Arkansas Long Term Care

Presentation to Health Care Legislative Task Force
August 19, 2015

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AHCA
ARKANSAS
HEALTH CARE ASSOCIATION

Acronyms

ALF – Assisted Living Facility
CNA – Certified Nursing Assistant
DME – Durable Medical Equipment, includes wheelchairs, walkers, etc.
VBP – Value-Based Purchasing
FMAP – Federal Medical Assistance Percentages, often times referred to as "federal match rate"
HCBS – Home and Community Based Services
LPN – Licensed Practical Nurse
LTC – Long Term Care
LTSS – Long Term Services and Supports, often times refers to entire continuum of care, includes both community and institutional services.
NH – Nursing Home
QA Fees – Quality Assurance Fees, often times referred to as "bed tax"
RN – Registered Nurse
SGR – State General Revenue
SNF – Skilled Nursing Facility

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Arkansas Skilled Nursing Facilities

- Starting in 2000, Arkansas skilled nursing facility providers worked with the Governor's Office, DHS and advocacy groups to develop a program that would be sustainable decades into the future, imposing a provider tax on themselves with a goal of having less reliance on state general revenue. **Since the inception of the program, the state general revenue requirements have been predictable, consistent and sustainable**.

- There is **more than $1 Billion in privately invested infrastructure** in 74 counties across Arkansas.

- In 2014, the State of Arkansas paid **$22.97 of general revenue per day** to provide 24/7 care to skilled nursing facility residents. The increase in state general revenue in the last ten years is below the rate of inflation. On average, **SNFs lost $2.14 per patient day** in 2014 on Medicaid.

- The slight increase in state general revenue is a reflection of the Arkansas state FMAP. The FMAP changes in direct proportion to state's economy. The increase that you see reflects .746 in 2004 to .701 in 2014.

Arkansas Skilled Nursing Facilities

Number of SNFs:	**229**
Number of Employees:	**22,929**
Total Patients Served:	**35,000**
Residents over age 85:	**42%**
Percent Dementia:	**64%**
Average # of Medications:	**10+**

Frequent Diagnoses:
COPD, cancer, Alzheimer's, arthritis, falls or other injuries, Depression, infections, osteoporosis, CHF, hypertension, post bone fractures, etc.

Two systems under one roof:

1. Short Term Care (Physical Rehabilitation)
Short Term, Paid by Medicare & Commercial Insurance Plans
Focus on physical, occupational and speech language pathology, in order to transition home if possible.

2. Long Term Care
Long Term, Paid by Medicaid, private pay, Veterans benefits and long term care insurance, over 64% residents have Alzheimer's/dementia.

More rehab in urban markets; more long term care in rural markets.

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What is a Skilled Nursing Facility (SNF)?

- Social Safety Net
- Virtually no Woodworking Effect
- Federally Mandated Program
- Statewide Occupancy: 72%

Rural Access:

- Skilled Nursing Facilities in 74 Arkansas Counties
- 39 counties do not have Assisted Living Level II
- Oftentimes largest health care provider in county
- Oftentimes largest employer in county

Care provided 24/7/365

Includes:

- Medical Director
- Skilled Nursing
- Medication Management
- Pharmacy Consultant
- DME – wheelchairs, walkers, etc.
- Meals & Dietary Consultant
- Utilities
- Hygiene supplies
- Social & Activity programs
- Non-Emergency Transportation
- Housekeeping Services
- Linens & laundry
- Major dental
- Etc.

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Skilled Nursing Facilities: Minimum Staffing

