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DEPARTMENT OF HEALTH

Nursing Homes Support Scheme (Fair Deal)

Volume 3: Review of Pricing Processes

August 2014

Section 3. Review of the processes and methods for setting prices for LTRC in public, private and voluntary nursing homes

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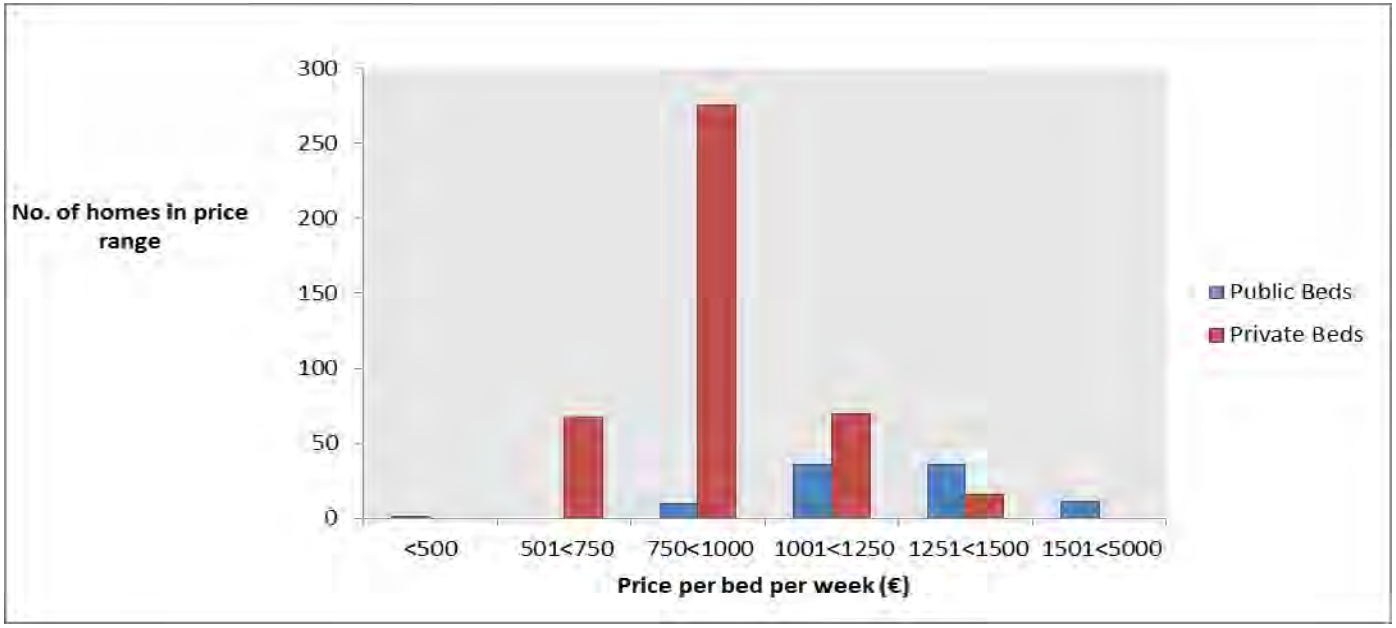
1.Background

Current Prices

Approximately 550 homes are licensed by HIQA to provide services under the NHSS. 429 of these are private or voluntary facilities which provide approximately 21,000 beds (per HIQA) and 122 are public facilities which provide approximately 5,321 beds (per the HSE). Prices for the provision of residential care in private and voluntary homes are negotiated by the National Treatment Purchase Fund ("NTPF"). The NTPF has no role in setting or negotiating prices for public facilities. The maximum price for every home is published on the HSE website (http://www.hse.ie/eng/services/list/4/olderpeople/nhss/costs.html). For private and voluntary homes this data is updated monthly, but for public homes the published price was last updated at 31 July 2011. Since that time we calculate that prices in public homes have increased on average by 3.1%. An updated public home price list is expected to be published once the financial out-turn of the implementation of all aspects of the Haddington Road Public Services Agreement have been evaluated. However, in this report we have used the updated public home prices as provided to us by the HSE.

The table below shows the range of prices in existence as at December 2013



It can be seen that there is a greater proportion of public homes that receive higher prices. This price differential between public and private is approximately 58% higher and this will be discussed further below.

1.Background

Current Prices

The NTPF commenced the process of negotiating prices under Section 40 of the Nursing Homes Support Scheme Act ("Fair Deal") in 2009. They have provided us with the following information on the changes in prices in the period 2010 to 2013. This indicates that the increase in prices negotiated (1.71%) has been lower than the increase in the CPI over the same period (3.79%):

At Yr End 31-Dec	National Average (NTPF Negotiated) Weekly Prices for Private LTRC at 31 December €	% Annual Change	% Cumulative Change	CPI	% Annual CPI Change	% Cumulative CPI Change	Refer HSE List #
2010*	873.39			97.6			24
2011	876.83	0.39%	0.39%	100.0	2.46%	2.46%	39
2012	885.21	0.96%	1.35%	101.2	1.20%	3.69%	53
2013	888.35	0.35%	1.71%	101.4	0.20%	3.89%	66

*First Full Year of NHS Scheme

As noted above, the prices in public homes have increased since 2011. We calculate that the average price has increased by 3.1% in that period. We do not have the 2009 comparative figures available.

The pricing model adopted for both the public and private and voluntary sectors is capitation based.

In our view this is the appropriate model since it ensures that payment is only received by a facility where a bed is provided. This is consistent with the concept of "money follows the patient" which is at the heart of the Fair Deal Scheme. However, we do note that there are some ways in which the current scheme could be improved which are discussed further in the sections below.

1.Background

The Fair Deal budget figure of €938m for 2014 covers the gross cost of public facilities and the net payments made to private and voluntary homes. In addition to this the State incurs some administration expenses on the Scheme.

Total patient contributions are estimated at €284m for 2013, of which we calculate €88m was in respect of patients in public facilities (which amounts are included in the €938m figure).In total therefore we calculate that the amount expended on LTRC is €1.134bn made up as follows:..

Patient contribution in public facilities - €88m

Remainder of €938m paid by state - €850m

Patient contribution in private & voluntary facilities - €196m

The amounts paid by patients are therefore 25% of the total expended on LTRC (being €284m out of €1,134m)

The role and effect of pricing

This is the revenue cost and excludes capital expenditure incurred by the State on public facilities.. We have requested updated details of the capital budget from HSE Estates but this has not yet been provided.

In this section we have set out our view of the role and effect of pricing for each of the main stakeholders in the sector, being:

1. The State (including the HSE);
2. Operators of private and voluntary nursing homes;
3. Providers of finance; and
4. Consumers.

