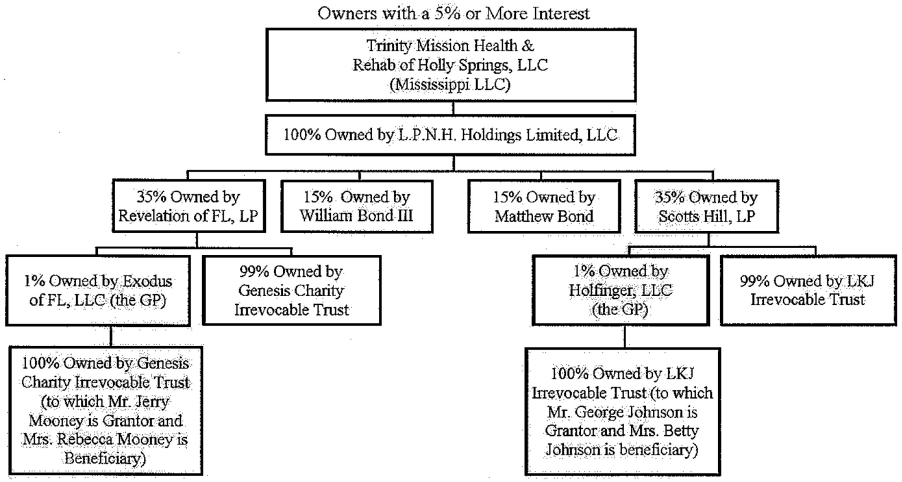

EXHIBIT A

Mr. STARK. Thank you very much. I would hope that Mr. Muller can tell us the difference between a grape and a watermelon and enlighten us in any way you would like. Turn on your mike and proceed.

STATEMENT OF ARVID MULLER, ASSISTANT DIRECTOR OF RESEARCH, SERVICE EMPLOYEES INTERNATIONAL UNION

Mr. MULLER. Thank you, Mr. Stark, Ranking Member Camp and other distinguished Members of the Committee. Thank you for giving me the opportunity to appear before you today. I am the assistant director of research for the Service Employees International Union, SEIU. SEIU represents almost one million health care workers, including more than 150,000 nursing home workers. Twenty years after Congress passed landmark nursing home legislation, the modest but real progress made since 1987 is being threatened by a new breed of nursing home operator, private equity. The private equity business model seeks to make extreme profit at the expense of nursing home residents, their families, care givers and taxpayers.

On September 23rd, *The New York Times* published an investigative story confirming what many caregivers in our Nation's nursing homes already know. Medicare and Medicaid resources that are intended to support vulnerable Americans are being diverted to the private benefit of wealthy investors. *The New York Times* found that among other concerns with private equity ownership of nursing homes, there are serious quality of care problems. SEIU, in a new report, Equity and Inequity: How Private Equity Buyouts Hurt Nursing Home Residents, which we are submitting as supplemental testimony, confirmed the findings of *The New York Times* article.

[The information follows:]

NCCNHR The national consumer voice for quality long-term care

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Alison Hirschel, President
Alice H. Hedt, Executive Director

November 9, 2007

The Honorable Fortney H. "Pete" Stark
Chair, Subcommittee on Health
House Committee on Ways and Means
1135 Longworth House Office Building
Washington, DC 20515

The Honorable Dave Camp
Ranking Member, Subcommittee on Health
House Committee on Ways and Means
1135 Longworth House Office Building
Washington, DC 20515

Dear Chairman Stark and Ranking Member Camp:

Twenty years after Congress passed landmark nursing home reform legislation, progress ensuring resident quality of care is threatened by the takeover of nursing home chains by private equity investors who are maximizing profits while isolating themselves from accountability to residents, workers, or regulators. A *New York Times* investigation, "At Many Homes, More Profits and Less Nursing," September 23, 2007, found that the typical private investor-owned facility scores worse on most quality indicators than other types of facilities; has 19 percent more serious health deficiencies than the national average; and ranks 35 percent below the national average in registered nurses. Unfortunately, staffing levels and quality of care at many for-profit, chain-operated facilities are already below acceptable standards.

The nursing home industry receives approximately $75 billion a year in federal Medicare and Medicaid funding. As organizations that represent nursing home residents, their families, and nursing home workers, we urge you to use the Medicare legislation currently under consideration to take initial steps to improve transparency, accountability and staffing throughout the entire nursing home industry. These include the following recommendations, which can be implemented at minimal cost:

Increasing the transparency and accountability of corporate ownership

- Require full disclosure to the Centers for Medicare & Medicaid Services (CMS) of all affiliated entities with a direct or indirect financial interest in the facility and their parent companies, and the owners (including owners of the real estate), operators, and management of each facility; and require that all these entities be parties to the Medicare provider agreement and listed on Nursing Home Compare. CMS should maintain an ownership database and monitor the quality of care provided by the companies. Severe penalties, including exclusion from Medicare, should be established for hiding ownership or affiliated relationships.
- Many nursing home chains have created complex corporate structures that make compensating residents who have been harmed and recovering penalties from entities that actually have assets very difficult. As early as 1979, a GAO report, *Problems in Auditing Medicaid Nursing Home Chains*, HRD-78-158 (Jan. 9, 1979), http://archive.gao.gov/f0302/108331.pdf, identified complex transactions and relationships in chains and recommended better auditing practices. CMS should address this lack of transparency and the related problem of "judgment proof" or bankrupt entities that commit wrongdoing, such as violations of regulations or fraud, by requiring a surety bond. The provider agreement should be amended to require that providers including purchasers of an existing facility or company, deposit assets in a surety bond with the amount (to be determined) proportional to the number of beds in the facility. The bond would cover

fines, civil monetary penalties, expenses associated with receiverships and temporary management arrangements imposed by state agencies, operational costs where residents are abandoned or workers are not paid, and attorneys' fees, litigation costs and damages awarded to plaintiffs in civil damage actions.

- Require CMS to certify the provider agreements annually to ensure that they are consistent with the current ownership structure and affiliated entities.
- Require CMS to post enforcement actions against facilities and maintain actual CMS Form 2567 survey reports on Nursing Home Compare.

Promoting improved staffing

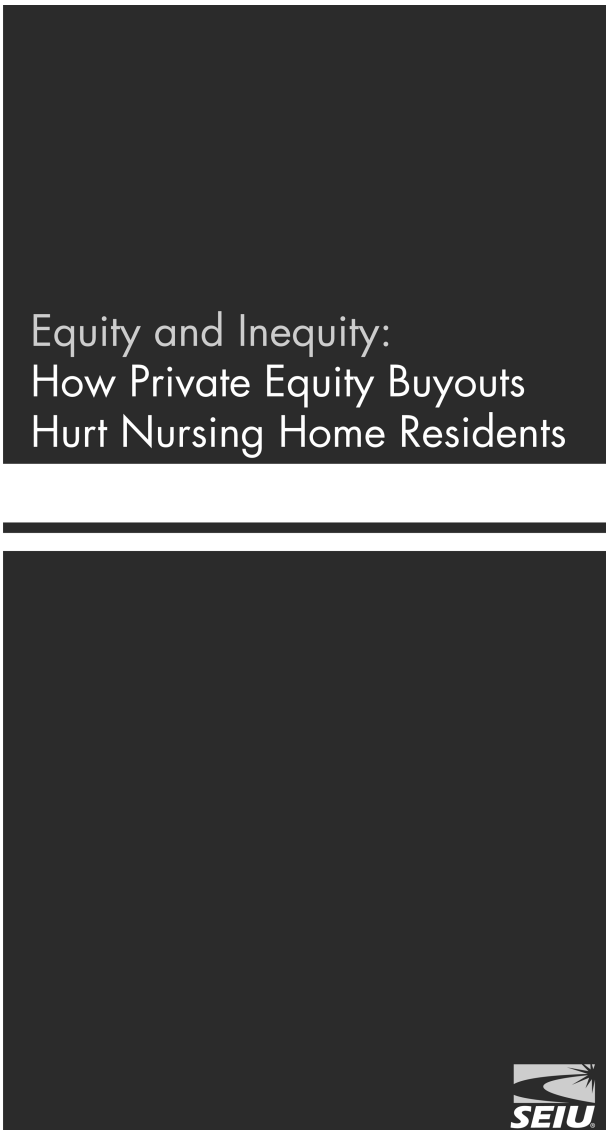
- Require CMS to collect electronically submitted data from facility payroll records and temporary agency contracts on a quarterly basis, including data on turnover and retention; and require CMS to report that information on Nursing Home Compare as quality measures that include a ratio of direct care nursing staff (RNs, LPNs, and CNAs) to residents and turnover and retention rates. CMS should monitor the reported staffing levels on a quarterly basis and direct that a survey be conducted at facilities where staffing appears to be low and/or declining. CMS has already developed a system to collect and report this staffing information. The National Quality Forum has also recommended that CMS establish a nurse staffing quality measure.
- Require that information on cost reports for Medicare be reported based on five cost centers: (1) direct care nursing services; (2) other direct care services (e.g., activities, therapies); (3) indirect care (e.g., housekeeping, dietary); (4) capital costs (e.g., building, equipment and land costs); and (5) administrative costs. The cost reports should be reported electronically to CMS and summary data should be made available on Nursing Home Compare. In 2004, MedPAC recommended requiring nursing facilities and skilled nursing facilities to publish nursing costs separately from other costs on cost reports. This recommendation was reiterated in a June 2007 MedPAC report (www.medpac.gov/Chapters/Jun07_Ch08.pdf).
- Require CMS to conduct audits of nurse staffing data reports and cost reports at least every three years to ensure the accuracy of the data reported and to prevent fraud. Severe penalties should be established for filing false reports or failing to file timely cost reports.

It is imperative that Congress take immediate action to prevent the further deterioration of care.

Please contact Janet Wells, NCCNHR Director of Public Policy, 202/332-2275, or Michelle Nawar, SEIU Assistant Director of Legislation, 202-730-7232, if you have questions.

Sincerely,
NCCNHR: The National Consumer Voice for Quality Long-Term Care
Alliance for Retired Americans
American Federation of State, County, and Municipal Employees
B'nai B'rith International
Center for Medicare Advocacy
Consumers Union
National Senior Citizens Law Center
OWL – The Voice of Midlife and Older Women
Service Employees International Union

cc: All Members, Subcommittee on Health, House Committee on Ways and Means


Equity and Inequity:
How Private Equity Buyouts
Hurt Nursing Home Residents
SEIU

Equity and Inequity:
How Private Equity Buyouts Hurt Nursing Home Residents

Executive Summary

As more private equity firms take over nursing homes, the effects these takeovers have on resident care are beginning to become clearer. From the buyouts of Mariner and Beverly nursing homes, we see increases in the number of resident care deficiencies along with a trend toward restructuring that in effect limits liability, minimizes tax responsibilities, and makes it difficult for the public to determine how effectively Medicare and Medicaid dollars are spent.

This pattern suggests that the Carlyle Group's buyout of Manor Care could harm its residents. Because Manor Care already has a poor record of resident care, the Carlyle Group must take action to improve care when they take over the company. Yet, the Carlyle buyout will saddle Manor Care with between $412 million and $440 million in annual interest expense in year one of the deal. If Manor Care cuts costs and requires cost reductions evenly across divisions and staffing levels, the company could cut 7,874 hours of CNA time per day (which equates to the time worked by more than 980 full-time CNAs). Furthermore, Carlyle has signaled that it will restructure Manor Care in a way that we believe shields it from liability, reduces its tax responsibilities, and makes it difficult for regulators to hold the company accountable for quality care.

Introduction

Stakes are high as the Carlyle Group, one of the world's largest private equity buyout firms, moves to complete the $6.6 billion leveraged buyout of HCR Manor Care, the nation's largest nursing home care provider. New research shows this deal could come at the expense of nursing home residents and taxpayers.

The Manor Care takeover is one of the largest to date in an industry where private equity ownership has become a national trend. By acquiring one of the nation's largest nursing home chains, Carlyle expects to be able to keep its nursing home beds full as the U.S. population ages, and expects Medicare to be a profitable revenue source for these beds.

Already, though, we've seen the negative effect that private equity buyouts have on the quality of care at nursing homes. Private equity firms take on significant debt to buy nursing homes and they must service that debt and the interest that comes along with it. But are these firms cutting costs to pay off the debt in a way that jeopardizes patient safety and care? Private equity firms restructure nursing homes to maximize profit but in the end create a maze of control and ownership that makes it difficult to hold nursing homes and private equity companies accountable for providing quality care.

Our new research shows that the debt and potential staff cutbacks could have significant, quantifiable effects on nursing home residents' dignity and day-to-day well-being. The cost of Carlyle's debt could mean longer waits for care, less assistance, and fewer hours of care from nursing staff.

The Carlyle Manor Care buyout raises serious concerns for nursing home staff trying to provide quality care, the taxpayers who fund the bulk of this care, and, most importantly, for the residents who may suffer. Meanwhile, Carlyle Group and Manor Care executives pay themselves millions while saddling Manor Care—a company that already has a record of failing to provide quality care—with billions in debt.

Carlyle has indicated an interest in closing the deal by the end of the year and Manor Care shareholders have already approved the deal, adding urgency to the questions about the impact of this corporate takeover and its role on seniors and people with disabilities who live in Manor Care homes.

Private Equity's Effects on Care

Decrease in the Quality of Care Delivery

In a recent front-page expose (9/23/07), *The New York Times* investigated what happens to nursing home quality of care when one chain of nursing homes in Florida was bought out by private equity firms. The *Times* found that among other concerns there have been serious quality of care deficiencies and staffing cuts, sometimes below federally recommended levels:

> "Serious quality-of-care deficiencies—like moldy food and the restraining of residents for long periods or the administration of wrong medications —rose at every large nursing home chain after it was acquired by a private investment group from 2000 to 2006....[1]"

Our new research, based on CMS data, supports this finding. We looked at two major nursing home chains, Mariner Health Care and Beverly Enterprises, that have already been bought by private equity firms. In December 2004,[2] National Senior Care acquired Mariner's 29,685 [3] nursing home beds in 252 facilities across 19 states.[4] To analyze the impact of National Senior Care's Mariner buyout on quality care, we compared the number of federal resident care violations from the inspection prior to the facility being bought by private equity with the number found during their most recent inspection for each of the homes. In Mariner's case, we found a 29.4 percent increase in violations of federal resident care. This was more than double the 11.9 percent increase of the other homes in the states in which Mariner operates.[5]

Mariner Health Care Inc. was taken private in December 2004 by National Senior Care Inc. of Atlanta, in a deal valued at about $615 million plus the assumption of $385 million in debt.[6]

Moreover, deficiencies are both more frequent and more serious in the years after the buyout. Serious deficiencies at Mariner facilities increased significantly more than in the non-Mariner homes in the states in which Mariner operates. For example, violations that caused actual harm increased by almost 67 percent as compared to 1.5 percent in non-Mariner facilities.

Deficiency Type	Mariner % Increase Post Buyout	Non-Mariner % Increase
All Deficiencies	29.4%	11.9
Potential for Minimal Harm	-8.0%	-13.3%
Potential for Actual Harm	33.6%	18.0%
Actual Harm	66.7%	1.5%
Immediate Jeopardy	87.5%	13.3%

Over the same period, the percent of Mariner facilities cited for 10 or more deficiencies during an inspection increased from 25.1 percent prior to sale to 43.8 percent of facilities. Other facilities operating in the same states as Mariner saw a much smaller increase over that time, from 21.6 percent of all facilities cited for 10 or more deficiencies to 25.9 percent of all facilities.

What do these deficiencies mean?

Deficiencies with "potential for minimal harm" are those that have the potential for causing no more than a minor negative impact on a resident.[7]

Deficiencies with "potential for actual harm" reflect noncompliance on the part of the nursing home in a way that causes, or has the potential to cause, no more than minimal physical, mental, or psycho-social harm to a resident.[8]

Deficiencies that "cause actual harm" cause real injury to fragile nursing home residents.[9] Examples of actual harm citations include:

- Failure to give residents enough fluids to keep them healthy and prevent dehydration.
- Failure to give residents proper treatment to prevent new bed (pressure) sores or heal existing bed sores.
- Failure to make sure that residents who cannot care for themselves receive help with eating/drinking, grooming, and hygiene.[10]

Deficiencies that "cause immediate jeopardy" mean that something the nursing home did or failed to do put residents' health, safety, and lives directly in harm's way. These deficiencies require immediate correction.[11] Examples of immediate jeopardy citations include:

- 1) Failure to hire only people who have no legal history of abusing, neglecting. or mistreating residents; or 2) failure to report and investigate any acts or reports of abuse, neglect or mistreatment of residents.
- Failure to protect each resident from all abuse, physical punishment, and being separated from others.[12]

Examples of resident care violations at Mariner homes post-buyout include:

Belmont Lodge Health Care Center—3/29/2007
After the facility failed to prevent and properly treat bed sores, one resident's wound worsened so much that the resident had to have his leg amputated above the knee.[13]

This resident developed a pressure sore on his left heel in November 2006. Over the following three months, this sore grew worse; it got bigger, became necrotic, and began to smell bad. Finally, in late February 2007, the resident was hospitalized for fever, pain in the wound, continued worsening of the sore, and a potential bone infection in the left heel. During the hospital stay, the resident's left heel had to be debrided to drain the infected wound, and then the resident's left leg was amputated above the knee as the result of the infected wound.

A family member of the resident told a state inspector that family members often found the resident either wet or soiled when they arrived for visits and that facility staff did not reposition the resident on a regular basis. Ensuring that a resident stays dry and is repositioned helps prevent the development of sores. In addition, the resident did not promptly receive a pressure-relieving wheelchair that his doctor had ordered.

About three weeks after the resident's leg was amputated, the resident had developed three more pressure sores on his right foot.

Palisades Living Center—12/14/2006
State inspectors cited the facility for failing to have enough nursing staff to meet residents' care needs. Residents told inspectors that there were no longer enough nurse's aides on the night shift to help residents with bowel and bladder management:
"I have defecated in my bed because I couldn't get help [on nights]."
"I've fallen asleep on my bedpan waiting for them to come back and take me off."
"The [nurse's aides] we have are good but there's just not enough of them."
"If there was just one more person [like there used to be] on nights, it would help."

Several residents reported that facility administration already knew of the understaffing problem, and believed that telling them "wouldn't do any good."

Nurse's aides told inspectors that sometimes they have had to work on an entire hall with 32 residents by themselves. One aide, while working alone on the hall during the night shift, told inspectors: "I'm overwhelmed. We used to be two here on nights but about three weeks ago they [facility administration] changed from eight-hour shifts to 10-hour shifts and [they decreased the nurse's aides] to just one on nights ... I definitely need more help ... there's just too many [residents] that need assistance."[14]

Decrease in the Quality of Care at Beverly

Mariner's performance post-buyout is not an anomaly. When we looked at the impact of the sale of Beverly Enterprise to Fillmore Capital Partners[15], the largest single nursing home company to be bought by private equity to date, we see a similar increase in federal violations during their most recent inspections when compared to inspections immediately prior to the sale. Since Beverly's sale in March 2006[16], their most recent annual inspections show a 19.4 percent increase in such violations, again more than double the 8.2 percent increase in violations cited in other homes located in the states where Beverly operates[17].

Deficiency Type	Beverly % Increase	Non-Beverly % Increase
All Deficiencies	19.4%	8.2%
Potential for Minimal Harm	29.0%	-7.1%
Potential for Actual Harm	19.1%	11.2%
Actual Harm	8.1%	-3.6%
Immediate Jeopardy	12.5%	13.0%

Just as with Mariner, each of these increases point to real harm to fragile nursing home residents. Examples of Beverly's violations:

Golden Living Center, Lima—12/4/2006
A resident, whose history of eating problems meant that she was supposed to be monitored while eating, was left alone in her room while eating a meal, choked on her food, and died at the hospital after efforts to clear her airway and perform CPR failed. This resident, who was mildly mentally retarded and had chronic airway obstruction, gastroesophageal reflux disorder, and seizure disorder, had a history of eating too fast. Facility staff reported that she "wolfed down" her food and would take excessively large bites. As a result, she was supposed to be supervised at mealtime and eat only in the dining room.[18]

Golden Living Center, Camp Hill—4/11/2007
Over the course of just three months, a resident in the facility experienced a severe weight loss of 14 percent of her total body weight. As the resident began quickly losing weight, her doctor prescribed a nutritional supplement for her, but the facility failed to give her the supplement as it was ordered, and then discontinued the supplement even though the doctor had ordered that it continue to be administered. The resident's care record did not reflect any attempts other than the improperly administered nutritional supplement to ensure that the resident maintained a healthy weight.[19]

Golden Living Center, Valley—12/1/2006
Even though nursing homes are required by federal law to have a registered nurse on duty for eight hours a day, seven days a week, there was no RN working in the facility one day a week during the time that state surveyors performed their inspection.[20]

The quality of care at nursing homes is a serious concern throughout the industry, but the analysis of the CMS data, indicates an even greater cause for alarm at private equity-owned firms.

Transparency and Accountability

Publicly traded companies are subject to federal securities laws and regulations as well as to daily scrutiny by financial analysts and the business media. However, private equity buyout firms operate virtually free of oversight and public accountability, their profits and practices largely hidden from view. Far from a coincidence, this lack of transparency is built into their business model, providing buyout firms with certain advantages that publicly traded companies do not enjoy. For example, private equity-owned companies do not have to:

- disclose to the public their debt levels, or other aspects of their capital structure;
- report executive compensation;
- report events that have a material impact on their business, whether positive or negative; or
- report acquisitions or divestitures.

In sum, buyout firms operate behind a veil of secrecy that allows them to conceal virtually all aspects of their business from regulators, affected stakeholders, the general public, and their competitors.

One of the defining characteristics of private equity buyouts of nursing homes is the lack of disclosure about how firms intend to reorganize the company after it has been purchased. The nursing home industry is trending toward separating the real estate and the operations components of nursing homes, which can impact the quality of care. A December 2006 study prepared by Harvard Medical School experts for the U.S. Department of Health and Human Services, detailed these impacts:

> "Integrated Health Services, Mariner Health Care, and, most recently, Beverly, are examples where equity groups purchased chains with the intention of separating the real estate and operations with the goals of limiting liability and enhancing profitability"[21]

As the *Journal of Health Law* describes,

> "Dividing the nursing home business into real estate investment and real estate operations will reduce the nursing home company's exposure to risks associated with owning and operating one or more nursing homes. The degree to which this reduction of risk can be maximized will be a function of how elaborate a corporate structure the particular company is willing to create. The ultimate structure would consist of forming a real property SPE [single-purpose entity] to hold each piece of real estate, as well as a separate operating SPE for each nursing home business."[22]

What is a private equity buyout?
Called "leveraged buyouts" in the 1980s, private equity takeovers use money invested by limited partners—typically wealthy individuals or public pension funds—to purchase an established company. These deals often entail significant levels of debt; the private equity firm contributes some equity and uses the assets of the target company as collateral for the majority of the purchase price. In order to ensure a profitable exit later the buyout firm may pursue a number of operational strategies to raise revenues and limit costs. The buyout firm itself makes money in two ways: through fees, including transaction and management fees during the life of the investment, and through their cut of the profits realized at sale, typically 20 percent.

