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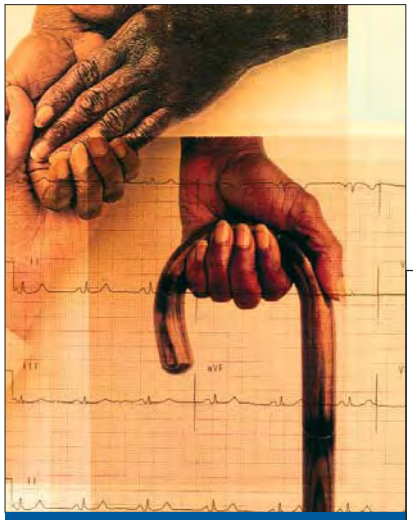

On the Cover

Long term care providers must strive to understand the critical shifts that are driving their businesses now and into the future. This month's feature *Megatrends in Long Term Care*, by Christopher C. Puri, Boult Cummings Conners & Berry PLC, discusses these major forces as six large "Megatrends" affecting long term care.

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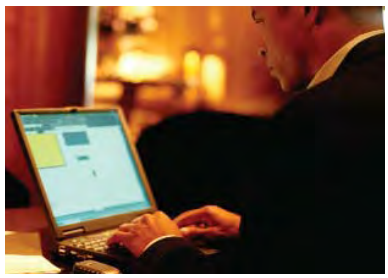

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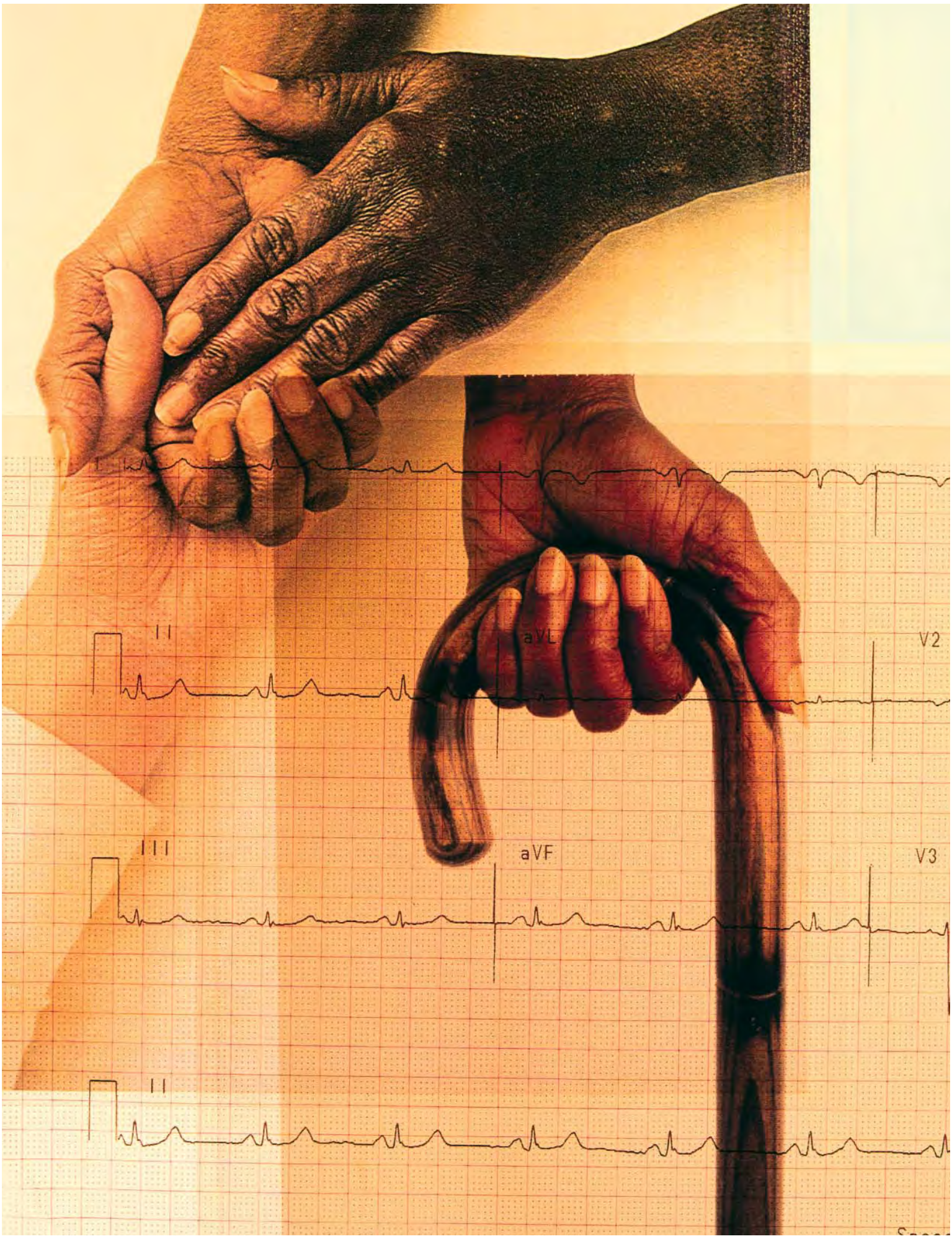
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Megatrends in Long Term Care

