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Details: November 26, 2007 Informational Hearing

WISCONSIN STATE LEGISLATURE ... PUBLIC HEARING COMMITTEE RECORDS

2007-08
(session year)

Senate
(Assembly, Senate or Joint)

Committee on Public Health, Senior Issues, Long Term Care and Privacy

(SC-PHSILTCP)

(FORM UPDATED: 07/02/2010)

COMMITTEE NOTICES ...

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INFORMATION COLLECTED BY COMMITTEE FOR AND AGAINST PROPOSAL ...

- Appointments ... **Appt**
- Clearinghouse Rules ... **CRule**
- Hearing Records ... bills and resolutions
  (**ab** = Assembly Bill)
  (**ar** = Assm. Resolution) (**ajr** = Assm. Joint Resolution)
  (**sb** = Senate Bill)
  (**sr** = Sen. Resolution) (**sjr** = Sen. Joint Resolution)
- Miscellaneous ... **Misc**

Senate

Misc

INFORMATIONAL HEARING

Committee on Public Health, Senior Issues, Long Term Care and Privacy

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The committee will hold an informational hearing on the following items at the time specified below:

Monday, November 26, 2007
1:00 PM
330 Southwest
State Capitol

The topic of the informational hearing will be the planned takeover of Manor Care nursing homes by the private equity group, The Carlyle Group, and concerns regarding the quality of care that would be provided with the change of ownership.

Testimony will include invited speakers.

Senator Tim Carpenter
Chair


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Please reply to Madison office

COOK&FRANKE S.C.
ATTORNEYS AT LAW

MERITAS LAW FIRMS WORLDWIDE

September 20, 2007

VIA HAND DELIVERY

Ms. Gail Hansen
State of Wisconsin
Department of Health and Family Services
Division of Supportive Living
Office of Quality Assurance
1 W. Wilson, Room 950
Madison, WI 53701-2969

Re: Manor Care of Shawano WI, LLC
d/b/a ManorCare Health Services-Shawano
Our Client/Matter No. 8856-0004

Dear Ms. Hansen:

This application is for Change of Ownership of a facility currently licensed to Marina View Manor, Inc. at 1436 S. Lincoln Street, Shawano, WI 54166. The applicant for licensure listed above, is Manor Care of Shawano WI, LLC. The proposed date of transfer is November 7, 2007.

A description of the transaction necessitating for the change of ownership is as follows: On July 2, 2007, Manor Care, a public company, announced that its Board had approved a transaction with The Carlyle Group ("Carlyle"), a global private equity firm, to take the company private through a stock sale at the parent level of the organization. Pursuant to an Agreement and Plan of Merger dated as of July 2, 2007 between MCHCR-CP Merger Sub Inc. ("MergerCo") and Manor Care, MergerCo will be merged with and into Manor Care, with Manor Care continuing as the surviving corporation. Carlyle will replace the current public shareholders of Manor Care (the "Stock Sale Transaction"). We anticipate the transaction will occur in the fourth quarter of 2007.

Contemporaneously with the Stock Sale Transaction, Manor Care will undergo an internal reorganization to restructure Manor Care's corporate ownership structure. Each Operating Sub that operates a SNF will transfer its operations and other non-real estate assets to a newly-formed single purpose entity limited liability company ("OpCo SPE") so that there will be a single OpCo SPE for each SNF. Then each Operating Sub that owns a SNF will contribute its real estate to a newly-formed special purpose property holding limited liability company

("PropCo LLC"). The OpCo SPEs will enter into a Master Lease with an affiliated Master Tenant and PropCo LLC to lease the property that was previously owned by that SNF. (Such transactions are sometimes known as a "transfer/leaseback transactions.") The OpCo SPEs and the PropCo LLCs will continue to operate under Manor Care, as at present.

Following the consummation of these transactions, the corporate existence of Manor Care will remain intact. Specifically, following the transactions:

- Manor Care will continue to exist as a separate corporation and retain its ultimate ownership interest in the OpCo SPEs and PropCo LLCs;
- Manor Care's current management team will continue to oversee the operations of its Facilities;
- The OpCo SPEs will be responsible for the operations of the Facilities;
- The PropCo LLCs will have no involvement in the oversight or supervision of the SNF;
- The name of each of the Facilities will remain substantially the same (except where needed to clarify or update current usage);
- Administrators and allied health professionals staffed in each Facility will continue to provide the same day-to-day management and patient services; and
- The type, quantity and quality of health care services offered by the Facilities will not change

Enclosed please find with the nursing home application and the following documents for filing in the above-referenced matter:

- Check # 0090575245 in the amount of $600.00
- Nursing Home Residents' Rights Complaint Report
- Authorization to Accept Personal Service and Receive Registered and Certified Mail
- Projected Cash Flow
- Projected Balance Sheet
- Organizational Chart

- 2 Health Insurance Benefit Agreement
- Expression of Intermediary Preference
- Resident Census and Conditions of Residents
- Long Term Care Facility Application for Medicare and Medicaid
- 2 Assurance of Compliance
- 2 Background Information Disclosure
    - No check is enclosed for the Current Administrator
    - Copy of check # 1185 in the amount of $7.50 is enclosed for the Vice-President of the Operating Company and signatory of the application.
- Draft Operating Agreement
- Contribution Agreement
- Resumes
- Certificates of Status
- Articles of Organization

I will also provide the following documents as soon as we obtain them:

- Hospital Transfer Agreements

Please do not hesitate to contact me if you have any additional questions.

