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The Dilemma of Nursing Home Closures:

A Case Study of Rural Maine Nursing Homes

by Mary Helen McSweeney-Feld and Nadine S. Braunstein

Abstract

Nursing home closures in the United States have accelerated in the past five years. Reasons for these closures include inadequate Medicaid reimbursement, increased emphasis on short-term rehabilitative stays for Medicare residents, geographic location of nursing homes, presence of hospital swing bed programs, and changes in Center for Medicare and Medicaid Services regulatory requirements for nursing homes. Increased minimum wage rates and limited on-the-job worker training have also led to staffing shortages, forcing bed reductions in nursing homes. This paper examines the premise that low Medicaid reimbursement is the primary reason for the closures of Maine nursing homes. The article evaluates state cost assumptions that determine Medicaid payments for skilled nursing care, programs for long-term care workforce development, and growth in service alternatives from hospital swing bed programs to home- and community-based services. Policy solutions for the closure dilemma are proposed, including changes in service diversification and better care coordination to build occupancy and financial stability.

INTRODUCTION

In the United States, rural Medicare beneficiaries age 65 and older have greater odds of residing in nursing homes than Medicare beneficiaries in urban areas do (Coburn et al. 2019). However, the nursing home industry has faced recent challenges leading to accelerated nursing home closures in the United States over the past five years. A recent survey from the National Investment Center for Seniors Housing and Care reported that nearly one nursing home bed in five now goes unused and that nursing home occupancy has reached 81.7 percent, the lowest level since 2011, when it was nearly 87 percent (Span 2018). Lower occupancy rates lead to lower rates of service reimbursement, especially for nursing homes with a large number of residents with Medicaid as their source of payment. In some cases, this may lead to a nursing home terminating from the federal Medicare and Medicaid programs, either on a voluntary basis (when a board or owners decide to terminate) or due to an involuntary termination (when the state or the federal government force the closure due to care or safety issues). Research on nursing home terminations has also shown that avoidance of penalties associated with providing substandard care typically proceeds closure of a nursing home (Li et al. 2010)

Closure of a nursing home can have a devastating impact on a local community, creating loss of employment and loss of access to long-term care services close to home. Relocation stress is experienced by residents who have to be moved to other locations that may be a long distance from family members and loved ones. A study on nursing home closures by the Retirement Research Foundation found a lack of appropriate and nearby placements for residents, poor discharge planning for residents, lack of communication with residents and families, poor notice and inadequate time for the closure, staffing stress and departures, and transfer trauma experienced by affected residents (Rudder 2016). This study also recommended early participation by the state long-term care ombudsman program (LTCOP) in the nursing home closure process to assist in development of a relocation plan and to offer dedicated relocation specialists to help with communication and transition and the use of Civil Money Penalty Funds to support residents during the closure process (Rudder 2016).

Nursing home closures may be driven by a variety of factors other than occupancy issues. A variety of reimbursement and financial factors, workforce staffing challenges, and regulatory changes may also provide an explanation for these trends in nursing home closures. In 2018, Maine experienced a surge of eight nursing home closures, which displaced 250 people and resulted

in the loss of 400 jobs (MHCA 2019). A more robust understanding of the policy factors contributing to this surge may help stakeholders better understand the impact of nursing home closures on rural Maine communities and identify opportunities to prevent further closures.

REIMBURSEMENT ISSUES

To understand the impact of reimbursement on nursing homes closures, it is important to know the sources of the payments. Reimbursement for services for long-term care comes from governmental as well as nongovernmental sources. Federal government insurance programs such as Medicare and Medicaid (known as MaineCare in the state of Maine) are primary sources of payment, with commercial insurance as secondary sources for service reimbursement. Hospitals may also have transitional care units (TCUs), which provide short-stay nursing home services paid by Medicare. In more rural geographic areas with large numbers of low-income residents needing long-term care services and supports, the Medicaid program is the primary payer for such services. According to the Kaiser Family Foundation, Maine's payer mix (sources of payment) for nursing home coverage in 2017 was 67 percent from MaineCare, 12 percent from Medicare, and 21 percent from private pay or other sources (Kaiser Family Foundation 2017). The Veterans' Administration also provides reimbursement for veterans' long-term care services through their own facilities or through contracts with nursing homes and other community providers. Lastly, small rural hospitals designated as critical access hospitals may offer swing bed programs, which allow acute care beds to be used as long-term care beds in the event of bed shortages in nursing homes. Table 1 provides a summary of these reimbursement sources.

