STATEMENT OF

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ON

MAKING THE CASE FOR LONG-TERM CARE SERVICES AND SUPPORTS

BEFORE THE

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Testimony of

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Testimony of
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Senate Special Committee on Aging
"Making the Case for Improving Long-Term Care Services and Supports"

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Good morning Chairman Kohl and distinguished members of the Committee. It is my pleasure to be here today to discuss the role of the Centers for Medicare & Medicaid Services (CMS) and other Agencies and programs at the U.S. Department of Health & Human Services (HHS) that provide services and supports to Americans of all ages who require long-term care (LTC). HHS is composed of 11 Agencies, also known as Operating Divisions, which are responsible for public health, biomedical research, Medicare and Medicaid, welfare, and social service programs.

CMS is the HHS Agency responsible for administering Medicare, Medicaid, the Children's Health Insurance Program (CHIP), and other health-related programs. CMS is the largest purchaser of health care in the United States, serving 92 million individuals through Medicare, Medicaid, and CHIP and therefore, a significant purchaser of long-term supports and services. The Agency, and in particular, the Survey & Certification Group that I direct, is also charged with oversight and quality assurance of health care facilities through the survey & certification process, including nursing homes, home health agencies, and other provider types.

The HHS Administration on Aging (AoA) works to provide home and community-based services to more than 10 million older persons through programs funded under the Older Americans Act. AoA is involved in nutrition, transportation, adult day care, and other health promotion activities. In addition, AoA has a Long-Term Care Ombudsman that

provides advocacy services for nursing home residents around the country and a national caregiver support program.

In addition to the HHS operating Agencies that administer direct care programs, several different HHS research divisions study and evaluate the health and long-term care programs and policies of HHS Agencies, including HHS' Assistant Secretary for Planning and Evaluation (ASPE), CMS' Office of Research, Development and Information, CMS' Office of Policy, AoA's Office of Planning and Policy Development, and AoA's Office of Evaluation.

The Importance of Long-Term Care

The formal LTC system plays a vital role in helping people of all ages who have a chronic illness or disability to obtain the daily supports and services they need, and in supporting families to care for their loved ones at home or in the community. The community-based portion of the LTC system is also instrumental in supporting people with a disability to live in their own homes, participate in their communities, sustain their families, and often contribute to the national economy through their own employment. With $232 billion spent on LTC services in 2007,[1] the benefit structures, services, quality and financing of LTC have significant economic effects in the United States as a whole and in local communities where care is delivered.

As the two public programs of Medicare and Medicaid together comprise the single largest purchaser of long-term care, we have a serious responsibility to ensure that the LTC system provides cost-effective, high-quality care that is responsive to the public and the needs and preferences of the individuals who require care. This challenge will only increase as the number of elderly in the country, particularly those over age 85, continues to grow.

While the challenges in LTC are considerable, so too are the opportunities for Federal leadership and partnership, particularly given the substantial role of public programs in

[1] Calculated using 2007 OACT National Health Expenditures data.

financing LTC. Those partnerships are with States, families and caregivers, individuals who have a disability, private sector businesses, and the American worker. Progress through partnership can be seen clearly in just a few examples.

Opportunities for Federal Leadership and Partnership

Federal partnership with States. When some States took initiative to demonstrate the feasibility of statewide, organized, community-based long-term care systems, Congress acted to make such systems a *national* possibility by contributing Federal matching funds and regulations pursuant to passage of section 1915(c) of the Social Security Act in 1981.

The Federal-State partnership that resulted from that legislation has grown now to the point where all States[2] have Medicaid "home and community-based service" waivers (HCBS) and there are currently approximately 300 active HCBS waiver programs in operation throughout the country.[3] Despite the fears of critics that it would expand Federal spending, the HCBS program actually contained institutional costs and helped States moderate the growth of Medicaid spending overall.[4] Similarly, States and the private sector took the initiative to demonstrate risk-based capitation programs of all-inclusive care for the elderly (PACE). The Federal government assisted these innovations through Medicare and Medicaid waivers, and Congress later passed national legislation to make PACE a permanent entity within the Medicare and Medicaid programs.

