

News Currents

In Brief

Court Upholds Use Of Nutrition Assistants

Amicus Brief Highlights Program Successes

The U.S. District Court for the Western District of Washington has denied plaintiffs' bid to invalidate the government's feeding assistant regulations.

As an outgrowth of long term care's chronic shortage of nurses and certified nurse assistants, the Centers for Medicare & Medicaid Services (CMS) two years ago published a final rule permitting the use of trained feeding assistants to help meet patients' nutritional and hydration needs. The use of nutrition assistants was authorized on a state-by-state basis, with more than 15 states choosing to take part.

For more than a year, however, the regulations have been under attack in the U.S. District Court in Washington, where plaintiffs had filed a class action lawsuit, *Residents Council of Washington v. Thompson*, seeking to have the CMS regulations invalidated.

"On behalf of nursing home residents and hardworking caregivers throughout America, we are gratified the court reached the common sense decision that assisting residents and supporting facility staff with qualified, trained feeding and hydration assistants will improve quality of care and quality of life for residents," says Bruce Yarwood, acting president and chief executive officer of the American Health Care Association (AHCA).

"The Bush administration, as well as a solid bipartisan coalition in Congress, has consistently backed this sensible quality improvement initiative, and the nation's chronic, ongoing staffing shortage makes this legal decision even timelier."

The government, with AHCA filing an *amicus curie* brief, vigorously defended the regulations. In its brief, AHCA highlighted the speculative nature of the lawsuit by submitting numerous declarations from providers and patients—all with hands-on experience—who supported the use of feeding assistants.

In the ruling, the court agreed with the arguments in defense of the regulations, stating, "Plaintiffs have proffered no evidence that the proposed regulations will cause harm to nursing home residents beyond mere speculation and conjecture."

Similarly, the court noted that plaintiffs' characterization of the evidence supporting the regulations as anecdotal ignores "the numerous positive comments received from residents." Based on these findings, the court denied the plaintiffs' challenge and reaffirmed the validity of the feeding assistant regulations.

Yarwood says empirical evidence from across the nation indicates the CMS regulation is an innovative, effective way to assist patients and help



BEI Merger With NASC Hits Impasse

At press time, the BEI (formerly Beverly Enterprises) plan to merge with North American Senior Care (NASC) had reached an impasse. BEI announced an amendment to its merger agreement, which granted NASC an extension to meet certain financing commitments.

The amendment suspended limitations on BEI's ability to consider and explore other strategic alternatives until it receives the full \$60 million good faith deposit from NASC, although NASC agreed to increase its initial deposit by \$3 million.

Adding to speculation about the merger's possible demise was an announcement by Gulf South Medical Supply that the company would not renew its 20-year distribution relationship with BEI.

Gulf South said it was concerned about whether NASC would "honor and abide by past practices with regard to trade and credit terms," referring to its current litigation against SavaSeniorCare, which was bought out by NASC in 2004.

—Meg LaPorte

relieve the problems of workforce shortages and overburdened caregiver staff.

"Considering the staffing realities we face out on the front lines of care, the feeding assistant regulation is an excellent example of common sense regulatory change that simultaneously can improve care quality and achieve resource efficiencies," Yarwood says.

CMS is now conducting a study to gauge the prevalence of feeding assistants and their effect on quality of care and quality of life at the facility level.

—Joanne Erickson

Providers Embrace Hurricane Victims

Money, Shelter, Jobs Help Displaced Individuals

It started with a \$10,000 check from a member of the Arkansas Health Care Association (AHCA) Foundation and grew into more than \$20,000 in relief aid to victims of Hurricane Katrina. After matching the donation dollar for dollar, AHCA contacted churches, shelters, and other charitable organizations in the state to identify Katrina evacuees in need of financial assistance. Many local organizations then matched the grants with their own funds.

“I know it wasn’t a lot of money, but I feel as though it made a difference to some of the survivors,” says AHCA Executive Director Randy Wyatt.

