RETHINKING RURAL HEALTH CARE – A COMMUNITY EFFORT

Strength

Long-Range

Tenacity
Making Long-Term Care Feasible

June 15, 2009
9:45 a.m. to 10:45 a.m.

Wipfli LLP
Kim Heller, Partner
Dave Brenne, Director

Spooner Health System
Len Meysembourg, NHA
Agenda

Long-Term Care Concerns, Challenges, and Opportunities

Assessing Financial Performance

Revenue and Payor Mix Considerations

Operational Efficiency

SNF vs. Swing Bed for Medicare Services
Often a nursing home is a challenge for a hospital organization because:

- The majority of focus and strategic effort remains on hospital operations.
- Perception of nursing home services as less critical than hospital services.
- Management’s education and experience is typically in hospital administration. That is their “comfort zone.”
- Organization management is too busy to worry about the nursing home.
- Perception that the nursing home is doing as well as can be expected.
- Hospital administration and boards may try to manage the nursing home like they do the hospital.
- This can result in a disconnect between leadership of the nursing home and hospital which can make meaningful dialogue and change difficult.
Many hospitals are finding, however, they are being forced to make some tough changes and decisions regarding the long-term care operation.
From a Provider’s Perspective
Where We Were

Reported nursing home loss of $1,000,000 / year.
  • Approximately $40 - $60 per day per Medicaid resident

We wondered –

Are these losses offset with favorable LTC impact to the hospital?
  • IP Admissions / OP Revenue / ER Revenue

Should we get rid of the nursing home?
  • How would this decision affect our image in our community?
  • Would this have a negative effect on hospital services?
Nursing Home was full with a waiting list.

Hospital swing beds had quite a bit of capacity.

Averaged 2-3 Med A’s in the NH and 2-3 in the hospital.

There were significant challenges related to swing bed/nursing home utilization due to nursing philosophy/politics.
We had just hired a Nurse Case Manager to manage Med A’s in both SNF and Swing Beds but knew we were not capturing some things on MDS.

We contracted with Sundance Therapy to manage our Rehab because:

• Our hospital rehab department struggled to stay ahead of hospital needs.
• Our hospital rehab department did not necessarily understand the unique needs of the long-term care and swing bed residents.
• We never had continuity in Occupational Therapy.

Assisted Living units were unavailable in the area, and we anticipated increased demand for these services due to changing senior desires and impending implementation of state managed care in Wisconsin.
Strategic Challenges and Opportunities

Potential strategies to address strategic challenges:

• Implement long-term care task force at the Board and/or management level.

• Contemplate the level of commitment to long-term care and formalize a long term care strategic plan.

• Educate the board, management, and key hospital staff and stay current regarding long-term care operational and reimbursement issues.

• Consider other continuum of care options or services (i.e. dementia / assisted living).

• Consider evaluating separate corporation to minimize unfavorable CAH Medicare effect.

• Consider closing/selling/privatizing the nursing home. Must consider the financial and political (community) impact of closing the nursing home.

• Benchmark key financial performance indicators for revenue and cost.

• Evaluate utilization of nursing home vs. swing bed for Medicare Part A services.
Assessing Nursing Home Financial Performance

An Example
Assessing Nursing Home Financial Performance

<table>
<thead>
<tr>
<th></th>
<th>Hospital</th>
<th>Nursing Home</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Net patient service revenue</td>
<td>$13,372,000</td>
<td>$ 4,334,200</td>
<td>$17,706,200</td>
</tr>
<tr>
<td>Other revenue</td>
<td>346,600</td>
<td>108,900</td>
<td>455,500</td>
</tr>
<tr>
<td>Total revenue</td>
<td>13,718,600</td>
<td>4,443,100</td>
<td>18,161,700</td>
</tr>
<tr>
<td>Expenses</td>
<td>12,003,700</td>
<td>5,377,300</td>
<td>17,381,000</td>
</tr>
<tr>
<td>Net income</td>
<td>$ 1,714,900</td>
<td>$(934,200)</td>
<td>$ 780,700</td>
</tr>
</tbody>
</table>

Do you report the income (loss) from the nursing home operation separate from the income (loss) from the hospital and other operating units? If so:

- Does it look anything like this?
- What does this tell you?
- What doesn’t this tell you?
- What do you think you should do about the nursing home losses?
In a combined setting, it is important to understand “contribution” vs. reported income (loss).