1:6 direct care ratio

Licensed nurse, every 40 residents

Full time RN Director of Nursing

Medical Director

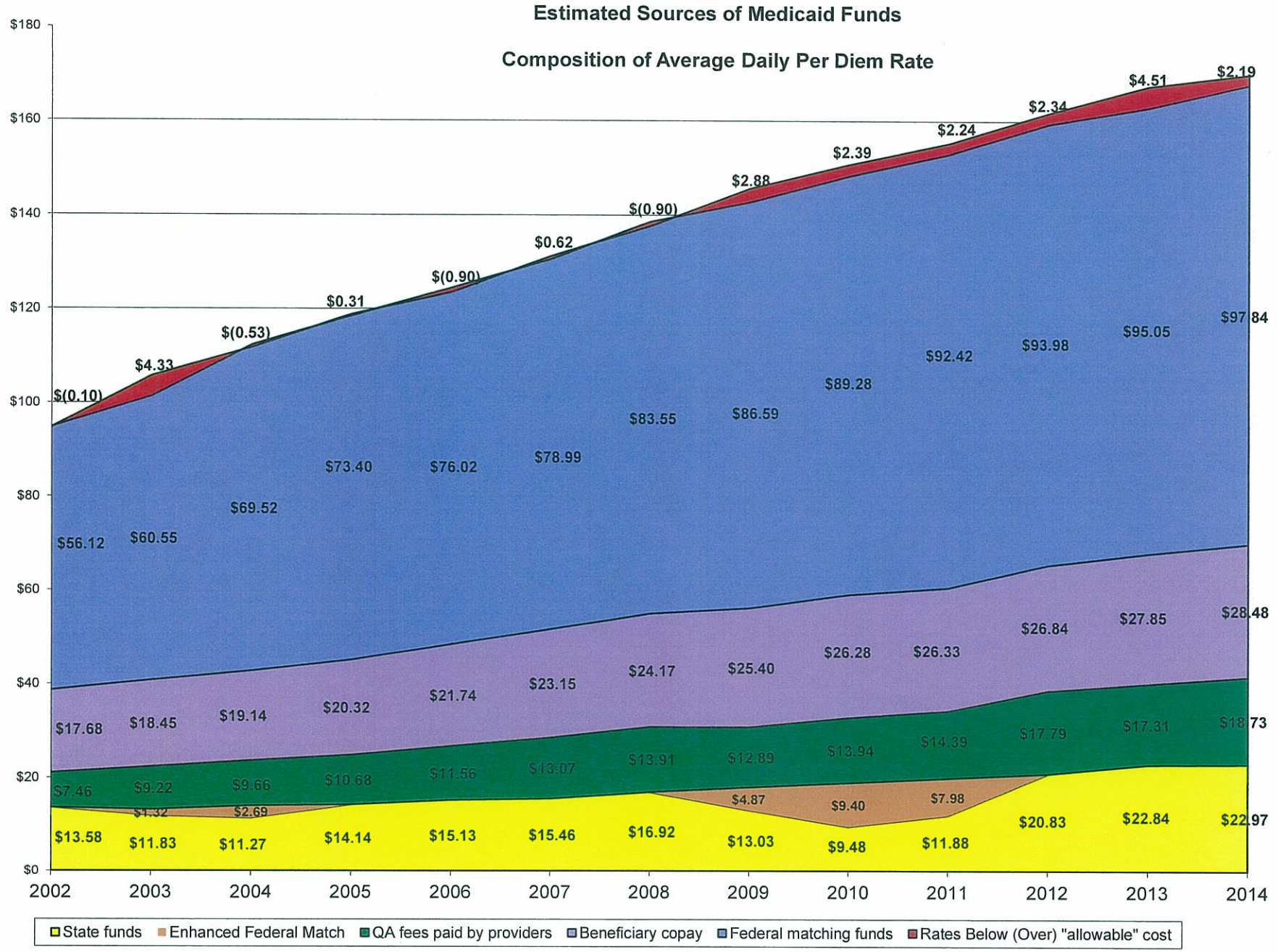
Nurse Consultants

Pharmacy Consultant

Dietary Consultant

Frontline staff are Licensed CNAs at minimum

The skilled nursing facility program allowed providers to **increase quality and staffing**, and has transparency with a public cost reporting system that does not allow profits to be made on direct care of patients.