Sincerely,

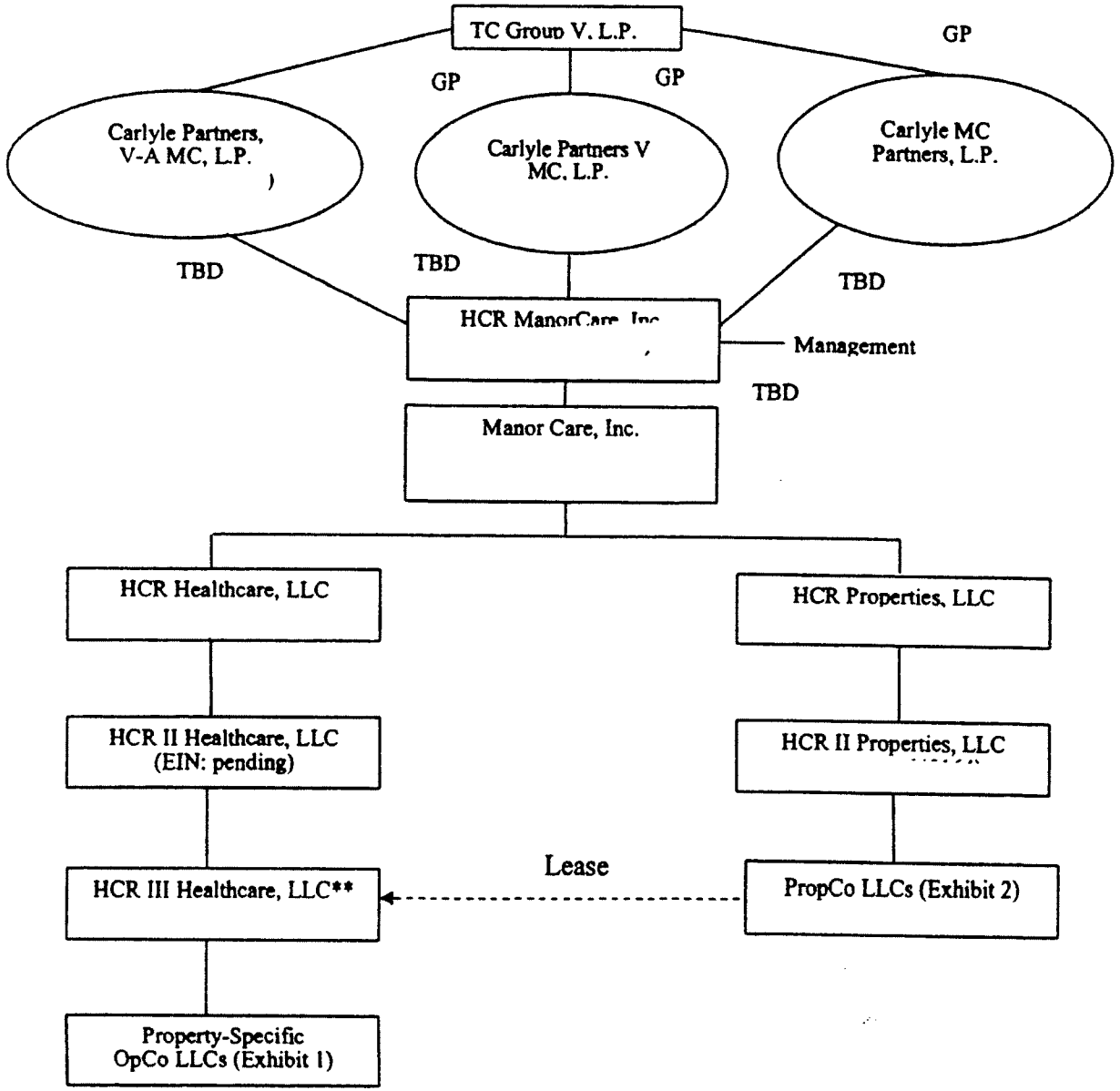
Maureen A. Molony

Maureen A. Molony

Enclosures

385655:666

Manor Care
Nursing Homes and Assisted Living Facilities*
(Simplified)



Business address for the Carlyle Partners entities is 1001 Pennsylvania Avenue, NW; Washington, DC 20004-2505. Phone number is 202-729-5626.

Business address for all of the remaining entities listed below is 333 North Summit Street; Toledo, OH 43604. Phone number for all of the remaining entities listed below is 419-252-5500.

Except as indicated, each entity is owned 100% by the entity listed above it. It is not expected that any entity or individual will have a 5% or greater ownership in any of the Carlyle Partners limited partnerships, which are part of a private equity fund with numerous passive investors. Each of these limited partnerships is controlled by its General Partner, TC Group V, L.P.

*Excludes [exclude any leased facilities that are not part of the CMBS structure]

**Some OpCo LLCs are owned directly by HCR III Healthcare, LLC while others are owned directly by HCR IV Healthcare. For OpCos owned by HCR IV

due April 2023, our 2.125% convertible senior notes due December 2023, our 2.125% convertible senior notes due 2035 and our 2.0% convertible senior notes due 2036 (collectively, the "notes") to amend the terms of the indentures governing the notes or to waive or amend any registration rights associated therewith and/or to commence a tender offer to purchase all or part of each or any series of notes, in each case on such terms and conditions as may be reasonably proposed by MergerCo. We have also agreed to prepare the consent solicitation and tender offer documents and execute supplemental indentures and amendments to registration rights agreements. MergerCo has agreed to reasonably cooperate with us in connection with such solicitations and tender offers and the preparation of the related documentation.