Frequent explanations for nursing home closures have centered on the failure of states to increase Medicaid payment rates for nursing home beds, especially for smaller homes located in rural areas. Research by Castle et al. (2009) found that high Medicaid occupancy rates in nursing homes were associated with a high likelihood of closure, especially for facilities with low Medicaid reimbursement rates, which is common in many rural areas. Growing acuity rates of nursing home residents combined with low Medicaid reimbursements led to a recent acceleration in nursing home closures in Maine, Nebraska, South Dakota, Texas, Wisconsin, and other states with rural populations.[1]

Calculations of MaineCare nursing home rates in Maine include three categories of rates: direct care (wages and benefits for nurses, nurses' aides, activity staff, plus billable medicines and supplies), routine costs (all other wages, benefits, and operating expenses), and fixed costs. Both the direct care rate and routine costs rate are capped, causing 40 percent to 50 percent of long-term care providers not to be paid the cost of direct care labor, as well as underfunding of nonclinical labor cost (Watson 2019). A recent meeting of Maine's Long-Term Care Workforce Commission highlighted the dilemma of state Medicaid direct care and routine cost rates based on outdated cost and wage information (Kowalski 2019).

TABLE 1: Sources of Reimbursement for Long-Term Care Services

Program	Description	Long-term care provider
Medicare	Federal government health insurance for older adults (65+), people on Social Security Disability for >2 years, people with end-stage renal disease and amyotrophic lateral sclerosis	Nursing homes, hospital transitional care units (TCU), home- and community-based services (HCBS)
Medicaid	Federal/state government health insurance for poor, people with disabilities, low-income older adults; means-tested	Nursing homes, assisted living (some states), HCBS
Commercial Insurance	Health insurance from employers, state insurance marketplaces, or self-paid	Nursing homes, TCUs, HCBS
Veterans' Administration	Health insurance for active military, veterans, and their families	Nursing homes, assisted living, HCBS
Self-pay	Out-of-pocket payments by patients/residents/family members for services	Nursing homes, TCUs, assisted living, HCBS

WORKFORCE SHORTAGES

Workforce shortages in the healthcare sector, combined with new federal staffing requirements for nursing homes, have contributed to the understaffing and subsequent closing of nursing homes, especially in rural areas. Maine has had long-standing challenges meeting the workforce needs of rural nursing homes, leading some healthcare systems to enter into contracts with nurses from the Philippines to address rural staffing needs (Tice 2018). Workforce shortages may also delay training for staff at nursing homes and may have led to issues in quality of care for residents at four Maine nursing homes (Tice 2019). An article in the *Washington Post* highlighted the converging issues of Maine's aging demographics, an insufficient quantity of nursing homes, the need to limit admissions to existing homes due to staffing shortages, low unemployment rates, and medical personnel nearing retirement age (Stein 2019). Recommendations in the 2018 *Making Maine Work* report (MDF 2018) included increasing the size and skills of the workforce as well as controlling healthcare costs, both of which are critical for addressing the shortage of nursing homes in Maine.

Nursing home staffing is a key part of the Center for Medicare and Medicaid Services (CMS) 5-Star Rating System that consumers can use to compare quality of nursing homes that participate in Medicare and Medicaid. The introduction of the facility staffing payroll-based journal system in October 2019 requires nursing home operators to submit quarterly payroll data (vs self-reported data) to assure adequate staffing for nursing home residents. Research by Geng et al. (2019) found that 75 percent of nursing homes nationwide were not in compliance with CMS staffing recommendations based on acuity levels. Congress also introduced S. 2993 (Ensuring Seniors' Access to Quality Care Act) in December 2019 to facilitate background checks for screening potential employees as well as HR 5216 and S. 2943 (Quality Care for Nursing Home Residents Act of 2019) to establish minimum nurse staffing requirements for nursing homes.