1.Background

Stakeholder	The role and effect of pricing
1. The State (including the HSE)	**1.1 Given a relatively fixed budget for Fair deal, price has a direct impact on capacity and waiting times.** The State typically funds 75% of the cost of LTRC for all residents. This means that for the State the price agreed for LTRC determines the economic cost at which it purchases the service. The current process for agreeing the budget for LTRC has tended to reflect a year on year reduction in response to general economic conditions (€974m 2013 to €938m 2014) and the overall HSE budget. It appears to us that neither price nor demand have been central to the budget setting process. Once the overall budget is set the number of beds to be supported is dependent on the prices which have been agreed. Put simply: *Budget = Number of beds which can be supported x price.* This means that prices directly impact the length of the waiting list for LTRC: • If prices increase then the number of beds supported must decrease and hence waiting lists increase; and • If prices decrease then the number of beds supported can increase and waiting lists decrease.

1.Background

Stakeholder	The role and effect of pricing
1. The State (including the HSE) (continued)	**1.1 Given a relatively fixed budget for Fair deal, price has a direct impact on capacity and waiting times.**

Impact of price change on system capacity			
Total available budget	938,000,000		
Number of beds supported based on current pricing (illustrative)	23,000		
Cost per bed to NHSS	40,783		
If price reduces by 5%		**If price increases by 5%**	
Price	38,743	Price	42,822
Available budget	938,000,000	Available budget	938,000,000
Number of beds supported	24,211	Number of beds supported	21,905
Change in beds supported	1,211	Change in beds supported	-1,095

1.Background

Stakeholder	The role and effect of pricing
1. The State (including the HSE) (continued)	**1.2 Price is used to incentivise the private and voluntary sector to provide capacity.** The HSE has expressed a desire to retain public 20% of LTRC beds, although this does not appear on an explicit policy objective. If this remains an objective, it means that the remaining 80% of beds are required to be provided by the private and voluntary sectors. This means that for the State the price has to incentivise private and voluntary providers to ensure the appropriate level of capacity is available. In recent years private and voluntary operators have voiced criticism that the trend of a reducing overall budget feeding into reducing real prices, has created uncertainty and has restricted investment in the sector. The NHI / BDO report reports that between 2009 and 2012 only 339 new beds per annum have entered the Irish market. This low level of new entrants has inevitably been impacted by the overall economic uncertainty within the Irish economy. Extension of the length of contracts offered by the NTPF to private and voluntary operators (which is taking place) will help to address the current level of uncertainty within the sector and provide greater certainty over price and thus help the financing of projects, although the private and voluntary operators will rightly remain responsible for assessing whether demand will be sufficient to support additional investment. **1.3 Price is a mechanism for allocating resources to LTRC facilities in the public sector.** The State itself provides approximately 5,300 beds for LTRC within 122 facilities under its control. Whilst each of these facilities has a published “price”, this is in reality a calculation reflecting the operating costs of the facility divided by the available beds per week. The price is therefore the mechanism by which the State allocates funding to cover the operating cost to these public facilities. Capital costs are not included in the Fair Deal budget for public facilities nor are they included in the price. As such the reported price is not directly comparable to private and voluntary sector prices as capital is not required to be remunerated in the public homes.

1.Background

Stakeholder	The role and effect of pricing
2. Operators of private and voluntary nursing homes	For the operator the price is required to: • Ensure it can operate a viable business by covering costs; • Provide sufficient return to fund the initial equity and debt investment; • Cover ongoing capital expenditure and reinvestment requirements; and • Incentivise or dis-incentivise provision of additional capacity. The price is not the only factor which has to be considered in assessing the viability of an operating home but it is a central factor . The private and voluntary operators currently remain responsible for assessing whether demand will be sufficient, when combined with price, to meet each of the above requirements.
3. Finance providers	The main providers of finance to the private and voluntary sector can be categorised as: • Equity providers – either owner – managers or external equity investors; • Debt providers, typically the Irish banks; and • For the voluntary sector donations or bequests. For the first two of these, the role of price is to enable decisions to be made on the viability of financing propositions. In other words they are in a similar position to the operator in requiring some level of comfort that the price (when combined with their own assessment of demand) appears sufficient to cover running costs and making a return on financial investment over the period of the finance arrangement. As such financiers have a significant interest in how prices are set, and how they are likely to be set into the future on an individual home by home basis. Visibility over future pricing is key to attracting the interest of both operators and financiers to the sector.

1.Background

Stakeholder	The role and effect of pricing
4. The consumer	The private contribution which the consumer has to make under the Fair Deal scheme is determined by their means and is independent of their choice of care provider. This means that the Fair Deal price has no impact on the consumer. This is in contrast to the situation for example in the UK where normally the consumer will often have the first interaction with the operator and will be required to agree the price themselves. Whilst the Fair Deal system has clear benefits for the consumer by avoiding them having to undertake a commercial negotiation at such a sensitive time for them, it does create a disconnect in the normal relationship you would expect to see between the consumer and the price they pay. In fact there is a possibility that this disconnect might lead consumers to select the highest available priced bed on the basis that they impute a higher quality to the higher priced offering. We are however aware that issues do arise for consumers in relation to additional charges levied by operators and there have been complaints that these are not adequately explained in advance. There appear to be two issues here: 1. The most serious issue is where homes seek funds from patients for items which should be available free of charge either via Fair Deal, medical card or other; Clarity of pricing is key here and we recommend that homes should have a published price list showing all costs. As discussed further below we also consider that it may be appropriate to appoint an Independent review body to monitor and respond to issues of this kind. 2. The second issue is what should be or should not be included within the Fair Deal price and we understand that the HSE is separately considering this within the overall Fair Deal review.

1.Background

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Our view

In the table below we have summarised the pricing models which exist for public and for private and voluntary homes.

	Public	Private and voluntary
Who determines the price?	HSE	NTPF in negotiation with providers
Who pays the price?	HSE plus patient contribution	HSE plus patient contribution
Who receives the price?	Public facility	Private or voluntary facility

We understand that one of the aims of current Health Reform policy is to separate the purchasing and provision roles currently undertaken within the HSE. In the context of the Fair Deal Scheme we believe this would be a positive move. We are aware that there is currently a perception that there are potential conflicts of interest where the HSE has the price setting role for facilities under its own control.

Our recommendation of an enhanced role for the NTPF in the price setting process within the public sector would be an element in demonstrating a clearer split of purchasing and provision.

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Role of NTPF

- The National Treatment Purchase Fund ("NTPF") has been designated by the Minister for Health pursuant to Section 40 of the Nursing Homes Support Scheme Act ("Fair Deal") as a body authorised to negotiate with proprietors of registered nursing homes to reach agreement in relation to the maximum price that will be charged for the provision of long-term residential care services to Nursing Homes Support Scheme residents.
- As part of this function the NTPF enters into "Approved Nursing Home Agreements" with registered private and voluntary nursing homes to record the maximum price(s) that have been negotiated. These details are provided to the HSE and the resulting prices are published.
- The NTPF provides monthly updates to the HSE with the details of pricing agreements to be included in the scheme.
- The NTPF's role does not include setting standards for Private Residential Facilities or the assessment of individuals for the purposes of determining their eligibility under the Fair Deal Scheme. The role of the HSE will include liaising with applicants, assessing their eligibility for the scheme and determining financial co-payment arrangements between nursing homes and individual residents, and disbursing State payments to private nursing homes.

