Affinity Health Services, Inc.
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State of Minnesota
Department of Veterans Affairs
Minnesota Veterans Homes
Feasibility Cost/ Benefit Study for Medicare / Medicaid Certification

Phase II a
Operational Recommendations and Considerations

942 Philadelphia Street, Indiana, PA 15701
Phone: 724-463-1010 Fax: 724-463-9555
www.affinityhealthservices.net

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Phase II a Operational Recommendations and Considerations

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"Definitions"

For the purposes of this report, the following definitions apply:

a) **Affinity.** "Affinity" means Affinity Health Services, Inc., a corporation providing Senior Community Management and Consulting Services

b) **MVH.** "MVH" means Minnesota Veterans Homes

c) **Nursing Home.** "Nursing Home" means a dually licensed facility participating in both Medicare and Medicaid

d) **Skilled services/care.** "Skilled services" means Medicare Part A skilled care as defined by CMS

e) **CMS.** "CMS" means Center for Medicare and Medicaid Services, a federal program

f) **CoP.** "CoP" means Conditions of Participation and are the minimum health and safety standards that providers must meet in order to be Medicare or Medicaid certified

g) **Rehabilitation services.** "Rehabilitation services" means a therapy program with Physical, Occupational and Speech therapy services a minimum of five days per week

h) **Restorative nursing services.** "Restorative nursing services" means nursing interventions that promotes residents ability to adapt and adjust to living independently as safely as possible

i) **MDS.** "MDS" means Minimum Data set, a core set of screening, clinical and functional status elements with common definitions and coding categories. The MDS is also used to determine the Medicare and Medicaid classifications for payment rates.

j) **PAS.** "PAS" means Preadmission Screening, and is a screening tool completed prior to admission to any nursing home, nursing facility or board and care home

k) **MHCP.** "MHCP" means Minnesota Health Care Programs

l) **DHS.** "DHS" means Minnesota Department of Human Services

m) **RUG Rates.** "RUG Rates" means Resource Utilization Groups, a program where reimbursement levels differ based on the resource needs of the resident

n) **Gap.** "Gap" means a tool that helps a company to compare it's actual performance with its potential performance

o) **HCBS.** "HCBS" means Home and Community Based Services

p) **OBRA.** "OBRA means Omnibus Budget Reconciliation Act of 1987 is a Federal legislation and regulation addressing Quality of Care

q) **RAP.** "RAP" means resident assessment protocol and is a part of the comprehensive assessment

r) **CLIA.** "CLIA" means Clinical Laboratory Improvement Amendments is a Federal requirement that every facility that tests human specimens for the purpose of providing information for the diagnosis, prevention, or treatment of any disease or impairment meet certain requirements

s) **DOM.** "DOM" means Domiciliary facility for assisted living

I. Executive Summary

The Minnesota Veterans Homes has contracted Affinity Health Services, Inc. ("Affinity") to conduct a cost benefit analysis to determine the feasibility for the five (5) homes to obtain Medicare and Medicaid certification. Affinity will be identifying the opportunities and challenges involved with this project including the financial impact on the various stakeholders. Affinity will also be providing a Gap analysis for compliance with CMS participation and an implementation plan for each facility to be utilized shall the MVH decide to proceed with certification.

This is the second of five (5) reports that will be provided to the Minnesota Veterans Homes as part of our contractual agreement. This particular report focuses on two main aspects. The first is the philosophical considerations of the Medicare and Medicaid programs and the second is identification of key operational considerations that would require a change in either culture or procedures within each facility should the MVH proceed with certification.

One of the primary objectives of the contract is to determine how certain key elements of the Minnesota Veterans Homes' operations compare to standard industry practices in Medicare and Medicaid certified facilities. In some cases we may refer to best practice standards. "Standard" or "Best" industry practices may be derived from a variety of sources, including:

- Nationally available publications and reference materials;
- Information published on publicly available websites (i.e., Department of Health, Centers for Medicare and Medicaid Services, etc.);
- Information obtained on other similar facilities;
- Proprietary data or information collected or retained by Affinity;
- A compilation of Affinity experience in the healthcare and senior living industry;
- Research and experience from previous veterans homes

When available, we will support standard or best industry practice recommendations with objective, documented sources. However, it is important to note that there are some observations, recommendations, and practices that simply are not well documented in publicized venues. We will, at times, rely on the collective experiences of our organization to identify operational considerations and recommendations for potential change.

As the MVH leadership evaluates considerations to become Medicare and Medicaid certified it is important for key decision-makers to have ample understanding of both the

philosophical programmatic nuances of both systems as well as the anticipated impact to the organizational structure, behavior, and practices.

These aspects of the certification process are "softer" considerations but are nonetheless important for the MVH leadership to consider as change in any organization can be challenging.

It is important to note that we are providing these considerations and operational implications should the MVH decide to pursue Medicare and /or Medicaid certification. We recognize our role in this engagement is to provide information and data necessary for the MVH key decision makers to make informed decisions regarding pursuit of the certification process. Understanding the impact to the organization is a fundamental consideration in this decision-making. Ultimately, the decision to pursue certification is a management decision. Affinity has not been engaged to act in a management capacity.

The final report will include two (2) different financial projections and subsequent impact to the organization should the MVH become a Medicare and Medicaid participating provider. The first projection and analysis will outline the impact of these two programs based on the assumption that the MVH will continue to operate under their current admissions and marketing structure. The second will provide a projected impact of these two government programs assuming the MVH changes their operational structure to mirror private sector operated nursing facilities. Any decision-making regarding the pursuit of participation in either of these programs prior to the issuance of the final report would be premature.

II. Methodology

Affinity Health Services, Inc. has gathered information regarding the current operations, business practices, and clinical and financial outcomes of the MVH through a variety of sources.

The observations and comments enclosed are a result of our on-site visits, document review, inquiries, observation, analysis and other work performed.

The data and information included in, and used as a basis for, this report was compiled from a variety of methods and sources, including but not limited to:

a.) Review of documents provided by Minnesota Veterans Homes;

b.) Observations made during on-site visits to each of the homes;

c.) Interviews with key management and departmental staff, including but not limited to:

i.) Nursing Home Administrator
ii.) Director of Nursing
iv.) Business Managers and Support Staff
v.) Admission Coordinators/Social Service Staff
vi.) Pharmacist
vii.) Therapist

Our report is focused on those areas that are believed to present the most significant operational impact for the Minnesota Veterans Homes should they choose to pursue either Medicare and/or Medicaid certification. This report attempts to identify and address those key business practices that should be considered should the decision-makers representing the Minnesota Veterans Homes' pursue certification.

In addition to our overall recommendations, the sections of the report that follow address our observations and findings in terms of the following:

- Minnesota Veterans Homes current practices;
- Industry standard or best practice recommendations of certified homes; and
- A brief synopsis of existing Gap's between the current practice and recommended best practices as found in Medicare / Medicaid certified homes

III. Analysis

A. Philosophical Considerations of Payment Programs

a. Medicare Program

The Medicare Program is a health insurance entitlement program for people age 65 or older, people under age 65 with certain disabilities, or people of all ages with End-Stage Renal Disease. Medicare administers four (4) types of insurance programs:

- Medicare Part A - Hospital Insurance and Extended Care,
- Medicare Part B - Supplemental Health Insurance,
- Medicare Part C - Medicare Advantage Plans and
- Medicare Part D - Prescription Drug Coverage.