For example, if the nursing home were to close or be sold:

- Services provided by the nursing home would be lost.
- At least some of the services provided by the hospital to nursing home residents may be lost.
- Costs associated with direct nursing home care, activities, etc., would be eliminated.
- Cost shifting from nursing home to hospital would occur.
- For Medicare cost reporting, all statistics related to the nursing home would be eliminated, additional costs would be allocated to the hospital, and CAH reimbursement would increase.
The following examples reflect some “what if” scenarios and are presented as examples only. They are based on actual projects completed for various combined facilities.

The financial effect would vary significantly by facility and is dependent on many factors. Each organization’s situation will affect the analysis related to operational decisions, and a customized analysis would be necessary to determine the impact on your organization. What helps one organization may hurt another organization and vice versa.
Example #1 – What would happen if the nursing home were sold and most services provided by the hospital to nursing home residents would be retained?

<table>
<thead>
<tr>
<th></th>
<th>Actual</th>
<th>Close Nursing Home</th>
<th>Effect of Assumptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Income</td>
<td>$ 1,714,900</td>
<td>$ 1,322,880</td>
<td>$ (392,020)</td>
</tr>
<tr>
<td>Nursing Home Income (Loss)</td>
<td>(934,200)</td>
<td>-</td>
<td>934,200</td>
</tr>
<tr>
<td>Combined Income</td>
<td>$ 780,700</td>
<td>$ 1,322,880</td>
<td>$ 542,180</td>
</tr>
</tbody>
</table>

- Hospital CAH reimbursement increases due to additional costs shifted to the hospital.
- Significant expenses previously allocated to the nursing home are not eliminated but rather shifted to the hospital.
- As a result, the financial benefit is significantly less than the “reported” loss of the nursing home.
- Is this enough of a benefit to warrant consideration of this alternative? Only an organization and its leaders can answer that question.
Example #2 – What would happen if the nursing home were sold and most services provided by the hospital to nursing home residents were also lost?

<table>
<thead>
<tr>
<th></th>
<th>Actual</th>
<th>Close Nursing Home</th>
<th>Effect of Assumptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Income</td>
<td>$1,714,900</td>
<td>$509,200</td>
<td>$(1,205,700)</td>
</tr>
<tr>
<td>Nursing Home Loss</td>
<td>$(934,200)</td>
<td>-</td>
<td>934,200</td>
</tr>
<tr>
<td>Combined Income</td>
<td>$780,700</td>
<td>$509,200</td>
<td>$(271,500)</td>
</tr>
</tbody>
</table>

- Hospital CAH reimbursement would decrease in spite of additional allocation of cost due to lost volumes.
- Significant expenses previously allocated to the nursing home are not eliminated but rather shifted to the hospital.
- As a result of the lost nursing home and hospital services, this decision could make the overall financial situation worse!
We are considering partnering with an outside organization for ownership of the nursing home.

In our case, we decided any partner must be:

- Compatible and willing to work together in managing Medicare admissions (SNF vs. Swing Bed) and sharing some services
- Not-for-profit
- Willing to invest in Sr. Housing

(Note that these parameters will vary for each organization)
Revenue and Payor Mix Considerations
Medicaid and Private Pay

• For most states, including Minnesota, Medicaid is the worst payor for nursing home services.
• Unlike many other states, Minnesota nursing homes cannot charge private pay residents any more than Medicaid residents. This poses an even greater financial burden on Minnesota nursing homes.
• Medicaid typically accounts for the highest share of residents. The Medicaid mix is typically higher in a hospital–based nursing home than a standalone nursing home (partially due to swing bed).
• Medicaid costs per day (and in Minnesota private pay costs per day) exceed reimbursement levels. This is true for both hospital-based and free-standing nursing homes.
• Average loss per day for Minnesota nursing homes projected at $23.26 which is approximately double the nationwide average (A)

Medicare is typically the best payor for nursing home services.

