Florida Life Care Residents Association
FLiCRA
A resident-led association to ensure quality of life in retirement communities

The Resident CONNECTION

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President's Message

FLiCRA, with the Board in full work mode here at midyear, is in a good position toward fulfilling our mission to ensure the quality of life for residents of continuing care retirement communities (CCRCs). Two new board members since November had little time to ease into their new roles in FLiCRA leadership. Shown to be "ready to roll" and already rolling are Jim Jandreau, Director At Large, and Ramsey Geyer, Region 2 Director. They join an active Board that recognizes there must be a close connection between thinking and doing, and are expected to help provide foresight, oversight, and insight in the Board's responsibilities to steer FLiCRA towards a sustainable future, through contacts with state elected officials and state regulatory agencies.

Multi-topic agendas are the norm for every board meeting. The three topics mentioned herein are among those requiring formation of study groups from among the board members tasked to bring back findings and recommendations to the full Board for further determinations.

Legislation - Before this year's 2016 State Legislative Session ended in March your FLiCRA Board was aware of the need for additional protective amendments to Florida law. This is even in the wake of last year's successful omnibus bill. The new provisions to Chapter 651, FS, that are now in effect resulted from well over a year of FLiCRA's collaborative efforts on a Joint Task Force with LeadingAge, the CCRC owners, operators, and our management association.

Now, working together again on proposed bills for the 2017 Session is particularly crucial, since CCRC ownership and management is being directly addressed in drafting proposals for legislation relating to ownership changes, acquisitions, and enforcement mechanisms for compliance with reporting requirements of the Office of Insurance Regulation (OIR), under the Florida Department of Financial Services (DFS).

The OIR, as the state agency responsible for regulation and enforcement of certain CCRC laws, recognizes that circumvention of these laws was experienced while dealing with actual CCRC situations, not hypothetical or "what ifs", during the nearly two-year-long court case of the DFS vs. a contested ownership of a CCRC with financial failures, and the resultant fall-out.

Fair and just treatment of a society's older peoples still must be addressed: almost 4,000 years ago the Code of Hammurabi, with 282 laws covering an extended area, found the need to include laws for the protection, care, and respect of the older population, with strong punishments set for violations.

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Here in our day and age, we find that FLiCRA must continue to propose and ensure passage of legislation to preserve and promote the protection of our CCRC residents.

FLiCRA Management Contract with PIAM – The Executive Committee and Board had benefit of the special skill sets Jim Jandreau provided as applicable to the responsibilities for the Board to hire and consider the renewal of contracts with an executive director and company to run the management activities of FLiCRA and manage day-to-day operations. Updates were recommended to the current contract for the valuable services provided by Partners in Association Management (PIAM) under talented Executive Director Bennett Napier. These additions include more technological protections along with enhancements that can be considered best business practices.

FLiCRA /National Continuing Care Residents Association (NaCCRA) Relationship – Rev. Bob Nicholson, President of NaCCRA, had a place on the agenda for the FLiCRA Board's February Meeting. At that time, in the interests of promoting NaCCRA growth, he requested that ways be explored for a stronger affiliation between the two associations. A Work Group of several FLiCRA Board Members was formed and headed up by Jim Jandreau. The Group held teleconferences with NaCCRA Board representatives; discussion points were brought back for further Board considerations.

From these three board topics alone you can be assured that the FLiCRA Board engages in substantive and productive matters of importance to members.

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Out of Network Law Passed by Florida Legislature and Signed by the Governor

House Bill 221 was passed during the 2016 legislative session. The new law limits the charges consumers face when they have no choice but to use out-of-network medical providers. It would leave insurers and healthcare providers to settle such disputes.

Twenty-three states in all are currently working towards or already have some consumer protections against surprise medical bills. One of them, New York, has among the strongest consumer protection laws for out-of-network billing in the country. It went into effect last April.

The law requires that patients in emergency medical situations pay no more to out-of-network providers than they would have paid to those that are in-network. If there is a dispute over medical bills, the consumer doesn't have to handle it. It must be settled between the insurer and the medical provider.

