



CLIENT ADVISORY

Health Reform 2010: Highlights for Nursing Facilities

The following are a list of key changes for nursing facilities that come out of the Patient Protection and Affordable Care Act of 2010 (J.R. 3590 (Pub. L. 111-148)) and its subsequent amendment through passage of the Health Care and Education Reconciliation Act of 2010 (H.R. 4872). Approximate dates of implementation and the applicable section in the PPACA are reflected in parenthesis:

Medicaid Expansion

- Beginning in 2011, states would have the option to provide Medicaid coverage to all low-income individuals through a state plan amendment. States would have to cover individuals with incomes at or under 133 percent of the federal poverty level (beginning in 2014) (Sec. 2001)
- The Federal government would pay 100% of the cost for the newly eligible from 2014 to 2016. Federal funding would decrease in subsequent years to between 82.3% and 95% of the additional cost to states. (Sec. 2001)

Medicaid Coverage of Long-Term Services and Supports

- Community First Choice option: Allows states, at a slightly higher federal match, to cover community-based attendant services to Medicaid beneficiaries with disabilities and incomes up to 150% of the Federal poverty line if the beneficiary otherwise would require hospital or nursing home-level care (effective 2011 under reconciliation bill) (Sec. 2401)
- Allows states to cover more kinds of home- and community-based services through a state plan amendment rather than a waiver, for individuals with higher levels of need (Sec. 2402)
- Extends the Money Follows the Person Medicaid rebalancing demonstration program through 2016 (Sec. 2403)
- Requires states to give Medicaid beneficiaries receiving services in the community the same protection against spousal impoverishment that beneficiaries living in nursing homes have (effective in 2014 for 5 years) (Sec. 2404)
- Appropriates \$10 million in each fiscal year 2010 through 2014 for Aging and Disability Resource Centers (Sec. 2405)
- Expresses the sense of the Senate that Congress should address long-term services and supports issues in a comprehensive way and encourage the use of funds for other than institutional care (Sec. 2406)
- Increases the Federal match for states that expand medical assistance for non-institutionally based long-term care services (beginning in 2010) (Sec. 10202)

Quality Measures

- Prohibits Medicaid payment for services related to a “health care-acquired” condition (effective July 1, 2011) (Sec. 2702)
- Requires CMS to conduct a study of the appropriateness of applying a health care-acquired Medicare payment policy to nursing facilities and other health care providers (the bill provides a payment penalty for hospitals in the top 25 percentile of rates of hospital-acquired, high-cost and common conditions) (report due Jan. 1, 2012) (Sec. 3008)
- Gives states the option to enroll Medicaid beneficiaries with chronic conditions in “health homes” under which they would receive team-based, comprehensive medical services, including care coordination (beginning Jan. 1, 2011 with a federal matching incentive of 90% for the first two years of implementation) (Sec. 2703)

Medicare Payments

- Skilled nursing facilities receive the full payment update in 2010 and 2011 (Sec. 3401)
- Beginning in 2012, the SNF market basket update will be reduced by a productivity factor based on “the 10-year moving average of changes in annual economy-wide private non-farm business multi-factor productivity” (productivity adjustment may reduce payment rates to below the previous year’s level) (Sec. 3401).
- Requires CMS to establish a national, voluntary pilot program encouraging doctors, hospitals and post-acute providers to improve services and achieve savings through bundled payments (by 2013). CMS will be authorized to expand this pilot by 2016 if it appears to be achieving its goals (Sec. 2704)

Value-based Purchasing

- Established a Center for Medicare and Medicaid Innovation within CMS to test new payment and service delivery systems. Funds are authorized to test models providing services not now covered under Medicare (by Jan. 1, 2011) (Sec. 3021)
- Requires CMS to submit a plan to Congress by 2012 for instituting value-based purchasing for skilled nursing facilities and home health agencies. For hospices, CMS would be required to implement quality measure reporting programs by 2014, and providers failing to report would be subject to reductions in their market basket update (Sec. 3006)
- Extends the Medicare therapy caps exceptions process through Dec. 31, 2010 (Sec. 3103)
- Authorizes physician assistants to order skilled nursing services (Jan. 1, 2011) (Sec. 3108)

Nursing Home Transparency

- Requires disclosure of ownership information, including a description of the governing body and organizational and management structure, to the extent not already publically available via IRS or SEC reporting (regulations in 2012, information publicly available 2013) (Sec. 6101)
- Requires all nursing facilities to implement compliance and ethics programs for their employees and agents. Intended to prevent and detect “criminal, civil, and administrative violations under this Act” (regulations in 2013) (Sec. 6102)