(A) Source: A Report on Shortfalls in Medicaid Funding for Nursing Home Care ELJAY, LLC FOR THE AMERICAN HEALTH CARE ASSOCIATION October 2008
Revenue and Payor Mix Considerations/Strategies

Private Pay

- Consistently charge a competitive extra daily fee for a private room
- Pre-bill your private pay residents for services to minimize bad debt and improve cash flow

Managing (and Maximizing) Medicare

- Who determines whether or not a Medicare admission is taken? What information is taken into account to make this decision?
  - Number of empty beds
  - Special needs of the resident
  - Short-term versus long-term resident
  - Swing bed versus nursing home placement
  - Financial resources of the resident
- Evaluate Medicare swing bed and nursing home days being provided by other hospitals and nursing homes in the service area. Determine if there are ways to attract additional Medicare residents.
Clinical Coding

• Medicare and many Medicaid programs reimburse nursing homes based on RUGs (Resource Utilization Groups). The RUGs scores are derived from the MDS (Minimum Data Set).

• When is the last time your staff went to a training regarding completing the MDS and understanding the RAI manual?

• How does your RUGs scores compare to other nursing homes? If your scores are below average, does your staffing reflect the same? If your scores are below average, have you considered hiring a consultant to review the MDS completion process and provide training in areas as needed?
Clinical Coding (Continued)

- Benchmark patterns against comparable facilities to determine if it appears improved coding practices could improve reimbursement. Example:

<table>
<thead>
<tr>
<th></th>
<th>Stand Alone</th>
<th></th>
<th>Hospital Based</th>
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<tbody>
<tr>
<td></td>
<td>Facility 1</td>
<td>Facility 2</td>
<td>Facility 3</td>
<td>Facility 3</td>
</tr>
<tr>
<td>Average Medicare Rate</td>
<td>$ 389.18</td>
<td>$ 419.63</td>
<td>$ 359.05</td>
<td>$ 347.43</td>
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<tr>
<td></td>
<td>389.66</td>
<td>389.66</td>
<td>389.66</td>
<td>389.66</td>
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<tr>
<td>Industry Comparable</td>
<td>389.66</td>
<td>389.66</td>
<td>389.66</td>
<td>389.66</td>
</tr>
<tr>
<td></td>
<td>Facility 4</td>
<td>Facility 5</td>
<td>Facility 3</td>
<td>Facility 3</td>
</tr>
<tr>
<td></td>
<td>(0.48)</td>
<td>(29.97)</td>
<td>(30.61)</td>
<td>(42.23)</td>
</tr>
<tr>
<td></td>
<td>3,041</td>
<td>5,175</td>
<td>3,163</td>
<td>4,132</td>
</tr>
<tr>
<td></td>
<td>(42.23)</td>
<td>(87.67)</td>
<td>(76.97)</td>
<td>650</td>
</tr>
<tr>
<td></td>
<td>(1,460)</td>
<td>155,095</td>
<td>(96,819)</td>
<td>(174,494)</td>
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<tr>
<td></td>
<td>(12.3%)</td>
<td>9.1%</td>
<td>(9.1%)</td>
<td>(2.5%)</td>
</tr>
<tr>
<td></td>
<td>(21.0%)</td>
<td>9.1%</td>
<td>(9.1%)</td>
<td>(2.5%)</td>
</tr>
<tr>
<td></td>
<td>(12.3%)</td>
<td>9.1%</td>
<td>(9.1%)</td>
<td>(2.5%)</td>
</tr>
</tbody>
</table>
In addition to payor mix and other revenue enhancement opportunities, organizational management needs to focus on cost areas where opportunities exist for the nursing home to improve financial performance, such as direct care staffing levels, adjusting the bed count, establishing behavioral units within the SNF, and addressing compensation and benefit levels which exceed benchmark levels.
Operational Efficiency

Staffing Levels and Acuity

• How does your direct care cost structure compare to free-standing nursing homes of comparable size?

• If your cost structure is higher, do you know why?
  • Facility layout
  • Patient acuity
  • Employee hours expectation
  • Overtime, pools, or staffing patterns

• Benchmarking allows for an organization to identify operational areas of variance to the norm. This doesn’t necessarily mean excess resources, but as an organization, you should be able to explain the reason for the variance.
Staffing Levels and Acuity (Continued)

• Many hospital-based nursing homes use a higher percentage of RN staff than LPN staff. Shifting to more LPNs and fewer RNs can have a positive impact on financial performance.

• If your census fluctuates, does your staffing fluctuate?
  • Do you use a call-in or send-home policy?
  • How often is your nurse staffing schedule reviewed?
  • How often is your actual staffing compared to the schedule?
Hourly Wages & Benefits

Is the nursing home wage scale based on the hospital wage scale?

