



**State of Illinois**  
Rod R. Blagojevich, Governor  
**Illinois Department on Aging**  
Charles D. Johnson, Director

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## **Older Adult Services Advisory Committee**

# **Nursing Home Conversion Work Group**

Date: November 27, 2007

Location: Illinois Health Care Association, Springfield

Attending: Marianne Brennan, Janice Cichowlas, Bill Dart, Matt Hartman, Myrtle Klauer (Co-Chair), Bonnie Lockhart, Phyllis Mitzen, (Co-Chair), Scott Musser, Renne Razo, Lester Robertson, Kevin Taylor and Steven Wolf

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### **Summary:**

The Health Facilities Planning Board can no longer afford to send staff (Bob Green) to these meetings because they are so short staffed. Phyllis will meet with Jeff Mark, HFPB Director. The nursing home survey is dependent on their support, and if they are not able to do it, we need to determine how we can obtain this information.

At the 11/26/07 OASAC Executive meeting, they discussed the need to gather hard data about the nursing homes (particularly publicly funded nursing homes), such as the number of available beds and the number of residents in nursing homes by county. We know how many residents are in Medicaid, for example; but we need more info about their needs, etc. In our July discussion with Nebraska we learned they conducted extensive research about N.H. geographically prior to implementing their program. Jan reported that Ohio systematically collects data on all residents who go into nursing homes. In Minnesota, they know the number of residents in nursing homes by county, the number of beds, etc.

**ACTION ITEM:** Phyllis will add questions to Minnesota about data they gathered.

The group discussed the need to form partnerships between nursing homes and their local communities.

In Illinois, the Choices for Care program, which pre-screens hospital patients prior to nursing home admission, collects data. We need to determine what data is collected and where that data is housed. We want to be sure to get ALL nursing home resident data, not just those on Medicaid. IDOA/CCU/Choices for Care also pre-screens DORS eligible patients and that data is of interest.

**ACTION ITEM:** Jan will check with IDOA to determine where the Choices for Care information and DON scores go once they are collected.

### **Discussion with Bob Held**

Minnesota had a LTC Task Force (1999-2000). It was an executive legislative branch task force (4 from house, 4 from senate, two from each party, 3 commissioners: Health, Human Services, Housing/Finance). They were to take a broad view, focusing on rebalancing LTC and supporting consumer preference. It was a consensus-building effort. See web site: [www.dhs.state.mn.us](http://www.dhs.state.mn.us).

*(continued on next page.)*

**Q: How was the bed closure program administered? How were the beds closed? How many closed? How many were laid away?**

BH: **Bed closures:** FY2000 (before enacted) there were 42,843 beds (all Medicaid, which is 97% of all Minnesota beds). A moratorium has been in place since the 80's. Also, a private pay client cannot be charged more than the Medicaid rate except for a private room. The Minnesota Veterans Homes are not in the Minnesota program. There are a few homes that are in Medicare. As of 9/30/07 there are now 35,568 beds. Most of the 7,281 beds (a sixth of the beds) were closed after the closure act was enacted.

- There was a predecessor bed closure plan (a law sought by two large providers; both not-for-profit). Minnesota is 70% not-for-profit or government owned homes. These two large facilities wanted a financial incentive for closing their facilities. The 2001 plan closure law was based on the earlier law (incentive payment slightly different).

The 2001 plan talked not only about closing facilities, but also keeping a facility open and closing some beds (5,140). There was authority for two years and then the bill ran out on June 30, 2003. A year later it was reinstated without a sunset clause. Some beds were closed without an incentive, but the majority closed with incentive payment. The process:

- A facility applies for a planned closure.
- Local support is required: County social services or AAA determine if it is an under-bedded area or not.
- The application process:

I. What they are going to do with the space available?

- Who will incentive payment be assigned to? (It was possible to assign it to an unrelated entity).
- Almost all applications were approved.