Federal partnership with families. The home and community-based services program each year helps elderly and younger people with a disability to live in their own homes in a cost-effective manner, where they are able to maintain their family relationships, existing support networks, and friends. The waiver programs support rather than supplant families in active caregiving. Similarly, AoA makes caregiver support programs

[2] 49 states have Medicaid HCBS waivers. Arizona has a demonstration under section 1115 of the Social Security Act that provides equivalent services to HCBS waivers.
[3] DEHPG Desk Reference. November 2008. p. 231.
[4] See, for example, Kaye, Stephen H, LaPlante, Mitchell P., and Harrington, Charleen: Do Noninstitutional Long-term Care Services Reduce Medicaid Spending? *Health Affairs*, Volume 28 Number 1, January/February 2009, 262-272.

an important part of its agenda, particularly through the National Family Caregiver Support Program (NFCSP).

Federal partnership with individuals who have a disability. When a number of States, such as Arkansas, partnered with the Robert Wood Johnson Foundation and HHS to demonstrate *cash and counseling programs* that enable individuals or families to be in charge of managing their own budget for long-term care and making their own long-term care choices, CMS responded in 2002 with the *Independence Plus* Medicaid waivers. Congress subsequently made changes to the Medicaid personal care benefit in 2005 to permit more States to make such programs available.

Federal partnership with the private sector and American workers. The vast preponderance of LTC providers are private sector, small business, non-profit and for-profit alike. About 3 million workers are employed in direct care occupations, caring for 15 million elderly and younger people with chronic illnesses and disabilities. Every day millions of American workers with personal skills and generous hearts dedicate themselves to caring for their community members in private homes, in nursing homes, and in a variety of personal care settings. In large measure those workers determine not only the quality of care for the people they support, but their quality of life as well.

Partnership among Federal agencies in the field of long-term care. CMS and AoA, for example, combined forces and funding in 2003 that now enable 40 States, the District of Columbia and select Territories to implement "one stop shop" Aging and Disability Resource Centers (ADRCs). The ADRCs offer objective information about all long-term care options that an individual or family might consider, and actively help families sort through what can otherwise be a confusing array of agency services to be negotiated.[5] ADRCs also assist families in assessing their needs, developing care plans and connecting them to the services they need.

[5] More information is at: http://www.aoa.gov/prof/aging_dis/aging_dis.aspx.

Similarly, AoA built upon an existing program encouraging community-based care for disabled and elderly individuals, and has recently partnered with the Department of Veterans Affairs (VA) to provide home and community-based services to veterans.[6]

Before explaining these programs and themes in more detail, it may be useful to clarify what we mean by long-term care, who it involves, and who are main providers of long-term care.

Background

What is Long-Term Care? There is one simple definition of long-term care with which we might all resonate: long-term care is simply society caring for itself. A more technical definition would describe the term "long-term care" as referring to the services and supports needed when the ability to care for oneself has been reduced by chronic illness, disability, or aging. Long-term care services and supports maximize independence by meeting health and personal care needs over an extended period of time. Long-term care services and settings are as diverse as the people who use them. Most long-term care takes the form of personal assistance, in which a caregiver provides basic help performing everyday activities of daily living (ADLs) such as bathing, dressing, using the bathroom, getting in and out of bed or a chair, and eating. For people with cognitive impairments, such as those with dementia or with severe developmental disabilities, ADL assistance may take the form of cuing.

LTC can be provided in a number of different settings, including informal home care and supports by family and friends; formal part-time care in the community through adult day care or home health services; and around-the-clock care provided in the community through HCBS waiver programs or care provided in an institutional setting such as nursing homes. Most individuals in need of LTC services will use a combination of these types of care during the course of their lifetime.

[6] More information is at http://www.aoa.gov/prof/Nursing/nursing_grants.aspx.

Who Uses Long-Term Care Services? People who need long-term care are a diverse group in terms of age and functional needs. Some individuals with disabilities have developmental needs that were apparent at birth and require daily assistance throughout their life. Other individuals of all ages may need short-term rehabilitative or skilled nursing care following an injury, surgery, or illness, such as an incident of stroke. In addition, since prevalence of disability increases as people age,[7] a growing number of retirees require long-term supports to assist them as they age and begin to lose mobility or cognitive functioning.

