Affinity Health Services

State of Minnesota

Department of Veterans Affairs

Minnesota Veterans Homes

Phase III Cost Benefit Analysis and Implementation Plan

Order of Contents

I. Executive Summary

The Minnesota Veterans' Homes (MVH) 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/or Medicaid certification. Affinity has identified the opportunities and challenges involved with this project including the financial impact on the various stakeholders. Affinity has also provided a Gap analysis for compliance with CMS participation. Additionally this report includes an implementation plan for each facility to be utilized should the MVH decide to proceed with certification.

This is the final of five (5) reports that have been issued to the Minnesota State Veteran Homes. This final report includes the following key issues:

- The potential costs and benefits associated with consideration of Medicare and or Medicaid certification;
- A brief summary of program eligibility;
- The impact of certain key regulations relative to the certification process;
- Opportunistic considerations for participation in the Medicare and or Medicaid programs independent of certification;
- The cost benefit impact for the Homes of participating in Medicare and Medicaid programs; and
- An implementation plan for each of the Homes should certification be pursued.

Currently, the MVH rely on three main sources of funding:

- Patient Pay funds or maintenance fees paid privately by the veteran toward their care (patient pay);
- Federal Per Diem (USDVA); and
- State Appropriations

Medicare and Medicaid certified State Veterans Homes (SVH) receive funding from three sources in addition to third party and governmental reimbursement. Homes

that successfully utilize third party programs have implemented many changes to their admission and discharge process. It is critical that the MVH adopt a different model of care and admission protocols, should they pursue Medicare certification. Without this adaptation, Medicare certification is not a fiscally viable option for three of the four MVH. Typically, when SVH services are provided under either Medicare and or Medicaid programs, a reduction in state appropriations is realized only by implementing the necessary operational changes.

Currently, more than one half of the SVH are Medicare and/or Medicaid certified. Many of these certified homes appear to have entered the program very early on in their infancy necessitating adoption of operating structures to support viability in these programs. Other SVH appear to have acquired certification in an effort to receive additional funding. In concert with other private sector organizations, many SVH are seeking additional funding sources in an effort to alleviate the amount of state appropriation subsidy.

Over the last decade, both the Medicare and Medicaid reimbursement systems have endured many changes. It has been well established that nursing home providers and health care providers in general have to quickly adjust to governmental and third party system and reimbursement changes. Presently, there are multiple proposed changes that will impact future reimbursement under the governmental payer systems. The most critical change anticipated in late 2010 is the change from the Minimum Data Set 2.0 (MDS 2.0) to the MDS 3.0. This change will most likely produce a myriad of modifications to providers' current operational systems and revenue realization. Future changes requiring provider adaptations including Health Care Reform are the reality of operating under these governmental programs. Both Minnesota Medicaid reform and the National agenda for Long Term Care has intently focused on shifting funds to home and community based services. In addition, the financial crises the nation is currently facing will most likely mandate further changes. While the MVH are not currently enrolled in these reimbursement programs, it is critical to consider the future unpredictability of these programs as part of the decision-making process in contemplating the pursuit of certification. Knowledge and understanding of the frequent changes that occur with payment systems is critical to remaining viable in this industry.

Based on our review of the Medical Assistance regulations that govern Minnesota Medicaid, there are some exceptions to the program specifically for the State Veterans Homes that are not applicable to the private sector. These exceptions make it possible for the MVH to seek Medicaid certification.

Most recently, the VA Per Diem Regulations (Pub. L. No. 109-461), known as 70% Disabled Veterans Program, was published as a final rule in the Federal Register Vol. 74, no.81, Wednesday, April 29, 2009. Implementation of this regulation would create additional risk potentially requiring increased reliance of the SVH on State appropriations, particularly for those homes that receive Medicare and Medicaid funding. Non-certified SVH are also at risk to incur increased reliance on State appropriations due to how this program is being implemented. It is our understanding that various members of the SVH and their counsel are working diligently to delay implementation of these regulations to allow for examination and impact analysis to be completed.

It is important to note that the information and analysis provided within this report is relevant to MVH key decision-makers in their consideration of pursuing certification through either the Medicare and or Medicaid programs. This report is not intended to provide an analysis or opinion of the MVH operations in respect to their current operating structure and programmatic requirements.

It is important for key decision-makers to consider the impact of these programs under two (2) separate and distinct scenarios. As a result, the ensuing analyses provide two (2) consequential scenarios. Under the first scenario, we provide analysis and summary of the cost benefit for the MVH if they pursue certification and continue with the same operating structure, including the Admissions and Waiting List rules required under Chapter 9050 Department of Veterans Affairs. Secondly, we provide an analysis and summary of the cost benefit to the MVH should they pursue certification and resultantly change certain operating practices, including the Admissions and Waiting List rules under Chapter 9050.

We recognize our role in this engagement to provide compulsory information and data to afford MVH key decision-makers the opportunity to make informed decisions regarding pursuit of the certification process. Understanding the impact to the organization is a fundamental consideration in this decision making process. Ultimately, the decision to pursue certification is a management decision. Affinity has not been engaged to act in a management capacity.

II. Methodology

Affinity Health Services, Inc. has outlined the information that key decision-makers should have in order to make a well-informed decision regarding pursuit of Medicare and or Medicaid certification. This information is presented throughout the remainder of this report in a feasibility and cost/benefit format. The report considers impact to the current operations, business practices, clinical practices, care delivery systems, and the financial outcomes to the MVH under the Medicare and or Medicaid programs.

The Information and comments in this Phase III report are a direct result of the on-site visits, document reviews, interviews, observations, analysis, and research performed by our professional consulting staff.

