



**SKILLED NURSING FACILITY ANALYSIS  
SECTOR 3  
CITY OF DETROIT**

***September, 2007***

**© *Plante & Moran/Detroit Area Agency on Aging***

## **Background**

The Detroit Area Agency on Aging (DAAA) has been in the process of assisting and analyzing the care needs of the elderly in the City of Detroit. By initiating the Dying Before Their Time Task Force, the DAAA has brought attention to the significant care needs of seniors in the city and the lack of services to meet those needs.

A major concern facing DAAA is the number of long-term care beds that have been lost recently, due to the closure of nursing homes in the City of Detroit. An additional number of skilled nursing facilities (SNFs) are currently experiencing financial and operational difficulties and might close, taking additional beds out of service. As a result, this project was undertaken in order to identify facilities vulnerable to closure and strategies to improve the overall quality of care in Detroit skilled nursing facilities.

The initial phase of the study included an extensive analysis of the facilities located in Sector 3 (Eastern region) of the City of Detroit. Onsite facility visits were conducted and both regulatory and financial and operating statistics were reviewed in detail.

The second phase of the study included a limited analysis of the remaining Medicaid certified facilities in the City of Detroit. Regulatory and financial and operating statistics were compiled and reviewed from public data sources. No onsite facility visits were conducted.

This report includes a synopsis of the findings and recommendations from both studies.

## **Project Scope and Objectives**

- Assess the facilities located in the City of Detroit for the purpose of identifying clinical and financial operating issues that may affect the facility's ability to provide high quality care, barriers to meeting regulatory requirements and facilities at risk for closure
- Evaluate how well the demand for services is being met
- Identify strategies for improvement for vulnerable and struggling facilities

## **Project Team**

The Project Team included the following consultants from the Plante & Moran Senior Care & Living Services Group:

- Jerry Gumbleton, CPA, Partner
- Betsy V. Rust, CPA, Manager
- Brenda Sowash, BSN, RN, Senior Consultant
- Melanie Nabozny, RN, Senior Consultant

## **Methodology and Data Sources**

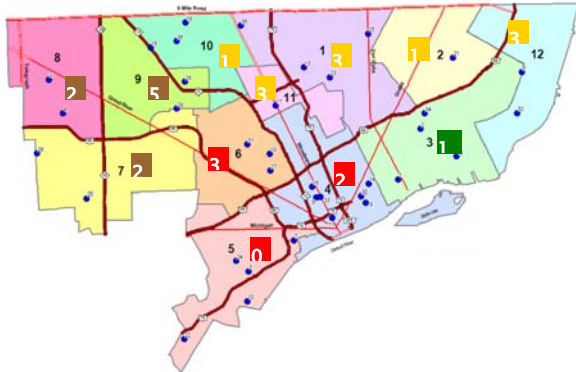
- Most recent facility survey histories were analyzed
- Quality Indicator reports were reviewed for the majority of facilities.
- Financial and Operating statistics were analyzed from 2005 Medicaid Cost Reports and October 1, 2006 Rate Sheets
- Resident interviews were conducted in some instances.
- Facility tours were conducted to target environmental, Life Safety, resident care and dignity concerns.
- Facility chart reviews were completed.
- Key owners and nurse management personnel were interviewed.

## City of Detroit Skilled Nursing Facilities

A total of 4370 licensed beds in 36 Medicaid certified facilities are available in the DAAA's service area, including Highland Park, Harper Woods and the Grosse Pointes. There is one facility that is not certified for Medicaid.

- There is significant ownership of beds by four entities (56%)
- The predominance of ownership is by proprietary organizations. There are only five not-for-profit facilities.
- There are significant clusters of facilities (Sector 3 serving the city's east side and Sector 9 serving the northwest). There are some sectors with little to no bed capacity.