Governor Mills established a Long-Term Care Workforce Commission in 2019 to explore the shortage of staffing to meet the needs of Maine's aging population.[2] Testimony from stakeholders helped the commission understand the scope of the issues and make its recommendations. An important issue facing employers in the long-term care sector is the increase in the minimum wage—which was $7.50 an hour from 2009 to 2016—to $12 an hour in 2020. Statewide increased wages and low unemployment leads to greater competition for workers in Maine, placing pressure on nursing homes to attract and retain nursing home staff.

Although Maine's minimum wage increased, Maine's calculations for MaineCare reimbursement for nursing homes were not updated.

Although Maine's minimum wage increased, Maine's calculations for MaineCare reimbursement for nursing homes were not updated. In 2019 the Maine Legislature passed LD 1758, "An Act to Clarify and Amend MaineCare Reimbursement Provisions for Nursing and Residential Care Facilities," providing $1 million in additional nursing home workforce funding, yet Governor Mills held the bill without signing it into law, stating that she had concerns about the state exceeding a federal funding cap. In December 2019, Governor Mills allowed this measure to go into law, with the request that these additional funds go to pay the direct care workforce rather than for administrative costs or executive compensation (Shepherd 2019). In a letter to the Senate President and Speaker of the House, she also recognized that the current payment system for nursing homes is outdated and complicated and directed the Department of Health and Human Services to "examine reforms that would promote simplicity, quality, value, transparency and accountability."[3] These are important first steps toward improving reimbursement to nursing home operators, which in turn could lead to attracting and retaining staff for these facilities and allowing them to stay open.

FINANCIAL MANAGEMENT

Some US nursing homes are closing due to financial mismanagement by the owner-operators of facilities. Nursing homes may be sold to companies with poor track records of care, as was evidenced when Avante, a Florida-based nursing home chain, sold its facilities to Sentosa Care in 2018. Sentosa had a history of poor-quality care, with large numbers of violations (Craver 2018). Skyline Healthcare in Wood-Ridge, New Jersey, a company that acquired and then closed more than 100 nursing homes in 11 states, had owners cited for staffing shortages and unpaid wages (Flynn 2019; Spanko 2019). Skyline was deemed an "unknown firm" by the *Philadelphia Inquirer* at the time that it took over homes in Pennsylvania (Flynn 2018), and additional concerns about the firm's working capital available to pay its bills were observed when they took over homes in South Dakota as well as Kansas (Ryan and Marso 2018). Financial problems can also extend to mortgage financing issues, as was the case with Rosewood Care Centers, a chain of nursing homes in Illinois that recently defaulted on mortgages backed by the Department of Housing and Urban Development (Goldstein 2020).

> Critical access hospitals with swing bed programs are also paid a significantly higher daily payment rate from Medicare for nursing home care....

The presence of rural nursing homes near small, rural critical access hospitals that have beds designated by Medicare as *swing beds* (beds can be used for acute care as well as nursing home services) may also contribute to their closures. Since the implementation of the Medicare nursing home prospective payment system in 1998 and subsequent exemption of critical access hospital swing bed services from this prospective payment system in 2002, financial incentives were created to have critical access hospital nursing beds close in favor of providing nursing care through critical access hospital swing beds (Gale et al. 2012). Although swing bed programs are intended to be used when only when local nursing home beds are not available, they may be convenient for hospitals to transition patients from acute care to nursing home care. Critical access hospitals with swing bed programs are also paid a significantly higher daily payment rate from Medicare for nursing home care, averaging $1,500 a day in Maine (vs the nursing home rate of $450 a day). Swing bed programs are also exempt from Medicare's minimum data set reporting requirements, which may make it difficult to measure the quality of care (Gale et al. 2012). Fifteen of Maine's sixteen critical access hospitals in rural areas have swing bed programs, and at least one recent rural nursing home closure has been attributed to competition from such a program (Mary Jane Richards, pers. comm., October 10, 2019).