Christopher C. Puri, Boult Cummings Conners & Berry PLC, Nashville, TN

On September 25, 2007, General Motors (GM) announced that it had struck a deal with the United Auto Workers union (UAW) for a new labor agreement. By most public accounts, the core of the disagreement between the two sides had nothing to do with the thousands of UAW workers currently at GM plants. Instead, the debate centered on what healthcare was due to the 423,000 UAW retirees and spouses, and how to pay for it. The linchpin of the deal turned out to be GM's commitment to set up a trust fund for retiree healthcare, known as a Voluntary Employees Beneficiary Association, or VEBA. GM wanted to form the VEBA in order to get $51 billion in retiree healthcare debt off its books. In return for the hedge against rising healthcare costs,[1] GM will pay a guaranteed $30.9 billion between now and 2010, with potential additional payments of $1.6 billion depending on the sufficiency of the VEBA funding for the next 25 years. The VEBA will be run by an independent board overseen by the UAW.

So what does a labor dispute in the auto industry have to do with healthcare providers, and more specifically long term care (LTC) providers? A lot. The GM deal underlies a number of themes transecting the healthcare landscape. First, the payors of healthcare are searching for cost certainty from the exploding potential for future healthcare costs as baby boomers retire. By example, GM reduced its potential future costs for healthcare into a lump sum of certain dollars today. Second, beneficiaries of healthcare are being asked to share more and more in the risk and the cost of future benefits. By example, retiree beneficiaries are partially at risk for the proper management to maintain the solvency of the VEBA so that it can provide the contracted future benefits. Lastly, the "social contract" of healthcare in the "golden years" is being reshaped, and in many ways, completely renegotiated. Certainly many of the UAW retirees and current GM employees never envisioned such a dramatic change in the way their healthcare benefits are secured.

Understanding these "Megatrends" provides LTC providers, but more importantly their counsel who advise them, a sound foundation and framework for responding strategically, and taking advantage of these fundamental changes.

These cross-currents are not limited to simply large company healthcare cost discussions. The landscape for LTC providers also is changing because such a large segment of the population affected by these cross-currents are consumers of LTC. These changes are not always front page news, and many times they are not even noticed by those in the profession every day. Nevertheless, LTC providers must strive to understand the critical shifts that are driving their businesses now and into the future. This article tries to summarize those major forces into six large trends that we will call "Megatrends," borrowing from the term coined by futurist-author John Naisbitt. Understanding these "Megatrends" provides LTC providers, but more importantly their counsel who advise them, a sound foundation and framework for responding strategically, and taking advantage of these fundamental changes. The six "Megatrends" that affect the future of LTC or will change providers' approach to and business strategies in LTC are:

- Changing Reimbursement;
- Government as a Market Player;
- Standards of Quality;
- Diversification;
- Litigation and Liability Continue; and
- Advances in Technology.

Let us now examine the Megatrends in detail.

Trend 1: Reimbursement Will Decline on a Per Capita Basis

One of the most powerful and ever-increasing pressures on healthcare payors since the implementation of managed care in the 1980s and 90s has been the pressure to reduce the costs of healthcare. As the GM deal indicates, all of the players in the healthcare system are looking for cost certainty from the future costs that the baby boomer population surge will bring to the system. Part of the issue for GM was the desire to hedge their future employee costs in today's dollars. The goal is no different for federal and state governments, which are the payors of anywhere from 85% to 90% of total Medicare skilled nursing facility (SNF) and Medicaid nursing facility (NF) costs, and the majority of all LTC.