### Detroit Area Agency on Aging Service Area



# = Number of Skilled Nursing Facilities

- ❖ **NORTHERN REGION = 10 SNF's**
  - Sectors 1, 2, 10, 11, 12 (1276 beds)
- ❖ **SOUTHERN REGION = 5 SNF's**
  - Sectors 4, 5, 6 (629 beds)
- ❖ **EASTERN REGION = 13 SNF's**
  - Sector 3 (1218 beds)

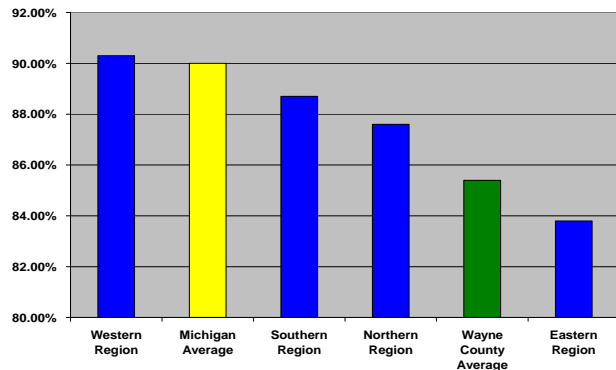
### Summary of Significant Findings

- ❖ **Patient Profiles and Facility Capacity**
  - The Detroit SNFs have a significant population of patients atypical to the average long term care facility in

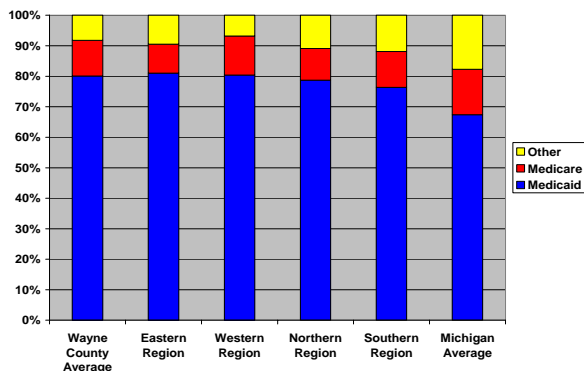
Michigan. These groups include adult, non-elderly residents, HIV dependent and homeless individuals, and persons with chronic mental health, substance abuse and behavior issues. We also noted a very high incidence of residents with wounds and infections as compared to other facilities.

- Medicaid utilization in Detroit is higher than Michigan averages.
- Medicare utilization in Detroit is less than Wayne County and Michigan averages. There is a strong correlation between higher Medicare utilization and favorable financial results. Many of the facilities indicated difficulty in accessing Medicare residents through the hospital discharge process.
- Occupancy in Detroit is less than Michigan averages. Occupancy is lowest in the Eastern Regions where there appears to be excess capacity.
- A significant number of patients are sent to the hospital when they could be cared for at the nursing home due to the lack of adequately trained staff. As a result, both Medicaid and Medicare incur higher costs to care for these patients.
- Medicare Special Needs Plans (Fidelis) have enrolled many Detroit Medicaid residents in their Part A Advantage Plans. They provide onsite case management and caregiver assistance for their enrollees. As a result, this may improve the overall quality of care in Detroit facilities and will likely reduce the rate of readmission to hospitals.

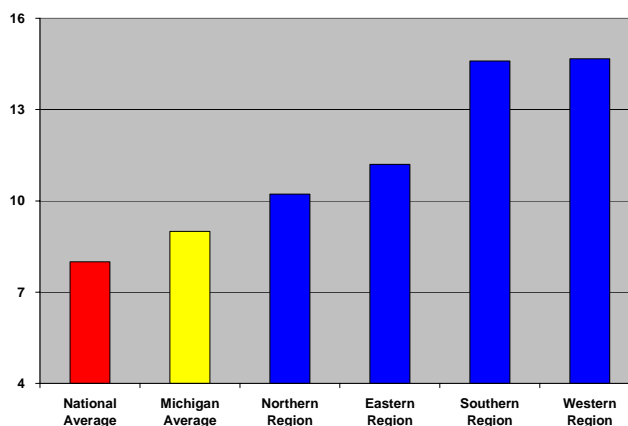
### Facility Occupancy



## Facility Payor Mix



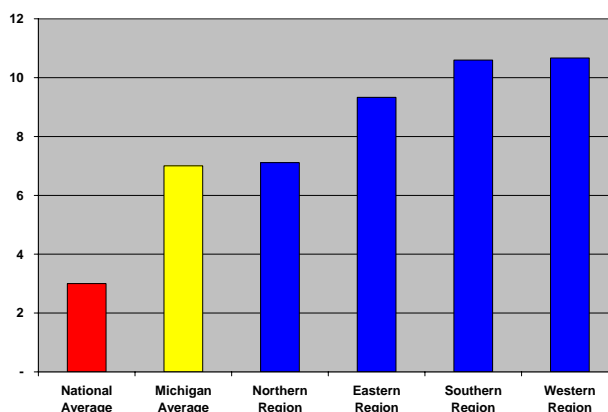
## Detroit Skilled Nursing Facilities Average Number of Health Citations



