New England
ADMINISTRATOR

December
2019

"Never put off till tomorrow what may be done day after tomorrow just as well."
-Mark Twain

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Marketing healthcare in times of trouble

by Irving L. Stackpole, RRT, MEd

THERE IS A TEMPTATION IN TIMES OF TROUBLE TO REACH FOR DIFFERENT MARKETING TACTICS. This inclination is not exclusive to health care or long-term care markets. When what you've been doing no longer works, it's time to try something different, right?

This logic has been used in many recent articles and presentations about how skilled nursing providers can "survive" and or "thrive" in the midst of the most significant sector-wide contraction ever. While the logic is appealing, the suggestions have been, for the most part, too simplistic or impractical.

Definitions Make a Difference

By "marketing,"I don't mean advertising, promotions or communications. These are certainly important but the underlying core of marketing is the management of the provider/consumer interface. This means understanding demand from customers and consumers, and matching that demand with appropriate services ("supply"). In most marketplace areas in the United States demand has been declining, and the supply has been contracting slowly in the face of that declining demand. This is a new phenomenon in the skilled nursing sector, and has prompted consultants, pundits and others to suggest a host of quick fixes and alleged solutions to the situation.

Irving L. Stackpole

If You Build It, They Will Come?

For example, a recent article that appeared in McKnight's suggests that the way forward for skilled nursing providers is to invest in physical plant renovation and upgrading their properties. It's certainly true that there have been precious few capital investments in SNF physical properties since the late 1980s, early 1990s.

To put this in sharp relief, no business or leisure traveler would stay at a Hilton or Marriott that hadn't been updated for 30 years!. Yet this is what we expect of the SNF consumer. The comparison breaks down because SNF consumers don't have a lot of choice; most of the inventory in most marketplace areas is pretty grim.

This begs a fundamental question: Where would the money come from for a sector-wide upgrade? Let's assume that there are 7000 skilled nursing centers that can and should be renovated; is the HUD program going to underwrite this level of investment? Can private funds be borrowed or secured based on the weak cash and market positions of most nursing centers? Many SNFs are already highly leveraged; how would further loans or debt be secured?

Do Something Different

Another frequently flogged tactic is diversification. Diversification into gero-psych, dialysis or ventilator care, for example, is only practical if demand in the marketplace is present, there are no other providers who have a lock on the referral channel, and a feasibility or ROI is foreseeable. Any of these programs can succeed in a particular market, however the demand for these .services is often "thin" And the providers supplying the demand have often been in the market for a long time so they have built up a secure, preferred referral channel. Breaking into that market pathway can be difficult, time-consuming, and expensive.

Renovations to make a property more attractive, and diversification into new streams of business are not fundamentally bad ideas. I suggest that there is no one-size-fits-all, and there are no simple answers to the supply and demand imbalances that are manifest in many markets. What is needed is an eyes-open, careful analysis of what's needed in the market, the likely source of payment for that demand, and a realistic assessment of your ability to absorb that demand in a profitable timeline.

What Works

The unfortunate fact is that what will work in one marketplace may be a complete flop in another. There is no substitute for careful market analysis.

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Physical, occupational, and speech therapy contract negotiation

–Top 11 things you need to know for PDPM

by Kris Mastrangelo, OTR/L, MBA, LNHA

With the advent of PDPM (Patient Driven Payment Model) on October 1st, 2019, two of the hottest questions are:

- Should a skilled nursing facility (SNF) outsource therapy services?
- What is the best fee structure between the SNF and therapy contractor?

Approximately 50% of SNFs use outside vendors to perform physical, occupational and speech therapy services for their patients inclusive of all payer sources (Medicare Part A, Medicare Part B, managed care, managed Medicare, Medicaid, private and ACOs).

The utilization of a therapy service vendor offers the SNF many benefits, such as staffing, program development, and oversight, and can be quite appealing. One of the most common reasons noted for using a contract therapy vendor: "It's one less thing I need to worry about."

Kris Mastrangelo

Let's count down the top 11 things you need to know for PDPM:

1. Compliance Risk

It cannot be reinforced enough that the SNF owns the risk, regardless of whether the therapy department is in-house or contract labor.

