Nursing Home Care And Its Financial Health

JOHN MORRISSEY

Say a prayer for the venerable Catholic nursing home, often many decades old, challenged to stay up to date, and at the mercy of a financial model that doesn't cover the cost of doing business. Its biggest source of revenue, the Medicaid program, pays as little as 73% of the cost of care, a recent analysis shows.[1] Its best bet for profitable business — post-hospital therapy and rehabilitation paid by Medicare — increasingly skips past the nursing home stop and directly to home health care. The patients that nursing homes do receive often have more complex needs than in previous times, eating into Medicare margins. Specialized managers and direct-care workers alike are hard to find and afford.

There are ways out of this daunting predicament, often involving expanding into related senior living arrangements that subsidize the skilled nursing and long-term care operations. "It's well documented that Medicaid rates do not cover the cost of care," said Katie Smith Sloan, president and CEO of LeadingAge, an association representing aging-focused organizations. "It's absolutely necessary that the [financial] models diversify revenue sources, whether it's by adding assisted living, which largely is private-pay, or it's adding more short-term rehab."

Large senior-care systems can help formerly freestanding nursing homes build that diverse residential care community, supply expertise that single-site facilities can't afford, update aging structures, and help find and train the workforces.

Those needs are often beyond the capabilities of nursing homes going it alone, "so it really puts a freestanding nursing facility operator in a very difficult circumstance — and at some point, they're going to either have to partner with a larger organization that has the capital to keep their facilities competitive, or outright sell or close," said Timothy Dressman, vice president of business development for CHI Living Communities. The senior care division of CommonSpirit Health, CHI Living includes 12 nursing homes, 11 of them part of a continuing care retirement community.

Nursing home care runs deep in the missions of Catholic orders and other nonprofits serving the elderly. The LeadingAge annual ranking of the top 200 senior-care organizations lists nearly 50 that were founded more than 100 years ago.[2] "Where nonprofits really stand out is the deep and abiding focus on mission, on service, to the exclusion of profit," said Sloan. "Faith-based, mis-

"It's absolutely necessary that the [financial] models diversify revenue sources, whether it's by adding assisted living, which largely is private-pay, or it's adding more short-term rehab."

— KATIE SMITH SLOAN

sion-driven organizations were caring for older adults long before government payments were available, and they've been the mainstay of aging services for many years."

But the Medicare Act of 1965 changed the rules and sparked competition, said Dan Hermann, president and CEO of Ziegler, an investment banking firm for the senior living industry, which co-sponsors the LeadingAge senior-care analysis. Medicare and Medicaid greatly increased the market volume, he said: "It blasted out the new construction of freestanding nursing homes."

The explosion of funding ushered in a new level of financial sophistication necessary to bill for government reimbursement and to follow the dictates of Medicare and Medicaid certification and the requisite regulations issued by the Centers for Medicare and Medicaid Services. Aging facilities housing two or three residents per room faced off against new buildings offering single-occupancy suites. Catholic nursing homes devoted to serving the poor found them uniformly covered by Medicaid, a money-loser that worsened as its percentage of census got higher.

Medicaid represents between 63% and 68% of a nursing home's payer mix, according to multiple studies. Another 13% on average comes from Medicare skilled nursing care, but that small pie slice of the overall mix potentially can offset much of Medicaid's shortfall. Recent findings from the National Investment Center for Seniors Housing & Care illustrate the contrast: nursing facilities in 2019 were paid an average of $216 per day by Medicaid and about $544 per day by Medicare.[3] At those rates, Medicaid at 68% of daily census would actually represent 55% of daily revenue, while Medicare at 13% of census would constitute 26% of revenue.

Medicare as the gap-filler in the nursing home budget is "fragile," Sloan cautioned. The impact is very market-specific, in terms of the types of cases referred to each facility and the margins generated, "but I still think it is part of the equation of the business model for the nursing home."

A more financially sound solution with a reliable future is to create housing options within a senior campus to attract seniors healthy enough to want congregate living, either in independent apartment buildings or assisted living adjuncts, with the comfort of knowing that they can move on to nursing care if and when the time comes for that more intensive level of residential care.

"The communities that are withstanding the best right now ... are those that have the larger continuum of care," said Lisa McCracken, director of senior living research and development for Ziegler. "Independent living, you're just paying to live there. Generally, the staffing levels are not the same, they don't need the same level of care giving."