President Obama has also proposed in his 2017 budget for Health and Human Service a provision to end surprise out-of-network medical bills. Separately, the Center for Medicare and Medicaid Services now requires disclosure when an out-of-network physician will be providing services to protect consumers from surprise billing in emergency situations.

STEPS TO AVOID OUT-OF-NETWORK CHARGES

While the states are making progress to protect you, you can help yourself as well. Before you go to the hospital:

• Check that the healthcare provider or hospital you use has a contract with your insurer that makes it "in-network."

• If you have a planned surgery, ask your primary doctor whether there will be other doctors or services involved in your treatment. Then call your insurer to check if they are also covered by your plan.

• If you are charged for out-of-network expenses that were beyond your control ask your healthcare provider if they will take a lower payment so that it's comparable to an in-network price.

• Ask your insurer to negotiate with the doctor on your behalf. If that doesn't work, file an appeal with your insurer. If the insurer denies your appeal, file a complaint with your state insurance regulator.

Under the new Florida law, members of preferred provider organizations will receive protection from surprise billing by medical providers outside their network.

The bill stemmed from complaints by patients who went to hospitals within their networks for emergency care and were then stunned to receive large, unexpected bills from doctors who were not members of the patients' insurance networks.

The new law extends protections previously in place for HMO members to members of PPOs and exclusive provider plans, or EPOs. It bars patients from being billed for emergency services or covered non-emergency services provided in a hospital or other facility in the patient's insurance network for any amount that exceeds the co-insurance, co-payment or deductible contracted between the patient and the insurer.

For non-emergency care, hospitals will have to post names and links of all contracted insurers, as well as names and contact information of all practitioners and practice groups under contract with the hospital. Patients will be given statements that services may be provided by out-of-network providers and that they should contact practitioners to determine to which networks they are contracted.

Call for Nominations

It's election time again! No, we are not talking about the presidential race.

We are talking about the FLiCRA board elections.

The next slate of the state FLiCRA Board of Directors will be elected November 3rd at the 2016 Annual Conference. This year's annual conference will be hosted at Sandhill Cove in Palm City.

Detailed meeting information will be available in mid-August.

The association is seeking interested members to submit their names for consideration for open director at large seats on the state board. For FLiCRA Regions, those Regions that have open seats in 2016, Regional Directors will be elected by the chapters within the regions by early fall.

The Board of Directors for FLiCRA consists of twelve members, four of which are Directors at Large. Previous service as a local Chapter Board member is not required but may be helpful in fulfilling the duties of a state Board member.

Qualities and Duties of FLiCRA Board Members

The members of the FLiCRA Board of Directors are the stewards of the association and are responsible for reflecting the views and interests of all of our members. The Board also provides leadership, a shared vision and sense of mission for the association and is responsible for the fiscal health of the association.

A board member must be a current member of the association.

Proven Performance
Leadership requires knowledge, talent, skill, vitality and the ability to make a difference. In the association environment, that translates into a solid track record of contributing to the success of programs, events or projects.

Commitment
Serving as an association leader is both an honor and a reward; it requires a demonstrated commitment to the organization and its mission and goals.

Time and Ability to Serve
Participating fully in association activities requires extra time for attending meetings.

Understanding of Team Work
Many people contribute their efforts toward the realization of an association's goals and objectives – no one does it alone. Well-developed interpersonal and communication skills are essential to effective teamwork.

Sound Judgment and Integrity
In many instances, popularity brings potential leaders into the limelight of an association; popularity must be tempered with good judgment and integrity when difficult decisions are required.

Communication and "Teaching" Skills
By virtue of their position, current leaders serve as mentors and teachers to future leaders. Enthusiasm – a zest for serving the association is an important ingredient that leaders must possess.

Ability to Subordinate Special Interests
Leaders often emerge because of their special expertise or effective representation of a specific constituency. Leadership, however, may require subordinating those interests for the greater good of the association. In essence, an effective board member brings their expertise and specific experience to the table to provide value, but such experience and expertise should not drive the policy making process for the collective good.

Be Strategic Thinkers
Intuitive and interpretive skills enable leaders to understand the people around them, internalize the data they receive, recognize the relationships that exist between the systems within their world and integrate all these elements into a coherent whole.