It is estimated that there are currently 8 million people age 65 and older receiving paid LTC services. This number is expected to increase to 10 million in 2020. In addition, approximately 5 million people under age 65 living in the community have long-term care needs.[8]

In a recent study examining the LTC needs, use, and costs of care that current 65-year-olds will face over the rest of their lives, it was predicted that:

- 65 percent will spend some time at home needing LTC services;
- 30 percent will receive care at home for more than two years; and
- 11 percent will require care for more than five years.[9]

Furthermore, the study showed that nearly a quarter of retirees will rely on informal care provided by family members at home for at least two years.[10] Projections regarding LTC provided in around-the-clock facilities estimated that 35 percent of current 65-year-olds are likely to need such formal LTC, with five percent spending more than five years in nursing facilities in the future.

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[7] U.S. Census Bureau, Economics and Statistics Administration. *Americans with Disabilities: 2005.* Published December 2008. Page 4. http://www.census.gov/prod/2008pubs/p70-117.pdf.
[8] Ibid.
[9] Kemper, P, Komisar, H, & Alecxih, L Long-Term Care Over an Uncertain Future: What Can Current Retirees Expect?. *Inquiry*, *42*, Retrieved April 4, 2008, from http://www.inquiryjournalonline.org/inqronline/?request=get-abstract&issn=0046-9580&volume=042&issue=04&page=0335.
[10] Ibid.

Who Provides Long-Term Care and in What Settings? Of Americans with ongoing LTC needs, 17 percent reside in nursing homes while the other 83 percent live in the community where the majority of their care is provided by unpaid family members and friends.[11] In 2006, an estimated 30-38 million caregivers provided informal care valued at $354 billion.[12] In addition, the HCBS waiver program serves over 1 million people in their homes and communities; it is the primary care system for individuals of all ages with mental retardation or developmental disabilities and is a major system serving the elderly and individuals with physical disabilities. Today nearly 1.5 million individuals are in approximately 15,800 nursing homes on any given day, and about 3 million people will spend some time in a nursing home each year.[13] Although we do not have definitive data, approximately one million people live in alternative residential settings, including assisted living facilities, which are usually privately operated and not certified by Medicare and Medicaid.[14] The Department is conducting a nationally representative survey of these places to fill a major gap in public knowledge about these settings, the services provided in them, and the people who live there.

Who Pays for Long-Term Care? Long-term care is financed in a variety of ways, but there is one thing all agree on: paid LTC by trained individuals is generally expensive. At an hourly rate of $19, four hours of daily care by a home health aide could consume more than $27,000 a year for an individual needing care in his/her home.[15] Those in need of around-the-clock facility-based care face an average of $70,000 a year for a semi-private room in a nursing home.[16] In 2007, one year of care in an intermediate care facility for persons with developmental disabilities averaged $123,565.[17]

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[11] Georgetown University Long-Term Care Financing Project *February 2007 Fact Sheet*. Retrieved April 7, 2008, from: http://ltc.georgetown.edu/pdfs/medicare0207.pdf.
[12] "Valuing the Invaluable: A New Look at the Economic Value of Family Caregiving," AARP Public Policy Institute, June 2007.
[13] Centers for Medicare & Medicaid Services, Survey & Certification Group, OSCAR database.
[14] Spillman, Brenda and Kirstin Black, *The Size of the Long-Term Care Population in Residential Care: a Review of Estimates and Methodology*, Report prepared for ASPE by the Urban Institute, February 2005.
[15] *Metlife Market Survey of Nursing Home and Assisted Living Costs.* October 2007. P 4.
[16] Ibid.
[17] http://rtc.umn.edu/docs/risp2007.pdf

Contrary to popular opinion, LTC is not routine health care, and is generally not covered by standard health insurance. People who pay for these services out-of-pocket account for approximately 18 percent of the total long-term care spending. Another 3 percent are covered by other sources, including the voluntary sector, and 7 percent of LTC services are paid for by private health and long-term care insurance policies.[18] In 2005, approximately 7 million private LTC insurance policies were in force, up from 1.2 million in 1990.[19] These policies are helping individuals and families shoulder the burden of the increasing costs of long-term care services.

