News Currents

LTC Advocates Eye '09 Challenges

Legislative Hurdles In New Administration

With a Democrat in the White House and the party still controlling the House and Senate, the Employee Free Choice Act will be at the top of the industry's legislative watch list, as the 111th Congress begins and President-elect Barack Obama is sworn into office, observers say.

As the new session starts in January, legislation left unfinished at the end of 2008 will need to start from scratch, including the Employee Free Choice Act, commonly known as the card-check bill.

Obama

The bill allows a majority of workers to sign petition cards to certify a union instead of a secret ballot. The Bush administration opposed the bill, but Obama supports it. The House of Representatives passed the bill, but the Senate did not. The American Health Care Association (AHCA) opposes the bill.

Disaster relief, therapy caps, arbitration rules, and proposed transparency requirements also are on the legislative agenda. Work will continue to change the Stafford Act to allow for-profit long term care providers to have the same access to federal relief funds as not-for-profits in the event of a natural disaster. Current law specifically bars for-profit facilities from getting funding if the president declares a federal disaster after a hurricane or other event.

The Long Term Care Quality and Modernization Act, proposed by AHCA, is likely to come back. The bill, introduced in both the House and the Senate, would change the Medicare three-day hospital stay rule to a one-day stay and update policies on diabetes management and consolidated billing. The bill also would amend the tax code to reduce depreciation and promote building renovation and health information technology.

The industry will also watch for Congress to extend the exceptions process for Part B therapy caps.

Of particular interest to assisted living providers are the Home and Community Services Copayment Equity Acts in the House and Senate. If passed, the new law would eliminate Medicare Part D copayments for residents covered under Medicare and Medicaid in assisted living residences.

Meanwhile, the Fairness in Nursing Home Arbitration Act and the Nursing Home Transparency and Improvement Act are also likely to be reintroduced, AHCA says. Legislation that would eliminate the use of pre-dispute arbitration agreements in long term care facilities passed through House and Senate committees but did not make it to a floor vote. The transparency bill, which also has Senate and House versions, would require detailed public disclosure of facility ownership information and also would require details on staff levels, including nursing wage and benefit information.

AHCA and other industry leaders will also pay close attention to the Centers for Medicare & Medicaid Services to see if the Medicare resource utilization group "forecast error adjustment" is proposed again. The agency proposed the $770 million adjustment earlier this year, but rescinded it in August on the promise that it would resurface.

—**Suzanne Struglinski**

In Brief

Agreement Brings VA, SNFs Together

A new agreement has been developed for use between private-sector nursing facilities and their local Department of Veterans Affairs (VA) medical centers.

Under the new model contract:

- Nursing facilities will not be held to onerous requirements in the Service Contract Act and Executive Order 11246.
- VA will accept a new resource utilization group (RUG) reimbursement system that combines the RUG-53 groups into 10 categories, with rates applying to all routine, ancillary, and medication costs for covered services.
- VA will accept compliance with the Centers for Medicare & Medicaid Services' mandatory life safety code.
- VA will recognize the Health Insurance Portability and Accountability Act compliance as adequate to protect veterans' health information, in lieu of complex business associate agreements.

According to the American Health Care Association (AHCA), the agreement is the culmination of two and one-half years of work between the organization and VA.

The agreement will be piloted with select providers before being rolled out for general use.

—**Lynn Wagner**

CMS Limits Fed Medicare Recoveries

Provider Timing Is Key To Successful Deployment Of Rule

A new federal rule limits the federal government from recouping money it believes providers have been overpaid for certain Medicare claims if the providers decide to file an appeal.

Timing is key in the new process implemented by the Centers for Medicare & Medicaid Services (CMS).

Detailed timelines outline when providers need to formally submit their appeal to put the recoupment process on hold while it is determined whether facilities need to refund money to Medicare or not.

The Medicare Modernization Act of 2003 included a provision that limits the recoupment process while an overpayment appeal is pending. Before the law was enacted, if a provider appealed an overpayment claim, Medicare could still recoup the money it claims the provider owes during the appeals process.

CMS recoups money by reducing current or future Medicare payments to make up the amount owed back to the government.

CMS published a proposed rule for implementing this provision in September 2006. It has not published a final rule in the *Federal Register* but made it effective through a CMS "Manual System Change Request" issued Sept. 12.

The rule became effective on Sept. 29, according to the transmittal. A *Federal Register* notice is working its way through final approval and will reflect the same change, according to a CMS official.

CMS emphasizes that a rebuttal letter does not stop Medicare from recouping money toward the overpayment, but through the new rule a request for redetermination will.

Providers have 30 days to appeal or ask for a redetermination of the overpayment from the date of the demand letter, according to CMS.

"Timeliness of this request is important because if you don't send this request within 30 days, Medicare can begin to recoup on the 41st day from the date of the Medicare demand letter," according to CMS.

A CMS official says beginning on the 41st day allows time for an appeal request sent on day 30 to be processed in time before the recoupment would begin. If there is no real request, recoupment would start 41 days from the date of the demand letter.

If providers request redetermination within 30 days, the new rule limits recoupment on post-pay denials of claims for benefits under Medicare Part A or Medicare Part B.

CMS cannot recoup money, but interest also will begin to accrue on the money owed.

If the first redetermination of the overpayment is denied, providers can request further consideration by the qualified independent contractors (QICs) within 60 days, which continues to put recoupment on hold.