### ❖ Clinical Services – Regulatory Compliance

- Detroit SNFs have a higher level of health and life safety citations than Michigan and National averages.
- A contributing factor to the high number of life safety citations is the significant age of the physical plant.
- During the site visits of many of the facilities, we noted a higher degree of concern/harm than what was cited during the latest survey. Several jeopardy situations were found during the site visits.
- All facilities had observed concerns in incident and accident prevention and monitoring
- There was a high correlation between the “hands on” involvement of the management group and the efficiency and effectiveness of the facility.
- There was a wide disparity in the expertise and capability of the Nursing Administration Staff. We noted more employee turnover in the management positions than in the staff positions which leads to decreased clinical outcomes and poor system implementation
- Overall, the facilities did not appear significantly understaffed. Many of the facilities reported staffing at higher levels than the average Michigan facility.
- Existing staff need additional training and education to increase their effectiveness and improve patient outcomes.

## Detroit Skilled Nursing Facilities Average Number of Life Safety Citations

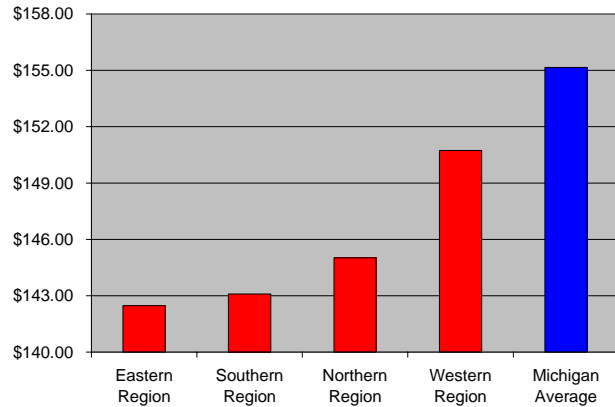


### ❖ Medicaid Reimbursement

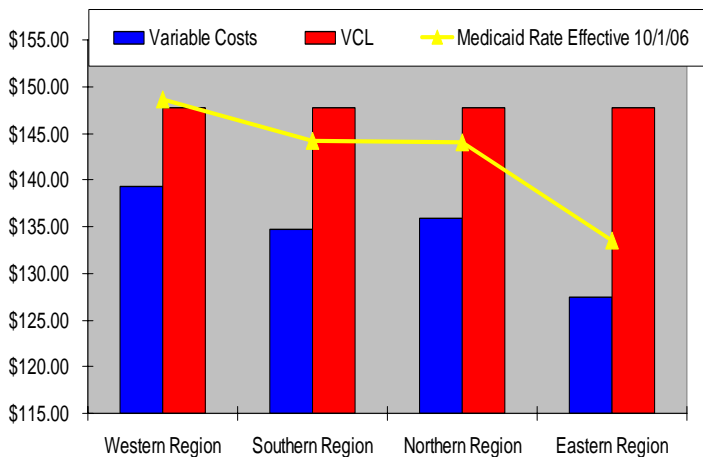
- The majority of Detroit SNFs are reimbursed under the Medicaid limit for operating expenses.
- A significant number of facilities experienced un-reimbursed but allowable costs due to low occupancy as Medicaid imputes an 85% occupancy level to facilities in determining allowable cost.
- Medicaid has further limitations on specific classifications of cost (referred to as support) and some providers experienced un-reimbursed cost due to this issue.
- For the Medicaid rate year beginning October 1, 2006 through September 30, 2007, the total un-reimbursed but allowable cost due to these issues was approximately \$2,000,000.

