

Striking at the Root of Change Caused by Economic Chaos:

*The Solution is Thinking with Your Brain, Not with Your Memory
(Easier Said Than Done)*

According to legend, someone once asked Albert Einstein what single question he would pose to God if he ever had the chance. The brilliant physicist thought a moment and said, "I would ask 'How did the universe start?' because everything after that is just math." That made sense; all scientists enjoy learning new facts. But then Einstein reconsidered. He said, "Instead, I would ask 'Why was the universe created?' because then I would know the meaning of my own life."

The lesson in this little parable has nothing to do with Einstein or God or the universe, but confirms the importance of seeing past the details in order to understand the big picture. After all, it was Einstein who said, "Imagination is more important than knowledge," reminding us that it doesn't take a genius to have brilliant ideas, just vision.

Bold, outside-the-box understandings of ideas we think we already comprehend will become crucial in 2011, as familiar reimbursement practices in the health care industry recede into the past, like a memory. In response to the headlines from Albany screaming about budget slashes and state debt woes, monumental changes to Medicaid reimbursements are set to go into effect and nursing facilities will no longer be able to rely on old habits or memories of how things once were. But perhaps a better understanding of past practices *can* guide us in planning for future change.

Walking the Tightrope

Health care facilities are licensed by federal and state governmental agencies and are periodically examined by third-party governmental survey teams to ensure conformity to mandated patient care guidelines. This survey term's focus is on patient care and not the cost of giving that care. Therefore, it is the management team's responsibility not only to comply with patient care requirements, but also to simultaneously keep expenses at a level consistent with the facility's *revenue stream*. If the nursing facility loses this balance, operations could deteriorate rapidly, both financially and clinically.

The Movement of Care Away from Nursing Homes

Census Bureau figures show New York State's projected population of individuals over age 85 at 439,007 as of July 1, 2010. This demographic is expected to increase 11 percent over the next five years, to 487,445. More significantly, this reflects a 41 percent growth in New York's 85-and -over population since the year 2000, when this age bracket numbered just 311,488.

Based on these figures, it appears that the need for nursing home beds is increasing, yet many nursing home beds are being closed. One of the reasons for bed closures is that the New York Department of Health has shown a readiness to close mismanaged, financially distressed nursing homes in recent years. Furthermore, Section 2801-e of the Public Health Law authorizes the Commissioner of Health to establish a voluntary residential health care facility Rightsizing Demonstration Program in order to temporarily decertify or to permanently convert nursing home beds to other levels of care, not to exceed 5,000 residential health care facility beds. Approximately 1,807 residential health care facility beds are currently authorized under this program. The Department has remaining authority to approve an additional 3,193 beds. This demonstration program is designed to promote the development of alternative levels of care, discourage inappropriate nursing home placements, encourage the reduction of beds, generate Medicaid savings (Medicaid spending is reduced by right-sizing beds) and assist nursing homes in maintaining viability during a period of declining occupancies.

Many financially ailing nursing home organizations have developed a functional blindness to their own deficits because they desire to change their results without changing their thinking. They are not suffering financially because they cannot resolve their problems but because they cannot see their problems. Therefore, nursing home managers that are challenged by the States desire to close beds because of financial distress must make a move away from popular thinking.

Numerous changes in technology, business practices, and the economic environment have given rise to new conditions and problems for nursing home managers to navigate. Not the least of their problems is the propensity to cling to obsolete accounting methods of practice.

The Use of Averages in Today's Models

Nursing facility financial statements, cost report presentations and third party rate computations of the past tended to lump together all services and programs and resident classes in one overall equation. One set of numbers was divided by another single set of numbers to reach an average unit cost, and that was that. Total cost divided by total days equaled the average. Years ago, one could use comparisons, year-to-year and month-to-month, to drive facility healthcare decisions because of the consistency in spending patterns from one year to the next; this is no longer true. Over the years, the costs of caring for patients grew steadily, throwing the equation of average costs out of balance.