Estimated Sources of Medicaid Funds
Composition of Average Daily Per Diem Rate
$180
$160
$140
$120
$100
$80
$60
$40
$20
$0
2002
2003
2004
2005
2006
2007
2008
2009
2010
2011
2012
2013
2014
$(0.10)
$4.33
$(0.53)
$0.31
$(0.90)
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$93.98
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$20.32
$21.74
$23.15
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$25.40
$26.28
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$27.85
$28.48
$7.46
$9.22
$9.66
$10.68
$11.56
$13.07
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$13.94
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$18.73
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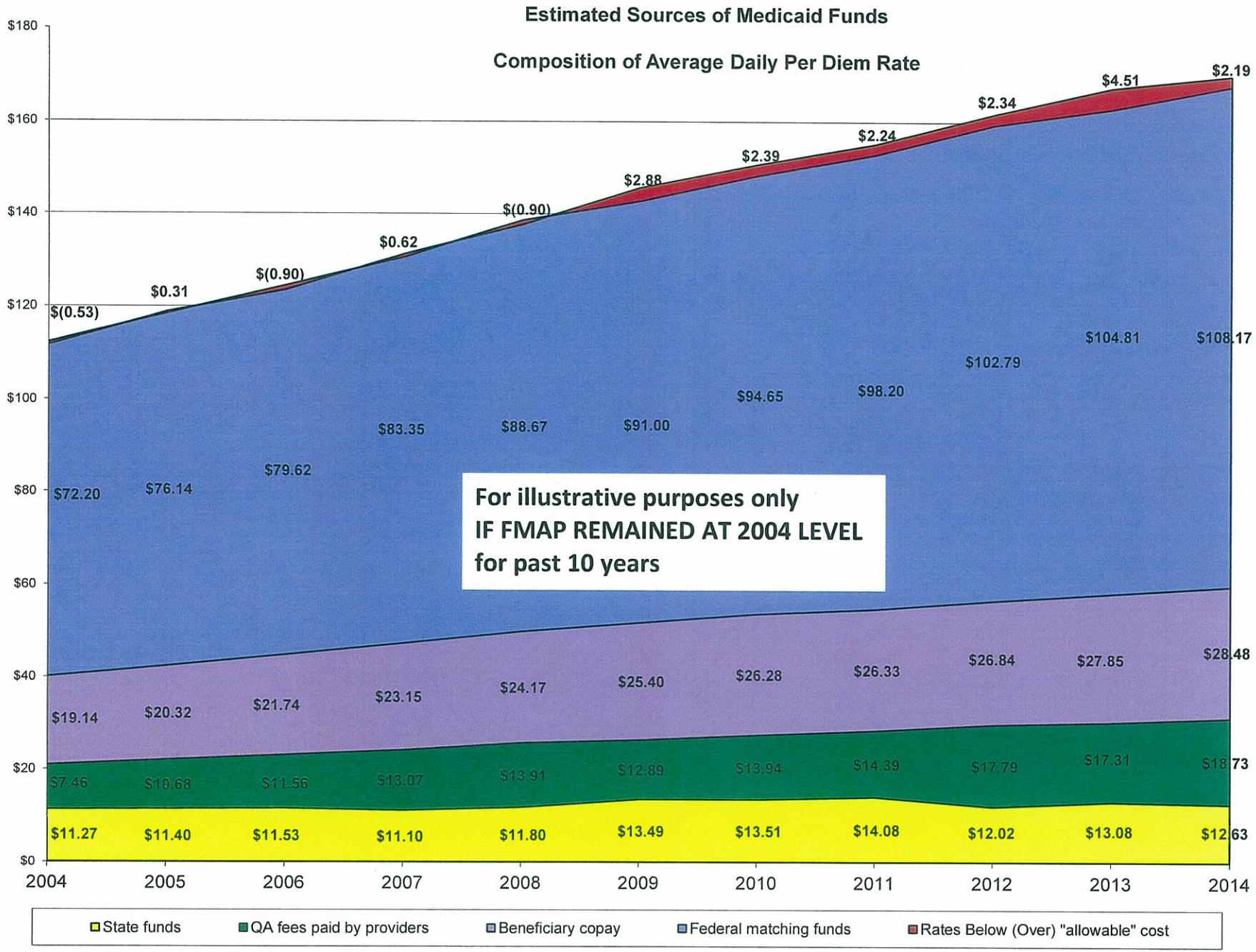
$15.13
$15.46
$16.92
$13.03
$9.48
$11.88
$20.83
$22.84
$22.97
State funds
Enhanced Federal Match
QA fees paid by providers
Beneficiary copay
Federal matching funds
Rates Below (Over) "allowable" cost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$79.62
$83.35
$88.67
$91.00
$94.65
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$102.79
$104.81