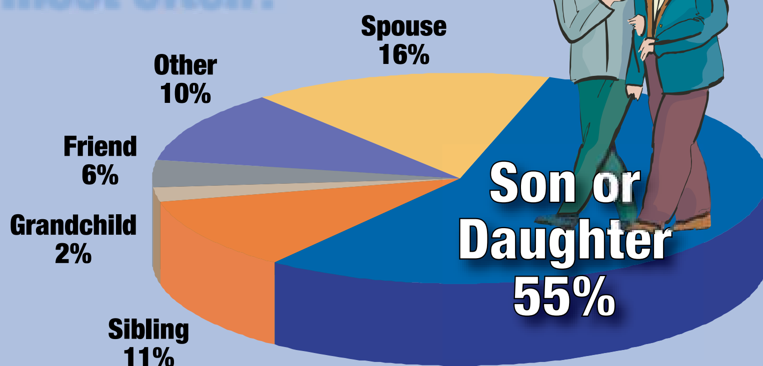
Providers then have the third option to appeal to the administrative law judge (ALJ) but recoupment would start after the QIC upheld the overpayment.

If the Medicare overpayment decision is upheld by the ALJ, Medicare will recoup or otherwise get its money back, plus interest.

If the overpayment is reversed, Medicare will pay back principle and interest collected, plus a penalty interest back to the provider, the CMS official says.

—Suzanne Struglinski

By the Numbers



Source: 2007 National Survey of Consumer and Workforce Satisfaction in Nursing Homes by My InnerView Inc.

Medicaid Shortchanges Actual Costs

Disparity Likely To Widen As Economic Crisis Deepens

Medicaid budget shortfalls will underfund the actual cost of long term care by $4.2 billion in 2008, according to an Eljay analysis of Medicaid financing released by the American Health Care Association (AHCA) in October.

The report illustrates the need for state Medicaid relief from Congress, says AHCA President and Chief Executive Officer Bruce Yarwood.

"Given the substantial gap between the cost to provide quality care and what Medicaid actually pays and the steeply rising pressure on state budgets, long term care providers and the seniors they care for have good reason to be fearful that imminent state budget cuts could threaten access to care," Yarwood says.

The pending economic stimulus bills in the House and Senate each contain increases for federal matching dollars for Medicaid.

The Eljay analysis, the sixth annual report compiled for AHCA, found that for every dollar of allowable costs incurred for a Medicaid patient, the Medicaid program reimbursed about 93 cents, according to the "2008 Report on Shortfalls in Medicaid Funding for Nursing Home Care." This translates into a $12.48 shortfall per Medicaid patient, per day, according to the report. The calculation is based on the difference between states' projections of Medicaid-allowed costs and nursing facility payment amounts.

When critical operating costs not recognized by Medicaid are added to the mix, the shortfall rises 2 percent to 3 percent, the report said. These unreimbursed costs—including bad debts, income taxes, marketing, and certain legal and professional fees—boost the payment gap by at least $3.47 per patient per day, to a shortfall of over $15 per day. This disparity is likely to widen as the cost of essential goods and services rises more quickly than anticipated, leading to higher-than-expected provider costs, the report warned. Furthermore, as the economic crisis deepens, a growing number of states are wrestling with budget deficits, and many are revisiting the payment increases given to nursing facilities in a more sanguine fiscal environment, the report said.

Some states, including Florida, Georgia, Rhode Island, and Virginia, have already moved to roll back reimbursement. "As a result of the current sluggish economic situation and declining state tax revenue, there is downward pressure on nursing home Medicaid rate increases," the report says. "It is likely that the positive trends in Medicaid cost coverage achieved in the past few years will reverse in the coming years. This instability and unpredictability in Medicaid funding will make it more difficult for providers, especially those with high Medicaid volume, to meet consumer and regulatory expectations."

—Suzanne Struglinski and Lynn Wagner

STATES WITH MOST SEVERE MEDICAID SHORTFALLS

State	Shortfall
1. New York	$548.1 million
2. Illinois	$379.3 million
3. Ohio	$281.3 million
4. Pennsylvania	$261.2 million
5. New Jersey	$241.9 million
6. Texas	$235.0 million
7. California	$203.6 million
8. Wisconsin	$200.0 million
9. Massachusetts	$197.0 million
10. Florida	$185.0 million

Source: "A Report on Shortfalls in Medicaid Funding, October 2008," Eljay

Tool Links Health And Environment

Research from a Texas A&M architecture professor has tested a tool that can measure senior living environments, making it possible to correlate residents' health and satisfaction outcomes with the physical environment of the assisted living buildings.

Susan Rodiek, a professor of architecture at Texas A&M University, College Station, has developed and tested the reliability of an assessment instrument on 68 assisted living communities in three different geographic regions of the United States.

Testing proved the instrument to be reliable, according to an article on the research published in the *Seniors Housing and Care Journal*. The instrument can be fine-tuned into a checklist that designers of senior living environments can use to benefit residents and providers, Rodiek wrote. "The concept behind this evaluation tool can be adapted by both providers and design practitioners for use in practical projects" by choosing different facets of the physical environment to evaluate.

According to the journal article, the 63-item instrument received validity testing in a multiregional study conducted at six randomly selected assisted living facilities that involved 1,569 respondents.