The amendments contained in any such supplemental indenture or registration rights agreement will become effective upon signing, but not operative until the closing of the merger and, if applicable, the acceptance of the applicable tender offer. The closing of any tender offer will be conditioned on the simultaneous occurrence of the closing of the merger. Simultaneously with the closing of the merger and in accordance with the terms of any consent solicitation or tender offer undertaken at MergerCo's request, MergerCo has agreed to provide Manor Care with the funds reasonably necessary to consummate such tender offer and/or consent solicitation (including the payment of all applicable premiums, consent fees and all related fees and expenses).

In addition, we have agreed that prior to the closing of the merger, will take such actions as may be reasonably requested by MergerCo to effect termination or settlement, or any cancellation and payment, of any interest rate swap agreement, warrant, option or other contract or agreement executed in respect of any hedging arrangement entered into by Manor Care in connection with our convertible notes (including any amendment or termination hereof) effective as of the closing date of the merger, in each case as may be permitted by the indenture governing such series of convertible notes.

Neither we nor any of our subsidiaries is required to make any monetary payments or concessions or incur any other liability in connection with any consent solicitation, tender offer or termination of a hedging arrangement prior to the effective time of the merger (except to the extent MergerCo agrees to reimburse us for the amount of any such payment). MergerCo has agreed, promptly upon our request, to reimburse Manor Care for all reasonable out-of-pocket costs incurred by us or any of our subsidiaries in connection with any such action and has also agreed to indemnify and hold harmless Manor Care, our subsidiaries and our respective representatives from and against any and all losses, claims damages, liabilities, costs, expenses, judgments, fines and other amounts suffered or incurred by them in connection with any such action

CMBS Restructuring

In connection with the merger and the financing under the CMBS facility and prior to or upon the closing date, we have agreed to (with the reasonable assistance of MergerCo) use reasonable best efforts to undertake a restructuring of certain of our subsidiaries that own and operate certain skilled nursing and/or assisted living facilities to place the real estate assets for those facilities in a series of special purpose bankruptcy remote entities meeting rating agency criteria (the "real estate SPEs") and place the business consisting of the managing and operating of those facilities (including holding the related licenses) in another series of special purpose bankruptcy remote entities that will indirectly lease the real estate assets from the real estate SPEs (collectively, the "CMBS restructuring").

The parties to the merger agreement have agreed to use reasonable best efforts to develop the specific steps necessary to implement the CMBS restructuring and to minimize potential incurrence or imposition

of cost, expense or taxes as a result of the CMBS restructuring, and to otherwise reduce any material negative effect of the CMBS restructuring on Manor Care and our business and operations; *provided, however*, that neither party is required to agree to a potential modification to, or more specific plan to effect, the CMBS restructuring if such proposed modification or specific plan results in any materially adverse economic or legal consequences to such party.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LTCQ

Acquisition of Nursing Home Chains by Private Investment Groups
Abbreviated Analysis of the New York Times Article
November 6, 2007

LTCQ, Inc. was founded in 1992 as a data-driven consulting company by four leading academic experts in the field of long-term care: Barry Fogel, MD, Lewis Lipsitz, MD, Vincent Mor, PhD, and John Morris, Ph.D. Dr. Mor, Chair of the Department of Community Health at Brown University, and Dr. Morris, a senior researcher at Boston's Hebrew Rehabilitation Center for Aged Drs. Fogel and Lipsitz are both geriatricians and professors at Harvard Medical School. LTCQ is the industry leader in providing data driven business intelligence to the long term care industry, serving more than 1,600 facilities nationwide. We are privately held and have 40 employees including clinical teams of advanced practice nurses and nursing home administrators, master's and Ph.D.-level researchers and technologists, and a highly-skilled executive team.

The New York Times (NYT) article of 9/23/2007 on the acquisition of nursing home chains by private equity (PE) investors has evoked great concern among families, advocates and politicians nationwide. However, the article is based on the application of problematic analytic techniques to problematic data. LTCQ offers the following observations, based on our long experience in analyzing public data on nursing homes, and chain-by-chain analyses of public data on over 800 of the 1,200 PE-owned facilities referenced in the NYT article – those for which we had accurate knowledge of the dates the PE firms acquired the properties. We could not analyze data on the full set of 1,200 facilities, as the NYT did not disclose their identity, but doubt the results would be materially different.

1) **Undisclosed expertise of those analyzing complex datasets.** The author reports on the analysis of complex datasets with many data quality issues and pitfalls for novice analysts. Just the data management necessary to create analyzable datasets can be daunting. He does not disclose whether he performed the analysis himself, or whether he relied on others to prepare the data and analyze them. Thus,it is not possible to evaluate whether the analysts were qualified to do a proper analysis of the data – or whether he relied on individuals with a declared bias against for-profit chain ownership of nursing homes.

    a. **Example of likely invalid data sampling.** Facilities are surveyed approximately annually, but they may not have a regular survey in any given year. For example, in calculating a summary statistic for a group of facilities in 2002 one must rely on data from surveys conducted in 2001 for over 25% of facilities. If an analyst uses such data to describe changes in a facility acquired at the beginning of 2002 a significant amount of *pre*-acquisition data will actually be used. The author did not say how he dealt with this issue.

