

The Least Among Us:

An Analysis of Medicaid-Intensive Nursing Homes in Detroit and the Patients That They Serve

Synopsis of Research Findings



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Detroit area Medicaid-dependent nursing homes are in a crisis. Dependence on inadequate Medicaid reimbursement for services to an increasingly non-traditional population that includes the mentally ill, developmentally disabled or chronically ill younger adults is creating a degree of difficulty beyond the expectations and training of most people who work in critically needed nursing homes.

A study conducted for the Detroit Area Agency on Aging (DAAA) by Richard Douglass, Ph.D. and his research team found that Detroit area nursing homes dependent on Medicaid reimbursement face a complex, generally unknown and often misunderstood set of conditions that challenge their survival. Many common beliefs and stereotypes no longer apply. The old image of a nursing home filled with the frail elderly remains while the reality is strikingly different. Widely publicized, primarily negative, facts are often taken at face value and used to convey an image of a system that is on a downward spiral with little hope of providing compassionate, high-quality care to those most in need.

In an environment of multiple nursing home closures, high regulatory deficiency rates, decreasing revenue and negative media coverage, the purpose of this study was to identify and examine the issues and circumstances facing Medicaid-dependent nursing homes in DAAA's Planning and Service Area (PSA) 1-A as compared to other facilities in Southeastern Michigan. According to Dr. Douglass, primary investigator for the study, the outcome is a report that challenges some beliefs and stereotypes that are widely held among academic and practicing gerontologists and health care professionals.

Key findings of the study and accompanying recommendations are highlighted in this Synopsis.

Background

DAAA's service area, PSA 1-A, consists of Detroit, Hamtramck, Highland Park, Harper Woods, and the five Grosse Pointes. According to Census 2000 data, the agency has a sixty-plus population of 146,806 (23% decline from 1990) and a poverty rate of 24.9% -- more than double that of any other PSA in the state of Michigan. The number of persons age 65 and over living in nursing homes was 4,265; eighty-eight percent (3,733) of this population reside in nursing homes within the City of Detroit.

Research Team

The research team was led by Richard Douglass, Ph.D., Director of Health Administration at Eastern Michigan University, under the institutional oversight of the Eastern Michigan University Human Subjects Review Committee. Dr. Douglass was assisted by William Laverty, a retired hospital administrator and undergraduate Health Administration students Joyce Blair, Kyle Gilmore and Monika Stefankovic.

Methodology

Three different methods were used to gather information from various sources and points of view. Methods included:

- ✓ *Review of practice-based and research literature about nursing homes that are substantially dependent on Medicaid for patients and revenue,*
- ✓ *Analysis of secondary data from state and federal regulatory agencies, and*
- ✓ *Gathering of primary data from owners, administrators, staff and advocates of Medicaid-dependent nursing homes through focus groups and interviews.*

Medicaid-dependent nursing homes were defined as facilities that are dependent on Medicaid for 85% or more of their residents, and therefore, as the primary source of revenue. The level of Medicaid dependency may vary within a facility in a given year depending on the number of nursing home residents receiving Medicaid support.

Few Published Studies

- ❖ Approximately **70%** of nursing home patients in the United States are Medicaid dependent. Yet, there are few published studies on Medicaid-dependent facilities.
 - ✓ *Most research focuses on Medicare-based skilled care services. This includes not-for-profit, charitable, hospital-affiliated and other relatively affluent sectors.*
 - ✓ *One of the consequences of limited information is that geriatric educational material is drawn from studying institutions and patients in relatively resource-rich environments where most nursing home patients **do not live**.*

Management

- ❖ Medicaid-dependent nursing homes are most commonly for-profit corporations that are either independently owner-operated, chains or associations of for-profit businesses. These facilities often lack the following:
 - ✓ *Subsidies from other revenue generating operations such as assisted living or senior apartments;*
 - ✓ *Resources available to not-for-profits through gifts and grants; and*
 - ✓ *Administrative depth or the capacity to successfully manage all business and patient care components with sufficient expertise.*
- ❖ Managerial turnover is as much of a challenge for Medicaid-dependent nursing homes as is the widely recognized nursing shortages in health care.
 - ✓ *Frequency of administrative turnover increases as facilities become more dependent on Medicaid and the clinical case mix of traditional frail elderly with mentally ill and other categories of disabled younger adults grows.*
 - ✓ *This situation places Detroit's facilities at high risk of managerial upheaval.*
 - ✓ *Shortage of appropriately trained nurses and nurse aides and absenteeism are universal problems.*