"By making environmental evaluations more quantifiable and reliable, it became possible to compare health- and satisfaction-related outcomes associated with physical environments," Rodiek wrote.

—Lisa Gelhaus

AHCA Elects Board Officers, Members

Staggered Terms Keep Consistent Leadership Flow

The Council of States of the American Health Care Association (AHCA) elected the new Board of Governors during the 59th Annual Convention & Expo in Nashville in October.

Rick Miller from Oregon will continue to serve as chair with Robert Van Dyk from New Jersey as vice chair.

Miller

William Levering from Ohio, Gail Clarkson from Michigan, and Rick Mendlen from California will return as at-large board members. Rich Kase of Cypress Management from Florida was elected as an at-large member for the first time. In addition to the at-large members, Wade Peterson from North Dakota will serve as not-for-profit representative, according to the election results.

National Center for Assisted Living Representative Howie Groff from Minnesota, Affiliated State Health Care Association Executives Representative Jim Carlson from Oregon, and Associate Business Member Representative Gail Rader of New Jersey will be back as ex-officio board representatives.

All were elected at the convention by unanimous vote.

In addition to those elected at the October convention, individuals continuing to serve on the board are Immediate Past Chair Angelo Rotella and At-Large Representatives Lane Bowen from Kentucky, Leonard Russ from New York, Neil Pruitt Jr. from Georgia, and Richard Pell from Pennsylvania. Van Moore from Oregon will continue to serve as the developmental disabilities residential services representative.

"AHCA is honored to have such a distinguished board of governors," says AHCA President and Chief Executive Officer Bruce Yarwood, who also serves on the board.

"These individuals will help AHCA continue to build a future focusing on the vitality of our long term care community and strengthen efforts to improve the quality of care for millions of elderly and disabled Americans nationwide."

—**Suzanne Struglinski**

NCAL Votes On New Leadership Lineup

Howie Groff, president of Tealwood Care Centers, in Bloomington, Minn., will serve as 2008-2009 chair of the National Center for Assisted Living (NCAL), based on the elections from the 59th Annual AHCA/NCAL Convention & Expo held in Nashville in October.

Groff

Other newly elected officers include Vice Chair Nicolette Merino, Avamere regional director of operations, from Wilsonville, Ore., and Secretary/Treasurer Michael Shepard, chief executive officer (CEO) of The Shepard Group in Pine Bluff, Ark.

The elections also bring in six new board members, who will serve a two-year term. The newly elected members are Deb Choma, nurse administrator, Shard Villa, Salisbury, Vt.; Vickie Cox, executive administrator, Heritage at Dover, Dover, Del.; Jeffrey Hyatt, owner of Hyatt Family Facilities, Yakima, Wash.; Christian Mason, chairman and CEO of Vigilan Corp., Woodburn, Ore.; Jan Thayer, owner and CEO of Riverside Lodge Retirement Community, Grand Island, Neb.; and Kristin West, vice president of operations, Kemper Co., Strongsville, Ohio.

Those remaining on the board, whose terms expire in October 2009, are Nancy Andrews, director of housing and assisted living for Valley Memorial Homes, Grand Forks, N.D.; Jim Birchem, president and CEO of ElderCare of Minnesota, Bemidji, Minn.; Edie Gerelli, vice president of operations for Chelsea Senior Living, Summit, N.J.; Patricia Giorgio, president and CEO of Evergreen Estates, Cedar Rapids, Iowa; Joe Perkin, regional director for Midwest Health Management, Topeka, Kan.; Dean Solden, president of Solden Development Co., Ann Arbor, Mich.; and Faun Spencer, owner of Twilight Care, Minnetonka, Minn.

—**Suzanne Struglinski**

Special Focus Facility Scoring Released

Most Recent Survey Results Get Most Heavily Weighted

Details about the scoring methodology for the 10-year-old Special Focus Facility (SFF) program were recently disclosed by the Centers for Medicare & Medicaid Services (CMS) following numerous requests by long term care advocates.

"As CMS has increased its focus on SFF nursing homes, we recognize that there is an increasing interest in understanding the rationale and method for determining which nursing homes are selected for the SFF program," an Oct. 10 memo from CMS to state survey agencies said.

According to the memo, the SFF scoring methodology includes the following five steps: health deficiencies, revisits, weighting by year, list per state, and state recommendation and selection.

Health care deficiencies identified during the most recent three standard survey cycles and during the last three years of complaint surveys are the most heavily weighted. They "represent the most significant factor in the identification of which facilities merit close attention in the SFF initiative. The more deficiencies, and the more serious or widespread those deficiencies, the higher the SFF deficiency score," the memo says.

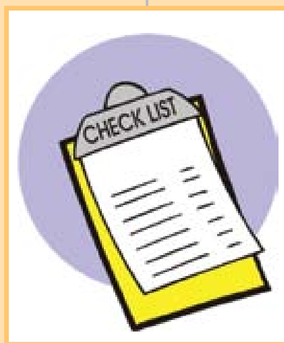
The deficiency score includes deficiencies that are identified during the last three standard (comprehensive) surveys and complaint surveys that occurred in each of the past three years and in which a deficiency was identified.

Each identified deficiency is evaluated according to two dimensions: the scope of the deficiency, such as whether the deficiency was isolated to one person or was widespread throughout the nursing facility, and the severity of the deficiency, such as whether an individual suffered injury, harm, impairment, or death.