Utilizing a therapy provider may lessen the perceived stress of overseeing the therapy department logistics, however, it does not minimize the SNF's risk. Remember, all the therapy services are being billed through the SNF provider number; hence, the submission of a clean claim is the burden of the provider, not the therapy vendor.

2. Indemnification of Charges

Do not be fooled with "indemnification" clauses that evoke a false sense of security. These statements proclaim that denied claims will be guaranteed/reimbursed by the therapy company to the SNF.

Caveat:

- If the claim is deemed a False Claim, the government does not permit indemnification.
- Indemnification typically applies to only the "therapy portion" of the lost revenue.

3. Align Incentives (Care and Cost)

Choose a therapy provider that offers a fee schedule that is in alignment with providing optimal care. In other words, be sure that the contractual arrangement does not contradict the provision of therapy due to costs.

For example, paying a per day RUG level (or PT/OT/ST Component) incentivizes the therapy provider to give less therapy.

Today, most SNFs utilizing contract therapy pay $.97 to $1.30 per minute for Medicare Part A patients, with the average fees at $1.00 per minute. This affords an inherent alignment as the minutes have a direct relationship to the level of reimbursement.

Under PDPM, this arrangement may not make sense. The SNF wants to be sure that there is no incentive for the quality of care to be jeopardized by financial motivators.

Under PDPM, if the SNF pays the therapy vendor by the RUG level or Therapy Component, there needs to be oversight that the services were rendered.

4. Rates by the Hour

Consider obtaining a fee structure that is an hourly fee. This ensures that the SNFs only paying for the hours associated with efficiency for patient care rendered. (See item 8.)

5. Rates by Discipline and Degree

Consider negotiating an hourly rate that is commensurate with the skill level of the healthcare professional. In other words, the registered therapist, therapy assistant, and aide hours will be varied. The higher the skill, the higher the rate. This prevents paying registered clinician rates for aide-level services.

6. Rates by Mode of Therapy

Like the above rates by discipline and degree, consider obtaining an hourly fee by mode of therapy:

- Evaluations
- Individual
- Groups
- Concurrent

This prevents paying individual rates for group services.

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A UNION CAMPAIGN

by W. Bruce Glass, FACHCA, CNHA, CALA

Next to the arrival of surveyors, the most dreaded event by any administrator is an approach by a union.

In New England, the most active labor group is Service Employees International Union (SEIU), but they are not alone in their pursuit of healthcare membership. Hospitals most often have to deal with one of several nurses' organizations. But a number of other unions operate in nursing homes with some success. Fortunately, thus far they have made few inroads into assisted living.

This is the story of an actual union campaign.

Deutsches Altenheim, German Centre for Extended Care, is a multi-service, not-for-profit organization in Boston, Massachusetts. Founded in 1914, it currently provides skilled nursing, assisted living, adult day health, outpatient rehab, memory care, and post-hospital rehabilitation at its West Roxbury campus. It has a staff of approximately 260.

The United Steelworkers (USW), based in Pittsburgh, represents workers in various manufacturing fields and has also diversified into healthcare—primarily in the Midwest.

It began one evening on the sub-acute unit. A patient's family member overheard a part-time nurse grumbling about an injustice—real or imagined. As it happened, he was a business agent for a USW chapter.

Sensing an opportunity for a union that was struggling with declining membership, he approached the two nurse. In the subsequent conversation, he assured them he could bring about improvements in wages, benefits, and working conditions. They listened.

Shortly thereafter, three organizers flew in from Pittsburgh and set up shop in the local Holiday Inn. Thus began their campaign to bring Altenheim employees into the fold.

Management was initially surprised by the action, because staff turnover was under 10%, and the majority of employees had worked at the facility for many years. An open-door policy meant that staff members felt free to bring concerns to management at any level. Because of that relationship, undermining the stealth often used by unions, management learned almost immediately of the union approach.

The USW is a long-established manufacturing union, so it began a traditional campaign

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in a field where it was barely visible (at the time, the organization represented only two nursing homes in the Midwest). Using their initial contact, the organizers held a series of "get acquainted" meetings at the homes of sympathetic nurses. Flyers began appearing that included criticisms of management and tales of the unions' myriad benefits.