2. The process for setting prices for private and voluntary nursing homes

Pricing process undertaken by NTPF

- Renewal Pack sent to proprietor from NTPF
- Renewal Pack returned for NTPF approval
- Negotiations
- Deed of Agreement

In the following sections we discuss each stage of the pricing process.

2. The process for setting prices for private and voluntary nursing homes

Pricing process undertaken by NTPF	
Process	**Activity Overview**
Renewal Pack sent to proprietor from NTPF	The NTPF send out renewal packs to each home approximately eight weeks before any negotiations commence. The pack requires each home to provide the following information at that particular date: • Capacity of the home; • Business set up of the home i.e. whether it is a company/partnership/Sole Trader; • Its links with any other Homes in the country; • Staff levels both actual and Whole Time Equivalents; and • Most recent Financial Statements and/or Management Accounts, including a breakdown of Income and Expenses. The NTPF request the completed renewal packs to be returned to them approximately six weeks before negotiation meetings commence. During this time they review the information to ensure it is complete, if not the NTPF representatives requests any outstanding information. A new Home into the Fair Deal Scheme will be provided the same renewal pack.

2. The process for setting prices for private and voluntary nursing homes

Pricing process undertaken by NTPF	
Process	**Activity Overview**
Renewal Pack returned for NTPF assessment	The NTPF representatives use the information from the packs to assess the following financial information in relation to the Home: • Operating costs, variable and fixed e.g. payroll, medical supplies, food, insurance, depreciation; • Finance costs e.g. rent payments, loan repayments, bank interest; • Overall financial performance; • Local market prices; • Prices previously set by the NTPF; and • Budget constraints. From the information provided, the NTPF representatives try to understand the financial issues each home faces e.g. loan repayment or HIQA costs issues. However, these issues do not directly affect their pricing process. The NTPF also provides a certain amount of advice/guidance to the Homes in relation to cost structures e.g. if they believe the payroll costs are very high as compared to the number of beds in the Home. But this information is provided to the Home in order for the Home to review and try and restructure rather than NTPF adjusting their price to reflect these costs. The analysis of each home is not uploaded onto any central system but this information is kept in manual form and saved within the Homes individual folder. The NTPF will complete a standardised financial template/cost analysis template which ahs been developed internally and which incorporates all the financial information provided to them.

2. The process for setting prices for private and voluntary nursing homes

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Pricing process undertaken by NTPF	
Process	**Activity Overview**
Negotiations	Generally the NTPF representatives use the standardised financial template when assessing the financial position of the home although each template is tailored to the individual circumstances. Each representative retains notes from their negotiations with the home, but such notes are not typed up in detail unless the meeting was a difficult one and they believe there may be follow up meetings required. When negotiating prices the following guidelines are taken into account by each representative: • costs reasonably and prudently incurred by the nursing home and evidence of value for money; • price previously charged; • local market price; and • budgetary constraints and the obligation of the State to use available resources in the most beneficial, effective and efficient manner to improve, promote and protect the health and welfare of the public. There is no formal training in place for NTPF negotiators, their main aim is to build relationships and try to meet with the Home in between negotiation meetings. Regular catch up meetings are difficult to accommodate though as there are only four negotiators within the NTPF department with approximately 420 Homes country wide within the Fair Deal Scheme, more than 100 Homes attributable to each representative. The NTPF try to spread the negotiation meetings out throughout the year. Usually the meetings are held three months after the Homes' financial statement year-end dates. The NTPF estimates that 50% of prices are agreed on the first day of negotiations.

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2. The process for setting prices for private and voluntary nursing homes

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Pricing process undertaken by NTPF	
Process	**Activity Overview**
Negotiations (continued)	If negotiations cannot reach agreement there is a staged process available: • An NTPF Review process is the first stage, where an NTPF representative not previously involved in the failed negotiations will carry out a review of the those negotiations (a second opinion / peer review). This may include further discussions with the nursing home. All offers to the nursing home previously made and rejected will be withdrawn. The reviewer will make an offer of a Fair Deal price to the nursing home following this review and such an offer may include a Fair Deal price that is higher, lower or at the same level as the existing price. If there is no agreement at this stage (i.e. the nursing home reject the offer) the file is passed to the NTPF Director of Finance for further, second stage, review. • The second stage review consists of a fresh and comprehensive review of all aspects of the file by the NTPF Director of Finance. If agreement cannot be reached at this stage a final review by the NTPF CEO will be carried out. • This third stage review will involve the NTPF CEO reviewing the process to date to assess whether it has been fair and reasonable and whether recommendation(s) made have been based on an assessment of all relevant information and the application of the stated criteria. If at this stage agreement cannot be reached the NTPF will issue a letter to the nursing home advising them that at the end of the current agreement the nursing home will no longer be an 'approved' nursing home for the purposes of the Scheme and the HSE will be notified accordingly. At each stage of the Review process the nursing home may contribute additional information in writing to support their case. Homes are also able to take legal action if they believe the process has been unfair and the number of threats of such legal action has increased significantly according to the NTPF.

2. The process for setting prices for private and voluntary nursing homes

Pricing process undertaken by NTPF	
Process	**Activity Overview**
Deed of Agreement	The deed of agreement is the contract between the nursing home and NTPF specifying the maximum price that the nursing home can charge Fair Deal residents for long-term residential care as defined in the deed. These prices are fixed for the term of the deed. The deed of agreement will specify the commencement date and the expiry date of each deed. Prices agreed will be fixed for the term of the deed of agreement. At the end of the agreement term a new process of negotiation on pricing will be entered into with the nursing home and all issues, including price, will be open for discussion and agreement.

2. The process for setting prices for private and voluntary nursing homes

In addition to reviewing the process detailed above, we have undertaken a review of a number of case files and have held a series of meetings with NTPF representatives and with representatives of the private and voluntary operators.

Based on our work, including our review of the submissions, we have the following comments on this process:

1. The NTPF has provided, and continues to provide, an efficient mechanism for agreeing prices with the private and voluntary sector;
2. The NTPF has established a consistent approach to negotiating prices, including a clear review process in the case of disputes;
3. Stakeholders outside the NTPF, have expressed the view that they are unable to determine a pricing methodology from the NTPF;
4. There are issues facing Section 39 voluntary facilities as a result of their inclusion within the Fair Deal scheme;
5. There are some potential additional areas where we believe the NTPF's skillsets and expertise could be leveraged; and
6. There are a small number of operational issues which should be addressed.

We discuss each of these further below.

