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Senior Living Providers: Preparing for Health Care Reform
April 30, 2010

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What Happened?

- In March 2010, Congress passed and the President signed health reform in:
  - **The Patient Protection and Affordable Care Act**
  - **The Health Care and Education Affordability Reconciliation Act of 2010.**
    - ◊ Increases **access** to health coverage (32 million)
    - ◊ Aims to **reduce costs** via payment reductions and focus on wellness and prevention
    - ◊ Seeks to reward **"value-based"** care delivery

- Impact of the Act:
  - Cost: $940 Billion over 10 years
  - Coverage: + 32 Million by 2019

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What Do We Know For Sure?

- Very little…………..
- The law has been passed, but…..
  - Will it sustain legal challenges?
  - How will the administrative rule impact implementation?
  - Will we be able to stick with the timeline based on the complexities?
  - And others…..
- America* is concerned and business leaders are beginning to speak out:
  - Majority do not believe the CBO cost estimates are realistic
  - The numbers opposed to reform legislation are declining, but the 45%+ that are opposed are strongly opposed
  - Business leaders such as the CEOs of AT&T, 3M, Caterpillar, and others are beginning to estimate and report what they expect the new bill will cost and it is in the billions
- Payers across the country are exploring new payment methodologies including gain sharing and bundling and not waiting for reform implementation

Rasmussen Reports: Health Care Reform Final Tracking Poll, Friday January 22, 2010 www.rasmussenreports.com; Wall Street Journal, Mr 30 & 31st, 2010; USA Today March 27th

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Let's Keep it Simple…..

Reimbursement

will be cut….

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Some thoughts for senior living providers on reacting to health care reform…..

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More In Depth Understanding of Your Local Health Care Market

•***Health Care and Aging Services are driven by local culture, customs and care delivery patterns. Successful strategic planning will require a comprehensive understanding of:***

- Demographic characteristics
- Local culture norms
- Area health care practice patterns for all levels of services
- Current program and service offerings
- The decision-makers for buying decisions
- Competitor advantages and distinctive characteristics
- Referral source needs and challenges

•*Continuously scanning the environment and collecting market trend information in aging services and health care as well as related fields such as banking and retail, will increase the likelihood that aging services providers are creating effective and targeted strategies.*

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Reacting to Changes in Third Party Reimbursement or Financing of Long-Term Care

Reform Elements/Other Influencers

- Medicare market basket productivity adjustments for skilled nursing facilities and hospice providers
- Home Health payment rebasing
- Reductions in Medicare Advantage plan payments
- Potential Independent Payment Advisory Board recommendations
- Implementation of MDS 3.0
- Implementation of RUGS IV
- Reduction in time to submit Medicare claims

Provider Response

- Create a culture of operational excellence
- Prepare operationally and begin training staff
  - MDS 3.0
  - RUGS IV
- Calculate the potential financial impact of changing reimbursement systems
- Create robust measurement systems that capture greater clinical, demographic, market and financial data
- Create automated processes for collecting data that will tie to other providers who care for clients across an episode

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Reacting to Changing Delivery Systems

Reform Elements/Other Influencers

- Payment Bundling initiatives
- Value-Based Purchasing Initiatives
- Reductions in hospital payment streams
- Additional quality metrics surrounding rehospitalization
- Increased shift of aging services to lower cost levels of care
- Incentives for states to rebalance their Medicaid spending toward more home and community based spending

Provider Response

- Begin developing stronger relationships with hospitals and physicians
- Begin to develop which roles your organization may play in the new models (contractor, subcontractor, manager etc.)
- Evaluate how care managers and physicians may plan an enhanced role in the community and in your organizations
- Measure your rehospitalization rate and begin focusing on ways to improve it
- Study demonstration projects
- Get involved with networks developing in your marketplace
- Develop robust quality and performance measurement metrics

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Fee for Services vs. Capitation

Fee For Service

- Overuse of higher reimbursed services under use of less lucrative services
- Medical culture that places little value on activities such as care coordination that are not reimbursed
- A fragmented delivery system that patients and providers find increasingly difficult to navigate

Full Capitation

- Under use of services to enhance profitability
- Strong incentive for care coordination to maximize efficiency and
- Exposes providers to a level of risk that few are capable of managing well