REGULATORY FACTORS

A paradox has been created by the growing aging population in the United States coupled with reductions in nursing home beds and nursing home closures. Regulatory requirements intended to control costs have had a significant role in these changes. Under the Affordable Care Act, hospitals face financial penalties for readmissions of Medicare patients within 30 days (postdischarge). Some hospitals have responded by designating these patients as "under observation" rather than admitting them as inpatients (Baugh and Schuur 2013). If these patients are discharged to a nursing home, they will not be covered for rehabilitative services as they did not meet the three-night stay rule for Medicare to pay for nursing home care, which has led to patients returning to their homes and using home care services for continued rehabilitative care (Naylor et al. 2012). In Maine, policymakers have tightened the medical eligibility criteria for accessing nursing facility services (Fralich 2015) and encouraged growth in the use of home- and community-based services by older adults. Growth in Medicare Advantage plans (Medicare Part C plans) has also diverted patients from skilled nursing to home care and shortened the period that Medicare will pay for nursing home rehabilitative services. Consumers

are also actively choosing to stay at home with the use of home care services, assistive technology, and other community supports.

Maine's policy to rebalance funding away from nursing homes and toward home- and community-based services for older adults has also created more options for individuals needing nursing home care. A recent report by Griffin and Gattine (2017) suggests that cost-effective allocation of public financing resources across the continuum of home, residential, and nursing home settings in Maine should be considered. Research on this topic found that nursing homes in more competitive environments were significantly more likely to close (Castle 2005). Subsequent research by Castle et al. (2009) found that nursing homes with higher rates of deficiency citations, hospital-based facilities, chain members, small bed size, and facilities located in markets with high levels of competition were more likely to close. In addition, recent research on the availability of home- and community-based services in areas where nursing homes have closed showed that policies encouraging growth in such services may be outpacing their availability, especially in rural areas (Tyler and Fennell 2017).

In 2018, Maine had a citizen "Homecare for All" ballot initiative that would have established universal home care for seniors and persons with disabilities (Griffin et al. 2018). If approved by Maine voters, it would have provided benefits to an estimated 13,100 seniors who needed assistance with at least one activity of daily living, which is approximately 10,000 more people than currently receive such services. This legislation would have also improved working conditions for home care workers. The concept of helping elders remain at home and supporting family caregivers was widely popular, yet the measure did not passed because of fear of higher taxes (Butler 2019). Revised state legislation to address these important issues in Maine could be introduced in the future.

Despite these complex financial, workforce, and regulatory factors, nursing home closures are not inevitable. This case study of recent closures of rural nursing homes in Maine offers a perspective on how communities may be able to navigate the multiple factors that can lead to closure of long-term care facilities.

CLOSURE OF RURAL MAINE NURSING HOMES: THE PERFECT STORM

It could be said that Maine's nursing homes have been affected by the perfect storm of conditions: small nursing homes that serve large numbers of Medicaid residents, facing staffing challenges and competition from rural hospital swing bed programs, and contending with changing federal regulations that provide incentives for potential residents to return home after a hospital stay. In 2014, the Maine Legislature established the Commission to Study Long-Term Care Facilities to address increasing concerns about the long-term viability of Maine's nursing homes. The commission was charged to review three critical areas: funding, staffing, and access, particularly in rural areas (Erb 2014).

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According to the US Census Bureau, Maine's population is the oldest in the nation, with the median age of 45.1 years as compared with the US median age of 38.1 years (US Census Bureau 2018). Maine is second only to Vermont with 62.7 percent of the population age 65 and older living in rural areas (Symens Smith and Trevelyn 2018). As baby boomers continue to age (they will comprise around 24 percent of Maine's population by 2026), it is estimated that Maine's median age will continue to increase (Maine State Economist 2018). Maine also has some of the neediest nursing home residents in the country, with 56 percent diagnosed with dementia (the second highest rate in the United States) and the fourth highest rate of people needing help with activities of daily living (Farwell 2014). Diagnosis and treatment of neurological, cognitive, mental health, and substance-use disorders in old age is especially difficult in Maine given the rurality of the state and the scarcity of specialists (Singer and Renfrew 2015). Nursing

homes in Maine are generally small, caring for 66 people (compared to the national average of 110) (Erb 2014), and the state's rural nursing homes have even lower occupancy rates. Maine has also relied heavily on nursing homes as a primary source of long-term care services relative to other states (DeRose 2019). MaineCare has underfunded nursing homes for the last several years, reimbursing them based on costs calculated in 2005, with rewards for larger nursing homes with greater economies of scale, which are frequently located in urban areas (Farwell 2014). Challenges for nursing staff in the state are also affected by low reimbursement levels, which are frequently insufficient to provide a living wage for direct care workers and nurses providing care for complex residents.