As the new owners of Mariner, National Senior Care hired roughly 80 attorneys from a half-dozen law firms to help design and execute a complicated web of corporate structures that took nearly seven months to complete. To help pay for the deal, National Senior Care immediately sold approximately two-thirds of the homes it had purchased to another company called SMV Property Holdings.[23] SMV set up separate real estate holding companies for each of the properties purchased[24] and then leased the facilities back to Mariner or SavaSenior Care,[25] an affiliate of National Senior Care.[26] Adding to the structural complexity, documents submitted to California regulators indicate that at least some former Mariner homes are actually run by subsidiary operating companies that are unique to each location.[27] Not surprisingly, the lawyers who helped set up the National Senior Care deal called it one of the most complicated transactions they had ever been involved in. [28]

While we don't know the exact amount of rent that the Mariner homes paid to these related parties, the building and fixture-related capital costs that Mariner reported on its Medicare cost reports rose by 60 percent the year after National Senior Care took over. (In the previous three years it had increased by a total of only 11 percent.) In addition, interest expense payments, an indicator of how much debt has been incurred, increased by 145 percent from 2004 to 2005, the year after the buyout. At the same time, the number of Mariner facilities that reported any interest expenses in 2005 was more than four times the number that had reported interest expenses in any of the previous three years.[29]

The restructuring undertaken after a nursing home moves from being a public company to private ownership also makes it difficult to hold nursing home companies accountable for poor care, because more entities are involved in the transaction of business in the home.

The New York Times found:

> "Private investment companies have made it very difficult for plaintiffs to succeed in court and for regulators to levy chainwide fines by creating complex corporate structures that obscure who controls their nursing homes … The Byzantine structures established at homes owned by private investment firms also make it harder for regulators to know if one company is responsible for multiple centers. And the structures help managers bypass rules that require them to report when they, in effect, pay themselves from programs like Medicare and Medicaid."[30]

While the restructuring may help increase profitability, it makes it far more difficult for taxpayers, residents, and their survivors to hold the company accountable for the care it provides.

Profiting from Public Funds

At the same time that *The New York Times* and our research shows care suffers under private equity's ownership, Medicare and Medicaid resources that are intended to support vulnerable Americans are being diverted to the private benefit of wealthy investors.

Taxpayers trust these Medicare and Medicaid dollars will go toward providing seniors with quality care. Medicare's conditions of participation and other rules permit for-profit nursing homes and other providers to participate in the Medicare program. Standards of care are the same for all ownership types. The industry is overwhelmingly financed by public funding, with many companies relying on Medicare and Medicaid for as much as two-thirds of their income. Yet nursing home companies owned by private equity firms appear to fall short of these standards more often than other nursing home types.

While the heavy debt load may force cuts to operating expenses, the takeover will result in a windfall of as much as $254 million for top Manor Care executives and directors, including as much as $186 million for Manor Care CEO Paul Ormond[31]. Simultaneously, Carlyle stands to reap fees on the deal that could total hundreds of millions of dollars. These fees and payouts would be better spent on resident care. Smaller fees and payouts to insiders, and a larger equity contribution by Carlyle, would mean less overall debt would be necessary, and less cost pressure would be placed on nursing services and other important components of quality care.

Net Tax Impact of the Carlyle Buyout of Manor Care

Based on available data and conservative assumptions, we believe that Carlyle's buyout of Manor Care will reduce net taxes paid to federal and state governments by approximately $612 million during the time Carlyle holds it at

as private company.[32]

THE CARLYLE MANOR CARE BUYOUT

Behind the Buyout: Facts about the Carlyle Group Takeover of HCR Manor Care

Private equity buyout firm: The Carlyle Group, Washington, D.C.
Company being bought out: HCR Manor Care, Toledo, Ohio

Deal value: $6.6 billion
Equity financing: $1.3 million (13 percent)
Debt financing: $ 5.5 billion (87 percent)

Sale price: $67 per share, representing a 20 percent premium over Manor Care's stock price on April 10[33]

Deal announced: July 2, 2007
Deal closed: Expected to close by the end of 2007

Fees reported to date*:

- $35 million to JP Morgan for fairness opinion and transaction fee
- $5 million to Citigroup for fairness opinion

*The Carlyle Group will receive significant additional fees for arranging the deal: For example, buyout firms typically charge as high as 1 percent of the value of the transaction for overseeing the transaction, in this case an estimated $60 million. Buyout firms also typically are paid an annual management fee. Information regarding the management fees for this deal, if any, has not yet been made public.

Executive Compensation

- Manor Care CEO Paul Ormond–Up to $186 million stock payout
- Other Manor Care executives–Up to $68 million combined in stock payouts

About HCR Manor Care

HCR Manor Care, based in Toledo, Ohio, is one of the largest nursing home providers in the country, with more than 37,000 resident beds nationwide and $3.6 billion in annual revenue.

About the Carlyle Group

With more than $75 billion in assets under management, the Carlyle Group is one of the five largest corporate buyout firms in the nation. Washington, D.C.-based Carlyle owns companies that together employ more than 280,000 workers. The firm's three co-founders, David Rubenstein, William Conway, and Daniel D'Aniello each have a net worth estimated by *Forbes* at more than $2.5 billion. A recent study estimated Rubenstein's 2006 compensation at $260 million. For more information on the Carlyle Group, visit www.BehindtheBuyouts.org/carlyle

When the primary source of revenue for a target acquisition is taxpayer funding, there should be a greater level of accountability and assurances that those funds will be used for their stated purpose. Roughly two-thirds of HCR Manor Care's skilled nursing, assisted living, and rehabilitation revenues came from Medicaid and Medicare reimbursements in 2006.[34] Therefore, elected officials with oversight of those programs have the right—indeed, the responsibility—to understand the financial implications of the buyout transaction and their potential impact on patient safety and quality of care.

Based on the very limited information disclosed to the SEC by Manor Care, serious concerns have been raised about the ability of the Carlyle Group to service the new debt burdens they intend to place on the company without significant cost cutting measures that could undermine quality patient care in the company's more than 280 nursing facilities.[35]

SEIU has examined both the past care record of HCR Manor Care and forecasts for how the nursing homes will operate under Carlyle, and the facts raise serious questions about the company's ability to provide high quality care to seniors at a good value to taxpayers.

Manor Care's Resident Care Record

Even prior to the buyout, Manor Care has a record of failing to provide all its residents with quality care. Under federal law, nursing homes are required to be inspected every nine to 15 months. Over the past three survey cycles, violations of basic patient care standards at Manor Care nursing homes have increased by 23 percent.[36] By comparison, violations of care standards increased by 14.5 percent between 2004 and 2007 for non Manor Care nursing homes in the states in which Manor Care operates.[37]

Eighty-one percent of Manor Care facilities reported nursing staff levels below 4.1 hours per resident per day[38]—a figure recommended in a government-commissioned study.[39]

Some problems have happened again and again—despite the fact that Manor Care administrators assured state inspectors that the problems would be corrected and prevented in the future.

For instance, 30 Manor Care homes in Pennsylvania have been cited more than once over the past three survey cycles for failing to give residents care and services to maintain the highest possible quality of life, 10 have been cited more than once for failing to have a proper program to prevent infections from spreading around the home, and eight have been cited for failing to store, cook, and give out food in a safe way.[40]

Of Manor Care nursing homes nationwide, only 4 percent were in full or substantial compliance with federal care standards on their most recent inspection. Ninety-six percent were cited for resident care violations that caused or had the potential to cause more than minimal harm to residents.[41]

Examples of Manor Care's patient care violations:

- **Manor Care at Arlington Heights, Ill.:** Facility staff gave a resident an overdose of her antidepressant medication, which resulted in respiratory failure and her hospitalization. The resident was given a dose of an antidepressant drug that was four times the prescribed amount, and was later found unresponsive by facility staff. Facility staff called 911 and ran a full code; the resident was transported to the hospital, where she was intubated, put on a ventilator, and given charcoal to treat overdose-induced respiratory failure.[42]
- **Heartland of Perrysburg, Ohio:** A resident who was known to wander was left unattended, fell down a set of concrete stairs, and died. This resident, who had senile dementia and serious vision impairment, used a wheelchair. In addition to her wandering, she was also known to open doors on her own and have poor judgment of safety issues. According to a state inspection report, the resident, while unattended, opened the door to a secured stairwell, wheeled herself to the top of the stairs, and fell. A facility nurse later found her at the bottom of a flight of stairs, "face down on her right side with [her] wheelchair partially on top of her. She had no vital signs, no respirations; [her] pupils were fixed and dilated, and there was blood from a laceration on her head." The county coroner found that the reason for the resident's death was a subdural hematoma resulting from her fall down the stairs.[43]
- **Heartland of Bellefontaine, Ohio:** A resident's blister was left untreated and developed into an infected, necrotic pressure sore. Nurses at the facility had identified a blister on the resident's right heel, but did not put together a plan to prevent this blister from becoming a serious pressure sore. Over the following weeks, the sore got worse, developed a bacterial infection, became necrotic, began to smell bad, and was debrided. Meanwhile, the facility repeatedly failed to relieve pressure on the resident's heel; more than three months after the resident's blister became a sore, the resident was observed sitting in a chair with no interventions in place to relieve pressure on her right heel.[44]
- **Manor Care Health Services, Camp Hill, Pa.:** The facility's failure to ensure routine dental examinations resulted in one resident having surgery to remove all of her teeth. She had developed tooth

decay, fractured teeth, and abscesses over the course of seven months. The resident had not been given any dental care in nearly three years, even though facility staff knew she had broken, missing, and decaying teeth, and despite an existing order from her doctor to have a dental examination. When the resident was admitted to the facility in 1998, she had all of her own teeth and had no broken teeth or mouth pain.[45]

Carlyle Debt and Pressures on Care

According to Manor Care's SEC filings, the company had approximately $994 million in debt and paid $31.5 million in interest in 2006.[46] The Carlyle Group's proposed buyout includes $5.5 billion in debt,[47] a more than five-fold increase of Manor Care's debt burden. If we assume an average blended interest rate in the range of 7.5 percent to 8 percent on $5.5 billion, Manor Care's annual interest expense in year one would be between $412 million and $440 million.[48] As a result of the Carlyle Group buyout, Manor Care's annual interest expenses could increase by approximately $400 million over prebuyout 2006 levels.

Manor Care's massive new debt obligations could affect staffing and resident care if Manor Care decides to cut costs in order to make its interest payments. Among other costs, Manor Care could cut its long term care operating expenses, more than half of which were attributable to staffing and other labor-related expenses in 2006.[49] These types of labor-related cuts could reduce the quality of care provided to Manor Care residents nationwide.

If Manor Care cuts costs and requires cost reductions evenly across divisions and staffing levels, the company could cut 7,874 hours of CNA time per day (which equates to the time worked by more than 980 full-time CNAs). This would likely reduce CNA-provided care in the average Manor Care nursing facility from 2.1 hours per resident per day to 1.9 hours per resident day per day.

To gauge the impact this staffing reduction could have on resident care, we can turn to a model developed in a study commissioned by the federal government's Centers for Medicare and Medicaid Services (CMS). This model determined the nurse's aide staffing necessary to carry out five daily care needs in nursing homes:

1. Consistently repositioning and changing wet linens for incontinent residents who could not successfully toilet if given assistance.[50]
2. Providing timely toileting assistance for incontinent residents who could successfully use the toilet. Residents should be toileted every two hours.[51]
3. Providing feeding assistance to either physically dependent residents or those with low food intake.[52]
4. Providing exercise to all residents. Some residents need exercise assistance at least three times a day while other, more mobile residents may only need exercise assistance once every two days.[53]

5. Providing assistance that enhances the ability of residents to dress and groom themselves.[54]

When staffing levels decrease, residents must either wait longer for assistance with these activities or, in extreme cases, may see their needs go unmet. Over the long run, an inability to meet patient care needs could lead to health problems for Manor Care residents.

A potential cost-cutting decrease in staffing in Manor Care nursing homes' from the current average of 2.1 hours of CNA care per resident per day to 1.9 hours of CNA care per resident per day would have real, tangible effects on the fragile nursing home residents that rely on Manor Care to meet their daily needs. Using a model articulated in a study produced for CMS, we estimate:

- Approximately 21,700 Manor Care residents will need incontinence-related care such as changing, repositioning, or help using the toilet. If CNA staffing is cut from 2.1 hours per resident per day to 1.9 hours per resident per day, treatment could be missed for *more than 21,700 incontinence-related incidents*—enough missed incidents to affect every resident who needs this basic care.
- Incontinent residents could also have to wait more than 30 minutes more for each episode of incontinence care—meaning that residents could be left longer with soiled linens and clothes.
- Approximately 32,200 Manor Care residents will need assistance with exercise. If CNA staffing is cut from 2.1 hours per resident per day to 1.9 hours per resident per day, many more incidents of exercise-related care will be missed—enough missed incidents to affect most of the 32,200 residents who need exercise-related care. Exercise is critical to preserving residents' mobility and physical and mental health.
- Approximately 16,900 Manor Care residents will need help with eating and 32,000 Manor Care residents will need assistance with dressing or grooming. If Manor Care cuts staffing to make its interest payments, waits for feeding and grooming care will likely grow longer and more care episodes will probably be missed. Eating, dressing, and grooming are basic activities fundamental to each resident's health and quality of life.

Restructuring

Public documents indicate the Carlyle Group is planning changes to the corporate structure of nursing home chain HCR Manor Care, as part of its pending $6.6 billion takeover deal.

The changes could limit Carlyle's legal liability in the case of poor patient care and make it difficult for regulators and plaintiffs' attorneys to hold the buyout firm responsible for what happens to residents inside the homes. *The New York Times* uncovered similarly "Byzantine" corporate structures in a Sept. 23, 2007, investigation of other nursing homes owned by private equity firms.

Hiding the Assets[55]

Applications for nursing home licenses in Maryland, Michigan, Washington, and West Virginia lay out a four-tiered structure for Carlyle to shield Manor Care's assets and distance itself from any liability for poor care in Manor Care homes.

(1) Create a corporation as a holding company to own the entire Manor Care chain.
(2) Create limited liability corporations for the operations of individual Manor Care homes.
(3) Create limited liability corporations for the real estate holdings of individual Manor Care homes.
(4) Create another affiliated corporation to lease all the properties from the ownership corporations, and then sublease to the operating corporations.

The documents were obtained by SEIU in public records requests. In the other states where Manor Care operates, similar documents have been unable to be obtained, or requests for the documents are pending.

What *The New York Times* Investigation Found

"Private investment companies have made it very difficult for plaintiffs to succeed in court and for regulators to levy chainwide fines by creating complex corporate structures that obscure who controls their nursing homes.

"By contrast, publicly owned nursing home chains are essentially required to disclose who controls their facilities in securities filings and other regulatory documents.

"The Byzantine structures established at homes owned by private investment firms also make it harder for regulators to know if one company is responsible for multiple centers. And the structures help managers bypass rules that require them to report when they, in effect, pay themselves from programs like Medicare and Medicaid."

Excerpted from *The New York Times,* "At Many Homes, More Profit and Less Nursing," by Charles Duhigg, Sept. 23, 2007.

Misrepresentations

In response to *The New York Times* investigation, Manor Care has claimed in communications to employees that it has no intention of changing its "operating structure" or of separating its nursing homes' real estate from management. At least one local Manor Care administrator told reporters, "There will be no changes at the corporate or local level."[56]

But Manor Care's own SEC filings reveal that it plans a significant "restructuring" as part of the deal.[57] The company's "restructuring" will send each nursing home's operations to an entirely new corporate entity and will separate real estate and operations into two completely separate companies. It is clear from the filings that the restructuring comes at Carlyle's request, as the merger agreement provides for "unwinding" the structure if the deal does not go through.

Limited Liability

Part of Carlyle's restructuring plan involves creating a limited liability corporation, or LLC. The advantage of doing this was explained in a 2003 article in the *Journal of Health Law:*

> *"In the context of nursing home ownership and operation, legal entities such as corporations, limited liability companies and limited liability partnerships can be formed to benefit nursing home companies by limiting the financial liability and Medicare and Medicaid exclusion exposure of the real estate investors and business owners… The business entities can also prevent litigants from obtaining judgments against related companies, and the owners personally, in proceedings alleging Medicare or Medicaid overpayments, false claims, or negligence."* [58]

Furthermore, the assets that are held by other entities are so heavily mortgaged that there are few available funds.

Restructuring to Help Finance a Leveraged Buyout

Companies with extensive real property holdings have often been attractive to private equity firms seeking to pay themselves dividends and recoup investments even before selling the company, though not always with positive results for the longevity of the business. According to the *Wall Street Journal,* "Manor Care owns, rather than leases, nearly all its own facilities and boasts arguably the best real estate portfolio in the business."[59] The Carlyle takeover of Manor Care is valued at $6.6 billion, but Carlyle has only committed to putting up to $1.3 billion in equity into the deal.[60] As one analyst noted "Unlocking the real estate value is key" to making this highly leveraged buyout work.[61] Sure enough, according to published reports, Carlyle plans to use Manor Care's real estate holdings as collateral for $4.6 billion of the overall debt.[62]

Conclusion

Because of serious questions that Carlyle's leveraged buyout of Manor Care raises for nursing home residents, taxpayers, and the public, legislators and regulators should closely examine the deal before allowing Carlyle to move forward. Past private equity nursing home buyouts coupled with Manor Care's resident care record and Carlyle's acquired debt suggest residents at nursing homes could be put at risk if the deal closes. Now is the time to take action to protect nursing home residents and be good stewards of taxpayer funding.

Methodology

Deficiency Data Sources

Data on nursing home inspections comes from the Centers for Medicare and Medicaid Services (CMS) Online Survey, Certification, and Reporting (OSCAR) data. Descriptions of specific resident care problems in individual states are from state inspection reports generated by state inspectors as part of regular facility inspections, documented in Statements of Deficiencies and Plans of Correction(see below).

Defining a Violation

Federal regulations governing patient care conditions are contained in the 1987 Omnibus Budget Reconciliation Act (OBRA) and are found in 42 CFR 483.10 ff. These guidelines are used to assess a nursing home's compliance with basic patient care standards.

State inspectors inspect facilities under contract with the Centers for Medicare and Medicaid Services (CMS). When state inspectors enter a facility, either for an annual inspection or to investigate complaints, they have a responsibility to cite all violations of state and federal regulations. This report examined only violations of federal regulations identified on annual certification surveys. Inspectors complete the CMS Form 2567, also known as the Statement of Deficiencies and Plan of Correction.

The Inspection Process

State inspectors visit each nursing home every nine to 15 months to ensure that facilities are complying with federal and state standards for resident care. A team of inspectors evaluates the facility for approximately one week during each inspection visit. Since a review of the care given to each resident in a facility is time consuming, the team observes the care given to a selected number of residents, called "sample residents," who represent the overall facility.

Inspectors note violations of federal regulations on the Statement of Deficiencies and Plan of Correction, including a reference to the specific regulation violated and a description of what the inspectors found in each case. The violations are discussed with the managers of the facility being inspected, who must submit a proposed "plan of correction" to remedy each violation and prevent its recurrence. The plan of correction is then added to the statement of deficiencies.

Establishing the number of nursing homes operated by Mariner Health Care

Mariner Health Care, a national nursing home operator, was acquired by the private equity company National Senior Care in December 2004. According to SEC filings, the deal closed on December 10, 2004.[63]

Three documents helped establish the number of homes operated by Mariner as of Dec. 10, 2004, the date Mariner closed its sale to National Senior Care. As part of Massachusetts regular cost reporting requirements on two Mariner-owned facilities in that state, Mariner was required to list all of the skilled nursing facilities it either owned or operated, along with their addresses. In its 2003 cost report, filed with the Massachusetts Division of Health Care Finance and Policy on April 30, 2004, Mariner listed 252 related skilled nursing facilities. This list was cross-checked against two facility listings, Annex Two and Annex Three, that were prepared as part of Mariner's bankruptcy filings.

Because this analysis looks at what happens when nursing home companies fall into private hands, we only wanted to look at facilities that National Senior Care continues to own or operate as of October 2007. Establishing operators for nursing homes is difficult and made more complicated by the variety of legal entities nursing home companies establish to shield themselves from liability.

Of the 219 homes included in the analysis, 181 are listed in the directory of facilities on the Sava/National Senior Care Web site[64] To establish the current operator for the remaining facilities we used information from state licensing agencies and state corporate records, occasionally relying on a facility's Web site information to determine ownership. Where we were unable to definitively establish continued National Senior Care operation of a nursing facility, we did not include that facility in the analysis.

Establishing the number of nursing homes operated by Beverly Enterprises

Beverly Enterprises Inc., a national nursing home operator, was acquired by a private equity firm, Fillmore Capital Partners, LLC on March 14, 2006.[65] The Beverly name was retained for its leased facilities (Beverly Living Center). As of August 2006, the other facilities, roughly 260 facilities, operate under the name Golden Living Center.[66] The parent company is Golden Horizons and is based in Fort Smith, Ark.[67]

Beverly's latest Web sites refer to 344 nursing facilities but the full facility list for each state only amounts to 332[68]. Of those 332 nursing facilities, three were eliminated from the analysis: Lake Ridge Adult Daycare, Minnesota; Golden Living Center–Watertown, South Dakota; and Golden Living Center–Arab, Alabama. The Lake Ridge facility was not comparable in operation to other nursing facilities, no inspection data was recorded for the Watertown facility, and there was no post-sale inspection data for the Arab facility. Therefore, the analysis is based on 329 facilities for which there is valid data.

Facilities Included in Peer Group Analysis

Though CMS establishes the guidelines for survey inspections nationally, enforcement (and interpretation) of those standards is left up to individual state Medicaid programs. To establish a peer group of facilities with which to compare the Mariner and Beverly facilities, we looked at all other facilities in the states where Mariner and Beverly operate. For Mariner this meant 19 states[69] and for Beverly this meant 23 states[70].