The primary purpose of the Medicare Part A benefit is to provide continued treatment to a beneficiary immediately following inpatient hospitalization to encourage appropriate use of more economical alternatives to inpatient hospital care. Program payments for services rendered to beneficiaries by providers (i.e., hospitals, nursing homes, and home health agencies) are generally made to the provider. In each benefit period, payment may be made for up to 90 inpatient hospital days and 100 days of post-hospital extended care services. Nursing care provided in nursing homes under the Medicare Program are considered extended care services.

Nursing home residents in a covered benefit period have very specific care needs. In addition to meeting several technical requirements, there is specific care coverage criterions that must be met in order for a patient to be covered under their Medicare Part A benefit. Under the current structure of the MVH, a patient with the Medicare Part A benefit is not able to utilize this insurance entitlement to receive care in a MVH facility. The practices and process changes that would be necessary should the MVH decide to provide Medicare Part A benefits at their nursing homes will be identified.

In the nursing home industry, the Medicare Program is considered the strongest payer of nursing home care. In a typical certified nursing home, the percentage of residents on Medicare covered services averages between 10-14% of the total resident population. Even with this small percentage of residents, the Medicare Program for most homes provides the organization with a profit margin. This margin helps to offset the losses that are typically incurred by the Medicaid Program. For this reason, nursing homes

marketing and census building efforts are focused on residents with daily skilled needs that would be covered under the Medicare Program. Hospitals in need of placing patients needing skilled services expect a quick and efficient admission into a nursing home.

Currently there are very few residents cared for at any of the MVH facilities that meets the qualifications for use of the Medicare Part A benefit. There are a number of reasons that contribute to this and these are addressed in detail throughout this report. In order for the MVH to assist potential and current residents to realize their Medicare benefits many operational and philosophical changes would need to occur. If these changes do not occur Medicare participation would not benefit the organization to its fullest potential.

In a typical nursing home, once a resident no longer requires Medicare Part A skilled care, the resident is either discharged to home, a lesser level of care, or remains in the nursing home as a long term resident. The more residents discharged to home or to a lesser level of care, the more resident days that are generated from the Medicare Part A program. If there are no vacancies at the facility and the facility cannot accept patients from the hospital with the qualifying stay, the Medicare Program is severely limited due to the lack of admissions. Medicare Part A is a short term benefit and as stated earlier can only be utilized after the qualifying hospital stay.

b. Medicaid Program

The Medicaid Program is a state administered program available to low-income individuals meeting specific income guidelines. In addition to income, there are also resource and asset tests that must be met in order for an individual or family to qualify for medical assistance benefits. The primary purpose of this program is to care for indigent individuals and families without sufficient resources to meet personal and care needs. Medicaid eligibility determinations look not only at an individual's current income, assets, and resources but several previous years. There is a five (5) year look-back period that is reviewed to determine Medicaid eligibility. Assets and resources transferred within this five (5) year period are scrutinized prior to determining Medicaid eligibility.
Under the current veterans' system, an individual can transfer assets and resources to a spouse up to the day prior to admission to the facility and up to a year prior for transfer of assets to other family members or individuals. This is a very attractive benefit for veterans as it affords them and their family the opportunity to retain assets and resources and still receive care and services at the MVH based on their monthly income. This benefit in itself serves as a marketing strategy that attracts veterans to one of the homes for care.

Changing this benefit would require a drastic philosophical change within the MVH. Any decision to gravitate toward this payer model may be met with resistance from various stakeholders. The decisions to pursue Medicaid certification would most likely result in many changes, some anticipated and others unpredicted, for the MVH. Multiple options or levels of utilization of the Medicaid Program that may be beneficial to both an eligible veteran and to the organization will be explored.

It is important to note that there are significant programs and strategies that have been implemented or planned to assist Minnesota in right-sizing or rebalancing the nursing home industry. This effort is similar to other states efforts to reduce spending to nursing homes by placing less emphasis on institutional care and more on lesser levels of care and home and community based services. These efforts include:

- Moratorium on construction of new nursing home beds
- Pre-admission screening managed by Long Term Care Consultation
- Funding for HCBS through waiver programs
- Statewide strategic planning and analysis for service Gaps
- Service development grants
- Nursing Home bed layaway programs
- Planned voluntary bed closures through an incentive program
- Single bed incentive planning

The state is tasked with improving consumer access to services and has developed resource centers and outreach sites for improving referrals and dissemination of information. Minnesota's Long Term Care Consultation Services, under Statute 256B.0911, was developed to assist persons with long-term or chronic care needs in making the long-term care decisions and selecting options that meet their needs and reflect their preferences.

Another goal has been for this service to contain costs associated with unnecessary admissions to nursing homes and to identify services in the least restrictive environment. Statute 256B.0911 directs that the commissioners of human services and health shall seek to maximize use of available federal and state funds and establish the broadest program possible within the funding available.

Minnesota's aggressive approach was successful in decreasing their paid Medicaid days by 41% from 1995 to 2007 and still they continue to have more beds than the national

average. This 41% decrease in Medicaid days caused a large number of facility closures and downsizing resulting in a 27% reduction in beds over a 20-year period.

It is important for the MVH to note the significance and success of these initiatives in the state and the likely culture change they would produce for the various stakeholders inclusive of both providers and recipients of veteran's benefits. Historically the MVH have focused on providing care and services for the veterans and or their spouses as a long term commitment and long term stay in the homes.

B. Operational Considerations for Participation in Medicare and Medicaid Programs

a. Admissions / Marketing

Current Practice: Admissions / Marketing

In the three smaller nursing homes, Fergus Falls, Luverne, and Silver Bay, the social service personnel are responsible for admissions and report to the Administrator. At Minneapolis the social service department reports to the Director of Nursing. Hastings is the exception where admissions does not operate under social services and is a separate department that reports to the Director of Nursing.

There are no defined marketing activities as each home has an admission waiting list. There are public relations functions within each community and that involvement serves both the homes and the residents well.

The number of monthly and annual admissions in each is significantly lower than the average or the typical nursing home that is Medicare certified. The homes operate within the MVH guidelines for admission and discharge criteria. In addition the MVH facilities do not typically admit any resident for a short term stay. The residents are usually admitted for permanent placement without active discharge planning to a lesser level of care, even when their need for assistance with care improves.

The lack of short term residents with discharge potential is one of the reasons the MVH has a lower than industry average admission rate. The waiting list in some homes is a minimum of six months in duration.

