

Long-Term Health Care

What Issues Will the Legislature Face in Promoting Adequate Access to Nursing Facility Services Over the Next Decade?

Summary

One of the Legislature's challenges over the next decade is to promote adequate access to nursing facility beds for the state's population. Our review suggests that it is possible that there will be a disparity between the need for nursing facility services and the growth of bed supply over the next decade. Furthermore, the current Medi-Cal reimbursement system may be (1) contributing to low supply growth, (2) causing access problems to nursing facility beds for Medi-Cal clients, and (3) providing incentives that encourage expansion of facilities that are more costly to operate.

There are several options from which the Legislature can choose to address these issues. These options include changes in the Medi-Cal reimbursement system, expansions of community-based services that are alternatives to nursing facility services, and increased availability of long-term care insurance.

Long-term care in nursing facilities will continue to be one of the Legislature's major challenges over the next decade. The primary issue before the Legislature is how it can promote access to long-term care services in nursing facilities for the state's population. Our review indicates that the need for these services will increase in California due to a growing aged population and a growing population with long-term disabling diseases like AIDS. Growth in the supply of nursing facility beds is highly dependent on reimbursement policies of the Medi-Cal system, which provides about three-fifths of the revenues to the nursing facilities industry. Should it decide to do so, the Legislature has a good

are adhering to regulations. The regulations cover such items as staffing, medical records maintenance, and infection control.

Nursing facilities also have to meet minimum earthquake, fire, and life safety standards established under state building standards. To assure compliance with these standards, the Office of Statewide Health Planning and Development (OSHDP) reviews all plans for construction. These reviews take a few weeks to several months, depending on the quality of the plan and the size of the project.

The state also regulates nursing facility personnel. The DHS certifies nurse aides' compliance with state training requirements. Certified nurse aides (CNAs) are the primary caregivers in long-term health care facilities. In addition, the Department of Consumer Affairs licenses nursing facility administrators, nurses, and physicians.

Certification

All health facilities that seek funding under Title XVIII (Medicare) and Title XIX (Medi-Cal) must be certified by the federal government. The DHS conducts the certification reviews to evaluate the facilities' compliance with Medicare and Medi-Cal "conditions of participation" on behalf of the federal government. Under the Omnibus Budget Reconciliation Act (OBRA) of 1987, the DHS may conduct certification reviews only for non-state-operated facilities. The federal government conducts certification reviews for state hospitals and developmental centers.

Medi-Cal Reimbursement

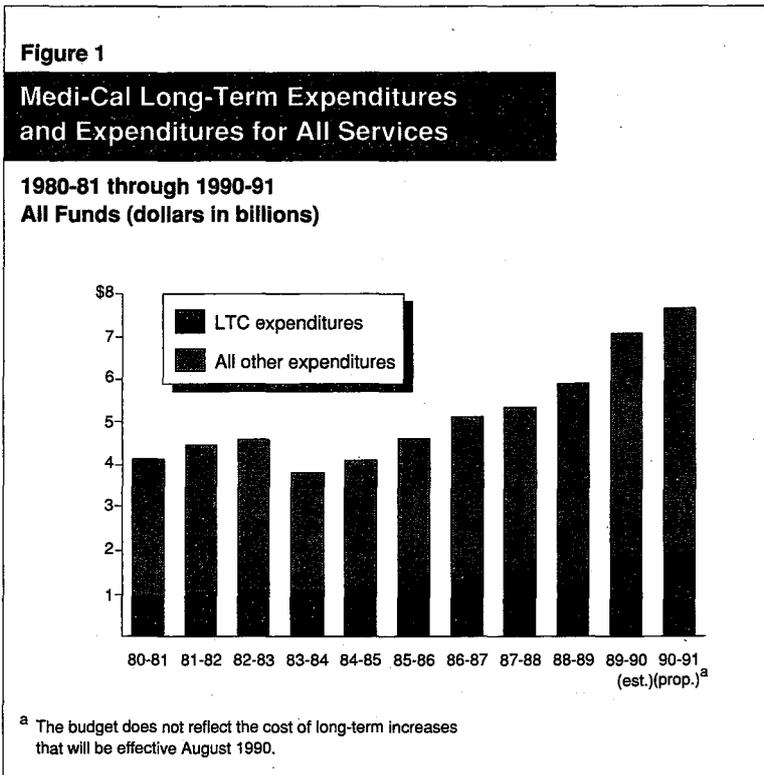
The California Medical Assistance program (Medi-Cal) is a joint federal-state program intended to assure the provision of necessary health care services to public assistance recipients and to other individuals who cannot afford to pay for these services themselves. Medi-Cal reimburses nursing facilities on a per diem basis. This reimbursement covers the services the facilities provide, such as nursing care, food, laundry, etc. Physician services, drugs, and acute care hospital services are reimbursed separately.