Complaint deficiencies are calculated by providers for each annual period to

OIG To Examine SNF Ownership, Medicare Billing

Nursing facility ownership, Medicare coding and billing, and a laundry list of other topics appear on the Department of Health and Human Services (HHS) Office of Inspector General (OIG) agenda for fiscal year 2009.



The 115-page work plan, released Sept. 25, identifies what OIG has deemed "most worthy of attention" for the coming year.

Most nursing facility matters fall under the Centers for Medicare & Medicaid Services portion of the plan.

Under Medicare Part A and Part B planned OIG reviews include:

■ Skilled nursing facility (SNF) consolidated billing;

■ Accuracy of coding for SNF Medicare resource utilization groups' claims;

■ Mental health needs and psychotherapy services under Medicare Part B in nursing facilities;

■ Calculation of Medicare benefit days;

■ Minimum data set data oversight; and

■ Nursing facility residents aged 65 or older who received antipsychotic drugs.

OIG also plans to review ownership structures at investor-owned nursing facilities, Medicare payments for nursing facility residents receiving hospice care, and Medicaid payments to nursing facilities treating dual-eligible patients, among several other topics, according to the plan.

For Part B services in nursing facilities, OIG plans to conduct an overall review of Part B services for nursing facility residents whose stays do not fall under Part A and durable medical equipment payments for nursing facility beneficiaries.

More specifically, OIG will examine claims and payment for enteral nutrition therapy and enteral nutrients, home blood glucose testing supplies, and power wheelchairs.

The work plan gives no specific release dates for the OIG reports outlining the reviews' findings but indicated they will come out some time next year or during fiscal year 2010.

OIG estimates that during the past several years, it has allocated "about 80 percent of our resources to reviews and investigations of the Medicare and Medicaid programs and 20 percent to HHS' public health and human services programs."

The entire work plan can be found online at oig.hhs.gov.

—Suzanne Struglinski

produce three complaint survey scores. Standard deficiency points are calculated by providers and by survey cycle to produce three standard survey scores.

As the second step in the scoring process, revisits are a major factor in SFF scoring. Additional points are given if a facility required more than one revisit to demonstrate substantial compliance.

The additional SFF points are assigned to the facility for each additional revisit after the first revisit: Fifty points are assigned for the second revisit needed to demonstrate substantial compliance on the health certification portion of each standard survey, 75 points are given for the third revisit, and 100 for a fourth revisit. Revisit points are added only for standard surveys, not for complaint surveys.

The results are totaled, and weights are assigned to each period, with more recent results weighted more heavily. For each provider, the deficiency score and revisit score are added to create a total score for each of the three periods. In calculating the SFF score, more recent scores are weighted more heavily than results from earlier surveys.

The most recent period is assigned a weighting factor of one-half, the previous period has a weighting factor of one-third, and the second prior survey has a weighting factor of one-sixth. The scores are then added to create the overall SFF score.

> 'Each deficiency is evaluated according to scope and severity.'

Standard survey periods refer to the period in which the standard surveys are completed—generally from nine to 15 months from the earlier standard period. Each nursing facility, therefore, has three standard surveys included in its SFF scoring.

Deficiency findings from complaint investigations are standardized in 12-month periods so all nursing facilities are treated in the same way, for three 12-month periods. Facilities are grouped within each state, and the 15 facilities with the highest SFF scores—"the most serious and persistent health care deficiency histories"—are sent to the state for consideration.

In the final step of the process, each state reviews the candidate list, brings its state-specific knowledge and information to bear, such as the results of state licensure surveys, and recommends a final selection to CMS.

Lyn Bentley, director of regulatory services for the American Health Care Association, made repeated requests to CMS for clarification of the scoring methodology, including a Federal Freedom of Information Act request, she says.

In response to CMS' disclosure, she lauded the agency for "finally making this critical information public."

—Meg LaPorte

Sunrise Deal Terminated Due To Market Conditions

Blaming uncertain market conditions, Health Care REIT, Toledo, Ohio, recently called off a pending transaction with McLean, Va.-based Sunrise Senior Living and an affiliate of Arcapita, Atlanta.

Health Care REIT had planned to acquire the affiliate's 90 percent interest in a venture owning 29 seniors housing properties managed by Sunrise.

> 'Sunrise will continue to own 10% of the properties.'

"Given the uncertainty in the capital markets, we determined the transaction would not be in the best interests of our stockholders under the original terms," George Chapman, chairman and chief executive officer of Health Care REIT, said in an Oct. 30 statement.

Termination of the deal will have no impact on Sunrise's 10 percent interest in the venture, according to a statement, which also noted that it will continue to manage the properties under long-term contracts expiring in 2025.

Because of the termination, however, Sunrise will not receive the estimated cash distributions of approximately $50 million to $60 million and will not realize the estimated gain of approximately $41 million to $51 million that it anticipated in connection with this transaction, the statement said. "We are pleased to continue owning 10 percent of these properties and to continue managing them for our capital partner. We have had a long and successful relationship with Arcapita," said Mark Ordan, Sunrise's chief investment and administrative officer.

"Given the extreme uncertainty of the current capital markets, in order to maintain as much financial flexibility as possible, we are working closely with our banks and other sources of capital to provide additional sources of liquidity," Ordan said.

