Health Care Reform: Skilled Nursing Providers

Health Care Reform Means Change for Skilled Nursing Facility Providers: The Good, The Bad, and The Ugly

By Kathleen M. Griffin, Ph.D.

On July 14, 2009, the first of the health care reform bills came out of the gate: *America's Affordable Health Choices Act of 2009*, a 1,000+ page House bill attributed to work by three committees, Ways and Means, Energy and Commerce, and Education and Labor, together forming the "Tri-Committee on Health Care." The next day, the Senate Committee on Health, Education, Labor, and Pensions (HELP) approved its own draft legislation, the *Affordable Health Choices Act*.

The next step will be a bill from the Senate Finance Committee, chaired by Max Baucus (D-Montana) and now anticipated within the next several weeks. Then, markup will begin and we will see if there will be a health reform bill ready for passage in August, as President Obama had hoped. The pundits say "no" and that passage of a health care reform bill will likely occur at the last possible moment, prior to Congress's Christmas recess.

In the meanwhile, House Bill 3200, *America's Affordable Health Choices Act of 2009,* provides some sense of Congress's attitude toward Medicare reform. To fund the universal health coverage required by the bill, the House Bill calls for tightening the Medicare payment belt over the next several years and changes in payment methodologies, which will have significant impact on skilled nursing facility (SNF) providers. There are three areas of critical importance to SNF providers in the House Bill. At least two of these areas will likely show up in the Senate bill in a few weeks. The three areas, and their potential impact on SNF profitability, are☺

- Medicare payments to SNFs beginning in 2010 (negative).
- Bundled payments for post-acute care (positive).
- Nursing facility transparency rules (negative).

HR 3200: Medicare Payment Reductions to SNFs Beginning in 2010

Beginning in 2010, five provisions of the House Bill would have a negative effect on Medicare payments to SNFs.

First, on January 1, 2010, the SNF market basket update for October 1, 2009, (+2.1 percent) will be removed. The Centers for Medicare and Medicaid Services (CMS) had estimated that the market basket increase would have added $600 million to SNF payments in FY2010 (October 1, 2009, through September 30, 2010).

Second, beginning in FY 2010, there will be a productivity adjustment in the market basket increase for SNFs, meaning that any market basket increases could be offset by the percentage change in the 10-year moving average of annual economy wide private nonfarm business multi-factor productivity. The productivity adjustment cannot reduce the market basket increase below zero so at least as of January 1, 2010, any productivity adjustment to the SNF market basket increase will not apply as the market basket increase will be zero.

Third, the proposed recalibration case-mix adjustment for FY2010 is endorsed in the House Bill. CMS estimated in its May 12, 2009, proposed rule that the recalibration will reduce payments to SNFs by $1.05 billion.

The first and third reductions together could decrease Medicare payments by over $20 per day. But there's more, and it will probably not be pretty for most SNFs.
Fourth, beginning January 1, 2010, payments for non-therapy ancillaries will increase by 10 percent while payment for the therapy case mix component will decrease by 5.5 percent. Non-therapy ancillary services are then to be analyzed by the government to ensure the accuracy of payment so that a new budget neutral classification system for Medicare SNF payments can be implemented in FY2011. The analysis of non-therapy ancillary's payments would include indicators such as age, physical and mental status, ability to perform activities of daily living, prior nursing facility stay, RUG category, and length of stay.

Fifth, beginning October 1, 2010, (FY2010), Medicare payments to SNFs may be reduced by 2 percent to allow for budget neutral high cost outlier payments for both therapies and non-therapy ancillaries.

One bright spot for SNFs with robust Medicare Part B and outpatient therapy programs: Exceptions to the therapy caps policy would be extended to December 31, 2011.

Conclusion

Because some, if not all, of these reductions will be part of the final health reform bill, SNFs can count on declining Medicare payments in the future. Market basket increases are incremental to payment rates for the previous year so without a market basket increase in 2010, any increase in FY2010 will be based on 2009 rates. The double whammy is that future market basket rates could be decreased by productivity increases but the triple whammy is the case-mix recalibration and the very negative impact on SNF daily Medicare payments.

The interest in non-therapy ancillary payments and new high cost outliers suggests that Congress is preparing and encouraging SNFs to admit more medically complex patients, paving the way for a low cost option under bundling for post-acute care.