The Homes do not currently provide the type of skilled services necessary to care for the Medicare skilled level of care such as Intravenous Therapy and Rehabilitation Therapy. Due to the current admissions process and waiting list, the veteran would likely receive skilled care services as an inpatient at the hospital, VA Medical Center, or at a nursing home that does provide these services. The resident's need for skilled care and their

status on the admission waiting list makes it difficult for the Homes to admit a resident eligible for Medicare Part A.

The residents are admitted, in order, according to the date on which the application is received, as long as all other financial and care need requirements have been met. The admission and application process is outlined in Chapter 9050 Department of Veterans Affairs, Veterans Homes, Admissions, Discharges, Cost of Care Calculations, and Maintenance Charges. Section 9050.0055 Admission Process, Waiting List, Priority and states the following: "the applicant's position on the waiting list is determined by the date on which the application form is received." The waiting list process practically eliminates the ability of the MVH to admit the resident directly from the hospital taking advantage of a 3-day hospital stay requirement for Medicare Part A.

Once a resident is admitted to a Home they are typically not care planned for discharge potential to a lesser level of care. Per observation in the MVH we identified residents who could be evaluated for care and service needs and have a potential for discharge to a lesser level of care. During interviews, key managers frequently identified the MVH as the resident's final place to live. It is important to note that if the resident transferred assets prior to admission their ability to afford another level of care or to utilize a Medicaid based home and community program may be limited.

The discharge planning process differs from the typical nursing home. The discharge plans do not indicate that there is an active process in place to seek alternate placement options as the care needs change or improve. Review of one particular discharge plan indicated that the resident was not a discharge to home potential because of the resident's choice to remain. One MDS out of 323 MDS's completed identified discharge potential on the resident assessment. This is less than ½ of a percent compared to 15% to 25% in a Medicare certified nursing home. This higher rate of discharge potential is representative of the culture in nursing homes.

We found a more active discharge planning process in place at both Domiciliary Care programs. There were more veterans discharged and had planned discharges back into the community setting or home. We identified this different culture in both interview and discharge statistics.

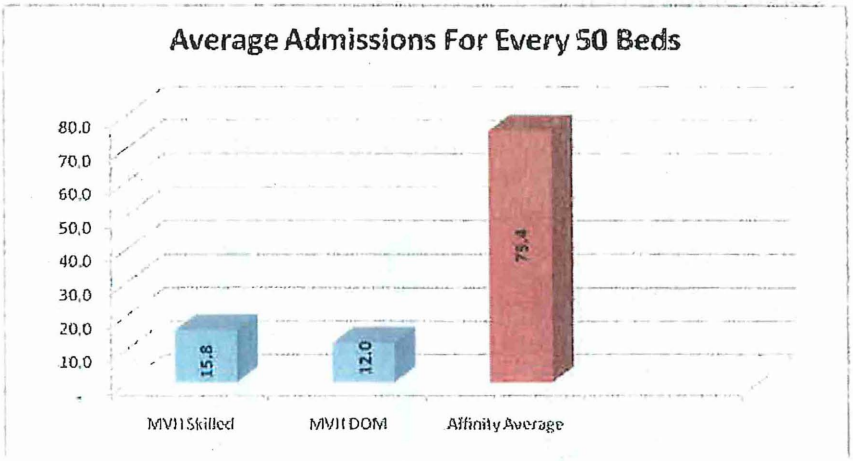
Industry Practice: Admissions / Marketing

Private sector nursing homes cater and actively market to hospitals for the large majority of their admissions. Hospital admissions are desirable for multiple reasons including the utilization of Medicare and/or Managed Care insurance. As stated earlier, Medicare skilled patients are the highest payer source. Medicare skilled services in a nursing home are defined as and must meet the following criteria:

- Skilled nursing or skilled rehabilitation services are needed on a daily basis;
- Daily skilled services can be provided only on an inpatient basis in the nursing home;
- Services must be reasonable and necessary for the treatment of the patient's illness or injury

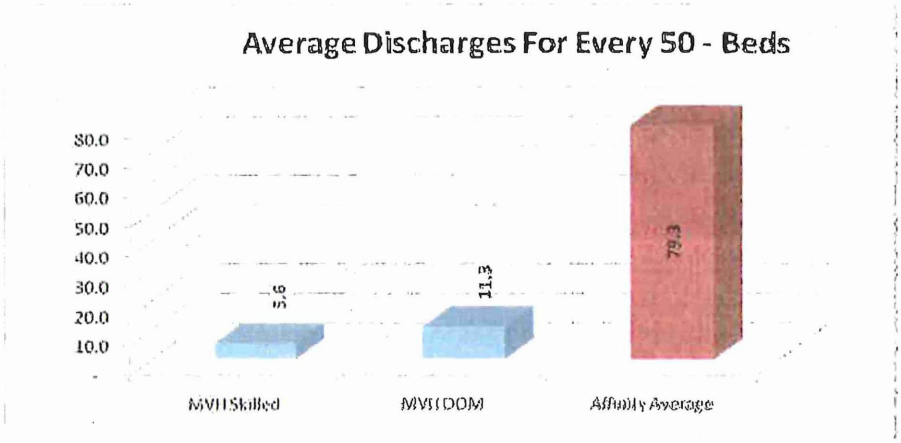
When a patient is discharged from the hospital to the nursing home they usually receive short notice and the hospital needs a quick response. Hospitals have limited time to wait for a response as the hospital is not being paid once it is determined there is no longer a need for acute care. There are also typically many other placement options available through private and non-profit nursing homes, hospital based units, and home and community based services. Many nursing homes leave vacancies available so they can accommodate the short term resident. The greater the admission volume of short term patients the more admissions the facility can accommodate.

Below is a chart that represents the average number of admissions on an annual basis at the MVH compared to facilities in the Affinity client base (Medicare certified facilities). We used 50-beds as the basis for the admission and discharge statistics. This represents the number of admissions for every 50 - beds in 2008.

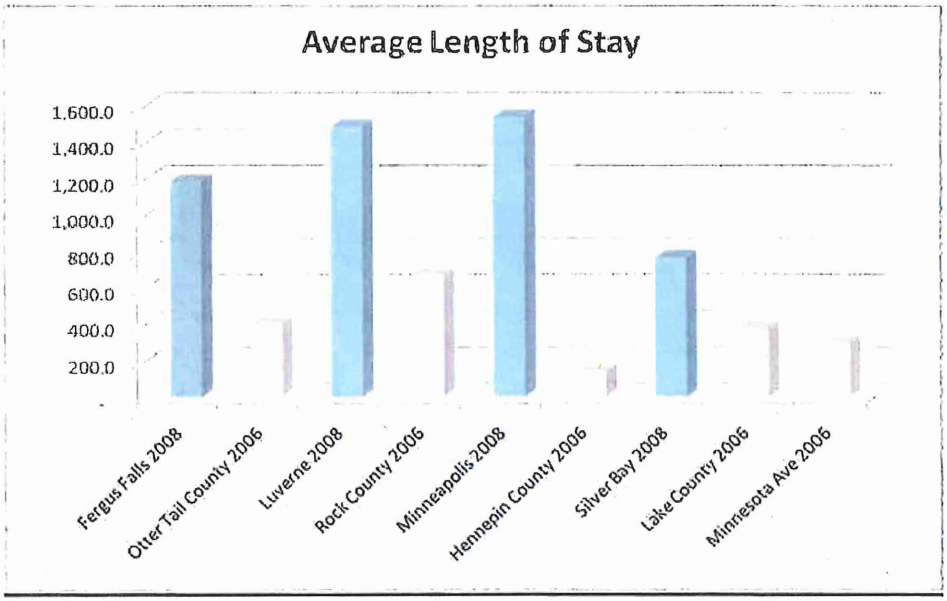


The Interdisciplinary teams in the nursing homes develop and implement discharge plans at the time of admission for anticipated discharge to a lesser level of care or if the resident desires to return home. Through a planned discharge process these residents are discharged to a lower level of care or return home when the daily skilled services are no longer needed. Discharge planning is a large component of the overall plan of care for each resident and is addressed on a regular basis.