Mariner and Beverly Health Violation Analysis

CMS makes health violation data available in quarterly reports beginning in the third quarter of 2003. For the violation analysis before the buyout, we used the inspection survey results closest to and before the date the sale closed. For Mariner, this was Dec. 10, 2004, and for Beverly it was March 14, 2006. For the analysis of the current number of violations, we used the most recent survey data available based on a download of CMS quarterly inspection data, which included inspections through Sept/ 26, 2007.

Peer Group Violation Analysis

For the peer group comparison to Mariner, this analysis looks at homes which had a survey completed in 2004 prior to Dec. 10, the Mariner sale date.[71] For the analysis of the current number of violations at those homes, we used the most recent survey data available based on a download of CMS quarterly inspection data, which included inspections through Sept, 26, 2007. If a facility has not been surveyed since 2005, it is not included in this analysis. The total number of peer group homes included in the Mariner analysis was 7,867 prior to the buyout and 7,814 homes that have had inspections since the buyout.

Since the Beverly sale was relatively recent, a number of facilities in Beverly's states have not had an inspection since the sale[72]. However, in order to present a more complete analysis of the conditions of non-Beverly homes in these states, they are included in the presale analysis. The total number of peer group homes included in the Beverly analysis was 8,593 prior to the buyout and 8,197 homes that have had inspections since the buyout. The percent increase in deficiencies was calculated on a number per facility basis.

Calculating Percentage Changes in Violations by Level of Violation

CMS quarterly data includes descriptions of each violation for which a facility has been cited. Each deficiency is also categorized based on the scope and severity of the problem, using a 12-point grid. Violations labeled A, B or C are Level 1 violations, violations with potential for minimal harm. Violations labeled D, E or F are Level 2 violations, violations with potential for actual harm. Those labeled G, H, or I are Level 3 violations, violations where actual harm occurred, and those labeled G, H or I are Level 4 violations, violations that place residents in immediate jeopardy.

To determine the percentage change in each level of violation, this analysis first counts the number of deficiencies per facility by level that Mariner or Beverly facilities were cited during the surveys immediately before their respective sales and in the survey most recently taken at the facility, and then the percent change in the number of deficiencies per facility at each level is calculated. The same analysis is performed on the peer group universe.

Calculating the Amount That Costs Will Be Cut Due to Increased Debt

Manor Care has provided the public with very little information about how it intends to cover its increased interest expenses resulting from Carlyle's highly leveraged buyout model. As discussed above, we have assumed for purposes of this report that Manor Care will cut costs to make its higher interest payments and that it will cut costs proportionally across all its lines of business (e.g., if nursing homes are 80 percent of revenues then 80 percent of cuts will come from nursing homes) and proportionally within each line of business (e.g. if CNA staffing costs are 13 percent of nursing home costs then 13 percent of cuts will come from CNA staffing).

Interest Expenses Attributed to CNA Staffing

The amount of debt interest payments that would have to come from CNA staffing was calculated as follows: Amount of debt x percentage of revenue attributable to nursing homes x percentage of nursing home costs attributable to nurse's aides.

This number was then divided by the number of Manor Care nursing home beds and then divided by 365 to come up with a debt per bed per day figure.

The debt per bed day was then multiplied by the number of Manor Care beds in the state to come up with an amount of money lost per day.

Nursing Home Revenues

Nursing Home revenues were determined by totaling the amount of revenue from Manor Care nursing homes as reported in its 2005 Medicare cost reports. To arrive at the percentage of revenues attributable to nursing homes we compared the Medicare cost report total to the 2005 total revenue amount listed in the company's 10k filing from Feb. 21, 2007. Since we did not have Medicare cost report data for all of Manor Care's nursing homes we estimated the total revenue by comparing the number of resident days reported to the Centers for Medicare and Medicaid Services (CMS) with those in the cost reports and increased the costs by the same proportion.

To confirm this result, we also subtracted the annualized fourth quarter 2005 revenues from Manor Care assisted living facilities reported in an earnings conference call on Jan. 27, 2006, from total skilled nursing and assisted

living revenues in 2005 reported in Manor Care's 10k filing from Feb. 21, 2007. To arrive at the percentage of revenues attributable to nursing homes we compared the estimated nursing home revenue to the 2005 total revenue amount listed in their 10k filing from Feb. 21, 2007.

In both cases the nursing home revenues were determined to be 80 percent of total revenue.

Staffing Data

Staffing data for each facility was obtained from the CMS Online Survey Certification and Reporting (OSCAR) database. As part of the annual inspection process, each facility reports its staffing for the two-week period prior to the inspection. These figures are then recalculated to reflect hours per resident day. Staffing data was used from the most recent annual inspection.

Percentage of Nursing Home Costs Attributable to Nurse's Aides

The percentage of nursing home costs attributable to nurse's aides was calculated as follows:

First, we calculated the annual cost of the nurse's aides using the following formula: weighted average of nurse aide hours per resident per day x number of resident days x national average CNA wage[73] x amount paid for benefits[74] x 365.

Second, we divided this number by the estimated total nursing home revenues to come up with a percentage of nursing home costs attributed to nurse's aides. This number is a conservative one since we assumed that nursing home revenues and costs were equal. If Manor Care made a profit on its nursing home business then this number will be understated.

Calculating Amount of CNA Reductions

To calculate the amount of CNA hours that would be lost as a result of the increased debt, we took the amount of money lost per day and divided it by the cost of each CNA hour.

The number of CNAs lost was derived by dividing the total hours lost by eight.

The cost of each CNA hour was calculated as the average 2005 CNA wage divided by a benefit factor of .716. (From the June 2007 Bureau of Labor Statistics Employer Costs for Employee Compensation for service workers in nursing care facilities.)

The CNA hours per resident per day are weighted averages calculated by adding each facility's total CNA hours together *(i.e.*, CNA hours per resident per day x total residents) and dividing by the total Manor Care residents).

Calculating the Effect of Inadequate Numbers of Certified Nurse's Aides on Resident Care

The model used in this report was developed by John F. Schnelle, Ph.D., Sandra F. Simmons, Ph.D., and Shan Cretin, Rand Corp., for a study produced for the Centers for Medicare and Medicaid Services. The study addressed the "Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes." For a full description of this model, see Chapter 3 of the Phase II Final Report—available on the CMS Web site. As described in our report above, this model was developed to determine the minimum CNA time needed to provide care in five basic care processes. It did this by looking at the amount of time needed to carry out each care process and the number of times each process needed to be carried out for the different types of residents in a facility *(i.e.*, the number of care episodes that need to be provided).

By looking at how much staff time is required to provide all the necessary care, we can start to look at how much care won't be provided with lower staffing levels. Implicit in this are certain assumptions about prioritizing time.

For purposes of this report we have made the following assumptions:

- All homes are low workload homes (see the "Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes" study above).
- If care processes need to be dropped, then they will be dropped equally as to all residents who need the care. For example, if 15 episodes of incontinence care cannot be provided, then we assumed that 15 residents who need incontinence assistance would each miss one episode of care *(e.g.*, instead of being turned every two hours there would be once in the day where they didn't get turned for four hours).
- We assumed—based on the Schnelle *et al.* study—that the care processes most likely to be dropped first are incontinence care and assistance with exercise. This is based on interviews done with caregivers as part of the simulation study. Building on this assumption, we assume for purposes of this report that all care processes that will not be provided (*i.e.*, all missed incidents of care) will be incontinence care or assistance with exercise. In the real world, the type of care not provided would vary (*e.g.*, residents might not get assistance with eating instead of not getting assistance with exercise), but the underlying fact that certain, necessary care would not be provided does not change.
- The CMS study only looked at the effects that reduced staffing would have on care in increments of 0.2 hours per resident day (*e.g.*, effects at 2.2 hours per resident per day, at 2.0 hours per resident per day,

etc.). When necessary, we filled in the additional .1 increments (*e.g.*, effects at 2.1 hours per resident per day) by averaging the care episodes missed in the two adjoining increments. For example, the number of care episodes missed at 2.1 hours per resident day was assumed to be the average of the care missed at 2.2 hours per resident per day and 2.0 hours per resident per day.

- The model is conservative in the assumptions it makes about the numbers of CNAs it would take to provide the necessary care. It assumes that all CNAs will work at extremely high productivity and efficiency levels.

The calculations in the simulation study are based on a low workload 40-bed unit with 100 percent occupancy. In this unit:

- 27 residents (67.5 percent) need assistance with incontinence care –repositioning, changing and/or toileting.
- 21 residents (52.5 percent) need assistance with eating.
- 40 residents (100 percent) need some form of assistance with exercise/mobility. For some residents it's only once every other day, for others it's as much as three times a day.
- 40 residents (100 percent) need some assistance to help dress and groom themselves. For some residents it's only a couple of minutes for others it can be as much as 15 minutes.

To calculate the number of incidents for which care would not be provided if Manor Care cut CNA staffing from 2.1 hours per resident per day to 1.9 hours per resident per day, we first took the number of care episodes (incontinent and exercise assistance) provided at the 2.1 hours per resident per day and subtracted the number of care episodes provided at the 1.9 hours per resident per day staffing levels.

This number of missed care episodes was then compared to the number of residents needing the particular care to come up with a percentage of residents that missed care that day. For example, if 10 exercise-related care incidents in a particular nursing home would be missed, and if there were 10 residents in that home who are likely at some point to need exercise-related care, then we assumed that the 10 missed incidents were spread evenly among the 10 residents and that all 10 residents (100 percent) would be affected by the reduced staffing.

The calculations on the number of Manor Care residents affected are based on extrapolating the percentage of residents affected in a 40-bed unit to the total number of Manor Care residents. For example, if 30 percent of the residents in the 40 bed unit missed at least one episode of incontinence care, then the report assumes that 30 percent of all Manor Care residents would miss at least one episode of incontinence care.

To calculate the total percentage of residents not receiving care we compared the number of care episodes missed to the total amount of care that should have been provided. In the case of incontinence care, this was 240 episodes per day in a low-workload 40-bed unit, and for exercise assistance (all other care) it was 323 episodes for a similar 40-bed unit.

Net Tax Effects of the Carlyle Buyout of Manor Care

Based on available data and conservative assumptions, we believe that Carlyle's buyout of Manor Care will reduce net taxes paid to federal and state governments by approximately $612 million during the time Carlyle holds it at as private company. What follows is an explanation of our assumptions and calculations.

Carlyle is buying Manor Care for $6.3 billion, with an equity contribution of $1.3 billion, and debt financing totaling $5.5 billion, consisting of $900 million in senior secured credit facilities and $4.6 billion under a secured real estate (CMBS) credit facility.[75] Based on current LIBOR rates and spreads, we assume an average blended interest rate of 7.5 percent to 8 percent for the debt.[76] We also assume that Manor Care will maintain a constant debt load, neither paying it down nor increasing its leverage during the Carlyle holding period.

Over the last four years, Manor Care has grown earnings before taxes (EBT) at a compound annual growth rate of approximately 6 percent[77], and we assume that growth rate will continue during the Carlyle holding period. We assume the length of that period to be five years, using the assumption JP Morgan used in its fairness opinion.[78] We also assumed an exit multiple of EBITDA equivalent to the purchase multiple, and that Carlyle would achieve an IRR of 21 percent, all consistent with the JP Morgan fairness opinion.[79]

For tax rates, we assumed that tax rates effective in 2006 would remain constant throughout the duration of Carlyle's ownership of Manor Care, including the effective corporate tax rate, the tax rates for dividends and for capital gains, as well as the tax rate for Carlyle's partners' carried interest. Finally, we assume that Manor Care's public shareholders are all taxable investors, since it is difficult to calculate the percentage of shares owned by tax-exempt investors, even though assuming some percentage of tax-exempt investors would exacerbate the effect of the transaction on tax revenues, since the taxes collected on capital gains created by the LBO exceed the taxes foregone by the lack of dividend payouts.

With those assumptions, here is a summary of our calculations:

With the assumed 6 percent growth rate, we assume Manor Care's EBT during the Carlyle holding period will total approximately $1.7 billion. However, the incremental interest payments on the debt will also total approximately $1.7 billion, completely wiping out the company's corporate tax liability.[80] Without those interest payments, Manor Care's corporate tax liability on the $1.7 billion in EBT would have totaled $615 million. In addition, if Manor Care had remained a public company and continued to pay out dividends at the current annual rate of 68 cents/share to shareholders, again assuming a 6 percent annual growth rate, shareholders would have received $320 million in dividends during the Carlyle holding period, which at the current 15 percent dividend tax rate would have generated $48 million in taxes, assuming all shareholders were taxable.

However, it could also be argued that the buyout itself created capital gains that generated taxes above what would have been collected absent the buyout. The $67/share buyout price represents a 20 percent premium over the closing stock price of $55.75 on April 10, 2007, prior to the company's April 11 announcement it would evaluate strategic alternatives.[81] If one assumes that all holders as of April 10 earned incremental long-term capital gains of $11.25 per share as a result of the buyout, and that all holders were taxable, then the buyout generated incremental capital gains taxes of $124 million.

Finally, if we plug all of our assumptions into a simple leveraged buyout model, then Carlyle would earn a total profit of $1.84 billion upon selling Manor Care after five years. Carlyle keeps 20 percent of that profit as its carried interest, and under current law Carlyle's individual partners' portions of that carried interest is taxed at the 15 percent rate for capital gains. If the tax treatment of carried interest were to be changed from capital gains to ordinary income, then the increased taxes Carlyle partners would owe the IRS would be $73.5 million.[82]

Summing these numbers up, if one adds up all the tax implications of the Carlyle LBO of Manor Care, federal and state governments stand to lose more than $600 million in tax revenues from Manor Care during the expected period of Carlyle ownership as a result of the LBO.

Parenthetically, we should note that Manor Care currently derives two-thirds of its revenue from government sources, i.e. Medicare and Medicaid. Using the same assumptions, those revenues add up to more than $15 billion in tax-funded dollars for healthcare services paid to Manor Care during the period of Carlyle ownership.

Endnotes

1 *New York Times*, "At Many Homes, More Profit and Less Nursing," by Charles Duhigg, Sept. 23, 2007.
2 The deal closed on Dec. 10, 2004, according to the company's filing with the SEC: http://www.sec.gov/Archives/edgar/data/882287/000095014405001475/g93259bsv8pos.htm.
3 This number, obtained from publicly available CMS data, represents the number of beds at 248 of the 252 facilities that were part of the deal. Four facilities that were part of the deal have since closed, and we are unable to find bed counts for those facilities.
4 Of the 252 facilities that were part of this deal, only 219 appear to still be operated by the company. For the purposes of this before and after analysis, only the 219 that continue to be operated by National Senior Care are looked at. A more detailed look at how the Mariner footprint was established and other issues can be found in the methodology section of this document.
5 CMS Quarterly data downloads beginning in the third quarter of 2003. Most recent survey data available based on a download of CMS quality inspection data which includes inspections through September 26, 2007.
6 Francis, Theo. "Real Estate Is Driver of Manor Care Buyout Deal—Nursing Home Firms, Attractive at Moment, Are Acquisition Targets." *Wall Street Journal*, July 3, 2007, A2.
7 Centers for Medicare and Medicaid Services, State Operations Manual, "Appendix P—Survey Protocol for Long Term Care Facilities—Part I—(Rev. 22, 12-15-06)," Section IV: Deficiency Categorization.
8 Centers for Medicare and Medicaid Services, State Operations Manual, "Appendix P—Survey Protocol for Long Term Care Facilities—Part I—(Rev. 22, 12-15-06)," Section IV: Deficiency Categorization.
9 Centers for Medicare and Medicaid Services, State Operations Manual, "Appendix P—Survey Protocol for Long Term Care Facilities—Part I—(Rev. 22, 12-15-06)," Section IV: Deficiency Categorization.
10 Based on information from "About the Nursing Home—Inspections," Centers for Medicare and Medicaid Services Nursing Home Compare data, downloaded 10/29/2007.
11 Centers for Medicare and Medicaid Services, State Operations Manual, "Appendix P—Survey Protocol for Long Term Care Facilities—Part I—(Rev. 22, 12-15-06)," Section IV: Deficiency Categorization.
12 Based on information from "About the Nursing Home—Inspections," Centers for Medicare and Medicaid Services Nursing Home Compare data, downloaded 10/29/2007.
13 Belmont Lodge Health Care Center, inspection dated 3/29/2007. Available online at http://www.hfemsd1.dphe.state.co.us/hfd2003/dtl3.aspx?tg=0314&eid=9GVR11&ft=ncf&id=020619&bdg=00&reg=FF04
14 Palisades Living Center, inspection dated 12/14/2006. Available online at: http://www.hfemsd1.dphe.state.co.us/hfd2003/dtl3.aspx?tg=0353&eid=FRUQ11&ft=ncf&id=021137&bdg=00&reg=FF03
15 Beverly Finishes Sale to Fillmore, Arkansas Democrat-Gazette (Little Rock), March 15, 2006.
16 http://www.sec.gov/Archives/edgar/data/1040441/000114336207000017/0001143362-07-000017.txt
17 Center for Medicare and Medicaid Services, September 2004-September 2007.
18 Golden Living Center—Lima, inspection dated 12/4/2006. Available online at: http://www.ltcohio.org/consumer/viewinspection.asp?Regid=F&Tag=0324&Id=GIWD1&StaffId=AONMT&Date=12/04/2006&Key=100377&Plan=Y.
19 Golden Living Center—Camp Hill, inspection dated 4/11/2007. Available online at: http://app2.health.state.pa.us/commonpoc/Content/PublicWeb/ltc-survey.asp?Facid=030502&PAGE=1&NAME=GOLDEN+LIVINGCENTER%2DCAMP+HILL&SurveyType=H&COUNTY=CUMBERLAND
20 Golden Living Center—Valley, inspection dated 12/1/2006. Available online at: http://www.ltcohio.org/consumer/viewinspection.asp?Regid=F&Tag=0354&Id=BVPR1&StaffId=RDRSR&Date=12/01/2006&Key=100621&Plan=Y
21 http://aspe.hhs.gov/daltcp/reports/2006/NHdivest.htm
22 Joseph E. Casson and Julia McMillan. "Limiting Liability Through Corporate Restructuring." *Journal of Health Law, Fall 2003*, p. 11.
23 Counsel to Counsel Magazine. "A Study in Complexity: Mariner Health Care Inc. and Powell Goldstein LLP" by Scott M. Gawlicki, March 2005, pp. 27-29.
24 Standard and Poors, "Presale: Credit Suisse First Boston Mortgage Securities Corp.," published December 7, 2004, reprinted from RatingsDirect, p. 6.

25 Counsel to Counsel Magazine. "A Study in Complexity: Mariner Health Care Inc. and Powell Goldstein LLP" by Scott M. Gawlicki, March 2005, pp. 27-29.
26 Mariner Health Care Inc. Form DEFM14A filed with SEC on10/22/04, p. 5.
27 Review of Licensure and Certification Applications submitted to California Department of Health Services by several former Mariner facilities, including Diamond Ridge HealthCare Center (Pittsburg) application signed 12/5/05, Excell HealthCare Center (Oakland) application signed 1/10/07and Hayward Hills HealthCare Center (Hayward) application signed 3/6/07.
28 Counsel to Counsel Magazine. "A Study in Complexity: Mariner Health Care Inc. and Powell Goldstein LLP" by Scott M. Gawlicki, March 2005, pp. 27-29.
29 Cost growth figures are based on analysis of 2001–2005 Medicare cost report data for 212 facilities currently operated by National Senior Care and purchased from Mariner in December 2004. Analysis excluded facilities that did not report complete data in all years analyzed. Capital-related costs for buildings and fixtures and interest-related expenses were taken from Sheet A, column 2, lines 1 and 53 of the cost report. Data was summed for facilities submitting multiple cost reports and costs were annualized by facility.
30 *New York Times*, "At Many Homes, More Profit and Less Nursing," by Charles Duhigg, Sept. 23, 2007.
31 *Toledo Blade*, Manor Care sale would enrich execs; Firm's officials may receive more than $200M for stock, July 6th 2007.
32 For an explanation of our assumptions and calculations see Methodology
33 April 10 is the day before HCR Manor Care announced it had retained JP Morgan to help it evaluate "strategic alternatives."
34 Manor Care Inc., Form 10-K filed with SEC on 2/21/2007, p. 5.
35 Manor Care Inc., Form 10-K filed with SEC on 2/21/2007, p. 17.
36 Based on information from "About the Nursing Home–Inspections," Centers for Medicare and Medicaid Services Nursing Home Compare data. For the violation analysis of the current state of these facilities we used the most recent survey data available based on a download of CMS quarterly inspection data which included inspections through Sept. 26, 2007.
37 ibid
38 Based on information from "About the Nursing Home–Staff," Centers for Medicare and Medicaid Services Nursing Home Compare data. For the staffing analysis of the current state of these facilities we used the most recent survey data available based on a download of CMS data which included staffing reports through Sept. 26, 2007.
39 Schnelle, et al. Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes: Phase II final report. Centers for Medicare and Medicaid Services, December 2001.
40 Based on information from "About the Nursing Home–Inspections," Centers for Medicare and Medicaid Services Nursing Home Compare data. For the violation analysis of the current state of these facilities we used the most recent survey data available based on a download of CMS quarterly inspection data which included inspections through Sept. 26, 2007.
41 Based on information from "About the Nursing Home–Inspections," Centers for Medicare and Medicaid Services Nursing Home Compare data. For the violation analysis of the current state of these facilities we used the most recent survey data available based on a download of CMS quarterly inspection data which included inspections through Sept. 26, 2007.
42 Manor Care at Arlington Heights, complaint investigation dated 6/7/2007. Available online at: http://www.idph.state.il.us/ltc/docs/SurveyResult/6000228FA06072007.pdf
43 Heartland of Perrysburg, certification inspection dated 1/26/2006. Available online at: http://www.ltcohio.org/consumer/viewinspection.asp?Regid=F&Tag=0324&Id=TIPH1&StaffId=RMOAS&Date=01/26/2006&Key=100808&Plan=Y
44 Heartland of Bellefontaine, complaint investigation dated 1/2/2007. Available online at: http://www.ltcohio.org/consumer/viewinspection.asp?Regid=F&Tag=0280&Id=EZEH1&StaffId=AOTTN&Date=01/02/2007&Key=100798&Plan=Y

45 Manor Care Health Services—Camp Hill, complaint investigation dated 6/8/2007. Available online at: http://app2.health.state.pa.us/commonpoc/Content/PublicWeb/ltc-survey.asp?Facid=382102&PAGE=1&NAME=MANORCARE+HEALTH+SERVICES%2DCAMP+HILL&SurveyType=H&COUNTY=CUMBERLAND

46 Manor Care Inc., Form 10-K filed with SEC on 2/21/2007, p. 44-45.

47 Manor Care Inc., Form DEFM14A filed with SEC on 9/14/07, p. 5.

48 A blended interest rate range of 7.5% to 8% is estimated using a one-month London Interbank Offered Rate (LIBOR) of approximately 5% plus a spread of 275 basis points (bps) on the $700 million term loan to be used to finance the deal, and an assumed spread of 200 bps above LIBOR on the $4.6 billion commercial mortgage-backed securities (CMBS) facility also used to finance the deal. A lower spread above LIBOR *(i.e.*, a lower interest rate) is assumed for the CMBS facility due to the security of the underlying property. See Donnelly, Chris, "Manor Care seeks TL Commitments at 98 OID," S&P LCD News, Oct. 19, 2007, and Donnelly, Chris, "Manor Care Details Financing for $6.6B LBO," S&P LCD News, Sept. 14, 2007. One month LIBOR was accessed on October 23, 2007 at http://www.bankrate.com/brm/ratewatch/1mo-libor.asp.

