Nursing Facility Issues: Testimony Prepared for the F.T.C. June 11, 2003

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Overview of the NF Market

- 1,699,647 beds in 16,441 facilities
- 65% for profit; 28% non profit; 6% gov't
- 1.5 million residents (one day census)
  - Medicare 10%, Medicaid 67%, Other 23%
- Median occupancy (certified beds) 88%
  - HI (97%), MN (95%), CT (95%)
  - TX (74%), AR (75%), OR (72%)

What Type of Information is Disclosed to Nursing Facility Consumers about the Cost and Quality of Services ?

- Federal regulations require facilities to provide information about:
  - included services for which resident cannot be charged (services defined in law and regulations)
  - other services facility offers; associated charges
  - Medicaid & Medicare eligibility
  - advocacy groups

Nature of information disclosed - cont.

- how to file complaints
- most recent state survey results
- resident rights

- Publicly-available information
  - Nursing Home Compare (demographics, survey results, staffing, quality measures)
  - State public reporting systems
  - Privately operated reporting systems

Is information provided adequate to allow consumers to make well-informed purchasing decisions?

- Publicly available information plus visits may sometimes be adequate, but…
- NF selection challenging for consumers
  - options may be limited; location the key factor
  - elderly needing nursing home care more likely to be those without informal support to help with decisions
  - Quality is multifaceted and important factors may change as resident needs evolve, but
  - Moving is difficult and rare

Is information adequate - cont.

- Available quality measure information complex; difficult for consumers (and researchers!) to interpret
- Unknown whether consumers will use available information in decision-making
  - rigorous evaluation of CMS quality initiatives needed to assess effectiveness in changing consumer and/or facility behavior - research in other settings shows limited use of quality information by consumers

What additional information do consumers need or want?

- Customer satisfaction survey results
- Staffing adequacy relative to resident needs
- “Quality of life” - environment, staff attitudes, special programs, ability to meet spiritual needs, dining services, etc.
- Suitability for prospective resident’s needs (e.g. rehab services, Alzheimer’s unit, etc.)
- Financial data - spending on direct care vs. administrative and capital

Why are facilities not already providing this information in the marketplace?

- Many facilities do provide some or all of this information. Uniform reporting not yet possible on key items (e.g., staffing) - not consistently collected in a standardized format.
- Some states make information available on some of these elements (e.g., OH, CA, IN)
- Some information can only be obtained first-hand (i.e. facility visits, interaction with staff & residents)

Does quantity and quality of information consumers would find helpful vary?

- Likely yes, but empirical studies scant
- Key debates:
  - How accurate/reliable do data and measures need to be?
    - What are the risks v. benefits of “moderately good” data?
  - To what extent can/should accuracy/precision be sacrificed for the sake of comprehensibility?
    - Information overload v. potentially misleading summary measures
- Need both for more research AND better application of what is known to current efforts—involve expert “marketers” in the process

What is the state of the art with regard to measures of nursing home quality- structure, process, or outcome?

- Increasingly sophisticated analyses of limited data
- Recent development efforts have focused on outcome measures. AAHSA supports CMS' & state measurement efforts and research to address recognized limitations:
  - lack of clear linkages between care processes and outcomes - facilities may have little ability to influence measured outcomes
  - Risk adjustment problematic

State of the art of quality measures - cont.

- instability of estimates over time calls into question their predictive value
- rankings and comparisons misleading due to skewed and tightly clustered distributions
- In most cases, no objective benchmarks of expected performance - measurement only relative to means, other facilities. Notable exceptions for outcome measures include Texas' effort to determine evidence-based quality measures (e.g., when are restraints medically appropriate?)

State of the art of quality measures - cont.

- correlation among measures low - defies assumption that one can identify the “best” overall homes across multi-dimensional measures
- selection bias, ascertainment bias & censoring through variations in discharge practices limit ability to make accurate comparisons

State of the art of quality measures - cont.

- Current structure and process measures generally derived from survey
  - Use of deficiencies as a quality measure limited by rating inconsistencies- extensive inter- and intra-state variations require special research methods
  - Links from elements of structure and process to outcomes not well documented
  - Construction of national measures of staffing currently impeded by need for better data

What are the risks of relying on (and disclosing) process-based measures of quality?

- Process measures may be preferable in LTC - complex sets of intrinsic factors contribute significantly to resident outcomes
- Quality measurement in acute care moving more toward process measures – limits need for complex risk adjustment (e.g., aspirin given on presentation with MI)

Risks of relying on & disclosing process measures – cont.

- Funding needed for research to develop evidence-based care process models for LTC residents – few currently exist
- Major risk of relying on any measures of quality of care alone (process or outcome) - disregards other elements of quality in LTC (e.g., “quality of life”)

How would competition on quality measures affect costs, prices, and decisions by payors and customers?

- The effect of CMS' QM on customer choices is unknown
- Markets are distorted by dominance of public payments. Medicare and a handful of states set public prices unresponsive to individual facility spending.
- But there is some evidence of effective competition on quality to some degree. Grabowski (2003): the evidence (from sophisticated econometric study) is consistent with a market whose largely uninformed (about quality) consumers use ownership as a marker.

How would competition affect cost, quality, prices, etc (con't)

- Angelelli, et al. (2003):
  - Studied relationship between survey deficiencies and terminations 1992-2000, controlling for various factors (including surveyor differences across states)
  - Nursing homes that receive a high number of deficiencies are more likely than others to exit the Medicare/Medicaid market and have lower occupancy before termination (voluntary or not).

How does compensation affect quality?

- Adequate compensation is critical to delivery of high quality care.
- But increasing payments from public funds *per se* does not assure quality improvements.

Can compensation be harnessed to enhance the performance of nursing homes?

- Public payments can be structured to encourage/not discourage spending on direct care staff which in turn has been linked to better quality, variously measured.
- Research on other types of “performance based contracting” is not encouraging, but is limited and largely quite old.
- Carefully-constructed demonstrations with good evaluation components would be useful.