Ten nursing homes in the state, mostly in rural areas, closed between 2012 and 2018. Transferring residents from closing rural nursing homes to urban ones with available beds may have the same impact on residents as nursing home evacuations: there may be increases in the onset of dementia and deterioration in physical condition due to unfamiliar living quarters, which may precipitate decline and possible death. Despite funding challenges and stringent state-mandated staffing ratios, Maine's nursing homes generally have one of the lowest rates of deficiencies and highest quality of care as determined by federal survey data and the state ombudsman office (Farwell 2014). However, Maine's nursing homes face unprecedented competition from growing consumer interest in home- and community-based services, as well as use of rural hospital swing beds for short-term rehabilitation needs.

POSSIBLE SOLUTIONS AND POLICY RECOMMENDATIONS

Possible solutions for this crisis require innovative strategies and thinking. Service diversification would be one option for rural Maine nursing homes. Nursing homes with high occupancy rates have introduced new services such as amputee, pulmonary and vascular rehabilitation, cardiac recovery and congestive heart failure management, dialysis care, and other services requiring use of specialized technology.[4] Others have considered marketing to younger residents and implementing contracts with local Veterans Administration hospitals with limited post-acute care services. Still others have partnered with home care agencies and/or implemented adult day services to take advantage of long-term services and supports opportunities for residents resistant to moving into a nursing home. A recent legislative initiative by Representative Anne Perry of Washington County, an area with a large concentration of older adults, proposes that MaineCare pays for bed hold when a nursing home resident uses a hospital (Mundry 2019). Changes in the reimbursement case mix calculation to increase reimbursement for the costs of both clinical

POLICY CONSIDERATIONS TO ADDRESS MAINE NURSING HOME CLOSURES

- Revise regulations to introduce new services such as amputee, pulmonary and vascular rehabilitation, cardiac recovery and congestive heart failure management, dialysis care, and other services requiring use of specialized technology
- Offer adult day services to take advantage of long-term services and supports opportunities for residents resistant to moving into a nursing home
- Change regulations to allow MaineCare to pay for bed hold when a nursing home resident uses a hospital
- Adjust the reimbursement case mix calculation for nursing homes, which will lead to higher profit margins and build good will and trust among families and their loved ones in the surrounding area
- Change occupancy standards calculations for nursing homes
- Coordinate critical access hospital swing bed programs with rural nursing homes to ensure the needs of the local population are met
- Limit the opening of new nursing homes through rigorous determination of need (DON) or certificate of need (CON) provisions
- Address nursing staff shortages through local apprenticeship programs and contracts with foreign-born and -trained nursing staff
- Create *learn and earn* programs to attract workers from other industries, with tax incentives for sponsoring organizations

and nonclinical workforce could lead to higher profit margins and build good will and trust among families and their loved ones in the surrounding area.

Changes in the calculation of occupancy standards could also help boost Medicaid reimbursement for rural nursing homes in Maine. South Dakota, for example, uses the greater of the nursing home's actual occupancy rate or 3 percent less than the state average. Another example is in rural South Carolina, where nursing homes that have occupancy rates less than the state average have Medicaid rates calculated based on the greater of the nursing home's actual occupancy rate or the average rate for that county. If a county in South Carolina has only one nursing home, its Medicaid payment rate is based on the greater of the nursing home's actual occupancy or 85 percent (Laes-Kushner 2018). In this way, payment rates become a more accurate reflection of actual occupancy than a reflection of possible, unrealistic occupancy standards for rural nursing homes. Other options for Maine include limiting the opening of new nursing homes through rigorous determination of need (DON) or certificate of need (CON) provisions. Maine is a CON state for long-term healthcare services; however, new nursing homes continue to open or renovate in more populous areas of the state despite the closures of nursing homes in rural areas. The proposed opening of a new 94-bed eldercare center providing skilled nursing, long-term, and memory care services by Southern Maine Health Care, as well as a new veterans' home in Augusta are examples of these developments.