- Bed escrows or de-licensure of beds would mitigate this issue and has been utilized by a few providers. However, some facilities are hesitant to reduce bed capacity based on the belief that some providers will soon close, providing future opportunities for improved census at their buildings.
- The provider tax program contributes positively to financial results for most facilities

### 2005 Operating Expenses Per Patient Day



### October 1, 2006 Medicaid Rates – Exclusive of the Provider Tax Program



*The Medicaid rate is the sum of the variable (operating) and capital costs.*

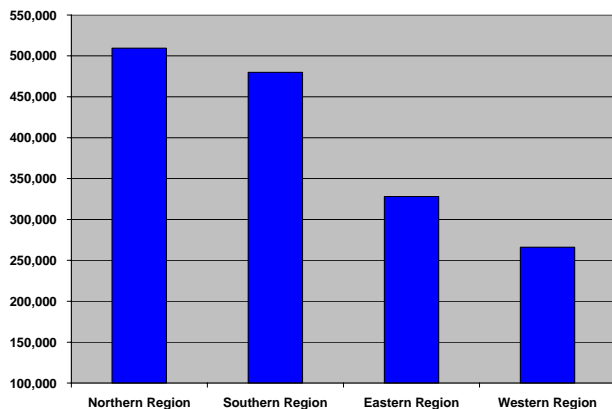
#### ❖ Facility Operations

- Operating expenses per patient day were less than statewide averages (computed at 85% occupancy).with the greatest differential in the nursing services area.
- Significant variations between Detroit facilities were noted in nursing, dietary, and plant operation and maintenance services.
- Employee benefits and workers compensations costs as a percentage of wages were less than statewide averages for most facilities.

#### ❖ Capital Reimbursement Issues and Opportunity for Investment

- There is a correlation between capital reimbursement and length of ownership. The majority of facilities have been owned for more than 12 years, which is favorable for reimbursement.
- There has been minimal reinvestment in the majority of facilities, and most are under the capital asset value limitations for reimbursement.
- Many of the facilities have little outstanding debt.
- Many of the facilities would be eligible for additional reimbursement for capital expenditures.
- There are certain unfavorable limitations in the Medicaid regulations related to replacements of existing assets and total facility replacements that deter owners from investing.
- Several owners reported difficulty in accessing capital for renovation projects due to the unwillingness of lenders to finance urban nursing homes.
- Financing rates for Detroit SNFs are often higher than market rates.

### Average Capital Expenditures During Five Year Period from 2000-2005



#### ❖ Financial Management

- There were varying degrees of reimbursement knowledge among the owner/administrator group. There was less knowledge about the complicated capital reimbursement regulations
- Almost all of the facilities reported a profit per resident day for the year ended 12/31/05 (Medicaid rates for 2005 were established based on cost and census data from 2003).
- Collection of accounts receivable is a significant problem for many of the facilities due to delays in establishing Medicaid eligibility and non collection of patient pay amounts
- Designated Department of Health Services (DHS) workers are utilized in some of the facilities to expedite the Medicaid eligibility and enrollment process.

### Conclusions

#### ❖ Bed and Service Capacity

- There is excess capacity in the Eastern Region. The remaining geographical areas have occupancy comparable to Michigan averages with some facilities experiencing occupancy less than 85%.
- The excess capacity results in unreimbursed cost for many providers and resulting cost savings to Medicaid.
- There is a significant demand for services for at risk groups such as

ventilator dependent, substance and other abusers, and individuals with significant wounds and pressure ulcers. A large number of homeless individuals were served in the Eastern Region.

#### ❖ Regulatory Compliance and Clinical Services

- The majority of facilities have higher than average health and life safety citations and remain at risk for continuing this pattern as many of the citations are due to a lack of investment in physical plant or systemic management issues.
- The facilities have a significant number of life safety deficiencies related to building, sprinklers, and other areas. In addition, many have variances for other physical plant issues. Many of the facilities have the opportunity for additional capital reimbursement within the limitations of the current system. However, that system has significant disincentives for replacement and renovation that discourage such investment (full amount of investment is not always recognized).
- Overall, staffing levels appeared reasonable in comparison to industry averages. Increased education and reduced turnover in key management positions would likely improve the quality of care.