Today’s nursing home operator can no longer rely exclusively on an average unit of measure for providing various levels of care because the type of care delivered at today’s nursing homes is anything but average; in fact, the average length of a resident stay has declined substantially for many nursing care providers. Because of this, the “cost average” is no longer a functional method of cost analysis because patient care costs fluctuates with each patient’s particular length of stay, as illustrated in Chart #1:

Chart #1: Average Cost Reported on Cost Report and Financial Statement

Total Admissions & Social Services Costs:			\$ 216,000 (A)		
"Total" Patient Days:			36,000 (B)	=	\$ 6.00 (B) Avg. Cost per Day
<u>Patient Utilization</u>		<u>Length of Stay</u>	<u>Cost</u>	<u>Days</u>	<u>Cost per Day</u>
20% Medicare		30 days	\$ 177,000	7,200	\$ 24.58
70%	Medicaid	365 days	32,000	25,200	\$ 1.27
10%	Private	365 days	7,000	3,600	\$ 1.94
100% Average		298 days	\$ 216,000 (A)	36,000(B)	\$ 6.00 (B)

This simple example underscores the inequities created by the application of cost averages, a common practice of yesteryear that *must* become an uncommon practice in the future.

Understanding Third Party Revenue Models with Memories in Mind

- Medicaid/Medicare Cost Reimbursement—prior to 1986

Prior to 1986, New York nursing home managers were concerned solely with spending models because both Medicare (Federal) and Medicaid (State) reimbursed the facilities on a “spend it to get it” basis (within the constraints of ceiling limitations).

The cost based methodologies used prior to 1986 did not provide for a profit provision; however, surplus margins could be attained on a short term basis if the nursing home contained costs below the trend inflationary factor; however, the containment of costs in one period could reduce reimbursement in future base periods in a “spend it to set it cost base system”.

- Medicaid Modified Cost Pricing begins in 1986

A major change to New York State Medicaid reimbursement occurred in 1986. The cost-based methodology was replaced with a modified pricing method in which 1983 base year costs were compared to a statewide price for the direct and indirect component of the operating rate and a subsequent price or cost was selected. A standard direct price was consistently used for all nursing homes in the state regardless of sponsorship, region or bed size; unlike the indirect price. It should be noted the direct price was adjusted by the specific case mix acuity level of the facility using “all” patients, (Medicare, Private and Medicaid residents).

For the first time, a nursing home manager could make a favorable margin on a patient stay if the nursing home were able to keep costs below the base price and control the rate of growth of these costs.

- Medicare Prospective Pricing System (PPS) Begins in 1995

Starting in 1995, nursing facilities in New York that participated in the Medicare Part A Demonstration Project received substantially higher reimbursement rates of pay without a reduction on their Medicaid rate. This was the result of a payment system that was based on a “prospective pricing system” (PPS) driven by a predetermined charge for a resource utilization group (RUG), rather than by a “retrospective **cost** reimbursement.”

Medicare introduced PPS to all nursing facilities in the country in 1999. The prices developed by the federal government were substantially greater than the cost-based rates used in New York. Medicare Part A patients were no longer held to diluted (average) cost reimbursement. PPS Rates for these types of services substantially increased NYS nursing homes’ revenues.

These same PPS Rates were financially devastating for many non-New York nursing homes, which had previously been paid using a reimbursement cost method based on segregating, identifying, and concentrating of costs attributable to a distinct nursing unit cluster of rooms.

Thus, the PPS rates issued in 1999 were substantially higher than the average unit cost methodology used by New York, but significantly lower than that specific unit cost used with the cost-based distinct-part reimbursement methodology.

- Medicaid Modified Cost Pricing was Updated in 2007 using 2002 Costs (2006-2010 Legislation)

Section 2808.2-b of Title 10 of the Public Health Law was revised and the new modifications were approved by the New York State Legislative and Executive branches during the 2006 NYS Budget approval. Rebasing legislation enacted in 2006 authorized an update of the Medicaid rates based on a new cost base year (1983 to 2002).

