Testimony Before
The Pennsylvania House of Representatives
Aging and Older Adult Services Committee
Regarding House Bill 1052

October 4, 2011
Harrisburg, Pennsylvania

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An Association of Pennsylvania Non-Profit Senior Service Providers

Good morning, Chairman Hennessey, Chairman Curry, and distinguished members of the Aging and Older Adult Services Committee. My name is Russ McDaid, and for the past seven plus years I have served as Vice President of Public Policy for LeadingAge PA, formerly known as PANPHA. LeadingAge PA is a statewide association of more than 360 non-for-profit senior care and service providers. Our members are proud of their long history of service to Pennsylvanians in a variety of settings, including nursing facilities, assisted living residences, personal care homes, senior housing, adult day services, and home health services. LeadingAge PA also represents almost exclusively, the Commonwealth's Continuing Care Retirement Communities—which is where the "aging in place" concept originated.

Thank you for granting us this opportunity to testify regarding House Bill 1052—a proposal sponsored by Rep. Mauree Gingrich—creating an alternative process by which nursing facilities can challenge the issuance of a deficiency citation by the Department of Health resulting from a compliance survey performed by the agency. LeadingAge PA has worked for a number of legislative sessions to reform the process through which nursing facilities may appeal these deficiency citations. We appreciate the continued leadership of Representative Gingrich in sponsoring this proposal, and strongly endorse HB 1052.

We would also like to acknowledge the contribution that the Department of Health has made during the discussions of this proposal. From the moment the bill was introduced, Secretary Avila and Departmental staff have been working with Representative Gingrich and the impacted stakeholders to explore ways that they can make the creation of a truly independent IDR process work, rather than looking for ways to oppose such a provision as the Department had in the past. Their recognition that a meaningful, independent IDR process is essential to nursing facility quality assurance activities, providing consumers and their families with the most accurate picture of quality as they choose a facility when their care needs require one.

Nursing facilities are subject to annual certification surveys by the Department of Health. At the completion of these surveys, the Department issues to each facility a statement of deficiencies outlining the specific provisions and regulations with which the nursing facility was deemed to have been out of compliance. Federal regulations (42CFR488.331) have required the state survey agency offer an "Informal Dispute Resolution" (IDR) process for facilities to dispute licensure survey findings. The Pennsylvania Department of Health has administered an IDR process consistent with these federal requirements. However, while the Department's current IDR process meets the minimum federal guidelines, in eyes of providers, the process falls far short of the impartial process necessary to provide a fair appeal and review of deficiency findings.

Until recently, a facility's submission for an IDR was received and adjudicated by the Department of Health's regional field office in which the facility is located. This is same office that had conducted the original survey. The process therefore leant itself to allowing the same office to both issue the deficiency and to also make the appellate determination as to whether that deficiency citation was appropriately issued. In essence, the field office served as traffic cop, prosecutor, judge, and jury. The "I" in IDR certainly did not stand for "independent".

The Department evidently had heard the criticism of the same field office having ultimate jurisdiction over the survey and IDR process, and made an internal administrative adjustment. The Department took the IDR appeal out of the hands of the field office and placed the responsibility of hearing the appeal in the central office in Harrisburg. Our member nursing facilities found this to be little more than a symbolic step, as their experience with the IDR process had not changed.

I would love to have the opportunity to share the countless stories of our facilities that have attempted to avail themselves of an IDR for a citation that—to their eyes—seemed to be unwarranted. Unfortunately, I am not able to do so. Invariably, when we poll our members, this issue always rises to the top of their concerns; yet, when we ask for examples, we often hear that they would rather not share their specific experience due to the fear of retribution from surveyors upon their next licensure survey. Even when we promise the cover of anonymity, our members consistently balk at having particular instances mentioned in the public debate because "it will get traced back" to them. This "fear of retribution" may be nothing more than anecdotal conjecture and perception; however, as the cliché claims "perception is reality".

In spite of the perceived specter of retribution, we have had a member consent to our sharing their experience with a recent IDR appeal. Earlier this year a LeadingAge PA member was issued a deficiency citation for "fail[ure] to provide ongoing abuse prevention training for one of their employees." This "employee" was not an employee of the facility, but was an employee of a construction contractor that performs routine work on the facility's campus. This individual was going to be a consistent presence on the campus, and the facility accordingly performed a criminal background check and infectious disease testing prior to the "employee" commencing work in May 2006. Our member then took, what the facility thought was, the additional step of providing abuse training for the individual. They took this step knowing that this individual would be routinely performing work on the campus for the foreseeable future, and wanted the individual to be aware of the vulnerabilities of the residents the campus served. The criminal background and health screenings were updated annually, but the abuse training was not.

The facility felt it was in full compliance, and the Department gave our member no reason to believe otherwise. It was not until March 2011—five years later—that the Department issued the citation for failure to provide "ongoing" abuse prevention training for the "employee" in question. The administrator was at a loss after receiving the deficiency. This was the first time the provider's management was aware that an employee of a construction contractor, with no direct contact to residents, was deemed to be an employee of the provider itself. The facility's administration then contacted peers at neighboring facilities and no one seemed to be aware of this interpretation. The facility checked the Department's website and bulletin boards and found no communication of this change. They felt they had a strong case for an IDR.