Both government and the profession itself are frantically pursuing the goal of outcomes measurement.

The federal and state governments are looking for ways to reduce the escalation of costs going forward. That escalation of costs is clearly borne out by the demographic imperative that an aging baby boomer population will create. Estimates suggest the future number of disabled elderly who cannot perform basic activities of daily living without assistance may as much as double from 2000 through 2040, resulting in a large increase in demand for LTC services. Spending on LTC services just for the elderly is estimated to increase by more than two-and-a-half times between 2000 and 2040, and could nearly quadruple in constant dollars between 2000 and 2050 to $379 billion, according to some estimates.[2] At these projections, there are simply not enough dollars in the system. While LTC providers may likely experience an overall growth in the total budget of Medicare and Medicaid on a per gross dollar basis, the per capita reimbursement will decline on an overall basis as those dollars are spread out over more people. Providers will have to find ways to deal with lower per unit reimbursement given that dynamic.

The changing reimbursement trends on the payor side are coupled with an increasing clamp down on the beneficiary side. Through the Deficit Reduction Act of 2005 (DRA), government is increasingly limiting the ability of beneficiaries to shelter assets and income in order to qualify for government paid for LTC. More of the payment responsibility is shifted to private individuals and private resources if they are seen by government as "able" to afford their own care. The lengthening of the asset transfer and look back periods in the DRA is likely to mean that more individuals will rely or have to rely on private resources to pay for care. Again, this government effort echoes GM's effort to provide more cost certainty to the reimbursement system by increasing the risk sharing by individual beneficiaries.

Trend 2: Government as a More Sophisticated Market Purchaser/Player

Another Megatrend that seems likely to continue is the effort of the federal government to increase its presence as a market purchaser of LTC. For the foreseeable future, federal and state governments are still the dominant purchaser of LTC. According to an analysis of government spending figures, Medicare and Medicaid payments funded approximately 70% of all long term care costs in the U.S. in 2005.[3] Conscious of its purchasing power, government continues to increase its influence as a market purchaser of LTC. In doing so, it plays an important role in changing the system through the services it pays for and how it pays for them.

One of the more marketed departures from traditional ways in which the government purchases LTC is its efforts to trade flexibility with consumers in exchange for fixed benefits that are not "provider specific." The Centers for Medicare & Medicaid Services (CMS) has accelerated its

endorsement and funding of a program called "Money Follows the Person" or MFP. Like a block grant, MFP allows an individual in an institutional LTC setting the option to freely control the spending of their benefit dollars in a community service alternative setting. The MFP Rebalancing Demonstration will support state Medicaid efforts to "rebalance" their long-term support systems by offering $1.75 billion over five years in competitive grants to states.[4] Specifically, the demonstration will support state efforts to transition individuals from institutions who want to live in the community, and promote a strategic approach to implement a system that provides person-centered services and improvement of such services in both home and community-based settings and institutions.