The Affinity team has transitioned into the final milestone of this engagement by preparing the Phase III report that provides financial projections and costs associated with the Medicare A, B, and D Programs and Medical Assistance. The forecasts presented in this report represent two (2) models for consideration for MVH. As outlined above, our analysis, forecasts, and projections includes two (2) situational scenarios representing MVH impact of these programs while maintaining current operating structure as well as impact of these programs under an operating structure reflective of that in homes that successfully participate in these programs. The two (2) models are labeled as follows:

- MVH Current Operating Structure
- MVH Industry Standard Operating Structure

Expense Methodology

During the initial data-gathering phase of this engagement, we analyzed MVH expenses to identify operating costs per patient day for each of the facilities. In order to accurately identify these costs, we had to perform the labor-intensive exercise of realigning the provided MVH financial reports into an industry standard format. It should be noted that currently the MVH are not required, for purposes of reporting, to utilize or to allocate their expenses into cost centers that are standard for the industry. This conversion and realignment of expenses into appropriate cost centers serves as the basis for stating the MVH financial impact. In instances where it was impossible to identify the MVH cost, we utilized Affinity proprietary database costs to determine MVH impact.

It is also important to note that the expense realignment process was an interactive process between our consulting team and the MVH financial department staff. MVH finance staff reviewed the data for verification purposes. This validated cost information is utilized throughout the analysis. In instances where we were not able to identify specific costs or where costs may not be currently incurred in the organization, industry averages and Affinity proprietary data was used to determine anticipated financial impact to the organization.

Additionally, our methodology and assumptions contained in the report includes:

- Average wage information provided by MVH and then multiplied by the reported benefit factor to determine average labor costs;
- Projected training costs included in the report are based on Affinity's experience in MDS, revenue management and collections, governmental cost reporting, and other pertinent training associated with Medicare and Medicaid certification;
- Projected Software costs were based on average costs provided by industry software vendors; and
- Projected costs associated with Life Safety Compliance were based on estimates of the labor and materials to achieve substantial compliance with these requirements.

Revenue Methodology

The MVH has no prior history to enable forecasting Medicare Part A and Medicaid room and board rates. Therefore, the RUG scores that were retrieved from the MVH computer system were utilized to establish the rates, as they would be calculated with the Homes current resident caseload and acuity. Although it has been established that there are accuracy issues with the MDS, it is the most reliable and documented data available to forecast rates. The DOM care facilities did not have MDS data therefore; the State average Medicaid rates were used for those forecasts.

Other notable revenue projection methodology includes:

- An average Maintenance revenue per patient day for each facility was identified;
- Projected Medicare Part A patient days for each facility were established from the admission and discharge census data provided by each of the Homes; and

- Projected Medicaid patient days were identified in two of the homes. We utilized the average of these Medicaid days for purposes of the financial projections which we believe to be conservative

III. Analysis

A. Program Eligibility

a. Pharmacy

Currently, the MVH utilizes both internal and external pharmacies. There are benefits to both programs. First, the price that the MVH achieves by ordering via the state contract with McKesson is the best pricing that we have identified on the market. In contrast, the internal pharmacies do not bill third parties and there is a lack of internal resources with appropriate knowledge and skills to perform the billing functions. The evaluation of the costs associated with in-house billing is contained in the Medicare Part D analysis. The only criterion for the in-house pharmacy to become eligible to bill Medicare Part D is for completion of the application process for each plan covered under the Medicare Part D program. Our evaluation did not identify any barriers precluding the MVH from independently billing Medicare Part D and other insurances should the decision be made to participate in the Medicare Part D program.

Fergus Fall has a contractual relationship with a contracted pharmacy specializing in long-term care. One of the advantages of this contractual relationship is that they assume the responsibility of billing for Medicare Part D, Medicaid, and other third party payers. In the case of Fergus Falls, this contractual relationship has proven valuable from both a service and cost perspective. Additional management considerations include savings in physical space and personnel resources currently assumed by those facilities with in-house pharmacy.

We recommend that any contracted pharmacy relationship pursued by MVH require the contractor to bill all third party insurances for payment of all pharmacy items as a condition of the contract. This is standard practice within the long-term care industry.

b. Rehabilitation

Currently, the MVH utilizes both contracted and in-house therapy. The rehabilitative therapy services currently delivered does not meet the eligibility requirements under either the Medicare Part A or Part B programs. Additionally, there is a lack of substantial documentation systems and processes to support billing of the Medicare or Medicaid programs. Much of the rehabilitative service currently delivered to MVH residents' does not meet the requirements of the Medicare and or Medicaid programs and thus do not qualify to be billed under these programs for reimbursement.

Rehabilitation therapy programmatic changes are necessary for reimbursement of these services under the Medicare and or Medicaid programs. In the ensuing cost benefit analysis we use industry standard average costs and revenues to forecast reimbursable Medicare Part A and B potential revenues and expenses related to therapy. Our forecast assumes the MVH's use of exclusive contracted therapy services in all facilities. Meeting eligibility requirements typically is best served throughout the industry, with contracted rehabilitation services specializing in the long-term care industry, in those nursing homes that are Medicare and or Medicaid certified. The cost of training internal staff and providing the necessary monitoring of systems is typically difficult to achieve with the use of in-house therapy staff. It is not uncommon for the organization to negotiate with the contracted therapy company to consider employing and training the current in-house employees, when a transition from in-house therapy to a contracted provider is made. Typically, contracted services are more cost effective as contracted providers have the industry expertise to respond quickly to changes in payment systems. They have sufficient resources to provide the necessary education and training to the front-line therapy staff, have established best practice documentation and care delivery systems, and they are able to monitor and control service delivery and staffing needs based on caseload in the most efficient means.

c. Skilled Nursing Services

The definition of skilled care under the Medicare guideline includes;

> *"If the inherent complexity of a service prescribed for a patient is such that it can be performed safely and/or effectively only by or under the general supervision of skilled nursing or skilled rehabilitation personnel, the service is a skilled service; e.g., the administration of intravenous feedings and intramuscular injections; the insertion of suprapubic catheters, ...etc.".*

Additional examples of skilled services include, but are not limited to:

- Intravenous or intramuscular injections and intravenous feeding;
- Enteral feeding that comprises at least 26 percent of daily calorie requirements and provides at least 501 milliliters of fluid per day;
- Naso-pharyngeal and tracheotomy aspiration;
- Insertion, sterile irrigation, and replacement of suprapubic catheters; and
- Application of dressings involving prescription medications and aseptic techniques.