II. The incentive payment is a rate adjustment for the remaining open beds.

III. Planned Closure Rate Adjustment (PCRA). ( i.e.,  $PCRA \times \text{beds closing} / \text{rate} / 365 = \$\$ \text{ ???????}$ ). Ex: 100 beds PCRA = \$5.68/day/bed

**Laying away beds or permanently de-licensing a bed:** They get property rate adjustment so cost is allocated over fewer beds thereby providing a financial incentive over and above the PCRA rate. (Property rate would go up by \$12 on average/bed + \$5.68 PCRA)

**July 2004:** The PCRA was negotiated with each nursing home individually. The Department commitment was no added cost to the State. It was a paradox because government should be transparent and not negotiate different rates. Minnesota came up with formulas based on whether a facility closes; there would be cost savings to the state. You can divert people from nursing homes by closing beds. 100 empty beds diverts 50 people within 3-6 months. There are savings because the caseload goes down, and patients are diverted to HCBS. There was a revenue loss from the bed surcharge.

**2005:** N. H. industry moved to cumulative negotiations based on the availability of funds in the pool. This did not add costs to the State. Some proposals have huge savings, while others don't have savings. The negotiations depends on the availability of money in the pool and what a particular closure is worth to the state (obsolete nature of facility, cost/quality, whether provider is contributing to rebalancing LTC --home health, telemedicine, assistive living, etc.).

There was never a broadly articulated goal of the two programs other than to be less over-bedded. It also depended on availability of alternative services. 2% of beds are closing in a given year. The market is gradually

*shifting, utilization goes up, and you are building a market for HCBS. Assisted living might be overbuilt, but it drives nursing home occupancy down. Minnesota has never been able to figure out what the driver is for closing beds. More than likely it is the continual building of HCBS, assisted living, etc.*

*See the Minnesota web site for the Status of LTC Minnesota Report. Information is revised every two years. See section on N.H. It identifies the utilization rate of N.H. by age (85+ utilization has been reduced by more than half).*

*In 1984, in Minnesota, 36.4% of 85+ in N.H. Today, 17%*

*They project the number of beds available thru 2025 by looking at 5 & 10-year trends. They also look at the number of beds needed by looking at trends for 65+ and 85+. They then determine the number of beds they will need by laying the trends over each other and see where they cross. Using the worst-case scenario, the number of beds needed would exceed the number available as early as 2009. However, If alternative programs work, one should never need more beds. They track closely on regional basis. They attempted legislation to suspend bed closures but it didn't pass this year and another initiative is not currently planned.*

*No parts of the state of Minnesota are having an access problem. Any facility can take advantage of the de-licensing and closure of facilities if they meet the criteria.*

**Q: Initially it didn't take off very fast? Was the buy-back rate too low? (by Kevin Taylor)**

*BH: Right now average PCRA factor is \$3000.00. Arguably it could have been higher.*

*Essentially, all the savings are used up with the buyback. It's probably too high of a payback rate.*

*Facilities didn't feel much pressure to do anything at first because they had two years. At 6 months from expiration, 1500 beds had been closed. Suddenly a flood hit. Within 3 years from expiration, 4900 closed. Nursing homes had to make a decision between paying a surcharge for empty beds vs. closing the beds and getting payment.*

*In combo with licensure and single-bed incentives, the buy-back is pretty substantial. The single bed incentive (EX 100 beds goes to 50 beds), create new single-bed rooms by de-licensing a bed after effective date of legislation. Rate adjustment would be 20% X ratio of # of new single-beds created / # of beds in service. The payment rate increase of \$13 on average + \$12.00 property rate + \$5.00 PCRA. A provider can take advantage of all three incentives by creating a single bedroom.*

*Since 2004, the number of beds closed is as follows:*

*2004: 1664 closed*

*2005: 1062 closed*

*2006: 912 closed*

*2007: 709 closed*

*2008 first quarter: 273 closed*

*If a facility can keep beds occupied they won't close them. You can't get incentive if you discharge a person in order to close a bed. It must be an unoccupied bed.*

*The negotiating pool comes from money statutorily made available to give PCRA. However, no matter how much money they get, the nursing homes are ultimately unhappy because the savings realized by the state are greater than what they get. The process is making everyone unhappy. There's an arbitrary limit of \$5500 for Planned Closures. Some have gone to full \$5500, but it still makes people unhappy.*