49 Manor Care Inc., Form 10-K filed with SEC on 2/21/2007, p. 24.

50 "Restoring Urinary Continence," American Journal of Nursing, January 1991, Diane Kaschak Newman, Karen Lynch, Diane A. Smith, Paula Cell.

51 "Translating Clinical Research into Practice: A Randomized Controlled Trial of Exercise and Incontinence Care with Nursing Home Residents" John F. Schnelle Ph.D. et. al. *Journal of the American Geriatric Society, approved for publication September 2002.*

52 "Malnutrition and Dehydration in Nursing Homes: Key Issues in Prevention and Treatment," Sarah Greene Burger, Jeanie Kayser-Jones and Julie Prince Bell, National Citizens Coalition for Nursing Home Reform, June 2000.

53 "Mobility: A Basic Human Need", Teresa Tempkin, Quality Care Advocate, June/July 1993.

54 "Costs of Promoting Independence" John F. Schnelle, Ph.D. and Cornelia Beck, Ph.D., *Journal of the American Geriatric Society, September 1999.*

55 Quoted in "Inquiries at Investor-Owned Nursing Homes," *New York Times*, Oct. 24, 2007.

56 "Manor Care Buyout has Local Effect," *Williamsport Sun Gazette*, Oct. 11, 2007.

57 Manor Care 14A filing, dated 9/14/2007, pp. 62-64

58 Joseph E. Casson and Julia McMillan. "Limiting Liability Through Corporate Restructuring." *Journal of Health Law, Fall 2003*, p.2

59 "Real Estate Is Driver Of Manor Care Buyout Deal," *Wall Street Journal*,July 3, 2007.

60 Manor Care 14A filing, dated 9/14/2007, p. 5.

61 Quoted in "Real Estate is Driver of Manor Care Buyout Deal," *Wall Street Journal*,, July 3, 2007.

62 "Ill Wind hits Carlyle Healthcare Deal," *Financial Times*, October 25, 2007.

63 http://www.sec.gov/Archives/edgar/data/882287/000095014405001475/g93259bsv8pos.htm.

64 "http://www.savaseniorcare.com/www/Locations/Default.aspx"

65 Beverly Finishes Sale to Fillmore, *Arkansas Democrat-Gazette* (Little Rock), March 15, 2006.

66 Golden Chain of Corporate Names, Arkansas Business, Febr. 26, 2007.

67 Ibid.

68 http://www.beverlycares.com/BL/Find+a+Nursing+Home/C_LocationSearch_Landing.htm
http://www.goldenlivingcenters.com/GGNSC/Find+a+Nursing+Home/C_LocationSearch_Landing.htm

69 Those 19 states are Alabama, California, Colorado, Connecticut, Georgia, Illinois, Massachusetts, Maryland, Michigan, Mississippi, North Carolina, Nebraska, Pennsylvania, South Carolina, Tennessee, Texas, West Virginia, Wisconsin, and Wyoming.

70 Those 23 states are Alabama, Arkansas, California, District of Columbia, Georgia, Indiana, Kansas, Kentucky, Massachusetts, Maryland, Minnesota, Missouri, Mississippi, North Carolina, Nebraska, New Jersey, Ohio, Pennsylvania, South Carolina, South Dakota, Tennessee, West Virginia, and Wisconsin.

71 There were problems with CMS 2003 violation data and this prevented us including those homes whose survey date closest to the sale was in 2003.

72 n=396

73 *2005-2006 AAHSA Nursing Home Salary and Benefits Report*; Hospital and Healthcare Compensation Service, effective date of data May 2005.

74 Bureau of Labor Statistics Employer Costs for Employee Compensation—June 2007, Service Workers in Nursing Care Facilities p. 23.

75 Manor Care, Inc Preliminary Proxy Statement, Schedule 14A, filed Aug. 6, 2007, with the SEC. Total capital exceeds the purchase price because of fees and expenses, and to fund a revolving line of credit.

76 A blended interest rate range of 7.5% to 8% is estimated using current one month LIBOR of approximately 5% plus a reported spread of 275 bps on the $700 mil term loan of Manor Care's operating company, and an assumed lower spread of 200 bps above LIBOR on the $4.6 billion CMBS loan, due to the security of the underlying property. See Donnelly, Chris, "Manor Care seeks TL Commitments at 98 OID," S&P LCD News, Oct. 19, 2007, and Donnelly, Chris, "Manor Care Details Financing for $6.6B LBO," S&P LCD News, Sept. 14, 2007. One month LIBOR was accessed on Oct. 23, 2007 at http://www.bankrate.com/brm/ratewatch/1mo-libor.asp.

77 Capital IQ

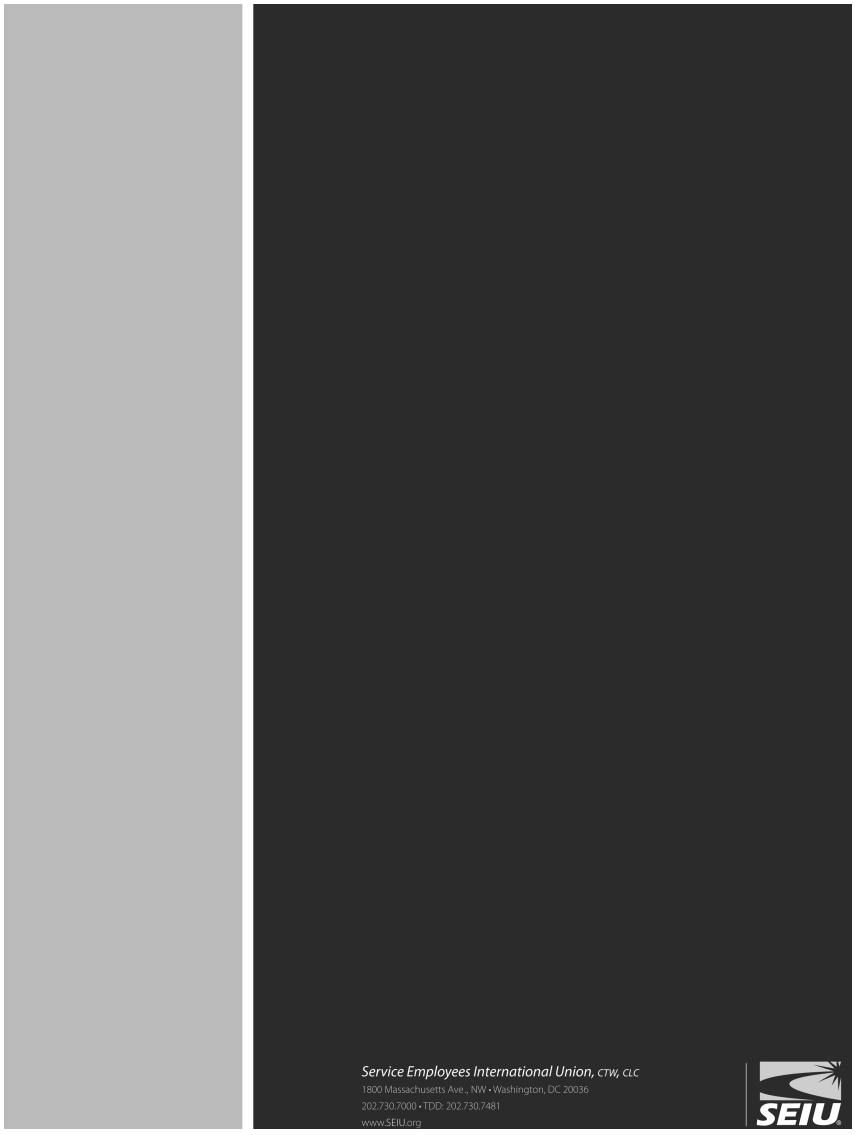
78 Manor Care, Inc. Schedule 14A, Aug. 6, 2007, p. 28.

79 Ibid.

80 Manor Care's FY 2006 interest payments were a low $31.5 million, with most of its debt being in the form of long-term, low-interest convertible notes. We assume those payments would have remained constant had Manor Care remained a public company, and we subtract the five-year total of those payments from the payments on the new debt Manor Care will take on to fund the buyout. While these interest payments would be taxable to taxable holders of the debt, most taxable debt is held by tax-exempt investors. Raghavan, Anita, "Debt and the Corporate Tax Base," *Wall Street Journal,* June 16, 2007, p.A5.

81 Manor Care Press Release, July 2, 2007, at http://www.hcr-manorcare.com/investor/strategicalternative.asp

82 It should be noted that Carlyle's limited partners will also pay taxes on their share of the capital gains to the extent that they are taxable. This analysis does not seek to compare what Manor Care's public shareholders would have paid in capital gains had the company remained public, since it would be difficult to calculate what Manor Care's public share price would be even with the same growth assumptions, and it is difficult to model capital gains tax collections from the sale of public shares absent a corporate transaction.. However, since public companies tend to have a higher percentage of taxable shareholders than private equity limited partnerships, it is safe to assume that the same amount of capital gains would produce a higher amount of taxes in a public company than in one owned by private equity.



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Mr. MULLER. SEIU analyzed OSCAR deficiency data available from CMS. We looked at two major nursing home chains, Mariner Health Care and Beverly Enterprises, which were bought buy private equity firms. In December 2004, Mariner Health Care, comprised at that time of 252 facilities with about 30,000 nursing home beds across 19 States was taken private by National Senior Care, a private equity firm. To analyze the impact of the buyout of Mariner, we compared the number of Federal resident care violations from the annual inspections prior to being bought out by private equity with the number of violations found during their most recent annual inspections.

The results were distressing. We found a 29.4 percent increase in violations of Federal resident care standards during their most recent inspections. This was more than double the 11.9 percent increase in violations among non-Mariner homes in the States in which Mariner operates. The next analysis we did was to look at the severity of the violations. Violations of resident care, otherwise known as deficiencies, have four levels of severity: Deficiencies with potential for minimal harm; deficiencies with potential for actual harm; deficiencies that cause actual harm; and finally, the most serious deficiencies, those that cause immediate jeopardy.

As you can see from this slide, we looked at all four categories and discovered that not only are there more deficiencies in the now private equity-owned Mariner homes, but the most serious deficiencies, those causing actual harm or immediate jeopardy, increased the most. Deficiencies that caused actual harm increased by 66.7 percent for Mariner homes, while only increasing 1.5 percent for non-Mariner homes. Immediate jeopardy deficiencies increased by 87.5 percent, compared to a 13.3 percent increase for non-Mariner homes.

As you can see from the next slide, over the same period the percent of Mariner facilities cited for 10 or more deficiencies during an inspection increased from 25.1 percent prior to the sale to 43.8 percent of facilities after the sale. Non-Mariner homes in the same States saw a much smaller increase over that time, from 21.6 of all facilities to 25.9 percent of all facilities. As *The New York Times* article indicated, Mariner's performance post-buyout is not an anomaly, and for more details I refer you to our report.

Furthermore, holding private equity firms accountable for poor quality of care is exceedingly difficult. Private equity firms restructure nursing homes to maximize profit, but in the end, create a maze of control and ownership that makes it difficult to hold nursing homes and private equity companies accountable for providing quality care.

A December 2006 study prepared by Harvard Medical School experts for the U.S. Department of Health and Human Services detailed these impacts. Quote, Integrated Health Services, Mariner Health Care, and most recently Beverly are examples where equity groups purchased chains with the intention of separating the real estate and operations, with the goals of limiting liability and enhancing profitability.

Now, private equity firms are poised to become even more dominant in the nursing home industry, as the Carlyle Group, one of the world's largest private equity buyout firms, moves to complete

the $6.6 leveraged buyout of HCR ManorCare, one of the Nation's largest nursing home care providers. ManorCare claims it has no intention of changing its operating structure or of separating its nursing home's real estate from management. But ManorCare's own public filings indicate it plans a significant restructuring as part of the deal.

As you can see from this slide, documents filed by ManorCare with State regulators indicate that the company's restructuring will send each nursing home's operation to an entirely new corporate entity and will separate real estate and operations into two completely separate companies, with multiple layers of corporate ownership between these companies and the parent company. This four-tiered structure may shield ManorCare's assets and distance itself from liability because part of Carlyle's restructuring plan involves creating multiple limited liability corporations. Limited liability means just that, limited. If patients can only get redress from the entity operating the home, that entity may have no real estate assets, and little ability to pay.

While I am neither a lawyer or an accountant, and thus cannot testify as to the legal aspects of this corporate restructuring, I do know, based on a study of other nursing home buyouts, that these proposed structures raise some troubling questions. For example, will the Federal Government, State regulators, residents and their families be able to hold Carlyle accountable with its maze of limited liability corporations? How can the Federal Government and the States ensure transparency and accountability in this buyout and others? Our research demonstrates that care suffers under private equity's ownership, and at the same time these companies appear to shield themselves from liability for their poor care.

Congress must exercise its oversight authority to ensure that Medicare and Medicaid dollars are spent as intended, to provide high quality care. As Congress considers a Medicare bill, we urge you to include Medicare reforms that increase transparency and accountability. Last week SEIU, in conjunction with other advocacy organizations, sent your Committee a letter outlining our suggestions for reform.

We would like to submit that letter as supplemental testimony for the official record of this hearing.

[The information follows:]

******* Not available at the time of printing ********

Mr. MULLER. We would urge you to use the nursing home revisit fees as a tool to hold private equity homes accountable for quality of care and safety. Taxpayers trust that Medicare and Medicaid dollars will go toward providing seniors and the disabled with the quality care they deserve. Profits should not come at the expense of nursing home residents, their families, caregivers and taxpayers. I thank you for inviting me here today to testify about SEIU's concerns about private equity ownership of nursing homes. Thank you.

[The prepared statement of Mr. Muller follows:]

Prepared Statement of Arvid Muller, Assistant Director of Research, Service Employees International Union

Thank you for giving me the opportunity to appear before you today. I am the Assistant Director of Research for the Service Employees International Union (SEIU). SEIU represents almost one million health care workers, including more than 150,000 nursing home workers.

Twenty years after Congress passed landmark nursing home reform legislation, the modest but real progress made since 1987 is being threatened by a new breed of nursing home operator—private equity firms. The private equity business model seeks to make extreme profit at the expense of nursing home residents, their families, caregivers, and taxpayers. On September 23, *The New York Times* published an investigative story confirming what many caregivers in our nation's nursing homes already know: *Medicare and Medicaid resources that are intended to support vulnerable Americans are being diverted to the private benefit of wealthy investors*.

The New York Times found that among other concerns with private equity ownership of nursing homes, there are serious quality of care deficiencies. SEIU, in a new report "Equity and Inequity: How Private Equity Buyouts Hurt Nursing Home Residents," which we are submitting as supplemental testimony for the official record of this hearing, confirmed the findings of the NYT article. SEIU analyzed Online Survey, Certification, and Reporting (a.k.a. OSCAR) data available from the Centers for Medicare and Medicaid Services (CMS). We looked at two major nursing home chains, Mariner and Beverly Enterprises, which were bought by private equity firms. In December 2004, Mariner Health Care Inc. (252 facilities with 29,685[1] nursing home beds across 19 states) was taken private by National Senior Care Inc., a private equity firm.[2] To analyze the impact on quality care of National Senior Care's buyout of Mariner, we compared the number of federal resident care violations from the annual inspection prior to being bought by private equity with the number of resident care violations found during their most recent annual inspection for each of the homes. The results were distressing. We found a 29.4% increase in violations of federal resident care standards during the most recent inspections since it was acquired by National Senior Care. This was more than double the 11.9% increase in violations in the other homes in the states in which Mariner operates.[3]

The next analysis we did was to look at the severity of the violations. Violations of resident care, (a.k.a. deficiencies) have four levels of severity.

The first, deficiencies with "potential for minimal harm" are those that have the potential for causing no more than a minor negative impact on a resident.[4]

Next are deficiencies with "potential for actual harm" reflecting non-compliance on the part of the nursing home in a way that causes, or has the potential to cause, no more than minimal physical, mental, or psycho-social harm to a resident.[5]

Then there are deficiencies that "cause actual harm" causing real injury to fragile nursing home residents.[6] Examples of actual harm citations include:

- Failure to give each resident enough fluids to keep them healthy and prevent dehydration.
- Failure to give residents proper treatment to prevent new bed (pressure) sores or heal existing bed sores.
- Make sure that residents who cannot care for themselves receive help with eating/drinking, grooming and hygiene.[7]

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[1] This number, obtained from publicly available CMS data, represents the number of beds at 248 of the 252 facilities that were part of the deal. Four facilities that were part of the deal have since closed, and we are unable to find bed counts for those facilities.

[2] Francis, Theo. "Real Estate Is Driver of ManorCare Buyout Deal—Nursing-Home Firms, Attractive at Moment, Are Acquisition Targets." *Wall Street Journal*, July 3 2007, A2.

[3] Aug 23 07 download of OSCAR.

[4] Centers for Medicare and Medicaid Services, State Operations Manual, "Appendix P—Survey Protocol for Long Term Care Facilities—Part I—(Rev. 22, 12–15–06)," Section IV: Deficiency Categorization.

[5] Centers for Medicare and Medicaid Services, State Operations Manual, "Appendix P—Survey Protocol for Long Term Care Facilities—Part I—(Rev. 22, 12–15–06)," Section IV: Deficiency Categorization.

[6] Centers for Medicare and Medicaid Services, State Operations Manual, "Appendix P—Survey Protocol for Long Term Care Facilities—Part I—(Rev. 22, 12–15–06)," Section IV: Deficiency Categorization.

[7] Based on information from "About the Nursing Home—Inspections," Centers for Medicare and Medicaid Services Nursing Home Compare data, downloaded 10/29/2007.

Finally we have deficiencies that "cause immediate jeopardy" meaning that something the nursing home did or failed to do put residents' health, safety, and lives directly in harm's way. These deficiencies require immediate correction.[8]

Examples of immediate jeopardy citations include:

- (1) Failure to hire only people who have no legal history of abusing, neglecting or mistreating residents; or (2) failure to report and investigate any acts or reports of abuse, neglect or mistreatment of residents.
- Failure to protect each resident from all abuse, physical punishment, and being separated from others.[9]

We looked at all four categories and discovered than not only are there more deficiencies in the now private equity-owned Mariner homes, but the most serious deficiencies—those causing immediately jeopardy, increased the most. TALK THRU CHART/SLIDE.

Deficiency Type	**Mariner % Increase Post Buyout**	**Non-Mariner % Increase**
All Deficiencies	29.4%	11.9%
Potential for Minimal Harm	−8.0%	−13.3%
Potential for Actual Harm	33.6%	18.0%
Actual Harm	66.7%	1.5%
Immediate Jeopardy	87.5%	13.3%

Over the same period, the percent of Mariner facilities cited for 10 or more deficiencies during an inspection increased from 25.1% prior to sale to 43.8% of facilities. Other facilities operating in the same states as Mariner saw a much smaller increase over that time, from 21.6% of all facilities cited for 10 or more deficiencies to 25.9% of all facilities.

There are real people behind these violations who suffered needlessly. After one facility failed to prevent and properly treat a resident's bed sores, the resident's wound worsened so much that the resident had to have his leg amputated above the knee. And 3 weeks after the resident's leg was amputated, the resident developed three more pressure sores on his other foot.

As the NYT articles indicated, Mariner's performance post-buyout is not an anomaly. When we looked at the impact of the sale of Beverly Enterprise to Fillmore Capital Partners, we saw a similar increase in federal violations during their most recent inspections when compared to inspections immediately prior to the sale. Since Beverly's sale to a private equity company in March 2006, their most recent annual inspections show a 19.4% increase in violations, more than double the 8.2% increase in violations cited in other homes located in the states where Beverly operates.[10] The quality of care at nursing homes is a serious concern throughout the industry, but this analysis of the CMS data, indicates an even greater cause for alarm at private equity-owned firms.

And holding private equity firms accountable for poor quality of care is exceedingly difficult. Private equity firms restructure nursing homes to maximize profit but in the end create a maze of control and ownership that makes it difficult to hold nursing homes and private equity companies accountable for providing quality care. A December 2006 study prepared by Harvard Medical School experts for the U.S. Department of Health and Human Services, detailed these impacts:

> "Integrated Health Services, Mariner Health Care, and, most recently, Beverly, are examples where equity groups purchased chains with the in-

[8] Centers for Medicare and Medicaid Services, State Operations Manual, "Appendix P—Survey Protocol for Long Term Care Facilities—Part I—(Rev. 22, 12–15–06)," Section IV: Deficiency Categorization.

[9] Based on information from "About the Nursing Home—Inspections," Centers for Medicare and Medicaid Services Nursing Home Compare data, downloaded 10/29/2007.