Below is a chart that represents the average number of discharges on an annual basis at the MVH compared to facilities in the Affinity client base (Medicare certified facilities). This represents the number of discharges for every 50 beds in 2008.



The average length of stay in the MVH far exceeds the industry standard. Below is a comparison of the MVH nursing facilities average length of stay for 2008. This length of stay is compared to the average of all other nursing homes in the county and the Minnesota nursing homes in 2006.



Brief Summary of Gap's Between Current Practice and Industry Practice:

Admissions / Marketing

- Admission Practices vary significantly between the MVH and Industry Practice
    - Admissions into a Medicare certified nursing home are typically based on the resident's acute care need as opposed to an extensive waiting list
    - Admission volume is high in Medicare certified nursing homes and admissions may average several residents weekly or even daily as opposed to several admissions per month in the MVH
- The discharge planning process varies significantly between the MVH and Industry Practice
    - Through both regulatory initiatives and culture change practices discharge planning in Medicare certified facilities is active and is structured around placement into the least restrictive environment
- The resident's length of stay in the MVH is longer than the Industry Practice due to not participating in the Medicare Part A program and also due to the admission and discharge practices
- The resident acuity level in the MVH is lower than Industry Practice found in Medicare and Medicaid certified homes

b. Reporting Structures

Current Practice: Reporting Structures

The three small nursing homes operate under a typical reporting structure with the key department managers reporting directly to the Administrator. Fergus Falls has some variation to their structure due to the implementation of the universal worker concept. The larger homes have some variation in their reporting structure simply due to the size of the facilities and the necessity to alleviate some of the direct reporting line from the Administrator.

The therapy or rehabilitation department warrants significant discussion. We identified the therapy departments for the most part function as restorative nursing departments that perform consistent with maintenance level nursing programs as opposed to providing skilled therapy. It is not considered unusual for therapists to report to the Director of Nursing as opposed to the Administrator because of the interface between these two departments.

The MVH Administrators report to the Deputy Director and they receive supervision and support for Quality Assurance, Finance, Operations, and Human Resource functions.

If the MVH should decide to apply for Medicare and/or Medicaid certification there would be recommendations regarding the reporting structure from both a facility level and central office level. These recommendations would take into consideration the amount of utilization of the Medicare and Medicaid programs in each home.

The various report formats and structures do not currently accommodate third party insurances. The current accounting and billing systems do not accommodate supervisory access from central office. In addition to the lack of accounting and billing structure, the reporting structure for MDS management functions and therapy functions are not established.

Industry Practice: Reporting Structures

The following reporting structures in a Medicare and Medicaid participating nursing home that are the most successful include the following departments or functions within a particular department:

- An MDS coordinator who reports directly to the Administrator
- Billing personnel responsible for third party billing who report directly to the business manager or finance director
- A Therapy Department that includes three disciplines (Physical, Occupational and Speech Therapy) and is managed by a therapy director
- A Restorative Nursing Program that is managed by the nursing department and has three tiers – Rehabilitative, Active Restorative, and Maintenance Restorative programming
- An Admissions and Marketing department that is separate from social services

Stand alone facilities operate without a corporate reporting structure but multi-facility organizations typically have centralized resources to monitor and assist with:

- Regulatory compliance,
- Third party billing / reimbursement,
- Finance, clinical, and operational support, and
- Admissions and marketing support

Accounting practices are typically established on an accrual basis and are consistent with identifying costs and revenues in detail and according to reimbursement guidelines. Third party billing reports are detailed by payer type and are tracked with very specific collection guidelines and supporting documents. All third party billing functions are required to be billed electronically and the facility computer systems would need to support these functions.

Brief Summary of Gap's Between Current Practice and Industry Practice:

Reporting Structures

- Industry Standard places a stronger emphasis on the MDS, RAPS and care plan process and the documentation that supports the coding and subsequent reimbursement RUG group in Medicare and Medicaid certified homes
- For reimbursement in a Medicare or Medicaid certified home the Industry Standard is to utilize resources or experienced personnel to support the third party billing functions, establish a centralized accounting system to monitor the homes and prepare reports as necessary
- From a clinical, regulatory, and financial perspective the Industry Standard is to have a Rehabilitative Program that consists of Physical, Occupational and Speech Therapy available on a daily basis, defined as five days per week, as per CoP

c. Labor/Staffing Patterns

The labor and staffing patterns of those departments that would be significantly impacted by Medicare / Medicaid certification were evaluated. The departments that would have changes to either training or structure include nursing, rehabilitation, business office/accounting, pharmacy, and admissions/social services.

Current Practice: Labor/Staffing Patterns Nursing

The Nursing Administration Department varies among the MVH as to the number of staff and the job duties assigned. Similar positions within the administrative support staff for the Director of Nursing include an Assistant Director of Nursing, Staffing Coordinator, RN Quality Assurance / Infection Control / Staff Development and RN House Supervisors / Senior RN. At least two of these positions exist in each home. In Minneapolis there is a larger number of nursing administrative staff due to its size and unit locations.

RN's who provide direct care and supervision are assigned on each unit and each shift. The number of LPN's is less than industry standards as RN's are utilized as the primary professional nurse. The LPN's primary function is to administer medications. The exception is Minneapolis where LPN's are utilized more heavily than RN's.

The completion of the MDS is one of the largest variables among the MVH. The assignment for this task ranges from an Assistant Director of Nursing, and Senior RN, to Staff RN's assigned to a unit. Each home performs the entire comprehensive assessment process that includes completion of RAP's and care plans. The homes follow the established OBRA assessment schedule but not a Medicare skilled assessment schedule. The key nursing staff at the Homes has previously received MDS

2.0 training as well as some advanced MDS 3.0 training. However, since the Homes do not participate in the Medicare / Medicaid programs the reimbursement part of the MDS process is not understood. Some professional nursing staff have previous experience in a Medicare certified nursing home and at least one RN is certified in the MDS. The MVH computerized medical record is utilized differently in each home with variation in charting requirements.