2) **Questionable alignment of time periods**. The article reports on changes between 2000 and 2006 in staffing and survey performance. The author probably compared 2000 data with 2006 data, though acquisitions of facilities by PE took place on a range of dates within that period, right up to its end in 2006. If this is what he did, many of the changes observed

may have taken place *prior* to the acquisition of the facility. LTCQ knows this to be the case with staffing at one major chain that was acquired in 2002. This chain had a drop in RN staffing from 2000 to 2001, but then actually *increased* staffing after PE acquired the facility. The drop from 2000 to 2006 was totally explained by events occurring before the acquisition. Many facilities reduced staffing between 1999 and 2001 because of major changes in Medicare reimbursement that adversely affected their revenue.

3) **Licensed staff counts excluded LPN.** 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 PE firms.

4) **Reliance on OSCAR staffing data is limiting.** The article drew its staffing data from OSCAR data, not payroll records or staff schedules. OSCAR staffing data are based by sampling staff hours over a two-week period; the data are collected using a complex and difficult-to-understand form that usually is completed by facility staff who often have no connection to the payroll or scheduling processes. Even when the hours they report are accurate they are not necessarily representative of year-round staffing. Examination of the raw staffing data from OSCAR shows improbable values for staff ratios, such as >10 hours per resident per day, or less than 1 hour per resident per day of total staff time. Because the form collects data over a two-week period, a common mistake is for facilities to report hours over a one-week period, leading to a reported staff ratio one-half of those that actually exist.

   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 (agency) staff. Most long-term care experts would agree that an experienced staff with a low turnover rate may provide better care than one with somewhat more staff hours due to heavy use of agency staff and relatively inexperienced nurses. Finally, the total staffing of nursing homes includes physical and occupational therapists, physician extenders, medication aides, and other ancillary personnel. In facilities with a high rehabilitation and/or sub-acute care population these staff play a major role, and may decrease the number of nursing hours needed for optimal care.

5) **Comparisons drawn to national staff ratios ignore state and local influencers.** The author compares staff ratios with *national averages*. Using *national* data neglects differences in state regulations and local labor markets. Using *averages* amplifies the effect of outliers such as hospital-based sub-acute facilities with very high numbers of registered nurses. It also amplifies the effect of data errors. In any case, the distribution of hours is not (statistically) normal. For these reasons, the majority of *all* nursing homes in the US are *below the national average*. The use of *geographically-adjusted benchmarks*, a more appropriate analysis, mitigates much of the difference between PE-owned facilities and others.

6) **Comparisons drawn to national survey performance ignores well documented regional variations.** The author notes that serious deficiency citations rose at PE-owned

facilities, "even as citations declined at many other homes and chains". It is also true that citations increased at many other homes and chains *not* owned by PE firms. The author compared deficiency counts of "typical" PE-owned facilities (not specifying where he was reporting on a mean, median, or mode) with the *national average* number of deficiencies. It is well-known, and acknowledged by CMS itself, that there are large differences from state to state, and within some large states, in the rigor with which surveyors apply regulations. Since the geographic distribution of PE-owned facilities is not uniform, it is inappropriate to use a national average as a benchmark. Many PE-owned facilities are located in states and survey districts where the average number of deficiency citations received by all facilities is greater than the average number received nationally. PE-owned facilities are disproportionately located in such areas. When geographically adjusted benchmarks are applied, it is no longer true that the number of serious deficiencies is 19 percent higher at PE-owned facilities.

7) **Complaints typically rise after change in ownership, regardless of new owner.** LTCQ found that complaint allegations and complaint survey deficiencies tend to rise significantly in the year or two following a change in ownership. After that time, the level begins to fall to pre-acquisition levels. Certain effects attributed by the author to PE ownership may actually be due to the disruptive effects of a change in ownership and management, a phenomenon described in peer-reviewed journals on nursing home quality as applicable to ownership changes not involving PE firms. If a snapshot of a facility's performance is taken during the transition period it will look worse than it did before the acquisition or three years after it. If the author had used a baseline during the peak in complaints and a follow-up three years later he would have found improvement under PE ownership.

8) **Clinical management cannot be measured by unadjusted CMS Quality Measures.** The author points out that nursing homes owned by PE firms had worse scores on 12 of 14 publicly-reported quality measures (QMs). These measures have acknowledged limitations, particularly in the area of pressure ulcers, where they do not distinguish between pressure ulcers present on admission and those acquired in the facility, and do not credit facilities for decreasing the number, size, and stage of a resident's pressure ulcers. The QM for pressure ulcers is all-or-nothing. Facilities that specialize in wound care and admit many residents with advanced or multiple pressure ulcers will always look bad on such measures. By contrast, OSCAR has information on the percentage of residents in a facility with pressure ulcers that were *acquired after admission.* Many facilities owned by PE firms have reduced the rate of such ulcers.

    a. **Further example of Quality Measure limitations.** Facilities that treat greater numbers of more medically acute or complex and/or functionally impaired residents will look worse on QMs, because they are not fully adjusted for residents' baseline condition or baseline risk of adverse outcomes. In general, the chains purchased by PE firms served a relatively high number of residents on Medicare and Medicaid as opposed to private pay. Private pay residents tend to be healthier than Medicare and Medicaid residents, so facilities with high private pay proportions would look better on many of the QMs even if the quality of care was the same.