[10] *Ibid*.

tention of separating the real estate and operations with the goals of limiting liability and enhancing profitability."[11]

As the new owners of Mariner, National Senior Care hired roughly 80 attorneys from a half-dozen law firms to help design and execute a complicated web of corporate structures that took nearly 7 months to complete. To help pay for the deal, National Senior Care immediately sold approximately two-thirds of the homes they had purchased to another company called SMV Property Holdings.[12] SMV set up separate real estate holding companies for each of the properties purchased[13] and then leased the facilities back to Mariner or SavaSenior Care,[14] an affiliate of National Senior Care.[15] Adding to the structural complexity, documents submitted to California regulators indicate that at least some former Mariner homes are actually run by subsidiary operating companies that are unique to each location.[16] Not surprisingly, the lawyers who helped set up the National Senior Care deal called it one of the most complicated transactions they had ever been involved in.[17]

While we don't know the exact amount of rent that the Mariner homes paid to these related parties—all owned by National Senior Care—the building and fixture-related capital costs that Mariner reported on its Medicare cost reports rose by 60% the year after National Senior Care took over. (For comparison purposes, in the previous 3 years it had increased by a total of only 11%.) In addition, interest expense payments, an indicator of how much debt has been incurred, increased by 145% from 2004 to 2005, the year after the buyout. At the same time, the number of Mariner facilities that reported any interest expenses in 2005 was more than four times the number that had reported interest expenses in any of the previous 3 years.[18]

Private equity firms are poised to become even more dominant in the nursing home industry as the Carlyle Group one of the world's largest private equity buyout firms, moves to complete the $6.6 billion leveraged buyout of HCR ManorCare, the nation's largest nursing home care provider. This buyout should raise serious concerns for nursing home staff trying to provide quality care; for state surveyors whose job it is to provide ongoing oversight on behalf of Medicare; for the taxpayers who fund the bulk of this care and; most importantly, for the residents who may suffer as Carlyle Group and ManorCare executives pay themselves millions while saddling ManorCare with billions in debt. It is unclear how ManorCare could service such high debt without affecting the quality of care.

In response to *The New York Times* investigation, ManorCare has claimed in communications to employees that it has no intention of changing its "operating structure" or of separating its nursing homes' real estate from management.[19]

But ManorCare's own SEC filings and filings in the states reveal that it plans a significant "restructuring" as part of the deal.[20] While I am neither a lawyer nor an accountant, and thus cannot testify as to the legal aspects of this corporate restructuring, I do know based on study of other nursing home buyouts that this corporate restructuring should raise serious concerns. It appears from the documents filed by ManorCare that the company's "restructuring" will send each nursing home's operations to an entirely new corporate entity and will separate real estate and operations into two completely separate companies, with multiple layers of corporate ownership between these companies and the corporate parent. Applications for nursing home licenses in Maryland, Michigan, Washington, and

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[11] http://aspe.hhs.gov/daltcp/reports/2006/NHdivest.htm

[12] Counsel to Counsel Magazine. "A Study in Complexity: Mariner Health Care Inc. and Powell Goldstein LLP" by Scott M. Gawlicki, March 2005, pages 27–29.

[13] Standard & Poors, "Presale: Credit Suisse First Boston Mortgage Securities Corp.," published December 7, 2004, reprinted from RatingsDirect, page 6.

[14] Counsel to Counsel Magazine. "A Study in Complexity: Mariner Health Care Inc. and Powell Goldstein LLP" by Scott M. Gawlicki, March 2005, pages 27–29.

[15] Mariner Health Care Inc. Form DEFM14A filed with SEC on 10/22/04, p. 5.

[16] Review of Licensure & Certification Applications submitted to California Department of Health Services by several former Mariner facilities, including Diamond Ridge HealthCare Center (Pittsburg) application signed 12/5/05, Excell HealthCare Center (Oakland) application signed 1/10/07 and Hayward Hills HealthCare Center (Hayward) application signed 3/6/07.

[17] Counsel to Counsel Magazine. "A Study in Complexity: Mariner Health Care Inc. and Powell Goldstein LLP" by Scott M. Gawlicki, March 2005, pages 27–29.

[18] Cost growth figures are based on analysis of 2001–2005 Medicare cost report data for 212 facilities currently operated by National Senior Care and purchased from Mariner in December 2004. Analysis excluded facilities that did not report complete data in all years analyzed. Capital-related costs for buildings and fixtures and interest-related expenses were taken from Sheet A, column 2, lines 1 and 53 of the cost report. Data was summed for facilities submitting multiple cost reports and costs were annualized by facility.

[19] "ManorCare Buyout has Local Effect," *Williamsport Sun Gazette*, October 11, 2007.

[20] ManorCare 14A filing, dated 9/14/2007, pp. 62–64.

West Virginia lay out a four-tiered structure for Carlyle to shield ManorCare's assets and distance itself from any liability for poor care in ManorCare homes (talk thru slide):

(1) Create a corporation as a holding company to own the entire ManorCare chain;
(2) Create limited liability corporations for the operations of individual ManorCare homes;
(3) Create limited liability corporations for the real estate holdings of individual ManorCare homes;
(4) Create another affiliated corporation to lease all the properties from the ownership corporations, and then sublease to the operating corporations.

Part of Carlyle's restructuring plan involves creating multiple limited liability corporations, and "limited liability" means just that, limited—if patients can get redress only from the entity operating the home, that entity may have no real estate assets. Will the federal government, state regulators and residents and their families be able to hold Carlyle accountable with a maze of LLCs? How can the federal government and the states ensure transparency and accountability in this buyout and others?

The New York Times and our research demonstrate that care suffers under private equity's ownership and at the same time these companies appear to shield themselves from liability for their poor care. Congress must exercise its oversight authority to ensure that Medicare and Medicaid dollars are spent as intended—to provide high quality care. As Congress considers a Medicare bill, we urge you to include Medicare reforms that increase transparency and accountability. Last week, SEIU, in conjunction with other advocacy organizations sent your Committee a letter outlining our suggestions for reform. We would like to submit that letter as supplemental testimony for the official record of this hearing. We also urge you to use the nursing home "revisit fees" as a tool to hold private equity-owned homes accountable for quality of care and safety. Taxpayers trust that Medicare and Medicaid dollars will go toward providing seniors and the disabled with the quality care they deserve. Profit should not come at the expense of nursing home residents, their families, caregivers, and taxpayers. I thank you for inviting me here to testify about SEIU's concerns about private equity ownership of nursing homes.

Mr. STARK. Thank you very much. I don't want to say I don't care what the ownership structure of nursing homes—what form it takes. I am concerned about several things. As a person who a thousand years ago organized a bank, I was able to fool the regulators into thinking I was a good person. You know, of high responsibility and ethics and morals. But there was a requirement you couldn't start a bank if you were a crook. I suspect to get a legal license, Mr. Hulshof has to prove what we all know, that he is an honorable, respectable gentleman or he couldn't have got admitted to the Bar. I don't know what we do in hospitals or other areas, but in many areas, it is the individuals who will be responsible for the management who have to be vetted.

I suspect that that should be true in nursing homes, that those individuals who will make decisions about how money is spent or how money is invested ought to pass some kind of muster. That is step one. Two, I think you ought to be able to get a hold of these people in a meaningful way. If you have got a billion dollar corporation and you are going to assess piddly little fines of a couple hundred bucks a day, that doesn't make any difference to them. But if they are subject to, you know, if you got a good lawyer like Mr. Hulshof after them, and you have got some million dollar judgment against them and there is only $50,000 in the bank, that doesn't do you much good. It won't even pay his fees, much less pay anything to the person who was damaged.

So, it seems to me that you have the management quality assurance of however you do that; and secondly, you have to have some way, whether it is bonding or insurance, and bonding makes some sense to me, but I am not that familiar with what they cost and how easy it is to enforce a judgment or a fine against a bonding company. But if you can do that, then it is oh, never mind to me, again, whether the operator of the nursing facility is paying rent or paying interest or owns the property, the real estate free and clear, as long as regulators or aggrieved or harmed patients can get after them.

The other issues, and I don't think they have anything to do, I don't think we can identify them very clearly, at least I think we get into a brouhaha, is basing factors of quality or minimum standards of service based on ownership. I suspect that there are standards, whether it is food that is prepared in a sanitary, hygienic, and sufficient manner; whether the building has proper safety precautions like fire escapes and that sort of thing; whether there is adequate staffing.

I don't want to get into the—I don't think that Congress wants to decide whether you need RNs or other types of professionally trained people. Somebody should be able to set minimum standards of care as you suggest, General Johnson, and baseline, and hopefully we could go from there. But where we can provide to State regulators the opportunity to enforce their mandates because they can't collect on a fine or they can't cause enough financial impetus for the owner or the director to do the right thing, I think it is incumbent on us to do that. I think that means that we have to set some sort of standards for each unit and relate the ability to get the assets to the owner, to the aggregate of the facility and/or facilities. If it is the CEO of Carlyle, then the CEO of Carlyle ought to be at risk, it seems to me, for what happens in the lowliest, smallest subsidiary in his or her arrangement of corporations. That will get their attention, I suspect, more than just issuing a statement of concern, which sounds very nice, but which is unenforceable.

So, I appreciate all of your testimony, and if anybody disagrees with that they can raise their hand. Otherwise I am going to recognize Mr. Camp to agree with me. You can add to this later, but I know a lot of my colleagues want to question or inquire. Mr. Camp?

Mr. CAMP. Thank you, Mr. Chairman. I just have a few questions, and my time is limited, so Ms. Harrington, I would like to better understand—or Dr. Harrington, I would like to better understand the magnitude of the issue before us today. Can you please tell me what percentage of nursing home beds are owned by private investment groups, if you know, nationwide?

Ms. HARRINGTON. Nationwide we don't know right now. But that is partly because CMS does not have a tracking system, and private equity owners do not have to be listed as the licensee.

Mr. CAMP. Looking at *The New York Times* article, they said that six of the ten largest chains had been purchased, which is about 141,000 beds——

Ms. HARRINGTON. Yes, that is right.

Mr. CAMP [continuing]. Which would be about 9 percent.

Ms. HARRINGTON. Yes, that is right.

Mr. CAMP. They said in the smaller chains, they have bought an additional 60,000 beds. So, it looks like currently about 200,000 beds. Would that be fair? Which would be roughly 15 percent of the beds nationwide in private investment. Dr. Schnelle, you make the point that adequate staffing levels in nursing homes decline. As those decline, so does the quality of care. Can you tell me what would the effect of a $6.5 billion reduction in Medicare nursing home payments do to the ability—on staffing ratios?

Mr. SCHNELLE. I can't give you a number. Obviously, it would make them significantly worse than they are now. But my other point was you might not recognize how much worse care would be with existing measures. The care that would be significantly worse would be at the bedside level.

Mr. CAMP. Is whether the staff in the facilities are union or nonunion a part of your study? Would that make any difference?

Mr. SCHNELLE. Wasn't part of my study.

Mr. CAMP. So, you didn't look at it?

Mr. SCHNELLE. No.

Mr. CAMP. In your opinion do you think it would make a difference?

Mr. SCHNELLE. I am not sure.

Mr. CAMP. All right. You published a report for CMS in 2002?

Mr. SCHNELLE. Yes.

Mr. CAMP. Which you make recommendations for minimum staffing levels in nursing homes.

Mr. SCHNELLE. Yeah.

Mr. CAMP. Did you estimate how much it would cost to provide those new minimum staffing requirements?

Mr. SCHNELLE. I didn't, but CMS did. It would cost significantly more.

Mr. CAMP. Do you know if any of the recommendations in your report have been adopted by CMS?

Mr. SCHNELLE. No, they have not been adopted.

Mr. CAMP. Okay. Do hospitals have minimum staffing requirements, if you know?

Mr. SCHNELLE. Yes. In some States at least. In California they do.

Mr. CAMP. In most States do they?

Mr. SCHNELLE. I don't know.

Mr. CAMP. Mr. Johnson, in Mississippi, are nursing homes licensed?

Mr. JOHNSON. Yes.

Mr. CAMP. Who licenses nursing homes in Mississippi?

Mr. JOHNSON. The State Department of Health.

Mr. CAMP. Are there State insurance requirements as a part of the license?

Mr. JOHNSON. To my knowledge, no.

Mr. CAMP. So, in Mississippi there are no bond or insurance requirements?

Mr. JOHNSON. No, sir.

Mr. CAMP. All right. Are you aware of other State laws with regard to nursing home licensing?

Mr. JOHNSON. No, sir. I did not research that.

Mr. CAMP. All right. Well thank you, Mr. Chairman. At this time I will yield back my time. Thank you.

Mr. STARK. Mr. Thompson, would you like to inquire?

Mr. THOMPSON. Thank you, Mr. Chairman. I want to pick up on the issue of the minimum standards, the staffing, relationship between staffing and quality of care. I think a couple of you had mentioned that this was an issue in your statements. I read recently a study, I think it was published earlier this year, stating that the nursing shortage would be about 350,000 across the country by the year 2020. In California there was another study that was just recently done that says in our State alone, we are going to face a shortage of about 11,000 nurses over the next 5 years.

In the nursing home industry there are currently some 100,000 RN and nurse-related positions that are open in facilities across the country. They are open because people that run those facilities can't find individuals to fill those positions. So, irrespective of how you come down on the issue of minimum standards or ratios, we are facing a pretty big shortage of nursing personnel. If we are going to, I think, address the issue of quality care, we are going to have to figure out how to close that gap.

I would like to hear from the witnesses if you have any ideas as to what this Committee can do to help to close that gap and to address the workforce shortages as it pertains to nurses.

Ms. HARRINGTON. I would like to address that. Coming from the school of nursing and having thought about this a lot, we have done studies of the relationship of staffing turnover and wages, and the main problem is the wages in nursing homes are too low, significantly lower than hospital wages, and that causes high turnover.

But the workload is the major factor that causes the turnover. If you don't have adequate staff, then the employees, the RNs as well as the nursing assistants, do not stay. So, we have to have adequate staffing levels, and that is a big problem.

Low pay is the reason we have the current vacancies. Now, there is a problem in the future, but if we don't address the working conditions, the wages, right now, then we are not going to have nurses be willing to go into nursing in the future. That is what is going to cause the shortage.

Mr. THOMPSON. Again, it is not just in nursing homes, it is an across-the-board shortage.

Ms. HARRINGTON. There is a shortage, but in nursing homes it is acute because they are paying such low wages, and there are about 300,000 nurses that don't work. They don't work right now because the working conditions are not good.

Mr. THOMPSON. What determines if it is an acute shortage and just a shortage? If I am going to the hospital next month for a problem, and there isn't an adequate number of nurses, from my perspective it is pretty acute.

Ms. HARRINGTON. But you have to have a hospital, and a nursing home has to be willing to hire enough staff so that the nurses are willing to stay there and work, and that is what they are not doing right now.

Mr. THOMPSON. So, that the workload and wages, as you see it, are the big issues.

Ms. HARRINGTON. Those are the big issues.

Mr. THOMPSON. So, any reduction in either side of the financial ledger for nursing homes, be it Medicaid or Medicare, is going to further impact us?

Ms. HARRINGTON. Well, it already has, because nursing homes have already dropped the RN staffing by 25 percent, but we don't know where the money goes. It is not necessarily that they need money, it is that they need to be accountable for the money that Medicare has already given them for the staffing. Right now they don't have to staff at the level that Medicare has paid them for.

Mr. THOMPSON. Would anyone else like to comment?

Mr. JOHNSON. Yes, Representative. In my work when I was Director of the Medicaid Fraud Control Unit, I, on a regular basis, was present in nursing homes. One of the reasons that it is difficult to get nurses to stay there is because a lot of residents are nonambulatory, so it is a very physically demanding position.

Also, in some nursing homes—a lot of nursing homes—you have Alzheimer's units, or you have persons who are suffering with dementia for whatever reason, and they are very difficult to deal with. So, when you have the opportunity to go work in a hospital setting, with the things that you have to deal with normally on a daily basis, versus the nursing home setting, and the hospital is paying significantly more, why would you go work at the nursing home?

So, I agree that it is a matter of, one, money. However, I am not saying that the nursing homes don't have the money to actually pay these people. If you want someone to do a job, if you want it properly staffed, if you pay enough, the people will come. So, I am not saying that they don't have enough money to pay. They may be unwilling to reduce their profit margins to pay significant enough money to get the nurses to come——

Mr. THOMPSON. With all due respect, sir, there is a national nursing shortage, not just in nursing homes, but across the board. So, if you are going to make that argument, you have to make it across the board. If there is one nursing job that is vacant and paying more with better working conditions, I don't care where it is, you are going to create the situation that you are talking about.

My question was more of a macro question: How do we deal with the overall nursing shortage so we can supply the nurses, because as you stated in your testimony, there is a relation between staffing and quality of care. It is not enough just to say you have got to pay more money.

My time has run out. Thank you, Mr. Chairman.

Mr. STARK. Thank you.

Mr. JOHNSON. May I respond?

Mr. STARK. Did you want to respond? I don't know who you were addressing that to.

Mr. English, how many votes do we have?

I am going to ask if Mr. English would like to inquire, and then we have three votes which should take us about 25 minutes. So, we will recess and try and reconvene.

Mr. ENGLISH. I thank the Chairman.

I realize our time is short here, but, Dr. Harrington, looking at your studies, they strangely confirm some of the concerns that I

have had about nursing home quality over the years, although I have probably identified maybe a different specific focus for how to deal with that problem. I know that your studies are kind of blind to the conclusion that the purchase of nursing home chains by private equity companies are a substantial threat to the quality of care because of the financial incentives for profits. Also I think you conclude they lack the experience and expertise to oversee nursing homes.

Looking at the same set of facts, I had come to the conclusion that the payment system needed to have incentives for quality, and for that reason in the last Congress I introduced a pay-for-performance initiative that would create the financial incentives for nursing homes to move in the direction of quality. I am not sure that from an ideological standpoint everyone would like the idea of financial incentives, but I wonder, looking objectively at your studies, isn't it fair to say that your concerns about profits would be addressed by a pay-for-performance structure, given especially since nursing homes have in place already some fairly detailed quality standards, and that this might be an easier test case for pay-for-performance than many other health care services?

But also more to the point, don't all nursing homes, regardless of ownership, have to abide by these same Federal and State regulations or face financial penalties or even risk expulsion from the Medicare and Medicaid programs?

So, I guess my question is, looking at the facts, aren't there potential carrots and sticks both to address the quality problem perhaps more directly than focusing on ownership?

Ms. HARRINGTON. Well, the Federal staffing standards are totally inadequate. You only have to have one RN on duty 8 hours a day, 7 days a week, and that could be a 1,000-bed facility or a 50-bed facility.

Mr. ENGLISH. What about State regulations?

Ms. HARRINGTON. The States vary in their regulations. Some have very good regulations, like Florida right now, it has very good regulations; but others have almost no regulation, they just go along with the Federal standards. Most surveyors do not look at the staffing, they don't have time to audit the staffing and the facilities staff up at the time of the survey. So, the data we have on staffing is not accurate, which is why we want electronic reporting of staffing.

I think a pay-for-performance focus, if it is focused on staffing and turnover rates, I think that might be a good way to go. It depends on how it is structured, though, because if the pay is not a high enough incentive, and there is a better incentive just to take it off in profits, I don't think the nursing homes will change their behavior. So, it could work, depending on the structure.

Mr. ENGLISH. Your research concludes that nursing homes with higher profits have lower quality of care, and you recommend limiting the amount of profit a nursing home can make. For some of us that is a little bit of a quaint proposal, but you are looking exclusively at the Medicare margin.

I think if the industry were here today, they would make the counterargument that they rely on high Medicare margins to offset low Medicaid margins. I think you would have to concede what

some of the States have been doing on Medicaid reimbursements is very, very troubling.

As Medicaid pays for the bulk of long-term care provided in nursing homes, wouldn't you concede that it is important to look at overall margins to get a complete view of profit levels?

Ms. HARRINGTON. Yes, I agree. But I think if you set up cost centers under Medicare and not allow the shifting of funds across the cost centers, many States would set up the same type of arrangement. Right now, as long as the nursing homes can take the money and use it for profit, they have no incentive to keep the staffing up. So, that would help solve the problem at both the Medicaid and the Medicare level.

Mr. ENGLISH. Thank you for your presentation, and thank you, Mr. Chairman, for allowing me to inquire.

Mr. STARK. Mr. Camp and I are usually able to agree on most everything. We are trying to agree on whether we have three votes or four votes on the floor, but in any event I suspect it will be shortly after quarter of 12:00 that we can reconvene. So, the Committee will stand in recess subject to the call of the Chair at approximately 11:45.

[Recess.]

Mr. STARK. As soon as we can find our witnesses or round up some new ones, we will reconvene.

The Committee will resume, but before I recognize Mr. Hulshof to inquire, I would like to repeat a statement that I made at the opening of this hearing. I have heard since then that, quite frankly, many lobbyists and members of the nursing home community have been whining and suggesting that they were not invited to this hearing, and nothing could be further from the truth.

The Minority staff has advised us that they called and asked the representatives and advocates for the nursing home community if they had any witnesses, and they said, no. We called and asked, and never in the history of this Committee have we sent engraved formal invitations, we have always done it by phone. For any member of the nursing home community to suggest that they are not invited is absolutely false, and I just want to make sure that that is clearly on the record. They will be welcomed back at any time that they think would be nice for them to let us know their position, but they were invited and chose not to be here, and I—in fairness to both of them, Minority and Majority, that is not correct.

With that I recognize Mr. Hulshof.

Mr. HULSHOF. Thank you, Mr. Chairman. Let me state for the record that both you, Mr. Chairman, and Mr. Camp were accurate; there were four votes, but only three recorded.

Mr. Johnson, I left Oxford, Mississippi, with my law degree about 7 years before you graduated summa cum laude with your business degree, and I have great fondness of my time in the State of Mississippi.

You create in your written statement on page 4 beginning, an interesting hypothetical analysis, a corporate structure, and I think the gist of that hypothetical is that a nursing home licensee establishes the corporate structure to divest its assets for the purpose of limiting its financial liability in the event of a lawsuit.

I don't want to comment on our legal brethren in the State of Mississippi and the proliferation of plaintiffs' lawsuits in that State, but some States do—I am not sure if Mississippi does, but I know Missouri and other States have actually allowed those transferred assets to be fair game in a lawsuit. Does Mississippi allow that, for instance—does not?

Mr. JOHNSON. No, sir, not unless you can show that the transfer was fraudulent.

Mr. HULSHOF. Okay.

Mr. JOHNSON. That would require that you show that it was conveyed at an amount largely below what anyone would consider fair market value.

Mr. HULSHOF. You asked some really interesting questions, and perhaps we should visit beyond the scope of this hearing. One of the questions that you have left lingering, in fact you said lingering inquiry, can the interest of nursing home residents be adequately protected through rigorous enforcement of minimum standards by State regulatory agencies? Can they?

Mr. JOHNSON. Yes, I touched on that briefly in my opening statement in that as a regulatory agency, State regulators as a whole, we come in and we identify misconduct, substandard care, deficiencies, and we take a proactive stance then to remedy that substandard care, misconduct, deficiencies. However, often the harm has already occurred.

Mr. HULSHOF. Right.

