Health Care Reform and its Impact on Nursing Homes

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The Legislation
Two Bills
1. H.R. 3590 – The Patient Protection & Affordable Care Act
   - This bill makes up the bulk of the actual reform package.
2. H.R. 4872 – The Health Care & Education Reconciliation Act of 2010
   - This bill amends the first by a legislative process known as reconciliation.

General Provisions
- Significant expansion of health insurance coverage;
- Establishment of State Health Benefit Exchange programs;
- Expansion of Medicaid coverage;
- Changes in Medicare & Medicaid.
General Provisions

• Combined, these two bills call for over 150 different studies to be conducted by OIG and CMS.

Major Provisions Impacting LTC Providers

• Accountable Care Organizations;
• Payment Bundling;
• Nursing Home Transparency;
• Elder Justice Act;
• CLASS Act
• National and State Background Checks

Accountable Care Organizations

• What is an ACO?
• According to CMS, an ACO is: “an organization of health care providers and suppliers that agrees to be accountable for the quality, cost, and overall care of Medicare beneficiaries who are enrolled in the traditional fee for service program who are assigned to it.”
Accountable Care Organizations

- The ACO program is intended to create coordinated care systems, where a patient is efficiently treated across care settings – from physicians' offices to hospitals to long term care.
- Creates a “shared savings program” where the ACO is eligible to receive “shared savings” from Medicare if it meets certain quality benchmarks.
- Along the same lines, however, the ACO may be accountable for additional payments to Medicare for poor quality care.

Accountable Care Organizations

- Despite the release of proposed regulations in March, 2011, ACOs are still a nebulous concept.
- Who is the ACO exactly? Is it a new type of provider? Is it a joint venture between different providers?
- What are the quality benchmarks?
- How great are the savings/incentives? How great are the penalties?
- The answers to these questions still are not clear, and we do not have any final rules yet (get used to that because it's a running theme for health care reform).

Accountable Care Organizations

- The proposed rule focuses on the concept that ACOs should be grounded in “primary care” providers such as physicians and hospitals.
- The “shared savings” are based upon the difference between Medicare’s average expenditures for a given category and the ACO’s expenditures.
- In other words, ACOs are paid for providing more efficient service.
Accountable Care Organizations

• PPACA defines certain types of entities who are eligible to form ACOs, and a number of entities are not specifically listed as eligible. Among those not listed are:
  • Federally Qualified Health Centers (FQHCs)
  • Rural Health Centers (RHCs)
  • Long Term Acute Care Hospitals (LTACHs)
  • Nursing Homes

Accountable Care Organizations

• Under the proposed rule, CMS has not yet decided whether to allow providers such as nursing homes to participate in ACOs.
• The public comment period continues until June 5, 2011.
• Regardless of whether nursing homes ultimately may participate, it is important to understand the structure of ACOs.

Accountable Care Organizations

• Some concerns:
  • Will ACOs become the “gatekeepers” for long term care providers?
  • Is participation in an ACO worth the risk?
  • What do you do if nursing homes cannot participate in ACOs?
  • Is an ACO even appropriate for nursing homes and other long term care providers?
**Accountable Care Organizations**

What Comes Next?

Greater emphasis on measuring health care quality and efficiency with less unnecessary spending. It is still unclear how widely ACOs will be adopted, but the suggestion seems to be that they have the potential to alter the health care delivery system.

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**Payment Bundling**

- PPACA establishes a 5-year pilot program to explore the effectiveness of "payment bundling."
- With bundled payments, a provider or group of providers would receive a single payment for each "episode of care" for a patient.
- Program scheduled to begin January, 2013.

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**Transparency**

- Transparency Provisions:
  - New disclosure rules
  - Accountability provisions
  - Reporting expenditures
  - Updates to Nursing Home Compare website
Transparency

➢ Under existing law, Medicare providers are required to disclose:
➢ Any person or entity that owns directly or indirectly an ownership interest of 5% or more; and
➢ Officers and directors (if a corporation) and partners (if a partnership).

Transparency

➢ The reform bill expands the information required to be disclosed to include the facility’s organizational structure.
➢ “Organizational structure” means:
➢ In the case of a corporation, officers, directors, and shareholders with a 5% or greater interest;

Transparency

➢ “Organizational structure” means:
➢ In the case of a limited liability company, the members and managers of the limited liability company (including, where applicable, the percentage each member and manager has of the ownership interest in the company);
➢ In the case of a partnership, the general partners and any limited partners with an ownership interest of 10% or greater;
Transparency

• “Organizational structure” means:
  • In the case of a trust, the trustees of the trust; and
  • In the case of an individual, contact information for the individual.

Transparency

Additionally, facilities must now disclose more detailed information about officers, directors, trustees and managing employees of a facility, including names, titles, and start dates of service.

➢ “Managing employee” is broadly defined as any individual who directly or indirectly manages, advises or supervises any element of the practices, finances, or operations of the facility.

Transparency

Facilities must also submit information on any additional disclosable party of the facility.

➢ “Additional disclosable party” means any person or entity that:
  • Exercises operation, financial or managerial control over the facility, or provides policies and procedures for the operations of the facility; or provides financial or cash management services to the facility;
“Additional disclosable party” means any person or entity that:
• 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; or
• Provides management or administrative services, management or clinical consulting services, or accounting or financial services to the facility.

“Additional disclosable party” means any person or entity that is a:
• Holder of a mortgage, deed of trust, note, or other obligation secured by the entity or the property of the entity.

These definitions of disclosable parties are problematic because they are so broad.
• Nearly any party with whom a facility contracts would appear to be disclosable, including third party vendors who provide administrative or consulting services, i.e., pharmacy, housekeeping, accounting, etc.
• This represents a significant increase in the compliance burden on providers.
• May also increase the likelihood of disclosable parties being named in litigation.
Transparency

Currently, facilities must have some transparency information ready for submission upon request by certain state or federal agencies (Department of Health & Human Services (“HHS”), OIG, State long term care ombudsman, etc.).

