



Meeting Minutes



Detroit Long Term Care System Change Task Force Business & Economic Development Subcommittee Meeting Minutes

Date: Friday, January 9, 2009

Time: 2:00 p.m.

Place: NexCare Health Systems
10503 Citation Drive, Suite 100
Brighton, Michigan 48116

MEMBERS PRESENT

Dr. Richard Douglass, Co-Chair
Rick Scherrer
Robert Long
Reggie Hartsfield

STAFF

Faiz Esshaki, Facilitator

GUEST

Erin George, Plante & Moran
Rashmi Roy, EMU Grad Student

RECORDER

Leah Pippen

MEMBERS ABSENT

Phillip Pierce, Co-Chair
Pat Anderson
Jim Branscum
Douglass Diggs
Charles Dunn
Brian Holdwick
Marc Johnson
Mark Lang
James Tesen
Louis Guyton
Lawrence Jackson
Denise Rabidoux
James Tesen

I. CALL TO ORDER/ WELCOME & INTRODUCTIONS

The meeting was called to order at 2:48 p.m. Richard Douglass asked everyone to state his or her name for the record.

II. APPROVAL OF MEETING MINUTES – DECEMBER 10, 2008

The meeting minutes of December 10, 2008 will be approved at a later date due to technical difficulties experienced with the recorder.

III. FINALIZE RECOMMENDATION SUMMARY OF POLICY AND ADMINISTRATIVE RULES

Faiz referred to the Proposed Policy Development Process & Time Line and stated that subcommittees will need to submit all phase I policy recommendations to the Leadership/ Steering committee by January 30, 2009. He recognized that Business & Economic Development is charged with three strong strategies; some of which are phase I and some are phase II, which would continue beyond the legislative body.

Phase I would be identifying necessary changes in administrative rules that would have an immediate impact on making some changes in the nursing home industry in the region and possibly statewide.

Phase II would include changes that will have more of an impact long term. For example, what kind of a recommendation can we develop that will improve the lending opportunity to the nursing home industry in the region?

The Leadership/ Steering (L/S) committee consists of the chairs of each subcommittee, the experts and the facilitators. When the subcommittees submit their policy recommendations, a sub-group of the L/S committee called the Policy Review Team, will review and filter each recommendation until they develop the final recommendations by February 28, 2009. The Policy Review Team will submit the final recommendations to the Task Force Co-Chairs, Senator Buzz Thomas, Representative George Cushingberry and Paul Bridgewater on March 13, 2009. They will review them and the finalized recommendations will be distributed to the entire task force on March 20, 2009. We will then hold the LTC Policy Forum, inclusive of all Detroit Legislators, stakeholders and community advocates adopting those policy recommendations. This time line coincides with the revelations of the 09-10 budget that is slated to be completed by June. So if there are any changes that have an impact to the budget, sometimes Cushingberry can advance those by trying to go through the house or the senate.

The Policy Recommendation Template requires the following information:

- Policy Recommendation
- Rationale
- Regulation, Administrative Rule, Policy or Other Governing Laws Citations
- Impact of Proposed Policy Recommendation

Rick Scherrer recalled discussing inner governmental transfer, which would become a long term focus rather than short term. He went on to explain that we may have a means of getting inner governmental transfer by collecting local dollars from area nursing home owners. That money can be taken and doubled and distributed as incentive to owners who should close. This would relieve excess capacity and help the remaining facilities to meet the 85% occupancy rate.

Rob Long suggested addressing each policy summary individually to decide what we will recommend and move along in order to deliver a report by January 30, 2009. The two that address the occupancy issue are:

- Minimum Occupancy Requirement
- Beds Out of Service

We will begin with recommending relief of the 85% while allowing an opportunity to take beds offline. Rick mentioned bed banking as a way to convert 4-bed wards to 2-bed wards allowing the owner to retain ownership of the beds without losing anything for it. If an owner gave them up without banking, it would decrease the value of the property. In most circumstances, bank documents would not allow owners to give up beds because all of the lending decisions were made on the presumption that the facility generates a specific amount of revenue off of a set number of beds. Bed banking would take the 85% issue out of play without making any policy changes.

In the short term, the people that commit to giving up those beds get a two-year –no 85% occupancy on their cost reports. This could be used in phase II to convince lending institutions that they should come on board with us.

Rick stated that a banking policy would be five-year interim, but during that interim, the owner could apply for a number of beds back due to a need and the beds could be brought back online. After a two-year period most owners will not want the beds back because they will see the increase in value.