Mr. JOHNSON. So, the question then becomes—I am probably not the best person to answer this question, but, you know, I was in private practice for several years prior to taking a position with the Attorney General's Office, and I do know that the following is true. You can have a tremendous injury, someone that comes in with paralyzation or severe burns or whatnot, to see a plaintiff's attorney, and if there is nothing that you can get from the tortfeasor, the person who is at fault, then you don't even sign the victim up; you don't become their attorney.

So, the question then becomes if we are only looking at this from a standpoint of can we maintain the line on holding nursing homes to a minimum standard. The vast majority of the time—through regulatory action, I believe the answer is yes.

Mr. HULSHOF. Could I cut you off right there, if you don't mind, because I am limited on time, so I appreciate your answer.

Mr. JOHNSON. Sure.

Mr. HULSHOF. Let me go on to a couple more areas quickly.

Mr. JOHNSON. Okay.

Mr. HULSHOF. Dr. Harrington, in my last colloquy between my colleague Mr. English and yourself, you indicated or at least suggest your idea that Medicare should perhaps limit nursing home profits. For consistency sake, should Congress and CMS also take similar actions to limit the profit margins of hospitals and physicians?

Ms. HARRINGTON. Well, I don't want to comment on hospitals and physicians, but I know that the vast majority of nursing home revenues comes from the government, whereas hospitals and physicians' revenues don't necessarily come from the government. We know for sure that the nursing homes are cutting staffing. So, if

you did not want to limit profits, if you simply set up the cost centers so that money could not be taken from the direct and indirect care cost centers, that would, in fact, help tremendously.

Mr. HULSHOF. Mr. Muller, in the few moments I have remaining, I have read your witness statement, it is very well documented and very well cited. I did not see a citation—you quote extensively from *The New York Times*, but I see no citation to the *Palm Beach Post*. Are you familiar with the editorial that came out Tuesday, November 13th, in the *Palm Beach Post*, sir?

Mr. MULLER. No, I am not.

Mr. HULSHOF. If the Chairman would indulge. SEIU, through you, have been quite critical of Mariner and Carlyle, and yet the editorial talks about SEIU support for the buyout of nursing home chain Genesis HealthCare by Formation Capital, which is a private equity firm, because apparently some secret deal or deal that I guess the secret terms of which have recently been allowed. I find a little inconsistent in your testimony you talk about and address this shielded liability issue, and yet when the service employees union actually signed off on the private equity buyout of Genesis, the agreement included a provision that SEIU would walk the halls of the California Assembly to lobby for reduced legal liability for nursing homes in the State of California.

Do you care to address that inconsistency?

Mr. MULLER. I am not aware of those policy issues, but I do know that we have been working to try to improve quality care as a union representing 150,000 nursing home workers who are on the frontlines and are dealing with these issues all day long. We are very invested in trying to figure out all the different ways we can to try to improve the quality of care, and we will work with whomever we can to try to do that.

Mr. HULSHOF. Probably not a fair question given that you have not seen it, so, Mr. Chairman, if it is not part of the record, I would ask the *Palm Beach Post* editorial of Tuesday, November 13th, 2007, be included for whatever purpose it may serve in the record.

Mr. STARK. Without objection.

[The information follows:]

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Section: OPINION

A UNION THAT'S LESS THAN IT SEEMS

Joel Engelhardt

It's hard to know who to trust in the latest tussle over a private equity company going billions into debt to buy a nursing home chain. With nursing homes, it's probably best to trust no one. If you've been in one lately, as a visitor, worker or patient, you know what I mean.

Like most people, I find it hard to trust the corporate giants that seem determined to treat nursing homes as commodities. In this dispute, Goliath is the Carlyle Group, which owns Dunkin' Donuts and Hertz and promises to deliver a quality nursing home product.

Carlyle is buying HCR Manor Care, which owns 500 nursing homes in 33 states, including 29 in Florida and seven in Palm Beach County. The homes operate under the Heartland, Arden Courts and Manor Care names. The price for Manor Care is $6.3 billion, of which $5.5 billion will be borrowed.

On the other side, complaining that Carlyle will lay off employees to shave costs, is an anachronism -- a growing American labor **union**. The Service Employees International **Union** (SEIU) has begun a national campaign against the sale with newspaper ads demanding hearings in six states, including Florida. A recent ad in The Palm Beach Post cited a New York Times investigation that described how staffing cuts often follow takeovers by private equity firms. "Carlyle should outline its plan to improve care for Florida's seniors," the ad says, "before we give them licenses to operate nursing homes."

It looks as if the **union** is unloading on Carlyle out of a sincere concern for workers and nursing home patients. That would be the **union's** preferred response to the ads, but that response would be far too generous.

SEIU, the nation's largest health-care **union**, is to organized labor what private equity buyers are to nursing home chains. Under Andy Stern, its president since 1996, SEIU has been throwing out the confrontational labor-vs.-management model. Instead, it is seeking a collaborative role, as Mr. Stern described in his book Getting America Back on Track: A Country That Works. "Employees and employers," he wrote, "need organizations that solve problems, not create them."

What he means is clear because of groundbreaking reporting by SF Weekly, a San Francisco alternative paper. In 2004, the paper disclosed the secret terms of a deal between the **union** and major California nursing homes. Mr. Stern's **union** agreed to use its influence to lobby in the state Assembly for payment guarantees, which passed, and reduced legal liability for nursing homes, which didn't. In return, the **union** got to **unionize** a third of the homes. As a further concession, the **union** agreed not to strike.

Among the other concessions in the "Agreement to Advance the Future of Nursing Home Care in California," now available on the Internet, is the "negative rhetoric" clause. It states that the parties "recognize the need to present a united voice on common goals." It bans personal attacks and goes on to say that "neither the employers nor the union shall involve external organizations (i.e., media, legislators, regulators, health-care providers) in any effort to damage the reputation or credibility of the other party, nor will the union attempt to leverage employer acquiescence through voluntary adverse reporting to any regulators or other oversight agency," except for major abuse as required by law.

So, if your mother is not being turned every day, and the bed sores are literally killing her, and the workers know this is happening but can't do anything about it because on some shifts there are only two caregivers for 47 patients, the workers, through their union, have pledged to say nothing. To no one.

Ah, what price silence? I'd love to support the SEIU's efforts to force closer scrutiny of Carlyle's buyout. But it's hard to trust an organization that would promote the California deal, and a similar one now being pushed in Washington state.

If the SEIU can make life miserable enough on Carlyle -- already Congress and the Pennsylvania legislature have agreed to hold hearings -- it must believe that it can force Carlyle to the negotiating table. If that happens, expect the ad campaign against Carlyle's buyout to halt. If a union sellout is the price of labor peace, it's too costly.

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Mr. STARK. Mr. Emanuel, would you like to inquire?

Mr. EMANUEL. Thank you, Mr. Chairman.

This is more of a statement up front. Having a bill on the floor that deals with the mortgage crisis, one of the problems of the mortgage crisis is that the debt was so dispersed and securitized that there was no single holder; that, therefore, nobody knew who to negotiate with on behalf of the homeowner. One of the purposes of the hearing, that was a piece of the problem, not the only problem. But the financial instruments had become so sophisticated that where there is no single holder of the mortgage and nobody living in the home had somebody to deal with when it came to the problem we have today.

Here in this hearing we are talking about the different—totally legal, but different structures that are put in place by folks who own these nursing homes, and yet when it comes to holding that nursing homeowner accountable for the care given, because of the structure, there is nobody accountable.

Ms. HARRINGTON. Exactly.

Mr. EMANUEL. I appreciate Dr. Harrington is the first I will call on since she is nodding, "Exactly." She a very sophisticated, very smart woman. I am sure you are sophisticated.

The fact is that on the floor we are dealing with a problem that has beset now the entire mortgage and homeownership industry, and yet here we are dealing with this specifically as it relates to the nursing home industry. The fact is that Chairman Frank, who is on the floor dealing with this, has said, what has happened in the last 5 years is an amazing amount of sophistication brought to different financial instruments, some of it helping people to buy homes. But through that securitization what we also have is a situation where the regulations haven't stayed in pace with the different financial instruments or ownership structures that had been moving.

It is okay that private equity would go into buying up nursing homes, chains, et cetera. There is nothing wrong with that. But if nobody is accountable for the care delivered, then the very purpose of the nursing home is merely for profit and not for delivery of a service and a product. One of the ways to make sure that that service and product that in many ways the taxpayers are paying for is to ensure that there is somebody at the other end of the line that is accountable.

So, to anybody who would like to grab this, because you are not going to stop private equity from coming in or a REIT structure for that matter, but what regulations or oversight would you recommend so we are on top of the game that—what is going on in the private sector so that folks who are paying the bill, the taxpayers, feel like their money is being well spent in delivering, and the reason they are willing to do this is because a service is being provided to the elderly?

Dr. Harrington.

Ms. HARRINGTON. Well, we want to see that all the companies involved with a nursing home be disclosed, and that CMS develop a tracking system for all the owners and companies involved.

Another way to improve things would be to make these people sign the provider agreement. Right now the licensee is the only one

that signs the provider agreement. So, the REIT is not involved. The multiple holding companies are not involved. So, if all parties had to sign the Medicare provider agreement, that would be a step forward.

Mr. STARK. Can you yield at that point? Is there a Medicare, a Medicaid provider agreement in California, Medi-Cal as well?

Ms. HARRINGTON. There is a Medicare and Medicaid provider agreement.

Mr. STARK. They are different?

Ms. HARRINGTON. No. Some nursing homes do not take Medicaid, and in that case it would only be a Medicare provider agreement, but if they are duly certified, they would sign one provider agreement.

Mr. EMANUEL. What you are suggesting, though, is that one way to do this is that whoever signs that provider agreement between CMS and X, that is the responsible party?

Ms. HARRINGTON. Well, right now only the licensee has to sign it. So, all these multiple levels of companies don't have to sign it, so they don't have any responsibility in a sense.

Mr. EMANUEL. Even though the owner is ultimately responsible for providing the service?

Ms. HARRINGTON. Right. CMS doesn't even know who they are, so there is no tracking system that you know who the owners are.

Mr. EMANUEL. Anybody else?

Mr. Johnson.

Mr. JOHNSON. In Mississippi, by statute, we have a rule that in order for a certificate of need to be obtained or for a transfer to happen with respect to a nursing home, that any entity that is going to have a 5 percent or greater ownership has to be disclosed.

Mr. EMANUEL. But what about ultimate—I don't want to say legal, but accountable, some level of accountability beyond just the ownership? I understand the 5 percent threshold, but where is it for the purpose of accountability that if the service is subpar, if there are violations to the senior citizens for their health and welfare, beyond the 5 percent, where is the accountability for insuring that that care is going to be improved beyond the fact that you documented that your own 8 percent, 9 percent, 12 percent? There isn't, is there?

Mr. JOHNSON. There is not. So, as a State regulator, other than making sure that these companies meet the minimal standards threshold and thereby allow them to continue receiving their Medicaid, Medicare income stream, that is it. However, as far as any mechanism for—say, for example, if it is a wrongful death case, and a company is not insured, then there is no way to go after the assets.

Mr. EMANUEL. Mr. Chairman, I would—in this hearing, I would assume hopefully one of the things that comes out of this—and I yield back the remainder of my time, if I have any—the sense that you are accountable—am I over—if I am over——

Mr. STARK. Go ahead.

Mr. EMANUEL. Is that somehow we have to bring into line accountability with the profit, and I have no problem. Actually there is a good thing if private equities are here if they see an oppor-

tunity. That is not the problem. The problem is to make sure that we have in place the same level of accountability and same level of interest if accountability is measured that you can be motivated by profit and do well, that is not the problem, but the fact is that you are also accountable for the service you deliver and that somebody is minding the store here.

Mr. STARK. As usual the gentleman's aim at the nail is quite accurate.

Mr. Camp, did you have further inquiry?

Mr. CAMP. Yes. I would just state that I think there are a labyrinth of regulations and rules covering nursing homes. I think we obviously—I would agree with my colleagues that the form of ownership is not as much of a concern to me or who is the owner as much as the fact that the compliance with existing rules and regulations occurs. Certainly the licensee is responsible for complying with all of Medicare's rules and Medicaid's rules and regulations.

Mr. EMANUEL. Will the gentleman yield?

Mr. CAMP. Yes.

Mr. EMANUEL. I think all sides want to make sure that, A, there is good service delivered, and if there is a problem, that we know what is happening and that somebody is accountable. But as you will appreciate, and I think you do, that if, in fact, the structure is created to merely protect the investors from not just liability, from any accountability, that is then a problem.

Mr. CAMP. Yes.

Mr. EMANUEL. Okay.

Mr. CAMP. I think we just don't have enough information. I think there are States that require insurance, have insurance requirements in order to be licensed. Obviously Mississippi apparently does not. But why isn't the State legislature then taking action then to require—if they have been able to put in a requirement that ownership be disclosed, why not also have minimal insurance requirements?

So, I think we need to get some more information in terms of what is the state of play around the country in terms of what are States doing. Clearly your point about it is about the care and the quality of care that is delivered, I think that really needs to be the focus of this Committee.

Mr. HULSHOF. Would you yield?

Mr. CAMP. Yes.

Mr. HULSHOF. I will say to my friend from Illinois, I agree in principle with your statement, but regulation for regulation's sake, there could be, for instance, differing opinions. Congress wanted to address the WorldCom issue, and so as a result—or Enron, and as a result we passed Sarbanes-Oxley, and there have been varying opinions about whether that accountability measure, if the good has outweighed the possible harm.

Then to address Mr. Camp's point, having some consistency in enforcement, I know firsthand some years ago because we did some constituent advocacy in Missouri, a nursing home privately owned, but by a family company was written up by a very aggressive regulator because they had provided a pat of butter on the tray of the meal of a diet-restricted patient and faced, in my view, enormous fines.

So, again, the goal is the same. I would say to my friend from Illinois, those residents deserve—and especially because of taxpayer moneys going to support their care—the enforcement of important safety regulations. But I agree with my friend from Michigan that in law school they used to say, bad cases make bad law. I am not sure. Anecdotally we can all probably talk about tough cases, but I would like to see some more data before we run headlong into some sort of regulatory issue. Thanks.

Mr. CAMP. I would just say that some of the reasons these legal entities have been created is because of the explosion of lawsuits we have seen throughout society, many with merit, but many without merit, and how do we sort through that. So, that is also a concern I think we need more information on.

I would be happy to yield.

Mr. EMANUEL. To your one point about data, I am not saying this is the Bible from *The New York Times*, but it does compare privately owned nursing homes versus the national standards by other nursing homes, and it shows the care there. So, I am not saying—I am open for State-by-State data, company-by-company comparison, et cetera.

Two, as to the Sarbanes-Oxley reforms, we may have taken a hammer to a problem, but if you talk to a number of CEOs who have problems with provisions of the bill, all would acknowledge two things: One, that forcing the CEO to put his or her signature at the bottom of the page knowing they are responsible for a report is far more important than any other item in there, that they knew if their name was on there, they had to go through that document and not just let the CFO and the treasurer at the company do that; two, as a wake-up call to the Board that they had accountability.

So, I would say that although you can point to problems, I would say that, in fact, although it may have overshot the runway in some areas, it got the job done, and everybody knows that what happened through a long period of time there were successes there, that the Board and the CEO were accountable for what happened and what was documented and reported to the Securities and Exchange Commission.

Second, I am not looking for regulation for regulation purposes. I would be open to setting a minimum standard, and then every State, if they wanted to exceed that standard—we don't mean to pick on you, Mr. Johnson, or your State, but if Mississippi doesn't require some level of insurance, but other States do, since Medicare is paid for by the Feds and Medicaid at least 50 percent is paid by the Feds, I think we have not just statutory, but fiduciary responsibility to the taxpayers that there is a standard. You want to exceed the standard, that is what the legislature is for. If you just want to hit the bar, that is your job, too.

Mr. CAMP. Thank you, Mr. Chairman.

Mr. STARK. Thank you.

I would just like to add to this, and, again, the witnesses feel free to chime in, just a couple of issues. Mr. Hulshof wondered whether we set rates, and we do for hospitals. We actually do set DRG rates.

To Mr. Camp's issue of how they could survive a $6½ billion cut, it wasn't a cut, it was just a freeze of what they are getting now.

The difference was this: Acute care hospitals had a margin of about 5 percent and the nursing homes 15 percent. The Medicare part of acute care was negative, so we let them have the full market basket—we didn't, but MEDPAC recommended it—whereas it was better at a 15 percent margin for Medicare for nursing homes, so we didn't give it to them.

Now, we didn't sit around and noodle that through with our own calculators here. We got that advice through MEDPAC, and we have changed that every year. We have made adjustments, and in effect it is a form of rate setting.

As to minimum standards and regulations, I am overjoyed. We got a response from the American HealthCare Association about their successes in improving quality, and one of the successes they state is that they say that there is a decline in the use of physical restraints. Well, guess what? In 1987, we mandated that in the law, and I suspect that is why there has been a decline in the use of physical restraints, and not just through some restraint fairy putting that message under the pillows of them. So, that some regulations, as we do with acute care hospitals, we have conditions of participation.

It seems to me that if we have been, and I think I have been, incorrectly looking at private equity funds, I don't really think that is the issue here today. We may have some examples of wealthy investors with a lot of assets adjusting nursing homes to make more profit. That could be an individual. It could be Bill Gates or Warren Buffett could do that, too, I suppose, as an individual.

The question is, at least in my mind and I think Mr. Camp, ought we to have some minimum standards as we do for acute care hospitals for nursing homes to participate in Medicare? Those ought to set whatever we find or whatever our advisors—the nursing home industry certainly should be part of that—and set that in the record.

Then the question of penalties, and how does General Johnson or others—how do they enforce those? If somebody has devised a loophole so they can shield themselves from enforcement, it seems to me we could structure that in a way that would make the rules enforceable.

Mr. HULSHOF. Would you yield, Mr. Chairman?

Mr. STARK. Yes, I will yield.

Mr. HULSHOF. Very briefly, and I apologize to the witness for hearing this sort of out-and-out discussion, but I think it is useful. But you are exactly right, Mr. Chairman, DRG rates or a host of reimbursements are set, and so if you see a Medicare patient, you know, for instance, what you are going to be reimbursed for a particular procedure, rate setting and market baskets. Quite frankly, as a real aside, tangential aside, I think unfortunately our health care decisions are often driven by the reimbursement rates, but I have said that on other occasions.

When you talk about profit margin and what is too much or too little in the citation of 13 percent or 15 percent for nursing homes, a couple weeks ago sitting in those chairs we had some representatives of some big insurance companies providing Medicare Advantage, and I seem to recall during that testimony one company in particular said they weren't making even a 3 percent profit margin.

So, I bristle a bit. I am reluctant to embrace the idea of determining the profit margin, yes, on rates and reimbursements, and even, as Dr. Harrington pointed out, often a provider will see a Medicaid patient knowing that Medicare is going to help kind of pay for the bills and to keep the doors open.

So, I think this has been a very useful hearing, but I hope we are not going to get too far afield by Congress, in its infinite wisdom, deciding what the private sector or the profit margins or percentages should be, and I appreciate the gentleman yielding.

Mr. STARK. I concur with the gentleman.

I did want to ask Dr. Harrington, because I had mentioned it to staff and one of my colleagues who hasn't returned from the vote, but in California are there many entities that are solely Medi-Cal or solely Medicare; is that common or——

Ms. HARRINGTON. No. At the current time nationally it is 95 or 98 percent that are duly certified.

Mr. STARK. Would it serve any purpose of separating these entities; in other words, even if they had to operate under the same roof and said, wait a minute, you have to have separate beds, separate rooms, separate staff for Medicare, which I think gets the more acute patients?

Ms. HARRINGTON. They were separated to an extent when you had cost-based reimbursement for Medicare. But once Congress moved to the prospective payment for Medicare, they just set the Medicare rate. Medicaid sets its rate, which is mostly prospective, and the nursing homes can do what they want. This is what exacerbated the problem.

Mr. STARK. You think that was a bad move?

Ms. HARRINGTON. Absolutely. A 25 percent drop in our staffing when that happened, because they are allowed to move the money from the direct care over into the profit center now. There is no control over how they spend the money.

Mr. STARK. Could the witnesses help me here? It is my sense that Medicare patients have a higher acuity and require more care?

Ms. HARRINGTON. Yes. In theory that's right, but in practice they have more staffing.

Mr. STARK. Let's get through the theory first.

When it all gets "funged," we pay one rate, and Medicaid, I think, almost universally pays a lower rate.

Ms. HARRINGTON. About a third.

Mr. STARK. It would seem to me that perhaps you save a little on the Medicare side to cover your costs on the Medicaid side; that if we separated that somehow, we could be sure that the Medicare dollars were going as Congress—as we would intend. Say, look, if these are the cases that are entitled to this Medicare rate, and the States will have to do—in conference with Mr. Dingell as they choose, but I don't—would this do harm to the system?

Ms. HARRINGTON. You could separate it, but the real problem is you give them—you have this complex formula for giving them a rate, which is based on their staffing, the client staffing needs and therapy needs. Once you give them the rate, they can take the money and run, and that is what is happening.

Mr. STARK. Would any of the witnesses like to add anything to enlighten the Chair or my colleagues before we adjourn and send you off to lunch?

Mr. JOHNSON. Yes, sir.

Mr. STARK. General Johnson.

Mr. JOHNSON. Yes, one thing. There has been some reference made to the explosion of lawsuits in the context of nursing homes over the past few years. Mississippi is one of the States that has enacted tort reform. Also now almost all of the nursing homes require binding arbitration agreements before taking a patient.

So, the issue is not so much as, "we are going to get some runaway verdicts, so therefore we need to look out for the nursing homes in that regard" as it is, "what would be the source for a true or legitimate recovery as found by an unbiased arbitrator? Should there be funds available in the form of insurance, a bond or attachment of assets in that event?" So, I think it is a very different situation; the landscape now in Mississippi is quite different than it was 3 years ago.

Mr. STARK. Well, I am going to go off the record and adjourn the hearing.

[Whereupon, at 12:30 p.m., the hearing was adjourned.]

[Submissions for the Record follow:]

Statement of
Bruce Yarwood, President and CEO
American Health Care Association

for the
U.S. House Ways & Means Health Subcommittee
"Hearing on Trends in Nursing Home Ownership and Quality"
November 15, 2007

Assuring quality of care for the millions of Americans who rely on critical long term care services is the driving force behind the advocacy efforts of the American Health Care Association (AHCA) and its nearly 11,000 member facilities.