2. The process for setting prices for private and voluntary nursing homes

	Comments on the process
1. The NTPF provides an efficient mechanism for agreeing prices.	We note from the NTPF's submission to the Department that they highlighted that in the short timeframe which was available to them when they commenced the process of price setting in 2009, a decision was made to maximise the take up of the scheme, while leaving the State, on average, in no worse a financial position than had been in situ for families prior to Fair Deal. Whilst this had advantages in ensuring the scheme got off the ground quickly and successfully, one of the impacts of this strategy was that the initial prices the NTPF agreed were inherited prices with in-built price disparities. These reflected, for example: • Higher prices in Dublin, the East Coast and Cork which operators had been able to agree due to lack of capacity; • The higher cost of land and building costs for more recent builds versus older facilities which may have had no or very low land values; and • Employment costs tied to the public sector within the Section 39 homes which came under the remit of the NTPF. It also meant that the majority of contracts were relatively short term and have had to be renegotiated. However, we believe that this renegotiation process has been effective and the NTPF has sought to increase the length of contracts offered. The extension of contracts where possible can provide greater certainty to operators, and also has the effect of reducing the number of contracts which need to be negotiated annually. We believe that in terms of operational efficiency, the NTPF should be commended for managing to negotiate with 400+ operators with a small staffing complement.

2. The process for setting prices for private and voluntary nursing homes

	Comments on the process
2. A consistent approach	Our work leads us to the view that the NTPF has a consistent approach to each negotiation. This approach is centred on an analysis of the historic financial situation of each individual home. This does mean though that prospective costs, for example at the current time the costs of HIQA compliance, may not be taken into account until such time as they have been incurred. Where the initial negotiations are not successful in agreeing a price, the review process is clearly set out and, based on our work, appears to be consistently applied. Whilst the NTPF has adopted a consistent approach to price negotiations, there is no evidence of a formal price setting methodology in place. We recognise that in the past, and particularly given the largely inherited price regime it took on at the inception of Fair Deal in 2009, that basing pricing on a predetermined methodology was impractical. However, going forward, we are of the view that a methodology to set prices should be established, taking into account factors such as size of home, acuity of patients, operating cost structures etc. This appeals process has been criticised by operators within the submissions with the argument that there is no transparent or independent appeals body where negotiations are deadlocked. Our own view is that: • The NTPF was established as an independent body and appears to us to be very conscious of the need to be seen as independent; • If an operator felt that the NTPF had acted illegally or outside the stated process, there are legal remedies available by direct application to the Courts and these are regularly and increasingly taken by operators; • It is apparent from our discussions with the NTPF that the risk of an operator mounting a successful legal challenge to its process or findings, is a major concern and therefore we consider this helps maintain adherence to a consistent process within the NTPF; and • We also consider that the existence of a further level of appeal, outside the NTPF, could become a self-fulfilling process generating more appeals, with operators keen to exhaust every avenue.

2. The process for setting prices for private and voluntary nursing homes

	Comments on the process
2. A consistent approach (continued)	We are aware that the NTPF has been criticised by some operators for what is described as a combative approach. It must be recognised that in any price negotiation the nature of the NTPF's role means it will often find itself in an adversarial position with operators. Indeed, if operators were expressing universal approval of the NTPF then that might itself be a cause for concern that it is not being sufficiently robust. Arguably greater transparency over the price setting process, and the use of an objective price setting methodology should assist in being seen to be equitable in price negotiations. We have also seen no evidence of private or voluntary operators going out of business for purely financial reasons, despite the generally inclement economic environment in Ireland in recent years. This again might lead one to conclude that the prices negotiated by the NTPF are not uneconomic.

2. The process for setting prices for private and voluntary nursing homes

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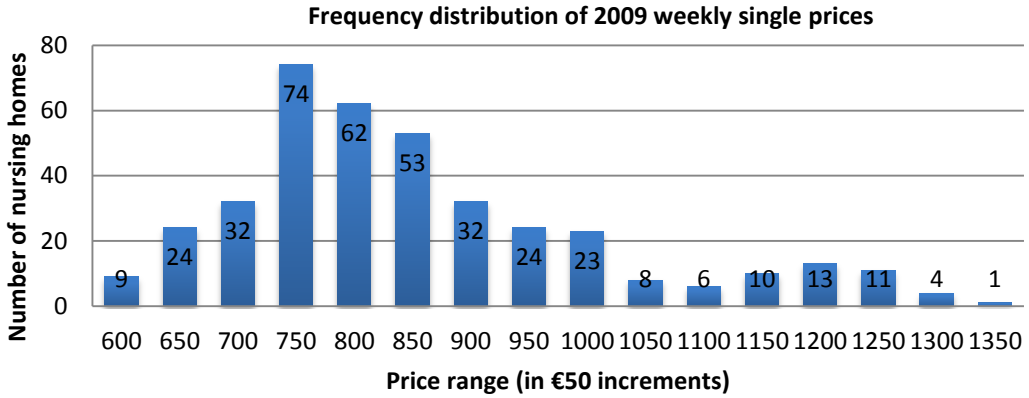
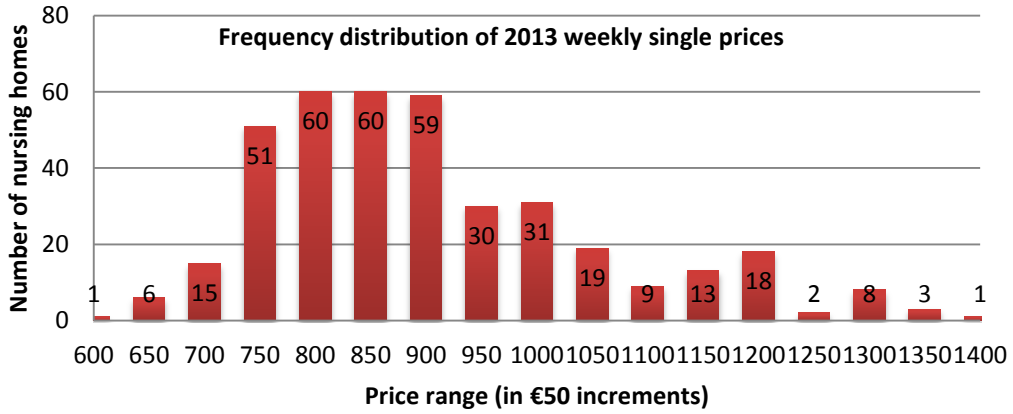
Comments on the process

2. A consistent approach (continued)

We have also identified that the NTPF has made some progress in reducing the level of price differentials. The graphs below show the numbers of private and voluntary nursing homes at each price range and the narrowing of the population in the 2013 figures as compared to 2009, is indicative of a greater consistency of price achieved by the NTPF. (This table only includes Homes which were in Fair Deal at both dates).