Rob asked if we should compose a suggestion to allow an option to convert the rooms back without keeping them the way they are, appearing to be 4-bed wards. Richard answered that it would have to be a specific administrative rule that we target.

Faiz stated that this recommendation would not be budget neutral in the first year; however, it is cost efficient. A few years down the road, it will reduce expenditures; it will provide quality for the

consumers and incentive for the discharge planners to refer Medicare clients. It could even draw private pay patients overall affecting your case mix. Richard stated that the case mix is significantly affected by the perception of quality in the facility. Improving quality would benefit everybody.

A question was asked if there is a way to estimate the impact. Richard answered that it would be a difficult thing to predict. We could state our expectations; and with the right language, we would not be held to anything that we couldn't deliver.

Rob asked if the recommendation would be derailed because it does not have a dollar sign next to it. Because it is a possibility, Rob suggested producing a list of "what if scenarios". For example, if a facility is at 85% calculations can be made using reasonable rate conversion to provide a close prediction of how cost neutral the plan is over time with the ability to specify how much time that is. We have to be prepared to address those that will derail the recommendation because of cost. Richard agreed that we have to provide expertise. Faiz suggested a contact that he would meet with informally to discuss that possibility. Faiz stated that we could offer the concept on January 30 and they will have a month to return it with direction.

Rob Long will write up a draft of the policy recommendation on the minimum occupancy requirement and beds out of service, and send copy to Richard and the members of the subcommittee. The subcommittee could then develop ongoing dialogue by the next meeting.

Faiz asked Rob to use the policy recommendation format provided and address the following questions:

- What will be required of providers to achieve these objectives?
- What will be required of MDCH?

Addressing the 2-year lag, it was decided that the subcommittee we would provide a policy recommendation to waive the 85% occupancy.

Rick suggested that we recommend eliminating replacement asset cost. If owners bank beds, we have to consider what happens to the cost per bed.

Rob asked if everyone was comfortable with making a recommendation that will not be cost neutral immediately, rather cost effective over time.

The subcommittee agreed that they would like to proceed. Erin George reminded the members of the subcommittee about the sprinkler system requirement in 2013. There will be a definite need for some sort of upgrade eventually anyhow.

Rob revisited the occupancy limit and asked if there would be any validity to recommendation for the state to buy the beds. Rick stated that the subcommittee had discussed this topic in a previous meeting. He noted that a fair amount of owners in Detroit have invested their retirement fund into running these facilities or that they were family owned businesses that just can not keep up. The question is, should the state have a pot of money to buy them up. If the beds go out of service, the residents will go to the facilities that remain in business. Rob asked if that could be use of the inner governmental transfer money. Erin asked, if then wouldn't it have to be spent directly on Medicaid approved services?

Richard addressed the for-profit/ non-profit divide. We had discussed using DAAA to solicit grants and distribute to for-profit facilities.

Faiz explained that if an owner has a regular reimbursement rate of 86%, and we can improve it to 98% he would benefit financially. The funding would come from the pot of money or grants and filter through the DAAA. We would then take the differential from the increase in revenue and pay the nursing home beds offline. It can be done through the Medicaid reimbursement system or through banking institutions. Erin thought that it would be safer for DAAA's solicitation license to do it through the reimbursement process, because then you are setting up a trust fund anybody could use and the percentage of what was gained is clean. Faiz stated that if this is done with inner governmental

transfer, it has to be reimbursed according to Medicaid and Medicare guidelines. DAAA would get the funds and transfer them to the state. The federal government matches it to the state. All funds would be placed into the pot. The funds would have to be tapped into through reimbursement. Richard realized that there is a mechanism to create the fund, but there is no mechanism in place to distribute the funds.

Rob asked if it is a good idea to consider a buyback plan from the inner governmental transfer money if we can figure out a way to do it.

Illegible

Richard stated that another aspect of the for-profit/ non-profit divide is not being eligible for other sources of funds (research grants, direct federal grants, foundation grants, etc.)

The quality of care is enhanced for patients in non-profit facilities because they are designated as teaching nursing homes. Richard came up with the idea that if the grant funding came in as a consortium of for-profit facilities sharing Medicaid patients and you are the recipient of the grant... How do we make the nursing home industry more like the rest of the healthcare system?

Faiz's brainstorming on access to capital: Why can some entities approach MSHDA to get financing with low interest rates? How do we establish a process where for-profit nursing facilities can do the same? How do we reduce the bad debt for the nursing home industry in terms of the reimbursement rate?