Public sources (e.g. Medicare, Medicaid, and the VA) pay for the vast preponderance of long-term care services. However, Medicare covers only a fraction of LTC costs, 22.4 percent in 2007, and limits services to post-acute settings.[20] Many of these post-acute or skilled services are delivered by long-term care providers or in long-term care settings. Specifically, the traditional Medicare fee-for-service benefit covers care in these facilities under specified conditions:

- Skilled Nursing Facilities (SNFs): Medicare pays for SNF care for up to 100 days in a benefit period, following a 3-day minimum inpatient hospital stay for a related illness or injury.
- Inpatient Rehabilitation Facilities (IRFs): Medicare pays for stays in an IRF for beneficiaries requiring longer rehabilitation, often following a previous inpatient hospital episode of care.
- Long-term Care Hospitals (LTCHs): Certified by Medicare as acute care hospitals, LTCHs treat Medicare patients requiring hospital-level care for an average length of stay of greater than 25 days.
- Home Health (HH) Services: Medicare coverage for HH services is limited to reasonable and necessary part-time or intermittent skilled care or therapy. A beneficiary must meet certain criteria and be home-bound in order to receive HH care that is reimbursed by Medicare.

[18] National Health Care Expenditures Data, 2007.
[19] "Who Buys Long-Term Care Insurance." America's Health Insurance Plans, April 2007, page 11.
[20] OACT analysis of National Health Care Expenditures Data, 2007.

For those who qualify for assistance, each State Medicaid program must offer nursing facility services and HH agency services, but many forms of LTC services are optional benefits and the availability of community-based LTC services varies by State. In 2006 for example, 33 States covered personal care services; 24 States covered private duty nursing services. Cost-sharing structures for such services vary by State as well.[21] Medicaid also pays for institutional services for a group of individuals with severe intellectual or developmental disabilities whose cost of care is substantial. In 2007, all but three States operated Intermediate Care Facilities for the Mentally Retarded (ICF/MR). There were 96,527 residents in 6,419 ICF/MR; this includes a small number of large State-operated institutions, but the average ICF/MR served 15 residents and was privately operated. As of June 2007, a total of 437,707 individuals with intellectual or developmental disabilities received services in 167,857 settings, including 115,569 who were served in their own homes.[22]

Medicaid is the mainstay of long-term care financing, funding 48.5 percent of LTC payments in 2007.[23] Of the total Medicaid LTC expenditures in 2007 ($113 billion), approximately 53 percent funded institutional services (nursing homes and ICFs-MR) and 47 percent was spent on for community-based services (HCBS waivers, HHAs, personal care, etc).[24]

AoA and ASPE Initiatives to Support Long-Term Care

As stated previously, HHS, CMS and AoA have developed ongoing initiatives to strengthen long-term care and provide necessary services to those who qualify by partnering with other government Agencies and community stakeholders.

HHS' ASPE has led a number of research initiatives to examine challenges and trends to the long-term care workforce. In 2004 ASPE and the National Center for Health

[21] Kaiser Family Foundation Analysis available at http://www.kff.org/medicaid/benefits/index.jsp?CFID=10860190&CFTOKEN=84403082.
[22] http://rtc.umn.edu/docs/risp2007.pdf
[23] OACT analysis of 2007 National Health Expenditures Data.
[24] Ibid.

Statistics conducted the National Nurse Aide Survey and the National Survey of Home Health Aides as part of the National Nursing Home Survey. In addition, ASPE is currently conducting a nationally representative survey of residential settings (such as assisted living), to expand knowledge about the long-term care settings and services used by many Americans. HHS and the Department of Labor (DOL) are collaborating this year to examine the feasibility and design of an evaluation of the DOL's Registered Apprenticeship program for long-term care workers in which 40 long-term care employers offer registered apprenticeship employment and training to approximately 2,000 apprentices in 20 States.

For the past nine years, the AoA has operated the NFCSP providing information, assistance, training, respite care and other services to more than 700,000 caregivers each year. CMS also has efforts to support caregivers, and recently held the *Ask Medicare* caregiver initiative in September 2008. The *Ask Medicare* initiative provides information, tools and materials to assist the caregiver and their loved ones in making informed healthcare decisions.