$108.17
$19.14
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$21.74
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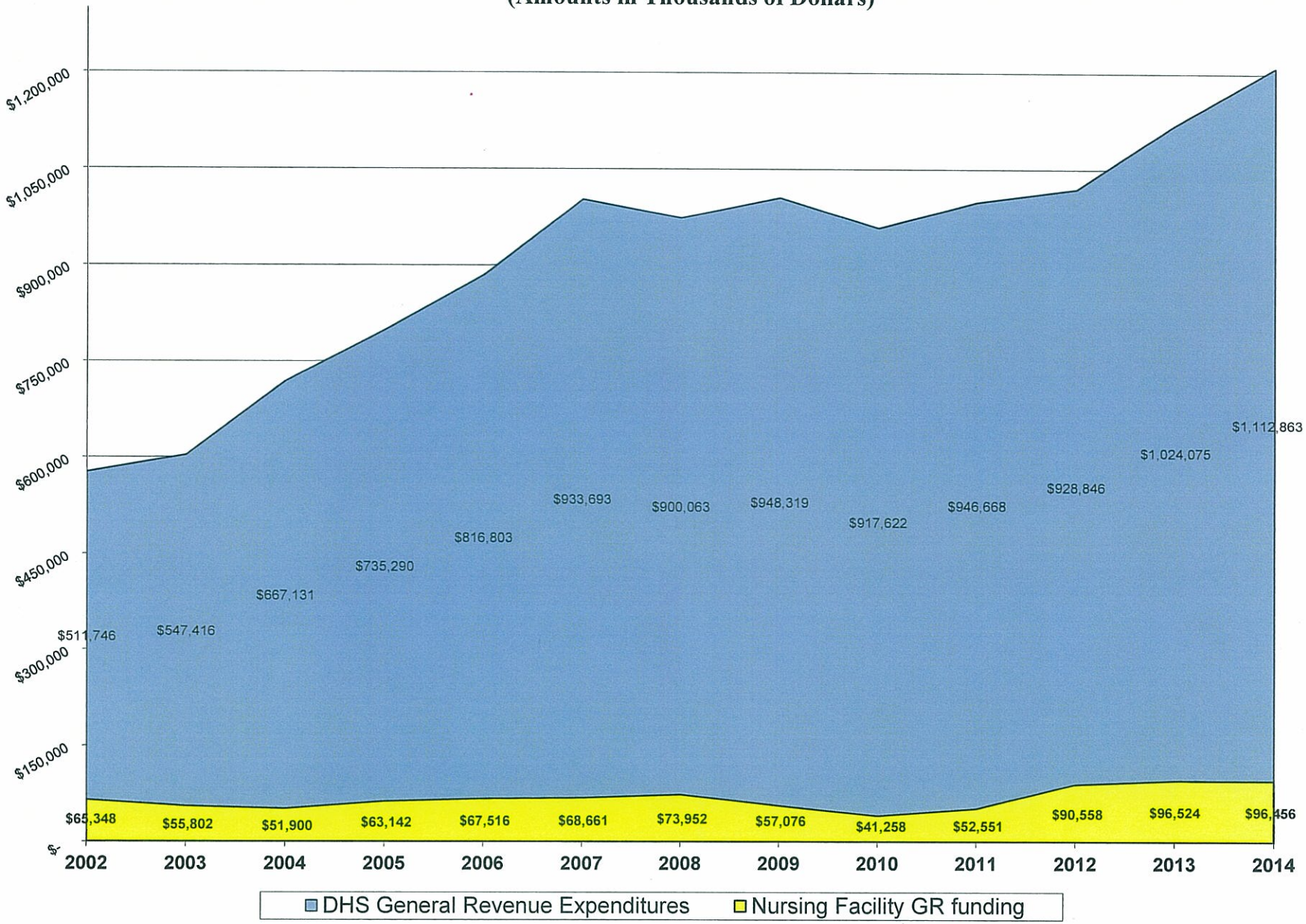
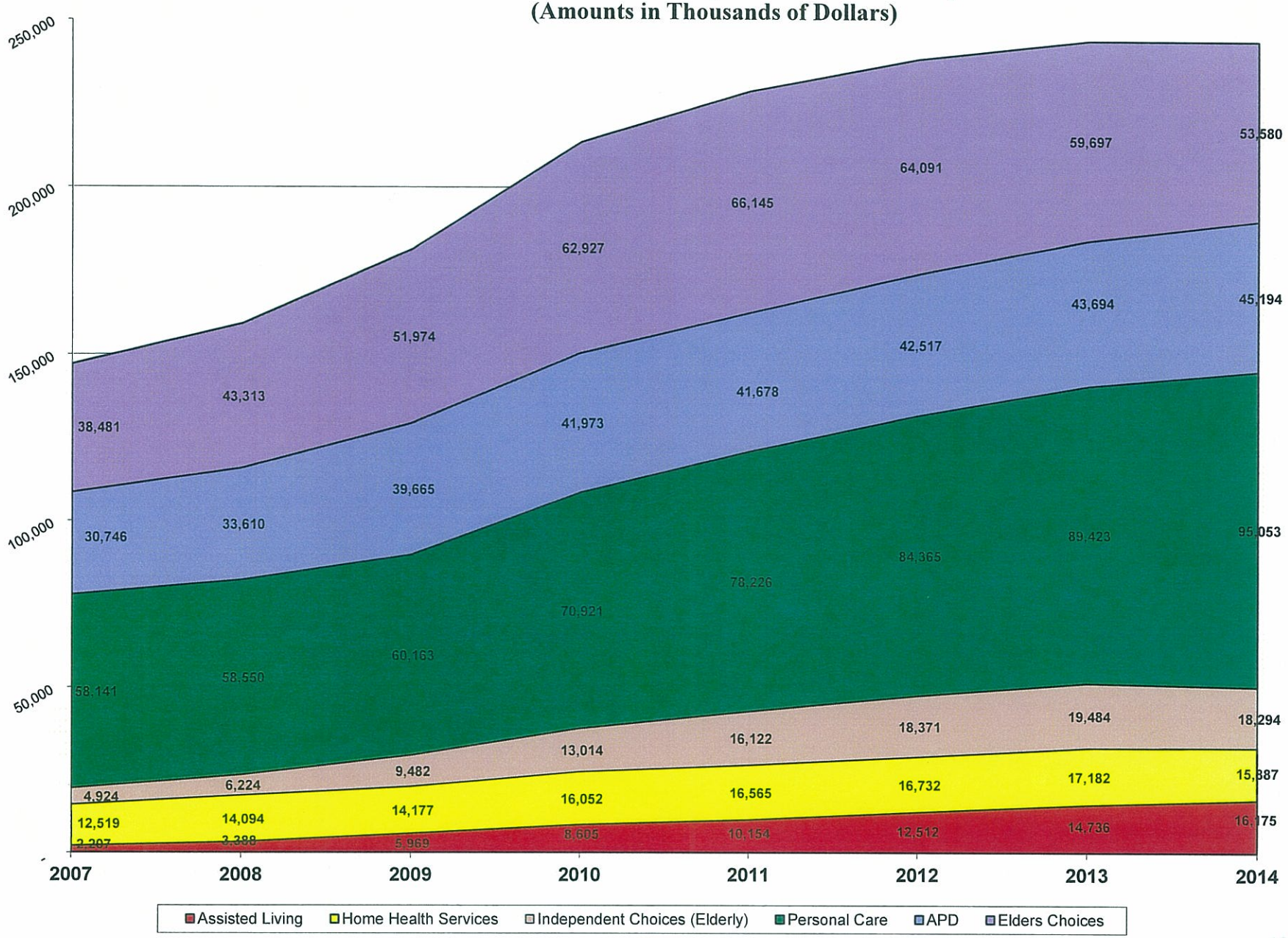
$17.31
$18.73
$11.27
$11.40
$11.53
$11.10
$11.80
$13.49
$13.51
$14.08
$12.02
$13.08
$12.63
For illustrative purposes only
IF FMAP REMAINED AT 2004 LEVEL
for past 10 years
2004
2005
2006
2007
2008
2009
2010
2011
2012
2013
2014
State funds
QA fees paid by providers
Beneficiary copay
Federal matching funds
Rates Below (Over) "allowable" cost

