Iowa Nursing Facilities Issue Brief
Facility Consolidation

There has been a long-standing DHS Policy that as many as 8,000-10,000 more licensed beds should be removed from the system in Iowa. Long-term care professionals are alarmed with this position and are very concerned that DHS policy changes will result in additional closures and possibly significant business failures. Clearly, this puts a large number of rural Iowa communities at risk. Other states have addressed similar issues with a variety of methods, including: bed-buy-back, bed banking, state receivership, etc.

Problem – Too Many Low Occupancy Nursing Facilities

The Senior Living Trust Fund (SLTF) was created to expand availability of services to the frail aging citizens of Iowa. A primary objective of this program was the conversion of traditional nursing facilities to provide assisted living services. Agency and State leaders cited the excess capacity of licensed nursing facility beds as one of the weaknesses of the long-term care delivery system in Iowa. The original design of the SLTF designated $80 million for conversion and service expansion. The data suggests that approximately $14 million has been distributed ($10.4 million from Round 1 and $3.5 million from Round 2). The conversion program was designed with good intentions; however, the uncertainty of future Medicaid funding combined with the administrative requirements of the program resulted in low participation. Additionally, the second year of the program was halted specifically due to other funding needs within Medicaid.

Since the creation of the SLTF, there has been steady growth in alternative long-term care services and consequently a consistent decline in the utilization of nursing facility beds. There are also a number of pressures, both internal and external, that are impacting the solvency of nursing facility providers across the State including:

- Increasing Insurance Premiums
- Professional Nursing Shortages
- Direct Care Worker Staff Shortages
- Life Safety Code changes which require substantial capital improvements
- Maintenance and Improvement Cost of and Aged Infra-structure
- Overall Medicaid Funding Cuts

Since the implementation of the Modified Price Based Case-Mix Reimbursement System (payment system) for nursing facilities, there have been a number of nursing facility closures across the state (see Table 1 below). Additionally, the payment system increased the occupancy limitation from 80% to 85%, which penalizes low occupancy providers. This change resulted in approximately 80-100 providers reducing their licensed capacity during 2003 and 2004. Recent data suggests that approximately 1,500 to 2,000 licensed beds have been removed from service since 1999. This includes Conversion Grants that have removed 304 licensed beds (221 beds in Round 1 plus 73 beds in Round 2).

Closures Since Implementation Of Case-Mix System	Licensed Beds
The Abbey - Des Moines	80
Georgian Court – Oskaloosa	38
Clearview Manor - Prairie City	75
Sunrise Guest Home – Fredericksburg	32
Chautauqua Home - Charles City	71
USA Healthcare – Dows	50
USA Healthcare – Earlham	39
USA Healthcare – Woodward	39
St. Francis Continuation Care Center - Burlington	80
Leon Care Center	50
Easton Health Center - Des Moines	51
Total Closures	605

Table 1

The expansion of alternative long-term care services has allowed many more elderly Medicaid beneficiaries to obtain these services outside of nursing facilities. In 1999 there were on average 2,400 beneficiaries accessing benefits. By 2004 this number has **increased by 3,100** to over 5,500 or more than 130%. Over the same period, Medicaid beneficiaries in nursing facilities has **decreased by 1,350** or 10%. Further expansion of Home Health services for Medicaid beneficiaries is another cause for the decline even though the changes have increased the overall Medicaid budget substantially.

Occupancy rates for nursing facilities continue to decline and the decrease in Medicaid beneficiaries appears to be the leading cause. In general, the statewide occupancy has dropped to approximately 84% in 2003 from a peak of 93% in 1991 (see Figure 1 below).