AoA's Nursing Home Diversion Program:

As a complement to the CMS "Money Follows the Person" initiative, AoA is currently supporting State Nursing Home Diversion (NHD) programs that target individuals who are not Medicaid eligible but who are at high risk of nursing home placement and spend down. Targeting this population has important implications for Medicaid since most of the Medicaid-eligible elderly people in nursing homes entered as private paying individuals and then exhausted their private resources and "spent down" to Medicaid eligibility. By helping individuals to remain in the community, the NHD program can help individuals redirect their own resources to community-care and realize their personal preference for staying at home. Under the initiative, 20 states are assisting these at-risk individuals to arrange for flexible, service packages that they can self-direct in order to get the services necessary for remaining in a community-setting. The VA is partnering with AoA on this initiative to provide home and community-based services to veterans of all ages, including younger disabled veterans returning from the wars.

Current CMS Long-Term Care Activities

Home and Community-Based Services Waiver Program. Historically, the Medicaid program has had an "institutional bias" when rendering LTC services, because the majority of Medicaid LTC dollars went to nursing home care (as a mandatory service option) versus home and community-based LTC services. In recent years as laws have given more flexibility, there has been a shift away from the institutional bias resulting in more individuals in need of LTC supports and services transitioning back into community-based environments and utilizing HCBS waiver programs. In Fiscal Year (FY) 2007, spending for HCBS waiver programs, personal care, and home health services accounted for 47 percent of all Medicaid LTC expenditures.[25] HCBS waiver programs are currently operating nationwide. Where previous ratios of institutional to community-based spending were as high as 80/20, the more recent 53/47 ratio reflects the progress of the rebalancing efforts in the growing community-based initiatives.[26]

Home and Community-Based Services State Plan Option. Congress, through the Deficit Reduction Act of 2005 (DRA), created the Section 1915(i) Home and Community-Based Services Medicaid State Plan Option. Beginning January 1, 2007, States have the option to amend their Medicaid State plans to offer HCBS as a State plan optional benefit. On April 4, 2008, CMS published a proposed rule (73 Fed. Reg. 18,676) to further clarify this benefit. This option breaks the prior eligibility requirement that an individual can receive community services only if he or she needs an institutional level of care. At the same time, States will be able to tighten the standard for admission to institutions and refine eligibility for home and community-based waiver services without having to request Section 1115 demonstration authority. Demand in the States is strong for more HCBS options, as evidenced by the large number of beneficiaries on waiting lists for access to HCBS waiver services. As an example, the State of Iowa took advantage of the new benefit to provide statewide HCBS case management services and "psycho-social rehabilitation services" at home or in day treatment programs that can include such things as support in the workplace. Services approved under this State plan optional benefit will

[25] OACT analysis of National Health Care Expenditures Data, 2007.
[26] Ibid.

help individuals delay or avoid institutional stays or other high-cost out-of-home placements. The State of Nevada is also providing the HCBS State Plan option benefit.

Money Follows the Person Rebalancing Demonstration. Through the DRA, Congress also created the CMS "Money Follows the Person (MFP) Rebalancing Demonstration." This demonstration supports State efforts to "rebalance" their LTC support systems by offering $1.75 billion in competitive grants to States over 5 years. With this critical assistance, States will be able to make targeted reforms in their State to shore up the community-based infrastructure so that individuals have a choice of where they live and receive services. Specifically, the Federal government will offer the incentive of a MFP-enhanced Federal Medical Assistance Percentage rate for a period of 1-year for each person that the State transitions from an institution setting into the community.

Twenty-nine states and the District of Columbia are currently participating in MFP.[27] These participating States collectively propose to help approximately 35,000 individuals (47 percent of whom are elderly) transition themselves to community-based environments consistent with their preferences and family relationships. Under MFP, individuals will be tracked for three years to monitor their quality of life in the community and to assess their service utilization and health outcomes. The demonstration information will provide CMS with a research platform for future long-term care policy decisions.

This week, CMS held a three-day national conference on the "Money Follows the Person Rebalancing Demonstration."