Medi-Cal is a major payor of nursing facility services in the state. According to data from a one-day census conducted in December 1988 by the OSHDP, Medi-Cal funded the stay of 62 percent of the residents in nursing facilities in the state. The DHS estimates that Medi-Cal expenditures for nursing facility services will be \$1.9 billion in 1990-91. (This amount does not include the rate increases due to the facilities starting August 1990.) Nursing

facility residents account for a disproportionately large share of the Medi-Cal budget relative to their numbers. They account for 25 percent of the total Medi-Cal budget for health services and 2 percent of the total Medi-Cal caseload.

Long-term care expenditures are not only a large portion of the Medi-Cal budget, they are growing rapidly, as is the budget as a whole.

Figure 1 shows Medi-Cal expenditures for long-term care services over the past decade.



WHO PROVIDES LONG-TERM HEALTH CARE SERVICES IN CALIFORNIA?

Long-term health care services are available in various settings, ranging from institutions to the client's home. Nursing facilities, however, provide a majority of long-term health care. Nursing facilities include *skilled nursing facilities* and *intermediate care facilities*. According to 1988 OSHPD data, about 72

percent of the residents in these facilities are aged 75 and over. Nursing facilities admit 76 percent of their residents from hospitals. From there they go home (23 percent), go to the hospital (40 percent), or die (23 percent). (No discharge data are available on the remaining 14 percent of residents.) Seventy-one percent of those admitted stay at these facilities for six months or less.

In this section, we describe the various categories of formal long-term health care services. First, we describe 24-hour care facilities, the main providers of long-term care. Figure 2 summarizes these services and shows the number of beds licensed under each category. We then describe certain community-based services, which provide alternatives to 24-hour care.

Skilled Nursing Facilities (SNFs)

SNFs provide "continuous skilled nursing and supportive care to patients with primary need of skilled nursing services on an extended basis." Licensing regulations require SNFs to provide an average of at least three nursing hours per patient-day. Typical SNF patients include those who are incontinent, in need of tube feedings or wound dressings, and have other conditions that require 24-hour observation and constant availability of skilled nursing services. There are two general classifications of SNFs: "freestanding" and hospital-based.

Freestanding SNFs. As the name implies, freestanding SNFs are those which are not attached to a hospital from a licensing perspective. According to the OSHPD, 91 percent of the state's skilled nursing beds in 1988 were located in freestanding SNFs. During that year, there were 1,137 freestanding SNFs in the state, representing a total of 104,185 licensed beds. These facilities had a 90 percent occupancy rate.

In order to accommodate the skilled nursing needs of mentally ill individuals, the state developed a category known as *skilled nursing facility / special treatment programs* (SNF/STPs). These are freestanding facilities that provide programs designed to meet special treatment needs of mentally ill individuals. Instead of the minimum requirement of three nursing hours per patient-day, SNF/STPs are only required to provide 2.3 nursing hours per patient-day in addition to the staffing requirements of the special treatment program. SNF/STPs account for an additional 4,295 freestanding SNF beds.

Hospital-Based SNFs. Hospital-based skilled nursing services may be provided through *distinct-part skilled nursing facilities* (DP/SNFs) or *swing beds*. The DP/SNFs are those which are located in an identifiable area of an acute hospital with a set