#### ❖ Medicaid Reimbursement and Operating Issues

- The majority of facilities are reimbursed at rates less than existing Medicaid limits for operating expenses and could be eligible for increased reimbursement for staff training or other facility improvements. However, such increases are dependent upon Medicare and Medicaid Regulations on allowable costs, continued funding of the Medicaid Program at existing levels and the normal two year lag in reimbursement rates.

- Staffing levels appeared comparable to other facilities. However, wage rates, benefits, and workers compensation costs were less than Michigan averages.
- There has been minimal capital investment in the majority of facilities. Although there are opportunities to obtain additional reimbursement for capital expenditures for most of the facilities, the existing system has significant constraints for replacement assets that serves as a disincentive.
- Cash flow is an issue for many of these providers. Facilities indicated significant delays in establishing Medicaid eligibility for beneficiaries and in collecting private pay amounts. In addition, owners also indicated the inability to access short term working capital or long term funding due to the increased credit risk associated with Detroit facilities.
- The majority of the facilities have the potential to remain financially viable.

### **Recommendations for Strategies to Strengthen Detroit SNFs and Improve Resident Care**

Improvements in the quality of skilled nursing facilities in the City of Detroit can be accomplished through the joint efforts of providers and the Michigan Department of Community Health. Following are strategies that would strengthen individual providers and promote an increase in quality.

- ❖ **Reduce Total Bed Capacity to Reflect Population and Demand for Services**
  - **Providers** - Voluntarily de-license beds which will also lead to improved reimbursement rates through elimination of the 85% occupancy issue.
  - **MDCH** - Increase enforcement of survey standards and timely implementation of plans of correction. Assist in transition of homeless resident population that is not nursing home eligible

- ❖ **Invest in Staff**
  - **Providers** - Increase retention of key management through improved compensation, leadership training, and enhancement of the physical environment through capital investment. Increase access to higher skilled workforce through improved compensation plans.
  - **MDCH** - Facilitate interagency participation in job training and recruitment efforts in the City of Detroit
- ❖ **Facilitate Access for Special Population Groups**
  - **Providers** - Ensure adequate training for staff to appropriately care for special population groups such as ventilator dependent, AIDS, substance abusers and wound care patients.
  - **MDCH** - Provide an incentive for providers who care for a disproportionate share of these residents consistent with appropriate performance indicators. Assist providers in identifying resources to supplement training and education for special population groups
- ❖ **Invest in Physical Plant**
  - **Providers** - Invest in Physical Plant. Obtain counsel on financial and reimbursement implications of capital projects. Continue to seek capital from both traditional and non-traditional lending sources. Work with State associations to encourage Medicaid to adopt more flexible reimbursement regulations consistent with other states
  - **MDCH** - Increase enforcement of survey standards. Provide education and assistance to providers in understanding capital reimbursement regulations. Provide exceptions to reimbursement regulations on asset replacements to encourage investment. Provide access to capital for facilities to complete renovation projects.

❖ **Improve Care Planning and Delivery**

- **Providers** - Increase facility clinical expertise to reduce hospital recidivism. Increase facility expertise in completion of the MDS and related care plans. Increase analysis of Quality Indicator and other clinical data to identify staff training needs.
- **MDCH** - Work with Medicare Special Needs Plans such as Fidelis for case management assistance of Medicaid SNF residents. Institute a process to provide ongoing support to providers in the implementation of activities that strengthen care delivery systems (outside of survey)

❖ **Strengthen Financial Position of Providers to Promote Long Term Sustainability**

- **Providers** - Voluntarily de-license beds which will result in improved Medicaid reimbursement rates. Increase attention to reimbursement regulations to take advantage of opportunities to improve rates. Utilize DHS Outstation Worker Program where possible to improve the timeliness of Medicaid eligibility determinations
- **MDCH** - Remove 85% occupancy rule or grant relief to providers in the year they de-license the beds. Consider options to increase the flexibility of the reimbursement system that avoid linking payment to occupancy standards or to definitions of cost classification (i.e. base and support). Enhance the efficiency and effectiveness of the Medicaid eligibility process (e.g. increase the number of case workers or decrease the processing time). Investigate opportunities to assist providers in minimizing bad debts associated with patient pay amounts