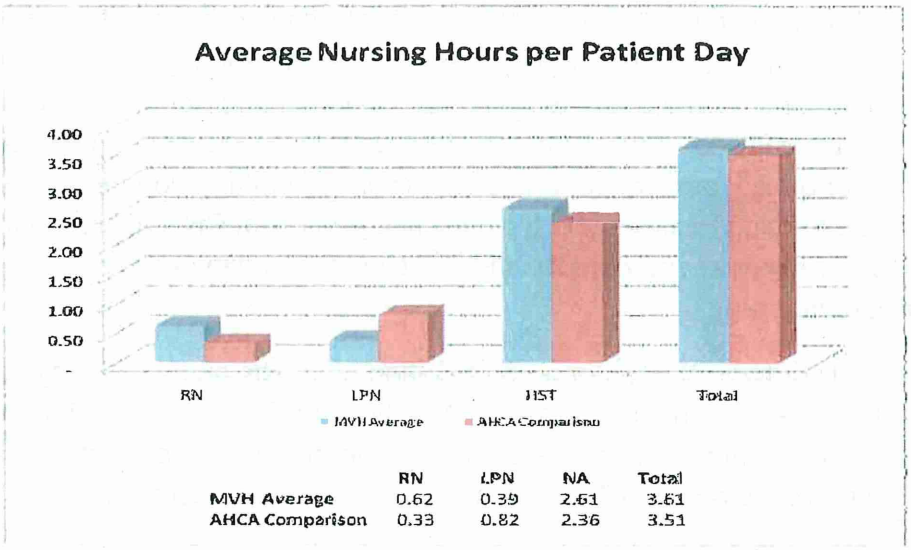
All levels of nursing staff report to their immediate supervisor. The Director of Nursing is responsible for the overall management of the nursing department. The administrative nursing team and the RN assigned to MDS completion reports to the Director of Nursing.

The RN's are all professionally trained, through licensure, to provide any skilled care service that a resident might require. However, since the homes usually do not admit a resident requiring a skilled level of care, the professional staff may need refresher courses in some skilled service areas. Some examples of Medicare skilled services include intravenous (IV) Therapy, intravenous (IV) antibiotics, and advanced wound care. The homes do admit and have residents who receive a higher level of care and services such as wounds and pressure ulcers, oxygen therapy including BiPAP, hospice and end of life care, foley catheters, feeding tubes, colostomies, and residents who receive off site dialysis treatments.

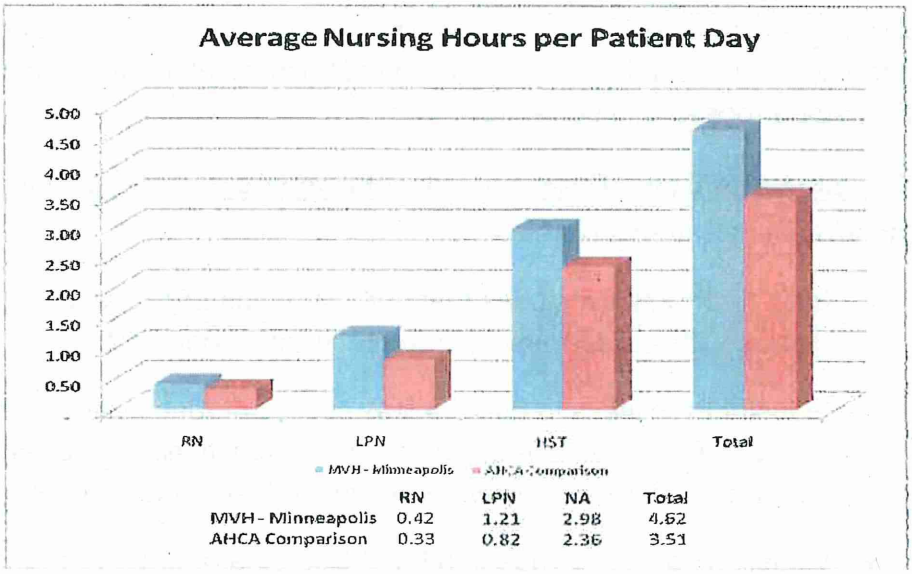
Each Home has an approved CLIA certificate for performing on site lab functions such as glucose monitoring. The Homes do not complete the various forms that are required in a Medicare / Medicaid certified facility, i.e. Physician Certification and Recertification.

There are significant differences between the three smaller nursing homes' hours per patient day of nursing staff at an average of 3.61 and the Minneapolis nursing home hours per patient day of nursing staff at 4.62. The State of Minnesota through one of its health care association's reports that the State's average nursing hours per patient day is comparable with the American Health Care Association (AHCA) reported average hours per patient day of 3.51.

The following charts indicate the average hours per patient day for direct care staff at the three smaller nursing homes and for the Minneapolis nursing home as it compares to the AHCA average. These hours include RN, LPN and Aide hours only. There is no nursing administration, restorative nursing or transport attendants included.



	RN	LPN	NA	Total
MVH Average	0.62	0.39	2.61	3.61
AHCA Comparison	0.33	0.82	2.36	3.51



	RN	LPN	NA	Total
MVH - Minneapolis	0.42	1.21	2.98	4.62
AHCA Comparison	0.33	0.82	2.36	3.51

There was no data available that could be used to calculate the actual hours per patient day for nursing from the payroll records. The hours per patient day was calculated using the typical staffing pattern as reported by each of the homes. The best practice for calculating hours per resident day is the use of actual payroll data that accounts for all hours worked including overtime.

Industry Standards: Labor/Staffing Patterns Nursing

The industry standard for nursing administration consists of the Director of Nursing and a team that assists in the management, oversight, and development of the nursing department. In the average 85 to 120 - bed nursing home the nursing administrative team typically consists of an Assistant Director of Nursing, an RN assigned to wound care or quality assurance, and a non-licensed staffing coordinator. In larger 150-400 bed skilled nursing facilities you typically find additional RN's assigned to staff development and / or risk management functions including handling of resident incident and accident investigations.

One (1) or two (2) RN's or a combination of an RN and an LPN typically manages the MDS process. Nursing homes that participate in Medicare and operate under a Medicaid case-mix reimbursement system may have an MDS Coordinator or MDS Case Manager, who reports directly to the Administrator and is considered a department manager.

As stated earlier in this report, Medicare certified nursing homes may admit and discharge several residents a week. The nursing administrative team is closely involved in the admission inquiry process, review of hospital information, and coordinating the discharge process with social services.

Brief Summary of Gap's Between Current Practice and Industry Practice:

Labor/Staffing Patterns Nursing

- Industry Practice includes that both RN's and LPN's receive training and stay current with skilled nursing care practices as per CoP
- Industry Practice is to utilize a less costly approach with more balanced staffing between RN's and LPN's. Some nursing functions are assigned to trained LPN's for a more cost effective approach in Medicare and Medicaid certified homes
- Industry Practice includes an MDS Coordinator or Case Manager who reports to the Administrator as a department manager responsible for quality of care as well as the reimbursement specialist of the certified home

Current Practice: Therapy

The therapists currently operate in a similar manner to a restorative nursing department as opposed to providing skilled therapy services that occurs in a Medicare certified home. They instruct the restorative nursing department and establish goals for the nursing staff but do not necessarily treat as a clinician.