Figure 2

Nursing Facility Characteristics

Category	Description	Staffing	Number of Facilities ^a	Number of Licensed Beds ^a
SKILLED NURSING FACILITIES (SNFs)				
Freestanding	Continuous 24-hour nursing care	Registered nurse (RN) or licensed vocational nurse (LVN) on duty 24 hours, 7 days per week, average 3 nursing hours per client-day	1,137	104,185
SNF/special treatment programs (SNF/STP)	Continuous 24-hour nursing care for mentally ill clients	RN or LVN on duty 24 hours, 7 days per week, average 2.3 nursing hours per client-day, plus STP staffing	41	4,295
Distinct-part (excluding state institutions)	Same as SNF	Same as SNF	131	7,061
Swing bed	Same as SNF	Same as SNF	14	202
INTERMEDIATE CARE FACILITIES (ICFs)				
Freestanding	Intermittent 24-hour nursing care	RN or LVN on duty 8 hours per day, 7 days per week, average 1.1 nursing hours per client-day	140	3,796
Distinct-part (excluding state institutions)	Same as free-standing ICF	Same as free-standing ICF	3	25
ICF for the developmentally disabled (ICF/DD)	Intermittent 24-hour nursing care for DD clients	RN or LVN on duty 8 hours per day, 7 days per week, average 2.7 nursing hours per client-day	33	2,730
Distinct-part ICF/DD (excluding state institutions)	Same as ICF/DD	Same as ICF/DD	1	49
MORE...				

number of beds licensed for SNF services. Although most hospital-based SNF services are delivered in DP/SNFs, some hospitals that do not have DP/SNFs may provide these services through swing beds. Small and rural hospitals located in areas with a shortage

Figure 2 CONTINUED

Category	Description	Staffing	Number of Facilities ^a	Number of Licensed Beds ^a
INTERMEDIATE CARE FACILITIES (ICFs) CONTINUED				
ICF/DD-habilitative	Intermittent habilitative and nursing care for 4 to 15 DD clients	Qualified mental retardation professionals 1.5 hours per client-week; direct care hours vary from 4 to 8.5 per client-day	329	2,450
ICF/DD-nursing	Intermittent developmental and nursing care for 4 to 15 DD clients	Direct care hours vary from 5 to 7 hours per client-day ^b	— ^b	— ^b
STATE INSTITUTIONS				
Distinct-part SNF	Same as free-standing SNF	Same as free-standing SNF	10	2,911
Distinct-part ICF	Same as free-standing ICF	Same as free-standing ICF	5	3,686
Distinct-part ICF/DD	Same as ICF/DD	Same as ICF/DD	7	5,263
CONGREGATE LIVING HEALTH FACILITY				
Congregate living health facility	Continuous or intermittent nursing care for up to 6 clients; residential setting	RN or LVN 24 hours, 7 days per week, average 8 to 12 nursing hours per client day ^b	5	49

^a As of December 31, 1988.
^b The Department of Health Services has not yet developed permanent regulations.

of skilled nursing beds and a surplus of acute care beds may designate a certain number of their acute beds to "swing" to skilled nursing when the need arises. There were 7,061 DP/SNF beds in the state (excluding state institutions) and 202 swing beds in 1988, according to OSHPD statistics.

Intermediate Care Facilities (ICFs)

ICFs provide "inpatient care to clients who need skilled nursing supervision and supportive care needs but do not require continuous nursing care." Thus, ICF services differ from SNF services in that ICFs provide intermittent, instead of continuous,

nursing care. The state requires ICFs to provide an average of at least 1.1 nursing hours per patient-day. The needs of the residents in ICFs are typically less than those in SNFs.

ICFs may be freestanding or a distinct-part (DP/ICF) of a hospital or a SNF. In 1988 there were 3,796 freestanding and 25 DP/ICF beds (excluding state institutions) in the state, with a 99 percent occupancy rate.

The state also licenses ICFs in one of three other categories.

ICFs for the Developmentally Disabled (ICF/DDs). These facilities provide 24-hour care, habilitation, developmental, and support health services to developmentally disabled residents whose primary need is for developmental services and who have a recurring, but intermittent, need for skilled nursing services. In addition to intermittent nursing care, ICF/DD services include a developmental program. On the average, these facilities provide at least 2.7 nursing hours per client-day. Patients in these facilities typically need specialized developmental and training services. In 1988 there were 2,730 freestanding and 49 DP/ICF/DD beds (excluding state institutions).

ICFs for the Developmentally Disabled-Habilitative (ICF/DD-Hs). These facilities provide habilitation, developmental, and supportive health services to 15 or fewer developmentally disabled persons who have intermittent recurring needs for nursing services but do not require continuous skilled nursing care. These facilities also provide active treatment programs. Minimum direct-care staffing requirements vary from four hours per client-day for facilities with four clients to 8.5 hours per client-day for facilities with 15 clients. The residents in these facilities typically have two or more developmental disabilities. Clients with serious aggressive or self injurious behavior or serious nursing needs are not accepted in ICF/DD-Hs.