Next came an effort to obtain card signatures. Among the most important tools of the organizer, signed cards legally authorize union representation. In order to succeed and petition the National Labor Relations Board for an election, it is generally accepted that more than 60% of eligible employees must sign these cards.

Under NLRB rules, both sides are bound by certain restrictions during the union drive. For management, the most important is "TIPS." One may not:

- **Threaten** "If the union gets in, we may be forced to close"
- **Interrogate** Ask staff members about their interest in the union.
- **Promise** "If you reject the union, we'll increase pay."
- **Spy** Listen in on employees' conversations or plant someone at a union meeting.

It is critical for management to obtain a competent labor attorney at this point to avoid unfair labor practices (ULPs), which could cause fines or even a mandated imposition of union representation. A common union tactic—one used in this case—is to file numerous ULPs to harass and cause ongoing expenditures to defend against them. One of these involved a maintenance man who attempted to get employees to sign cards—physically chasing them while on duty. When management ordered him to desist and return to his workstation, a ULP was filed.

The union is entitled to obtain a list of employee names—lacking addresses or phone/e-mail numbers. But, often, a sympathetic office employee will pass these on to the organizers. Fortunately, that did not happen during this campaign.

Union organizers are not permitted to solicit on the property (provided the facility has an enforced "no solicitation" policy). Often organizers will test that policy, especially during off hours. On several occasions, organizers were asked to leave the premises.

Management is allowed to meet with staff to present its case, but may not ask individual opinions about the union. It may, however, listen to anyone who volunteers a comment. In this case, the union was unaware of the loyalty of the German Centre's staff, which freely and voluntarily apprised management of union activities.

An interesting sidelight to the campaign was territoriality. SEIU was not happy with the USW 's intrusion in what they considered their turf, and mounted pickets of their own aimed both at the German Centre and USW. However, SEIU officials soon realized that they were unlikely to win the campaign, and quickly abandoned the site.

It took a bit longer for USW to realize they were fighting a losing battle, but after four weeks, the three organizers packed up and went back to Pittsburgh—not even bothering to petition for an election. As it turned out, they managed to get a total of nine cards signed out of 205 eligible employees.

Of course, not all union campaigns have such a happy ending. Unions, and particularly SEIU, still consider nursing

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UNION ACTIVITY IN NEW ENGLAND

There is a great disparity of union activism between southern and northern New England. Vermont has no unionized homes, Maine has only three, and New Hampshire has 11, but ten of them are county-owned homes.

The picture is very different in the more liberal and Democratic states. Rhode Island has only 8 unionized homes out of 82, but the union has been active in promoting mandated staffing ratios as well as increased payment.

In Massachusetts, only 35 out of 353 belong to a union. A strong push in the later decades of the 20th Century did not significantly increase that number.

In Connecticut, union influence has been the greatest, with 61 of 217 under contract. With strong support form Democratic politicians, unions have been a powerful force in regulation and reimbursement.

Service Employees International Union (SEIU) is, by far, the most aggressive union in senior care, and is one of the few national unions gaining membership. Utilizing the community approach, whereby clergy and other community leaders are recruited to support organizing activity, they have had considerable success, both nationally and in New England.

With more than 400,000 members between them, Local 199, based out of New York, and MA State Council in Boston, have donated more than $10 million each year to Democratic politicians in the region. Fortunately, their primary focus of late has been in hotels and colleges, which has taken some pressure off nursing homes and assisted living.

To learn more about SEIU, UFCW, or any other union, go to www.unionfacts.org.