**Q: Were there any displaced workers from the closures?** (by Bonnie Lockhart)

BH: *In FY 2007: Not a huge number. Five facilities were closed (3 in Minneapolis, 1 in a small town, and another merged so workers kept their jobs). Workers tended to move to other facilities. I don't like complete closures, except in the case of obsolete facilities, because they are traumatic for small towns, especially the loss of employment overall. However, other services ARE being built at the same time and providing employment, therefore, employment is shifting to community services. No part of the program addresses this.*

**Q: How do people find out about the program? And are there incentives for culture change?** (by Phyllis Mitzen)

BH: *A bulletin is published at end of every session describing all the changes. Public meetings are held, directed at providers, to inform them of the nature of the changes. Trade associations do a lot of training.*

*Bob does not know of incentives for culture change. The state does provide some incentives for cost/quality. There is a report card with 7 quality measures. Consumer quality of life and satisfaction is based on face-to-face interviews (14,000/yr) to develop this measure. Together this provides a quality score, which adds a quality add-on to their payment rate.*

*You don't want to close high quality facilities, however. Therefore, in the negotiating process, they look at a ratio (high quality related to cost) incentive for partial closure. If low quality is related to cost, the incentive is for total closure.*

*Minnesota is a RUG state (not Illinois): 1.0 rate (middle of the rate set) and creates a ratio in that rate and the quality score. Middle scored ignored. More consideration is given, the further the score is from the median. They spend \$400 million as the state's share of nursing home payments, and the quality score costs \$350,000 to administer. 1/10% of what they spend to find out what they are buying seems reasonable.*

*The report card is on the health department web site (2000 hits/month, >70,000 hits): [www.health.state.mn.us/nhreportcard](http://www.health.state.mn.us/nhreportcard). This report card is a great benchmarking tool for facilities, for people looking for a facility, and for advocacy. Report cards started 1/06.*

**Q: What is the Medicaid rate?** (by Lester Robertson)

BH: *\$145-146/day*

**Q: Annual cost reports? How are rates adjusted?** (by Lester Robertson)

BH: *Yes, they submit annual cost reports. Method of setting rates has broken. They do not rebase rates based on costs annually. Whatever legislation says to do, Minnesota does. 2007 legislature passed a rebase rate that starts 10/1/08. Industry is very unhappy with this.*

**Q: How current are payments made?** (by Lester Robertson)

BH: *Medicaid is billed after the end of the month. A November bill can be submitted by December 1; the payment cycle is every two weeks. (Illinois is 60-90 days). They could be paid as quickly as a week to 10 days in Minnesota.*

**Q: How much has been saved because of planned closures?** (by Lester Robertson)

BH: *This is subject to a lot of debate. Would these closures have happened anyway? (If so, there are NO savings at all.) Or, N.H. could have marketed the open beds and filled them. Or, it has sped up the closure of the beds.*

*What is the value of the rate adjustment? Would N.H. have gotten bigger COLAS from legislature if they didn't get PCRA? On average, this has been a 2-3% COLA rate.*

*Bob likes the program and thinks it does result in closures, saves the state a little money, and rewards facilities for doing what the state has asked them to do.*

**Q: Did the bed moratorium help with the closure process?** (by Lester Robertson)

*BH: Doing planned closures without moratorium wouldn't make sense. You can move beds and make capital improvements, but you can add no new beds (unless legislation allows you to add a bed). This has been in place since 1980's. You must have a moratorium to prevent new beds from opening.*

*Minnesota Certificate of Need law sun-setted when Moratorium was passed.*

**Q: Rural/Urban differences?** (by Phyllis Mitzen)

*BH Closed beds all over the state. One county has none. There's probably a connection between the number beds/population, but no obvious urban/rural connection.*

**Q: How did people change nature of their business?** (by Phyllis Mitzen)

*BH: De-licensure law property rate incentive is only available if facility remains a nursing home. Often results in rooms with fewer beds, meeting rooms, therapy rooms, storage, etc.*

*Creates a more livable environment (vs. crammed rooms).*

**Q: What would you do differently?**

*BH: a) Governor's intent was cost savings. Human Services intent was rebalancing agenda. The incentive was to close beds. We expected the industry to say that wasn't enough, but they didn't. It might have been more effective if closing beds was a bigger factor, but then there would have been fewer savings. He wishes it had been a larger factor and that they should have come in with a larger factor at the front end.*