- ❖ Medicaid-dependent nursing home ownership transfers are common and indicate instability. The following table outlines ownership transfers that have occurred since 1984:

Change of Ownership	PSA 1-A	PSA 1-B	PSA 1-C
# Nursing Homes	7	4	2
2 Transfers per Home	4	3	1
3 Transfers per Home	3	1	1
Total # Transfers	15	9	5

Medicaid Reimbursement

- ❖ Low Medicaid per diem reimbursement rates do not compensate for severity of illness or intensity of care needed to serve a clinically complex mix of patients.
 - ✓ *These rates are lower than other nursing home payor rates and may be below the actual cost of services.*
- ❖ Slow Medicaid certification of new or existing patients causes severe cash flow problems and can trigger a major crisis for independent facilities with no corporate depth.
 - ✓ *Medicaid applications can require months to process for approval.*
 - ✓ *Facilities are expected to absorb the cost of care for such "pending" cases.*
- ❖ Patients are often transferred to Medicaid-dependent facilities after Medicare "spend down" in private-pay or Medicare-based nursing homes.
 - ✓ *This transfer constitutes a form of "patient dumping" because the recipient facility is obligated to care for the patient with no resources beyond Medicaid reimbursement.*
- ❖ Although Medicaid reimbursement rates are set annually, approved rate increases may not be implemented for as long as two years after reporting higher costs.
 - ✓ *Since anticipated costs cannot be included in rate increase requests, Medicaid-dependent nursing homes find it nearly impossible to keep up with cost increases, maintain competitive salaries and fringe benefits or even make essential repairs and perform required maintenance.*

Regulation, Deficiencies and Inspections

- ❖ A predictable higher number of deficiencies were noted consistently when Medicaid dependent facilities were compared to Michigan or National averages and are consistent with national studies. The nature of these results is not clear.
- ❖ Minority patient populations are more likely, based on national data, to be residents of facilities with over 40% more deficiencies than facilities predominantly serving white residents.
- ❖ Occupancy rates for the Medicaid-dependent facilities were higher in PSA 1-A than in surrounding PSAs 1-B and 1-C. Possible reasons for these higher rates include:
 - ✓ Closure of nursing homes in PSA 1-A and redistribution of patients to other remaining Medicaid-dependent homes; and
 - ✓ Closure of Michigan State Mental Hospitals, such as Northville and the distribution of these patients into different venues of care.

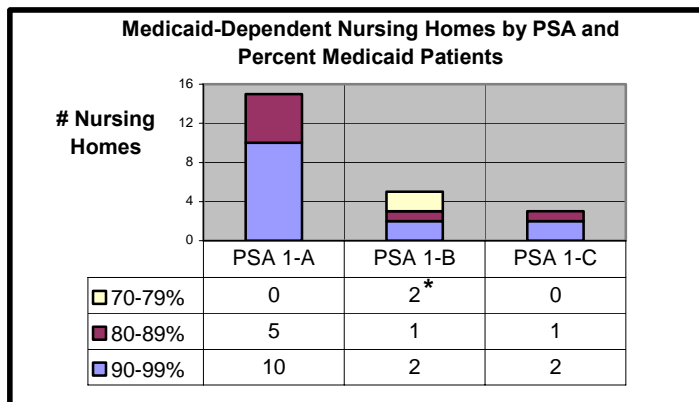
Regulatory Data: 85%+ Medicaid-Dependent Facilities

	PSA 1-A n=13	PSA 1-B n=6	PSA 1-C n=3
Total Number of Beds	1,423*	366	381
Number of Residents	1,192**	338	292
Number of Regulatory Deficiencies	166	43	52
Average Number of Residents by Facility	91.7	67.6	97.3
Average Number of Beds by Facility	109.5	73.2	127.0
Percent Filled Beds on Medicaid	92.3	85.8	90.0
Percent Occupancy	88.1	92.3	86.0
Number of Deficiencies/Beds	0.12	0.12	0.14
Number of Deficiencies / Residents	0.14	0.13	0.18
Registered Nurse Hours per Patient Day (mean)	0.32	0.60	0.48