DHS General Revenue Expenditures
(Amounts in Thousands of Dollars)



Arkansas Home & Community Based Services Expenditures
(Amounts in Thousands of Dollars)



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Typical Elderly Patient Transitioned Home From A Skilled Nursing Facility

- Requires more than one HCBS program (limited services during the day only)
- Higher rates of hospital readmission, limited oversight, more potential for fraud & abuse

Example: ElderChoices Waiver
Personal Care

Transitions from a Skilled Nursing Facility to Community

Money Follows the Person (federal demonstration project)

6 FTEs

Average time in community: 11 months

67 transitions in 2014

$7,013,499

A+ - DHS Program within DAAS

20 FTEs

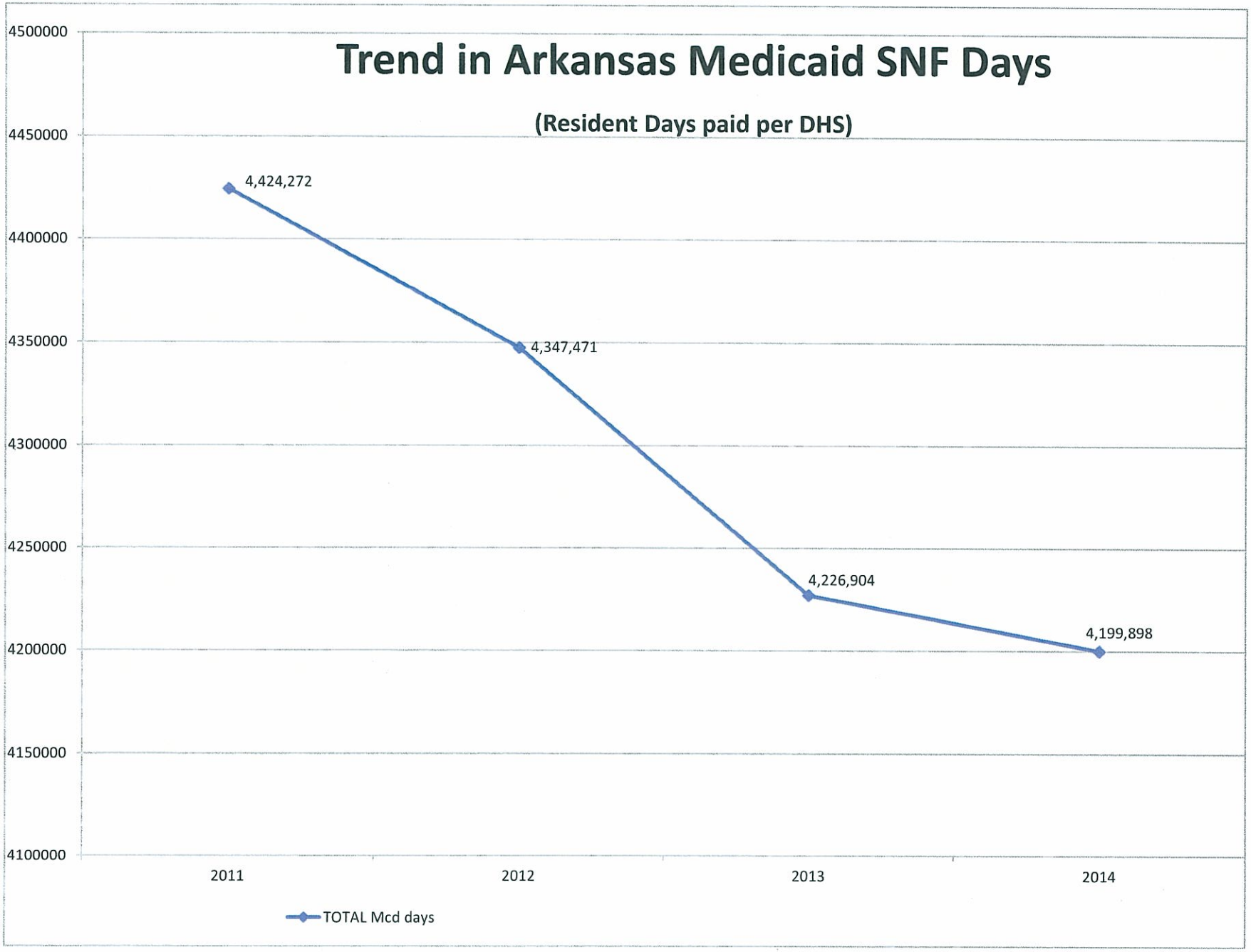
22 average transitions per year, per FTE

$2,831,558

Nursing Facilities

0 state dollars dedicated to transitions

Over 12,000 transitions to the community


Trend in Arkansas Medicaid SNF Days
(Resident Days paid per DHS)
4500000
4450000
4400000
4350000
4300000
4250000
4200000
4150000
4100000
4,424,272
4,347,471
4,226,904
4,199,898
2011
2012
2013
2014
TOTAL Mcd days