An unequivocal conclusion of LTCQ's study of over 800 PE-owned facilities is that ownership by a PE firm and operation by a different organization is compatible with the highest quality of care. Problems with care quality that do exist at some facilities owned by PE groups relate to the operations of the specific facility and not to ownership arrangements as such.


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SEIU
Stronger Together

Memorandum

To: SEIU Wisconsin State Council
From: SEIU
Date: November 13, 2007
Re: Wisconsin Nursing Home Licensure

This memorandum summarizes possible steps that the Wisconsin Department of Health and Family Services ("DHFS") may take with respect to pending licensure applications related to the Carlyle-Manor Care transaction.

Background

HCR Manor Care is currently a public corporation and operates 868 resident beds in Wisconsin. Earlier this year, the Carlyle Group announced plans to take the Manor Care chain private in a deal worth more than $6 billion.

The Carlyle Group is one of the country's largest private equity firms, with portfolio assets valued at $75.6 billion. Until recently, Carlyle has focused on the defense, aerospace, and energy sectors, and the firm has had relatively little experience in the long-term care industry.

We are concerned about the effect of the Carlyle buyout on quality of care at Manor Care homes for each of the following reasons.

Private Equity's Poor Track Record

According to a recent *New York Times* investigation and cover story, private equity firms have had a negative effect on patient care at nursing homes taken private. The *Times* reported that managers cut the number of registered nurses on staff at 60% of nursing homes acquired by large private equity firms between 2000 and 2006. In some cases these cuts drove staffing levels below legal requirements. The *Times* also reported that the typical nursing home facility purchased by a private equity firm before 2006 scored worse than the national average on 12 of 14 indicators used to track resident ailments.

Manor Care's Already Poor Record in Wisconsin

Under federal law, nursing homes are required to be inspected every 9 to 15 months. During the three most recent survey cycles, Manor Care's Wisconsin homes were cited for a total of 97 federal health standards violations. Furthermore, the number of violations cited jumped 59% in the most recent survey cycle. These violations include failure to make sure the

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nursing home is free of hazards that could cause accidents, and failure to protect residents from neglect, mistreatment, or theft.[1]

Highly Leveraged Buyout Model

More than 80% of the Carlyle Group's purchase of Manor Care will be financed by debt. The transaction will leave Manor Care with $5.5 billion in new debt, and SEIU has calculated that interest payments required on that debt could total more than $400 million in the first year alone.

Concerns Raised by Congress and State Legislators

SEIU is not alone in expressing concern about private equity's influence in the nursing home industry. In Congress, the House Ways & Means Subcommittee on Health and the Senate Special Committee on Aging are both scheduled to hold related hearings this week. The House Energy and Commerce Committee and the House Financial Services Committee have also announced investigations into the impact of private equity ownership on nursing homes. These announcements come on the heels of requests by Senators Grassley and Clinton for the Government Accountability Office to investigate private investor ownership of nursing homes, and letters sent by Senators Grassley and Baucus to five private investment firms seeking information on their ownership and management of nursing home chains, and to the Centers for Medicare and Medicaid Services about its oversight of such homes.

State legislators in Washington, Illinois, Michigan, Maryland, Florida, and Pennsylvania have all called upon regulators to investigate the Carlyle buyout of Manor Care, and legislative hearings have been announced in Pennsylvania, Michigan, and Maryland – meaning nearly one-third of Manor Care's nursing homes are already being subjected to legislative oversight.

Licensure Process

Nursing home licenses in Wisconsin are not transferable. Once a nursing home licensure application is complete, DHFS is required to make any inspection or investigation "necessary" to determine whether the applicant is fit, qualified, and able to comply with the statutory requirements. Wis. Stat. §50.03(4); Wis. Admin. Code §HFS 132.14(4)(a). DHFS may review both material provided in the application and any other documents that may appear relevant. Wis. Admin. Code §HFS 132.14(4)(b). No license may be issued until and unless an applicant has supplied all information requested. Wis. Admin. Code §HFS 132.14(3)(d).

Although DHFS has taken the initial step in this case of deeming Manor Care's applications complete, there is no basis in either statute or regulation for concluding that

[1] This 59% calculation is based on data for the three most recent survey cycles for which information was available when accessed on August 23, 2007. The description of specific violations is drawn from a certification survey dated March 22, 2007 for Manor Care Health Services – Appleton.

DHFS cannot request additional information from the Manor Care applicants. To the contrary, the requirement that DHFS conduct whatever investigation is "necessary" at this substantive stage means that DHFS must request and consider any information needed to determine whether the applicants are, *inter alia*, "fit and qualified."

Given the concerns already raised about quality of care in private equity-owned nursing homes, and the financial effects of this type of highly leveraged buyout, there is substantial additional information that DHFS needs to evaluate the licensure applications filed as part of this complex transaction. That additional information includes:

- Data regarding Manor Care's plans for revenue and profit growth, and how such goals will be achieved without compromising care while the new operating LLCs must simultaneously make new lease payments and payments on the company's new $5.5 billion in debt.