Medicare guidelines indicate that skilled services could also be:

- The development, management, and evaluation of a patient care plan;
- Observation and assessment are skilled services when the likelihood of change in a patient's condition requires skilled nursing; and
- Teaching and training activities, which require skilled nursing personnel to teach a patient how to manage their treatment regimen.

The RN's and LPN's at MVH are all professionally trained and licensed to provide care and services that any resident may need. The care and services that the residents at MVH currently require and receive does not consistently meet the definition of skilled Medicare services within the current guidelines. However, with appropriate training, documentation guidelines, and implementation of systematic changes these same residents may have the potential to be a Medicare skilled resident if all other eligibility requirements were to be met

Through our interviews and observations, it was identified that the MVH typically do not admit residents who require a higher technical level of care,

such as intravenous therapy, tracheotomy care, and advanced wound care. Through the mock survey process, we identified that should certification be pursued, the MVH would need to establish or revise policies and procedures as well as provide for nursing in-services for technical skills seldom utilized.

To receive payment for Medicare skilled services the certified facilities are required to complete and submit an accurate and timely Minimum Data Set (MDS) assessment. Through the mock survey process, it was consistently identified that the MVH did not follow all of the established guidelines for completion of the MDS resulting in inaccurate assessments.

To successfully bill and be paid for providing Medicare skilled services, certified facilities must follow specific guidelines for Medicare eligibility, length of stay, covered services, physician certification of skilled needs, and utilization review. Some of the staff at MVH has not been exposed to these guidelines and should Medicare certification be pursued, staff at each Home would need in-depth Medicare training.

An essential part of providing Medicare skilled services is documentation of services provided and resources utilized during the skilled resident's covered stay, such as:

- Skilled nursing care provided
- Documentation to support accurate MDS coding
- Accurate and timely nursing, social service, nutrition, and activity assessments
- Care plans
- Physician certification, orders, and routine progress notes
- Skilled Rehabilitation evaluations, treatment documentation, and monitoring of progress toward goals
- Restorative Nursing programs and documentation
- ICD-9 Diagnosis coding
- Case Management and interdepartmental communication
- Tracking of RUG and resident days for billing purposes
- Beneficiary notices
- Standardized policies
- Corporate Compliance

Documentation includes information for billing, provision of supplies and equipment, computer programming, and HIPPA compliance. Should the

MVH pursue Medicare certification, it is essential that training on the aforementioned documentation requirements be completed and the facility staff has a comfort level with these requirements.

d. Dom Care

The Domiciliary program at Hastings and Minneapolis is a board and care program that focuses on providing medical and mental health in a non-institutional setting. The residents do not require skilled nursing care and often transition back into the community.

If the MVH should choose to pursue Medicaid certification for its DOM care homes, the MDS becomes a critical factor in Medicaid reimbursement. The MDS is the basis of the Minnesota Medicaid Case Mix Classification System. Staff completing the MDS must be skilled at completing the assessment tool in accordance with the guidelines dictating accurate completion. Education and training on the entire Resident Assessment Instrument (RAI), including the completion guidelines, is critical for a successful transition.

The Minnesota Medicaid Case Mix System mirrors federal CMS guidelines for completion and submission of required tools. The Minnesota Case Mix System includes a Case Mix Review (CMR) audit process, with routine auditing of MDS's and reimbursement RUG levels for accuracy through the state program. As such, the reviewers select a percentage of MDS assessments completed at each certified facility and audit for accurate payments based on correct coding of the MDS reliant on medical record supporting documentation systems.

In concert with the Medicare program requirements, Medicaid requires accurate MDS data coding to support assignment of residents into the appropriate RUG group for payment purposes. Interdisciplinary team documentation and billing systems must work in tandem with the Medicare and Medicaid Programs.

Should the MVH pursue Medicaid certification for the DOM Care Homes, facility staff responsible for care delivery documentation will need specific education, training, and assistance with implementing appropriate systems necessary to properly complete and support accurate MDS completion, electronic data submission, documentation, and preparation for CMR visits. In-depth training on the nuances and requirements of the Medicaid Case

Mix Reimbursement System, re-classification rules, and program responsibilities would be a priority for the MVH DOM care homes. Infrastructure implementation for electronic billing, including training needs should also be considered for successful program implementation as a consideration of Certification.

B. State Veterans Homes Regulation Analysis

a. Department of Veterans Affairs – Chapter 9050

- Admissions and Waiting List

Should the MVH decide to pursue Medicare certification, it would be preferable for the Homes to operate under an admission model that accommodates admissions from acute care settings. In order to achieve this, it will be necessary to adopt changes to the current 9050.0055 Admission and Waiting List practices. The importance of operating under a revised admission model is addressed throughout previously issued reports, particularly the Phase IIa report. Should the MVH elect to become Medicare certified and continue to operate under the current waiting list model while maintaining the same occupancy levels and acuity, only one (1) MVH home would benefit from attaining Medicare certification under the Medicare Part A program. Although three of the four nursing homes would not benefit from the Medicare Part A program under their current admission model, these Homes' could benefit from Medicare Part B, Medicare Part D, and the Medicaid programs.