Fergus Fall, Luverne and Hastings do not have all three therapy disciplines (Physical, Occupational and Speech) available. Minneapolis has all three therapies and does actively treat but simultaneously performs other functions that are related to job duties

typically performed by nursing or activities personnel. Under contract Silver Bay has access to all three therapies.

There is no method to determine staffing levels for the therapy personnel whether contracted or in-house. In some homes it appears to be determined by the amount of services they have available to them. There are no documentation standards among the homes for therapy personnel and in interview and sample document review, we identified some therapists that do not document in the clinical record or supporting records. The Minneapolis facility has a therapy manager that manages all three disciplines of therapy. No documentation sufficient to support billing for rehabilitation services is currently completed.

Industry Practice: Therapy

Therapy departments are overseen by a Therapy Manager in Medicare and Medicaid certified homes. The Manager is responsible to identify the types and amount of staffing based on therapy case load. The Manager is the coordinator of resident care and is responsible to ensure the proper and adequate documentation. The Manager maintains detailed records that account for each of the therapist's time by discipline and their efficiency levels by percentage of treatment time vs. documentation time. Efficiency levels determine therapy staffing needs. There is also an allocation of time spent on detailed documentation and auditing necessary for compliance with the appropriate insurance programs.

Large therapy programs tend to use not only physical, occupational and speech therapist but also other paraprofessionals, i.e. physical therapy assistants and occupational therapy assistants to support the physical and occupational therapist. Therapists are responsible for development of the therapy care plan and participate in the active planned discharge process.

Therapy services can be provided either by in-house personnel or via contracted services. Contracted services are responsible to meet the CoP for Medicare and Medicaid. Per contract they can also be paid based on therapy minutes or Medicare RUG level as opposed to by the hour which minimizes cost exposure for the facility. This method requires the contracted therapy company to effectively and efficiently manage the therapy department and resources. Additional responsibilities managed by the therapy department are negotiated as an additional fee.

Therapy contractors and therapy personnel provide the necessary documentation to nursing homes to bill third party insurances. Medicare Part B is heavily utilized to reimburse the homes for non-skilled, outpatient services rendered in addition to the Medicare Part A program. This is an additional revenue stream in Medicare certified facilities.

Brief Summary of Gap's Between Current Practice and Industry Practice: Therapy

- Industry Practice is to provide at least three disciplines consisting of Physical, Occupational, and Speech Therapy as per CoP
- Industry Practice is to have the appropriate documentation to support treatment provided and services billed as per CoP to the Medicare and Medicaid programs
- Best practice is to determine staffing and efficiencies according to therapy caseload in Medicare / Medicaid certified homes
- Industry Practice in Medicare / Medicaid certified homes is that therapy services are utilized and billed for extensively in both Part A and B programs

Current Practice: Business Office / Accounting

Each home has a Business Office Manager / Accounting Supervisor who is responsible for the day-to-day financial operations of the home and reports to the Administrator of the home. They produce yearly revenue and expenditure budgets, monthly revenue/collections and expenditure reports that vary in degree of detail. They also perform monthly account reconciliations, estimate cost per diems, and authorize cash receipts and disbursements.

Under the supervision of the Business Office Manager, there are varying numbers of clerks, depending on the size of the home. They have responsibility for billing of monthly services, preparing expense invoices for payment, monitoring vendor files, processing expenditure invoices and payments, preparing resident fund deposits and transfer, purchasing and receiving supply items, and processing time and attendance transactions into the payroll system. There are various functions and committee items performed by the business office personnel that are either specific requests from the finance manager at the central office or reports specific to operating a State Veterans Home that monitor the financial performance of the home. Additionally, the Business Managers are actively involved with management of the contracted services.

This staffing model would not change significantly were the MVH to decide to pursue certification for Medicare or Medicaid. The significant changes that would occur would be in the functions of the business office and the computer applications necessary to perform the required tasks.

Industry Practice: Business Office / Accounting

The Business Manager / Director of Finance produces annual budgets and monthly financial statements that are detailed and accommodate a large number of revenue accounts including contractual accounts necessary for all third party insurances. The

expenses are also categorized according to department and are quite detailed. The payroll classifications are detailed by department, class of employee, and overtime. Recording of employee benefits, such as paid time off, health insurance, payroll taxes, workmen's compensation, unemployment compensation and any other benefits provided by the organization is detailed by type of benefit. This type of detail accommodates all the necessary billing and cost reporting processes and provides a method to monitor revenues and expenses.

Accurate data in the daily census that records each resident's insurance type/types is key to accurate accounting and billing records. One resident could easily have five different payer types and accounts in which the billing staff is responsible to bill. Gathering and recording this information correctly at the time of admission and periodically throughout the resident's stay is necessary for the accuracy. Medicare and Medicaid facilities track each Medicare Part A resident's daily RUG rates. This information would need to be accurate for billing purposes.

An income statement and balance sheet for each home is required. The nursing home and DOM care or other type of services would need to be separated for financial reporting. It is required that all services are accounted for separately. If this type of accounting system is not routinely maintained, all the information would need to be converted into an appropriate document when filing the Medicare and Medicaid cost report.

Billing of third party insurances is designated to either one or several business office personnel depending on the size of the facility and the amount of governmental and third party billing that is being performed. Billing is required to be done electronically for both Medicare and Medicaid. It is highly recommended to have very structured credit and collection policies not only for collecting all the receipts due to the organizations but to meet the requirements of third party insurances.

Identified industry best practices include training all department managers and purchasing agents on coding expense items into the appropriate cost centers in order to assist the business office staff in maintaining proper expense allocations. This method also assists in holding the management team accountable for following the systems established to record revenues and expenditures while monitoring their budgets.

Ideally, the computer system for accounting and billing is integrated with the clinical data to lessen the opportunity of errors. Data is entered on admission and flows through the system recording of all resident information for both the MDS and accounting records. Nursing home software systems are customized exclusively to perform the functions of billing, recording all the necessary insurances, and other revenue accounts. The system the home chooses should create a clear financial picture of the organization.

Brief Summary of Gap's Between Current Practice and Industry Practice:
Business Office / Accounting

- A detailed financial statement is prepared monthly under Generally Accepted Accounting Principles (GAAP) in Medicare certified homes
- A detailed general ledger is established to account for all revenues and expenditures necessary to prepare cost reports and properly record all third party revenues in Medicare certified homes
- Medicare / Medicaid certified homes have trained and experienced billing personnel
- An integrated software program generates reports, accurate data, and billing information to support reimbursement in Medicare / Medicaid certified homes

Current Practice: Pharmacy

Current pharmacy services are either delivered via a contracted arrangement or provided in-house within the MVH. Two (2) homes, Fergus Falls and Silver Bay utilize contracted pharmacy providers while the other three (3) homes provide pharmacy services in-house. The medication delivery systems vary by home. Record keeping for the pharmacy services appears to be detailed and accurate. The in-house pharmacy personnel are responsible for all functions of the department with the exception of billing.