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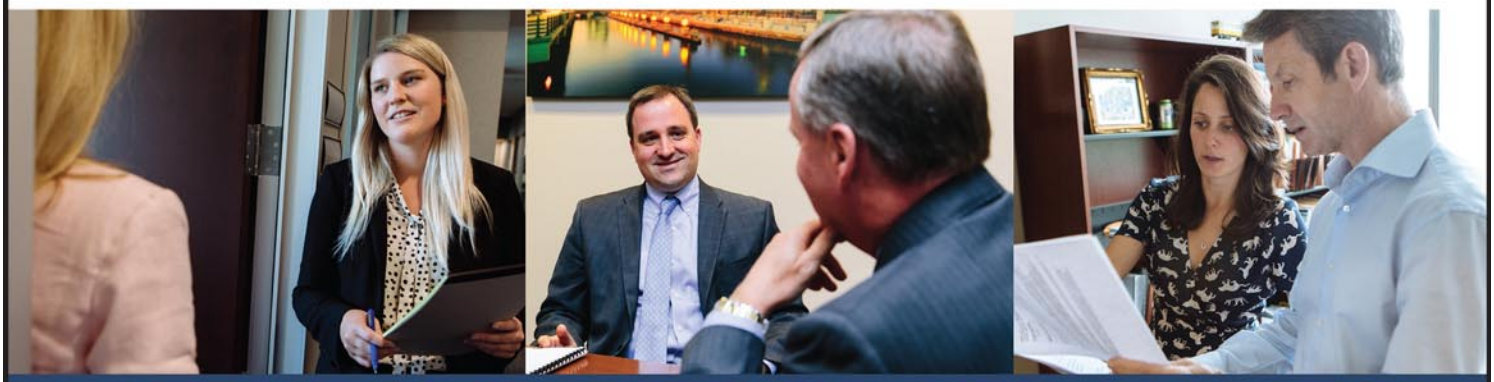

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Labor and employment law update 2020: What is next?

by William E. O'Gara

For healthcare employers sprinting (or staggering) to the finish line of 2019, the obvious question is "What awaits in 2020?" While there is never a perfect crystal ball, the following are several trends and workplace issues that are likely to dominate 2020.

Worker shortages and union activity

A critical challenge facing the healthcare industry is a shortage of healthcare workers that shows no sign of easing. A recent study estimates that the United States will need to hire 2.3 million new healthcare workers by 2025 to care for its aging population. The shortages impact virtually every occupation, with both high skilled positions like nurse practitioner and other positions such as CNAs expected to face continuing and growing shortages. The magnitude of the problem is reflected in recent United States Department of Labor employment projections predicting that in the next decade just two classifications—home health aid and personal care aid—will require more than 1.1 million additional workers. In 2020 the shortage will almost certainly worsen.

For many healthcare employers the ability to retain and compete for the limited pool of workers is constrained by low reimbursement from governmental and private insurers. The ongoing effort at the federal and state level to constrain healthcare spending has caused hospitals, nursing homes, and other institutional providers to do more with less and struggle financially. This, in turn, has impacted employee staffing and compensation.

William E. O'Gara

The combination of labor shortages and a limited ability to compensate workers can create fertile ground for union organizing. For healthcare employers, understanding the basics of how unions organize is a must. While emphasis in the business media has often been put on the changes in the composition of the National Labor Relations Board (NLRB), the reality is that the basic process of organizing a workplace has not changed in decades. Employees have the legal right to engage (or not engage) in union activities and to decide if unionization is advantageous. The critical step in unionization is a secret ballot election conducted by the NLRB. If the union wins the election, the employer is legally required to recognize it and negotiate in good faith to reach a contract. A signed contract reached after negotiations will secure the union's continued existence and provides a financial benefit to the union in the form of dues deductions.

The process of getting to an election is fairly straightforward. The union interested in organizing employees may be approached by one or more employees dissatisfied with the status quo. Alternatively, the union may identify an employer as a good target to organize and reach out to employees to see if they are interested in forming a union. Assuming there is some basic interest, the next step is to encourage employees to "sign cards." The pre-printed cards identify the union and indicate that the employee is supportive of the union representing him or her for the purposes of collective bargaining. The goal for a union is to have more than half of the employees sign the cards. When the union has more than half of the cards signed, it will present the cards to the local office of the NLRB. The NLRB will review the cards and contact the employer to schedule an election.

Often the employer does not learn of an organizing effort until the NLRB contacts it to schedule the election. The elections typically occur within a matter of weeks. For an employer, this limited window can impact its ability to effectively make a case to employees that it is not in their interest to vote in favor of the union. In addition, what an employer can and cannot say to its employees regarding unionization prior to an election is highly regulated by the NLRB. Not surprisingly, unions more often than not win these elections.