Long term care providers across the country joined forces with their com-

munities to assist individuals evacuated by Hurricane Rita and left homeless and unemployed in the wake of Hurricane Katrina.

Just two days after the hurricane left its devastating mark in Louisiana and Mississippi, AHCA announced the availability of approximately 5,000 licensed beds in the state, along with transportation assistance, supplies, and volunteers “in order to ease the strain on those affected by the hurricane,” Wyatt says.

When reports showed another terrific storm on its way, providers in Roanoke, Va., and Yuma, Ariz., set out to help sister facility Katyville Health Care and Rehabilitation, in Katy, Texas, just outside Houston, prepare

for Hurricane Rita. Katyville patients were being evacuated to Honda Health Care, in Honda, Texas.

Thomas Clarke, chief executive officer of Kissito Health Care, Katyville’s owner, and four of his employees arrived in Katy on Sept. 21, after driving two cars from Roanoke, ready to assist residents and staff with evacuation to Hondo. Clarke also had arranged for the availability of 250 gallons of gasoline to fuel buses for the transport of the residents, necessary employees, and supplies and equipment. “We decided that driving was the best idea since we were also able to bring supplies with us,” says Clarke. “After the Katrina disaster, I think people wanted to help in whatever way they could. My staff stepped up and volunteered to go without anyone asking them to do so. It was amazing.”

And more help was on the way. The staff assistance fund at the Palm View Rehabilitation and Care Center in Yuma, a Kissito facility, enabled three licensed practical nurses (LPNs) and three certified nurse assistants (CNAs) to charter an airplane to Hondo to help out with the evacuees.

The Palm View volunteers flew to Hondo airport Sept. 22, the day before Hurricane Rita hit land, and just in time to cover the night shift for weary Hondo Health Care nurses and CNAs who had been up for more than 24 hours preparing for the influx of nearly 50 evacuees.

But before initiating the transfers, Clarke and his Katyville colleagues had determined that some residents were too frail to be put on a bus to Hondo. At that point, Katyville operators were able to arrange ambulance transportation for 17 patients.

Clarke’s drive to Katy was not part of Katyville’s evacuation plan, but nei-

CMS Creates Special Medicaid Waiver

A new Section 1115 waiver initiative, developed by the Centers for Medicare & Medicaid Services (CMS) specifically for Hurricane Katrina evacuees, will permit Medicaid coverage for storm victims in whichever state they now reside. States must receive CMS approval to participate in this program—Texas was the first—which includes the following provisions:

- Evacuees can apply for Medicaid through a simplified application process within the host state;
- Evacuees are permitted to self-attest concerning their displacement, income, residency, resources, and immigration status;
- Host states can offer Medicaid benefits to low-income individuals in need of long term care within certain income parameters using a simplified eligibility chart based on eligibility levels from the affected states; and

■ States will not be required to meet budget neutrality tests.

CMS said the policy applies to any Medicaid beneficiary:

- Who has been evacuated from a nursing facility in the emergency areas;
- Who has been discharged from a hospital (in emergency or receiving locations) in order to provide care to a more seriously ill patient; or
- Who needs skilled nursing facility care as a result of the emergency.

In all cases, medical records should document the medical need for a SNF admission and how the admission was related to the hurricane and its aftermath.

CMS has created a toll-free number, (888) 477-7876, that facilities receiving evacuees from Katrina can call to connect on minimum data set information from other facilities.

—David Zuckerman

ther was the absence of the buses previously contracted for the sole purpose of evacuating the residents out of harm's way in the event of an emergency.

The prearranged buses, which had been contracted per the facility's evacuation plan, never arrived at Katyville. Operators had to scramble for alternate transportation in a city where the outgoing roadways were clogged for miles and the availability of gasoline was almost nonexistent.

But not to be daunted by an unforeseen setback, Hondo staff arranged for the use of two Hondo School District buses and one commercial bus to ease Katyville's crisis.