With the exception of Fergus Falls, there is currently no billing of third party insurances in any of the programs other than through the Aide and Attendance Program. With the exception of billing through the Aide and Attendance program and the Medicare Part D program at Fergus Falls, the MVH assume all the financial responsibility for pharmacy services. Pharmacy services are billed for residents who qualify for Aide and Attendance. Only Fergus Falls is currently utilizing the Medicare Part D program. The home was an active participant in developing the necessary systems to implement this program.

Industry Standard: Pharmacy

Pharmacy services use various systems for medication delivery. The most effective use in an active Medicare Program is a seven or fourteen day medication exchange. This is utilized for short term stay residents in order to minimize waste and costs of medications. The records and billing systems are very sophisticated. The pharmacy is in charge of billing all third parties including Medicaid, private insurances, and the Medicare Part D

program. The nursing home is responsible to pay the cost of the Medicare Part A resident as pharmacy services are bundled in the Medicare Part A daily RUG rate. Considering the frequent changes in payer types makes it critically important for business office personnel to work in tandem with the pharmacy to record the proper census and insurance information. The pharmacy tracks all resident payer types and the appropriate payer type changes. The bill is then carefully analyzed by a member of the business office to determine if all insurances were properly accounted for on a regular basis.

Brief Summary of Gap's Between Current Practice and Industry Practice: Pharmacy

- It is typical and usual for the pharmacy to provide a short term medication exchange for the Medicare Part A resident for cost containment purposes
- There is a need for effective communication systems between nursing, pharmacy, and business office that occurs on a frequent and timely basis regarding changes in resident insurance and payer status in a Medicare certified home
- Billing for pharmacy services is completed for all insurances by either the home or the contracted pharmacy service for homes participating in the Medicare program

Current Practice: Admissions/Social Services

Currently admissions are a part of the social services department with the exception of the DOM Care facility (Hastings). The two large facilities have more resources dedicated to this function due to higher volume. Both the admission and discharge planning functions fall into this department with discharge planning being a function of Social Services. There are very few admissions therefore this is not overly burdensome to the department.

Industry Practice /Recommendation: Admissions / Social Services

Several years ago, the traditional nursing home operated in a very similar manner as the MVH with admissions being part of social services. In an environment with increased length of stays and little resident turnover it made good sense to combine these resources. With the change in increased admission volume and the need to occupy the beds with skilled patients and more competition, the admissions function has become a separate department. The admissions and marketing functions are commonly joined together and are an active presence in the community at large as well as the hospital community. The need for Medicare certified facilities to attract skilled patients from the hospital and the speed at which the hospital prefers placement have necessitated a reaction from the industry to hire admission personnel that spend a significant amount of time directly in the hospital to expedite and facilitate transfers to their nursing homes.

Brief Summary of Gap's Between Current Practice and Industry Practice:
Admissions / Social Services

- The responsibility for admissions is typically segregated from social services, both as independent departments in Medicare certified homes

C. Impact Analysis for Key Facility Management and Ancillary Positions

Interviews with key department managers and other employees were completed on site at each home. These individuals were chosen because they have knowledge of the current practices that are included in our analysis and they are the employees that would have the most significant impact should the MVH decide to proceed with either Medicare or Medicaid certification. Additionally, we assessed for prior experience that may assist the homes should the MVH proceed with Medicare and/or Medicaid certification.

Below is a general overview of the impact analysis for positions necessitating change to most effectively and efficiently operate under Medicare / Medicaid programs.

- Administrator – If certification is pursued the Administrator would orchestrate the change in the philosophy of care. They would lead the other departments into the change process should the MVH decide to take a new direction. The biggest changes would affect the nursing, business office, therapy, pharmacy and admissions departments. Several of the MVH Administrators have previous experience working with the Medicare / Medicaid Program.

  The Administrators are acutely aware of how the admission process would need to be restructured to accommodate a shift to Medicare certification. A few Administrators expressed their concern about the Medicaid program having a negative effect on the Veterans and the Homes' themselves. The Administrators would have an increased level of accountability that would be associated with Medicare / Medicaid program participation guidelines. These items include increased exposure to licensing, certification, compliance, audits, and collections. They would be reallocating resources to support these functions in the home. As with any change in practice or process, leadership would be the determining factor in the level of success through any change process.

- Director of Nursing – If the MVH decides to pursue Medicare / Medicaid certification the nursing department would require restructuring and systematic changes. Although the MDS coordinator should report directly to the Administrator

the Director of Nursing would be responsible to restructure the nursing department in reference to the completion of the MDS / RAPs / Care Plans. The significance of the MDS for reimbursement should be a co-partnering effort between the DON and the MDS Coordinator. Nursing systems for skilled coverage documentation, MDS coding, care planning for skilled services, and discharge planning would need developed, instituted, and coordinated. The Director of Nursing would be responsible for coordination of training at all levels of nursing staff and for monitoring of compliance. The Director of Nursing would be responsible for policy and procedure changes for compliance to OBRA federal regulations as well as system development or changes. In addition, he/she would be responsible for the coordination of the admission and discharge nursing process with an Admission Director. The Director of Nursing would work directly with the Administrator to plan and implement changes.

- Business Managers – The Business Managers would be responsible for managing the necessary changes to the current accounting system, billing, and collection systems. There are no resources currently available in the business office with previous experience in billing third party insurances and managing data consistent with Medicare and Medicaid reimbursement systems. There would need to be provisions for training of these individuals should the MVH decide to pursue certification.

  The main emphasis for the business office personnel would be implementation of a customized computer software system installation and training. The current accounting system would not sufficiently accommodate the Medicare/Medicaid revenue and expense structures. The Homes' would need to purchase customized software and proceed with a software implementation that may require additional hardware to support the new system. Sufficient tracking of revenues and expenses is critical to establishing the necessary foundation of an effective accounting system.

- Admission Coordinators/Social Services –Minimally, changes to the admissions processes would require a revision of MN statute, Chapter 9050, that dictate the waiting list process and management of the list. This would need to change to effectively utilize the Medicare Part A Program. The function of admitting residents to the MVH is very clearly specified within Chapter 9050. All of the Homes' admission personnel were fairly consistent in the way they managed these guidelines. Through staff interviews we identified/confirmed the volume of admissions, referral sources, admission sources, acuity, admissions committee format and activity, and any circumstances of admission denials that may have occurred during their tenure. Increasing the volume of admissions, which may

occur with certification, would most likely require some additional time being dedicated to this role.

Currently, all Homes' are collecting resident insurance information. Minneapolis just recently initiated this practice. The process in each of the Homes' would need strengthened if Medicare certification is pursued. It is critical to identify and collect all the necessary information upon admission. The lack of proper insurance documents would have a negative impact on Medicare, Medicaid, and other third party insurance revenues.