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A union campaign thwarted

Continued from page 6

homes as prime targets. Recent NLRB rulings that greatly shortened the time management has to defend itself is a powerful weapon in union hands.

Unionized homes are relatively rare in New England. It is worth noting that well-run homes are rarely targeted. The financial constraints that we face throughout the region are not helpful, but money is rarely the main issue. Open communication and consistent, fair treatment of staff are far more vital, and will almost always insure an organization against unionization.

This USW conducted a traditional union campaign at the German Centre. However, SEIU, the most active healthcare union, often uses what is known as a "Community Campaign." Rather than seeking an election through card signing, the union will recruit clergy and other influential community leaders to pressure management to voluntarily accept union representation.

In rare cases, troubled homes have actually invited unions in, believing they would help recruit badly needed staff. (They don't.)

Resources

Unionfacts.org. This website provides detailed information on every union in the country. It can be a powerful weapon during any union campaign.

NLRB.gov. The governing body for all union activity sets the rules, conducts elections, and is godlike in its authority.

Of course, the Internet is boundless in the information available, some accurate, some not. And, finally, your attorney is your strongest ally. Periodic training of management staff is strongly recommended.

W. Bruce Glass, FACHCA, CNHA, CALA is licensed for both Nursing Homes and Assisted Living in several New England states. He is currently Principal of BruJan Management, an independent consulting firm. He can be reached at bruceglass@rocketmail.com.

Arbitration Agreements: New CMS Rule in Effect

by Alyssa Nugent

The Centers for Medicare and Medicaid Services (CMS) issued a final rule on the use of pre-dispute, binding arbitration agreements by long-term care (LTC) facilities that alleviates some of the uncertainty surrounding the agreements following the U.S. Supreme Court's 2017 decision in Kindred Nursing Centers v. Clark. The new rule repeals the outright ban of pre-dispute, binding arbitration agreements between an LTC facility and its residents enacted in 2016. The new final rule, issued on July 18, 2019, went into effect on September 16, 2019. LTC facilities are again able to utilize pre-dispute, binding arbitration agreements, albeit with some new restrictions and requirements.

Alyssa Nugent

Prior to the 2016 prohibition, pre-dispute, binding arbitration agreements were often included as part of the admission packet provided to residents and their families. Arbitration is a method of dispute resolution alternative to litigation. The dispute is presented to a neutral decision-maker, the arbitrator. The arbitrator's decision is binding on both parties.

Claims are generally resolved faster, and with lower expenses, through arbitration. Regardless of the benefits, patient advocate groups argue against the use of pre-dispute, binding arbitration agreements, because residents are asked to enter into such agreements without contemplating what the agreement entails. At the time of admission, residents are not considering that they may receive poor care or be the victim of violence while in an LTC facility. A pre-dispute, binding arbitration agreement covers all potential disputes. Some residents end up feeling robbed of their day in court when they are forced to pursue their claim through the arbitration process.

The U.S. Supreme Court's decision in Kindred Nursing Centers v. Clark threw the legality of the 2016 rule, enacted

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Labor law update 2020

Continued from previous page

For employers, the takeaway is that engaging with employees long before an organizing effort is critical. Unions successfully organize when workers believe that the employer has failed to respond to their issues and concerns. Employers need to be in constant communication with employees and must provide an effective process for issues and problems to be addressed and corrected. When that does not happen, your employees may view forming a union as the solution to all of their real and perceived problems.

Bullying in the workplace

In the past year there has been a growing focus on the problem of bullying in the workplace. Model legislation that would allow employees to sue employers based on bullying claims has been introduced in over 30 states. The issue shows no sign of fading in 2020 and the effort at the state level to pass legislation will likely continue to gain traction.

Employers should have a strong policy prohibiting bullying and a process to deal effectively with complaints. Much like the now familiar sexual harassment policies employers must have and enforce, employers should be on the front end of addressing bullying so that when workplace bullying laws are enacted, they are compliant from the beginning. Simply put, employers need to maintain a culture and work environment that does not tolerate bullying and effectively deals with issues in a timely manner.

