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Senior Living

by Tom Gale

**Directly Addressing 5-Star Ratings
can Indirectly Protect Access to Capital**

In December 2008 the Centers for Medicare & Medicaid Services (CMS) rolled out the Five-Star Nursing Home Quality Rating System, designed to make it easier for residents and families to compare nursing facilities. Nearly one year later, concerns still remain about how ratings are issued, particularly because of the impact they can have on facility perception by both potential residents and interested parties such as investors.

In 2009's tough capital markets, little evidence became available as to whether the rating system has impacted access to capital. Regardless, it is essential that board members, owners, executive directors, and other nursing facility stakeholders understand the system, the components that comprise the overall facility rating and the shortfalls being discussed.

Conversations with providers indicate that most of the public take the ratings at face value and are unaware of ongoing discussions about the methodology. This is of particular concern when an otherwise strong provider receives a low rating – the discrepancy between measurements and actuality are less relevant for weak facilities with weak ratings.

Understanding the system, flawed or not, will help an organization better articulate its rating to current and prospective residents, their families, staff members and other interested parties – including capital providers.

Calculating Ratings

Under the system, each facility that participates in Medicare and/or Medicaid receives a quality of care rating of one star (much below average) to five stars (much above average) based on the composite rating for three separate categories including health inspections, staffing levels and quality measures. These measures are then subjected to further weights and measurements, and stars are assigned based on the relative performance of the facility compared to its state peers and based on a normal distribution of ratings (e.g. the top 10% of performers receive five stars, and so down the line). The categories are:

- **Health Inspections-** This measure is based on the number, scope and severity of deficiencies found in state health survey inspections over the past three years and takes into account the number of revisits required for major deficiencies to be corrected.
- **Staffing-** Facility ratings are based on two measures: RN hours per resident day and Total staffing hours (RN+ LPN+ nurse aid hours) per resident day.

These staffing measures are derived from the CMS Online Survey and Certification Reporting (OSCAR) system, and are case mix (i.e. acuity)-adjusted based on the distribution of Minimum Data Set (MDS) assessment by the RUG-III group.

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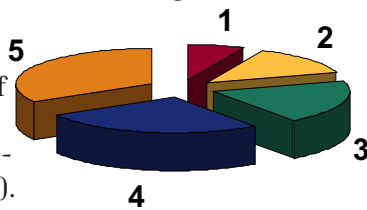
- **Quality Measures** - Measures developed from MDS-based indicators: Facility ratings for the quality measures are based on performance on 10 of the 19 quality measures posted on the Nursing Home Compare Web site. These include 7 long-stay and 3 short-stay measures.

5-Star Criticism

Each of the three dimensions of the overall rating has provoked debate and calls for change. In August 2009, 31 Attorneys General sent a letter to Health and Human Services Secretary Kathleen Sebelius calling for the temporary suspension of the rating system so it can be revised using more appropriate evaluation methodology. The most common discussions focus on the following issues:

Health inspection measurements are compared and rated against the performance of other facilities within the state, making it difficult for residents to compare the ratings of facilities across state lines due to differences in state survey teams, their methodologies and competition within the state. Health Inspections can even vary within states, as survey team leadership and stringency can differ by area. In addition, the data submitted to the five-star rating system's Online Survey and Certification Reporting (OSCAR) is often inaccurate and out of date. It is therefore possible for a facility to correct a deficiency and notify OSCAR, but continue to be penalized because the deficiency remains in the OSCAR database. Also, there has been a call for the elimination of the pre-determined percentage assignment of facilities to star rankings based on a "normal" distribution.

This "normal" distribution causes 67 percent of nursing facilities within each state to fall at or below average (1 to 3 stars).



The staffing measure contains multiple concerns as well. Most importantly, staffing data are reported by the nursing home itself and unverified by an oversight agency, which can raise doubt about the accuracy of the data. The staffing rating uses an arbitrary two-week snapshot at a point in time that may or may not be an accurate reflection of staffing levels, for example because of the way vacations or holidays happen to fall. In addition, staffing data, which is on average 9.4 months old, is case-mix adjusted with national RUG data that is also dated. This creates numerous methodological inaccuracies. Moreover, because staffing requirements differ by state,

it is difficult to make comparisons and adjustments with national RUG data. Finally, despite the fact that physician extenders, therapy staff and other facility employees do improve the quality of care of residents, they are not part of the staffing hours used to calculate this component of the five-star rating.

In regard to the quality measures, these measures were never intended to be definitive measures of quality and care. Instead, these measures are meant to serve as indicators of potential problem areas that need further review. Again, this field is reported by the nursing home itself and may not be entirely accurate. This measure and the five-star rating in general do not differentiate between facilities of different acuity levels. Those facilities with higher acuity levels are at a disadvantage in the rating system. Finally, ratings can be skewed for small facilities where each resident's data have a greater impact on percentile ranking.

Knowledge is Power

Most within the healthcare community acknowledge that the objective of the 5-Star Rating System was well intended, but the implementation was rushed and the methodology has its flaws. The new system may not be perfect, but it is readily accessible by the general public and is reported to be viewed by some 50,000 consumers per day on the CMS website.

It does not appear to have had much direct impact on banks, lenders or investors: In a small, informal survey of commercial banks and senior living borrowers, none said the Five-Star Rating System impacted access to capital, and most did not give it much weight at all. What remained most important in the credit profile were key qualitative and quantitative measures like management experience, financial performance, and state survey results and evidence of promptly addressing any identified issues.

Despite the current lack of direct impact on access to capital, however, the ratings could have an indirect impact if ratings are detrimental to the surrounding market's perception of the facility, staff morale and the ability to attract new residents. In that regard, it is vitally important for stakeholders to understand the system and its flaws, work diligently with the appropriate advocacy groups to bring about the desired changes and most importantly be able to articulate its nuances to current and prospective residents, their families, staff members and other interested parties including capital providers.