The modification in the code provided a hold harmless provision to allow a nursing facility to choose the higher of the 1983 or 2002 operating base rate calculations. Yearly specific appropriations relating to the phasing in of this legislation were approved and included in the 2007 & 2008 Medicaid rates.

Effective January 1, 2009, full implementation of the 2006 statute was to be started. However during the NYS 2009/2010 legislative budget approval process, this statute was amended pushing back the effective date to April 1, 2009 while adding a modification of calculating the case mix index *from all patients to Medicaid only*. A second amendment the State included was *capping* the full fiscal impact of the 2002 rebasing at \$210 million which scales back the full impact of the rebasing as originally proposed.

The State has since offset the proposed funding of \$210 million per year by eliminating the 2008 and 2009 inflation (trend and banking adjustments) factors.

Therefore, the 2006 legislation modifications had no virtual impact on funding increases to the nursing home industry as a whole *except* the legislation had a significant impact in the distribution of those same funds between various nursing homes throughout the state as illustrated in Chart 2:

Chart 2 Almost One-Half of Nursing Homes are Negatively Impacted with **\$215** million of the Reduction Concentrated Downstate (Rates Effective April 1, 2009)

NYPHRM REGION	#	WINNER	#	LOSER	#	2YEAR IMPACT
CENTRAL	34	45,377,024	15	(14,450,719)	49	30,926,305
LONG ISLAND	28	36,465,113	49	(100,883,141)	77	(64,418,029)
NEW YORK CITY	58	134,511,675	120	(286,159,424)	178	(151,647,749)
NORTHEASTERN	38	58,879,599	17	(6,241,322)	55	52,638,277
NORTHERN METROPOLITAN	54	69,145,347	40	(34,645,931)	94	34,499,417
ROCHESTER	40	42,990,237	11	(9,783,219)	51	33,207,018
UTICA	38	33,466,906	18	(12,858,013)	56	20,608,893
WESTERN	46	35,710,846	32	(23,859,857)	78	11,850,989
TOTAL	336	\$456,546,747	302	(\$488,881,626)	638	(\$32,334,879)
NYSDOH Slide						

Chart 2, drafted by the New York State Department of Health, has been revised in 2011 with the implementation of the Rebasing Mitigation Relief Plan (RMRP), released in March, 2011. The RMRP finalized rates derived from the accumulation of all the 2006-2010 legislation adjustments are expected to be paid fully (winners) and commencement of fund recoupment (losers) in July of 2011.

The RMRP effectuated a means to limit the impact to those specific homes negatively impacted (losers) by the 2006-2010 legislation adjustments by providing financial relief from the following sources: (1) reprogrammed financially disadvantaged funds (FD); (2) enhanced FMAP funds from the federal government; (3) increased assessment collections (in essence taxing the winners from the legislation and reallocating such funds to the losers); (4) credits from limits on appeals and reconciliations; (5) enhanced Veterans Administration funding and (6) recapture of first quarter 2011 trend factor savings.

In summary, the three fundamental truisms of the 2002 rebasing are (1) no new funding to the industry as a whole; (2) redistribution of budget neutral funds between winners and losers; (3) all nursing homes absorb the loss of inflationary costs after 2008 with the elimination of the trend factor. Therefore, its clear that today's nursing home manager should expect the continuation of budget neutral funding from the State of New York however, how those funds are distributed might significantly change in a statewide pricing methodology.

Statewide Pricing Concerns to High Cost Facilities

Statewide pricing is scheduled to start either October 1, 2011 or January 1, 2012 depending on the continuance of RMRP funding for the last quarter.

The rates generated from the statewide pricing (termed by NY State as “value based purchasing”) may exact a heavy financial toll on certain (high cost) nursing homes because **many nursing homes currently receive price advantaged rates of pay on a modified cost pricing system which may not be available in the new statewide pricing methodology as follows:**

The Medicaid rates promulgated prior to 2007 (based on the 1983 modified pricing/cost methodology) granted higher prices to specific nursing homes designated by either sponsorship affiliation with a hospital (hospital-based nursing home) or those that were larger than 299 beds. Also, all rate sheets received after April 1, 2009 (rates calculated on the 2002 base period) granted public nursing homes and small nursing homes (licensed for 80 beds or less) a safety-net provision for additional reimbursement if their 2002 base costs exceeded the ceiling prices.