*b) After enacted, how long do these rate adjustments stay in place? They stay in place forever paying \$2080. Now if they change this, it's as though the promise is being broken. The reason it stays in effect forever is it allows you to allocate fixed costs over fewer bed days. In 2007 they are rebasing the payment rates. As a result, they will pick up the costs for only two years. Legislation created a time frame of 2-3 years so facility would have time to get those costs into their base, and later it would go away. 2016 — 2-3 year life.*

## **Discussion of Minnesota Implications for Illinois**

- Our rate is \$104. Our Illinois capital system is so broken.
- Report Card: Interesting to see what they consider their quality data.
- With our Illinois money situation, we don't have enough staff to do interviews with 14,000 people.
- You don't want to reduce high quality home beds. Do want to close the low quality homes.
- What is Illinois using for quality? There used to be a quality incentive program, but is long gone.
- Reimbursement is being checked.
- There is a national campaign that goes until 9/2008 about quality in N.H. Of 800 nursing homes in Illinois that receive Medicaid dollars, 100+ have signed up for this campaign. There are no incentives to do this, however. There are eight goals, and they choose three of the eight to get the N. H. to start thinking about quality.
- There is no formal measure of quality.
- It is difficult to define 'quality,' let alone measure it objectively.

- Objective standards vs. 14,000 interviews of clients: Interviews are very expensive to conduct. Illinois would need to do around 30,000 interviews!
- For every Illinois resident in a N.H., 16% have bedsores. The national rate is 12%.
- The property rate seemed like a good incentive for Minnesota. We have a fairly low bed tax (property rate) in Illinois.
- The bed closure plan required a facility remain open as a N.H. A facility closure allows you to close the whole facility.
- There is an incentive for making rooms with more than one bed into single-bed rooms.
- Are N.H. losing money at 73% occupancy? Some do, some don't.
- Employment at N.H. has high turn over anyway. People don't stay long. It is underpaid and thankless. Starbucks employees get paid better, get benefits, and get more training than a N.H. worker!

ACTION ITEM: Who do we know in WI? Phyllis will determine if their program is still in existence and if so, set up a meeting with them. If not, she'll find out why and report back to the group.

## Status of the White Paper

Do we want our group focus to be conversion, or reduction, or both?

*Steve:* Minnesota doesn't convert beds; it shrinks the inventory. But, this creates leftover funds to help with HCBS.

*Response:* Converting a multi-bed room to a single-bed room does convert the way the facility is set up. It doesn't convert to other programs necessarily.

*Phyllis:* What do we want the White Paper to do? A lot of work has gone into the White Paper. Since written, our thinking has evolved. The paper addresses conversion of beds and closing of beds. Reread the paper and get comments back to Myrtle.

ACTION ITEM: Review copy and get edits to Myrtle by December 7<sup>th</sup>. Paper will then be submitted to OASAC full committee in January.

## Review of the 2008 Objectives

Other states to explore:

ACTION ITEM: Phyllis to look at an article she wrote about MI.

Propose a model in 2008. Next meeting can discuss this.

*Steve:* P. 3 of Workgroup Priorities

Conversion should not adversely impact a facility's [Medicaid] capital rate component of the Medicaid rate.

ACTION ITEM: Jan to check this change with Shelly to see if it can be corrected before the report is published.

ACTION ITEM: Jan to inquire as to whom it was that came from the Dept of Economic Development. The committee wants to invite her back, have her review our White Paper, and perhaps add her permanently to the committee membership.

## **Announcements, etc.**

Health and Medicine sponsors study groups when key issues arise. The latest issue is mandatory Medicaid enrollment in CCP, which will be explored on Wednesday, December 5, at UIC. Dave Vinkler will be there from AARP.

## **Future Meetings**

- Nursing Home Conversion Workgroup: Tuesday, January 29, 2008, 10:30 a.m. – 2:00 p.m. Meeting will be held at the Illinois Health Care Association, 1029 S. Fourth Street, Springfield, and by phone call-in.
- Full OASAC Meeting: Wednesday, December 12, 4:00 p.m., Governor's Conference on Aging, Marriott Downtown Chicago