Objective is to find a delivery model in between these two payment systems that reduces costs, encourages collaborations and rewards quality

Excerpts from National Institute for Health Care Reform Policy Analysis No. 1, January 2010

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Changing Care Delivery Models

- Accountable care organizations
- Bundled Medicare episodic payment systems
- Value Based Purchasing
- Medical Home

Common denominators (Coordination of Services, Cost Effectiveness, Enhanced Quality)

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Reacting to Coverage Expansion

Reform Elements/Other Influencers

- Expansion of Medicaid eligibility by increases in the % of federal poverty levels
- Community First choice option
- Enhanced funding for Aging and Disability Resource Centers
- Increased focus on home and community based services

Provider Response

- Revisit your strategic plan
  - What is the unmet need in the community?
  - Where are your core competencies?
  - Where do the above intersect with your mission?
- What is your diversification strategy?
  - Home Care
  - Adult Day Care
  - Hospice
  - Other H&CBS
- Revisit your marketing strategy

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Reacting to Transparency Requirements

Reform Elements/Other Influencers

- Enhanced disclosure of various data
- Implementation of compliance and ethics programs
- Changes to data on nursing home compare
- Demonstration programs on culture change and use of information technology
- Additional training requirements
- Establishment of nation-wide criminal background checks and other screening programs
- IRS/GAO activity

Provider Response

- Develop requisite data collection tools
- Implement procedures to ensure compliance
- Educate your staff on new transparency requirements
- Develop, and then tell your story.
  - How do you respond to increasing questions from the public with regards to publicly available information?
  - How do you communicate this information to potential partners, referral sources?

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Reacting to Insurance Mandates

Reform Elements/Other Influencers

- Individual mandate to obtain health insurance
- Employer penalties for not providing “minimum essential coverage”
- Establishment of temporary risk pool
- Free choice vouchers

Provider Response

- Educate yourself on these initiatives
- Calculate the potential impact on your organization
- Begin educating your employees on their options
- Identify organizational strategies
- Plan for the potential impact now

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Expanding Access to Health Coverage: Individuals

- **Individual Mandate to Obtain Health Coverage:** Beginning in 2014, individuals must obtain a minimum-level of health insurance coverage or pay a penalty.

- **Minimum Essential Coverage includes:**
  - Medicare, Medicaid, TRICARE
  - Insurance purchased through an Exchange, on the individual market OR
  - Employer-sponsored coverage

- **Penalties for Failure to Obtain Coverage:**
  - In 2014: greater of $95 or 1.0% of income
  - In 2015: greater of $325 or 2 % of income
  - In 2016: greater of $695 or 2.5% of income
  - Includes a hardship exemption.
  - Penalty is capped at three times the per person amount for a family.
  - Assessed penalty for dependents is half the individual rate.

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Expanding Access to Health Coverage: Individuals

- **Medicaid expansion:** Expands eligibility to individuals and families up to 133 % of the federal poverty level (FPL)

- **Premium and Cost Share Assistance:**
  - Individuals and families with household income of 133 - 400 % FPL may be eligible for sliding-scale assistance in the form of:
    - ◊ Tax credits to pay health plan premiums; and
    - ◊ Out-of-pocket reductions to help with cost sharing such as co-payments and co-insurance.

- **Establishes a temporary high risk pool** (pre-2014) to help uninsured with pre-existing conditions obtain affordable coverage.

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Expanding Access to Health Coverage: Employers

Law does NOT require Employers to offer health insurance

- **Beginning in 2014, Employers with 50+ FTEs must "pay or play":**
  - **"Play:"** Employer offers "minimum essential coverage" that is "affordable" to their employees
  - **"Pay:"** Employer pays penalties, <u>only</u> if any employees obtain federal premium or cost sharing assistance:
    - ◊ **Penalty for employers offering coverage =**
      - <u>At least</u>, $3000 x # of full-time employees receiving federal assistance BUT
      - <u>No more than</u>, $2000 x each full-time employee (except for first 30 full-time workers) penalty
      - No penalty for employees receiving free choice vouchers
    - ◊ **Penalty for employers not offering coverage=** $2000 x each full-time worker (except for first 30 workers)

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Free Choice Vouchers - Effective 2014

- All employers offering and contributing to employee health coverage, regardless of number of employees, must offer free choice vouchers to:
  - ◊ Eligible employees:
    - Required employee contribution toward the employer-sponsored coverage is between 8 – 9.8% of their household income
    - Household income is less than 400% FPL AND
    - Employee does not elect employer coverage.