Chart #3 prepared by the New York State Health Facilities Association (NYSHFA) illustrates how a selected sample of nursing homes (88% of total nursing homes in the state) are distinguished by sponsorship, region, bed size and whether they are free standing or hospital based.

CHART # 3

Region	Sponsor			Free Standing/ Hospital Based		Facility Size			Total
	Proprietary	Voluntary	Public	Free Standing	Hospital Based	More than 300 Beds	Or 80 Beds (299 to 81 or Less Beds)	Less than 300 Beds	
CENTRAL	12	24	5	34	7	6	11	24	41
LONG ISLAND	54	15	3	69	3	12	5	55	72
NEW YORK CITY	95	60	5	157	3	46	10	104	160
NO. EASTERN	19	27	9	50	5	4	12	39	55
NO. METRO	42	37	6	78	7	7	9	69	85
ROCHESTER	17	24	4	39	6	5	12	28	45
UTICA	14	35	4	42	11	1	15	37	53
WESTERN	20	34	9	52	11	1	10	52	63
TOTAL 574	273	256	45	521	53	82	84	408	574
Priced advantaged					53	82			135
Price advantaged			45				84		129

All rates received after April 1, 2009 contained built-in pricing advantages to the specific highlighted nursing homes. Furthermore, the ceiling price was conspicuously increased, which essentially offers more potential reimbursement to facilities that spend more than others.

It is uncertain whether these incentives will continue in statewide pricing because there is evidence issued from the NYS Health Department (presented in Chart #4) , to suggest that facilities that spent more and received more did less with the dollars they received.

CHART # 4

	PRI Acuity (Level of patient care)	Quality Indicators (5.0 being highest)	Operating Cost per Day	% of higher Cost per day
Proprietary	1.19	3.41	\$183.88	0%
Voluntary	1.17	3.28	\$215.84	17%
Public	1.11	3.28	\$248.79	35%

If today's finance manager chooses not to become more productive with the dollars currently received, than surely the reduced dollars of tomorrow will lead to a crisis of survival that could lead to failure (see Chart 5):

CHART # 5

<u>Nursing Home Closures</u>	
Past two years:	11
Past three years:	20
Past four years:	25

Statewide Pricing holds the Line for Future Government Funding to Nursing Homes

If nursing homes' costs grow faster than the prospective per diem prices, surplus margins will decrease, or losses will increase. Since there is no individual facility rebasing under statewide pricing statute, these diminished margins or higher losses cannot be recovered in the future.

Therefore, today's nursing home manager can expect that statewide nursing home costs will decrease with prospective regional pricing and budget slashes. Since the state intends to recalculate statewide pricing rates every six years and adjust for inflation for those same periods, the statewide prices could be systemically reduced for every successive recalculation.

The Presence of Mind - Statewide Pricing Implementation

The projected 12 **billion** dollar New York State deficit for 2011-2012 is the prime reason for Medicaid funding cut backs. Looking at the numbers, it was not hard to see the trouble brewing that led to this point. New York State is the highest in the nation in Medicaid spending with a 2009 per capita average of \$2,283; (more than the combination of the next three largest spending states, California, Texas and Pennsylvania) and more than double the national per capita average of \$1,026.

Total Medicaid spending in New York State was estimated at \$45.4 billion in 2009, an increase of 1 percent from 2008. And, almost \$11 billion of that spending went to long-term care facilities, with \$6.4 billion going specifically to nursing home facilities.

It is the opinion of many State reimbursement officials, retired and actively employed, that the State of New York will eventually adopt statewide pricing, with good reason. The government can demonstrably contain its costs by reimbursing a "standard price" rather than the "current cost" of providing health care services.