Pannone Lopes Devereaux & O'Gara LLC will present a workshop on this issue in early 2020. Stay tuned.

William E. O'Gara is a Principal at Pannone Lopes Devereaux & O'Gara LLC. He leads the firm's Employment Law, Litigation and Mediation teams. With over 25 years of experience, he has handled a wide range of cases including employment discrimination, wage and hour claims and sexual harassment claims. He assists clients in matters ranging from contract negotiations to arbitration and has successfully mediated a wide array of disputes both at the pre-litigation stage and before trial. As part of his practice, Attorney O'Gara conducts workplace investigations and provides training for managers and supervisors on employment-related issues, and represents clients before state and federal courts, as well as administrative and regulatory agencies. Attorney O'Gara earned his J.D. from Northeastern University and is admitted to practice law in Rhode Island and Massachusetts.

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39% of healthcare organizations are hit daily or weekly by cyberattacks

by Phil Cardone

Cybercriminals are on a mission to gather high-value medical records. Why? Because they're incredibly lucrative for hackers looking to make money on the dark web.

In fact, medical records can sell for up to $1,000 per patient due to the amount of data found within the documents, including social security numbers, dates of birth, credit card information, and more. So, what happens to the patients who have their medical records compromised? They're often left struggling with the aftermath for years.

What is the dark web?

The dark web, also known as tor or the onion web, was released in 2004 as a more secure, encrypted form of the Internet. It encrypts traffic to keep end-users anonymous and un-linkable to their devices. Websites end in .onion rather than .com or other variations we commonly see. Although the dark web has some reputable purposes, it's become a commonly used place for cybercriminals to buy and sell illegal products and/or services, such as weapons, drugs, and stolen data.

Phil Cardone

A cybercriminal can purchase all of the necessary tools and services to commit a massive, coordinated cyber-attack. Check out some of the prices on goods dedicated to this exact purpose:

- DDoS attack: $50 a day
- Targeted attack: $4,500 and up
- Hacking emails: $40 and up
- Infecting with ransomware: $750 and up
- Hacking websites: $150 and up

As mentioned above, medical records are very lucrative and sell for a high amount on the dark web.

What is the risk of cybercrime for healthcare organizations?

The risk is high given the nature of how valuable medical records are. Radware, a leading security solutions provider, released a report stating that healthcare is the most second commonly attacked sector—falling shortly behind government. The average healthcare organization spends $1.4 million to recover from an attack. And to make matters worse, 39% of healthcare organizations reported being hit daily or weekly.

What makes the aftermath so costly? There are a range of factors contributing to the high cost of recovering from an attack:

- Productivity loss
- Recovering systems
- Reputational damage
- Drops in stock values
- Loss of patients

Does cybercrime put patient lives at risk?

Ransomware, in particular, is an increasing concern for healthcare organizations. Essentially, ransomware involves a hacker encrypting your systems and/or data and demanding a ransom fee in exchange for giving you access back. Cybercriminals can potentially take advantage of people who have ailments treated with cloud-based monitoring services, automated administration of prescription medicines, and other devices connected to the internet.

They're able to commit a ransomware attack that stops the delivery of important health services —putting patient lives at risk. It's a scary concept, especially when you consider how advanced and sophisticated cybercrime has become.

What should healthcare organizations do to minimize risks?

Healthcare organizations must work with an experienced IT company that knows what they're doing when it comes to minimizing risks. They should be familiar with HIPAA rules and regulations, in order to ensure they're implementing the right technical safeguards to protect electronic health records. This may include:

- Running anti-virus scans on a regular basis to detect and eliminate threats.
- Implementing web-content filtering software to block access to dangerous sites.

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Upcoming Events

Friday, December 13, 2019
Conn. Chapter Holiday Luncheon

Sunday to Tuesday, December 15 to 17, 2019
New England Alliance Winter Meeting
Woodstock Inn and Resort

Monday, April 1, 2020
Mass. Chapter Annual Meeting

Sunday, May 3, 2020
ACHCA Convocation & Expo

The Medicare Expert's top 11 things you need to know for PDPM

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7. Rates by Payor

Consider negotiating the same fee structure regardless of insurance payor source.