The capacity to create a more diverse senior living community has been a significant factor affecting the likelihood of survival during a period of consolidation among health care systems in general, and senior care in particular, said Hermann. Whether nursing homes came together in health system mergers or were freestanding, "the general theme on who's doing well is that they committed to grow and rotate into independent living, and had attractive land in a nice suburban setting to work with."

Medicaid represents between 63% and 68% of a nursing home's payer mix, according to multiple studies. Another 13% on average comes from Medicare skilled nursing care, but that small pie slice of the overall mix potentially can offset much of Medicaid's shortfall.

Landlocked nursing homes, on the other hand, were not positioned for survival, especially in poorer urban or isolated rural areas. These are facilities lacking in restorative capital, exposed to a high-Medicaid population, highly likely not to be savvy about Medicare-reimbursed rehabilitation or convalescence. "Therefore, in this environment, they are having losses that are starting to become unsustainable," Hermann concluded.

Dressman of CHI Living was even less optimistic: "Any freestanding nursing facilities, regardless of where they are located, are struggling financially." If they are eking out a positive margin and can't divert money into improvements or maintenance, "buildings are starting to be really

out of date, their equipment is starting to get old," he said. It can be the start of a slide that ultimately can lead to a decision to sell or close.

That often was the case for the 90 closings or divestitures of Catholic-sponsored facilities across the past 10 years that the LeadingAge analysis recorded. Sixty percent of those were sold to a for-profit operator, and only about 1 in 4 caught on with another nonprofit sponsor. The rest were shut down.

Though joining with another nonprofit is usually the preferred goal, often it's easier to find a for-profit buyer, Dressman said. "Even with our organization, we will certainly have conversations with nonprofit freestanding providers, but to take over one of those and think you're going to make it viable financially is a tall task," he related. One of the key factors is whether they are "sitting on a plot of land where there's an option to grow out assisted living or independent [living]."

To grasp the significance of the senior living movement, consider the housing-forward approach of the Benedictine system, operating more than 40 senior care and living communities in five Midwest states. Of a total 4,000 "doors" in the system, a way of listing living units of all types, the current ratio is 47% housing to 53% nursing, said Jerry Carley, president and CEO. "Our strategy over the next two years is to get to 60 percent independent living and assisted living, and 40 percent skilled nursing. It gets us to a nice cash-flow, financially sustainable position."

One way to get there is by building new facilities. In December 2019, Benedictine opened a 98-unit campus in Northfield, Minnesota, with independent/assisted living and memory care, but no skilled nursing home on the premises. A similar project opened in December 2020 in Shakopee, Minnesota, paired with an existing 109-bed nursing home about two miles away. The new 198-unit campus will help supplement the finances of the nursing home even though not physically on the same property, Carley explained. Residents who eventually need skilled nursing can be transferred down the road.

Benedictine doesn't consider acquiring standalone nursing homes without the option of associated congregate care, he emphasized. "We kind of know what the future is going to hold for them [stand-alone facilities], and it's difficult to make them financially sustainable long term."

Catholic and other nonprofit nursing homes that hope to survive as freestanding businesses have to carefully reconsider how to transform their mission-driven service to people who are elderly and otherwise vulnerable, as well as how they set up and diversify the use of their buildings and campuses to their full potential.

The nursing home was instituted and long managed as a charitable undertaking on behalf of financially and physically vulnerable people, which in this day and age means those depending on Medicaid.

The nursing home was instituted and long managed as a charitable undertaking on behalf of financially and physically vulnerable people, which in this day and age means those depending on Medicaid. The addition of facilities that attract seniors paying their own way runs counter to that charitable undertaking. If the mission is to take in and care for the vulnerable, paying customers are, by definition, not the target demographic.

"You've made a decision to be compassionate, but the model doesn't afford you to offer that unless you are part of a larger-scale entity or if in a good neighborhood you're offsetting it with independent living, assisted living and memory care," Hermann asserted. "If you've chosen to serve Medicaid ... you make a decision: Can I [also] be private-pay? Well, those aren't the poor people, private-pay is going to be wealthy. But to serve [only] Medicaid, by definition you have to be sophisticated in order to survive on reimbursement rates that most providers say is below cost."

Sophistication extends to reimagining every square foot of a building. Competition from for-profit facilities, which now make up 70% of the market for skilled nursing and residential care facilities, should spark efforts to modernize and update to meet demand for attractive surroundings and private rooms that for-profits have turned into consumer expectations, said Susan McDonough, Catholic eldercare and skilled nursing specialist for Ziegler.