Because the details of the pricing system have not yet been agreed upon, there is a possibility that a statewide pricing system will be delayed past the proposed October 1, 2011 or January 1, 2012 implementation date.

The Transitional Period—Striking Back At the Threat of Statewide Pricing

Any delay in the implementation of statewide pricing will function as a transitional period for all nursing facilities to trim down their spending budgets in anticipation of reduced funding.

The transitional period could be an invaluable opportunity to identify and tackle financial problems head-on, before they become dire, but only for those who can see the big picture.

Henry David Thoreau once wrote, “There are a thousand hacking at the branches of evil to one who is striking at the root.” The visionary of today will strike back at the impending redistribution of funds not by taking a wait-and-see attitude, but by taking action. The proactive thinker must formulate a business plan to balance potential revenue decreases by either identifying spending cuts or, if spending cuts are unattainable, by enhancing revenue streams (admitting higher scoring patients). This must happen now, before statewide pricing is implemented.

All nursing facilities, therefore, must consider segregating costs and revenues by program or services rendered, knowing that this is the only viable solution to analyze operational results, as each facility’s cost structure and revenue stream is unique.

New Idea’s for New Times

Numerous changes in technology, business practices, and the economic environment have given rise to new conditions and problems for nursing home operators to navigate.

Today’s nursing home operator can no longer rely exclusively on an average unit of measure for providing various levels of care because the type of care delivered at today’s nursing homes is anything but average. Residents admitted to modern facilities are different from those in the past. Patient acuity has increased significantly. Nursing homes routinely take in patients discharged from the hospital less than one week from post-operating care. They perform complex wound care and extensive IV therapy, along with a myriad of other technologically advanced services once provided only in acute care settings. Nursing departments have adapted to include sub-acute admissions, shorter-stay residents, and altered staffing patterns. In some cases, registered nurse staffing as well as nursing hours per patient day have increased to accommodate heavier care residents. Yet nursing homes find it difficult to attain high levels of occupancy (98% to 99%) today because of a marked decrease in length of stay combined with the rise in popularity of alternative care programs.

All the disciplines involved assume greater burdens as a result of shorter stays and higher discharge rates. Though they offer the potential for higher reimbursement rates and a greater revenue stream, shortened lengths of stay not only affect the nursing and rehabilitation departments, they also create new burdens for the bookkeeping, dietary, social services, admissions, administration, and housekeeping services.

With the potential for budget cuts looming, all nursing home facilities will be left scrambling for answers, wondering how they will make up any significant difference in reimbursement reductions. Fortunately, there are solutions for those who are willing to escape from thinking with their memory. Moving from abstraction to reality is achieved with a purpose in mind — a concerted desire to change the status quo by erasing programmed habits. By asking new questions and finding new solutions, it is possible to find value in day-to-day operations.

A New Way of Thinking

Assessing Patient Costs at the Time of Admission:

It is imperative to periodically evaluate how admission decisions are made in today's environment. How are patients admitted? Is there a strategy governing this and what is it? Does the strategy have any substantial facts to support it? How does a nursing facility change its strategy when there is a change in occupancy? Is the admissions coordinator aware of the strategy, and is it formalized as written policy? What happens if the acuity levels drop—is the direct, hands-on nursing and rehabilitation staff reduced in real time? When should a nursing facility change its standard criteria for admissions?

Assessing patient costs at the time of admission aids the facility in maximizing staff performance levels and assessing the financial viability of potential patients.

Identifying Revenues/Costs by Unit of Service – Accounting for the Difference

Tracking revenues and costs by unit of service is not a conventional practice for nursing home accountants and managers; indeed, this type of tracking is rare in the nursing home industry today. In retrospect, it is obvious that the concepts of cost finding, cost tracking, and cost accounting are essential new tools in the changing healthcare climate.

The visionary who can maintain or enhance bottom line results while facing today's New York State budget slashes will become stronger (as others become weaker) by continuing to attract targeted admissions.