Upon the ambulances' arrival at Hondo the morning of Sept. 23, after navigating through back roads and gridlocked Houston traffic, the frailest patients were admitted and triaged before the three buses carrying 31 residents, supplies, and equipment arrived later that afternoon.

By that time, the facility was over capacity, so the volunteers used mattresses and blankets donated by a local prison to transform the dining room into a sleeping area. "We stacked the mattresses on top of each other to make the beds as comfortable as possible, and we used partitions to set up privacy areas for the residents," says Christy Knopp, Hondo administrator.

"We helped transfer residents off the bus and greeted them with 'Welcome to Hondo' nametags and breakfast," she says.

Clarke and his Virginia colleagues stayed in Katy to ride out the storm and ensure the facility's security.

Proving that charity comes in many forms, the Palm View staff assistance fund was set up a number of years ago to assist a nurse with cancer, and it was maintained to provide similar assistance to other staff members. "Who knew that one day we would use the fund to charter an airplane to Texas," says Sandra Hale, director of nursing.

Recognizing that assistance to

Katrina victims could also be delivered in the form of employment, the Arkansas Health Care Association staff and members placed job advertisements in three local newspapers as well as the *Arkansas Gazette*.

Aimed specifically at displaced nursing facility personnel looking to either relocate or temporarily reside in the state, the ad prompted many calls to the AHCA office.

"We were able to connect people with facilities in their area," says Wyatt.

The Arkansas association also worked with the state nursing board and long term care office to waive the reciprocal licensing fees and background check fees for applicants.

Providers across the country joined Arkansas in advertising positions specifically to nursing facility workers in need of work.

Massachusetts-based Senior Health Management said that it was "coordinating with community and private organizations" to determine the options for travel arrangements to new locations, assisting with family housing

and providing uniforms and professional tools.

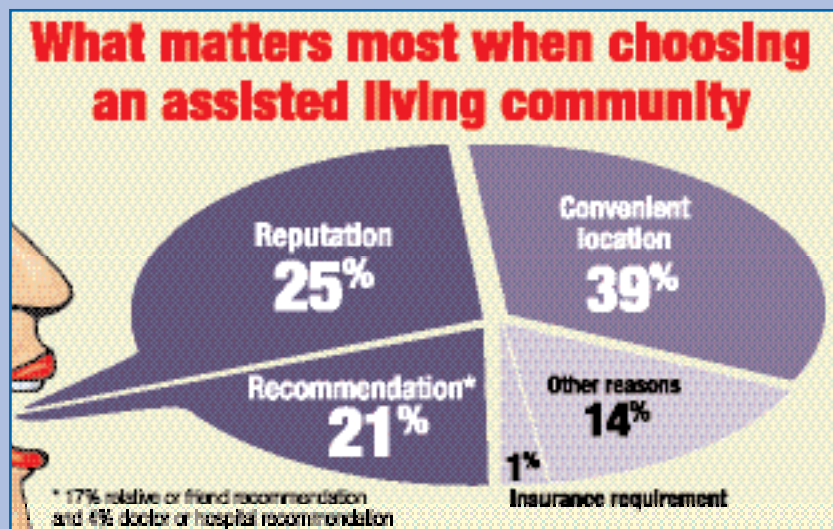
Shortly after Katrina's arrival, Northport Health Services in Tuscaloosa, Ala., began communicating electronically to its facilities in four states to coordinate the advertisement of the company's job openings to workers relocated to the state.

"We made fliers and took them to Red Cross shelters in the area to recruit people to fill positions," says Greg Wooten, administrator of Park Manor Health Care and Rehabilitation. Through both the fliers and word of mouth, Wooten made offers to a half dozen individuals displaced by the hurricane. "One is now attending classes to become recertified as a CNA," Wooten says. "She had previously worked as a CNA in Louisiana. We placed her on the payroll while she takes the class."

He added that one of the facility's new employees has already expressed interest in applying for a company scholarship to nursing school to become an LPN.