Self-Directed Budgets for Personal Assistance Services. Congressional action through the DRA gave new authority for Medicaid State plans to offer a benefit for self-directed personal care services to individuals, also known as "Cash and Counseling." Self-directed personal care services have been historically provided through HCBS waivers

[27] Thirty States and the District of Columbia were awarded MFP grants; South Carolina has since withdrawn from the program.

and Medicaid Section 1915(c) demonstration waiver programs. With this new authority, self-directed personal care services, including self-directed personal care services provided by family members, can now be provided under Medicaid State Plan Options instead of through waiver or demonstration authority. States will also be able to provide services or items to individuals in need of LTC that maintain their independence or substitute for human assistance. Five States have been approved for 1915(j) self-directed personal assistance service State Plan option benefit: Alabama, Arkansas, Florida, New Jersey and Oregon.

State Long-Term Care Partnership Program. Lastly, the DRA allowed additional States to offer a new long-term care financing program previously available in only four demonstration States. The State Long-Term Care Partnership Program was established to help individuals take more responsibility in planning and financing their future LTC needs by providing incentives for the purchase of LTC insurance. Under the LTC Partnership Program, an individual who purchases a qualified LTC policy and uses its benefits is allowed to apply for Medicaid coverage without having to spend down all of his or her assets first. Specifically, an individual will be able to qualify for Medicaid while retaining assets in the amount of insurance benefit payments made on their behalf. These newly protected assets will also be exempted from Medicaid estate recovery provisions. To date States have responded enthusiastically; as of December 2007, 36 States offered Partnership policies in their State, had approved State plan amendments for qualified State Long-Term Care Partnership Programs, had submitted a State plan amendment, or were in the process of developing Partnership programs.

Real Choice Systems Change Grants for Community Living. Real Choice Systems Change (RCSC) grants have enabled States and other eligible organizations, in partnership with local disability and aging communities, to design and construct infrastructure to address critical elements of successful systems transformation. These grants have resulted in effective and enduring improvements in community-integrated services and long-term support systems in large and small communities across the nation. The infrastructure that has been developed as a result of RCSC grants enables individuals

of all ages to live in the most integrated community setting suited to their medical needs, to have meaningful choices about their living arrangements, and to exercise more control over the services they receive.

Since FY 2001, Congress has appropriated annual funding for RCSC grants to improve community-integrated services. These system changes are designed to enable children and adults of any age, with any payer source, who have a disability or long-term illness to:

- Live in the most integrated community setting appropriate to their individual support requirements and preferences;
- Exercise meaningful choices about their living environment, the providers of services they receive, the types of supports they use, and the manner by which services are provided; and
- Obtain quality services in a manner as consistent as possible with their community living preferences and priorities.

Program of All-Inclusive Care for the Elderly (PACE). PACE is a capitated benefit for frail elderly authorized by the Balanced Budget Act of 1997 (BBA) that features a comprehensive service delivery system and integrated Medicare and Medicaid financing. The PACE model was developed to address both the acute and LTC needs of individuals aged 55 or older who are eligible to receive nursing facility care under both Medicare and Medicaid. For most participants, the comprehensive service package permits them to continue living in the community while receiving services, rather than reside in an institutional setting. Capitated financing allows providers to deliver all services participants need rather than be limited to those reimbursable under the Medicare and Medicaid fee-for-service systems. The BBA established PACE as an optional benefit under the Medicare and Medicaid programs. It is available under Medicare to qualifying Medicare beneficiaries who are living in PACE service areas and under Medicaid in States that elect to provide PACE services as a State option to qualifying Medicaid beneficiaries who are living in PACE service areas. Operationally, the PACE program is

unique as a three-way partnership between the Federal government, the State, and the PACE organization.

Outreach and Education

Own Your Future Campaign. Through a partnership among CMS, AoA and ASPE, CMS launched the *Own Your Future* Campaign in January 2005 to spread the word that Medicare generally does not pay for LTC services and to clarify that Medicaid pays only for limited services for the poor and disabled. This joint Federal-State initiative is designed to help the next generation of Medicare beneficiaries prepare for their LTC needs.