ICFs for the Developmentally Disabled-Nursing (ICF/DD-Ns). This is the most recently established ICF category. These facilities provide 24-hour personal care, developmental services, and nursing supervision to 15 or fewer developmentally disabled persons who have intermittent recurring needs for nursing services but do not require continuous skilled nursing care. Minimum direct-care staffing requirements vary from five hours to seven hours per client-day. Typical ICF/DD-N residents include those who have two or more developmental disabilities and a need for nursing services, such as colostomy care or gastrostomy feeding, on an intermittent basis.

State Institutions

State hospitals and developmental centers provide both SNF and ICF services. In 1988, 11 institutions had a total of 2,911 SNF, 3,686 ICF, and 5,263 ICF/DD beds. They had an average occupancy rate of 84 percent. All 11 state institutions are licensed as acute hospitals because they have acute medical/surgical wards.

Congregate Living Health Facilities (CLHFs)

CLHFs provide services to six or fewer residents who need skilled nursing care on a recurring, intermittent, extended, or continuous basis. These facilities are distinct from the SNFs and ICFs in that each CLHF must specialize in serving ventilator dependent, terminally ill, or catastrophically or severely disabled persons. Presumably, the level of care provided by CLHFs is more intense than an SNF but less intense than an acute care hospital. However, Ch 1393/89 (AB 68, Polanco) redefined this category, and the DHS has not yet developed regulations in response to these statutory changes.

Community-Based Long-Term Care

All the above services are provided in around-the-clock facilities. There are other types of long-term care providers, however, serving as alternatives to 24-hour facilities. Most of these alternatives are "community-based," which means that they provide services to clients who live in their homes. These community-based alternatives evolved in recognition that some clients can avoid, or at least delay, nursing facility admission if alternatives are available.

Adult Day Health Centers (ADHCs). ADHCs provide an alternative to institutionalization for older impaired persons or those with functional impairments who are capable of living at home with the help of health care or rehabilitative or social services. ADHC services include planned recreational and social activities and rehabilitation, medical, nursing, nutrition, psychiatric or psychological, social work, and transportation services. According to the DHS, there are currently 63 licensed ADHCs in the state.

Home Health Agencies (HHAs). HHAs also fill the skilled nursing needs of those who wish to remain in the community but cannot go to ADHCs. In addition to skilled nursing services, HHAs may provide physical, speech, or occupational therapy; medical social services; and home health aide services. There are currently 449 licensed HHAs in the state. However, the DHS advises that this number may increase dramatically in the next year because

of the HHA licensing requirement revisions under Ch 856/89 (AB 2266, Connelly). Under Chapter 856, additional HHAs are subject to licensure.

Licensing and Reimbursement Categories

The services discussed above are licensed by the DHS. Virtually all of them are also Medi-Cal reimbursement categories. The only exception is the CLHF, which is currently not considered a Medi-Cal benefit. Other differences include institutions for mental diseases (IMDs) and hospice services, both of which are Medi-Cal reimbursement categories but are not licensing categories. IMDs are SNF/STPs that have been designated as IMDs by the federal Health Care Financing Administration. Federal law prohibits Medi-Cal from reimbursing for IMD services provided to beneficiaries between the ages of 21 and 65. Hospice services are nursing, medical, and counseling services provided to terminally ill clients. Hospice services may be provided by hospitals, nursing facilities, HHAs, or other providers certified to provide hospice services by Medicare.

WHAT FACTORS AFFECT THE DEMAND FOR NURSING FACILITY BEDS?

There are three major factors affecting demand for nursing facility beds. Two of these involve the users of nursing facility services, while the other deals with the availability of other alternatives.

With regard to the users, the need for long-term health care services is measured by a person's dependence on others in performing activities of daily living (ADL) and the frequency of required medical and nursing attention. Activities of daily living include bathing, dressing, using the toilet, getting in or out of a bed or chair, continence, and eating. Two groups of people tend to have high ADL dependencies and require higher frequencies of medical and nursing services: the elderly and people with long-term impairments.

The Elderly

The most obvious and the greatest source of demand is the elderly population. This is primarily because more chronic problems set in as people grow older. Hence, the bigger the elderly population, the higher the demand for long-term care services.