—Meg LaPorte

By The Numbers



Source: Family satisfaction surveys conducted in 2004 in 26 states by My InnerView Inc.™ (www.myinnerview.com)

Seniors Housing On The Rebound

NIC Reports Gains In Occupancy Rates, Loan Performance

Healthy occupancy rates, unprecedented loan performance, and falling capitalization rates were music to the ears of attendees at the recent National Investment Center for the Seniors Housing & Care Industry (NIC) 15th Annual Conference in Washington, D.C.

Speaking to a record number of nearly 1,600 conference attendees, NIC reported that the seniors housing industry has “made a strong recovery from a period of falling occupancies and poor loan performance.”

Among the notable indicators was the 4.25 percent increase in loan performance, from 94.25 percent in second quarter 2004 to 98.5 percent in second quarter 2005—the highest number NIC has ever tracked for this indicator. “We have said for years the industry needed to be at 98.5 percent, so, naturally, we’re very encouraged,” NIC President Robert Kramer told conference attendees.

Loan volume rose to \$692 million during the second quarter of this year, up from \$674 million in the first quarter, also “very encouraging news,” said NIC Research Director Anthony Mullen, noting that this “finally puts the seniors housing industry on par with other commercial real estate asset classes.”

Mullen added that median occupancy rates for independent living (92 percent) and assisted living (89 percent) for the second quarter of 2005 were the highest that NIC has tracked since the second and third quarters of 2000. Median occupancy rates for independent living were 90 percent in the first quarter of 2005, and assisted living occupancy rates were 88 percent in the first quarter.

Median occupancy rates for skilled nursing facilities (SNFs) and continu-

ing care retirement communities (CCRCs) remained steady from the first quarter, NIC reported.

Capitalization rates for assisted living ranged from 7.25 at the low end to 10.5 at the high, with a mean of 9.2. Those for independent living ranged from 7 to 10.5, with a mean of 8.2.

SNFs averaged 12.9 percent second-quarter capitalization rates, with a range of 8.1 to 14.5. But CCRCs had an average capitalization rate of 8.6. “The marketplace is not penalizing nursing beds inside of CCRCs to the same degree as freestanding nursing beds,” Mullen said. “So I think the rationale of the CCRC model is being proven out here by the cap rate pushing down more toward independent living than up toward nursing homes.”

Industry insiders provided their own observations and analyses regarding the state of the profession today and going forward. Granger Cobb, president and chief executive officer (CEO) of Summerville Senior Living, and Thilo Best, president and CEO of Horizon Bay Management, agreed that the profession will most likely experience significant consolidation among

provider companies over the coming year.

George Hager Jr., chairman and CEO of Genesis HealthCare, speculated that the impending Medicare Part D coverage, which will kick in on Jan. 1, 2006, will most likely affect SNFs more significantly than other provider categories because dual eligibles will be automatically enrolled in Part D plans. “Since 60 to 70 percent of the SNF sector is comprised of dual eligibles, facilities will be burdened with the administrative task of assisting patients with enrollment,” Hager said.

As for Part D’s impact on clinical care in SNFs, Hager noted that since each plan will have a different formula, the burden of managing and switching medications will fall on clinicians in the facilities. “The concern is to avoid disruption of residents’ pharmaceutical needs,” said Hager.

NIC presented a new logo along with a slight but substantive name change. The new name replaces the word “industries” with “industry” to signify it being viewed as a single-asset class, said Kramer.

—Meg LaPorte

NCAL Elects Officers For 2006

The National Center for Assisted Living (NCAL) has held elections for the 2006 term, and its slate of officers were unanimously elected by NCAL’s state leaders and board of directors. The new officers are:

- Chair: Van Moore, senior vice president of operations, Westcare Management, Salem, Ore.;
- Vice Chair: Marj Shell, owner, Fall Creek Retirement Village, Pendleton, Ind.;

- Secretary: Howie Groff, president, Tealwood Care Centers, Bloomington, Minn.; and

- Treasurer: Nicolette Merino, regional operations director, Chelsea Senior Living, Summit, N.J.