Increasing Quality and Transparency

CMS takes seriously its responsibility to ensure the quality of care provided in long-term care settings. Nursing homes participating in the Medicare and Medicaid programs are required to meet over regulatory requirements that address 180 aspects of care based on expectations that Congress set forth in law to protect nursing home residents and assure optimum quality of care and quality of life. These requirements cover a wide range of topics, from protecting residents from physical or mental abuse and inadequate care, to the safe storage and preparation of food. Through the Survey and Certification program, CMS has contracts with State governments to perform health inspections and fire safety inspections of these certified nursing homes, as well as investigate complaints about nursing home care. The health inspection team consists of trained inspectors, including at least one registered nurse. These inspections take place, on average, about once a year, but may be done more often if the nursing home is performing poorly. Approximately 15,800 onsite, comprehensive ("standard") surveys are conducted each year, in addition to about 50,000 onsite complaint investigations that focus on the particular areas of complaint.

Beginning in 2004 and annually since, CMS has published on its Web site an Action Plan for Further Improvement of Nursing Home Quality to set a vision and provide the public

transparency on CMS' efforts to continuously improve nursing home care.[28] The 2008 plan includes initiatives in key areas including: Consumer Awareness and Assistance, Survey, Standards and Enforcement Processes, Quality Improvement and Quality Approaches through Partnership, and Value Based Purchasing.

Beyond routine inspections, CMS continues to focus on improving the quality of care in nursing homes through quality initiatives and the evolution of its *Nursing Home Compare* Web site. In November 2002, CMS began a national Nursing Home Quality Initiative, which includes quality measures that are shown at the *Nursing Home Compare* Web site (www.medicare.gov/nhcompare). The website enables consumers, providers, States and researchers to compare information on nursing homes. Many nursing homes have already made significant improvements in the care being provided to residents by taking advantage of these materials and the support of Quality Improvement Organization staff.

CMS continues to improve *Nursing Home Compare* through increased user-friendly site functions, additional facility information (including Special Focus Facility status), and the new five star quality ratings for each nursing home. Beginning December 18, 2008, CMS made star quality ratings available on the *Nursing Home Compare* Web site for each of the nation's 15,800 nursing homes that participate in Medicare or Medicaid. Facilities are assigned star ratings from a low of "one star" to a high of "five stars" based on health inspection surveys, staffing information, and quality of care measures. This information is designed to assist consumers as they compare nursing homes in a particular geographic area. As *Nursing Home Compare* continues to evolve, long-term improvements could potentially include dynamic consumer testing, the addition of new quality measures, improved staffing data based on payroll sources and reported quarterly rather than annually, increased user interactivity to refine search capabilities, and information from resident and family satisfaction surveys.

[28] The 2008 plan can be found at http://www.cms.hhs.gov/CertificationandComplianc/Downloads/2008NHActionPlan.pdf.

The Survey and Certification model is effective for the nursing home industry but is not a model that transfers to community-based long term care settings. Therefore, there are a variety of approaches to LTC quality that are important. In community-based long-term care settings, CMS requires States to provide assurances of quality in order to secure approval of each home and community-based waiver application, and has designed a quality framework to assist States. CMS is further advancing quality assurance in HCBS waivers through the MFP demonstration. Each State approved for MFP funding must ensure direct reporting to CMS on specific quality measures. State responsibilities include submission of claims data as part of quality of care indicators, a longitudinal analysis of the quality of life of participants, and fulfillment of more robust programmatic quality assurance requirements that include risk mitigation, critical incident reporting and an emergency back-up system. A required quality of life assessment provides an important opportunity for face-to-face visits with individuals who are receiving community-based long-term care. States are using a variety of approaches to this assessment, ranging from hiring a survey firm, sending State staff, to using advocacy and peer groups. CMS will analyze both data driven and operational impacts to inform future policy making.

Conclusion

Mr. Chairman, thank you for the opportunity to draw attention to the important topic of long-term care and describe what CMS and HHS are doing to address the challenges. Regardless of the care setting, timeframe, or payer, all Americans need access to high-quality, flexible and personalized LTC supports and services. HHS and its partner Agencies are committed to continuing our current efforts to engage caregivers in this discussion, while supporting the design and delivery of LTC supports and services that enable individuals with cognitive and physical impairments to have access to quality LTC in their home communities. In the end, long-term care in our country is about people – the people who need assistance and care, the people working to provide it, and their family members and friends. I am happy to answer any questions that you may have.