• This typically results in wage rates that are higher than NH industry levels.
• This can make it easier to recruit staff to the nursing home, but it results in average wage rates that are higher than surrounding free-standing nursing homes.
• Consider using shift differentials to staff difficult shifts, but maintain a separate wage scale for the nursing home.
• Remember, CAHs are cost reimbursed so higher wage rates are at least partially reimbursed.
• NHs, however, do not receive additional $$ for higher wage rates.

• How does your benefit package compare to other local free-standing nursing homes?
  • Most hospitals offer the same benefit package to their nursing home staff as their hospital staff because it makes recruiting and retention easier.
## Operational Efficiency - Benchmarking

### Variance from Benchmark - Financial Effect - Selected Departments

<table>
<thead>
<tr>
<th></th>
<th>Nrsng/Activ/Soc Svcs</th>
<th>Dietary</th>
<th>Laundry</th>
<th>Hskp</th>
<th>Plant/Mtce</th>
<th>Subtotal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost per Day - Sample Facility</td>
<td>$ 71.25</td>
<td>$ 17.45</td>
<td>$ 2.55</td>
<td>$ 5.45</td>
<td>$ 8.12</td>
<td></td>
</tr>
<tr>
<td>Minnesota Benchmark (75th%)</td>
<td>67.68</td>
<td>14.53</td>
<td>2.19</td>
<td>3.41</td>
<td>8.66</td>
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<tr>
<td>Variance from Benchmark</td>
<td>3.57</td>
<td>2.92</td>
<td>0.36</td>
<td>2.04</td>
<td>(0.54)</td>
<td></td>
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<tr>
<td>Annual Days</td>
<td>44,308</td>
<td>44,308</td>
<td>44,308</td>
<td>44,308</td>
<td>44,308</td>
<td></td>
</tr>
<tr>
<td>Annual Impact</td>
<td>$ 158,180</td>
<td>$ 129,379</td>
<td>$ 15,951</td>
<td>$ 90,388</td>
<td>$(23,926)</td>
<td>$ 369,972</td>
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### Variance from Benchmark - Financial Effect - Selected Departments

<table>
<thead>
<tr>
<th></th>
<th>Capital (Depr/Int/Lease)</th>
<th>Payroll A&amp;G</th>
<th>Payroll Taxes &amp; Benefits</th>
<th>Other</th>
<th>Subtotal</th>
<th>Total - Select Depts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost per Day - Sample Facility</td>
<td>$ 10.32</td>
<td>$ 17.45</td>
<td>$ 14.48</td>
<td>$ 5.45</td>
<td></td>
<td></td>
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<tr>
<td>Minnesota Benchmark (75th%)</td>
<td>4.41</td>
<td>13.96</td>
<td>16.14</td>
<td>3.41</td>
<td></td>
<td></td>
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<tr>
<td>Variance from Benchmark</td>
<td>5.91</td>
<td>3.49</td>
<td>(1.66)</td>
<td>2.04</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Annual Days</td>
<td>44,308</td>
<td>44,308</td>
<td>44,308</td>
<td>44,308</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Annual Impact</td>
<td>$ 261,860</td>
<td>$ 154,635</td>
<td>$(73,551)</td>
<td>$ 90,388</td>
<td>$ 433,332</td>
<td>$ 803,304</td>
</tr>
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</table>

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## Hours per Resident Day - Direct Care - Financial Effect

<table>
<thead>
<tr>
<th></th>
<th>RN</th>
<th>LPN</th>
<th>Aide &amp; Ward Clerk</th>
<th>Direct Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Actual hours per resident day</td>
<td>0.55</td>
<td>0.56</td>
<td>3.20</td>
<td>4.31</td>
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<tr>
<td>Target</td>
<td>0.36</td>
<td>0.35</td>
<td>2.80</td>
<td>3.51</td>
</tr>
<tr>
<td>Variance from Target</td>
<td>0.19</td>
<td>0.21</td>
<td>0.40</td>
<td>0.80</td>
</tr>
<tr>
<td>Total Resident Days</td>
<td>21,231</td>
<td>21,231</td>
<td>21,231</td>
<td>21,231</td>
</tr>
<tr>
<td>Annual Hours</td>
<td>4,034</td>
<td>4,459</td>
<td>8,492</td>
<td>16,985</td>
</tr>
<tr>
<td>Average Hourly Rate</td>
<td>$28.20</td>
<td>$21.60</td>
<td>$12.80</td>
<td>$16.06</td>
</tr>
<tr>
<td>Annual Impact</td>
<td>$113,759</td>
<td>$96,314</td>
<td>$108,698</td>
<td>$272,779</td>
</tr>
</tbody>
</table>
Improved MDS management

- Utilized outside consultants
- Hired an excellent Nurse Case Manager for nursing home and in hospital swing beds.
- CMI for Medicare from 1.14 > 1.76 even with many Med A days going to swing beds.