Former NCAL Chair Bob Van Dyk, president and chief executive officer of Van Dyk Health Care, Ridgewood, N.J., becomes NCAL’s immediate past chair.

—Lisa Gelhaus

Medicare Drug Benefit Ready To Go

Providers Prohibited From ‘Steering’ Potential Enrollees

At press time, the Centers for Medicare & Medicaid Services (CMS) was set to launch the first phase of the Medicare Modernization Act (MMA), which includes a new prescription drug benefit (Part D) for Medicare beneficiaries. As of Oct. 1, beneficiaries—including long term care patients and residents—should have received notification from CMS that it’s time to select a prescription drug plan from among those recently designated by Department of Health and Human Services Secretary Michael Leavitt.

Providers are prohibited by CMS from “steering,” or attempting to steer, undecided potential enrollees toward specific plans, or a limited number of plans, that may serve the financial interests of the provider. CMS has indicated its concern that:

- Providers may not be fully aware of all plan benefits and costs;
- Providers may confuse the beneficiary if there is a perception that the provider is acting as an agent of a specific plan, rather than as an agent of the beneficiary; and
- The potential for financial gain when providers steer beneficiaries toward a specific plan or plans could result in recommendations that do not address all of the concerns or needs of a potential enrollee.

Providers are permitted to help potential enrollees by offering objective information on specific plan formularies, based on a particular patient’s medications and health care needs. They may also provide objective information regarding specific plans such as covered benefits, cost sharing, and utilization management tools.

Leavitt has formally approved 10 organizations to offer Part D prescription drug coverage on a national basis,

as well as a number of regional organizations that include:

- Prescription drug plans in every state, with no area needing the “fall-back” plan that would have been required without at least two organizations competing;
- Between 11 and 20 prescription drug organizations with multiple plans in each region; and
- At least one prescription drug plan with a premium of less than \$20 per month in every state except Alaska.

Oct. 1 also marks the official beginning of the marketing season during which the various drug plans are permitted to distribute informational materials on their formularies and services. This includes plans that work both with traditional Medicare coverage and with Medicare Advantage programs, which include prescription drug coverage and other services.

All approved plans will meet Medicare’s requirements for providing medically necessary drugs, including formulary standards, as well as standards for access to convenient retail pharmacies and to drugs in nursing facilities.

Of special importance to providers are the provisions for dual eligibles, whose prescription coverage will move from Medicaid to Medicare Part D under MMA. To ensure a seamless transfer by Jan. 1, 2006—the scheduled start date of MMA—these individuals will be randomly assigned to CMS-approved drug plans.

Dual eligibles must be notified of their enrollment status by Oct. 15, and they then have until Dec. 31 to make their own selection. One way or the other, they will be covered as of Jan. 1, Leavitt said.

—David Zuckerman

CNAs March On The Capital

The job of convincing Congress and the president that health care policy decisions—especially those concerning Medicare and Medicaid—must take into account the special needs of long term care patients and their caregivers fell to the nation’s certified nurse assistants (CNAs) recently, when some 500 CNAs from across the



United States descended on Washington to confront lawmakers. The event was organized by the National Association of Geriatric Nursing Assistants as part of its 10th annual convention. The massive rally on Capitol Hill was a first-ever for CNAs.

CMS Unveils Pay-For-Performance Demonstration Project

The Centers for Medicare & Medicaid Services (CMS) recently unveiled draft recommendations for a pay-for-performance demonstration project that would give financial incentives to nursing facilities that meet certain standards for providing high-quality care.

The demonstration, which is expected to begin in late 2006 or early 2007, will include a “few hundred facilities from three to four states,” according to CMS.

Though participation in the demonstration is voluntary, CMS noted that participants will have the opportunity to earn incentive payments, receive public recognition for high performance, and have the potential to influence national policy.

The draft design contains a list of potential performance measures, including outcomes from state survey inspections, patient outcomes (minimum data set-based quality measures), facility staffing, and incidence of potentially avoidable hospitalizations.