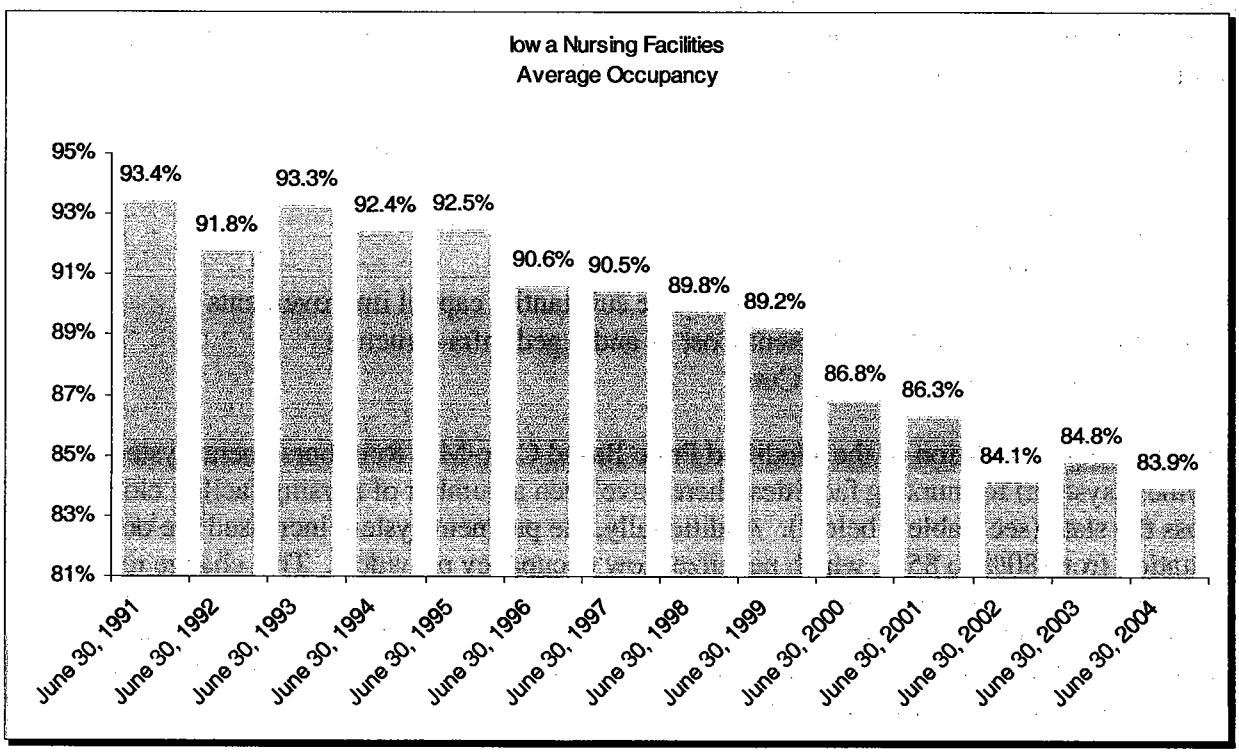

Figure 1

Decreasing occupancy is leading to more facilities and areas across the state with unused capacity. Analysis of the 2003 cost report data indicated 92 facilities with 75% or less annual utilization compared to 80 facilities in 2000. The 2003 data showed 24 facilities with 60% or less occupancy compared with 12 in 2000. Further analysis of the 2003 data demonstrated that 13 Iowa counties with multiple facilities experienced 75% or less utilization. You can see in Table 2 below that the lowest county occupancy level was 68%.

County	2003 Average Occupancy
Sac County	68.4%
Decatur County	70.9%
Chickasaw County	71.8%
Wayne County	71.8%
Howard County	72.1%
Louisa County	72.7%
Madison County	73.3%
Woodbury County	73.8%
Page County	74.0%
Jefferson County	74.2%
Buena Vista County	74.4%
Cerro Gordo County	75.2%
Taylor County	75.6%

Table 2

The problem is that large numbers of low utilization facilities is inefficient and places greater burden on the Medicaid reimbursement system. Further, low utilization facilities are at a greater risk for continued financial losses and ultimately business failure.

SOLUTION – Promote Consolidation In Areas With Excess Capacity

The Senior Living Trust Fund was created to promote balance in the long-term care delivery system. $65 million of potential conversions have not occurred as planned. The combination and consolidation closure of facilities in targeted areas can further balance the delivery system. At the same time it will reduce overall expenses by removing duplicate costs and multiple capital components and increasing the utilization of remaining facilities will improve efficiency. The proposal is to direct $15 million of Conversion Grant resources to target specific nursing facilities for closure and consolidation with remaining facilities in the targeted area.

The goal should be to close 10-15 facilities and 600 to 900 licensed beds across the state. The development of this program would be specifically designed so there is very little impact on access and quality with the overall goal of reducing total Medicaid costs. Fixed costs of low utilization providers are about 50% of total costs and by removing these from the Medicaid reimbursement formulas the program will actually save money – both short and long term. Existing providers may require waivers or renovation to meet the higher levels of occupancy. This program should also provide some funding so that the access and quality objectives can be

achieved. In some cases it may even require limited expansion of the licensed capacity so there are no future access concerns.

The solution should be to target specific facilities for consolidation or closure. Using $15 million to this effort can result in the closure of hundreds of licensed beds in areas where excess capacity can absorb nursing facility residents in the targeted facilities. The long-term savings to the program will quickly outpace the cost to the State by reducing fixed overhead costs.

This proposal is not set forth to alarm providers or communities and for this reason no specific names of facilities or cities have been identified. Below are 2 case studies to demonstrate the potential savings to the State and the impact on communities. If this plan is conceptually or theoretically acceptable, market forces should be anticipated to drive the process. No specific facility should be identified or designated for closure. However, pairs or groups of facilities should be encouraged to join their efforts to benefit their area and the State. Additionally, market forces, or even a bidding process, should determine the values in this type of program. The examples below are only to help demonstrate how providers may approach the settlement process or the resources necessary to end the business. There is a wide range of possibilities to implement a program such as this. Furthermore, varying types of operating and ownership structures offer unique methods to accomplish the overall goals towards reducing the number of facilities.