- Care Services "Provided"

9050-1030 addresses the care and services to be provided to the MVH. The definition of "Provided" services that are identified under Subpart 1a. include: physician services, rehabilitation services, transportation and other ancillary type services. Many of the services included in this regulation, which are currently provided by the MVH, can be billed to Medicare and other third party insurances. "Provide", according to the regulatory definitions included in 9050 requires the MVH to provide and pay for inclusively the delivery of the defined ancillary services. This regulation appears to be in direct conflict with billing of third party insurances for these items contained in this Subpart.

Cost of Care Calculation

As suggested in a previous report, the MVH may want to analyze their current rate setting process (cost of care calculation) to determine if costs of particular services currently included within the rate setting calculations are billable under Medicare B, Medicare D, or other third party insurances. This regulation (9050.0500 Cost of Care) may be in direct conflict with the recommendation for the MVH to bill other parties for these ancillary services. Adjusting the cost of care calculation methodology should correct any potential duplication for ancillary services. Additionally since the 70% Disabled Veterans Program pays the facility the lesser of this calculation or the Federal Per Diem, reexamining this process is recommended. Currently all the Cost of Resident Care Summary reports indicate each MVH cost of care is less than the forecasted VA per diem rates with the exception of Minneapolis.

b. VA Per Diem Rates - 70% Service Connected

The 70% Disabled Veterans Program was enacted December 22, 2006. The regulations were not issued until April 29, 2009. In essence, this regulation authorizes the Department of Veterans Affairs to pay higher all-inclusive per diems for care provided to Veterans with service-connected disabilities (70%) in State Veterans Homes. These regulations are complex and predicted to have a significant impact on all the SVH, regardless of whether or not they participate in either the Medicare or Medicaid programs. These VA per diem rates are reported to range from $280 to $310 per day. The SVH is paid the lesser of this published federal per diem rate or the calculated cost of care, as determined under OMB Circular A-87. It is projected that the OMB A-87 rate may frequently be less than the VA Published Per Diem Rate.

Another significant issue is the high cost services that are typically billed for by outside providers that include Dialysis, CT Scans, MRI, Chemotherapy, Radiation, Prosthetics, Emergency Room and Medications. It appears that this regulation prohibits the SVH to have these services billed to Medicare Parts B and D provided to a service-connected veteran eligible for this program. The VA per diem payment under this Program, are payment in full to the SVH. These ancillary services are costly to provide.

Should the MVH become Medicare and or Medicaid certified and these regulations remain intact, the Homes' would likely receive less reimbursement for days beyond the 20th day of a veterans Medicare Part A stay. The VA has said that it may allow SVH to bill Medicare Part A for days 1-20 of a veteran's stay. Because the veteran has a co-pay under the Medicare Part A program after day 20 and there is not a co-pay required for the VA per diem, the veteran would likely apply for the Per Diem option if they have no other insurance. Under the veteran per diem program there is no requirement for the veteran to pay. The same financial scenario may hold true for the Medicaid resident depending on the particular treatment plan involved. There is insufficient data available at this time to accurately project the impact of the 70% Disabled Veterans Program.

These regulations have generated a high level of anxiety and political activity amongst the SVH. The SVH, as a whole, is predicted to lose a significant amount of money from these new regulations, particularly those that are already Medicare certified. There are currently thirty-one (31) States that receive funding under the Medicare program. The federal per diem reimbursement will most likely be less than what they currently receive. The non-Medicare certified homes have less exposure to the negative financial impact of these regulations because they are not receiving high levels of reimbursement at the present time.

Various stakeholders within the SVH are working diligently to lobby Congress to pass a clarifying amendment to Section 211 of the Veterans Benefits, Health Care, and Information Technology Act of 2006 (Pub. L. No. 109-461) (the "Act"). Through an amendment, stakeholders are seeking to postpone mandatory implementation of this regulation for a two (2) year period so that the financial impact of this regulation on State Veterans Homes' can be adequately identified. This proposal includes provisions to allow SVH, in the interim, to serve service-connected disabled veterans under existing VHA Community Nursing Home Provider Agreement (aka "ProVA"). Part of this amendment calls for The National Association of State Veterans Homes ("NASVH") to report to the Committee on Veterans Affairs of the US Senate and House of Representatives with any recommendations that it has to modify the provisions of the Act at the end of 18 months. Finally, during this time, cost and payment data for residents of Medicare-certified and Medicaid-certified SVH shall be compared among the Program, existing Medicare and Medicaid programs, and contracted programs between the VA and private

nursing homes for the care of the veterans with service-connected disabilities.

c. Medicare and Medicaid Regulations

a. Nursing Home Bed Moratorium

Although the Minnesota State legislature declared a moratorium on Medical Assistance licensure and certification of new nursing home beds and construction projects that exceed $1,000,000, the Commissioner of Health authorized an exception. The Commissioner of Health, in coordination with the Commissioner of Human Services, may approve the addition of a new certified bed or the addition of a new licensed nursing home bed under certain conditions. The conditions are outlined in MN Statute 144A.071 Subdivision 3(b) stating that an exception to the moratorium can be issued if the facility is to be operated by the Commissioner of Veteran's Affairs. It is our recommendations that the MVH have their legal counsel contact the appropriate parties in regards to regulations regarding bed moratorium for a thorough interpretation of this regulation.

b. Provider Surcharge

The Minnesota Statute 256.9657, states, "(a) Effective July 1, 1993, each non-state-operated nursing home licensed under chapter 144A shall pay to the Commissioner an annual surcharge according to the schedule in subdivision 4. The surcharge shall be calculated as $620 per licensed bed."

The MVH are state operated homes and therefore appear to be excluded from the surcharge; however, it is our recommendation that MVH legal counsel contact the appropriate parties in regards to the Provider Surcharge.

c. Long-Term Care (LTC) Consultation Services

Long-Term Care Consultation Services include a variety of services designed to assist elders and their families make decisions about long-term care needs. This service promotes the provision of long-term care services in the home of the beneficiary. Long-term care consultants assist those needing services to choose services and supports that reflect their individual needs and preferences.