* Calculated as PSA 1-A Bed Total of [1643 – 220] beds for two facilities for which deficiency data were not available (LaSalle Nursing Home and Northland Nursing Center)

** Includes no data for two facilities for which data were not available (LaSalle Nursing Home and Northland Nursing Center)

Sources: www.medicare.gov, www.hospitaldata.com, www.medicare.gov, Center for Medicare and Medicaid Services, www.hospitaldata.com, Health Care Association of Michigan



* At % sample cutoff as of May 2004

- ❖ Regulatory data do not appear to suggest widespread poor quality of care when highly Medicaid-dependent facilities are compared.
 - ✓ Inspections do little to directly measure quality of care.
 - ✓ Studies that present regulatory deficiencies as evidence of poor quality rely on comparisons between non-equivalent facilities; poorly resourced urban facilities are compared to facilities with a significantly different clinical case-mix and more adequate sources of revenue.
- ❖ Several studies suggest that state survey inspection teams are reported to be aggressive, inconsistent in their observations, unpredictable in their distribution of citations and subject to regional variations in survey team performance.
 - ✓ Most Medicaid-dependent facility managers, administrators, owners and senior staff consider state inspectors to be adversaries rather than advocates.
 - ✓ Anecdotal statements about the subjectivity of inspectors are prevalent locally and nationally.



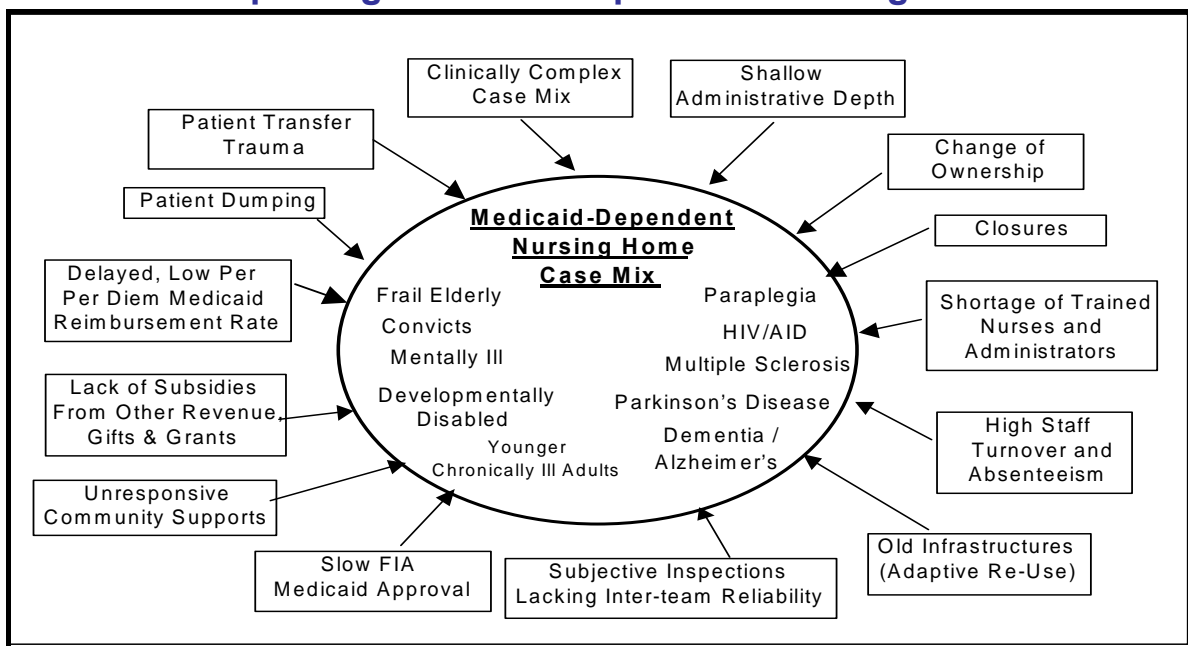
Patient Characteristics and Clinical Case Mix