HR 3200: Bundled Payments for Post-Acute Care

Although SNFs may find the first steps of bundling to be negative, SNFs that do things right should benefit under post-acute bundling.

Hospital Readmissions

The first step of bundling refers to hospital readmissions. Beginning in FY2011, hospital payments for readmissions of certain high-risk conditions (heart failure, acute myocardial infarction [AMI], and pneumonia) within a 30-day period will be reduced. Similarly, payments to post-acute providers, including SNFs, for patients with those conditions who are readmitted to the hospital within the 30-day period will be reduced to the following percentages of the normal payment for the post-acute provider:

- FY2012, 0.996 percent
- FY2013, 0.993 percent
- FY2014, 0.99 percent

The three conditions may be expanded in FY2013 to include four more conditions: chronic obstructive pulmonary disease (COPD), post-surgical coronary artery bypass graft (CABG), post-surgical percutaneous transluminal coronary angioplasty (PTCA), and other post-surgical vascular conditions.

Hospitals and post-acute providers will be monitored to determine if they have taken steps to avoid patients at risk to reduce the likelihood of increasing readmissions for applicable conditions. If they have not, sanctions may be applied.

A study would also be conducted within a year after enactment of the health reform bill to determine how the readmissions policy could apply to physicians.

Post-Acute Bundling

Within three years after enactment of the health care reform bill, HR 3200 calls for a government-developed plan that will detail specifications for bundled Medicare payment for post-acute services. The House Bill transfers the responsibility for all aspects of bundled payment to the Secretary of Health and Human Services, essentially charging CMS with determining how and to what entity payments will be made, cost and risk sharing among acute hospitals and post-acute providers, whether physician payment should be included in the bundle, how payments would be reduced to account for increased system efficiencies under bundling, quality outcome measures, and which existing rules would need to be changed for post-acute payment bundling, e.g. the requirement for a three day acute hospital stay prior to admission to a SNF.

Currently, there is a demonstration project (acute care episode demonstration) that bundles acute hospital and physician payments for certain orthopedic and cardiovascular surgeries. HR 3200 would convert the program to a voluntary pilot program to include post-acute services. The pilot program may be expanded if it shows that it maintains or increases quality of care and reduces Medicare expenditures to yield a certain level of savings.

Conclusion

How do SNFs "do things right" to benefit under bundling? First, pay attention to hospital readmissions. CMS has reported that 22 percent of SNF patients are readmitted to the acute hospital. Determine your readmission rate and set a goal for reducing that rate by at least 2 percent per year beginning now. Work with your clinical staff to determine what they need to do to manage Medicare Part A patients in the SNF instead of calling 911. Some strategies that have worked for SNFs include:

- Daily, or at least every other day, visits by physicians and extenders for all short-term Medicare Part A patients and 24-hour on-call coverage by these same physicians or nurse practitioners. Educating your high volume admitters on physicians and extender SNF billing procedures and making billing easy will win them over.
- Protocols for nursing staff before physicians or nurse practitioners are called so that patient issues may be handled telephonically instead of by sending the patient to the hospital emergency room.
- Training in the latest nursing procedures by critical care nurses—perhaps through an arrangement with a referring hospital.
- Clinical care pathways for commonly seen medically complex conditions such as COPD and CHF

Convert your nurse liaisons into care transitions coordinators with training to become experts in proven methodologies such as Care Transitions Intervention (www.caretransitions.org) or Guided Care (www.guidedcare.org).

- Manage the patient's transition to the SNF while the patient is in the hospital by ensuring that the patient and family fully understand discharge plans and orders.
- Work with the patient and family while the patient is in the SNF for short-term post-acute care to create a personal health record, prepare the home for the patient, make the follow up appointment, and prepare a list of questions for the patient's primary care physician.
- Add a home visit to your therapy program to ensure that the patient's home is in ready condition for the patient.
- Conduct follow up calls to your Medicare patients who were discharged home to check on status and ensure that they have seen their primary care physician.

Measure your short-term Medicare patient's functional status at admission and at discharge and create internal benchmarks to ensure quality outcomes or use a commercial program that can compare your SNF with similar SNFs.