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2. The process for setting prices for private and voluntary nursing homes

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	Comments on the process
3. The NTPF and a pricing methodology	It is apparent that the NTPF holds a wealth of data on the costs of operating a private and voluntary nursing home and would therefore potentially be in a position to develop models of typical costs which it believes are reasonable. We understand that the NTPF would prefer to avoid the development and publicising of such a cost model, because they feel that this could be taken as a "benchmark price" for all operators. They feel that this would be at odds with their current approach which is based on historic costs actually incurred at each home. However, we believe that in a system which is highly dependent on the private and voluntary sector to provide existing, and possibly additional, beds, some clarity of expected pricing will be vital to enable investment certainty. This should, in our view, involve considering: • The optimum size of units; • Staffing ratios (with differential assessment for higher acuity units); and • Rates of return on investment sufficient to fund initial and ongoing investment. We also believe that this type of pricing methodology may be capable of being linked to the SAT which is planned to be introduced later this year, to provide for a more nuanced set of prices reflecting the acuity levels of patients. In our view, it is difficult to argue that prices are fair and equitable unless they in some way reflect costs of care, which are unquestionably higher in homes with more challenging patients requiring higher levels of care. Taken together this could lead to a price negotiation process based on an objective model. A SAT related pricing methodology would reward units which are prepared to invest in the additional resources which are required to provide specialist care to the most challenged of residents. It would also penalise operators who may attempt to "cherry pick" potential residents who are less demanding in terms of resources. We are aware that the NTPF is currently in the process of agreeing long term contracts with certain providers which guarantee prices for planned new facilities. By taking this step it would seem to us that the NTPF is already putting some benchmark prices in the public domain, and we believe it would be helpful to the future strategy for the sector if the methodology behind this could be publicly available.

2. The process for setting prices for private and voluntary nursing homes

	Comments on the process
4. Issues facing the voluntary sector (Section 39 homes)	The NTPF and the Department is aware that the ten Section 39 facilities face particular challenges arising from their inclusion within the Fair Deal Scheme. These facilities provide approximately 500 LTRC beds but they face particular challenges due to inherited HSE pay rates and conditions, but Fair Deal rates of income, which reflect private sector employment costs. In the short to medium term these facilities are likely to face potentially fatal cash-flow difficulties as existing beds transition from the HSE grant basis to Fair Deal. This shortfall can, in some cases, be met by additional support from the voluntary body which supports the facility, but in other cases there is likely to be insufficient funding available from such sources. In these circumstances, if the facilities are to be retained the following are the available options which we have identified: • A proposed increase to the current Fair Deal rate; • A proposed reduction in operating costs; • A change from long term care providers to alternative options; or • HSE funding by way of a grant directly to the individual home. We are aware that the solution is likely to differ for each of the ten individual facilities. We also believe that consideration of the role of the voluntary sector needs to be included in any overall assessment of strategy.

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	Comments on the process
5. Possible additional roles for the NTPF	We have drawn attention below to areas where it might be possible that the NTPF's current role in negotiating prices could usefully be extended into other areas: 1. The NTPF have suggested that they might have greater ability to negotiate more economically advantageous prices with operators if they had the ability to provide operators with greater certainty of demand. This would involve the NTPF "directing traffic" in some way. This would however, go against the existing principle behind Fair Deal of "money follows the patient" and this is, in our view, a major policy shift. We would recommend though that some work is done to assess the potential savings and develop a model of how this might work in practice. 2. The NTPF's role does not at present extend to agreeing all prices with private and voluntary nursing home operators (for example respite and step down beds). Furthermore the NTPF does not have a role in negotiating the price with operators of related services, for example homecare packages, day-care and other community care initiatives. It would seem to us that the skillset and experience within the NTPF would be capable of adding value to such initiatives. 3. The other area which we would recommend should be considered is developing some role for the NTPF in determining the appropriate prices for public sector facilities. As discussed elsewhere, there is a significant disparity in the prices paid for public beds as compared to private and voluntary beds. Whilst there are reasons for this and whilst steps are being taken by the HSE to address this issue, we believe that the NTPF should have some role to play in this area.

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2. The process for setting prices for private and voluntary nursing homes

	Comments on the process
6. Operational issues	1. Under current legislation the NTPF is currently only able to negotiate contracts for the provision of new beds with existing operators. We believe that it would be sensible to amend the relevant legislation to allow such negotiations to take place with new operators, although we also believe that the NTPF's efforts in this area need to be closely integrated within an overall strategy for the sector which we discuss below. 2. Issues have been identified within the submissions regarding the practice of operators refusing to take certain patients and separately seeking to charge patients for extra services, over and above what is provided under Fair Deal. We are aware that a separate review is taking place of what should be included within the Fair Deal price and this should bring clarity. However we also believe that consideration should be given to appointing an independent person to deal with both of these issues. It is apparent that at present patients and their families are unclear on who to contact in relation to such issues. 3. Issues have arisen in negotiations where price agreement cannot be reached and existing contracts are at risk of running out. Where a pricing agreement does run out the home ceases to be an approved facility and there is a risk that existing residents would have to be moved. It might make sense to allow approved status to continue for existing residents, but the home could not accept new patients unless agreement is reached.

Section 3. Review of the processes and methods for setting prices for LTRC in public, private and voluntary nursing homes

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3. The process for setting prices for public nursing homes

Attached at Appendix A is the current methodology used by the HSE in setting prices for public nursing homes.

We would characterise this current system of setting prices for public nursing homes as one where the price is a capitation based model which uses the pre-existing cost structures (which were in place before Fair Deal) to derive the price to be paid. As such the prices are reflective of what is needed to run facilities on their existing basis, rather than a mechanism for driving efficiencies in the system.

In addition the price model for public nursing homes only covers the operating costs for facilities. Capital costs are not included.

The major issue in relation to price setting for public facilities which has been identified from our work is the price differential between the public and private and voluntary sectors.

Our analysis indicates that as at the current date the average weekly price paid for a bed in a public homes is €1,390 as compared to €878 in a private or voluntary home, some 58% higher. (Both calculations represent the weighted average per bed price).

In addition to this differential, one needs to take into account the fact that the private and voluntary sector price has to provide for:

- Finance costs associated with the original development of the facility and ongoing improvements; and
- A return on investment to the equity provider.

This means that the differential is even higher than calculated above, when all costs are taken into account.

We have established from our discussions with the HSE in the course of this review, that this price differential is well recognised and that work is currently underway to understand it and, where possible, address the underlying reasons.

We discuss these efforts below but before doing so we note that they are important initiatives both for the economic advantages they may confer but also in countering a prevailing private sector view of the public run sector as wasteful and inefficient by comparison with the private sector. Given that importance it is vital that clear objectives and measurement targets are put in place for these actions.

Private and voluntary operators and others also point to a perceived lack of independence in the price setting process, with the HSE seen as effectively setting the price for its own run facilities. Our recommendation that the NTPF could take on more of a role in setting prices for the public sector could be one way to help address this issue.

A further issue which has been brought to our attention relates to the manner in which variances from expected occupancy levels (which drive the periodic capitation related payments made to public nursing homes) are managed. Given that payment is calculated and made based on an expected occupancy, if the actual occupancy is higher or lower the amount received by the unit will exceed its costs or be insufficient to meet the full costs. We understand that there are ongoing discussions between the Department and the HSE to establish the position and to deal with any issues arising. We also believe this and the related issue of establishing a reasonable occupancy level, are amongst the areas which the Task Force which the HSE has established to look at pricing in public units.