"We intend to focus on managing efficiently, reducing overhead, and conserving cash so that we can make Sunrise a leaner, more more efficient company."

—Meg LaPorte

Survey: Nursing Facility Rates Steady

Assisted Living Costs Rise Slightly, Dementia Care Extra

Average daily costs of nursing facility stays for 2008 remained essentially unchanged from 2007, based on the MetLife Mature Market Institute's annual survey of nursing facility and assisted living costs released Oct. 28.

The national average rates for a semi-private room increased just by 1.1 percent, from $189 a day or $68,985 a year in 2007, to $191 a day or $69,715 a year in 2008, according to the report. The national average cost of a private room in a nursing facility actually went down $1 a day from an average $213 in 2007 to $212 in 2008.

Alaska still holds the highest average daily rate, at $577 for a private room and $566 for a semi-private room.

Louisiana, outside of Baton Rouge and Shreveport, had the lowest average rate at $127 for a private room. Minnesota, outside of Rochester or Minneapolis/St. Paul and Oklahoma, outside of Oklahoma City and Tulsa, tied for the lowest averages of semi-private rooms at $121.

The survey found that 81 percent of the 1,862 nursing facilities responding to the survey are freestanding, 17 percent have an assisted living unit or wing, and 30 percent have a separate Alzheimer's unit or wing.

The national daily average rate for a private room in an Alzheimer's unit or wing is $219 or $79,935 a year. A semi-private room in an Alzheimer's wing is $198 a day on average, or $72,270 a year, according to the report.

For assisted living facilities, the national average rate rose to $3,031 monthly, or $36,372 a year. This is a 2.1 percent increase above the 2007 average monthly rate of $2,969 monthly, or $35,628 a year, according the report.

Southern Maine has the most expensive average monthly base rate at $4,708, and North Dakota registered the least expensive average monthly base rate at $1,980 per month.

> 'Out of 1,518 assisted living facilities, 52 percent offered Alzheimer's and dementia care.'

MetLife reported the study found "advertised base rates for assisted living may not comprise the total cost families will pay when additional charges, like those associated with providing additional assistance, are added."

The average monthly rate for providing extra assistance with activities of daily living (ADLs) above the base rate is $386. The average monthly rate for providing assistance with instrumental ADLs, such as medication management, is $327.

Of the 1,518 assisted living communities surveyed, 52 percent offered Alzheimer's and dementia care, with half charging an additional fee for the service.

—**Suzanne Struglinski and Lisa Gelhaus**

Sun Healthcare Revamps Its Image

Irvine, Calif.-based Sun Healthcare Group is re-branding its image. The company, which ranked No. 5 this year on *Provider's* list of the Top 50 nursing facility chains, announced recently that it will be introducing a new visual identity, replacing its nearly 15-year look, for most of its business lines.

The new logo, a sun resting in the palm of a hand, reflects the company's new mission statement: Caring is the Key in Life, according to a company statement.

"While we are not changing the essence of our mission, which is to provide ethical, quality care for our patients and residents, we are changing how we talk about it. Our old statement was too long, and, as often happens with mission statements, no one could remember it," said Rick Matros, Sun's chairman and chief executive officer.

The new logo applies to Sun as well as SunBridge Healthcare Corp. and its affiliated companies, which operate long term and post-acute care centers in 25 states, and SolAmor Hospice, which provides hospice care in six states.

SunDance Rehabilitation Corp., which provides rehabilitation therapy, will be embracing a variation of the new logo.

"As a result of Sun's acquisition activity, different brands have been utilized throughout the company," Matros said.

"Our new branding will serve as a unifying event, allowing new employees, whether they came to Sun through acquisition or otherwise, to relate to the company in a unified fashion."

—**Meg LaPorte**

EPA To Study Drug Disposals

Agency Fears Leakage In Public Waters

The Environmental Protection Agency (EPA) has started evaluating public comments on its draft survey, developed to find out how long term care and other medical facilities are disposing of unused medication.

EPA believes health services account for the majority of institutional discharges of unused drugs to waste water, according to a statement that accompanied the draft questionnaire released in August.

Filling out the draft survey as it stands now could take facility staff an average of 41 hours and cost the facility $1,463 to collect the requested data and complete the questionnaire. EPA's draft survey requires a 30-day report on drug disposal, which could force facilities to create a new tracking system and train staff to use it.

However, the agency may adjust the survey based on the public comments it receives, so the costs and time involved could change.

The survey asks for details on the types of drugs administered, why some drugs were unused, who determines how to dispose of unused drugs, how they are disposed of, costs associated with managing unused drugs, and numerous related details.

It is unclear how many long term care facilities would get the survey; the agency will have more information on the size of the facility sample before its next posting.

The initial group of medical facilities included in the study are nursing and continuing care retirement facilities, along with hospitals and hospices.

No federal regulations monitor or bar medical facilities from disposing of excess, expired, or unwanted medications down the drain or toilet, which EPA says can lead to the drugs passing through public water treatment systems and into surface waters.

Through its responsibilities under the Clean Water Act, the agency wants to get a better understanding of how facilities manage drug disposal and the overall effect of the drugs on the water supply.

This could lead to future regulations.

The public comment period on the draft questionnaire and the agency's approach to conducting the survey closed Nov. 10. The American Health Care Association submitted comments outlining its concerns on the survey.