Maine is also faced with staffing shortages in nursing homes, which may affect the ability of rural nursing homes to provide continued quality of care. Staffing problems could be addressed through contracts with foreign-born and -trained nursing staff. For example, St. Mary's Health System in Lewiston, Maine, tried the traditional route of reaching out to high schools and colleges to recruit new nursing staff, but ultimately contracted with PassportUSA, an international healthcare staffing agency that helped them to fill approximately half of their nurse staffing needs with nurses from the Philippines. Since nursing license requirements and training in the Philippines are similar to those in the United States, the transition for staff has been smooth, and some have embraced their new role providing services in long-term care (Tice 2018). Other states such as South Carolina have used apprenticeship programs to recruit recent high school graduates as well as more seasoned workers from other industries into learn-and-earn opportunities for certified nursing assistant training, with sponsoring employers receiving tax credits from the state for their participation (McSweeney-Feld and Rubin 2019).

CONCLUSIONS

In a Senate Finance Committee hearing sponsored by Senators Chuck Grassley and Ron Wyden on March 6, 2019, representatives of long-term care organizations expressed concern with financial and operational problems in nursing homes. The hearing produced recommendations for a Government Accountability Office study (GAO 2018) of the financing of long-term care facilities. Some of the recommendations from this hearing specifically dealt with the use of federal funds, the calculation of administrative costs, and the determination of staffing levels. Participants also called for establishing minimum criteria for ownership or management of nursing homes that participate in the Medicare program (Grassley and Wyden 2019). The Center for Medicare Advocacy reiterated these concerns in a joint statement with other organizations, calling for greater oversight of public payments for care and stronger enforcement of the nursing home standards of care (Edelman and Valanejad 2019). If these recommendations become a reality, they may help Maine's nursing homes, as well as all long-term care providers, to become more transparent in their operation.

The optimal occupancy rate for a nursing home depends on many factors, and as a community healthcare provider, the nursing home should reflect the needs of the community. However, nursing home services are subject to economies of scale due to the high labor component of the service, and these economies are not available to smaller, rural nursing homes with low occupancy rates. Better local cooperation and service planning with rural hospitals offering swing bed programs could be viewed as potential solutions for states like Maine with rural nursing homes.

Maine needs policies that encourage healthcare systems to implement a flexible array of services that are not just hospital or home based (Singer and Renfrew 2015). People with dementia or cognitive issues, frail older adults who live alone or have no support system, and aging people with developmental

disabilities will need low-cost options for a combination of housing with supervision and services. Although institutional and skilled rehabilitative services will remain an important component of the long-term care system, converting some older communities into more modern facilities will be challenging (Fralich 2015). Diversifying their services and exploring new partnerships with the Veterans' Administration as well as other smaller critical access hospital systems could also help make these rural nursing homes more viable entities for providing dementia care, rehabilitation services, and other types of care for patients discharged from hospitals. In the end, there is no simple solution; Maine will have to consider what options work best for its resources and its residents.

NOTES

1. The following newspaper articles focus on several of these closures: "Nursing Home Abruptly Announces Closure, Affecting 70 Patients and 122 Employees," *Bangor Daily News*, August 9, 2018; "West Paris Nursing Home Plans to Close in 60 Days," *Portland Press Herald*, August 9, 2018; "Texas Nursing Homes Struggle with Lack of Funding," *Community Impact Newspaper*, June 23, 2017; "Two Western Wisconsin Nursing Homes Announce Closures," *US News and World Report*, April 3, 2018.
2. More information about the commission is available on this website: https://legislature.maine.gov/long-term care-workforce-commission.
3. The letter from Governor Mills to the Senate President and Speaker of the House is available here: https://legislature.maine.gov/doc/3610.
4. For examples, see the website of Augusta Center for Health and Rehabilitation: https://www.augustacenterrehab.com.

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