Pay for Performance - Quality Program

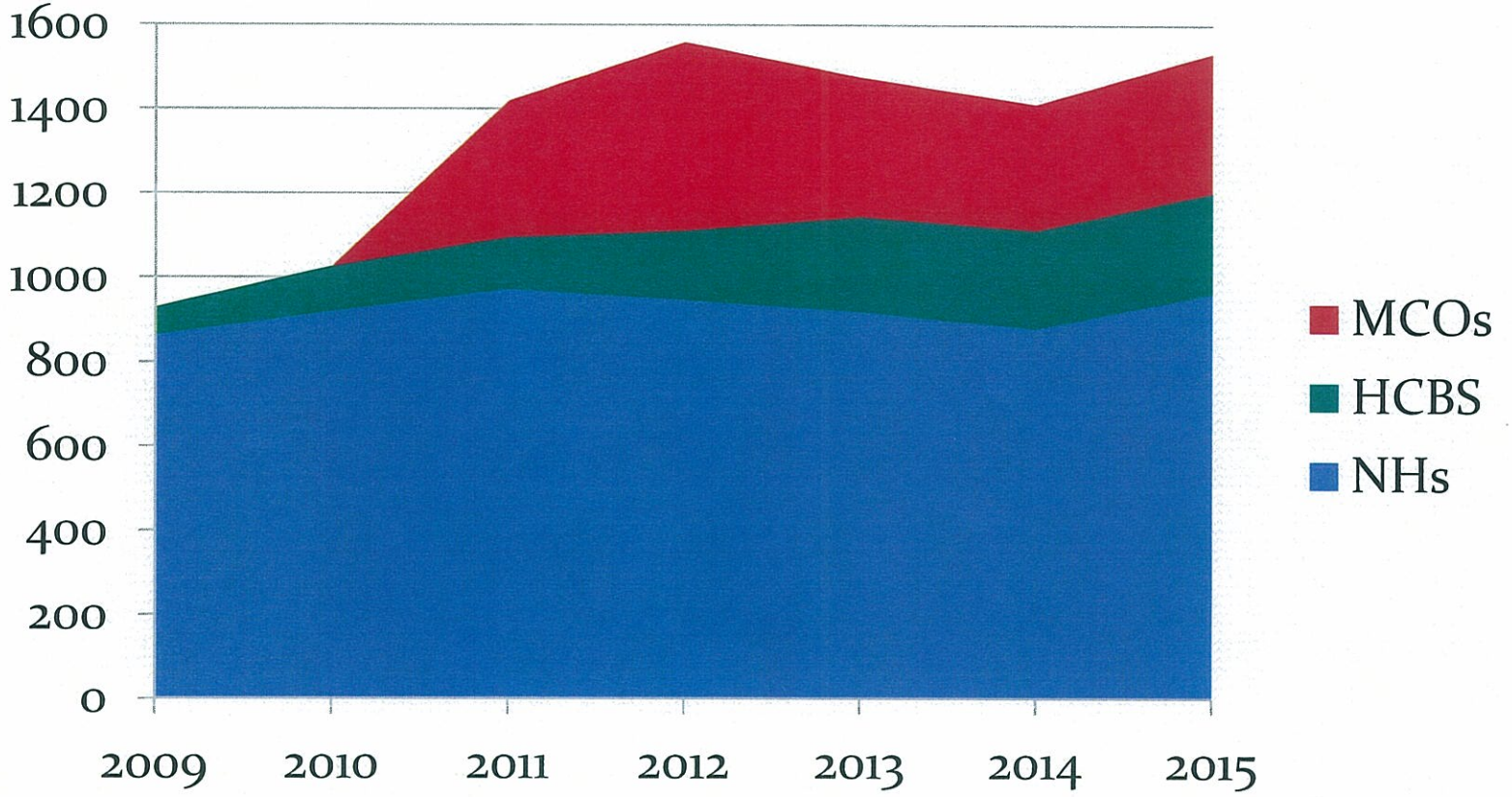
- Incentivize nursing facilities that are able to save money by avoiding high cost adverse events such as falls with injury and hospital readmission. Also measures discharge to community and customer satisfaction.

- The program would penalize the worst performers and take that savings and use to incentivize the high performing providers.