Across the country, skilled nursing facilities serve approximately 3 million elderly and disabled people each year – the vast majority of whom rely on government programs to pay for the cost of their care. Nationally, nearly two-thirds of nursing facility residents rely on the Medicaid program to pay for their long term care needs, and nearly 14 percent have their skilled care and rehabilitative services covered by Medicare. The provision of skilled nursing facility care truly is a partnership between the federal government and the profession that employs more than two million direct care workers caring for the nation's most vulnerable population.

The recent New York Times article, *"At Many Homes, More Profit and Less Nursing"* raised questions about the care provided in a small proportion of nursing facilities – those purchased by private equity investment firms. As the largest organization representing the profession, we must stress that we do not condone any activities that result in diminished quality in our nation's nursing homes. We have long been advocates for enhancing the quality of care and quality of life for the patients and residents who require skilled nursing care. In fact, the profession is as committed as ever to providing the highest quality care to every resident. We firmly believe that the findings included in the article in question do not accurately depict the state of our nation's nursing homes – and in some cases they are inaccurate and misleading.

Quality is Improving in America's Nursing Homes

AHCA, our member facilities and the long term care profession as a whole can point to concrete improvements in the quality of care delivered in our nation's nursing facilities in recent years. The Online Survey, Certification and Reporting (OSCAR) data tracked by the Centers for Medicare and Medicaid Services (CMS) clearly points to improvements in patient outcomes, increases in overall direct care staffing levels, and significant decreases in quality of care survey deficiencies. At the same time, an independent analysis confirms consistently high patient and family satisfaction with the care and services provided.

Positive trends related to quality are also evidenced by profession-based initiatives including *Quality First* and the *Advancing Excellence in America's Nursing Homes* campaign – both of which are having a significant impact of the quality of care and quality of life for the frail, elderly and disabled citizens who require nursing facility care. Through the development of a private-public "culture of cooperation" nursing homes are meeting the challenge of quality care head on, and this commitment has propelled the profession forward. Consider the following:

- Nationally, direct care staffing levels (which include all levels of nursing care: RNs, LPNs, and CNAs) have increased from 3.12 hours per patient day in 2000 to 3.39 hours in 2007.

- There are positive trends in the quality measures posted on Nursing Home Compare and tracked by the Center Medicare and Medicaid Services (CMS) including:

    - Pain for long term stay residents vastly improved from a rate of 10.7 percent in 2002 to 4.6 percent in 2007 – more than a 50 percent decrease;
    - Use of physical restraints for long stay residents dropped from 9.7 percent in 2002 to 5.6 percent in 2007;
    - Pressure ulcers were reduced for both low and high risk long stay residents – with hard to treat, high risk pressure ulcers reduced from 13.8 percent in 2002 to 12.8 percent in 2007; and
    - For short-term stay patients (many of whom are admitted to the nursing facility with a pre-existing pressure ulcer) the pressure ulcer measure also improved – from 20.4 percent in 2002 to 17.5 percent in 2007.

- Substandard Quality of Care Citations as tracked by CMS surveys were reduced by 30 percent in five years – from 4.4 percent in 2001 to 3.1 percent in 2006.

These quality improvements can be evidenced in the level of satisfaction of the patients and family members of patients in today's nursing home. In May 2007, *My Innerview, Inc*. – an independent research firm – released its second annual report on patient and family satisfaction for the care and services provided in nursing facilities. For two consecutive years, more than four out of five of the more than 92,000 individuals surveyed assessed their overall satisfaction as good or excellent – with nearly 90 percent of respondents rating highly the nursing care received.

Exposing Inaccuracies in a Misleading Report

Despite the fact that the long term care profession's commitment to quality improvement is producing significant positive results, the September 23rd *New York Times* article seemingly casts a dark shadow on our nation's nearly 16,000 nursing facilities. While the article focused on fewer than 10 percent of the nation's nursing homes – and its most troubling findings involved just five percent of all skilled nursing facilities nationwide – it had the effect of impugning the reputation of most long term care providers. Such an inference is unfortunate – and inaccurate.

The assertions in the article were distressing to AHCA and our member facilities and we took the issues raised very seriously. After further scrutiny of the data and conclusions, we and others have determined that there are several misperceptions about the challenges facing America's skilled nursing providers. We firmly believe that much of the article is based on the application of problematic analytic techniques applied to problematic data.

It is critical to highlight that in the weeks immediately following the *New York Times* story, contradictory evidence is emerging that refutes many of the findings highlighted.

After the article was published, the Florida Agency for Health Care Administration – the oversight agency that licenses and inspects many of the nursing facilities noted in the article – issued a report, *Nursing Homes Regulation, Quality, Ownership, and Reimbursement,* specifically to address the fact that "recent headlines have questioned the appropriateness of nursing home ownership by investment firms." In the October 2007 report, the agency specifically states that "(t)here is no evidence to support that the quality of nursing home care suffers when a facility is owned by a private equity firm or an investment company…" Further, the report clearly iterates that "(r)egardless of who owns or operates a nursing home, it will still have to meet regulatory requirements or be subject to state and federal sanctions." A copy of this report is attached to this statement.

Additionally, an analysis was conducted by LTCQ, Inc. – a data-driven consulting company lead by four leading academic experts in the field of long-term care – to determine the validity of the assertions and conclusions presented by the New York Times.

Their November 6, 2007, report states that "an unequivocal conclusion of LTCQ's study of over 800 [private equity]-owned facilities is that ownership by a [private equity] firm and operation by a different organization is compatible with the highest quality of care." The analysis further concluded that any issues concerning care quality at private equity owned facilities are related to "operations of the specific facility and not to ownership arrangements as such."

Key findings of the LTCQ analysis:

Staffing conclusions do not reflect full labor component in long term care facilities. The LTCQ analysis unveils that the "author focuses exclusively on RN staffing, while the industry in general – including non-profits and owner-operated facilities – has relatively more LPNs than RNs in its pool of licensed nursing staff. Looking at ***total licensed*** staff tells a different story than just looking at RNs. In fact, the facilities studied by LTCQ generally increased their LPN and total licensed staff ratios over the years after they were acquired by [private equity] firms."

Reliance on OSCAR staffing data is limiting. The workforce data highlighted in the article was drawn from OSCAR data, rather than more accurate sources such as payroll records or staff schedules. According to LTCQ, OSCAR staffing data are based by sampling staff hours over a two-week period and are not necessarily representative of year-round staffing patterns. As well, the OSCAR staffing data do not take into account any qualitative aspects of staffing such as staff experience, turnover rates, and the use of contract staff.

The unadjusted CMS Quality Measures do not accurately reflect patient conditions or outcomes. Facilities that treat greater numbers of more medically acute or complex patients will look worse on quality measures if they are not fully adjusted for residents' baseline condition – as is the case with the CMS Quality Measures (QMs). In general, the nursing homes purchased by the private equity firms highlighted in the article served a relatively high number of residents on Medicare and Medicaid as opposed to those who privately pay for their care. Private pay residents tend to be healthier than Medicare and Medicaid beneficiaries so facilities with high private pay proportions would fare better on many of the QMs even if the quality of care was the same.

A full copy of the LTCQ analysis is attached which more thoroughly addresses these and other areas of concern regarding the *New York Times* article.

Moving Forward to Ensure Continued Quality Improvements in Long Term Care

All nursing facilities in the United States are required to meet rigorous regulatory requirements in order to serve their residents. These requirements – and the survey and enforcement process used to implement the regulations and standards – are blind to the facility's ownership status.

As stated above, nearly 80 percent of the patients and residents in our nation's long term care facilities rely on government funding – Medicare and Medicaid – for specialized care and services. Non-governmental, private sources of capital are needed to ensure continued enhancements particularly in the areas of technology, staffing and structural improvements to an aging stock of nursing homes can be realized.

Greater capital investment increases worker productivity, improves service and quality care delivery to patients, and allows for renovation and improvements of aging physical plants. With budgetary constraints and limited resources, state Medicaid programs are reluctant to direct funding towards these forms of capital improvement. Instead, funding increases are commonly dedicated where they should be, to hands-on patient care. Private equity investment in the nursing home sector should continue to be a vital source of these necessary resources. In this regard, we whole heartedly agree with the conclusion presented in the Florida Agency for Health Care Administration report, which stated, "the quality of a nursing home depends upon the adequacy of funding available to provide care." AHCA further agrees that the New York Times analysis warrants further discussion and debate, but cautions that the conclusions of the article should not be applied with a broad-brush to the entire long term care profession.

AHCA and our member facilities remain committed to efforts and initiatives that enhance the quality of care for our nation's most vulnerable citizens – the frail, elderly and disabled. We want to ensure that quality long term care is never diminished, and thus, we welcome opportunities to work with this subcommittee and the entire Congress to protect and preserve quality senior care.

The wave of aging baby boomers that will require care in the not too distant future demands it.

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Statement of AARP

On behalf of AARP's nearly 40 million members, thank you for holding this important hearing today on nursing home quality. It has been 20 years since the enactment of national standards for nursing home quality in the Omnibus Budget Reconciliation Act of 1987 (OBRA '87). While the quality of care in our nation's nursing homes has improved over the last 20 years, significant progress still needs to be made. The recent *New York Times* article examining the sub-par quality of care in nursing homes owned by private equity firms is the latest reminder that quality of care in our nation's nursing homes is an ongoing issue. Approximately 16,000 nursing homes in this country provide care to about 1.5 million of our most vulnerable citizens. Federal and state governments have a responsibility to help ensure high quality for these residents, especially since Medicaid, and to a lesser extent Medicare, pay for a majority of nursing home services. This hearing offers an opportunity to assess the quality problems still lingering and to examine potential solutions to improve quality for all nursing home residents.

A Call to Action

On September 23rd, the *New York Times* published an exposé detailing the results of its own investigation into the quality of care in nursing homes purchased by private investors, including private equity firms. The *Times* investigation found that private investor owned nursing homes cut expenses and staff, scored worse than national rates in 12 of 14 quality indicators, and created complex corporate structures that obscured who controlled them and who is ultimately responsible for the quality of care they provide. These findings and others in the article are disturbing, but unfortunately are not new. Private equity firms are not the first nursing home owners to use complex corporate ownership and real estate structures—some nursing home chains have used structures like this already.

AARP supports congressional hearings—like this one—to examine nursing home quality problems, including concerns raised about facilities owned by private equity firms, and begin to look for ways to address these problems. Concerns about nursing home quality are not limited to any one state, owner or type of owner, and quality problems can harm residents regardless of where they occur. We believe that investigation by the Government Accountability Office (GAO) could also shed additional light on these issues and potentially offer constructive steps to improve quality.

Examples of Quality Problems

In recent years, media stories, GAO reports, and investigations by the Department of Health and Human Services' Office of Inspector General have revealed specific nursing home quality issues. Many facilities do provide high quality of care and quality of life to their residents. Some facilities are even transforming their culture to offer smaller more homelike settings with private rooms, more choice for residents, and more control to staff that is more likely to stay at the facility and provide consistent high quality care. However, there are also facilities that show significant quality deficiencies on their annual inspections that can cause harm to residents. Effective enforcement of quality standards and remedies, including closure, is important for these and all facilities.

Some nursing homes and their owners have taken steps that can make it more difficult for regulators and consumers to hold these facilities accountable for quality care. For example, corporate restructuring where a nursing home chain splits itself into single purpose entities (some owning the individual nursing home, others leasing and operating the facility, yet others holding the real estate) can obscure and complicate the answer to the question, "Who is responsible for the quality of care?" in any particular facility. The answer may not be just one entity or group of individuals, and they may not be easy to identify. When a regulator looks to assess a penalty for a deficiency, or consumers and their families seek to hold facilities accountable for poor quality of care, it can be more difficult for the regulator to collect a penalty or for the consumers to hold facilities liable for quality of care.

Disclosure requirements can provide important information about who has an ownership interest or controls a company or facility. But when a facility is owned by a private equity firm, the facility is no longer subject to certain public disclosure requirements. One should be able to identify the individuals or corporate entities that are responsible and accountable for the operation and quality of care in the facility. Transparency and accountability are vital for all facilities, regardless of their ownership.

Staffing in nursing homes also has an important impact on quality. Better staffing levels and well-trained staff with low turnover can improve quality of care for nursing home residents. Yet facilities may not always have sufficient staff, and addi-

tional resources provided to facilities for staff do not always result in staffing improvements.

It is also important to have reliable and up-to-date data on staffing levels in facilities—not just data that is collected once a year when a facility receives its annual survey. Accurate and reliable staffing data is important to consumers and their families when they choose a nursing home for their loved one. In addition, the Medicare Payment Advisory Commission (MedPAC) has recommended that the Department of Health and Human Services (HHS) Secretary direct skilled nursing facilities (SNFs) to report nursing costs separately from routine costs when completing the SNF Medicare costs reports. MedPAC also notes that it would be useful to categorize these costs by type of nurse (registered nurse, licensed practical nurse, and certified nursing assistant). This information would allow MedPAC to examine the relationship between staffing, case mix, quality, and costs.

In addition, staffing in nursing homes and other long-term care settings could be improved by addressing the serious need for an adequate, stable, and well-trained workforce. Direct care workers, such as personal care assistants, home care and home health aides and certified nurse assistants, provide the bulk of paid long-term care. Long-term care workers should receive: adequate wages and benefits; necessary training and education, including opportunities for advancement; more input into caregiving; more respect for the work they do; and safer working conditions.

Despite the reforms in OBRA '87 and improvements in care since that time, GAO has found that a small but significant share of nursing homes continue to experience quality-of-care problems. Last year, one in five nursing homes in this country was cited for serious deficiencies—deficiencies that cause actual harm or place residents in immediate jeopardy. GAO has also noted state variation in citing such deficiencies and an understatement of them when they are found on federal comparative surveys but not cited on corresponding state surveys. In addition, some facilities consistently provide poor quality care or are "yo-yo" facilities that go in and out of compliance with quality standards. Almost half the nursing homes reviewed by GAO for a March 2007 report—homes with prior serious quality problems—cycled in and out of compliance over 5 years and harmed residents.

These are examples of some of the challenges and issues that should be addressed to improve nursing home quality. In some cases, better enforcement of existing standards and requirements may solve the problem. In other cases, additional steps may be needed to address the problem.

Finally, we note that some nursing home residents may choose and be able to get the services they need in a home- and community-based setting with sufficient support from family and/or professional caregivers.

State Role

States play an important role in ensuring nursing home quality. For example, states license nursing homes to operate, conduct the annual surveys of nursing homes, and are also a payer and overseer of quality through the Medicaid program. State laws and regulations regarding nursing home quality vary, but there may also be useful models and lessons learned from state experiences. Rhode Island passed omnibus nursing home legislation in 2005 that took several steps, including requiring nursing home applicants to set financial thresholds and providing the state with additional tools to detect and address potential deficiencies, such as the appointment of an independent quality monitor at the facility's expense.

Ideas for Consideration

This hearing and others can help Congress learn about some of the problems and challenges to providing quality of care in our country's nursing homes, and help identify possible ideas and solutions that Congress, the Centers for Medicare and Medicaid Services (CMS), and others might pursue to improve nursing home quality, accountability, transparency, and staffing. AARP suggests the following ideas for consideration:

- Ensure that Medicare provider enrollment documents capture complete information on all entities and individuals with a significant direct or indirect financial interest in a nursing facility or chain;
- Require nursing facilities and chains to update their enrollment data at least every 3 years regardless of whether or not there has been a change in ownership;
- Review and revise current Medicare provider agreements to take account of new corporate organizational structures to ensure accountability for compliance with all Medicare requirements;
- Accelerate implementation of the Provider Enrollment Chain and Ownership System (PECOS) to include all enrollment data for nursing homes and chains;

- Link PECOS provider enrollment data to nursing home survey results and other relevant data to allow for better analysis of trends in outcomes in nursing home quality;
- Require nursing homes to report quarterly in electronic form data on staffing by type of nursing staff (registered nurses, licensed practical nurse, and certified nurse aides), turnover and retention rates, and the ratio of direct care nursing staff to residents. Require CMS to disclose this improved staffing data on the Nursing Home Compare website for consumers;
- Revise Medicare cost reports for nursing facilities to require separate cost centers for nursing services, other direct care services, and indirect care services;
- Audit staffing and cost report data at least every 3 years and impose sanctions for failure to report or for filing false information;
- Use civil monetary penalties collected for nursing home quality violations under Medicare to directly address urgent needs of nursing home residents;
- Enact the Elder Justice Act (S. 1070/H.R. 1783) and the Patient Safety and Abuse Prevention Act (S. 1577/H.R. 3078); and
- Finally, effectively enforce existing nursing home quality standards and penalties for violating these standards, and provide adequate resources to enforce these standards.

Conclusion

AARP is pleased with the renewed attention and interest that Congress has shown in nursing home quality. We look forward to working with Members of this committee and your colleagues on both sides of the aisle to further improve the quality of life and quality of care for our nation's nursing home residents.

Statement of Center for Medicare Advocacy

The recent investigative report in *The New York Times* describing the new phenomenon of private equity firms' taking over multi-state nursing home chains and the declining quality of care for residents that results [1] has brought to the public's attention two important issues—the nursing home industry's use of public reimbursement for private gain, rather than to provide high quality care to residents, and the poor quality care experienced by residents of many nursing homes.

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

In a 3-day series published November 18–20, 2007, the *Hartford Courant* reported that Haven Healthcare, a Connecticut-based chain caring for nearly 2,000 residents in Connecticut, provided seriously inadequate care at 10 of its 15 facilities in the state.[3] The chain failed to pay multiple creditors and the owner is accused of diverting reimbursement to fund his investment in a country music recording company

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

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

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

in Nashville, Tennessee and personal real estate. On the third day of the series, the chain and its 44 related entities filed for bankruptcy.[4]

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

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

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

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

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

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

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

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

2. Require accountability for public reimbursement. Congress needs to ensure that public reimbursement through Medicare and Medicaid funding is spent, as Congress intends, on the care of people who live in nursing homes. In testimony before this Subcommittee, Professor Charlene Harrington described the concern: Medicare reimbursement is based on specific amounts for various components of care, such as nurse staffing, but once a facility receives Medicare reimbursement, it can spend the money in whatever way it chooses. Professor Harrington called for

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[4] Lynne Tuohy and Lisa Chedekel, "Nursing Home Takeover Sought; After Haven Files for Bankruptcy, Blumenthal Wants Trustee to Control Facilities," *Hartford Courant* (Nov. 22, 2007), http://www.courant.com/news/custom/topnews/hc-haven1122.artnov22,0,5263895.story; Lisa Chedekel and Lynne Tuohy, "Haven Debt Woes," *Hartford Courant* (Nov. 20, 2007), http://www.courant.com/news/custom/topnews/hc-haven3.artnov20,0,2146972.story?coll=hc_tab01 layout. Haven Healthcare's bankruptcy filing is at http://www.courant.com/media/acrobat/2007-11/33896687.pdf.

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

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

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

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

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

cost centers and for rules prohibiting facilities from shifting reimbursement from one cost center to another (e.g., from staffing to administration). The Center for Medicare Advocacy supports Professor Harrington's recommendation that Congress ensure that public funds are used for their intended purpose.

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

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

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

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

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

- Deficiencies are not cited. The GAO[14] and State Auditors[15] repeatedly report that surveyors fail to identify and cite many deficiencies.

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

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

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

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

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

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

- Deficiencies are described as less serious than they actually are. Many deficiencies are identified as causing no harm to residents when, in fact, they cause harm.[16]
- Deficiencies that are cited do not lead to sanctions or lead to only minimal sanctions. Remedies that are discretionary are imposed infrequently; per day and per instance civil money penalties are often imposed at the lower ends of the allowable range; and temporary management is almost unknown. The Secretary does not impose denial of payment for all Medicare and Medicaid beneficiaries, as authorized by law.[17]

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

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

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

The nursing home industry opposed the comprehensive enforcement provisions of the Nursing Home Reform Law as the law was being enacted in 1987 and it has continued its opposition ever since, often trying to weaken the law or undermine it, or both. For example, the American HealthCare Association unsuccessfully challenged the per instance civil money penalty regulation that the Health Care Financing Administration promulgated in 1999.[19] Over the years, the industry has also developed a series of voluntary "quality initiatives"—*Quest for Quality*, *Quality First*, *Advancing Excellence in America's Nursing Homes*—that promise a commitment to high quality care, but that undermine the regulatory system by establishing alternative criteria for evaluating nursing facilities. In contrast to the criteria established by the regulatory system, these industry criteria reflect secret goals and targets for improvement that are voluntary, self-reported and unaudited, and lack public accountability.[20]

Voluntary efforts, such as those used by Quality Improvement Organizations (QIOs), do not improve care for residents. A recent evaluation of the National Nursing Home Improvement Collaborative found that the QIO's $1,400,000 project to reduce the incidence and prevalence of pressure ulcers in 35 nursing facilities (all members of multi-state chains) "did not significantly affect the overall rate of [pressure ulcers or PUs]," although it "substantially reduced the rate of Stage III and IV PUs."[21] The researchers, who are primarily affiliated with the QIO community, recommend excluding Stage I and II pressure ulcers from publicly-disclosed pressure ulcer rates. They also recommend reporting "process" measures, rather than "outcome" measures of pressure ulcer prevalence and incidence. These changes would make facilities appear to be doing a better job in addressing pressure ulcers—and reported pressure ulcer rates would suddenly fall—but they would not improve actual outcomes for residents. The American HealthCare Association applauds nursing homes' collaborative work with QIOs and "encourages CMS to swiftly adopt the study's recommended changes for measuring pressure ulcers."[22]

Conclusion

The New York Times identified problems in nursing home care when private equity firms take over nursing homes. These problems extend beyond private equity

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

[17] GAO 2007 Report, *supra* note 13.

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

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

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

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

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

firms and reflect problems throughout the nursing home industry. Congress needs to act in order to ensure that standards of care, including staffing levels, are high and that they are meaningfully and effectively enforced.

About the Center for Medicare Advocacy, Inc.

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

HCR ManorCare
November 19, 2007

Hon. Pete Stark
Chairman
Health Subcommittee
Committee on Ways and Means
United States House of Representatives

Hon. David Camp
Ranking Member
Health Subcommittee
Committee on Ways and Means
United States House of Representatives

Washington, DC

Dear Chairman Stark and Ranking Member Camp:

I write to clarify a number of factually inaccurate or misleading comments made by witnesses and third parties during the November 15, 2007 hearing on "Trends in Nursing Home Ownership and Quality." In particular we would like to address issues related to the transaction; its structure and transparency; the financial viability of the Company; and issues related to the operation of the Company after losing. I would be grateful if you would include this letter in the formal hearing record.