After reviewing the comments, EPA will decide whether to make any adjustments to the survey or its methodology and submit it for a further 30-day public comment period. At the same time, the survey will go to the U.S. Office of Management and Budget for review.

—Suzanne Struglinski

Stock Check

PROVIDERS	Symbol	Where Traded	% Current Price 10/31/08	Adjusted P/E Ratio	% Change From 1/1/08	52-Week Range High	Low
Skilled Nursing							
Advocat	AVCA	NASDAQ	$3.35	7.7	-70%	$12.54	$2.86
Ensign Group	ENSG	NASDAQ	$ 16.39	6.8	14%	$18.39	$7.50
Kindred Healthcare	KND	NYSE	$14.49	9.1	-42%	$33.25	$12.96
National Healthcare	NHC	AMEX	$41.01	6.5	-21%	$54.50	$34.60
Skilled Healthcare Group	SKH	NASDAQ	$12.28	8.4	-16%	$17.17	$9.35
Sun Healthare	SUNH	NASDAQ	$11.48	8.2	-33%	$18.78	$9.92
Assisted/Independent Living							
Assisted LIving Concepts	ALC	NYSE	$4.97	8.8	-34%	$8.89	$3.50
Brookdale Senior Living	BKD	NYSE	$8.59	10.6	-70%	$37.14	$6.23
Captial Senior Living	CSU	NYSE	$4.49	9.2	-55%	$10.12	$3.88
Emeritus Assisted Living	ESC	AMEX	$11.53	13.3	-54%	$33.03	$8.38
Five Star Quality Care	FVE	AMEX	$1.96	8.8	-76%	$10.20	$1.55
Sunrise Senior Living	SRZ	NYSE	$3.02	NA	-90%	$37.00	$2.57

Quote courtesy of www.seniorcareinvestor.com, Norwalk, CT (203) 846-6800
(1) Adjusted P/E=(marke cap + total debt + capitalized leases = cash)/annualized EBITDAR based on the most recent quarter.

PROVIDERS	Symbol	Where Traded	% Current Price 10/31/08	Adjusted P/E Ratio	% Change From 1/1/08	52-Week Range High	Low
REITs							
Care Investment Trust	CRE	NYSE	$11.18	6.1	4%	$12.74	$8.09
Health Care Property Investors	HCP	NYSE	$29.92	6.1	-14%	$42.16	$25.19
Health Care REIT	HCN	NYSE	$44.51	6.1	0%	$53.98	$37.44
Healthcare Realty Trust	HR	NYSE	$25.55	6.0	1%	$32.00	$20.57
LTC Properties	LTC	NYSE	$24.17	6.5	-4%	$31.17	$18.90
National Health Investors	NHI	NYSE	$29.94	7.3	7%	$35.00	$24.06
Nationwide Health Properties	NHP	NYSE	$29.84	5.9	-5%	$39.99	$25.04
Omega Healthcare Investors	OHI	NYSE	$15.07	8.0	-6%	$19.75	$11.52
Senior Housing Properties Trust	SNH	NYSE	$19.17	7.3	-15%	$25.21	$13.25
Universal Health Realty	UHT	NYSE	$34.71	6.7	-2%	$39.30	$20.98
Ventas	VTR	NYSE	$36.06	5.7	-20%	$52.00	$30.21

The rate used to capitalize the leases has been changed from 12.5% to 10.0% effective 1/31/06 to better market conditions

ID Theft Rule Hits Long Term Care

Providers Asked To Adopt Prevention Policies And Procedures

A Federal Trade Commission (FTC) rule that was recently applied to long term care facilities under the Fair and Accurate Credit Transactions Act (FACTA) of 2003 means facilities should have certain policies and procedures in place to protect against identity theft by residents or staff.

FTC recently applied the identity theft provisions of the act to health care providers—even though the health sector is not mentioned specifically in the rules.

The rule is comprised of three different but related rules—known as Red Flag Rules—that refer to a pattern, practice, or specific activity that indicates the possible existence of identity theft.

The first rule applies to nursing and assisted living facilities that use credit reports. The second rule, pertaining to creditors, may apply to facilities, although there is some uncertainty regarding its application. The third and last rule, involving credit cards, does not apply to facilities.

The first rule, which FTC began enforcing on Nov. 1, 2008, stipulates that users of consumer reports must have policies and procedures in place to respond to street address discrepancies from reporting agencies. This applies to facilities that use credit checks for employment purposes or for consideration of admitting private-pay residents.

According to Elise Smith, JD, vice president of research and reimbursement for the American Health Care Association (AHCA), "if a report shows an address that is not the same as what the applicant reported, the facility must take a few steps to investigate. The regulations require that in the event of an address mismatch, before making any decision based on the report, the recipient take steps sufficient to form a 'reasonable belief' as to whether or not this applicant is who the person claims to be," she says.

The rule also stipulates that there is no affirmative duty for the facility to report the discrepancy to the credit bureau or other agency, but companies must have a written policy in place.

Criminal background checks are not considered consumer reports.

The second rule, which has a compliance date of May 1, 2009, requires "creditors" to develop and implement a written identity theft prevention program. In comments to the agency, AHCA explained why this rule should not apply to long term care facilities: A long term care facility is "fundamentally unlike" the types of creditors that are specifically targeted in the rules, including banks, finance compwanies, car dealers, and mortgage brokers, the comments said.