The Catholic reputation for compassion, a bedrock of Catholic care, also can offer a market advantage, but it can't often overcome obsolete operations.

The Catholic reputation for compassion, a bedrock of Catholic care, also can offer a market advantage, but it can't often overcome obsolete operations. Studies by the Catholic Health Association and other sources show that "people still think very highly of religiously based organizations," McDonough said. "But if you walked into some Catholic facilities ... it reminds you of the Holiday Inns of the 1970s." And if a resident is going to share a room with two or three others there, when competitors offer a private room with a private bath, "you can see why people make decisions to go elsewhere."

A single-site Catholic skilled nursing facility tends to be bigger than local demand and work force can support. "That 300-bed nursing facility is a lot harder to manage than a 120-bed facility," McDonough explained. "So, one of the things folks have been doing is looking at what their scale should be ... to fit into what the market they now work in needs." Then converting the freed-up space to private rooms makes more sense than adding new rooms onto the building.

Just like senior housing adds profitability, freed-up space can be devoted to specialty services that turn a profit. Some examples are bariatric, behavioral health or memory care, said Sloan. Another use could be the leasing of space to other health-based services, such as dialysis or adult day care.

Services also could extend outside the facility to geriatric-care management, providing care coordination for the surrounding community, or to managing other properties for a fee, Sloan suggested. "It takes the skill sets that you have, which is providing excellent care services and support for older adults, and figuring out how else to apply that to serve a broader and different population that can offset some of the losses you're experiencing from Medicaid."

Day-to-day operation of nursing homes is scarcely possible without the personnel to go with it, and personnel costs are often more than nursing homes can manage on the revenue their Medicaid-heavy population can generate. The consequences include shortages of the basic floor workers to cover residents' needs as well as not enough of the expert managers required to oversee regulatory compliance, risk management, correct reimbursement and other essential aspects of an ever more complex nursing and financial environment.

Expertise is especially vital for skilled nursing. "Medicare is complicated — you have to make sure that you have somebody that really understands the Medicare reimbursement program," Carley noted. That means the capacity "to make sure that people are getting the services that they need, and that you're getting paid to provide those services."

The process of assessing needs and costs of incoming skilled nursing patients, using a coding manual called the Minimum Data Set, is so critically important under Medicare, because "if you're not taking credit for the services that you are providing, you could have a $100-a-day difference," Carley said. Benedictine has a full-time Minimum Data Set expert to consult with and look in on its member facilities, which on any given day combine for 350 to 400 Medicare recipients.

Another costly but necessary call for expertise is in the area of technology, such as for record-keeping and information exchange, which is "not an amenity, not a nice-to-have, you have to have it," McCracken said. "The ability to have the expertise and the financial wherewithal to implement some of those technologies, if you are a small organization" is "definitely a point of vulnerability."

Just like senior housing adds profitability, freed-up space can be devoted to specialty services that turn a profit. Some examples are bariatric, behavioral health or memory care.

The growing need for these specialized and well-paid positions is one argument raised for multiple-site systems. The proliferation of COVID-19 infections has accelerated that need,

from the technology to track and report cases to the pressure to field and execute CMS changes in policy, which Dressman said has been almost a daily occurrence. To that end, CHI Living has an administrator dedicated to communicating changes to each facility along with the training involved. "The freestanding facilities can barely keep up with the changes as they come," he said, citing as examples infection control policies and visitation schedules. However, there are freestanding facilities that fill an important function in the communities they serve, with one example detailed later in this article.

Finding and keeping sufficient numbers of workers for the long-term residential care side of the facility — certified nurse's assistants, nurse aides, medical technicians — is a challenge for all nursing homes but especially for small, freestanding facilities. High turnover and low pay lead to serious staffing shortages.

"It's not considered an attractive career path for many, and we underpay the workers who are providing essential services," said Sloan of LeadingAge. "The reason for the turnover is, these are hard jobs. It's tough work but it's also low-paid work that we as a society do not value." LeadingAge is pushing for higher pay on the argument that it increases productivity and decreases turnover enough to offset pay increases.[4]

But "how dependent on Medicaid you are often sets the tone for how much you pay," McDonough said. "To do difficult work, you are looking at a pool of people who ... can easily find (similar-paying) jobs in a whole bunch of settings that would be frankly a lot easier work."