- Track your patient outcomes over time and use that information to become a preferred post-acute provider for acute hospitals.
- Track the amount of Medicare payment to achieve the desired patient outcomes and compare your costs with national or regional norms for other post-acute providers so that you can demonstrate that you are indeed the provider with the lowest costs plus the highest quality patient outcomes. As a beginning, you may want to compare your payments with those made to other post-acute providers. While latest data is from 2007, Table 1 would be a beginning point for comparing costs. However, your patient outcomes must also be comparable to the higher cost post-acute providers, which is why you must measure both costs (Medicare

payments per SNF patient stay) and patient outcomes (change in functional status as a result of the SNF stay).

Table 1: Average Medicare Payment to Post-Acute

PAC Venue 2007	ALOS - Days	Average Medicare Pymt	Medicare Pymt Basis
LTACHs	26.9	$34,769	Discharge (LTC-MS-DRG)
Acute Rehab Hospitals & Units	13.2	$16,143	Discharge (CMG)
Skilled Nursing & Subacute Units	26.7	$9,750	Per Diem
Home Health Agencies*	60.0	$2,705	Per 60 Day Episode

Venues, MedPAC Report to Congress, March 2009

HR 3200: Nursing Facility Transparency Rules

About one-ninth of the over 1000 pages of the House Bill cover Subtitle B, the *Nursing Home Transparency Act*. The provisions aim to standardize nursing facilities through more easily accessible information, stronger enforcement, and staff training. Among the proposed changes are:

- Required disclosure of ownership.
- Within three years of enactment of the health care reform bill, a compliance and ethics program at each SNF to prevent and detect criminal, civil, and administrative violations and to promote quality care.
- By December 31, 2011, a Quality Assurance and Performance Improvement (QAPI) program incorporating best practices to be developed and submitted by every SNF.
- A determination if corporations that own large numbers of SNFs are undercapitalizing the facilities and if so, the impact of such undercapitalization on quality of care.
- Enhancements to the Nursing Home Compare site that include:
  - Staffing data for each facility (including resident census data and data on the hours of care provided per resident per day) including information on staffing turnover and tenure.
  - Links to state Internet Web sites with information regarding state survey and certification programs, links to Form 2567 state inspection reports on such Web sites, and the facility plan of correction or other response to such report.
  - The standardized complaint form.

  - Summary information on the number, type, severity, and outcome of substantiated complaints.
  - The number of adjudicated instances of criminal violations by employees of a SNF.

- Separate reporting of expenditures for direct care, indirect care services, capital assets, and administrative costs on cost reports beginning two years after enactment of a health reform bill.
- A standardized complaint form for use by a SNF resident in filing a complaint with the state and a state complaint resolution process to ensure there is no retaliation against the complainant or against a whistle blower.
- Two years after enactment of the health care reform bill, SNFs must electronically submit, based on payroll, direct staffing information in a uniform format.
- Specific civil monetary penalties (CMPs) to be imposed on a per-instance or per day amount for each instance or day of noncompliance.
- A pilot, independent monitor to oversee interstate and large intrastate chains of SNFs.
- Notification procedures for facility closures.
- Exclusion of clinical social worker, marriage/family therapist, and mental health counselor services from SNF Medicare PPS.
- Staff training in dementia and abuse prevention
- Study and report on training for certified nurses aides (CNAs and supervisory staff

Conclusion

Subtitle B tightens the regulatory noose around all SNFs and legislates a significant number of requirements related to preventing fraud and abuse. Many of the new requirements will add a burden of work to SNF administration and staff, likely resulting in cost increases.

The requirements also target multi-facility chains that must disclose ownership and demonstrate that their SNFs are adequately capitalized to furnish quality care. A monitoring entity is included to oversee SNF chains.

Contents of the Final Health Care Reform Bill

Will the “big three” set of requirements in HR 3200 discussed in this document end up in the final health care reform bill? A pretty sure bet is that the first two, Medicare payment reductions beginning in 2010 and Medicare payment bundling, will be part of a final bill. Both of these are slated to reduce Medicare costs, which is essential to pay for the universal health coverage part of health care reform. While the nursing facility transparency rules address some of the issues that have been brought to the attention of certain members of Congress, this section has little impact on Medicare costs and therefore may be abandoned in the final bill.

The next shoe to drop is the Senate Finance Committee bill. At that time, more will be revealed. Stay tuned.

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