OBRA '87 regulations require facilities to provide services to meet "the highest practicable physical, medical and psychological well-being" of every resident regardless of payor source.

The medical regimen must be consistent with the resident's assessment (performed according to the uniform instrument known as the MDS) and interdisciplinary care plan.

Any decline in the resident's physical, mental or psychological well-being must be demonstrably unavoidable. (483.25).

8. Productivity

Consider obtaining an hourly fee with a productivity standard. This ensures that you are only paying for the hours rendered in an efficient manner. An acceptable benchmark is 75%. Be sure to define what is considered productive versus non-productive time and that payroll reports and therapy software matches. Discrepancies are a red flag and may result in significant compliance issues.

9. Non-Compete

Give yourself flexibility with the unexpected reimbursement changes. Do not lock in to a payout for therapists. Structure a deal that allows you to have the ability to change the model (i.e., in-house) without incurring extensive buyout costs.

10. Medicare Part B Fees and MPPR Impact

An area that requires heightened attention is the fee structure between the SNF and therapy contractor specifically for Medicare Part B. This has been even more critical since the inception of the Multiple Procedure Payment Reduction (MPPR) back in April of 2013.

In general, a fee structure of 75% of fee schedule to the therapy contractor means that the SNF is losing money. At 75%, it is estimated that it costs the SNF approximately 8% of total charges.

For example, if the Medicare Part B charges are $100,000 for the month, the SNF pays the contract provider 75% or $75,000. The SNF thinks they are pocketing $25,000 of the charges. In fact, not only is the SNF not receiving $25,000, it is costing approximately $8,000 (8% of the charges) and the labor related to competing the Medicare Part B Billing.

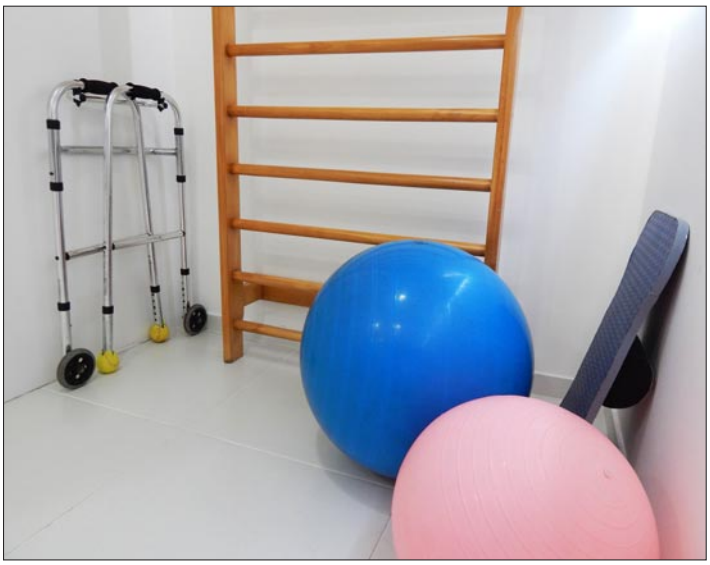
Let's review the Multiple Procedure Payment Reduction (MPPR):

Effective April 1, 2013 CMS implemented a process of reducing payment on multiple procedures rendered during the same visit.

This applies to all therapy procedures rendered in the same day!

For example, if occupational therapy and physical therapy both gave treatments on a Monday, CMS pays the highest dollar amount for one procedure and reduces all subsequent treatments (procedures) by 50% of the PE (practice expense) component for all disciplines. MPPR combines PT/OT and ST.

The geographic pricing index (GPI) and the relative value unit (RVU) of three components, work expense, practice expense and malpractice expense, are multiplied by the local conversion factor.



Any reduction of the practice expense is a game changer, because it essentially represents the lion's share of reimbursement.

The net result is the SNF receives 8% less total due to MPPR. Add in the 25% co-pay that typically is bad debt and the facility nets 67% of Medicare Part B charges.

Hence, 67% is the most you should be paying for Part B services.

11. Best Decision-Making considers all variables

Do not make therapy vendor contractual decisions based solely on expenses. Weigh the impact of all the variables including revenue. Be sure to see the forest for the trees. The total expense for therapy may be the same as owning the therapy staff, but the other aspects of the fees structure may offset this perceived savings.