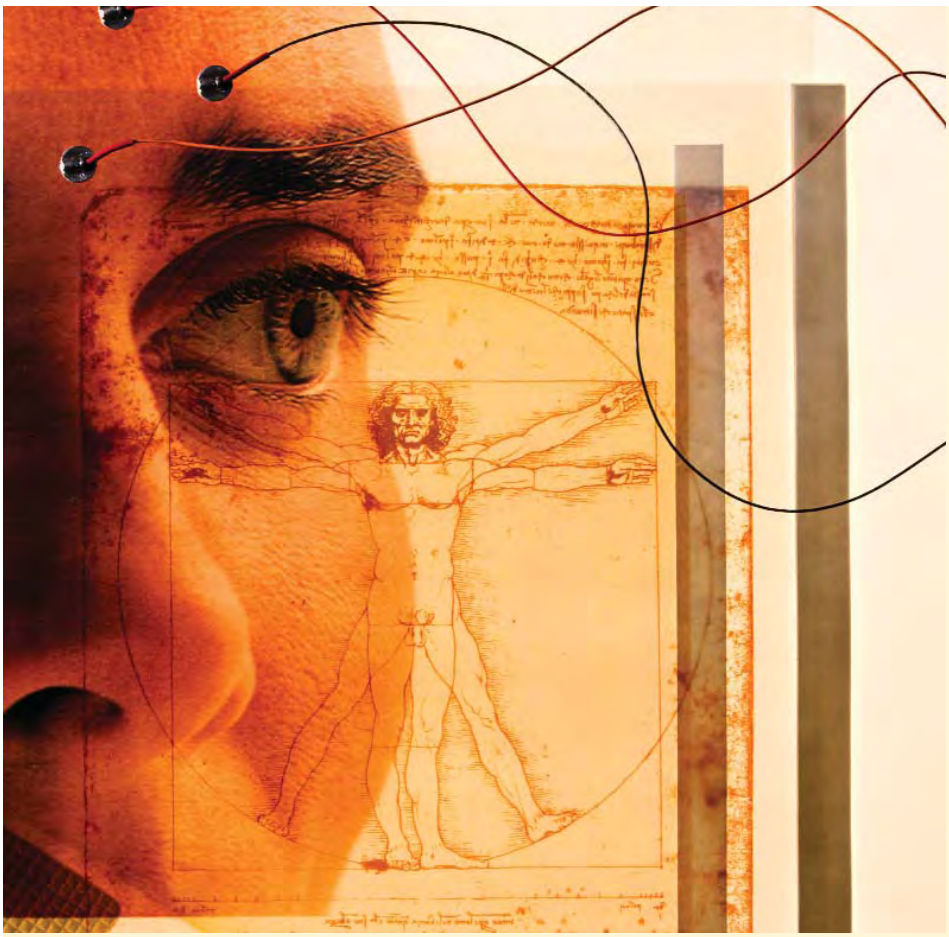
While government's desire in pushing these changes as an LTC purchaser is likely, to a large extent, budget driven, the new "consumer-directed" forms of purchasing and payment also capture the desire to re-engineer a system capable of providing benefits to the surge of individuals from the baby-boomer generation soon to be accessing LTC services.

Trend 3: Setting Standards of Quality

Another Megatrend related to the government's role as a market purchaser is its efforts in setting standards and benchmarking against common expectations of quality. These efforts will certainly mature in the next few years for LTC providers. Both government and the profession itself are frantically pursuing the goal of outcomes measurement. One of the most important features of these efforts is the integration of data to evaluate and drive quality improvement in facility operations, which payors, the government, and consumers have come to expect. While a common desire both in the industry payor community and for consumers, the concern of being on the low end of performance should be significant for facilities. Being in the low end of performance may likely mean that your facility has a much more difficult business situation in which to operate.

One very positive and exciting Megatrend that holds tremendous possibilities is the development and advancement of technology and the integration of technology into the care LTC facilities are providing.

Efforts such as "pay for performance" and recent attempts to withhold payment for medical errors in hospitals indicate that the government will increase its focus on the expectation that it only pays for services of a certain level of quality and value.[5] These new programs layer on top of an already and increasingly demanding survey process, especially for SNFs and NFs. In all these capacities, the government is playing an important role in setting the standards that are required for payment. In coming years, *demonstrable* quality will be expected for payment to an even greater and more sophisticated extent than it is now. As state Medicaid programs increasingly move to managed care programs in Medicaid and for dual eligibles, the ability of those managed care plans to selectively contract with pur-



chasers (LTC providers) based on quality outcomes becomes a paramount consideration. We may not be far away from seeing a situation where a quality outcome threshold will be set for payment, and may even drive the ability of particular providers to be involved in the program. Medicare Special Needs Plans already have such expectations, at least at a basic level.

Trend 4: Litigation and Liability Continue as a Method of Reform

It seems not a day goes by without another story about increased federal enforcement and increased private litigation against LTC providers. Perhaps we see increased litigation because of a desire by consumers to improve quality or as an effort by the federal government to ensure appropriate payment. LTC providers, especially nursing homes and assisted care living facilities, face another Megatrend in that they will continue to struggle with litigation that drains their resources for the foreseeable future. Examples of these efforts to increase liability and litigation in the system abound.