Statistics show that the state's elderly population has been growing rapidly and this growth is projected to continue over the next decade. According to Department of Finance (DOF) estimates, the state's 75-and-older population (which accounts for

almost three-fourths of the nursing facilities population) was 1.3 million in 1988, an increase of 300,000 persons, or 32 percent since 1980. The DOF projects that the 75-and-older population will grow to 1.8 million by 2000, an increase of 520,000 persons (42 percent).

The elderly population has grown and is projected to grow faster than the state's population as a whole. The 75-and-older group constituted 4 percent of the total population in 1980, 4.5 percent in 1988, and the DOF projects that the figure will reach 5.4 percent in 2000.

People With Long-Term Impairments

The other group of people who have high ADL dependencies and require frequent medical and nursing attention are those with long-term impairments. These clients may be younger. They include people in advanced stages of AIDS and Alzheimer's disease, among others. An increasing population of people with these and other chronic diseases, combined with improvements in medical technology to prolong life, will increase the demand for nursing facility services.

Availability of Alternatives

The other factor that affects demand for 24-hour nursing facility services is the availability of community-based alternatives. As we have noted in an earlier analysis of state programs for older Californians (please see *The 1989-90 Budget: Perspectives and Issues*, page 279), the availability of formal community-based alternatives may be a factor in explaining why California has a relatively low institutionalization rate among the state's elderly population. Only 2.8 percent of the state's 65-and-older population resided in nursing facilities in December 1988, compared to 5 percent nationwide. We note, however, that while community-based alternatives delay institutional placement in many cases, they do not totally eliminate the need for institutional long-term care services.

WHAT FACTORS AFFECT THE SUPPLY OF NURSING FACILITY BEDS?

In the nursing facility industry, 84 percent of the facilities are investor-owned. Consequently, as in any private market, the most important factor affecting the supply of nursing facility beds is profitability. The OSHPD reports profitability data on nursing facilities. That information indicates that, based on statewide rate-of-return figures, the industry has experienced very low levels of profitability. Unfortunately, the OSHPD data have serious shortcomings (for example, it is *unaudited* data and

presented in a way that makes it difficult to assess the financial health of the company providing the nursing facility services). Consequently, we are unable to draw conclusions from the OSHPD data about the profitability of the industry.

The key factors affecting profitability are the costs the industry faces in providing nursing care services and the source of revenues (or reimbursements) to facilities.

Industry Costs

The industry incurs two types of costs: entry costs and operating costs. The industry's entry costs are affected by the direct costs of construction and construction delays resulting from extended regulatory reviews, plus uncertainties associated with regulatory processes, including zoning. Entry costs have been reduced somewhat since 1987, when certificate-of-need requirements were eliminated. Previously, health facility construction could not proceed until the OSHPD certified that the facility was needed.

The industry's operating costs are mainly a function of labor costs, its biggest operating cost component. In fact, according to the OSHPD, labor costs for nursing services alone account for 45 percent of operating expenses in nursing facilities.

Industry Revenues

There are two primary sources of nursing facility revenues in the state. The first, and by far the larger of the two, is Medi-Cal. As discussed earlier, Medi-Cal covers about 60 percent of nursing facility residents. The other is private sources, which cover about 30 percent of nursing facility residents. Medicare, the Veteran's Administration, Lifecare, private insurance, and others cover the remainder. The combined influence of the two main payor sources drives the revenue picture of the industry.

Medi-Cal Reimbursement Methodology. Medi-Cal currently reimburses nursing facility costs on a prospective, flat-rate basis. The DHS classifies nursing facilities into certain peer groups based on their category (SNF, DP/SNF, ICF, state hospital), size, and geographic location and annually sets each group's rate at the adjusted median cost of the facilities in that group.

For example, to set the reimbursement rate of peer group A, which has 75 facilities, Medi-Cal would array the adjusted costs of the 75 facilities from lowest to highest. The adjusted costs for each facility are derived from cost report data submitted by the facility, adjusted to reflect disallowed costs (based on audits of a sample of all facilities) and inflationary factors. The adjusted cost of the 38th (median) facility, say \$60.00 per day, would be the

Medi-Cal reimbursement for the 75 facilities in that group, regardless of the amount each facility actually spends.