All applicants to certified nursing facilities, including certified boarding care facilities, are screened by Long-Term Care Consultation Services prior to admission for nursing facility care regardless of income, assets, or funding sources. The federally mandated Pre-Admission Screening (PAS) program assesses an individual's health status and level of independence in key areas of daily living to determine if he or she requires this level of service. This assessment also "screens" for identification of mental illness or mental retardation in order to prevent inappropriate admissions to nursing facilities of individuals who need different services.

One of the exemptions from the federal screening requirements is an individual who has a contractual right to have nursing facility care paid for indefinitely by the veterans' administration.

The payment for long-term care consultation services for each county must be paid monthly by the certified nursing facilities in the county. The monthly amount to be paid by each nursing facility for each fiscal year is determined by dividing the county's annual allocation for long-term care consultation services by 12 to determine the monthly payment and then allocating the monthly payment to each certified nursing facility based on the number of licensed beds in the nursing facility.

d. Conditions of Participation – Medical Assistance

Minnesota Statutes 256B.48 are the regulations for the Conditions of Participation for Medical Assistance. Certain areas of these MN statutes are worthy of discussion. The first significant item is the MN regulations regarding charging practices. Under most scenarios a Medicaid certified home couldn't charge a private paying resident a higher rate than the Medicaid rate. The exceptions include charging for a private room and certain situations for residents with special services.

The reporting requirements for Medicaid cost reporting that are referred to in our cost report analysis require nursing facilities without a certified audit to submit its working trial balance. The costs contained in the cost report shall be in sufficient detail to support the facilities cost report filing. We provided a significant amount of recommendations regarding this level of accounting detail to assist the

MVH to meet these reporting requirements should they pursue any type of certification. Attention to this type of detail in reporting is critical due to the regulations that penalize a nursing facility financially for failure to submit accurate reports.

Lastly, providers in Minnesota that have Medicaid certification are required to have Medicare certified beds. This requirement is typical in most states. The states require this regulation to ensure that nursing homes utilize a resident's Medicare benefit prior to utilizing State funds.

e. Conditions of Participation - Medicare

The law guarantees to Medicare beneficiaries that payment will be made for health services furnished by entities that meet the requirements of the Social Security Act. Health care entities, such as certified skilled nursing facilities, must qualify for participation in the programs and maintain standards of health care consistent with Conditions for Coverage requirements.

State Survey Agencies perform initial surveys (inspections) and periodic re-surveys of all providers. These surveys are conducted to ascertain whether a provider meets applicable requirements for participation in the Medicare and/or the Medicaid programs, and to evaluate the performance and effectiveness in rendering safe and acceptable quality of care according to state and federal regulations.

A nursing facility obtains Certification only when the State Survey Agency officially recommends that the health care entity meet the Social Security Act's provider definitions, and the provider complies with the standards required by federal regulations. Any nursing home that chooses to obtain Medicare and/or Medicaid certification must meet these requirements.

Affinity conducted a Gap analysis (mock survey) in each MVH to determine each facility's individual compliance to federal regulations necessary to obtain Medicare certification, should the MVH choose to pursue. The mock surveys were conducted in the same manner in each MVH Home utilizing the same approach, process, and tools. Each facility's operational practice was compared to the corresponding federal regulatory requirement. Gaps between the current facility practice and the federal

requirements were identified. A report was previously issued by Affinity that provides the MVH with information regarding MVH overall compliance with federal requirements as well as specific findings in each Home.

The observations and outcomes identified through the mock survey process serves as the primary basis for our recommendations in regard to staff education and training needs, staffing needs, policy development, and care delivery system changes. The associated costs involved with each of the ensuing recommendations are included in this final report.

The Implementation Plan phase of this report should assist the Central Office personnel in identifying and implementing the necessary actions should the MVH choose to pursue Medicare and/or Medicaid certification.

f. Life Safety Code

A standard life safety mock inspection was completed in each Home to evaluate compliance with the Life Safety Code and fire and building safety standards, which are developed, updated, and published by the National Fire Protection Association. These requirements have been adopted by the federal government for nursing home operations and as such are part of the federal requirements of Medicare participation.

Affinity conducted mock inspections that included visual inspection and observation as well as interview with key staff. The outcome of each inspection was included in a previously issued report dated August 31, 2009. Costs associated with correction of identified issues are included later in this report.

Any nursing facility that is considering Medicare certification or is Medicare certified must meet the requirements of the Life Safety code inspection. The MVH is accustomed to being evaluated for compliance to Life Safety code because they maintain state licensure status and life safety compliance is part of this status.

g. Minimum Data Set (MDS) 3.0

The Final Rule for SNF PPS published in the *Federal Register* on Aug. 11, 2009, changes the rate setting methodology in which Medicare reimbursement is determined. Resultantly, these changes to the Medicare reimbursement system will create a need for Medicare certified nursing homes to educate, train, and implement revised systems to manage skilled

resident care under the newly revised SNF PPS system. Although the Medicare reimbursement system has undergone slight amendments in rate setting and methodology since the inception of PPS in 1999, this change represents a drastic alteration with resulting negative financial impact to SNF PPS providers.

Two major components of the revised rules will affect providers in fiscal 2010, effective Oct. 1, 2009 and fiscal 2011, effective Oct. 1, 2010. Initially, there is a significant change in the recalibration of the case-mix indices (CMI) that will affect the rates for Medicare A SNF PPS. Secondly, is the move from a RUG-III to a RUG-IV reimbursement system, which will occur in tandem with the implementation of MDS 3.0 on Oct. 1, 2010.

It is anticipated that the changes published in the Final Rule will reduce payments to Medicare skilled nursing facilities by $360 million, or 1.1 percent below payments received in FY 2009. This adjustment is a federal effort to rebalance a prior year adjustment to the case-mix indexes (CMI's) and is intended to better align Medicare payments with costs.