3. The process for setting prices for public nursing homes

HSE initiatives for understanding and addressing the cost issue

We are aware of two main initiatives within the HSE and we discuss each of these below.

1. The Ballincollig experience
2. The cost review Task Force

3. The process for setting prices for public nursing homes

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1. The Ballincollig experience

HSE initiatives for understanding and addressing the cost issue

The HSE undertook to develop a new facility at Ballincollig, Cork utilising a new model, whereby the State would fund the capital cost of the new 100 bed facility (80 LTRC, 20 respite beds) but it would be run by a private operator under a five year contract, with an option to extend this to seven years.

Following a public tender process, a contract was signed between the HSE and Mowlam Healthcare which set the price for running the facility at €5.2m per annum.

We have been provided with a report undertaken by the HSE which examined the cost differential between what the cost would have been had the facility been operated as an HSE facility and the actual cost to the State.

The table below summarises the cost differences identified in that report.

HSE analysis of Public v Private provision at Ballincollig				
	Public	Private	Saving	
	€m	€m	€m	
Annual direct cost	7.00	5.20	1.80	
Add annual public provision for pensions	1.00	0.00	1.00	
	8.00	5.20	2.80	
Saving analysed by cost category				
Lower staff numbers			2.00	Mowlam used 100 wte versus 130 for a similar public facility
Lower wage rates			0.20	On average all grades were on higher rates of pay in Mowlam with the exception of HCA's who were on 18% less
Non-pay costs			-0.40	Assumed to relate mainly to profit margin of 9% allowed to Mowlam
Pension savings			1.00	
			2.80	

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3. The process for setting prices for public nursing homes

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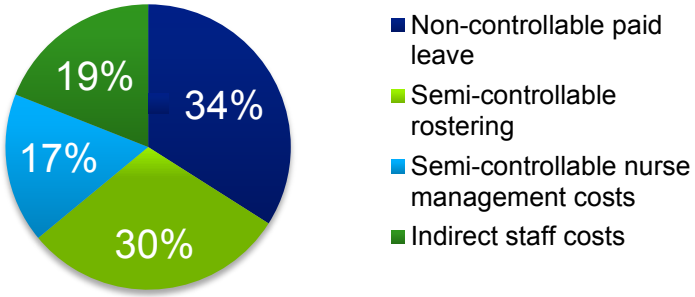
1. The Ballincollig experience (continued)

HSE initiatives for understanding and addressing the cost issue

The HSE report also attempted to split the annual cost savings (excluding pensions) between what it described as non-controllable costs and those that were semi-controllable.

Their analysis is summarised in the table below which shows that only 34% of the additional costs were deemed to be non-controllable.



The current Fair Deal rate for Ballincollig is €913 per bed per week and this compares favourably with the average price paid for private and voluntary beds in County Cork which we calculate at €877 per week. There is however a sense within the HSE that the price which was agreed with Mowlam may not fully reflect all the savings that a private operator might drive through a similar facility, as the HSE was keen to ensure that the facility faced no problems in achieving HIQA approval and therefore staffing levels were kept at a reasonably high level.

There are clearly lessons from the Ballincollig experience and the HSE appears keen to take these on-board and use the learning experience to reduce costs elsewhere. As the report on Ballincollig notes at page 6:

"The model of service provision at Ballincollig as outlined in this document should be used as a template for future public investment in residential care, not only in services for older people but with other care groups and services"

As against this, the Ballincollig situation involved the development of a new facility and there is some recognition that it may not be straightforward to drive similar cost changes through in existing facilities.

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3. The process for setting prices for public nursing homes

	HSE initiatives for understanding and addressing the cost issue
2. The cost review Task Force	The second initiative which the HSE has in hand is the establishment of a task force whose remit is to review the costs of the most expensive public sector facilities. This will start with the most expensive 10-30 homes and then cascade down. The methodology for the review will draw on the Ballincollig experience and will, like the Ballincollig review, seek to identify costs which can be reduced and those which cannot. It will also examine issues such as whether the facility can ever be made more cost efficient. In order to demonstrate its effectiveness, we believe that the Task Force should be given a very clear remit and targets. We also believe that its findings should be publicised, both internally and publicly (albeit some redaction may be required). Amongst the issues which we believe it should address are: • Examine and understand cost allocations at a granular level to ensure that Fair Deal funds are only used for Fair Deal purposes; • Benchmarking of costs incurred in public facilities with those in the private and voluntary sector. This should involve close co-operation with the NTPF; • Occupancy levels within the public units. Given that the current pricing process is capitation based but assumes a pre-determined level of occupancy, it is important that this occupancy level is a realistic target and is comparable with the levels achieved in the private and voluntary sector. Whilst we believe that both of these initiatives are welcome, we also believe that the wealth of knowledge of nursing home costs which is contained within the NTPF could be leveraged. At a minimum we believe the NTPF should have some input or role within this task force. Going further and as already noted in above, we also believe that the NTPF could usefully have a role in agreeing the prices within the public facilities.

Section 3. Review of the processes and methods for setting prices for LTRC in public, private and voluntary nursing homes

Contents

4. Overall comments on pricing

Other Matters	In this section we have discussed: 1. A brief summary of the demographic information which appears to drive future demand for increased capacity for LTRC. 2. Our views on the requirement for a clear overall strategy for the sector. 3. Some enablers to delivery which could meet any shortfall in capacity, and which have been identified during the course of our work, including: i. Provision by private operators; ii. Tax incentives; iii. State backed equity funds; and iv. Design Build Finance Operate contracts. 4. Increased patient contribution.
1. Demographic data	There is a large amount of demographic data available in relation to the impact of increases in the number of people over 65. For the purpose of this review we have not analysed or reviewed this data in detail, but we are aware that there seems a general consensus that there will be increases in the numbers of 65 and the growth in those over 85 will be particularly large. Absent any significant change in the model of care for the elderly, this increase in the over 65 population will lead to increased demand for LTRC beds. In the remainder of this section we have set out some ideas on how pricing and other issues might enable this increased demand to be met.

4. Overall comments on pricing

2. Overall strategy for the sector

Given the potential impact of the improving demographics in terms of longevity, we believe that it is important that more is done to bring together the good work which is currently underway in various parts of the sector into a single clear strategy, whilst recognising their separate roles in the system. For example, the HSE is addressing cost issues in public homes but the NTPF currently has no input into this work. We can see no reason why they should not have such a role.