The DRA also funds significant program integrity efforts. The Medicaid Integrity Program, or MIP, includes provisions that provide for new enforcement mechanisms and new data driven tools to identify fraud on behalf of providers. Efforts at the federal level are also making it easier for potential qui tam relators to bring false claims lawsuits. Under DRA Section 6032, Medicaid providers must provide policies and certain education to employees and contractors to ensure they know how to identify and report fraud and abuse. As Medicaid funds and the control of them are increasingly decentralized, both consumers and government are going to be looking at litigation as a means to improve accountability for the dollars that are spent. A recent announcement by the U.S. Attorney's Office in Philadelphia indicates they plan to use the federal False Claims Act against personal care homes and hospices in the same way they have used it to prosecute nursing homes for substandard care. In the press release, the U.S. Attorney said that "the potential for patient abuse and neglect is great in personal care and boarding care homes where residents with physical and mental health problems and financial woes often sign over their Social Security benefits to the proprietors and are completely dependent upon them."[6]

Private litigation on the tort side also continues unabated. In many states, tort reform efforts have had some effect in reducing lawsuits. However, significant amounts of litigation still drain tremendous resources from LTC providers, especially nursing homes and assisted living facilities in terms of dealing with quality of care issues and quality of care lawsuits.

Trend 5: Advances in Technology

One very positive and exciting Megatrend that holds tremendous possibilities is the development and advancement of technology and the integration of technology into the care LTC facilities are providing. Technology offers LTC providers an opportunity to serve patients in a much more cost-effective fashion. Electronic medical records (EMR) will become the standard much more quickly than providers expect. Technology will give providers an opportunity to serve patients more cost effectively. It also affords providers with the opportunity to improve operations and improve compliance because, in fact, technology can solve many of an LTC facility's day-to-day challenges. However, the struggle for providers will be that the technology comes at a high price. Along with all of the other issues that LTC providers face, the capital investment in such projects will be challenging for them. The whole EMR

All of the previous Megatrends culminate in the clear view that LTC is in the process of being redefined.

system also needs to quickly develop interoperability standards so LTC and acute care providers can share data easily.

Technology also is giving seniors the ability to remain independent for a longer period than even before. For example, an adult child who resides hundreds of miles away from a parent can utilize technology to help monitor that aging parent, and home care services to provide certain aspects of the parent's care, rather than urging mom and/or dad to move to an assisted living facility. New forms of technology—including connectivity technology to remotely monitor and supervise individuals and robotics to actually provide services to them—hold the promise and challenge of replacing certain segments of how LTC is currently delivered. Without doubt, technology will also push forward the desire of the "age wave" of LTC patients to receive care where they want and on their own terms.

Trend 6: Diversification

All of the previous Megatrends culminate in the clear view that LTC is in the process of being redefined. Both at the government level and at the individual consumer level, there is more and more demand for home and community-based services. Governments are pushing for the payment of these services as additional options for individuals, and changing government reimbursement through programs like the New Freedom Initiative to "rebalance" the mix of payments for institutional versus community services. For example, the total Medicaid dollar increase in non-institutional care increased over $22 billion (compared to $8.1 billion for institutional care) and comprised almost 70% of the increase in total new Medicaid LTC spending dollars. (*See* chart below.)

It will be increasingly difficult for providers to survive in the new market if they offer only a single service on the continuum (i.e., nursing home care). As the overall global budgets flow across service types and increasing numbers of beneficiaries, capturing multiple revenue streams for multiple types of LTC services becomes an essential business strategy.

Providers are not passive players in this system, however. In addition to the external stakeholders, the early adopters within the LTC services profession are playing and have played a major role in this redevelopment of LTC. To respond to these changes, counsel can assist providers in the acceleration of the business strategy of diversification. By expanding the available services offered, a provider can naturally expand the opportunities to secure that funding at numerous points on the continuum, rather than just at a single point as a nursing home or assisted living facility, for example. The business strategy appears deceptively obvious, but LTC attorneys can play an important role both with the analysis and understanding of the business aspect (the "advisor" role) as well as with the analysis of how various state and federal laws and regulations make that strategy easier or more difficult (the "counsel" role).

Medicaid Spending for LTC (1995-2005)[7]

Year	*1995*	*2000*	*2005*
Non-Institutional Care	$12.8 (19%)	$21.4 (28%)	$34.8 (37%)
Institutional Care	$51.2 (81%)	$56.2 (72%)	$59.3 (63%)
Total (in billions)	$63.4	$77.8	$94.5

How the AHLA LTC Practice Group Is Changing as Well

To accommodate and support healthcare attorneys with their practice and to help them excel in this changing landscape, AHLA's Long Term Care Practice Group (LTC PG) is evolving. The main mission of the LTC PG is to serve those lawyers who work with LTC clients; to expand on that mission, the LTC PG is broadening its scope and the types of value added resources it provides for practitioners.