Transition to the RUG-IV system increases the number of payment categories from the current 53 to 66. The SNF payment rates for each RUG group will also change. This effect will create an overall reduction in payments to a majority of Medicare nursing home providers because very few residents will qualify into the highest paying RUG categories, such as the Rehab / Extensive Service or the Extensive Services categories under the RUG-IV system. It is anticipated that this change will have little to no impact on the MVH Homes because residents cared for in the Homes currently do not receive the service qualifiers for these categories.

The MDS 3.0 RAI manual is expected to be published in October 2009 according to the CMS Implementation timeline. The MDS 3.0 includes a myriad of changes to the rules governing MDS coding, i.e. look-back periods for key services, activities of daily living resident performance and staff support provided, and cognitive performance coding and classification. The most significant changes we have identified are as listed below:

- Elimination of Section T - Therapy projections currently allowed on the 5-day Medicare MDS assessments;
- Modification of defined look-back periods to include only in those services provided in the SNF;
- An increase from 53 to 66 payment categories;

- Revisions to the ADL index score, which serves as a key criteria for reimbursement purposes;
- Changes to OMRA requirements marking the end of rehabilitative therapy; and
- Changes to concurrent therapy

The combination of the per diem rate changes and the probability of residents no longer qualifying for the higher RUG categories is a major concern for all Medicare skilled nursing providers. We are not able to accurately project the impact of these changes to the MVH Homes because the Homes' do not currently provide rehabilitative or extensive nursing services. The Medicare Part A financial impact and rate calculations are conservative estimates and therefore are at less risk for significant decreases as a result of these changes.

The MDS is a recurring theme throughout the report. These tools have an impact on both the financial and care aspect of the Homes. This assessment is analyzed for many different purposes and by many different parties. Just recently, the SVH began submitting the MDS to the VA. We believe it is worthy to recommend that regardless of the MVH decision to pursue Medicare and or Medical Assistance, the MDS and its accuracy needs to be a focal point for the organization.

h. Quality Indicator Survey (QIS)

The Quality Indicator Survey (QIS) is a revised nursing home survey process developed under CMS through a multi-year contract with the University of Colorado and the University of Wisconsin. The QIS is a staged nursing home survey process for the systematic and objective review of all regulatory areas including systematic methods to focus on selected areas for further review once the initial, comprehensive reconnaissance is completed.

Minnesota has already been selected as one of the first states to begin implementing the new process. It has been documented in various trade newsletters that all surveys in Minnesota will most likely be the new QIS survey rather than the traditional survey in the year 2010.

Through our investigation, we were informed by the MDH, that should a MN nursing facility apply for Medicare Certification, which requires a certification survey, that survey would most likely be performed via the traditional method versus the QIS survey process. However, this information could not be guaranteed by MDH; therefore, should the MVH choose to pursue Medicare certification, the survey preparation and

training plan should include both the traditional survey process and an overview of basic QIS methodology.

D. RUGS, Productivity, and Resident Acuity

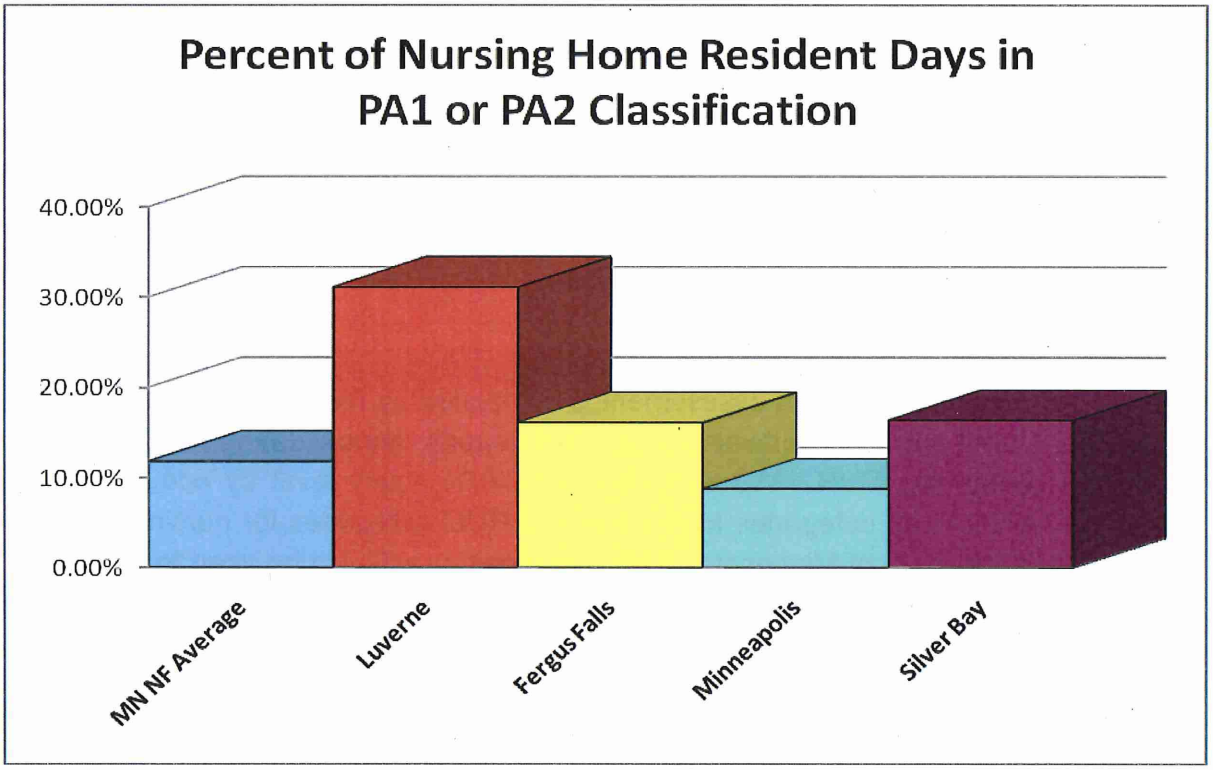
The RUGS distribution scores in the MVH represents lower acuity in comparison to average distributions of other Minnesota nursing facilities, average distributions in other states, and organizations in which Affinity has experience. There are many variables contributing to this lower than average acuity. Among those are the lack of direct hospital admissions, the exclusion of certain skilled services from admission to MVH Homes, and a different emphasis on discharge planning. It is important to note that based on our on-site record reviews, observations, and interviews that collectively, the Homes' most likely have higher acuity needs in activities of daily living than what is currently documented on the MDS assessment. We believe the likely assessment inaccuracies compounds the seemingly low acuity demonstrated in the chart, which follows.