Does this apply to both full-time and part time employees?

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Free Choice Vouchers

- Amount of “free choice vouchers” = employer’s monthly contribution to the cost of coverage
  - Highest % paid for any plan offered
  - Amount is tied to coverage selected (e.g., employer contribution amount for family coverage, if family coverage selected)
  - If voucher exceeds cost of plan purchased through Exchange, excess is refunded to employee
    - ◊ Excess amounts received by employee to be included in their gross income.
- Individuals receiving vouchers are not eligible for federal subsidies for premiums or cost-sharing
- Employers do not pay the “shared responsibility” penalty for employees who receive vouchers

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Comparing Penalty for Employers Offering Coverage Vs. No Coverage

Employer assumptions: 400 FTEs + FT employees, 100 FT employees are subsidy eligible

Scenario 1: Employer offers minimum essential coverage

Employer must pay a fee which is the lesser of:

- $3000 x 100 = $300,000 **(penalty) x (# FT employees w/subsidies)**

OR

- $2000 x (400 -30) = $740,000 **(penalty) x (FT employees)**

Employer Fee = $300,000

Scenario 2: Employer does NOT offer coverage

Employer must pay a fee =

$2000
x
(400– 30)
= $740,000

Employer Fee = $740,000

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Scenario 3: Employer provides minimum essential coverage

- 400 Employees
  - 250 take up employer-sponsored insurance
  - 50 receive free choice vouchers
  - 100 receive federal premium/cost share subsidies
- Employer must pay a fee which is the lesser of:
  - $3000 x 100 (# of FT employees receiving subsidies) = $300,000

    OR
  - $2000 x (400 (total # of FT employees – first 30 full time employees) = $740,000

Employer Fee = $300,000

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Calculating the New Total Cost of Employee Coverage

Employer offers insurance and:	100 FT employees covered by employer plan = $200 x 100 = $20,000
- Has 155 FT employees - Contributes $200 per month towards employee insurance premiums 25 FT employees = subsidy eligible 30 are eligible for free choice vouchers	25 FT employees eligible for federal subsidies = $3000 x 25 = $75,000 Penalty = (155-30) x $2000 = $250,000 *or* 25 x $3000 = $75,000 = $75,000 30 FT employees eligible for free choice voucher = $200 x 30 = $6,000 **Total cost to employer = $101,000**

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Nursing Home Transparency (Section 6101)

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Nursing Home Transparency

- Expands public disclosure regarding the ownership and operations of Medicare SNFs and Medicaid nursing facilities
  - Expands the required information on Form # 855
  - Owners & operators more accountable
  - Increase penalties for noncompliance
  - Improve staff training
  - Increase quality of nursing home care

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Nursing Home Transparency

- Required information
  - Organizational structure
  - Information related to officers; directors; trustees and managing employees of the facility including start dates of services .
- Managing employee
  - Individual who directly or indirectly manages, advises, or supervises any element of the practices, finances, or operations of the facility

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Nursing Home Transparency

- Additional disclosable party
  - Any person or entity that exercises operational, financial, or managerial control over the facility, or provides policies or procedures for the operations of the facility, or provides financial or cash management services to the facility
  - Leases or subleases real property to the facility or owns a whole or part interest equal to or exceeding 5% of the total value of such real property
  - Provides management or administrative services, management or clinical consulting services, or accounting or financial services to the facility

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Nursing Home Transparency

- Within 2 years from the date of enactment, the Secretary is required to issue regulations requiring the information to be reported to the Secretary in a standard format

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Accountability Requirements (Section 6102)

- Skilled nursing facilities and nursing facilities are required to have a compliance and ethics program within 36 months of enactment
  - Preventing and detecting criminal, civil, administrative violations and promoting quality of care
  - Regulations will be published
- Within 3 years of published regulations, the Secretary is required to evaluate the programs and submit a report to Congress

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Accountability Requirements (Section 6102)