The facility appealed the deficiency citation to the Department of Health. The appeal was denied. What the facility found vexing about the experience was not the rejection of the appeal, but the manner in which the rejection was communicated. The Department's

final ruling in this matter was a letter containing only four sentences, which, due to its brevity, I am able to include in its entirety.

> *This is in response to your request for Informal Dispute Resolution of the deficient practice identified during your survey completed on March 31, 2011, for F226.*
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> *Based on a thorough review of the cited deficiencies and the information provided, the following determination has been made:*
>
> ***F226 42 CFR 483.13(c) Staff Treatment of Residents***
>
> *The finding is accurate and does not indicate this citation was issued in error. As a result of this review a decision has been made that the deficiency cited at F226, will stand as cited.*

No rationale was given. No reference to a regulation, policy, or interpretive guidance was offered. The provider received nothing more than a statement amounting to "we were right." This is the clearest illustration of why the current IDR system is broken and is in need of reform.

Our intention in working with Rep. Gingrich and our colleagues at the Pennsylvania Health Care Association to create House Bill 1052 was to develop an alternate and truly "Independent" IDR process that would be conducted by an entity other than the Department of Health. We did not want to entirely substitute the existing process with the appellate procedure developed in this proposal. Instead, we decided to create an alternative administrative appeal that providers could choose to pursue.

The proposal places the authority to adjudicate the Independent IDR with Quality Insights of Pennsylvania, Pennsylvania's Quality Improvement Organization (QIO) which the Centers for Medicare and Medicaid Services (CMS) has mandated that each state have to act as an arbiter in peer review and quality improvement. QIPA's overarching mission is improving health and health care for all Medicare beneficiaries. Currently, QIPA collaborates with providers to achieve the QIO program's triple aim of improving care for individuals, improving health for populations and reducing health care costs. Specifically relating to nursing homes, QIPA has aided in reducing nursing home healthcare acquired conditions, including the rates of pressure ulcers and restraint use, and addressing adverse drug events. QIPA also helps facilities report health care data for improvement and identifies select communities to improve care transitions, ultimately leading to the reduction of preventable hospital re-admissions.

House Bill 1052 would allow a facility the choice of having the QIO administer an Independent IDR review with one of three levels of scrutiny: Desk Audit or paper review, On-Phone Review, or Hearing. However, under this procedure, unlike the current IDR process administered by the Department of Health, the facility would be responsible for shouldering the cost of pursuing the alternate Independent IDR. The cost of the review would increase corresponding to the increase level of review—with a desk audit being the least burdensome in terms of resource and also the least expensive.

The current IDR process follows the Federal regulations that require the facility to decide within 10 days of receipt of the Department of Health's statement of deficiencies whether to appeal a deficiency citation included in the statement. House Bill 1052 would retain the current 10 day deadline, but in addition to deciding whether to pursue an IDR, the facility will also have to choose whether to opt for the Department IDR or the Independent IDR. If the facility selects the Independent IDR, QIPA will have 45 days following receipt of a facility's request for an Independent IDR to issue a ruling following a review of the facts, the survey findings, the State Operations Manual—which is the guidebook for surveyors and providers that offers additional interpretive guidance of the regulations—and any additional applicable guidance. QIPA is obligated by the bill to offer not just a ruling, but a substantive rationale for its decision, providing recommended actions that the facility can implement to achieve compliance if it is found that the citation was appropriately issued.

By Federal mandate, the Department of Health will maintain ultimate authority to sustain or over-rule QIPA's ruling in an Independent IDR appeal. This is a non-waivable requirement under Title XIX of the Social Security Act. By virtue of its role as CMS's state survey agent, the Department of Health is not permitted to delegate the final authority to determine the appropriateness of a deficiency citation. However, if the Department decides to over-rule QIPA's findings, the bill calls for the Department of Health to issue a written explanation of its decision to override QIPA's determination. It is our belief that, due to the confidence and goodwill that QIPA has established as a good-faith partner of both government and providers, its determinations will be treated with an appropriate level of gravity by the Department of Health. Accordingly, we are confident that determinations by QIPA will not be over-ruled at an unacceptable rate.

Our confidence in the process envisioned by House Bill 1052 is such that we support the provision requiring providers to pay for this independent review. We recognize that the Commonwealth is in no position to invest any money in creating an alternative process for an administrative appeal. Furthermore, we certainly would not expect QIPA to be able to undertake such an obligation without the resources to accomplish it—as no one appreciates the burden of unfunded mandates like long-term care providers. With that being said, our members believe that the benefits of a truly independent IDR process is worth the investment of a reasonable "user fee."

In conclusion, I would like to reiterate LeadingAge PA's strong support for House Bill 1052. We commend and thank Rep. Gingrich for her leadership and willingness to tackle this issue. Her tireless efforts to improve the process of delivering quality long-term care to Pennsylvania's seniors are appreciated by the members we represent. We firmly believe this proposal will do just that.

Again, Mr. Chairman, thank you for allowing LeadingAge PA to testify before the committee this morning, and I look forward to answering any questions you may have.