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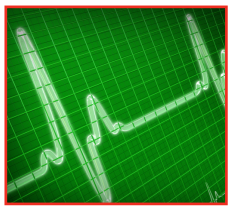


Thirteen Things Every Long Term Care Provider Needs to Know About Health Care Reform

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The Patient Protection and Accountable Care Act, as amended by the Healthcare and Education Reconciliation Act of 2010 (collectively, PPACA), contains several provisions that directly address long term care providers. The summary below describes the 13 most immediate changes that will affect the operations of every long term care provider. There are many more provisions affecting long term care providers, including some with more universal application to providers in general, as well as many provisions affecting long term care providers in their roles as employers and administrators of employee health plans. In addition, there are many available grant opportunities and demonstration projects created by PPACA, but here we focus on long term care providers and their operations.

1 New Requirements to Report Suspected Crimes. Virtually any person who owns or is an employee of a long term care facility that receives at least $10,000 annually in federal funding must report to the Department of Health and Human Services (DHHS) and local law enforcement any reasonable suspicion of a crime committed against any individual resident (or person who is receiving care from the facility). If the events that cause the suspicion result in serious bodily injury, the report must be made immediately – within two hours – or for other crimes, within 24 hours. This requirement applies to individual owners, operators, employees, managers, agents and contractors. Failure to make the report will subject these individuals to fines of up to $200,000 and exclusion from Medicare, Medicaid and other federal health care programs. If the violation exacerbates the harm to the victim, civil monetary penalties may be increased. DHHS has not yet provided any standardized forms or guidance as to whom such reports should be addressed and the required information; in the meantime some providers are reporting to their fiscal intermediaries in an attempt to comply. Employers must post a conspicuous notice regarding the employees' rights under this section and may not retaliate in any way against employees who make required reports.

2 New Deadline for Returning Overpayments. Long term care providers who discover an overpayment must repay it within 60 days from the date the overpayment was identified. Additional civil monetary penalties may be assessed for late returns of overpayments. This requirement is not as straightforward as it may seem, since there are many instances when the exact scope of an identified overpayment cannot be determined, let alone paid back, within 60 days of discovery. Providers who discover a potential overpayment should consult legal counsel immediately.

3 Maximum Period for Submission of Medicare Claims Reduced. As of January 1, 2010, all Medicare claims must be submitted within 12 months of the date of service in order to receive reimbursement. Providers must submit all claims for services provided before January 1, 2010, by December 31, 2010, in order to receive payment.

4 Compliance Plans Required for all Nursing Facilities. Beginning in 2013, all nursing and skilled nursing facilities must have an operating compliance and ethics program. This program must be effective in preventing and detecting criminal civil and administrative violations and in promoting quality of care. DHHS will establish a quality assurance and performance improvement program (referred to as the "QAPI Program") establishing standards relating

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to quality assurance and performance improvement and the development of best practices. Facilities will be required to submit a plan as to how the facility will meet the standards and implement the best practices. Regulations related to this requirement are due to be released in early 2012.

5 Annual Market Basket Updates Reduced. A "market basket" is the cost of a mix of goods and services used to measure price inflation. The annual Medicare market basket update is used to adjust payment rates. Under the new law, annual market basket updates for skilled nursing facilities, long term care hospitals, home health agencies, hospice providers and other providers are reduced. In some instances, this can result in payments actually being adjusted downward.

6 Disclosure of Ownership and Additional Disclosable Parties Required. Skilled nursing facilities and nursing facilities must have detailed ownership and other information available upon request. The information includes (but is not limited to) the identity of each member of the governing body and each person or entity who is an officer, director, member, partner, trustee or managing employee; exercises operational, financial, or managerial control over the facility (or any part of the facility), or owns an interest, directly or indirectly, of 5 percent of the operating entity or real property (including the owners of a mortgage, deed, note, or other obligations secured by the entity or any of the property or assets if the interest is equal to at least 5 percent of the total property or assets of the facility); provides management or administrative services; or provides clinical consulting, accounting, or financial services. For each of these parties, information related to the organizational structure and a description of the relationship of each party to the facility and to one another (including disclosure of the officers, directors, any shareholders having 5 percent ownership interest, any member, any general partner, limited partner having a 10 percent interest and any trustee) must also be provided. For now, this information must be available on request, but eventually there will be a reporting mechanism in place so that it is easily accessible to the public.