- Establishes a new Quality Assurance and Performance Improvement Program with standards established by HHS (regulations by 2011) (Sec. 6102)
- Requires CMS to add information on standardized staffing data, a summary of substantiated complaints, links to State inspection report and forms, the amounts of facility civil monetary penalties assessed, and the number of adjudicated criminal violations by the facility or its employees on Nursing Home Compare (available by March 2011) (Sec. 6103)
- Requires separate reporting of staffing expenditures on Medicare cost reports (re-design of reports by 2011) (Sec. 6104)
- Requires CMS to develop standardized complaint form for use by residents. States must establish a complaint resolution process (in effect by March 2011) (Sec. 6105)
- Requires CMS to develop a mechanism for nursing facilities to report staffing information in a uniform format based on payroll data, also reflecting use of contract or agency staff (development by 2012) (Sec. 6106)
- Requires the GAO to study the Five-Star Nursing Home Quality Rating System (report by 2012) (Sec. 6107)
- Changes the process for civil monetary penalties. CMS given authority to reduce CMPs by up to 50% if a self-reported, non-repeat deficiency is corrected within 10 calendar days after CMP imposed and no death or pattern of harm was found. Civil monetary penalties for deficiencies cited at the actual harm and immediate jeopardy level could be placed in escrow following completion of informal dispute resolution or 90 days after the CMP's were imposed, whichever date is earlier. If a facility successfully appeals a CMP, the money could be returned with interest. If unsuccessful, a portion of the penalty could be used to benefit residents (takes effect in 2012, regulations to follow) (Sec. 6111)
- Requires CMS to establish a two-year demonstration project to develop an independent monitor program to oversee and publish findings on interstate and large intrastate nursing home chains that trigger certain criteria, including the number of Special Focus Facilities within the chain, with the chain having an opportunity to respond and to pay for the monitoring costs. (by March 2011) (Sec. 6112)
- Requires facilities to give residents and the state up to 60 days notice of any plans to close and arrange for safe transfer of all residents through a plan approved by the state, providing for payment at CMS' discretion through the last date of discharge and CMPs and exclusion for failure to give the required notice (by March 2011) (Sec. 6113)
- Requires CMS to conduct up to 3 year demonstration grant programs on culture change and on use of information technology in nursing homes (by 2011) (Sec. 6114)
- Requires training on dementia care and abuse prevention for nursing home staff (by 2011) (Sec. 2121)
- Requires CMS to establish as nation-wide program of criminal background checks for employees of long-term care providers who have direct access to patients, based on a current pilot program (after current program completed) (Sec. 6201)

Waste/Fraud/Abuse Measures

- Requires CMS to develop procedures for screening health care providers participating in Medicare and Medicaid that at minimum would include licensure checks, but which

- could also include criminal background checks, fingerprinting, multi-state database inquiries, and random or unannounced site visits. Application fees of \$200 for individual providers and \$500 for institutional providers would be imposed each time they verify their enrollment (every five years) (by August, 2010) (Sec. 6401)
- Maximum period for submission of Medicare claims reduced to twelve months from date of service (effective now, exceptions pending) (Sec. 6404)
 - Medicare home health services and DME must be ordered by a health care professional or doctor enrolled in Medicare. Order must be in writing based on a face-to-face encounter between the doctor/health care professional and the beneficiary (effective July 1, 2010) (Sec. 6405, 6407)
 - Expands the number of metropolitan statistical areas to be included in round two of the competitive bidding program for DME, prosthetics, orthotics and supplies (effective now) (Sec. 6410)
 - Expands the recovery audit contractor (RAC) program to state Medicaid programs and to Medicare Parts C and D (Dec. 31, 2010) (6411)
 - Requires State agencies to exclude from participation any individual or entity that owns, controls, or manages an entity that has unpaid overpayments, is suspended or excluded from participation, or is affiliated with an individual or entity that has been suspended or excluded (effective now) (Sec. 6502)

Elder Justice Act

- Requires CMS to cooperate with the Departments of Justice and Labor to award grants protecting nursing home residents and provide incentives for individuals to train and work in nursing facilities (Sec. 6701 and following)
- Provides grants to develop stationary and mobile “forensic centers” to investigate possible abuse, neglect, or exploitation (Sec. 6701 and following)

Malpractice

- Authorizes grants to States to test alternatives to civil tort litigation. These models would be required to emphasize patient safety, the disclosure of health care errors, and the early resolution of disputes. Patients would be able to opt-out of these alternatives at any time (Sec. 6801)

Long-term services and supports

- Establishes the Community Living Assistance Services and Support (CLASS) program of voluntary, self-funded public long-term care insurance (Sec. 8002)
- Individuals begin paying premiums immediately, and, after a five-year vesting period, those with functional limitations have the option of receiving a cash benefit of around \$50 a day to offset the costs of long-term care services.

Employer Requirement to Offer Coverage

- Requires employers with more than 50 employees with at least one full-time employee who receives a premium tax credit to offer health insurance coverage or be assessed a range of fees, beginning at \$2000 per each full-time employee, excluding the first 30

- employees from the assessment (effective Jan. 1, 2014) (Sec. 1513, Reconciliation Sec. 1003)
- Requires employers with more than 50 employees that offer coverage but have at least one full-time employee receiving a premium tax credit to pay the lesser of \$3000 per each employee receiving the tax credit or \$2000 per full-time employee (effective Jan. 1, 2014) (Sec. 1513, Reconciliation Sec. 1003)
 - Provides a range of small business tax credits for employers contributing at least 50 percent of the costs of coverage for their employees, with credits phasing out as firm size and average employee wages increase (effective 2010) (Sec. 1421)
 - Requires employers with more than 200 employees to automatically enroll employees into health insurance plans offered by the employer. Employees may opt out of coverage (effective now, subject to forthcoming regulations) (Sec. 1511)

Sources: H.R. 3590, Patient Protection and Affordable Care Act; H.R. 4872, The Health Care & Education Affordability Reconciliation Act of 2010.

Conclusion

As the federal health reform legislation is implemented via the regulatory process, there will be significant additional work for nursing facilities seeking to keep up with changes in legal and operational requirements. The legislative changes are complex and extend over the next decade. The regulatory changes implementing the legislation will be substantial as well. If our firm can be of assistance in further identifying and interpreting these changes for you, please let Peter Mellette, Harrison Gibbs or Nathan Mortier know.