Because the MDS assessment is completed by the MVH, we were able to utilize the MVH software to generate reports demonstrating resident acuity within the MVH. We evaluated the MVH acuity level by comparing the MVH RUG categories to the average RUG categories for nursing facilities in the state of Minnesota. This methodology will also be used to determine the MVH facilities Medicaid rates for the purposes of the ensuing cost benefit analysis.

The chart, which follows, indicates the percentage of resident nursing home days in the lowest paying RUG categories, PA1 or PA2. Residents with the fewest care needs and resource utilization are classified into these two categories. They typically include residents without special care conditions, nursing rehabilitation needs, and those without need for much assistance with activities of daily living. Although the data for the Minnesota nursing homes is reflective of 2007 and the MVH data reflects the resident population in 2009, it is comparable as it demonstrates the well documented trend occurring in the state of Minnesota to discontinue admitting the lower acuity resident and shifting nursing home care towards accommodating those residents requiring higher levels of care.

The chart compares each of the MVH skilled nursing facilities resident acuity with the average acuity in the state of Minnesota. It also represents

the percentage of residents who qualified into the lowest two (2) RUG classification categories, which is reflective of residents with the fewest nursing care needs and services. The chart also indicates that Laverne has the highest percentage of residents who are considered lower acuity while Minneapolis serves the least amount of residents qualifying in the lowest levels.



Staffing productivity, as it relates to the resident acuity is most relevant in the areas of nursing and rehabilitation. In an earlier report, Affinity evaluated the total nursing hours per patient day. The ratios of RN staff to residents and the total nursing hours per day delivered in each facility is quite comparable to those efficiency standards provided in the industry. Resultantly, each of the four (4) skilled facilities should be able to accept and care for higher acuity residents, such as those receiving Medicare skilled services, without difficulty. The current staffing ratios appear adequate to care for any increase in resident acuity that will most likely result should the MVH pursue Medicare certification. When comparing

MVH nursing hours provided per resident day to State and National benchmarks, the MVH results are slightly higher than average. Because the MVH currently provides higher than average nursing hours per resident day in spite of the lower documented acuity needs of its' residents, it is our belief that the numbers of staffing provided by the MVH at the time of the study is currently sufficient should the decision be made to shift to a higher acuity model of care.

Presently, there is not enough information available to evaluate the productivity of the rehabilitative therapy department staff. The industry method used to evaluate productivity is a measure of billable time providing direct resident care against non-billable time for each therapist. Non-billable time may include, documentation, providing non-covered services, attending routine facility meetings, resident care conferences, etc. There is an industry benchmark to evaluate therapy staff productivity; however, there was insufficient documentation and record keeping calculating these measures among the MVH.

E. Cost Reporting Analysis

Both Medicare and Medicaid require participating nursing facilities to submit an annual cost report. Organizations either prepare the cost reports utilizing knowledgeable and trained in-house staff or subcontract this service to a professional healthcare consultant or healthcare accounting firm. The purpose of the following information is to assist the MVH in restructuring their accounting and record keeping systems in accordance with the accounting cycles required by Medicare and Medicaid. Obviously, the cost reporting requirements would apply only if the MVH choose to pursue certification.

a. Medicare Reporting Periods

For cost reporting purposes, Medicare requires submission of an annual report covering a 12-month period of operations. The provider may select any annual cost reporting period for Medicare cost reporting purposes regardless of the reporting period it uses for other programs. Once selected and reported accordingly, the provider is required to report on an annual basis using the selected reporting periods. Under certain conditions, a provider can obtain approval for a change in reporting period. The deadline for submitting an acceptable cost report is 150 days from the close of the reporting period. Each provider in a chain or multi-facility organization must file a separate, individual cost report.

b. Medicaid Reporting Periods

For cost reporting purposes Medicaid requires submission of annual reports covering a 12-month period ending September 30. The deadline for submission of the annual reports is February 2 of the year following the cost reporting period. The Medicare cost reporting principles must be utilized when reporting costs for the Medicaid report. As with Medicare requirements, each individual facility, regardless of affiliations, must file a separate cost report.

c. Home Office Cost Report

For Medicare and Medicaid purposes, a chain organization consists of a group of two or more health care facilities that are owned or controlled by one organization. Chain organizations may be operated by various religious, charitable, and or governmental organizations. Home offices usually furnish central management and administrative services, such as centralized accounting, payroll, personnel services, and purchasing. To the extent the home office furnishes services relative to an individual provider, the reasonable costs of providing such services are able to be included in the individual providers' cost report as reimbursable expenses. Home office costs included on the individual providers' cost reports should be based on a pre-determined allocation methodology and compiled on the HCFA 287 home office cost report.

d. Accounting Methodology

- Accounting Method:

  The Medicare and Medicaid programs require facilities to provide certain structured accounting policies and procedures. Medicare requires facilities to use the accrual method of accounting as recommended by Generally Accepted Accounting Principles (GAAP). The State of Minnesota's Medicaid program requires providers to use Medicare cost reporting principles.