The core elements of a single strategy would comprise:

- Co-ordinated planning to cover the range of alternative services which are available to the elderly from the health sector comprising home and community care, acute care and LTRC;
- A structure to effectively coordinate the perspectives of the various public sector stakeholders in LTRC, in particular the Department, the HSE, HSE Estates, HIQA and the NTPF;
- An appropriate level of private and voluntary sector stakeholder involvement in this planning, given the requirement for, and dependency on, private provision to form a major element of the plan;
- An evidence based analysis of the total number of beds which will be required identifying the required locations, the necessary timeframes and taking account of expected acuity levels and other specialist needs (for example LTRC residents in the under 65 category and severe dementia patients);
- Having determined infrastructure requirements, an analysis of the split of beds which will result between public, private and voluntary sectors, recognising the arguments in favour of some level of public capacity;
- A gap analysis between the requirements developed above and the current stock of beds, taking account of the likely impact of HIQA requirements which are likely to put pressure on the public stock, particularly the older stock. This is likely to involve cost benefit analysis on some facilities comparing the cost of attempting compliance with HIQA with the cost of a new build;
- Some models of what the required additional facilities will look like in terms of size, specialist requirements and links to other care delivery models; and
- Financial models for these “ideal” facilities which can then provide a clear methodology for pricing and which allow for differentiation of pricing so that more specialist facilities receive a price which reflects additional costs required to meet specialist needs.

4. Overall comments on pricing

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3.1 Private operators

3. Enablers to delivery

We are aware from discussions with HSE Estates that they face a significant shortfall between capital requirements and their available budget (although we still await details from them on the figures involved). We have also noted above the issues facing voluntary providers. This leads to the conclusion that it is likely that the majority of increased capacity is likely to be required from private operators, either existing or new entrants.

There is undoubted willingness expressed by such operators to be part of the solution and, at a simple level, if each of the 400+ current facilities increased its bed supply by 20 then this would result in 8,000 additional beds.

However, we believe that there are issues with allowing this to be the primary or only model for delivery of additional capacity:

- The equity gap issue - Based on our discussions with banks active in this sector, it is clear that they are prepared to lend to support new nursing home development but they are typically only willing to lend around 70% of cost and are looking for an equity investment of circa 30%. It is apparent that this is a difficult target for an operator with only one existing home to achieve. This means that there is a potential for private development to fall to larger operators. However, in that case banks have expressed concerns about the concentration of their lending risk and the potential lack of hands-on management by the equity provider. This problem is exacerbated by the limited number of banks currently active in this sector;
- Nevertheless, the nursing home sector, backed as it is with State funded contracts, is an attractive lending opportunity for banks, and all are aware of the potential growth in the private nursing home sector in the coming years; and
- There is also a potential disconnect with the overall strategy if provision of additional capacity is left entirely to the private sector. We believe there is a risk of either:
    - Unplanned development which is not consistent with any overall strategy, for example operators cherry-picking locations with over supply in some areas and insufficient elsewhere; or
    - A requirement for the State to micro-manage the strategic rollout.

4. Overall comments on pricing

An Roinn Sláinte
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3. Enablers to delivery

3.2 Tax incentives

A number of proposals have been made to incentivise private operators further to create additional capacity. These are discussed below, but they should all be viewed in the context of our comments on provision by private operators as set out above.

Capital Allowance Tax schemes

In the mid to late 2000's, it became common for developers and operators of nursing homes to seek third party investors to fund the cost of construction of a new nursing home in return for the "sale" of the capital allowances on the construction cost of the nursing home to the investors.

However, as part of the Supplemental Budget in April 2009, the Minister for Finance announced that he intended to terminate the accelerated capital allowance schemes for nursing homes, and that transitional arrangements would be put in place for projects that were at an advanced stage of development.

Since 2009 there have been other changes in the tax legislation which were designed to ensure that individuals pay a minimum level of tax on their income. This means that any similar scheme to these capital allowance schemes would not be attractive to investors.

We do not therefore consider that a tax incentive of this nature would be effective.

Capital Gains Tax exemptions

There is currently in place tax legislation which allows an exemption from Capital Gains Tax where a property is built by the end of 2014. This is not restricted to nursing homes.

Provided the property is held for seven years no Capital Gains Tax applies. An extension of this scheme could be considered, although this could not be restricted to nursing homes and would have to take account of whether there is an overall advantage across all relevant sectors in extending this scheme.

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4. Overall comments on pricing

3.2 Tax incentives (cont.)

3. Enablers to delivery

VAT derogation

Currently VAT at 13.5% is charged on the building cost of LTRC facilities and this VAT is irrecoverable for the developer. It has been suggested by NHI that removal of this charge could form part of the solution.

Whilst this could serve to reduce the cost of development of new facilities it may not fully address the key financing issue which is the “equity gap”. Even where the cost is reduced, if a bank will only fund 70% of the total cost, the requirement for significant equity will remain, albeit that if the overall cost of building a new facility was 13.5% lower, then the equity required would be proportionally lower.

Extension of EIIS schemes to the nursing home sector

The Employment Incentive and Investment Scheme (EIIS) allows individual investors to obtain income tax relief on investments made, in each tax year, into EIIS certified qualifying companies.

There is no tax advantage for the company in receipt of the EIIS, but securing EIIS status may enhance their ability to attract other external funding.

The maximum funding that a company can raise via EIIS is €10m. However no more than €2.5m can be raised in any 12 month period. To be compliant with the Scheme investors must hold shares in the company for a minimum of three years.

At present the operation, management of a nursing home or management of a property used for a nursing home is one of the excluded activities for the Scheme.

Whilst extension of EIIS may allow nursing home to raise equity funding which would otherwise not be available to the, the scale of EIIS available in the market is unlikely to be sufficient to attract the equity capital required to underpin the financing of the sector in the years ahead.

4. Overall comments on pricing

3.3 State backed equity fund

3. Enablers to delivery

This alternative could provide some level of State input to largely private sector development. It would involve a leverage of the existing State experience of sponsored funds with a healthcare focus or some form of loan guarantee scheme targeted at the sector.

For example, the recently launched Ireland Strategic Investment Fund (ISIF) has €6.8bn under its remit to invest in the Irish economy over the next number of years. Nursing homes offer a viable investment opportunity, particularly as pricing is State backed and demand is not in question, and new homes would not displace existing activity under a properly planned strategic development of the sector. Furthermore the growth in the number of homes to provide for the ageing population would create significant incremental employment across the country. A dedicated focus on nursing home care within the ISIF funds, working alongside new and existing operators and banks could help create an environment in which funding for new developments would be readily available.

However, there remains, in our view, a risk that the State could lose control of the strategic rollout as private sector operators will inevitably gravitate towards the centres which provide the likely highest rates and guaranteed demand, i.e. Dublin, the East and Cork.

This could be mitigated however by providing that the contracts for State equity support include stipulations in relation to location.