For example, a provider may think that converting from in-house to contract is a win because of the cost savings for the therapy labor. When in fact, the net savings is a massive revenue decrease and less labor for patient care.

A real-life example is a provider that made the leap from in-house to contract therapy solely because of a 500K decrease in labor expense. When in fact the Medicare Part B fees at 75% of the CPT Code cost the facility $500K. This is not a wash. There are financial and clinical ramifications of this decision including:

- Less labor
- Less revenue
- Less potential revenue

There may be other reasons for the conversion that prompted the deal. However, it is super important to lay out all the variables for the team to make the best decision.

Multiple Procedure Payment Reduction (MPPR)

	Practice Expense	Work Expense	Malpractice Expense
Unit 1	100%	100%	100%
Unit 2	50%	100%	100%
Unit 3	50%	100%	100%

Kris Mastrangelo, OTR, MBA, NHA, is president and CEO of Harmony Healthcare International and is a nationally-recognized authority of Medicare issues. She is a regular contributer to the New England Administrator. *Contact Kris : 800-530-4413. harmony-healthcare.com*

New CMS Arbitration Agreements Rule in Effect

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at 42 C.F.R. § 483.70(n), into question. Kindred Nursing Centers v. Clark arrived at the U.S. Supreme Court after it granted a writ of certiorari from the Kentucky Supreme Court. The case centered on two residents who had passed away while at a Kentucky LTC facility. Each resident's estate brought an action against Kindred Nursing Centers.

At the time of admission for each resident, their agent through a power of attorney entered into a pre-dispute, binding arbitration agreement. The Kentucky Supreme Court analyzed each power of attorney document and determined that the pre-dispute arbitration agreements were invalid, because the agents did not have the authority to enter into an arbitration agreement on behalf of the residents. The U.S. Supreme Court overturned the decision, finding that the 1926 Federal Arbitration Act preempts any state law that disfavors arbitration agreements. CMS ceased attempts to enforce the ban on pre-dispute arbitration agreements in 2017, due in part, to the Kindred ruling.

Since September 16, 2019, LTC facilities are free to use pre-dispute, binding arbitration again. Operators of LTC facilities should exercise caution before reintroducing pre-dispute, binding arbitration agreements because the new rule is not a return to the pre-2016 landscape. The new rule provides middle ground, addressing some concerns of patient advocates while still allowing LTC facilities to utilize the potentially cost-saving agreements.

First, the new rule prohibits LTC facilities from mandating the execution of a pre-dispute, binding arbitration agreement as a condition of admission or prerequisite for continued care. The arbitration agreement, itself, must explicitly state the same. Moreover, the facility must inform the resident or her representative of her right to refuse to sign the pre-dispute binding arbitration agreement.

LTC facilities that utilize these agreements are required to explain the document to the resident or her representative and secure an acknowledgment of understanding. The new rule also provides the resident or her representative a thirty-day right to rescission of the arbitration agreement. Each pre-dispute, binding arbitration agreement must provide for the selection of a neutral arbitrator agreed upon by both parties and the selection of a venue that is convenient to both parties. Any language that prohibits or discourages a resident or anyone else from communicating with federal, state, or local officials cannot be included in arbitration agreements under the new rule.

LTC facilities are required to keep a copy of the signed arbitration agreement and any arbitration decisions for a period five years. CMS has the ability to inspect any arbitration agreement or arbitration decision. A number of other minor provisions, designed to protect residents, are included in the final rule and discussed in the Federal Register at 84 F.R. 34718.

Before operators of LTC facilities dust off their old pre-dispute, binding arbitration agreements and add them back into their admission packets, each agreement should be reviewed by an attorney to ensure that it complies with all provisions of the new rule. Facility staff should be educated about what they are allowed to say to residents and their representatives about pre-dispute, binding arbitration agreements. Operations should carefully evaluate their admission procedures at large, and if needed, update their policies and practices to ensure not only that they are compliant with the new CMS rule, but also to ensure they are maximizing every cost-saving mechanism available to them.

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Cyberattacks

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