Under this reimbursement system, profitability of a given facility depends on many factors:

- The relationship of that facility's adjusted costs to the median adjusted costs (by definition, Medi-Cal reimburses about half of the facilities in a given peer group above their adjusted costs and the other half at or below their adjusted costs).
- The relationship of actual cost increases to the inflationary adjustments used in rate development (for example, a facility may not have provided staff salary increases in the amount assumed in the inflation adjustment).
- The mix of patients by type of patient (a facility with a greater proportion of "heavy-care" patients will have a more difficult time making ends meet than a facility with a lighter-care caseload due to staffing requirements).

Figure 3 shows the average Medi-Cal reimbursement rates for various nursing facility categories for the prior and current years. It shows that the reimbursement rate for freestanding

Figure 3

**Medi-Cal Daily Reimbursement Rates by Service Category
Weighted Averages for 1988-89 and 1989-90**

Category	1988-89	1989-90
SKILLED NURSING FACILITIES (SNFs)		
Freestanding SNF	\$51.84	\$60.26
Distinct-part SNF	128.37	147.25
Swing bed	124.60	133.71
Distinct-part SNF (state institution)	156.76	183.75
INTERMEDIATE CARE FACILITIES (ICFs)		
Freestanding or distinct-part ICF	38.62	44.22
ICF or distinct-part ICF for the developmentally disabled (ICF/DD)	59.42	66.16
ICF/DD-habilitative	78.45	91.83
ICF/DD-nursing	—	116.01
Distinct-part ICF/DD (state institution)	164.07	179.51
OTHER		
Congregate living health facility	—	NA ^a

^a These facilities are not eligible for Medi-Cal reimbursement.

SNFs (which account for the vast majority of beds) is \$60 per day. By comparison, the rates for hospital-based SNFs are two and three times as much.

Comparison of Costs and Revenues

According to 1988 OSHPD data, freestanding nursing facilities spent an average of \$57.35 daily (for all patients—Medi-Cal, private-pay, etc.) on nursing services, while Medi-Cal paid an average of only \$48.32 daily. Although these averages imply that facilities which accept Medi-Cal clients operate at a loss, a 1987 study by the Auditor General on the state's Medi-Cal reimbursement system showed that the industry earned a positive margin on about two-thirds of the Medi-Cal patient-days in 1985. The study indicates that Medi-Cal patients tend to be concentrated in facilities that earn a positive margin on Medi-Cal patients. This suggests that these facilities are either more efficient (that is, lower-cost) than the average or provide fewer services than the average.

Private sources also funded a large portion of nursing facility services. On the average, reimbursements from private sources are higher than Medi-Cal reimbursements and average facility costs. While Medi-Cal paid only \$48.32 per day to cover nursing services costs of \$57.35 per day, private sources paid an average of \$71.23 per day. If private-pay and Medi-Cal patients have similar needs and receive similar services, then the higher the ratio of private-pay residents a facility has, the greater the profit margin.

WHAT ISSUES WILL THE LEGISLATURE FACE OVER THE NEXT DECADE?

In this section, we discuss issues that the Legislature will likely face over the next decade.

Nursing Facility Bed Supply

The adequacy of the state's nursing facility bed supply will depend on the interaction of the factors discussed above. It is difficult to project the actual supply and demand dynamics over the next decade because of the lack of reliable data. However, the common perception is that the nursing bed supply has been, and is expected to remain, extremely tight. This appears to have been the case throughout the early 1980s, when statewide occupancy rates reached 94 percent.

Since that time, occupancy rates have declined, dropping to about 90 percent in 1988. OSHPD data suggest that this decline was a result of no growth in total patient-days in combination with

an increase in the number of beds (between 1980 and 1988, about 20,000 beds were added to supply). One factor in this lack of growth in patient-days may have been increased availability of community-based alternatives. Despite the decline in the state-wide occupancy rate, regional shortages may exist.

State agency projections of the number of new nursing facility beds needed by the year 2000 range from almost 34,000 (OSHPD, 1989) to almost 51,000 (Health and Welfare Agency, 1988). Given these demand estimates (especially at the high end), and the actual increase in bed supply between 1980 and 1988 (20,000), it is possible that the state could face a shortage of beds by the year 2000. We note, however, that certificate-of-need requirements that regulated health facility construction in the state until 1987 may have limited the growth of bed supply during most of the 1980-through-1988 period.