- Cost Center Descriptions:

  The Medicare and Medicaid programs require costs to be allocated according to defined cost centers. We recommend that the MVH consider utilizing the same cost center descriptions required by the cost reporting requirements.

- Cost Center Expense:

  The Medicare and Medicaid programs defined cost centers, include but are not limited to the following:
  - Salaries & Wages;
  - Payroll Taxes;
  - Health Insurance;
  - Workers Compensation;
  - Pension or Profit Sharing;
  - Other Employee Insurance and Benefits; and
  - Supplies and Materials to the appropriate cost center

- Fixed Assets:

  The Medicare and Medicaid programs require that providers maintain the following fixed asset accounts:
  - Land and Land Improvements';
  - Buildings and Building Improvements;
  - Fixed Equipment;
  - Movable Equipment;
  - Transportation Equipment; and
  - Accumulated Depreciation Accounts should be maintained for each capital account. Asset additions and disposals are reported on both Medicare and Medicaid cost reports.

- Depreciation and Property Insurance:

  The Medicare and Medicaid programs require depreciation and property insurance to be identified, as these items are a factor in determining reimbursable costs.

- Balance Sheet:

  The Medicare program requires the facility's balance sheet be reported on the cost report. Prior year retained earnings and year to date profit and or loss must reconcile with current year retained earnings.

- Revenue – Medicare/Managed Care/Medicaid:

  The Medicare and most Medicaid programs require Gross Room & Board and Ancillary revenue to be reported separately on cost reports. We recommend that these revenue categories be

recorded separately on MVH financial reporting statements. In addition, we recommend separate recording of "Other" types of revenue, including items such as telephone, laundry, vending, and other misc. items, which may produce revenue for the individual facilities. For third party payors, revenue recording includes the contractual allowances. The contractual allowances should be recorded separately under revenue.

e. Statistical Data

- Census Recording:

  The Medicare and Medicaid programs require resident days are maintained by RUG classification and payer source. In addition, many managed care organizations have similar requirements. Total admissions, discharges, and deaths are recorded and reportable by payer type.

- Statistics:

  The Medicare and Medicaid programs require maintenance of certain statistics for cost allocations, including:

  - Building Square Footage by Departmental Cost Center
  - Laundry Production per pound laundered
  - Meals Served over the cost reporting time period
  - Direct Hours Worked
  - Time Spent

- Productive and Compensated Hours:

  The Medicare and Medicaid programs require employee hours worked and hours paid for each cost center to be identified and recorded.

- Direct Care Staff Retention:

  Minnesota Medicaid requires a count of the number of employees at the beginning of the year. In addition, it requires tracking and recording of the number of employees who were employed the entire reporting year for a variety of job classifications.

- Medicare Questionnaire:

  The Medicare program requires information regarding each Home's operations related to:

  a. Organization structure
  b. Detail regarding co-insurance bad debts
  c. Cross-walk between facilities Medicare records and Fiscal Intermediary
  d. Detailed listing of wage-related costs

F. Outside Service Provider Contracts

Each of the MVH facilities currently contract various services to outside providers; including, physician services, rehabilitative therapy, including physical, occupational or speech therapist, dental providers, pharmacy, laboratory/diagnostic services, radiology, certain medical supplies, psychiatric services, and other professional services that are Part B billable by the service provider. These contracts vary by home in terms of the type of service agreements utilized.

Both certified and non-certified Homes have various types of contracted professional services who bill third party insurances for payment. Should the MVH decide not to seek Medicare and or Medicaid certification, they can still pursue contractually requiring outside professional service contractors to bill residents' third party insurances, including Medicare Part B, Medicare D, and Medicaid. Should the MVH choose to pursue certification, some of the aforementioned services would have to be provided and paid for by the Home while other services can still be billed to third party providers.

The following represents our analyses of the two (2) professional services provided currently through the MVH and paid for by the MVH that could be billed to third party insurances by the contracted service provider through an amendment to the current contractual agreement. The amounts included below represent the amounts paid for the respective professional service during calendar year 2008. Both of these services could be billed by a professional service provider should the MVH choose to forego Medicare certification. Physician Services can be billed by the service provider regardless of the decision to proceed with certification of either program. These amounts represent an annual cost savings to the MVH

Homes that can be achieved by amending the current contractual agreements with these providers to require the provider to bill third party insurances for payment as opposed to billing the MVH directly.

Medical Director/Physician Services	$ 789,865
Rehabilitation Therapy Services	$ 1,257,874

In a traditional nursing facility, both certified and non-certified, the physician is contractually responsible for billing third party insurances for their professional service when providing medical services to the resident population. However, it is industry practice for the nursing facility to compensate a contracted medical director for his/her administrative services required by federal regulation. These administrative services typically include; policy and procedure development, staff and physician training, incident and accident reporting monitoring, and supervision of practicing physicians. This is typically compensated according to a negotiated monthly fee. Most facilities retain one (1) physician who serves as Medical Director; however, there are instances when facilities provide specialty/niche services that a physician practicing in that specialty area serves as Medical Director over that unit or service delivery. While the monthly fee for administrative services is paid by the facility, any medical services provided to the resident population are paid through third-party billing. For the purposes of this analysis, we estimated that the physician could bill 75% of the physician-generated revenue to insurances. For the MVH this could save the organization over $500,000.00 by adopting these practices.

The Minneapolis facility has in-house services for Medical Director/Physician services. Subtracting these costs limits the outside contracted physician services potential billable amount to $100,000.00 per year.

The rehabilitation services are also billable to Medicare Part B and other insurances by an outside provider if the Homes are not certified. 70% of the MVH cost is a reasonable estimate for the billable portion. If we apply this 70% to the total cost at the MVH, there could be a potential savings of over $880,000.00.

Currently, there is an in-house rehabilitation department at the Minneapolis facility. Subtracting out this cost would lower the potential savings to approximately $250,000.00.