It is clear from Manor Care's regulatory filings that the company will be saddled with $5.5 billion in new debt following the Carlyle buyout. It is also clear that all real estate will be contributed to new property LLCs (referred to as PropCos), which means that the entities actually operating Manor Care's homes will be required to pay substantial lease payments they were not previously required to make. At the same time, it is clear – as is always the case in the private equity model – that Manor Care's private equity purchasers intend to increase revenue and profit in order to make the company marketable when the private equity investors divest by taking the company public again. Although Manor Care has made statements to the effect that it intends to continue providing the same level of care (care that is routinely cited as inadequate by federal regulations, *see supra*), the *New York Times* report reflects declining care at private equity-owned homes and Manor Care has not explained how it intends to increase revenue and profit *and* make the new interest and lease payments described above without affecting quality of care.

- Information about the assumptions made in Manor Care's financial statements, including recent past financial statements.

The projected financial data submitted to date reflect a series of assumptions that are not clearly identified or adequately explained. In order to evaluate the data, DHFS needs a clear description of each assumption and information about whether that assumption is in line with past data such as recent financial statements.

- Missing details about already disclosed adverse actions.

Manor Care checked "yes" in response to the question about whether "adverse action initiated by any state licensing agency resulted in the denial (D), suspension (S), or revocation (R) of a license." But Manor Care did not complete the table provided for details, instead attaching summary descriptions of terminations of four Manor Care facilities from certification as providers of Medicare and Medicaid. The types of adverse actions and effective dates are not clearly identified in the company's summaries. To

complete the application, Manor Care should be required to re-submit a complete table and attach all relevant correspondence for all terminations from Medicare and Medicaid.

In addition, Manor Care checked "no" in response to the question about whether "any adverse action initiated by a state or federal agency based on non-compliance resulted in civil monetary payments, termination of a provider agreement, suspension of payments, or the appointment of temporary management of the facility." But the company's descriptions of the four terminations mentioned above indicate that there were terminations of provider agreements and, for some facilities, monetary fines. To complete the application, Manor Care should check "yes" and re-submit a completed table with the information requested on the application form.

- Additional information regarding all persons directly or indirectly involved in management or with direct or indirect interests, and about creditors.

In its applications, Manor Care appears to have listed only HCR entities and the following Manor Care executives: Matthew Kang, Director, Secretary and Treasurer; Larry C. Lester, President and General Manager; Kathryn S. Hoops, VP; Steven D. Spencer, VP; Barry A. Lazarus, VP; and Larry Godla, VP. There are several other corporate parent organizations, as well as current Manor Care executives including the CEO, COO/EVP, CFO, and other VPs, all of the Board of Directors, and Carlyle Group executives that could have indirect authority over management or policies of the facility and indirect interests in the facility. These entities and individuals were not listed – even though Manor Care and Carlyle (the corporate parents) have recently made public statements about care at the facilities, implying that they have the authority to control care.

In addition, the Carlyle-Manor Care deal papers make clear that Manor Care will mortgage its real estate and fund the buyout with mortgage-backed securities. In order to get a complete credit picture going forward, DHFS must be provided with information about the creditors who will hold these significant security interests in Manor Care's premises.

- Information about staffing plans.

DHFS should ask for plans for staffing plans, including the number of full time hours, part time hours, and contracted hours by type of worker. The application only includes a copy of CMS form 671, which contains current staffing.

- More information about the Carlyle Group.

With the exception of a cover letter mentioning the transaction between Manor Care and Carlyle and a corporate organizational chart, the Wisconsin applications contain no further details or documentation about the Carlyle Group's finances, its plans for meeting the debt obligations incurred as a result of the transaction, or its record in patient care after past acquisitions. At a minimum, we suggest that the department request information and documents related to --

Carlyle's patient care track record after an acquisition and in other health care facilities in which it has an ownership stake. LifeCare Hospitals is the only health

care facility Carlyle has acquired, but Caryle has an ownership stake in several others. Documents to request should include: staffing levels before and after the acquisition, results of surveys and complaint investigations, and legal documents related to the alleged liability for any wrongful death, resident abuse, or corporate negligence by any healthcare company in which Carlyle has an ownership stake. These should include, but should not be limited to, documents detailing the legal proceedings surrounding LifeCare Hospital's alleged responsibility for 24 patient deaths in New Orleans following Hurricane Katrina.

Carlyle's finances and corporate structure. Documents, including tax documents, related to human resources restructuring, debt restructuring, executive compensation and cash flow for the healthcare companies in whom Carlyle has had a controlling ownership stake for the period during which Carlyle retained that stake. In addition, any other documents that would aid an assessment of how Carlyle's takeover of Manor Care will affect the financial solvency of that company as well as any potential legal liability it may face.

Fitness as a recipient of state funds. Any other documents that would aid an assessment of how Carlyle's takeover of Manor Care will affect Manor Care's ability to satisfy its legal and other obligations as a recipient of state funds. This could include audits of reimbursements from public funding sources for the last five years for any company in which Carlyle has an ownership stake; financial records detailing the ownership structure of any Carlyle-affiliated company which may contract with Manor Care following its acquisition; legal proceedings and settlements regarding allegations of Medicaid or Medicare fraud for any company in which Carlyle has an ownership stake or is in partnership with a Carlyle-owned entity; any reporting to Health and Human Services Office of the Inspector General as a result of Corporate Integrity Agreements or Certification of Compliance Agreements signed by any of Carlyle's portfolio companies, including, but not limited to LifeCare Holdings; and background check results for healthcare employees of any Carlyle-affiliate which received public funds in the last 3 years.