Effective boards of directors approach their role focusing on policy making not day to day operations of the organization. Micromanagement of operations is not an effective use of board time nor appropriate to fulfill fiduciary roles.

FLiCRA Board Service Time Requirements:
Each term on the board is a three year term, and a board member can serve up to two consecutive terms in a director position. Officers are one year terms.

Service on the FLiCRA board requires attendance at up to three in person meetings a year (February – ½ day meeting in person, May – Teleconference or in person, November ½ day in conjunction with the Annual Conference in person).

The FLiCRA state board may also meet by teleconference 2-3 additional times a year if necessary.

FLiCRA board members are reimbursed for travel under the following policy: Board members may be reimbursed for mileage, lodging and meal expenses for attending FLiCRA meetings.

To assist in developing a slate of candidates, all members who are willing to serve for nomination to the state FLiCRA Board of Directors should submit their names, address, phone numbers and a brief career bio to: Nominations Committee Chair Hugh Strachan by July 25, 2016 c/o FLiCRA 325 John Knox Road, L103 Tallahassee, FL 32303 or by email to bennett@executiveoffice.org

The FLiCRA Village on the Green Chapter hosted an event in May with FLiCRA Executive Director, Bennett Napier, CAE. Mary Ellen Early of LeadingAge Florida also provided remarks and answered questions during the chapter meeting. Leon Golden, Village on the Green Chapter President, is seated in the middle.

Hospitals Brace for New Medicare Payment Rules

Sweeping changes in Medicare payments could affect nearly 800 U.S. hospitals' bottom lines, but not everyone is ready for the switch.

The new rules will hold hospitals accountable for all the costs of hip and knee replacements for 90 days. If patients recover and go home quickly, hospitals could reap savings. If patients have complications or need lengthy stays in a rehab facility, hospitals could owe Medicare instead.

The so-called bundled-payment initiative is the first mandatory program under the Obama administration's plan to shift at least 50% of Medicare spending to alternative-payment models by 2018.

All hospitals in 67 randomly selected metropolitan areas, including New York and Los Angeles, are required to participate. Together, they perform about one-third of the 430,000 hip and knee replacements Medicare covers annually. The Centers for Medicare and Medicaid Services, or CMS, estimates the program will save $343 million on the $12.2 billion that Medicare will spend on the procedures over the next five years.

Some top hospital systems have offered fixed-price packages for heart surgeries and joint replacements for years, or are already working with Medicare bundles voluntarily. Other hospitals have yet to get a grip on their costs, experts say.

"We're concerned that very few hospitals and physicians have developed the infrastructure necessary to meet this deadline," said Thomas Barber, chief of the council on advocacy of the American Academy of Orthopedic Surgeons.

Recently, two U.S. representatives from Georgia introduced a last-ditch bill in Congress to delay the bundled-payment mandate, saying it "comes with tremendous risk and complexity for patients and health-care providers."

Amy Bassano, incoming deputy director of the CMS Innovation Center, said, "We feel good that hospitals are ready to start on April 1."

Unlike in some bundle programs with private insurers, hospitals won't receive a lump sum from Medicare to divide among the participating providers. Medicare will continue to pay surgeons, physical therapists, rehabilitation hospitals and others involved in hip and knee replacements separately on a fee-for-service basis.

At the end of the year, if all those payments average less than a target price CMS sets for each hospital, CMS will pay the hospital the difference, provided certain quality standards are met. If the payments average more than the target price, the hospital will owe Medicare the difference, starting in the program's second year.

Experts say hospitals' best chance to stay below the target is to minimize the need for postoperative care and discharge patients directly home whenever possible.

Currently, about half of hip and knee-replacement patients spend time in skilled-nursing homes, rehab hospitals or other "post-acute care facilities," which adds substantially to the cost. Another 33% of patients get care from home-health agencies. Post-acute care makes up more than a third of Medicare spending on joint replacements, studies show.

Officially, hospitals have little control over such facilities and patients can choose where to go. But hospital discharge teams can steer patients to facilities that give high-quality, cost-effective care and keep lengths of stays low.