CMS and its contractor for the demonstration, Abt Associates, presented their recommendations during a recent conference call during which participants were asked to make suggestions related to the design recommendations, offer ideas related to quality measures and payment incentives in the nursing facility setting, and suggest other issues relative to the demonstration project.

According to CMS, any Medicare savings derived from the demonstration’s quality improvements will be reinvested into an incentive payment pool.

—Meg LaPorte

Elder Care Costs Up More Than 5 Percent

Nursing Facilities, Home Care Register Increases

The average daily cost of a private room in a U.S. nursing facility jumped 5.7 percent in 2005, from \$192 last year to \$203, according to the “2005 MetLife Market Survey of Nursing Home & Home Care Costs,” published annually by the company’s Mature Market Institute. The highest

category in the MetLife survey—was found to average \$17 per hour. The survey reported that the highest cost for a home health aide is in the state of Vermont (\$31 per hour), and the top rate for a homemaker/companion is in Rochester, Minn. (\$23 per hour). The lowest rates in both categories (\$12 per

hour) were in Shreveport, La. The survey defines home health care aides as trained individuals who provide assistance with activities of daily living and more complex services under the supervision of nursing professionals. Homemaker/companions perform light housekeeping, shopping, and other chores that do not require hands-on assistance.

“The rise in these costs of 5 percent and more constitutes a crisis for many people who have not made the necessary financial preparations,” said Sandra Timmermann, director of the MetLife Mature Market Institute and a gerontologist. “Because long term care services are so costly, and the costs will increase significantly over time,

planning for long term care must be an integral part of the retirement planning process.” According to the National Center for Health Statistics, the average stay in a nursing facility is 2.4 years, bringing the total average per-person cost to \$177,828.

—David Zuckerman

AVERAGE DAILY/HOURLY RATES IN THE 10 HIGHEST- AND 10 LOWEST-COST MARKETS			
Market	Nursing Facility (Single Room)	Home Health Care Aide	Homemaker/Companion
Highest Cost			
Alaska	\$531/day	\$22/hr.	\$20/hr.
Stamford, Conn.	\$348/day	\$21/hr.	\$17/hr.
San Francisco	\$330/day	\$21/hr.	\$20/hr.
New York	\$320/day	\$15/hr.	\$15/hr.
Hartford, Conn.	\$292/day	\$23/hr.	\$18/hr.
Worcester, Mass.	\$287/day	\$22/hr.	\$19/hr.
Boston	\$277/day	\$22/hr.	\$21/hr.
Washington, D.C.	\$271/day	\$17/hr.	\$16/hr.
Rochester, N.Y.	\$269/day	\$20/hr.	\$18/hr.
Honolulu, Hawaii	\$262/day	\$19/hr.	\$17/hr.
Lowest Cost			
Shreveport, La.	\$115/day	\$12/hr.	\$12/hr.
New Orleans	\$118/day	\$14/hr.	\$14/hr.
Birmingham, Ala.	\$135/day	\$13/hr.	\$13/hr.
Little Rock, Ark.	\$137/day	\$14/hr.	\$14/hr.
Wichita, Kan.	\$139/day	\$16/hr.	\$15/hr.
Oklahoma City, Okla.	\$141/day	\$16/hr.	\$16/hr.
Kansas City, Mo.	\$146/day	\$17/hr.	\$15/hr.
Tulsa, Okla.	\$146/day	\$18/hr.	\$16/hr.
St. Louis	\$148/day	\$17/hr.	\$17/hr.
Charleston, SC	\$153/day	\$17/hr.	\$15/hr.

Source: “2005 MetLife Market Survey of Nursing Home & Home Care Costs”

rates were reported in Alaska (\$531 per day), while the lowest were in Shreveport, La. (\$115 per day), the survey found.

The cost of a home health care aide increased by 5.5 percent, from \$18 per hour to \$19 per hour, while the cost of a homemaker/companion—a new cate-