By 2012, regulations will be issued requiring the information to be reported to the Secretary of HHS in standard format.

By 2013, facilities will be required to make the information available to the public.

Transparency

• Reporting Expenditures
• For cost reporting periods beginning two years after enactment, facility cost reports must show wages and benefits for “direct care staff,” breaking out RNs, LPNs, CNAs, and other medical and therapy staff.
Transparency

Civil Monetary Penalty Differences
- Up to 50% reduction if deficiency is self reported and corrected within 10 calendar days and
  - One time per year
  - Not immediate jeopardy
  - CMPs must be paid immediately after IDR
  - During Appeal CMPs are held in escrow by CMS

Transparency

Notification of Facility Closure
- Within 60-days prior to closure Administrator must provide disclosure to
  - CMS
  - Ombudsman
  - Residents and legal representative

Transparency

Notification of Facility Closure
- In notice submit discharge plan
- During discharge period after notice cannot admit any new residents
- Penalties to administrator for failure to comply
  - CMPs up to $100,000 assessed against administrator
  - Exclusion from Medicare and Medicaid Programs
  - Other penalties as may be prescribed by law
The HHS Secretary must provide the following information on the Nursing Home Compare Website:

- Staffing data (including resident census data and hours of care provided per patient per day);
- State survey and certification information (including links to Form 2567s);
- Standardized complaint form;
- Summary information regarding the number, type, and severity of substantiated complaints; and
- The number of adjudicated instances of criminal violations by a facility or the employees of a facility.

All information on the Nursing Home Compare website must be provided in a manner that is easily accessible, searchable, and readily understandable to consumers of long term care services.
Transparency

What comes next?

Increased exposure of ownership structures and data regarding nursing home performance.

Corporate Compliance Plans

• Though corporate compliance plans have been recommended by the OIG for several years, PPACA makes them mandatory.
• Expect final regulations by March, 2012.

Corporate Compliance Plans

• Compliance program must be “reasonably designed, implemented, and enforced so that it generally will be effective in preventing and detecting criminal, civil and administrative violations … and promoting quality of care.”
Corporate Compliance Plans

• Requirements vary depending on the size of the organization.
• Organizations that operate 5 or more facilities will be required to have more formal compliance programs, which include written policies defining standards and procedures to be followed by employees.
• Compliance requirements may apply to corporate-level management of multi-unit nursing home chains.

National Background Checks

• Studies are to be commissioned to develop national background checks – possible elements:
  • Fingerprinting
  • State monitoring
  • NO CLEAR GUIDANCE BEYOND CURRENT GUIDANCE ON PROHIBITED CONVICTIONS

Elder Justice Act

• Originally introduced as a stand alone bill in 2004;
• “Elder Justice” refers to the prevention, detection, and prosecution of the abuse, neglect and exploitation of individuals age 60 and above;
**Elder Justice Act**

- Establishes an Elder Justice Coordinating Council within the Office of the Secretary of HHS. It is responsible for coordinating elder justice activities in the federal government, and for making recommendations to Congress;

- It also establishes an Advisory Board on Elder Abuse, Neglect, and Exploitation. It is responsible for creating short and long-term multidisciplinary strategic plans for the development of the field of elder justice, and to make recommendations to the Elder Justice Coordinating Council;

- Requires the Secretary of HHS to establish four stationary and six mobile forensic centers to develop forensic expertise on elder abuse;

- Establishes several programs and grants to increase the training and quality of LTC caregivers and surveyors;
Elder Justice Act
• Requires each individual owner, operator, employee, manager, agent, or contractor of a LTC facility that receives at least $10,000 in federal funds annually to report to the Secretary of HHS and one or more local law enforcement entities, any reasonable suspicion of a crime against anyone who is a resident of, or is receiving care from, the facility;

Elder Justice Act
• Also contains whistleblower protections for facility employees, and requires that documentation be posted conspicuously in each facility specifying the rights of employees under the Elder Justice Act.

Elder Justice Act
What comes next?
• Emphasis on detecting and combating elder abuse and neglect;
• With better forensics, comes more detailed investigations.
CLASS Act

- Community Living Assistance Services and Supports
- Federally supported long term care insurance program to pay benefits specifically to persons who are not in institutional settings.
- Intended for lower acuity patients

CLASS Act

- Assistance comes in the form of a cash benefit, based on the degree of disability, to be used to purchase community living and support services.
- Paid either daily or weekly
- Not less than $50/day
- Reduced if patient is on Medicaid (and Medicaid becomes secondary payor)

CLASS Act

- Enrollment in the program is voluntary;
- Enrollment is expected to be similar to a 401(k) program, in which a participating employer offers the option to have voluntary payroll deductions for CLASS premiums;
- Five year vesting period;
CLASS Act

• Program is required to be actuarially sound – solvent for at least 75 years;
• No taxpayer monies are intended to be utilized to fund the CLASS program;
• Secretary of HHS is required to conduct studies to determine exactly how this program will look.

CLASS Act

Timeline

• January 2011 – CLASS Act becomes effective under PPACA. Has no real effect, though the Administration on Aging has now been reorganized to include the CLASS program.
• January 2012 – CLASS eligibility assessment system begins.
• October 2012 – CLASS benefit program begins.

CLASS Act

• What comes next?

• Emphasis on patient choice;
• Shift away from institutionalized services;
• Wait and see what participation looks like;
Useful Link

• Kaiser Foundation’s Health Care Reform Implementation Timeline:
  http://healthreform.kff.org/timeline.aspx

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