To summarize, establishing an offset for the financial issue:

- Can we qualify nursing homes to get lending from MSHDA or some other source?
- Can we establish a process reducing the incorporation barrier asset to a broader spectrum?

Rob suggested holding dialogue with HUD rather than MSHDA, since MSHDA deals with housing more so than care related programs. The question was asked who set up the restrictions. Richard's guess is that President Obama will throw a lot of money into HUD. If we could get MSHDA/ HUD to assist in paying for what is currently a Medicaid paycheck. Faiz even stated that it would be good if we could even get a low interest loan from MSHDA/ HUD.

Rob stated that this would be far-fetched as a recommendation. Faiz said to just put it out on the table.

Rob visited the topic of going into capital and asked if elimination is our recommendation?

Illegible

The subcommittee decided that Replacement Asset and CAV are easy ones.

Rick said to retain whatever the building owners' tenure was.

One recommendation would be to eliminate tenure factor with the rationale that there is no logic. Richard would like to look at what some of the surveyors are most likely to ticket and find out how many of them can be eliminated, Things like, cigarette butts as evidence of open flame.

IV. DEVELOP PLAN FOR LENDING OPPORTUNITIES THROUGH FINANCIAL INSTITUTIONS

This topic has been moved to Phase II This will be an ongoing discussion and the lending institutions may be more involved in. Some ideas were touched on in Agenda Item number III.

V. CONTINUE DISCUSSION ON EXCESS CAPACITY AND CONVERTING NURSING HOMES INTO AFFORDABLE HOUSING

We discussed how we could provide incentive for the nursing home owners in the region who are struggling to close; which would eliminate excess capacity, improve the occupancy rate for the neighboring facilities that would continue business and still benefit the nursing home owners that have to close. An idea was to convert those nursing homes into an affordable living facility. MSHDA could provide financing for lodging through Section 8; we would provide home community based programs for the occupants of the nursing homes so that the owners will benefit. They will save a

significant amount of dollars by providing only home community based services so they no longer have to foot the bill for those nursing homes that are on the verge of closing.

Richard commented that this idea was developed on the observation that a lot of the marginal facilities are as full as they are with patients that are really housing clients, not nursing home clients and Medicaid are paying for them rather than MSHDA. We are trying to prevent them going out of business and create higher taxes for the community.

Faiz stated that the third tier of our objective is how we can encourage developers to invest in new developments that are more relevant for our region that would draw a more diverse payor mix.

Richard mentioned that Detroit wants to renovate Grand Boulevard, but Faiz stated that the Boulevard will soon be demolished. Rick asked what will happen to all of the residents in those facilities. Faiz responded that they will most likely be transferred. Richard noted that almost 20% of all nursing home beds in the state are in the East Grand Boulevard area. Faiz said that the East Grand Boulevard Nursing Home is going to be targeted for an affordable housing project. There is also another project in Grand Rapids that is scheduled to begin in April. Reggie asked if any contact has been made to the owners. Faiz stated that contact has been made with the one building that is being targeted. In order to be converted to affordable housing a building has to be suitable. If it is not, then it is better to start from scratch.

VI. SUBCOMMITTEE RESPONSIBILITY THROUGHOUT 2009

Richard stated that a lot of other subcommittees are looking toward us to make the first move because the rules determine the flow of the money. Richard would like to present to the Task Force that our subcommittee is presenting creative solutions to the status quo (using that verbiage) not only because of President-Elect Obama's agenda for change; it is obvious that we have to make a claim that we are proposing things that are new. This relationship with MSHDA might be one of those creative recommendations. We are not recommending closure; we are not recommending more money through Medicaid. We are saying let's develop a new way to take care of these people and the communities in which these facilities exist.

VII. OPEN DISCUSSION/ REMARKS

Rob stated that the draft of the recommendations would be sent to the subcommittee for review by Friday, January 16, 2009. We need two meetings to review and finalize by January 30. The next meeting date was set for Wednesday, January 21, 2009 at 12:00 Noon at DAAA – Ola Morris Conference Room. It was noted that Leah would not be in attendance due to scheduling conflict with the Access Subcommittee on January 21 at 1:00 p.m. Faiz stated that the focus of the upcoming meeting would be to refine policy recommendations and touch on Phase II. No minutes will need to be taken.

VIII. ADJOURNMENT

The meeting was adjourned at 4:40 p.m.

Respectfully submitted by:
Leah Pippen
FE/lp

Moving Towards Enhancing the Quality of Care