"The financial incentive will be very strong to shift patients into lower-cost settings," said James Michel, senior director of Medicare reimbursement at the American Health Care Association, which represents 13,000 post-acute care facilities. "We're going to

watch very closely to make sure the incentives aren't so strong that it comes at the expense of patient care." "It's very clear. If you can go home, you're better off going home, and if you can't go home, we can say, these skilled-nursing facilities do a good job and follow our discharge protocols," said Lou Shapiro, chief executive of the Hospital for Special Surgery in New York City, which has been participating in a voluntary bundled-payment program with Medicare for two years.

Starting next year, hospitals can move patients to skilled-nursing facilities faster, without keeping them for three nights first as Medicare rules now require. Only nursing homes with a three-star rating or higher from CMS will be eligible. That requirement could disqualify a substantial number in some areas, the AHCA says.

Some hospitals are concerned that the target prices—which range from about $16,000 to $35,000—don't take into account the varying severity of patient conditions or socioeconomic factors that can affect patients' ability to recover at home.

CMS has set a higher target—up to $60,000—for hip-fracture patients getting joint replacements. These patients tend to be older and frailer.

Otherwise, officials say the target prices should account for most other variables because they are based largely on each hospital's historic costs. By the fifth year, however, the targets will be based on regional averages.

"That could be very tough for some hospitals," said Joanna Hiatt Kim, vice president for payment policy at the American Hospital Association.

Hospitals that have experience with bundled payments say managing internal costs and patients' expectations is critical. University of Pittsburgh Medical Center cut its costs by 2% over two years in its hip and knee-replacement bundles, in part, by reducing variations in surgical practices and getting patients into "pre-hab" programs to improve strength before surgery.

UPMC's bundle under the Medicare program will include post-acute care for the first time. UPMC has three skilled-nursing facilities in its system and five more in a preferred network. "We believe they'll be good partners for the future," said UPMC chief quality officer Tami Minnier.

The new payment system could spur more hospitals to buy up post-acute care facilities or to avoid patients needing longer rehab stays, some observers say. CMS officials say they will be watching for such issues, as well as signs that providers are pushing needed follow-up care past 90 days to fall outside of the time frame for the payment bundle.

Corrections & Amplifications:
The American Health Care Association is a trade organization representing about 13,000 long-term care and post-acute facilities. An earlier version of this article incorrectly called it the American Home Care Association and said it represents 12,000 facilities.

By Melinda Beck
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While certainly not on FLiCRA's agenda (at this time), further 2016 scientific revelations into the Theory of Gravity have strengthened the possibility that Space and Time could be an illusion – something you might speculate about over coffee or drinks in our CCRCs' various versions of a pub. However, Here and Now, while we are in this particular Space at this specific Time, FLiCRA will function with our sense and perception of reality to not only pursue successful outcomes for the real problems that arise, but continue to make every effort for enactment of preventative measures.

DIRECTIVE: Help Keep FLiCRA Membership Strong to Keep FLiCRA Impact Strong.

Pat Arends, FLiCRA President

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Consumers Benefit from New State Law on Medical Bills

As part of the 2016 legislative session outcomes, Governor Scott signed a new law that deals with healthcare price and quality transparency systems.

Under the new Florida law, the state Agency for Health Care Administration must contract with a private vendor to provide a consumer-friendly, internet-based platform allowing consumers to research the cost of healthcare services. Services will be grouped by bundles to facilitate price comparisons of services provided in hospitals and ambulatory surgery centers. The price data—based on what providers actually receive from payers will be accompanied by quality measures.

Hospitals and surgery centers are required to provide access to searchable service bundles on their website, listing estimated payment ranges for each service bundle, by facility, within selected geographic boundaries, and nationally.

Beyond that, hospitals and surgery centers must notify prospective patients that other providers may deliver services in their facilities and bill separately and that these other providers may not participate in the same health plans. Hospitals also must disclose in advance their hospital facility fees.

In addition, health plans must provide on their websites a method for plan members to estimate their cost-sharing responsibilities, including for both in-network and out-of-network providers.

Consumers may request good-faith estimates of charges for non-emergency services from hospitals, surgery centers, and individual healthcare professionals. These estimates must be presented within seven days, or the providers face a daily fine for noncompliance. Similarly, patients may request a clear, specific itemized bill from the hospital or surgery center, and it must be presented within seven days.