Access to Nursing Facility Beds for Medi-Cal Clients

The current Medi-Cal reimbursement system may be a barrier to access to nursing facility beds for Medi-Cal clients. Nursing facilities tend to favor private-pay and Medicare patients over Medi-Cal clients because of their higher reimbursement rates. Hence, Medi-Cal clients have more difficulty in finding a bed than these other two groups.

Access problems may even be more acute for heavy-care Medi-Cal clients. Heavy-care patients generally have nasal gastric tubes or decubiti (bed sores), or are incontinent or ventilator-dependent. Because Medi-Cal's flat-rate reimbursement system does not recognize various levels of care, facilities prefer to accept lighter-care patients as their care is less costly. Heavy-care clients usually remain in hospitals until Medi-Cal staff or the hospital's discharge planning staff arrange nursing facility placements.

There are no readily available data that quantify Medi-Cal clients' access problems. However, two factors suggest that these problems exist.

Relative Decline in Medi-Cal Share of Clients. First, Medi-Cal clients make up a diminishing proportion of the population in nursing facilities. In a 1980 one-day census, 71 percent of nursing facility clients were Medi-Cal clients. By 1988, this number had decreased to 62 percent. On the one hand, this decline could mean that more Medi-Cal clients are using community-based alternatives instead of entering a nursing facility. On the other hand, it could suggest that nursing facilities are filling whatever increase in bed supply there was during this period with privately sponsored patients. We believe that the decline was a result of a combination of the two factors. While more Medi-Cal

clients may be taking advantage of community-based alternatives, the disparity in reimbursement rates between Medi-Cal and private sources in a predominantly for-profit industry suggests that there are significant incentives for nursing facilities to favor privately sponsored clients over Medi-Cal clients. The study by the Auditor General corroborated this hypothesis when it found that hospital discharge planners ranked Medi-Cal clients as considerably harder to place than privately sponsored clients.

High Use of Administrative Days. The second factor that suggests access problems for Medi-Cal clients is the state's high utilization of acute "administrative days." Clients are placed on "administrative status" when they stay in a facility that provides a higher level of care than the client needs. Generally, Medi-Cal places clients on administrative status in acute care hospitals when the client is awaiting nursing facility placement. In 1988-89, Medi-Cal authorized 84,000 administrative days (the equivalent of about 230 beds). These stays vary from a few days to months, depending on how difficult it is to place a client.

To address this problem, the DHS established a "subacute" reimbursement category under Medi-Cal. The subacute level of care is more intensive than skilled nursing care but not as intensive as hospital acute care. To date, only a few providers have participated in this program. The most frequently cited reason for this low participation rate is that the criteria for determining whether a facility can receive a subacute rate for a particular patient were too narrowly defined. The DHS has taken steps to revise these criteria.

Perverse Incentives in the Medi-Cal Reimbursement System

The current Medi-Cal long-term care rate reimbursement system offers perverse incentives to providers. In this section, we discuss some of the effects of the system on patient care, access, and costs.

In his 1987 study, the Auditor General found that Medi-Cal's prospective flat-rate reimbursement system, while effective at controlling costs, has several weaknesses. The system is a good cost control mechanism in that it encourages nursing facilities to spend below the reimbursement rate: the system rewards operators who run their facilities efficiently. However, a flat-rate system also rewards operators who provide minimal patient care and penalizes operators who provide additional services. The rates have no direct relationship to the level of service actually provided.

An example of the effects of the current flat-rate reimbursement system is demonstrated by the rate differential between DP/SNFs and freestanding SNFs. As Figure 3 shows, there is a wide disparity in reimbursement rates between DP/SNFs and freestanding SNFs. The average DP/SNF reimbursement in the current year is \$147 per patient-day, while the average reimbursement rate for freestanding facilities is \$60.

The rate differential is associated with two problems. First, the higher rates result in significantly higher Medi-Cal costs, without any requirement for a greater level of services. The differential in rates reflects differences in costs of operating the two types of facilities. On the average, in DP/SNFs patients receive a higher level of services and staff receive higher wages than in freestanding SNFs. However, DP/SNFs are subject to the same regulations as freestanding SNFs; they do not *have* to provide any additional services or to accept heavier-care patients to justify receiving a higher rate.

Second, this disparity in reimbursement rates is a problem because it provides an incentive for freestanding SNFs to become DP/SNFs by licensing in association with an acute care hospital. (We note that until recently, Medi-Cal tried to control DP/SNF utilization through a policy to approve DP/SNF stays only when a client could not be placed in freestanding facilities within a certain radius or travel time. Medi-Cal recently suspended this policy in response to a suit challenging this transfer policy.)