- Corporate Compliance Program
  - OIG published guidance for nursing facilities in March, 2000.
    - ◊ Written policies; procedures and standards of conduct
    - ◊ Compliance officer and compliance committee
    - ◊ Effective training and education
    - ◊ Effective lines of communication
    - ◊ Enforcing standards through well publicized disciplinary guidelines
    - ◊ Internal monitoring and auditing
    - ◊ Responding promptly to detected offenses and developing corrective action

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Other Provisions (Sections 6103 - 6107)

- Nursing home compare website
  - Staffing – hours of care provided per resident day
  - Tenure
  - Turnover
  - Training
  - Explanation of staffing based on patient mix
  - Links to state websites regarding state surveys
- Cost reporting
  - Separately report expenditures for wages and benefits for direct care staff

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Other Provisions (Sections 6103 - 6107)

- Secretary required to develop a standardized complaint form
- Within 2 years of enactment, facilities must electronically submit to the Secretary direct care staffing information based on payroll and other verifiable and auditable data in a uniform format
- Directs a study of the CMS 5-Star Quality Rating Systems for nursing homes and a report to Congress

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SNF RUG IV Implementation

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Medicare RUG IV

- PPACA delays the implementation of RUG IV until 10/1/2011
- Does not delay the implementation of the MDS 3.0
- Does not delay the change in the delivery of concurrent therapy
- Does not delay the change in the look back to the hospital stay

- Industry is working on reinstating RUG IV implementation on 10/1/2010

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RUG III / RUG IV Comparison

RUG III/RUG IV Comparison Published by CMS 7/6/2009					
	RUG III Days		Rate Range	RUG IV Days	Rate Range
Extensive Rehab	36.49%		$617.07 - $318.88	3.82%	$848.95 - $579.20
Rehab	51.75%		$528.59 - $252.13	75.93%	$620.76 - $257.88
Extensive Care	4.26%		$361.62 - $276.24	1.04%	$645.69 - $450.10
Special Care	3.03%		$271.58 - $252.95	10.11%	$436.13 - $270.03
Clinically Complex	3.22%		$270.03 - $211.04	5.58%	$352.30 - $214.15
Other	1.25%		$201.73 - $166.03	3.52%	$243.64 - $178.44
Based on FY 2008 Part A Days					
Rates as published 8/11/2009 Federal Register					
Urban Area - Without wage adjustment factor					

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MDS 3.0 & RUG IV Implementation Strategies

NOW is not too soon to begin!

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Preparing for RUG IV

- Software changes
- MDS training – 3.0
- RUG IV training
- Estimate potential revenue changes based on facility's Medicare population
  - What was the financial benefit of the hospital look back?
  - How will concurrent therapy & the projected therapy minute changes impact revenues?
  - How will the increase in nursing component impact revenues?
  - How will the domain changes impact revenues?
  - Will the change in ADL scoring impact revenues?

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Preparing for RUG IV

- Evaluate ancillary contracts and/or therapy staffing
  - Has your facility been providing concurrent therapy?
  - If so, will the staffing levels change?
  - How will the reduction in the therapy rate component impact therapy contracts or therapy dept. staffing?
  - How well do you manage consolidated billing services?
    - ◊ Labs, x ray, pharmacy
    - ◊ Infrequent services such as chemo

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Preparing for Change…

Key Focus for Senior Living Providers:

1. Creating an understanding of existing resident/patient care delivery patterns
2. Developing robust predictive measurement systems for utilization, quality and costs
3. Developing organizational capabilities for electronic health exchange and communications
4. Identifying and implementing best practices and strategies by diagnoses
5. Determining processes and demonstrating patient-centered care and patient engagement approaches
6. Engaging family and caregivers, particularly following Medicare SNF or Home Care episode to maintain relationships

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Conclusions

1. The promise of change will happen, but timing is uncertain.
2. A renewed focus on Mission is what will keep aging services providers grounded, sane and successful.
3. There is substantial work to be done to assure our organizations are prepared for proposed reforms.
4. Reimbursement will be reduced across all venues of care, but particularly hard hit will be Medicare and Medicaid beneficiaries.
5. New relationships built on creating mutual value will be required.
6. The economic recovery will be slow, but steady and will result in changes in older adults preferences, operations and the services offered.
7. Others…

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Questions?

Thank you for your attendance and participation today!

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