- ❖ Urban Medicaid-dependent facilities are far from the traditional public image of nursing homes filled with the frail elderly. These facilities are more likely than others to:
 - ✓ *Serve African American and other minority populations, and*
 - ✓ *Have a clinically complex case mix of substantially younger, resident populations who are mentally ill, disabled or suffer from chronic diseases.*
- ❖ Medicaid's requirement of 70% occupancy, as a prerequisite for reimbursement, increases pressure on facilities to accept non-traditional patients, principally the mentally ill, in order to maintain Medicaid status.
- ❖ Accepting an increasingly greater number of non-traditional, higher cost patients impacts clinical management, strains budgets and negatively affects marketability.
 - ✓ *Professional staff are often unable to focus on the geriatric needs of the frail elderly, as they have been trained to do, because a large proportion of their patients have other clinical needs.*

- ✓ *Clinical management of a complex mix of mentally ill and younger adults with chronic conditions is often more labor-intensive and costly than traditional geriatric care of the frail elderly.*
- ✓ *Marketability is negatively impacted as the facility becomes less desirable as a place of choice for private pay patients.*

- ❖ The frail elderly often become sicker and some die as a result of transfer to different nursing homes or other living arrangements. This is the well-documented phenomenon known as "transfer trauma". According to Focus Group participants:
 - ✓ *Some patients are transferred to nursing homes far from family and friends. Others may be sent to adult foster care settings or even homeless shelters.*
 - ✓ *Such moves are usually accompanied by reduced family visitation, depression and physical deterioration and can lead to accusations or legal suits by the family.*
 - ✓ *Patients transferred due to nursing home closures are often sent to other Medicaid-dependent facilities in danger of closure and are subjected to a second or third transfer when these homes subsequently close.*
 - ✓ *At least eight nursing homes have closed in PSA 1-A since 1999 and several are in jeopardy of closing.*

Factors Impacting Medicaid-Dependent Nursing Home Crisis



Conclusions

- ❖ Low Medicaid per diem reimbursement rates are the primary cause of the Medicaid-dependent nursing home crisis. Lacking profit generating operations and access to other sources of revenue, Medicaid-dependent nursing homes struggle to care for a non-traditional clinically complex mix of patients that are often more labor-intensive and costly to manage.
- ❖ Medicaid-dependent homes have become dumping grounds for many unwanted people in the community who have no alternatives. The practice of transferring patients from private pay nursing homes to Medicaid-dependent facilities after Medicaid 'spend down' of their assets is a contributing factor that adds to the financial problems of these facilities.
- ❖ Clinical management of the frail elderly, mentally ill, developmentally disabled and younger adults with chronic illnesses is a major problem for professional staff who were not trained to manage such a medically complex patient population and is not consistent with high quality care for any of the case mix categories.
- ❖ Regulatory deficiency information does not often provide an accurate view of Medicaid-dependent facility quality. Focus group interviews support reports of aggressive survey inspection practices, inconsistent observations, and unpredictable distribution of citations.
- ❖ Closure of Medicaid-dependent nursing homes is a tragic and traumatic event for patients and the community. Patients become sicker and some die as a result of "transfer trauma". The community is denied access to affordable, high quality nursing home care for all its citizens. Success of Medicaid-dependent facilities is in the best interests of the entire community.

Recommendations

- ❖ Public hearings should be held to follow-up on the following specific questions:
 - ✓ *Clinical case mix;*
 - ✓ *Sources and outcomes of transferred patients;*
 - ✓ *Adequacy of Medicaid reimbursement;*
 - ✓ *Processing of Medicaid applications;*
 - ✓ *Police and other infrastructure supports;*
 - ✓ *Community impact assessments when facilities are closed; and*
 - ✓ *Aggressive survey inspection practices.*
- ❖ Reconfiguration of current providers through pooling licensees with groups of proprietary facility owners and reincorporation should be considered. Reconfiguration would allow long-term providers in Detroit to provide higher quality of care and continue to do the work that they have done, in many cases, for generations.
- ❖ New venues of care created with public-private partnerships, shared risk and increased Medicaid reimbursement would present opportunities for old building stock to be replaced and provide for economic or residential development.
- ❖ Regulatory policies, procedures and processes need to be examined.
 - ✓ *Quality control in surveys and inspections should be examined. Inter-rater reliability standards should be developed and rigorously applied by survey teams to reduce the degree of subjectivity.*
 - ✓ *Other forms of incentives for reduction of excess bed capacity should be considered. The process of aggressive inspections, litigation, fees and fines is traumatic for patients and whole communities.*
 - ✓ *Advocacy-based regulation and enforcement would reduce the risk of facility closure and the subsequent loss of employment for nursing home staff and trauma of patient transfers.*