7 Reduction of Wasteful Dispensing of Outpatient Prescription Drugs. Regulations will be issued requiring prescription drug plan sponsors to utilize specific, uniform dispensing techniques in order to reduce waste associated with 30-day refills. Stakeholders, including facilities and pharmacies, will be consulted in drafting the regulations. This section is effective January 1, 2012.

8 Face-to-Face Meetings Required for Home Health, Hospice and DME. Certifications for home health or orders for durable medical equipment will require physicians (or appropriate non-physician providers) to document face-to-face encounters with the patient within a reasonable time frame preceding the physician's certification or order. Regulations will determine what is considered a "reasonable time frame." Similarly, hospice physicians or nurse practitioners must also have a face-to-face encounter with the patient before the 180th day re-certification and prior to each subsequent recertification. Hospice providers will be required to undergo a medical review process in order to approve stays over 180 days when the provider reaches a certain (yet to be determined) percentage of patients exceeding that time frame. Under PPACA, telehealth visits can satisfy the face-to-face requirement, but regulations will need to flesh out the minimum requirements for telehealth visits to qualify.

9 Complaint Survey Information Must Be Made Available. Beginning March 23, 2011, long term care facilities must make reports relating to any surveys and certifications of the facility during the previous three years available to the public upon request. Facilities must also post notices that such information is available.

10 New Background Checks Required on Direct Patient Access Employees. New regulations will establish procedures for long term care providers

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to conduct nationwide background checks on prospective "direct patient access" employees. Direct patient access employees are those who have access to and duties that involve one-on-one contact with a patient or resident. The background check will be required to include state and national criminal history checks and utilize abuse and neglect registries, licensing boards, and State Medicaid Fraud Control Units as well as a fingerprint check using the FBI's Integrated Automated Fingerprint Identification System. States will be required to develop "rap back" capability, meaning that if any employee is subsequently convicted of a crime, the state will notify the long term care provider employer. States are required to participate or face penalties.

11 Nursing Home Compare Website Requires More Information. Nursing facilities will need to include additional information for the Nursing Home Compare Website, including resident census data, hours of care per resident per day, and staffing turnover and tenure information. The website will also contain information about the relationship between nurse staffing and quality of care; links to state survey and certification information; a standardized complaint form and directions on how to file complaints; summary information on a facility's complaint surveys and outcomes; information related to crimes committed in facilities or by entities or employees that relate to abuse, neglect, exploitation or serious bodily injury; and information on civil monetary penalties levied against nursing home entities, employees, or their agents.

12 Notification of Facility Closures Required. Beginning in 2012, administrators are required to provide 60 days' advance written notice to DHHS, the state long term care ombudsman, residents and residents' legal representatives of a facility's closure. The notice must contain a plan for the transfer and adequate relocation of the residents. No new residents may be admitted on or after the date the notice is provided.

13 Home- and Community-Based Attendant Services and Supports Increased. PPACA shows a Congressional preference for home-based care over institutional care. It provides an enhanced matching rate of an additional six percentage points for reimbursable expenses, and creates an incentive program to eligible states to increase the proportion of non-institutionally-based long term care services. States are provided with new options for offering home and community-based services through a Medicaid State Plan rather than through a waiver. These programs can provide a range of non-medical services and supports including personal care attendants and certain in-home technologies to help individuals who would otherwise be eligible for institutional services live independently in their own homes. Programs can also cover transition costs such as first month's rent, utilities and basic linens and kitchen supplies. Approximately $3 billion is made available to finance the expanded availability of home-based services. These provisions are effective October 1, 2011, and generally sunset after five years unless renewed by Congress.

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