Case Study #1

Proposal – Close 1 Facility in county with multiple facilities including one city with multiple facilities. There are 5 facilities in 4 cities. The city with 2 facilities also has a hospital and is a county seat. Average Occupancy for the county is less than 70% with approximately 40% Medicaid utilization. All 5 of the facilities have average occupancy below 80% with 3 below 70%. Table 3 below provides a comparison:

Description	Beds	Occupancy	Occupied Beds	Empty Beds	Medicaid %	CMI
Facility 1	66	61%	40	26	36%	0.8952
Facility 2	77	69%	53	24	36%	0.9395
Facility 3	64	71%	46	18	40%	0.9681
Facility 4	21	80%	17	4	42%	0.85
Facility 5	60	61%	37	23	48%	0.8441
Total	288	68%	192	96	41%	0.8994

Table 3

This case assumes that Facility 5 will be closed. There is adequate availability in the remaining facilities and for all practical purposes Facility 4 won't be designated to receive additional residents. Facilities 1,2 and 3 have 68 available beds and transferring 37 residents is practicable. 2003 cost report data shows that the Private Pay rates for Facilities 1, 2 and 3 are within $120 per month of Facility 5.

Facility 5 currently records about $1,550,000 in long-term debt and the book value of the assets is $650,000. Determining a reasonable value is difficult, however, the projected savings to the Medicaid from the closing of Facility 5 can be calculated as follows:

Annual Administrative Costs	$ 200,000
Annual Environmental Costs	$ 155,000
Annual Property Costs	$ 150,000
Total Annual Overhead Costs	$ 505,000
Medicaid %	48%
Annual Cost Savings To Medicaid Program	$ 242,400

Table 4

Additionally, increasing occupancy in Facilities 1, 2 and 3 will dilute the average costs (primarily in these overhead items). For purposes of this example assume a conservative reduction of $3.00 per day in overhead for the remaining Medicaid residents in Facilities 1, 2 and 3.

	Medicaid Residents
Facility 1	14
Facility 2	19
Facility 3	18
Total Medicaid Residents	52
Average Reduction	$3.00
Annual Savings	$57,072

Table 5

Combining the Totals from Tables 4 and 5 is about $300,000 per year in savings to the Medicaid program, which will continue indefinitely. Assuming the negotiated payment to the target facility was $1.5 million, the state would have a payback period of 5 years or a return rate of nearly 20%.

Case Study #2

Proposal – Close 1 facility in city with 2 facilities. In addition to the 2 facilities shown in Table 6 below, this city also has a critical access hospital and the community has additional assisted living centers that do accept Elderly Waiver beneficiaries. Each of the facilities has similar operating characteristics and the average occupancy for the community is approximately 60%.

Description	Beds	Occupancy	Occupied Beds	Empty Beds	Medicaid %	CMI
Facility 1	112	60%	67	45	63%	0.8582
Facility 2	63	60%	38	25	63%	0.8987
Total	175	60%	105	70	63%	0.8785

Table 6

This case assumes Facility 2 will be closed. There is adequate availability in the remaining facility. Additionally, the critical access hospital in the community can provide support for certain heavy care residents. A large percentage of the residents to be transferred are Medicaid beneficiaries and the Private Pay rates for both facilities are the same.

Facility 2 has approximately $400,000 in long-term debt and the book value of the assets is approximately $400,000. Facility 2 has recorded operating losses in each of the most recent 3

years. The projected savings to the Medicaid program with the closure of facility 2 is calculated as follows:

Facility 2	
Annual Administrative Costs	$ 155,000
Annual Environmental Costs	$ 360,000
Annual Property Costs	$ 100,000
Total Annual Overhead Costs	$ 615,000
Medicaid %	63%
Annual Cost Savings To Medicaid Program	$ 387,450

Table 7

Increasing occupancy for Facility 1 will dilute the average costs for the overhead items shown in Table 7. Assuming an average reduction of $3.00 per Medicaid patient day from this dilution will result in the following savings:

	Medicaid Residents
Total Medicaid Residents	66
Average Reduction	$3.00
Annual Savings	$72,434

Table 8

Combining the Totals from Tables 7 and 8 will result in approximately $450,000 per year in savings to the Medicaid program, which will continue indefinitely. Assuming the negotiated payment to the target facility was $900,000, the state would have a payback period of 2 years or a rate of return of nearly 50%.

Summary

There are specific areas in the State where there is excess capacity of licensed nursing facility beds. The NF to Assisted Living Conversion program did not achieve the intended results. An alternative solution would be to target facilities for consolidation and closure. Using resources from the Senior Living Trust Fund, paying organizations to close facilities will ultimately save the Medicaid program millions of dollars. The state should begin developing criteria and incentives to promote voluntary closures in specific areas. However, the program should carefully consider access to services and continuity of quality care in these targeted areas. In connection with any closure, covenants to offer needed services may become part of the negotiated package from the remaining facilities in the area such as:

- Medicare Certification
- Respite Programs
- Hospice Programs
- CCDI Units

Using the Case Studies above as example shows the potential savings. There are several other similar situations where small increase in the capacity of one provider can assist in the closure of another low occupancy facility. Subsequent to a closure, remaining facilities may need to upgrade or renovate to maintain high quality service delivery. Some of the SLTF resources could be made available in the form of grants or loans to encourage providers to work within the framework of this program.