Separation of the Real Estate and Operating Entities

Witnesses at the hearing suggested that ManorCare and Carlyle were separating real estate and operating assets in an effort to minimize transparency and limit liability. Nothing could be further from the truth.

While there will be changes in the corporate structure post-transaction, ManorCare will continue to own and manage both the operations and real estate of the company. Responsibility and accountability will continue to lie with ManorCare.

More specifically, each operating company will be:

- An indirect, wholly-owned subsidiary of HCR ManorCare, Inc.
- Insured by HCR ManorCare, Inc.'s general and professional liability coverage described below. ManorCare will be insured at the same level post-transaction as it is today.
- Managed by the same ManorCare leadership team currently in place.

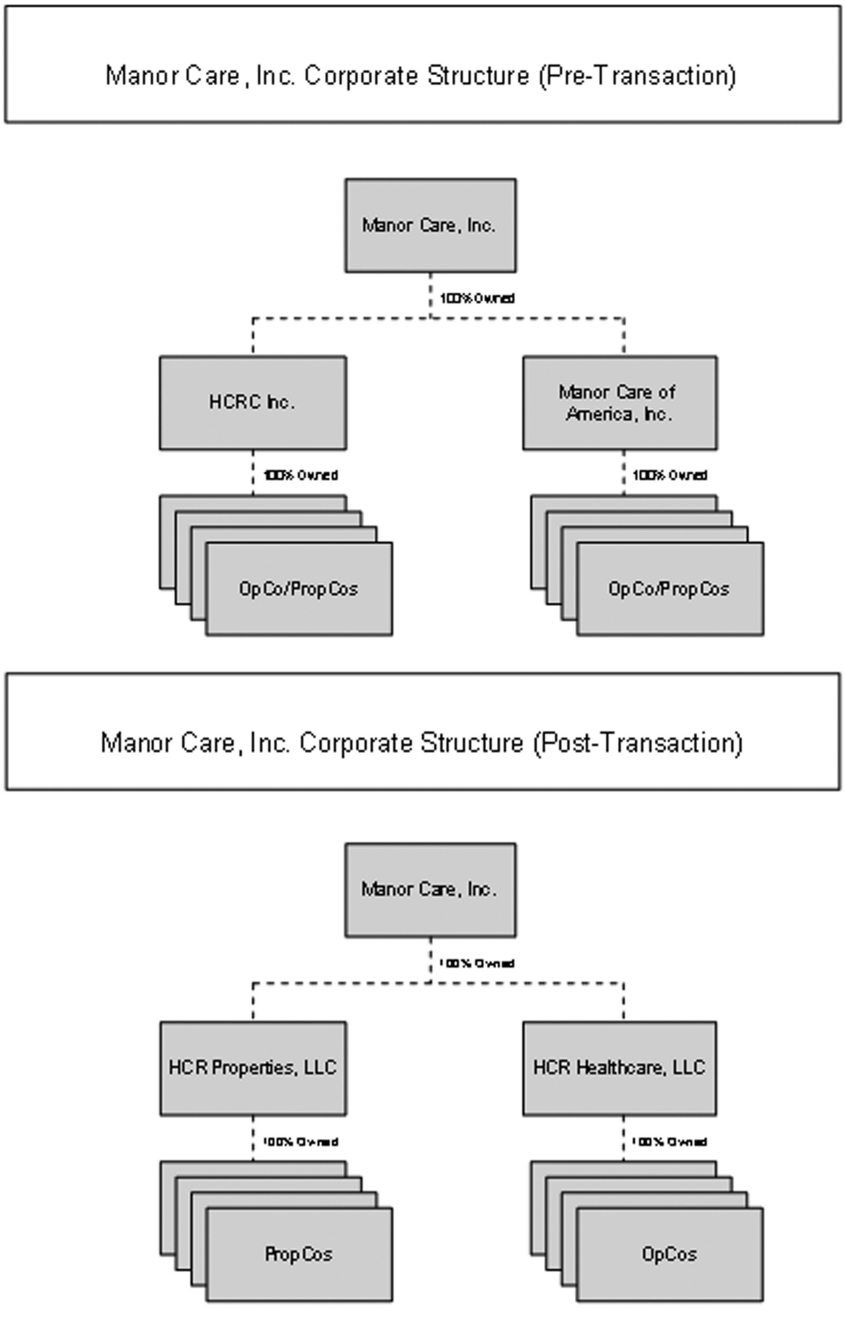
In order to finance the transaction, ManorCare has arranged financing secured by ManorCare's real property. The real property will be owned by indirect, wholly-owned limited liability subsidiaries. Because the real estate financing is secured only by real estate, our lenders required that the real property be organized in newly-formed limited liability entities tied to the specific mortgage for each of the lenders.

This structure in no way affects the day-to-day operations of the skilled nursing facilities. It is also not a shield against ultimate liability of ManorCare—all of the assets will still be owned 100% by the parent company HCR ManorCare, Inc.

ManorCare shares your goals with respect to transparency and have ensured that State regulators responsible for approval of the transaction have all essential information on our structure and ownership.

ManorCare's current general and professional liability program consists of $125 million primary and excess insurance including a $5 million self-insured retention as well as $100 million in property risk insurance provided by some of the largest

and highest rated insurers and re-insurers in the marketplace. The current coverage is unaffected by the change of ownership and will continue in place after the closing of the transaction.



Financial Strength of the Company

After this investment, HCR ManorCare will be the most financially solvent long-term care company in the United States. The Carlyle Group will be investing approximately $1.3 billion in equity in the company—twice the current level of equity that is on our balance sheet at the present time.

Our ability to service our increased debt results from the fact that we will no longer be making interest payments associated with prior debt; repayments of our debt; or share buybacks that we have effected over the past 5 years. During this period of time, the amounts that the Company has paid for these items (which will not occur in the future) will equal or exceed the new debt service on an annual basis. HCR ManorCare will be able to adequately fund our obligations and ensure continued quality care to our patients and families. Our financial viability has been reviewed by an independent third party, Duff and Phelps, which has provided to our independent Board of Directors an opinion attesting to the solvency and viability of the Company subsequent to the transaction. Our Board of Directors have dutifully represented the interests of our shareholders and our Company in ensuring that this arrangement with The Carlyle Group is in the best interests of all stakeholders, including our patients, families and employees as well as our shareholders.

Quality of Care

Testimony at the recent hearing referred to a recent *New York Times* article with intimations that the findings of *The New York Times* research presage poor care at transactions involving private equity firms. As the Committee has been made aware, the findings of *The New York Times* have been put into serious question as a result of reports completed by both the Agency for Health Care Administration of the State of Florida and by the firm, LTCQ, which is led by researchers from Harvard and Brown Universities and which specializes in data analysis of long-term care companies. We urge the Subcommittee to thoroughly assess and validate the assertions of *The New York Times*. Private investment in the long-term care sector has been a critical factor in providing essential capital since 1940 and remains a vital element today whether in the form of equity or debt. It is interesting that both of the studies referenced above indicate that there is no evidence to support that the quality of care suffers when a facility is owned by a private equity firm or an investment company.

In terms of our Company, HCR ManorCare is a leader in quality short-term post-acute services and long-term care. With more than 500 overall sites of care in 32 states, nearly 60,000 caring employees, and facilities spanning a care continuum of skilled nursing and rehabilitation centers, assisted living facilities, outpatient rehabilitation clinics, and hospice and home care agencies, HCR ManorCare was first in the industry to broadly measure patient care outcomes, with a continuing emphasis on meeting their care goals. Our Company has invested in clinical skills and technology to produce desired outcomes for patients who require more complex medical care and intensive rehabilitation, and does so in an environment that is more home-like than traditional providers (e.g., acute care hospitals). We provide high-acuity care to many of our patients, as well as chronic care services and we do so in a cost-effective manner ensuring that individuals receive care at the most appropriate setting.

Our principal mission is to have our patients use long-term care services as an interim step between the acute care setting and their primary residence. Our company discharges 150,000 patients a year from our skilled nursing facilities. We are very proud that nearly two-thirds of these individuals stay in our centers for less than 40 days and half less than 30 days. Our strong medical, nursing and rehabilitation programs facilitate a shorter-term use of our centers, which enables us to provide more care to individuals throughout the United States. As part of our commitment to the best in care, we are expanding technology in our organization, increasing the use of physician and nurse extenders, broadening our information dissemination, improving the lives and involvement of our employees and working to bring improved programs of care and services to our patients and their families.

Management and Expertise

As a shareholder, The Carlyle Group intends to build on HCR ManorCare's strong record. Carlyle believes that the best investment approach is to allow HCR ManorCare to continue doing what it is already doing so successfully—delivering quality care—and they intend to maintain the model that has shown proven results. The current management team at HCR ManorCare will continue to operate the company, and there will be no staffing reductions within our caregiver ranks due to the investment. We felt it was important to assure our patients and families that at no time have we considered, nor will we implement, a staffing reduction in our

centers as a result of this transaction. To that end, we provided assurances in writing to them, copies of which are included with the accompanying materials.

The HCR ManorCare Board will continue its Quality Committee and additionally appoint an independent and well-regarded committee of experts to advise the Quality Committee and Board on quality of care. And HCR ManorCare will continue publishing its Annual Report on Quality, a copy of which is available to the public on our website.

Again, we want to reiterate that within our transaction we will have the same management, staffing, policies and procedures and protocols and controls as well as additional oversight within our Board of Directors.

We view our participation in the overall health care system very seriously. We are pleased to have worked with your agency in the initial Quality First program and have moved forward to ensuring that all of our skilled nursing centers are involved with the Advancing Excellence program. We are committed to quality measurement and initiatives and will continue to work to increase transparency for our patients, families and referral groups on the issue of quality.

Summary

HCR ManorCare has provided exceptional and comprehensive health care services to millions of individuals over its history. We acknowledge and take seriously our responsibility to ensure that the care provided to our patients and families is consistent with all appropriate rules and regulations as well as all appropriate medical and clinical standards. We also believe that our structure, financial viability, governance, and commitment to quality provide our patients and their families with the assurances that the Subcommittee on Health of the Ways and Means Committee is seeking from financial sponsors and management professionals.

In closing, we are appreciative of this opportunity to provide additional information on the transaction between HCR ManorCare and the Carlyle Group, and appreciate this opportunity to reaffirm our commitment to continue managing the company with the same dedication to quality care, staffing levels, employee benefits, capital investment and the caring culture that has made HCR ManorCare the most uniquely successful and respected provider in our industry.

Please let us know if you have any questions or if we can elaborate further on any of these key points.

Sincerely,

Stephen L. Guillard
Executive Vice President
Chief Operating Officer

Statement of National Association of Portable X-Ray Providers

Chairman Stark, Ranking Member McCreary and distinguished Members of the Subcommittee on Health, the National Association of Portable X-ray Providers (NAPXP) is submitting testimony concerning the effect of nursing home ownership trends on nursing home accountability and its impact on our industry.

NAPXP is a national non-profit association representing portable/mobile x-ray providers. NAPXP members supply portable x-ray, ultrasound and EKG services to nursing homes and home care patients. The members of NAPXP are small and micro businesses whose companies provide services to the elderly in a safe, convenient fashion, as they, literally, provide care at patients' bedsides. Portable x-ray providers allow for the Medicare and Medicaid programs to obtain cost savings (estimated at $2 billion annually) as well as patient convenience (patients do not need to leave the nursing home or their own home in order to obtain the necessary services). However, the members of the association rely on Medicare reimbursement significantly as their services are provided principally to Medicare beneficiaries. As such nursing home accountability becomes a large issue for many of our members.

As you are aware, the nursing home industry has and continues to go through transformations. Many facilities have gone out of business, sold to other corporate entities or have declared bankruptcy. These ownership trends have impacted our industry in a negative way as well as the beneficiaries we provide our services to. We rely on the nursing homes to provide us accurate information in order to bill the Medicare program. Whether a patient is under a Part A stay or under their Medicare Part B benefit—makes a difference in the way we bill the Medicare program for our services. As a result, when the facility tells us that the patient is a Part B patient—and thus we bill the Medicare program—we rely on that information as

accurate. However, recently, the Medicare Recovery Audit Contractors have been issuing Medicare overpayment determinations to providers that service nursing homes. The reason—the patient was under a Part A stay when the provider billed Medicare Part B.

Because we obtain patient status information from the nursing home, we must rely on the facility to provide accurate information in order to be paid. The Medicare common working file contains information such as patient coverage status but it is not a "real time" data base. In fact it can take up to 2 years to build a patient file in the common working file. As such, we must rely on the information the nursing home provides. Unfortunately, once the overpayment determination letters are issued providers are expected to pay back the money to the Medicare program. Yet it was a nursing home reporting error, not an error by the provider that caused the incorrect billing. Our members have tried to recoup the monies from the nursing homes that provided us with inaccurate information, but are having a tough time recouping that money from the nursing homes. The reason—the overpayment determinations can go back years, and many of the facilities have changed ownership, are not in business any longer, or have declared bankruptcy. In essence, as a result of the ownership issues that are pervasive in the nursing home industry, providers are being held accountable for erroneous reporting by the facility.

Moreover, companies have been purchasing nursing homes in poor financial health and do not take over their financial obligations. The nursing homes declare bankruptcy. The new company wipes the slate clean and the companies providing services to the nursing homes—such as ours—bear the financial burdens.

NAPXP members have also been adversely affected by changes in ownership by nursing facilities. Many of our members have reported that nursing homes are terminating their contracts with portable x-ray companies due to a change in facility ownership that now requires the facility to contract exclusively with an x-ray provider that is owned by the parent company of the nursing facility. Under these financial arrangements, nursing facilities are reportedly not given an option to select a provider based on quality of care and cost, but must only use a provider that is tied to the financial ownership of the facility. Many of our members have been told that the treating physicians and other clinical staff would like to maintain the current providers—as they are providing good quality of care—yet are being forced to change due to the financial goals of the new ownership. These clinicians feel as though their medical judgment is being compromised. We urge the Health Subcommittee to investigate this thoroughly and examine the impact such arrangements may have on the quality of care provided to nursing home residents. We believe that the impact is significant and would like to provide a couple of examples.

Many of the nursing homes are being forced to abandon the quality of care that they are accustomed to just to feed the "bottom line" or based on some financial relationship the new owners have with another provider. Providers that often offer services in the evenings or weekends are no longer providing their services to the nursing homes as a result of these ownership changes and their focus on the bottom line. This can increase the costs to the Medicare program. Case in point is a patient that needs to have an x-ray and the provider does not offer weekend services. The patient may be required to be transported to the hospital to have this service done—rather than simply having the service conducted bedside. Medicare will incur the cost of the transportation to the hospital as well as the emergency room costs and all of the staff required for the services.

If a patient becomes sick on a Friday night with possible pneumonia, the facility may decide to wait to x-ray the patient until Monday—further compromising the patient's health. Or, the facility may simply put the patient on antibiotics, unnecessarily, thinking the patient may have pneumonia when a simple x-ray would confirm this diagnosis. Yet without weekend services the facility chose to wait until Monday to confirm the diagnosis.

A patient may have a warm red leg. A sonogram could be utilized to rule out a venous thrombosis. In all of these situations, clinical judgment may be compromised due to the provider that is servicing the facility. In many cases one of these ownership changes occurred and a facility, as stated above, is being forced to utilize a provider based on either the financial goals of the new owners or a financial relationship the new owners have with another provider.

Many of the new purchasers of nursing homes do not have any health care experience and are looking at nursing homes as an investment. An investment to make money and not necessarily to provide the best quality of care services possible.

The NAPXP recognizes that the focus of this hearing is on ownership trends and their impact on quality and accountability on care. However, we believe the issues we raised need to be addressed.

The NAPXP applauds the Subcommittee for holding this hearing today and for the commitment of Subcommittee members to address the ownership trends that are plaguing the industry.

Wisconsin Institute of Certified Public Accountants
Federal Tax Committee
Milwaukee, Wisconsin 53202
November 30, 2007

The Honorable Senators Max Baucus and Chuck Grassley
U.S. Senate Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Charles Rangel and Jim McCrey
Committee on Ways and Means
U.S. House of Representatives
1102 Longworth House Office Building
Washington, DC 20515

Gentlemen:

As an attorney for numerous small manufacturers and on behalf of the Federal Tax Committee of the Wisconsin Institute of Certified Public Accountants, I am responding to requests for comments to the Tax Technical Corrections Act of 2007 (H.R. 4195/S. 2374).

If signed into law, section 8 of the Tax Technical Corrections Act of 2007 would eliminate the incentive aspect of IC–DISCs for tens of thousands of closely-held manufacturers, a sector of the economy crucial to long-term growth and prosperity. This comment explains why the proposed legislation is inappropriate and would go against the longstanding policy of aiding domestic manufacturers of exported goods.

1. *The Proposed Legislation Hurts U.S. Manufacturers of Exported Products.* Manufacturers are the bedrock of a prosperous economy. Manufacturing jobs generally pay higher wages and have more generous benefits than jobs in other sectors. Furthermore, manufacturing jobs are considered especially valuable because they import wealth from around the world. Through their interactions with others, manufacturers spur demand in the retail, service and not-for-profit sectors. Now, however, with manufacturers closing U.S. plants and moving production to less expensive foreign locations, this ripple effect is working in reverse, magnifying the economic disruption caused by manufacturer exodus. The proposed legislation would effectively eliminate a key export incentive that helps put domestic manufacturers in an economic position closer to that of their foreign counterparts. Eliminating the incentive aspect of IC–DISCs will negatively effect domestic manufacturers, leading to reduced exports, lower productivity and fewer jobs.

2. *The Proposed Legislation is Unnecessary.* More than merely providing a "technical correction," the proposed legislation would work a substantive change by eliminating an export benefit that has existed without question. Nothing in the text or legislative history of the Jobs and Growth Tax Relief Reconciliation Act of 2003 suggests that the current tax rate on dividends paid from an IC–DISC is something that requires correction.

Furthermore, the Joint Committee's description of the Tax Technical Corrections Act of 2007 tries to argue that the proposed legislation is similar to the denial of a dividends received deduction on dividends received from an IC–DISC found in Code section 246(d). That section does deny the dividends received deduction with respect to dividends received from IC–DISCs because those dividends have not yet been subject to corporate-level tax. Code section 246(d)'s sole purpose is to prevent corporate shareholders of IC–DISCs from avoiding corporate-level tax on IC–DISC dividends altogether. However, this problem does not exist with respect to non-corporate IC–DISC shareholders because there is no corporate-level tax to avoid.

3. *The Proposed Legislation Goes Against the Longstanding Policy of Aiding Domestic Manufacturers of Exported Goods.* A review of the history of export incentives shows that Congress has a longstanding policy of aiding domestic manufacturers of exported goods and has only abandoned this policy after significant pressure from our foreign trading partners. Our foreign trading partners have not objected to the rate of tax paid by individuals on dividends received from IC–DISCs, making abandonment of this policy through the proposed legislation inappropriate.

In 1971, Congress enacted the domestic international sales corporation ("DISC") regime in an attempt to stimulate U.S. exports. A DISC afforded U.S. exporters some relief from U.S. tax on a portion of their export profits by allocating those profits to a special type of domestic subsidiary known as a DISC. In the mid-1970s, foreign trading partners of the United States began complaining that the DISC regime was an illegal export subsidy in violation of the General Agreement on Tariffs and Trade ("GATT").

In 1984, Congress enacted the foreign sales corporation ("FSC") regime as a replacement for the DISC regime in response to the GATT controversy. The FSC regime required U.S. exporters to establish a foreign corporation that performs certain activities abroad in order to obtain a U.S. tax benefit. Rather than repeal the DISC regime, Congress modified it to include an interest charge component, making all DISCs from that point forward IC–DISCs. Manufacturers often did not take advantage of the IC–DISC because until recently other regimes, such as the FSC and ETI exclusion, were more attractive.

In 1998, the European Union filed a complaint with the World Trade Organization ("WTO") asserting that the FSC regime, similar to the original DISC regime that preceded it, was an illegal export subsidy in violation of the GATT. In 1999, the WTO released its report on the European Union's complaint, ruling that the FSC regime was an illegal export subsidy that should be eliminated by 2000.

In 2000, Congress responded to the WTO's ruling by enacting the FSC Repeal and Extraterritorial Income Exclusion Act of 2000. The new extraterritorial income ("ETI") exclusion afforded U.S. exporters essentially the same tax relief as the FSC regime. Consequently, the ETI exclusion did not end this trade controversy as the WTO subsequently ruled that the ETI exclusion was an illegal export subsidy that should be eliminated.

In 2004, Congress enacted the American Jobs Creation Act of 2004 ("2004 Act"), which phased out the ETI exclusion while phasing in a domestic production deduction ("DPD"). With the elimination of the ETI exclusion, the only remaining incentive for exports was the IC–DISC. Rather than encouraging exports, the DPD allows a deduction for certain domestic production activities. While exporting manufacturers may take advantage of the DPD, the tax relief (and concomitant incentive to export) of the DPD is far less than that afforded by the IC–DISC.

As the foregoing history shows, Congress has only removed export incentives under significant pressure from our foreign trading partners. As our foreign trading partners have not objected to the tax rate on dividends received from IC–DISCs, it is inappropriate for Congress to abandon its longstanding policy of aiding domestic manufacturers of exported goods.

4. *The Proposed Legislation Is Not A Technical Correction Because It Is Not Revenue Neutral.* Because technical corrections are necessary to ensure that a tax statute operates as originally intended, there should not be a revenue gain or loss associated with a technical correction. This is because the revenue impact of a technical correction has already been included in the Joint Committee's revenue estimates of the provision in the original legislation to which the technical correction relates. Consequently, any provision that produces revenue is not a technical correction.

The sole purpose of section 8 is to raise the tax rate on dividends paid by IC–DISCs to individuals. Such an increase in the tax rate will raise revenue. Therefore, the provision is not a technical correction and not appropriate for this Act.

Here in the Midwest, America's heartland, we are home to more than one-third of all manufacturing jobs in the United States and generate more than $100 billion in revenue from exports each year. Considering the recent history of trade deficits and the weakening U.S. dollar, exports are the only positive aspect of the U.S. economy. The proposed legislation will harm tens of thousands of hard-working small businesses whose value to the economy cannot be overstated. Furthermore, the proposed legislation has no basis in the text or legislative history of the Jobs and Growth Tax Relief Reconciliation Act of 2003 and penalizes exporters who reasonably relied on the law. Accordingly, section 8 of the Tax Technical Corrections Act of 2007 should not be enacted into law.

Yours very truly,

Robert J. Misey, Jr.