If Manor Care fails to provide this additional information in a timely fashion, DHFS may deny the company's applications without prejudice to their quickly being re-filed, or Manor Care may agree to an extension of the ordinary deadline for the licensure process in order to allow the company sufficient time to gather the requested information.

It is important to note that there is no danger to patients posed by additional information requests like those described above. The agreement between Carlyle and Manor Care provides that regulatory approval is a condition to closing, which indicates that the two companies will not conclude the buyout and transfer operations until DHFS (like other state agencies) has sufficient time to review the licensure applications. In addition, the agreement between Carlyle and Manor Care provides that the deal need not close before *March 31, 2008* – and, in some circumstances, need not close until May 31, 2008. As a

result, there is no reason to short circuit the process. Manor Care may continue to operate and serve patients under its current licenses for many months to come.


FORWARD
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Statement by Senator Grassley to the Special Committee on Aging

Nursing Home Quality of Care

November 15, 2007

Good morning. I want to begin by thanking Chairman Kohl and the members of the Senate Special Committee on Aging for holding this important hearing. When I had the privilege of serving as chairman of this committee, many of our efforts were focused on abuse and substandard care in America's nursing homes. I'm glad to see that under the leadership of Chairman Kohl, this critical issue is remains a top priority and I applaud the committee's efforts.

In America today, there are nearly 1.7 million elderly and disabled individuals in approximately 17,000 nursing home facilities. This includes the men and women of the world war two generation – and our duty to ensure that they receive the quality care they deserve couldn't be higher.

But in addition to the Americans currently living in nursing home facilities, another issue lies on the horizon. As the baby boom generation gets older, the number of Americans in nursing home facilities is going to rise dramatically. Therefore, it's critical that we confront the issue of safe and high quality nursing home care today.

As the Ranking Member of the Senate Finance Committee, I have a special interest in nursing home care. The industry is often the subject of both my investigative and legislative work, and today I'd like to share some of my thoughts. In particular, I want to emphasize four areas that are of concern in the nursing home industry from my perspective: 1) the problem of repeat offender homes, 2) the issue of fire safety, 3) the need for greater transparency in nursing home quality, and 4) recent concern over reports that the rise of private equity firm ownership of nursing homes is resulting in poorer quality of care.

In the nursing home industry, the vast majority of homes provide quality care on a consistent basis. They provide an invaluable service to those who can no longer care for themselves, and we applaud them for this service. But as in many sectors – this industry is given a bad name by a few bad apples that spoil the barrel. A critical tool in confronting these bad actors are the sanctions CMS can place on homes for failure to meet certain standards of care. Yet too often, nursing homes are able to "yo-yo" in and out of compliance, temporarily correcting deficiencies and having the sanctions rescinded, only to fall back into noncompliance. When sanctions *are* put in place, nursing homes currently have the incentive to file appeal after appeal, delaying the imposition of penalties and adding costs to the taxpayer. So for me the key is to ensure that nursing homes provide quality care to residents consistently – day in and day out – and if they don't, the public should be aware of that fact.

A recent GAO report examined 63 nursing homes that had been identified as having serious quality problems. Of these, nearly half continued to cycle in and out of compliance between fiscal years 2000 and 2005. 27 of the 63 homes were cited 69 times for deficiencies warranting immediate sanctions, yet in 15 of these cases sanctions were not imposed. Eight of the homes reviewed cycled in and out of compliance *seven* or more times *each* period. This is unacceptable.

But the real meaning of substandard care isn't about numbers and statistics – it's about real people – our mothers, fathers, grandparents and other loved ones. Every day there are stories reported across this nation about residents suffering or even dying from preventable situations. Imagine, just recently I read about a nursing home resident in Florida who was taken to a hospital with bed sores, a partially inserted catheter, an infected breathing tube, and maggots in one of his eyes. Each and every one of you will agree with me – *this* is unacceptable. It is an outrage.

The current system provides incentives to correct problems only temporarily and allows homes to avoid regulatory sanctions while continuing to deliver substandard care to residents. This system must be fixed. In ongoing correspondence I've had with Kerry Weems, the acting administrator of CMS, that agency has requested the statutory authority to collect civil monetary penalties sooner, to be held in escrow pending the decision on appeal. I think this is a good start. Penalties should also be meaningful – too often, they are assessed at the lowest possible amount, if at all. Penalties should be more than merely the cost of doing business; they should be collected in a reasonable timeframe; and should not be rescinded so easily. These changes will help prod the industry's bad actors to get their act together or get out of the business.

Another pressing issue is that of fire safety, and as we saw in 2003, this is an issue of life-or-death importance. That year, 16 people died in a nursing home fire in Hartford, Connecticut, and 15 died at a home in Nashville, Tennessee. Neither home had installed automatic sprinkler systems. Despite the fact that a multiple-death fire has never occurred in a sprinklered home, there are approximately 2,773 homes still without full sprinkle systems.

Following these terrible events, I requested that GAO look into the matter, and have held an ongoing conversation with CMS on how we can better protect America's nursing home residents from preventable fires. In October of 2006, CMS began to move in this direction, and expects to issue a final rule in the summer of 2008. This is a much needed improvement that will surely save lives.

While a better penalty system and better fire safety will do much to increase nursing home safety, we've also got to give nursing home residents and their families better access to information about these homes. And to do that you need more transparency.