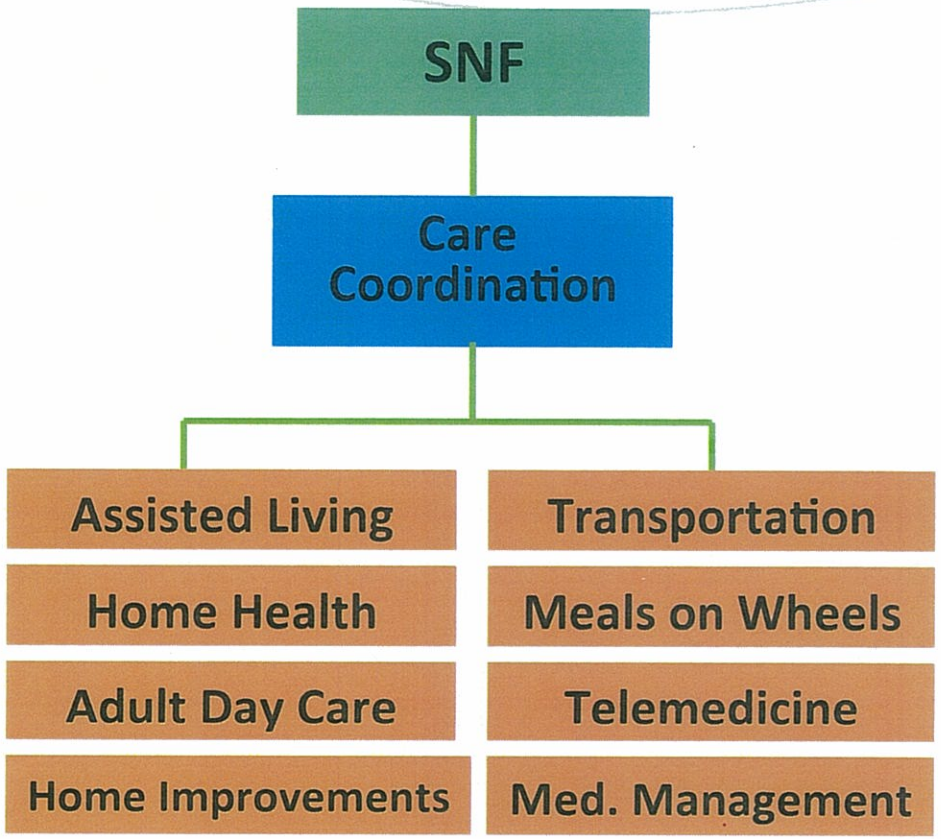
- This program has been developed at no cost to the state by a Geriatrician, David Gifford, MD, MPH, Senior Vice President of Quality & Regulatory Affairs for American Health Care Association, former Director of Rhode Island Department of Health and directed the CMS National Nursing Home-based quality improvement effort as Chief Medical Officer for Quality Partners of Rhode Island.

TENNCARE CHOICES

Cost of Long Term Care Services versus Capitated Payments to MCOs ($ Millions)



Care Coordination Model



1. Prepare proactive care plan / transitions
2. Monitoring & follow up during discharge to community
3. Coordinate or provide the necessary services to provide a seamless/event free return to the community.

Solutions

- We have specific suggestions that will reduce costs to the state, that are identified inside our payment system, that would not negatively affect patient care.
- Quality Program – Value Based Purchasing
- Care Coordination
- Liability & Litigation Cost Reduction

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Texas

The participants in this study represent approximately 10,500 occupied long term care beds in the state. This is approximately 11% of the state total long term care beds.

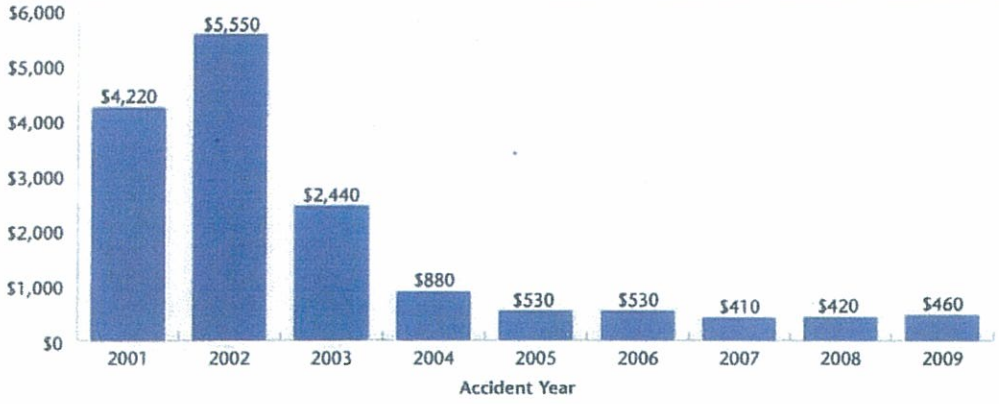
The following graphs present the loss cost per occupied bed, claim frequency per occupied bed, claim severity and loss costs relative to the Medicaid per diem reimbursement rate. Frequency is shown for claims with indemnity payments and expense only claims.

LOSS COST

Texas has stable loss cost levels since Tort Reform was enacted in 2003. The loss cost has remained consistently less than $1,000 per occupied bed and is currently at $460 per occupied bed.

The enacted tort legislation in Texas is often cited as a model to control tort costs, and the results are evident here. Beginning in 2004, the implementation in Texas provides for a $250,000 limit per claimant on non-economic damages. Further, the amount of non-economic recovery from a single provider is limited to $250,000. Loss costs in Texas plummeted after the tort reform was enacted and have remained level for a number of consecutive years.

Long Term Care Benchmark General and Professional Liability
Loss Cost per Occupied Bed
Limited to $1M per Occurrence
Texas



Source: AON Study

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