Monitoring bi-monthly for changes and information used to adjust “acuity-based staffing”/ (# of staff, ratio of professional, nonprofessional, and restorative staff)
Final Strategy for Consideration – CAH vs. Swing Bed
Long-term care and rehabilitative services provided to Medicare beneficiaries can be provided in either a nursing home or the hospital swing bed unit. Many hospitals with both a swing bed unit and a nursing home do not have a clear policy related to utilization of these areas.

A CAH can receive cost-based reimbursement well in excess of $1,000 per day for Medicare skilled care services provided in the CAH swing bed unit. Nursing home reimbursement for the same services may average $300 per day. Where should the services be provided?

In this analysis, the CAH must consider the full effect on cost reimbursement of transitioning the days. There will be an unfavorable reimbursement effect for other CAH services, but typically this unfavorable effect is not enough to outweigh the benefit of the higher reimbursement levels for these Medicare services.
Considerations:

- Are there beds available in either or both settings? (Is there a waiting list?)

- Will treatment in one setting or the other enable the organization to provide care to more community residents?

- What is the patient’s preference in terms of location?

- What is the patient’s anticipated “discharge-to” setting?

- Where will the patient receive the best care?

- Are there services that, due to expected cost or complexity of care, require the patient to be placed in a specific setting?

- What are the reimbursement implications of the setting of care?

- Are the nurses in the hospital willing to care for nursing home residents?
Example #3 – What would happen if all Medicare Part A services were provided in the CAH swing bed unit rather than the nursing home?

<table>
<thead>
<tr>
<th></th>
<th>Actual</th>
<th>Transfer Days to Swing Bed</th>
<th>Effect of Assumptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Income</td>
<td>$1,714,900</td>
<td>$2,048,200</td>
<td>$333,300</td>
</tr>
<tr>
<td>Nursing Home Loss</td>
<td>(934,200)</td>
<td>(1,058,100)</td>
<td>(123,900)</td>
</tr>
<tr>
<td>Combined Income</td>
<td>$780,700</td>
<td>$990,100</td>
<td>$209,400</td>
</tr>
</tbody>
</table>

- In this scenario, the nursing home has vacancies so nursing home days decrease by 1,300 and hospital days increase by 1,300.
- Hospital revenue and expenses increase due to additional volumes related to swing bed days.
- Nursing home revenue and expenses decrease due to lower volumes. Overall nursing home losses increase.
- Even though nursing home financial performance deteriorates, overall financial performance actually improves just by shifting the place of service for these patients.
• Swing bed utilization has gone from 1-3 per day to 6-8 per day.

• Med A in the nursing home increased from 2-3 residents to 12-18.

• Income resulting from contracted therapy (Med A) is significant ($16k-25k) per month with both units.
Remember the key potential strategies to consider:

- Implement long-term care task force at the board and/or management level.
- Contemplate the level of commitment to long-term care and formalize a long-term care strategic plan.
- Educate the board, management, and key hospital staff and stay current regarding long-term care operational and reimbursement issues.
- Consider other continuum of care options or services (i.e. dementia / assisted living).
- Consider evaluating separate corporation to minimize unfavorable CAH Medicare effect.
- Consider closing/selling/privatizing the nursing home. Must consider the financial and political (community) impact of closing the nursing home.
- Benchmark key financial performance indicators for revenue and cost.
- Evaluate utilization of nursing home vs. swing bed for Medicare Part A services.
Questions?
## Speaker Information

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Company</th>
<th>Address</th>
<th>Phone</th>
<th>Email</th>
</tr>
</thead>
<tbody>
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<td><a href="mailto:dbrenne@wipfli.com">dbrenne@wipfli.com</a></td>
</tr>
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<td>Spooner Health System</td>
<td>819 Ash St., Spooner, WI 54801-1201</td>
<td>715.635.2111</td>
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Thank you!