To begin implementing these practices, a facility needs to predict the utilization of services at the time of admission and then accurately track utilization, by resident, on an ongoing basis. It is equally important to accurately project and verify the cost per unit of service delivered. This data must be gathered and reported in a timely manner so that the facility may then evaluate the findings and test outcome results.

Before cost accounting, many administrators and owners scrambled to admit residents with higher acuities to produce higher gross revenues. Although it has been historically true that higher-acuity patients have generated increases in gross revenues in excess of the incremental costs of serving them, it is potentially dangerous to conclude that this will always be the case.

One must take into account for example, the absorption principle, which raises the possibility that staff utilization did not approach capacity levels in prior years. As admission policies began to target heavier-care patients, many New York nursing homes were able to absorb the underutilized staff, and the resulting revenues fell directly to the bottom line. This has led some nursing home managers to believe that high-acuity patients will always produce increased new "net revenues". But as utilization increases in these higher acuity categories, staff productivity eventually reaches its optimal level, and once that level is surpassed, the crossover will lead to a *decline* in net revenues.

Cost accounting provides nursing facilities the necessary understanding of unit of service margins and can serve as the basis in the development of an admission plan strategy, based on empirical data. Both the financial advisor and the healthcare provider of a skilled nursing facility must realize that financial reimbursement has changed and will continue to change. Today's manager must learn to use financial formulas to create results rather than to simply verify them. This can be accomplished in two steps:

- Predicting costs of a resident prior to admission. In this way, a provider can complement its patient mix, finding the right blend from among Medicare, Medicaid and private-payer sources, thus maximizing staff performance levels.
- Accurately tracking *daily* profit and loss margins. The result will optimize admissions efficiency, streamline operations, and capitalize on profit potential.

Pricing-based reimbursement methodologies demand the prediction of patients' costs prior to their admission. In other words, the patient's reimbursement rate must cover the services that will be provided. Knowing this information is crucial.

A provider can determine the financial feasibility of any resident prior to admission through a straightforward cost accounting system. Cost accounting enables a facility to take its aggregate operational costs and reduce them to a unit cost. This will allow the facility to visualize how expenses are incurred and verify that those expenses are being incurred proportionately or according to plan. Above all, assessing patient costs at time of admission will give a clear, big-picture understanding that would otherwise be lacking.

Indeed, tackling change is a difficult task, and that's why so few follow the road less traveled. Yet for those who are willing, it is an invaluable journey. The poet Robert Frost declared, "Two roads diverged in a wood and I — I took the one less traveled by, and that has made all the difference."

The Road to Recover—Cost Accounting in Real Time

A variety of nursing home cost accounting programs have been designed over the years. The SOPA (Standard Off-Par Approach) method to nursing home cost accounting (designed and developed by Horan, Martello, Morrone, P.C.) was illustrated in the August, 2003 issue of the *CPA Journal*.

The SOPA method of cost accounting is a measuring stick for tracking the difference between the average costs of all the units and a specific unit cost. This is achieved by building relationships between actual costs and a facility's statistical data associated with that cost. The financial costs of operating a nursing facility differ from facility to facility because of many factors (e.g., wage scales, utilities, facility layout, and property costs). The fundamental premise of SOPA is that it takes into account the unique and individual cost structure of the nursing home.

Making admissions decisions under statewide pricing is a risky practice. Estimating the cost of providing care using cost accounting will help make difficult admissions decisions easier. Basing these major decisions on their financial impact is no longer a luxury, but a necessity.

Just as Albert Einstein realized he must ask bigger, deeper questions about the cosmos, so too must we ask fundamentally new questions about our work technique. We can ask these questions intelligently using the tools of cost accounting. These techniques are not difficult, but they are tremendously powerful. They can help us see opportunities in what could otherwise be a grim-looking state of affairs for the nursing home industry. With cost accounting, we can understand exactly what is happening in our facilities and explore new solutions for closing the gap if and when reimbursement changes to a prospective pricing system. With an eye for data and a visionary's understanding of the big picture, we can focus on bottom line results and plan ahead to make more out of less. With statewide pricing looming over the industry in the near future, the timing could not be better.

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