Without changes in the Medi-Cal reimbursement system, these problems will likely continue, and perhaps get worse, in the future.

WHAT OPTIONS DOES THE LEGISLATURE HAVE TO PROMOTE ADEQUATE ACCESS TO NURSING FACILITY SERVICES OVER THE NEXT DECADE?

The Legislature has several options to address the issues discussed in the earlier section. The Legislature could promote adequacy of nursing facility beds by either reducing demand and/or increasing supply. In this section, we provide a brief overview of some of the alternatives available to the Legislature to promote adequate access to nursing facility beds over the next decade.

Changes in the Medi-Cal Reimbursement System

The current Medi-Cal reimbursement system is primarily designed to control costs. It is not designed to ensure an adequate supply of Medi-Cal beds. In addition, the current reimbursement system (1) does not relate the level of reimbursements to the level

of services facilities provide, (2) may contribute to access problems for Medi-Cal clients, and (3) creates incentives for building the more expensive distinct-part facilities.

The Auditor General study identified three alternatives to the current reimbursement system: a case-mix system, an outcome-oriented system, and a facility-specific system.

A case-mix reimbursement system sets reimbursement rates based on the level of services required by each patient. An outcome-oriented reimbursement system ties the rates to certain "outcomes," or quality of care. A facility-specific system, on the other hand, reimburses a facility based on its own costs, not on the median of its peer group. Of the three, the study recommended that the state adopt a facility-specific system. The study also recommended a supplementary rate for heavy-care Medi-Cal clients. The facility-specific system would tie reimbursement more directly to the facility's spending and provide more nursing facility bed access to heavy-care clients. A similar system is proposed by SB 1087 (Mello), which was in conference committee at the time this analysis was prepared.

The actual cost of such a system would depend on how it is structured. However, the system could cost significantly more than the current flat-rate system because (1) facilities would have incentives to spend more on care, (2) facilities would have incentives to classify clients as heavy-care in order to receive the higher reimbursement rate, and (3) this system is more complicated and, therefore, more difficult to administer.

The Legislature has a good opportunity to effect major changes in the reimbursement methodology in the budget year, should it decide to do so. This is because effective October 1, 1990, the Omnibus Budget Reconciliation Act (OBRA) of 1987 requires a consolidation of the SNF and ICF reimbursement categories into one. As Figure 3 shows, average SNF and ICF rates currently differ by about \$16 daily. Under the OBRA, ICF staffing and physical plant standards would be upgraded to the SNF level. These new standards would require the DHS to make changes in its rate-setting system, as SNF and ICF rates are currently devised separately. These changes could vary from minor adjustments to an overhaul of the whole system. The Legislature has demonstrated interest in changing the whole system through the advancement of SB 1087. The Medi-Cal reimbursement methodology eventually adopted in conjunction with the OBRA-mandated changes will have a significant influence on the supply of, and access to, nursing facility beds in the state over the next decade.

Expand Community-Based Programs

In order to reduce demand for nursing facilities, the Legislature also could expand community-based alternatives to avoid or at least delay entry into nursing facilities. For example, the Legislature has encouraged such expansion in the past by providing "start-up" grants of \$50,000 for each new adult day health center. We note that community-based programs are not necessarily less expensive than nursing facility services. However, to the extent that they prevent or delay institutionalization, they help reduce the pressure on nursing facility bed supply.

Expand the Availability of Long-Term Care Insurance

Another option for increasing bed supply is to expand the availability of long-term care insurance, thereby increasing the proportion of patients who are funded from non-Medi-Cal sources. Currently, private funding comes primarily from clients' own savings and other resources. Many privately funded clients become eligible for Medi-Cal within a matter of months after entering a facility because the high cost of nursing facility services depletes their resources. According to a 1987 report by the House of Representatives Select Committee on Aging, 47 percent of single Californians age 65 and older who live alone are at risk of impoverishment after 13 weeks of nursing facility stay. A long-term care insurance program would be effective only to the extent that (1) it covers the target population and (2) the premiums are affordable. Hence, financing of such a program becomes an important issue. The extent of the state's involvement in an insurance program is a policy decision that the Legislature would have to make if it chooses to pursue this option further.