4. Overall comments on pricing

3.4 DBFO model

3. Enablers to delivery

Another alternative would involve the State offering Design, Build, Finance, Operate bundled contracts for tender to the private sector. The key features would be:

- Location specific bundles of nursing home developments would be offered;
- These bundles would be of a scale to interest larger scale institutional investors (including ISIF backed) – typically 5-10 homes of 50-100 beds each i.e. 250 to 1,000 beds;
- The release of bundles for tender could be aligned to expected growth in demand both in terms of the overall LTRC population and specific geographic shortfalls;
- The bundles could also include a requirement to provide new public facilities (in line with the overall public policy of having a certain level of beds in public control). For those facilities where it is believed that the transfer of staff from public sector would be difficult the contract could exclude operating of that particular facility so that the operator simply provides DB&F and then receives an annual rental;
- Where the HSE has existing land available for use, this could be included within the bundle on the basis of a longer term buy back. This would help with financing issues;
- It might also be possible to work with NAMA to identify additional lands which could be included within the bundles;
- The involvement of the NTPF at an early stage and the development of typical cost models for different home types would provide a basis for evaluating potential bids;
- In contrast with a traditional PPP model, there would be no reversion to the State, but the operating element of the contract could be subject to renegotiation, albeit after a fixed initial term to give certainty to the operators;
- The contracts would offer no certainty of supply to the potential operators so that demand risk would remain with them and would be factored into their bids.

4. Overall comments on pricing

3.4 DBFO model

3. Enablers to delivery

In our view this model offers the opportunity to develop on the scale that is likely to be required for the sector.

A typical bundle might be as follows:

- Capex per facility - €10m
- Bundle of 10 - €100m
- 60% debt - €60m
- Equity requirement - €40m

This scale would in our view be sufficient to attract private equity interest to the sector, because the sector provides relative certainty of cash flow given likely increases in demand, provided that the growth in the sector is planned.

We are also aware that at the current time, there is a significant amount of capital available for investment into Irish property, as evidenced by the recent listings for two Real Estate Investment Trusts ("REITS") in Ireland raising a combined sum in excess of €600m, predominantly from overseas investors, and further similar sized REITS likely to be launched during 2014.

The availability of such large funds seeking investment opportunities in secure Irish property assets could present an opportunity for transformational change in the nursing home sector.

It should be noted that for overseas investors, if the investment is structured via a Qualifying Investment Fund ("QIF") then the income is tax free in Ireland.

4. Overall comments on pricing

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3.4 Our preferred model

4. Increased patient contribution

As detailed in the background section we calculate that the current amount of patient contribution amount to 25% of the total amount spent on Fair Deal.

Clearly if the level of co-payment were to be increased, this would release an element of Fair Deal funding for use to meet surplus demand and reduce waiting lists.

We understand that the 2013 Care Bill in the UK proposes the following basis for patient contributions:

- The asset threshold for any contribution to care costs will be set at £17,000 (according to some observers);
- The asset threshold for full payment of care home costs will be set at £118,000 (€147,500) (again this figure is widely used by not fully documented); and
- A cap of £72,000 will be fixed for the maximum payment an individual can be expected to pay for their long term care up to the end of their life.

On this basis, even assuming that the UK patient had no asset other than a home at the average value of UK house prices (approx €220k) they would be required to contribute €72,500 to their care, before receiving any state support. This equates to around 1/3 of the value of the home, as compared to the current cap in Ireland of 22.5%

To illustrate the impact, if prices remain the same, the increase in patient contributions lead directly to increased capacity as outlined on page 7 above.

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Section 3. Review of the processes and methods for setting prices for LTRC in public, private and voluntary nursing homes

Contents

Appendix A: HSE process for calculating the cost of care

Background:

Under the Fair Deal legislation, the HSE is entitled to recover its costs for the provision of long term residential care services under the Fair Deal Scheme. Ref: Section 33 of the Nursing Homes Support Scheme Act 2009.

Cost of Care:

The cost of providing long term residential care services as provided for in Section 33 of the Nursing Homes Support Scheme Act 2009.

Components of the Cost of Care calculation:

AFDN (Area Fair Deal Nominee)

Fair Deal Costs for period:

1. The AFDN are responsible for ensuring that the financial data is accurate prior to the Cube being updated for the month.
2. The AFDN must cross check the bed numbers reflected in the cube for the month.
3. AFDN must notify Corporate Finance Naas of any proposed changes to costs/formula in the fair deal cube. Corporate Finance sign off any changes to Costs before the Cube is adjusted.

Bed Stock:

1. Bed stock is the number of Fair Deal Beds registered as open at the end of each month per the Bed Register.
2. Services for Older Persons are responsible for the integrity and accuracy of the Bed Register.
3. Services for Older Persons sign off the Bed Stock at the end of each month for load to the Cube.

Number of Bed Days:

1. Number of days in the period * bed stock at monthend per the cube.

Occupancy:

1. Projected level at which it is deemed practical to have bed occupied. (to take account of turn around etc).
2. The HSE and DOH have agreed a 95% occupancy rate for the purposes of calculating the Cost of Care.

Calculation of the Cost of Care:

Cost of Care is calculated as a weekly cost (7 days in formula below)

Formula: (Fair Deal costs in the period / No. of bed days) * 7 Days) / Occupancy)

Process for Calculation of the Cost of Care:

The cost of care is designed to reimburse care units for the actual cost of care incurred in the provision of the fair deal service on a monthly basis.

A cost of care rate to be paid at the beginning of each financial year will be calculated based on the latest available data at the point in time which is reasonably representative of the running costs of a unit for the forth coming period.

The cost of care rate will be updated on an annual basis.

The Cost of care rate being paid will be reviewed vis a vis the cost of care rate calculated based on actual results each quarter. Where a material anomaly arises and there is a valid rationale for potential adjustment, the cost of care for a unit may be reviewed in the interim on an exceptional basis. It is the responsibility of the AFDNs to alert Corporate finance of any potential adjustments in a timely manner.

Other Caveats:

- The bed register is the central repository for bed stock numbers (Managed by Services for Older Persons)
- The AFDNs are responsible for the accuracy of the financial data on a monthly basis.
- Each area will need to be aware of any unusual distorting factors in their financial data and these should be notified to the Corporate Finance Fair Deal Mgr.
- For the calculation of the cost of care, AFDNs and Services for Older Persons will sign off on the financial data and bed numbers for inclusion in the Cost of Care Calculation.
- Back Dating Cost of Care is not feasible on the NHSS processing system.
- There will be no retrospective loading of the Fair Deal Cube.

Process for approval and finalisation of the Cost of care or any interim changes.

- Corporate Finance and Older Persons will agree the dates for updating the cost of care. This will need to be in line with Service plan timelines.
- Corporate Finance will calculate the first draft of the cost of care.
- Draft 1 of Cost of Care will be circulated to Older Persons and AFDNs, requesting them to revert with comments within a specified period of timeframe.
- All issues will be considered and discussed and where adjustments are deemed legitimate/valid by Corporate Finance in conjunction with Services for Older Persons management, such amendments will be made.
- Draft 2 of the Cost of care will be forwarded to the Director of Social Care & the CFO for sign off.
- The new rates are payable from 1st Jan or an agreed date (interim updates) and are published on the HSE website.

- Interim adjustments, these will need to be signed off at AND level in finance and Services for Older Persons.