In the coming year, the LTC PG will focus more on expanding the LTC resources available to PG members so they can meet the challenges of understanding these Megatrends in long term care and help their clients understand and seek the opportunities within them. A lot of the evolution will come in the form of more material, information, and resource sharing for all providers along the so-called continuum. Resources and programs will focus on sectors including assisted living, home health and hospice, and home and community-based services, as well as higher-end services like LTC hospitals and geriatric psychiatric hospitals.

Two of the first places PG members will see this evolution will be in the name of Practice Group and in the upcoming Long Term Care and the Law program. The LTC PG will be recommending to the AHLA Board a new name that captures the goal of providing resources across the entire spectrum of LTC for its members. At the sister Long Term Care and the Law program in New Orleans this year, the programming will offer for the first time a new track on assisted living, residential care facilities, and senior housing. The Long Term Care and the Law Planning Committee has been hard at work with a group of provider leaders in those business sectors to develop content that continues on the long tradition of that program as being the best source for legal education of regulatory, operational, and business programs in LTC. The re-creation of the program schedule will allow Long Term Care and the Law to meet the demand that many in those sectors have expressed for a program that provides the same excellent education for other LTC business sectors as it has done for SNF and NF providers.

The coming "age wave" is already impacting Medicaid LTC reform and the evolution to a new LTC delivery system. The challenges for federal and state governments, beneficiaries, providers, and their counsel are numerous and varied. Those challenges also hold within the great opportunities for LTC providers who innovate and adapt their business plans, and perils for those who refuse to do so. As with nearly all issues in healthcare, those challenges also hold great opportunities for knowledgeable LTC attorneys to add tremendous value to their clients' business and provide needed and highly valuable legal services.

Christopher Puri is an attorney with the Nashville, TN firm of Boult Cummings Conners Berry, PLC's in their Senior Housing and Long Term Care team. He is also a member of the American Health Care Association Legal Committee, a past chair of the AHLA Long Term Care Practice Group, and currently serves on the AHLA LTC and the Law Planning Committee. His practice focuses his practice on providing ongoing counseling on regulatory, reimbursement, legislative, and business development issues for long-term care providers. Through his practice, he has been active in developing long term care policy at both the state and national levels.

End Notes

[1] GM spends $4.8 billion a year on healthcare, an increase of 80% in a decade. The company estimates healthcare costs account for about $1,200 per vehicle, which is more than the cost of steel. Ted Evanoff, *GM Plan Illuminates Crisis in Health Care*, INDIANAPOLIS STAR, October 8, 2007.

[2] Long-Term Care Financing: Growing Demand and Cost of Services Are Straining Federal and State Budgets. Statement of Kathryn G. Allen Director, Health Care—Medicaid and Private Health Insurance Issues Before the Subcommittee on Health, Committee on Energy and Commerce, House of Representatives. Government Accountability Office Report GAO-05-564T (Apr. 27, 2005), p.2.

[3] Medicare and Long Term Care—February 2007 Fact Sheet. Georgetown University Long Term Care Financing Project., p.2, *available at* ltc.georgetown.edu/pdfs/medicare0207.pdf.

[4] Deficit Reduction Act (DRA) of 2005, Pub. L. No. 109-171, § 6071.

[5] The Hospital Inpatient Prospective Payment System (PPS) rule includes provisions withholding increased payment for certain "preventable conditions." While only limited to hospitals at this point, program changes like this could certainly be incorporated into the SNF and home health PPS systems if CMS views them as a success.

[6] *BNA Health Care Fraud Report* Email (Oct. 3, 2007).

[7] Health Policy Institute, Georgetown University, based on data from B. Burwell, S. Eiken, and K. Sredl, "Medicaid long-term care expenditures in FY2005" (Cambridge, MA: Medstat, July 5, 2006, memorandum).

To join the Long Term Care Practice Group, go to www.healthlawyers.org/practicegroups. For information on the Long Term Care and the Law program, see the box in this feature.