The relationship between facilities and residents is "premised exclusively upon one party (the resident) asking for vital care from the other party (the facility), not a loan."

AHCA has asked FTC to delay application of the rules to long term care facilities until the agency has issued planned guidance for the health care sector.

In the interim, AHCA members have been advised to take steps toward compliance. To assist with this effort, they are working with the Long Term Care Consortium, a group of AHCA staff and members, to develop guidance on examples of red flags pertaining to the two applicable rules.

—**Meg LaPorte and Lynn Wagner**

Juniper Expands Portfolio

Bloomfield, N.J.-based Juniper Communities, ranked No. 30 this year on *Provider's* list of the Top 40 assisted living chains, has acquired a memory care community from Encore Senior Living, Portland, Ore., for $3.1 million.

Formerly known as Encore Senior Village at Naples, the 70-unit facility is now known as Juniper Village at Naples.

"Juniper Village at Naples continues our company's expansion to serve markets where we have identified a need for our services," said Lynne Katzmann, founder and president of Juniper Communities.

Juniper officials said the facility will undergo upgrades and changes through the "addition of signature programs" that Juniper Communities offers in its other properties. They include daily and monthly "activities geared to promote and maintain an active body, an engaged mind, and a fulfilled spirit."

Also slated are interior and exterior initiatives to "green the residences and programs for environmental sustainability and eco-friendliness" through the company's use of green technologies and products, recycling, and energy.

In Touch College of Juniper University will also be added to the Naples menu of services. In Touch is an "education and talent development program designed to empower employees to recognize and care for a resident's individuality while developing their own skills and enhancing their careers."

Suzanne Struglinski

POLST Programs Catching On

Innovative Form Takes Advance Directives A Step Further

Implementing the use of a Physician Order for Life-Sustaining Treatment, known as a POLST, is more than just training staff how to fill out a form, advocates say.

Based on a new California law that requires all health care providers in the state—including long term care facilities—to honor a POLST, there's a movement to help staff members work together to make it an integrated part of resident care.

At the heart of a POLST, which started at the Oregon Health & Science University (OHSU), Portland, in 1991, is the desire to follow a patient's medical wishes near the end of life.

POLSTs take traditional advance directives a step further by following patients in their medical records, says Patrick Dunn, chair of the Oregon and National POLST Paradigm Initiative Task Force.

Determine Patient Wishes

The forms, signed by physician and patient, are usually in bright colors to be easily noticed. They document patients' wishes regarding resuscitation, medical intervention, use of antibiotics, and artificial nutrition into a physician's order, not just a listing of their preferences, says Dunn, who is also director of ethics education at OHSU.

For example, nursing facility residents can say they do not want to be transferred to a hospital and specify what measures they want or do not want to be taken.

Bernard Hammes, also a member of the task force, said a POLST form may not cost much, but different layers of staff need training on how to coordinate its use.

From the person at the front desk who handles paperwork, to social workers and those in charge of moving patients to a hospital in the event of an emergency and the paramedics who get them, all need to know a POLST exists and how to carry out its instructions.

"In order for a POLST form to work, everyone has to understand their responsibilities," says Hammes, who is the director of medical humanities at the Gunderson Lutheran Medical Foundation in Lacrosse, Wis.

> 'Facility residents can say they do not want to be transferred to a hospital.'

This is exactly why the Oakland-based California HealthCare Foundation approved more than $2 million to help support community coalitions, a statewide task force, and the development of a standardized approach to POLST education.

The California Coalition for Compassionate Care, Sacramento, is the primary grantee. The coalition awards smaller groups, usually divided by county and made up of hospitals, long term care facilities, and emergency services, portions of the grant to help them establish POLST protocols in their local communities. Home care agencies, physicians, and hospice providers also participate.

So far the grant has funded seven coalitions in 2007, with 10 additional groups set to receive funding by the end of the year.

Meaningful Conversations

Kate O'Malley, senior program officer at the California HealthCare Foundation, said the local coalitions lead training and workshops to help nursing facility administrators determine who at their facilities should be in charge of handling POLSTs, but also how to address the end of a resident's life.

"The POLST form is not what this is about, it is about having these conversations and how to have these conversations in a meaningful way," O'Malley says. "Completion of the POLST should not become a to-do list item. It should be a rich and meaningful conversation about their end-of-life wishes."

Judy Citko, executive director of the coalition, says implementing the use of a POLST "is a culture shift," so helping others learn more about it is vital to its success.

Part of the process is figuring out exactly how to have these conversations with patients and how to explain their options with them or their families.

Grants Enable Training

Using a share of the coalition's grant divided among seven counties, Steve Lai, MD, and Danette Flippin of the Geriatric Clinic at the Santa Clara Valley Medical Center started their own coalition to increase the knowledge and understanding of POLST locally. Part of their focus is helping staff ask patients about their final medical wishes, listening to their decisions, and guiding them through the form.

Flippin said that with the right communication tools, interdisciplinary health care teams from admissions staff, nurses, and social workers can help explore a resident's values, goals, and what it means to have quality of life. While a physician will ultimately sign the medical order, the other staff can learn how to counsel a resident with the options of what can be included ➤

on a POLST form and how to match it to their desires.

Jocelyn Montgomery, director of clinical affairs at the California Association of Health Facilities, said the coalition has also educated the state's licensing agency about the POLST so it is familiar with the forms and how they work in order to avoid surprises during a survey.