In rural areas, with mostly Medicaid on top of a limited job pool, nursing homes have problems with both low reimbursement and short staffing, said Dan Revie, a specialist in senior housing and care practice for Ziegler. "We've had providers that have limited admissions to their facilities in rural areas because they can't find enough workers to care for the residents."

Demographic shifts in rural towns gradually eat away at survivability, Carley added. As communities age, young people who move away aren't replaced, and population dwindles. That creates a census problem as elderly nursing home residents die and there are fewer people left who might move in. It also becomes a staffing issue, because there aren't as many younger people to draw from.

Occasionally a town in danger of losing its nursing home beats the odds through sheer grit. The townspeople of Shelby, South Dakota, population 650, and the surrounding two-county catchment area rallied to raise $500,000 to keep its nursing home open after its long-time operator, the Good Samaritan Society, a Lutheran-sponsored system, informed them it was shutting the facility down at the end of 2018.

"The reason for the turnover is, these are hard jobs. It's tough work but it's also low-paid work that we as a society do not value."

— KATIE SMITH SLOAN

The system cited Medicaid reimbursement shortfalls, numerous agency nurses on the payroll and not enough local help as reasons the location was not sustainable, said Dan Biel, a local businessman who helped spearhead the fund drive and became a board member of the Walworth County Care Center, incorporated and launched on Dec. 1, 2018.

He said the center's first goal was to eliminate agency nursing, which it accomplished as of February 2020. Nurse staffing agencies, which build in a profit margin on top of their compensation of agency nurses, charge more per worker than it costs a facility to hire its own, but they become necessary if that facility cannot fill the required number of positions.

The center successfully built a base of locally trained workers, attained a steady 50-50 ratio of Medicaid to private-pay, and has managed to operate in the black for two years, Biel said. Meanwhile the fundraising has continued — it passed the $1 million mark in February 2020 — and enough "rainy day" funding is on hand to keep the 60-year-old facility operating for about two years if it suffered a financial hit, he said.

Such happy endings are rare, though, and organizations that start thinking about the future from a position of strength end up with more possibilities, McDonough said. "You can't start too early to think about the future of your single site. This is an issue that goes from sponsor to board to senior

management. If you're struggling, or start to think you are struggling, plan now and think about options before it's too late."

Before considering a for-profit buyer, she advised, look to other Catholic organizations or other faith-based options "that might help preserve Catholic identity, or at least preserve some of the important things that Catholic organizations hold dear: social justice issues, care for the poor, taking good care of employees, serving populations that are considered vulnerable."

JOHN MORRISSEY is a freelance writer specializing in health care delivery, policy and performance measurement. He lives in Mount Prospect, Illinois.

NOTES

1. Hansen Hunter & Company for the American Healthcare Association, "A Report on Shortfalls in Medicaid Funding for Nursing Center Care," http://publish.ahcatech.org/facility_operations/medicaid/Documents/2017%20Shortfall%20Methodology%20Summary.pdf.
2. LeadingAge, "Nursing Homes Closures and Trends 2015-2019," https://leadingage.org/sites/default/files/Nursing%20Home%20Closures%20and%20Trends%202020.pdf.
3. National Investment Center for Seniors Housing & Care (NIC), "Skilled Nursing Data Report, Key Occupancy and Revenue Trends, https://info.nic.org/hubfs/4Q19_SNF%20Report_Final.pdf .
4. LeadingAge website, "Making Care Work Pay," https://www.leadingage.org/making-care-work-pay.

PAUSE. BREATHE. HEAL.

Peace in Anxiety

CHA
Catholic Health Association of the United States

For just this moment, bring your attention to your breath.

INHALE deeply and settle yourself into your body.

EXHALE the stress and tension you feel.

In these days of anxiety, a moment to pause is both a gift and a necessity.

GENTLE YOUR BREATHING, your gaze and your heart as you consider:

Where have I found peace in the past days?

THINK FOR A MOMENT.

In these days of anxiety where have I found peace?

[Pause to consider]

DWELL in the peace you have found and bring it with you into the rest of your day.

Even now, God is with you, as near to you as your breath. Continue giving yourself the gift to pause, breathe and heal, knowing you are not alone.

Peace I leave with you; my peace I give you. I do not give to you as the world gives. Do not let your hearts be troubled and do not be afraid. **JOHN 14:27**

JOURNAL OF THE CATHOLIC HEALTH ASSOCIATION OF THE UNITED STATES www.chausa.org

HEALTH PROGRESS®

Reprinted from *Health Progress*, Winter 2021