- Pharmacist – The pharmacy service regardless of whether provided in-house or through contracted services would have to track pharmacy charges differently and be notified promptly to maintain correct billing information on each resident. The record keeping for Medicare and Medicaid differs from the current system. The Medicare payment system includes a daily per diem rate that includes pharmaceuticals. Cost containment measures would become a significant part of the pharmacy service. If Medicare certified, it would be necessary for pharmacy to track medications for the various reimbursement systems to be used for billing.

- Therapist – Therapy is a key component of the Medicare / Medicaid program. Without appropriate therapy operations and training there would be significant opportunity for problems in both resident care and reimbursement. During our on-site visits, we interviewed therapists and nursing personnel regarding the current practices related to the therapy program. In the three smaller nursing homes, there would be insufficient resources to provide skilled therapy services according to the Medicare Part A and Part B programs. In Minneapolis, there may be sufficient resources but the program would require significant operational changes. Interviews with therapy revealed that currently licensed therapists are providing exercise programs as a part of their daily routine. This type of service is important to the overall program of the home but typically these types of programs are provided by the restorative nurses. Licensed therapists have a sophisticated level of training and as such are high cost services. Licensed therapists should be utilized for development and implementation of a rehabilitative treatment plan, as required by Medicare participation guidelines as opposed to providing care that could be performed by nursing staff.

  The rehabilitation philosophy of care would require a shift in culture surrounding the delivery of care, as referenced throughout this report. Adequate and sufficient documentation systems would need implemented to support the therapy department in the regulatory and reimbursement requirements if the MVH became Medicare / Medicaid certified. Nursing and therapy would need to work collectively in coordinating maintenance level programs through a restorative nursing

program. Therapy services would be reimbursable under both Medicare Part A and Part B. Sufficient billing records would have to be maintained.

- Physician Practices - Physicians are a key component to providing adequate and cost-effective services in any health care environment. The Medicare payment system includes a daily per diem rate which covers many of the services and resources provided at Medicare / Medicaid certified homes. While the daily per diem rate would not include physician visits, there would be significant implications to their standard practice decisions and resource utilization at the resident's level. Physician-directed resources, such as medications, laboratory and other diagnostics, therapy services, and various other treatments would be covered in the daily per diem rate. Cost containment measures, such as cost-benefit analysis and resource management, would be a vital part of effective and efficient care delivery under the Medicare program. In addition, the likely increase in resident acuity may require alterations in physician practice schedules and the amount of interface required between the physicians and the interdisciplinary team.

  The impact of Medicare certification on the practicing physicians would require further evaluation but would most likely result in system changes, education and training, and the development of resource management protocols. Physician visits would be billable under the Medicare Part B program and billing is typically the responsibility of the physician. This practice of billing Medicare Part B would impact how the homes currently calculate the cost of care and changes would be necessary should the MVH pursue Medicare and Medicaid certification.

D. Corporate Organizational Considerations

Medicare and Medicaid certified facilities develop and implement corporate compliance programs to ensure that adequate systems are in place to facilitate ethical and legal conduct. Implementing and maintaining an effective compliance program would require a substantial commitment of time, energy and resources. A corporate compliance program that ensures compliance with applicable federal and state statutes would be an important component of Medicare and Medicaid participation. While a compliance program is not a panacea guaranteed to eliminate waste, fraud, and/or abuse, an effective compliance program would assist the organization in assuring that federal and state resources would be utilized efficiently and programmatic requirements would be met if the homes become Medicare certified.

An effective corporate compliance program would typically be administered and monitored by senior leadership. The MVH has an existing corporate structure that could facilitate the creation, administration, and monitoring of a compliance program, should the

homes pursue Medicare / Medicaid certification. Essential elements of an effective compliance program include;

1. Designation of a compliance committee and compliance officer;
2. Written standards of conduct that clearly denote the organizations commitment to operating within all applicable regulatory and statutory requirements;
3. Written policies and procedures which direct the operation of the compliance committee, which includes; training of facility and corporate staff, duties and responsibilities of the committee, duties and responsibilities of management in promoting compliance, reporting and investigation of compliance concerns, and on-going monitoring strategies of regulatory compliance standards;
4. Record retention policies;
5. Compliance as an element of employee performance evaluations;
6. Conducting formal and informal training programs to communicate the regulatory requirements and guidelines for participation;
7. Initiating and communicating an effective communication mechanism for reporting of compliance concerns;
8. Comprehensive internal auditing and monitoring systems for critical operational areas;
9. Written policies, procedures, and documentation standards for addressing identified compliance concerns and initiating plans of corrective action; and
10. Reporting of compliance issues.

The existing multi-facility structure of the MVH necessitates standardized policies, procedures, and approaches that could be used as the foundation for a corporate compliance program, for Medicare / Medicaid certification for the whole organization. An effective and comprehensive compliance program is essential should the decision be made to proceed with participation in either or both the Medicare and/or Medicaid systems.

E. Report Conclusions/Recommendations

The Minnesota Veterans Homes may wish to consider reshaping their philosophy of care to be more consistent with the efforts of the national trend to "rebalance" the Long Term Care System. Rebalancing the system is a dominant focus of the Minnesota Health Care System as well as a nationwide initiative. The aging population is growing and the

demand for placement in the Veterans Homes will continue to increase. By reevaluating the care delivery model, the MVH may be able to begin to assist the veterans who have lesser care needs be cared for in a community setting or a less restrictive environment. A less restrictive environment is mostly desirable to the elderly as opposed to nursing home placement. This approach could benefit both parties. The veteran can maintain a higher level of independence until nursing home placement is imminent and the MVH can create more vacancies in the nursing homes for the post acute type veteran needing a higher level or skilled care. Additionally, if the MVH would follow similar trends than that of the traditional nursing home they would admit short term residents with excellent potential for discharge back into the community.

Recommendations for consideration if the MVH should choose to pursue Medicare and or Medicaid certification would be to:

- Establish a committee to examine MN statues, Chapter 9050 covering Admissions to determine new guidelines that would facilitate the admission of Veterans eligible for services under the Medicare Part A program
- Examine the discharge planning process and develop guidelines to support short term stays with use of community resources
- Examine new guidelines for admission screening for nursing facility care including assessing admissions utilizing the screening tool established for the Minnesota Medicaid program
- Examine the feasibility of offering Assisted Living or additional Domiciliary Care units particularly in the facilities that currently offer only nursing home care
- Conduct an assessment on the current population to identify residents who may be appropriate for a lesser level of care
- Conduct an assessment on the current population to identify existing residents who may be eligible for Medicaid benefits but have not applied for or are not currently receiving the benefit
- Provide education for the leadership team on home and community based services and other initiatives the state of Minnesota is using to decrease nursing home utilization
- Provide education for the residents, families, and community on alternative services available for long-term care services

- Develop policies to ensure that the homes' are collecting all third party insurance information and that admissions personnel assist the resident in Medicaid application if they are currently eligible for the program
- Evaluate the current ancillary services provided to residents that are currently paid for by the MVH that could be billed to third party insurances
- Examine the process necessary to restructure provider contracts to support Medicare and Medicaid billing opportunities in conjunction with evaluating the services that homes provide under the rate calculation