The public currently has access to some information on nursing homes through the website "Nursing Home Compare," located on Medicare's website. Yet for all the valuable information this website provides, it could be improved through the inclusion of

information on sanctions, as well as an identification of the worst offending nursing homes, often called "Special Focus Facilities." By listing these homes and the implemented enforcement actions online – information the government already has – the public would have better access to nursing home information and nursing homes would have an extra incentive to meet quality standards.

The process of choosing a nursing home is a very important and personal one for thousands of American families every year – we owe it to them to give them complete information when making this decision. Acting Administrator Weems, in a recent letter to me, gave his assurance that CMS would begin posting this information online. I thank him for his commitment and look forward to seeing this carried out. In this area, as in others, a little sunshine will go a long way.

Finally, I want to touch on an issue that has garnered a lot of attention lately – that of the purchase of nursing homes by private equity groups. Recent news reports have highlighted concerns over decreasing quality of care, decreased staffing, and decreased budgets at nursing homes purchased by private equity groups. At one home, it is alleged that 15 residents died in three years due to negligent care at a home purchased by one of these groups.

In response to these concerns, Senator Baucus and I have launched an inquiry into private equity firms and their ownership of nursing homes. Last month, we sent letters to five private equity firms asking for detailed information about their purchases and impending purchases of nursing facilities. If private equity ownership is in fact having the effect of decreased staffing, decreased budgets, and, in turn, decreased care, then something must be done about it. I plan to continue my inquiry and look forward to working with Senator Baucus to take whatever measures are appropriate in addressing this issue.

Those four issues – ineffective enforcement mechanisms, nursing home fire safety, the need for greater transparency, and concerns over private equity ownership – affect millions of vulnerable Americans and the United States Senate has a great responsibility in addressing them. Again, I thank Chairman Kohl and the members of this committee for holding this hearing, and look forward to working with you all on these matters. I also want to acknowledge the efforts of the group "Advancing Excellence in America's Nursing Homes." This group is a broad coalition of organizations dedicated to improving the quality of care and quality of life of nursing home residents. Coalitions such as this are vital to our efforts. In closing, all of us – and I mean private organizations, families, residents, caregivers, nursing home advocates, and the government – have a role to play in this important work if we want to be successful in our efforts to continue improving nursing home care. And indeed, much work remains to be done. Thank you.


FORWARD
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House Committee on Ways and Means

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Testimony Before the Subcommittee on Health
of the House Committee on Ways and Means

November 15, 2007

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 US 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 US Government Accountability Office, the US 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 US 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 US 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 nonprofit 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 (US 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 US. For-profit independent nursing facilities had a total of 3.85 hrpd and nonprofit 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 seven 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 six of the largest chains (including Mariner Health Care, Beverly Enterprises, Genesis HealthCare, and Manor Care), 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 in the past five 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, 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 freestanding 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 1/3 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 two 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 TRANSPARANCY 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 US 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.

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P. O. Box 7882 Madison, WI 53707-7882

November 20, 2007

Senate Committee on Public Health, Senior Issues, Long Term Care, and Privacy
Senator Tim Carpenter, Chair
Room 306 South
State Capitol

Hand Delivered

Dear Chairman Carpenter:

We are writing to ask that you hold a public hearing in the coming week to address concerns that have been expressed regarding The Carlyle Group's recent acquisition of Manor Care, Inc. As this matter is incredibly time sensitive – the Department of Health and Family Services is set to make a decision in this matter by the end of the month – we would suggest a hearing date before the month is out.

As you know, The Carlyle Group is one of the nation's largest private equity firms and plans to take Manor Care, Inc. private in a deal worth more than $6 billion. We believe this ownership transfer should be thoroughly scrutinized because of the poor track record that private equity firms in the long term care sector have displayed with regard to patient care. We are also concerned that the department's oversight responsibilities could be complicated by an ownership transfer to a private equity firm that is inexperienced in the health care field and not required to publicly report revenues, profits and other financial information.

Additionally, a recent *New York Times* investigation and cover story noted that managers of private equity firms have cut the number of registered nurses on staff at 60% of nursing homes acquired by these firms between 2000 and 2006. To date, The Carlyle Group has released no information detailing how it intends to increase revenue without replicating the negative impact that similar transactions have had on the quality of care provided in nursing homes owned by private equity firms.

In addition to problems with quality patient care, the *New York Times* story highlighted the fact that most private equity firm acquisitions have involved the creation of incredibly complex corporate structures that make it very difficult for regulators and patients' families to investigate and hold entities accountable for patient care deficiencies.

At the federal level, Senator Herb Kohl held a public hearing on this topic in the Senate Special Committee on Aging on November 15, 2007. The hearing led Chairman Kohl and Senator Charles Grassley (R-Iowa) to announce their intention to introduce federal legislation that will ensure consumers have access to information relating to the results of government inspections, the number of staff employed, and information about the home's ownership structure.

We applaud Senators Kohl and Grassley for proposing these necessary reforms and hope that your committee might be willing to provide a similar service to the people of Wisconsin by holding a hearing to ensure that our most vulnerable citizens continue to receive the high quality of care they deserve in the state's nursing homes.

Thank you for your attention to this request. Should you have any questions, please feel free to contact either of our offices.

Sincerely,

Dave Hansen
State Senator
30th Senate District

Robert W. Wirch
State Senator
22nd Senate District

CC: Senator Spencer Coggs (Committee Vice-Chair)
Senator Pat Kreitlow (Committee Member)
Senator Dale Schultz (Committee Member)
Senator Robert Cowles (Committee Member)