Montgomery said a POLST is a "step in the right direction" to help with consistency of care and coordination but also emphasizes that a POLST-type conversation should be

'Part of their focus is helping staff ask patients about their final medical wishes.'

taking place before a patient gets to a nursing facility. "It should start with their primary doctor or home health agency," Montgomery says.

Meanwhile, the San Fernando, Calif.-based Partners in Care Foundation recently secured a one-year, $60,000 grant specifically to train nursing facility staff on the POLST.

"The project's goal is to provide a tested method to make sure the patient's and family's agreed-upon decisions are respected and carried out," says June Simmons, president and chief executive officer of Partners in Care.

"In implementing this program, nursing facility staff will remove the barriers that bring about unwanted care and needless suffering, replacing them with more humane ways to honor an individual's end-of-life care wishes." ■

SNF Reaps Benefits Of In-House Child Care

Children and residents alike enjoy activities at "Camp Pickett," a day care program at the Pickett Care and Rehabilitation Center, Byrdstown, Tenn. The program has created "an instant culture change" at the facility and has been a positive experience for all involved, staff report. Started in an effort to boost employee satisfaction during tough economic times, Camp Pickett has brought residents and children together while also saving time and money for staff. The initiative was recently expanded from a summer-only to a year-round after-school activities program.

Disaster Relief Bill Would Aid For-Profits

Legislation that would allow private, for-profit nursing facilities to be reimbursed for disaster-related costs has been introduced by Rep. Ron Paul (R-Texas).

The measure would give for-profit providers access to funding for damages and other expenses incurred as a result of a major disaster or emergency declared under the Stafford Act.

Currently, only public and nonprofit facilities are eligible for such funds.

To be eligible under Paul's proposal, a nursing facility would have to be located within 30 miles of the disaster area and have at least three beds for the provision of nursing or personal care services for the elderly, "infirm or chronically ill."

The American Health Care Association (AHCA) has advocated for expanded access to disaster relief funds, noting the critical role of nursing facilities—regardless of their tax status—in providing emergency shelter and medical care in a disaster.

AHCA, while supporting the measure, is seeking a broader definition of covered facilities than the one in Rep. Paul's proposal, to include nursing facilities, assisted living, and intermediate care facilities for individuals with mental retardation.

—Lynn Wagner

New Dawn Assisted Living To Build Colorado Alzheimer's Facility

New Dawn Assisted Living has broken ground for a new community in Aurora, Colo. The facility is designed specifically for those with Alzheimer's disease or other memory problems.

Scheduled to open in spring 2009, the building, designed by Lantz-Boggio architects of Englewood, Colo., will be a single-story made up of three separate residential-style homes with 16 private apartments with private baths.

The interior, designed by CSD Interiors based in Baltimore, contains "retro accessories." Exterior, enclosed gardens give residents safe access to the outdoors. The facility also will contain residential kitchens, beauty/barber shops, dining rooms, sun porches, and activity spaces.

IRS Raises LTC Insurance Deductions

Tax deductibility levels will increase for long term care insurance polices purchased in 2009, based on new limits released by the Internal Revenue Service (IRS).

Those who itemize their tax deductions can deduct medical expenses after they reach 7.5 percent of their adjusted gross income.

The American Association for Long-Term Care Insurance (AALTCI) explains that the IRS considers tax-qualified long term care insurance premiums as a medical expense up to a certain limit based on the insured's age.

Premium costs over the IRS limit cannot be included as a medical expense, according to AALTCI, which encourages the use of a tax professional for more specific details.

The updated tax code released in October has increased the allowable limit for all age groups from the 2008 rules.

Jesse Slome, AALTCI executive director, says that beyond individual tax benefits, small-business owners can also benefit from tax rules on long term care insurance.

"Tax-advantaged long term care insurance is one of the few remaining significant tax-savings benefits for small business owners," Slome says.

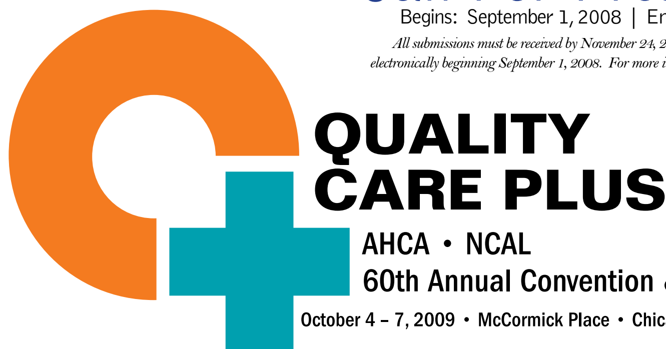
"In certain situations, the cost of long term care insurance can be fully tax deductible for the business. Even spouses can be covered under a tax-advantaged plan."

—Suzanne Struglinski

Call For Presentations

Begins: September 1, 2008 | Ends: November 24, 2008

All submissions must be received by November 24, 2008. Applications should be submitted electronically beginning September 1, 2008. For more information visit www.ahcaconvention.org.



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You are invited to submit a seminar proposal for consideration. The focus for the AHCA/NCAL 2009 convention program will include content that supports our mission of care to the long term care community. Don't miss this opportunity to share your expertise with other professionals.

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ncal National Center for Assisted Living