



Hospital-Based SNF Medi-Cal Cuts: A Crisis in Beneficiary Access

California’s hospital-based skilled-nursing facilities (SNFs) — an essential part of the patient-care continuum — are threatened. Planned decreases in reimbursement to California’s Medicaid program (Medi-Cal) will result in significant reductions in services. Beneficiary access, already limited, will erode still further. Other levels of care will be impacted as beneficiaries remain in acute care or even intensive-care units (ICUs).

SNFs owned and operated by acute-care hospitals as distinct parts are commonly referred to as hospital-based SNFs. Compared to freestanding SNFs, hospital-based SNFs care for patients of greater medical complexity, and are often the only option for patients with complex medical and behavioral health needs or living in rural areas. Throughout California, hospital-based SNFs increasingly serve as safety-net providers for individuals unable to access care in other settings.

Current Medi-Cal rates do not cover the costs of providing this specialized care. As a result, most hospital-based SNFs currently operate at a loss. If the proposed Medi-Cal reductions go forward, the financial viability of hospital-

based SNFs will be further weakened, and providers will be put in the difficult position of deciding which services, beds or units to reduce or eliminate. Combined with other cuts to state programs, this

Medi-Cal reduction will jeopardize not only hospital-based SNFs, but their affiliated hospitals. The resulting lack of access, particularly in rural areas, will be devastating for Medi-Cal beneficiaries.

California Hospital-Based SNFs and Subacute-Care Units: Essential Providers in the Continuum of Care

More than 10 percent of California’s SNFs are based within, but considered distinct parts of, hospitals.¹ California’s hospital-based SNFs care for a wide variety of patients and provide a broad range of services. Most individuals are admitted to hospital-based SNFs because they require specialized services that they are unable to access in other settings. Many high-acuity patients with complex medical needs are admitted to hospital-based subacute-care units² for long-term care. Still others go to hospital-based SNFs for a short term of transitional or rehabilitative care following a stay in an acute-care hospital.

Medi-Cal beneficiaries make up the majority of California hospital-based SNF volume: 77 percent of patient days come from Medi-Cal, 14 percent from

Medicare and the remaining 9 percent from other payers.³ In comparison, Medi-Cal accounts for 67 percent of freestanding SNF patient days.⁴

California hospital-based SNFs care for patients with complex medical needs.

Care provided in hospital-based SNFs and subacute-care units is fundamentally different than care provided in freestanding SNFs. Nationally, hospital-based SNFs make up 6 percent of the industry. However, they make up more than one-quarter of all SNFs that serve medically complex patients, which the Medicare Payment Advisory Commission (MedPAC) estimates as at least 31 percent of patients.⁵ In California, the national trends apply. Little data on differences in acuity among freestanding and hospital-based SNF patients are publicly available; however, the relative resource use related to direct patient care in each setting provides insight into the average level of care required for patients.

Hospital-based SNFs have significantly higher nurse staffing levels than freestanding SNFs. On average, hospital-based SNFs have over 230 percent more

CHA Special Report is produced by the California Hospital Association. Avalere Health supplied independent research and analytic support.

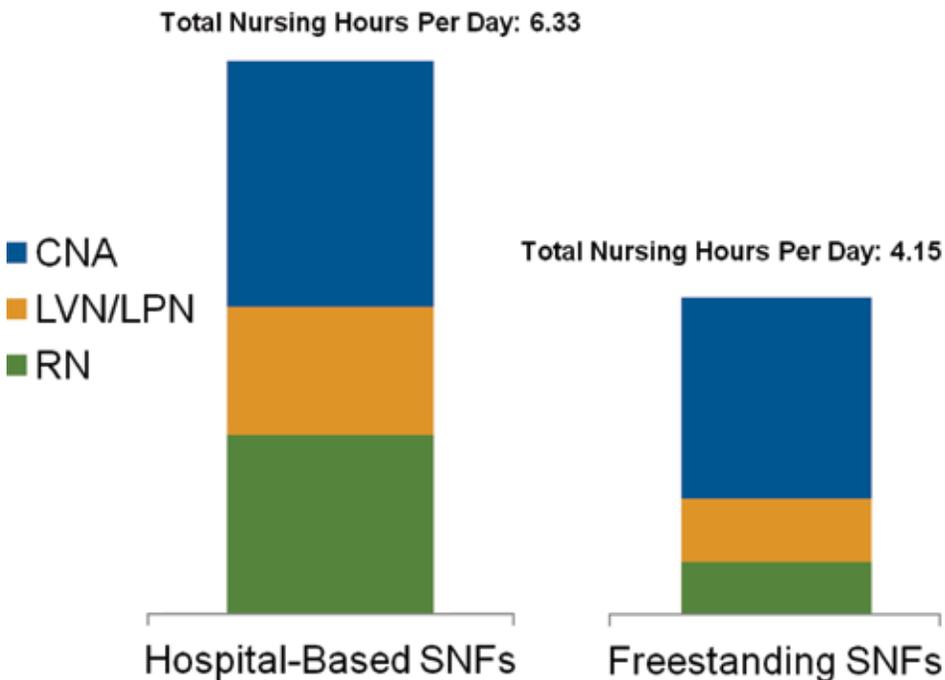


licensed nurse staffing and more than 50 percent more overall nurse staffing.⁶ According to the Centers for Medicare & Medicaid Services' Nursing Home Compare database, California's hospital-based SNFs provide 6.33 nursing staff hours per patient day, compared to 4.15 nursing staff hours per patient day in freestanding SNFs.⁷ Another analysis found that patients in hospital-based SNFs receive, on average, almost twice the number of nursing hours per day as patients in freestanding SNFs.⁸ Hospital-based SNFs also provide more highly skilled nursing hours than freestanding SNFs. Nursing Home Compare data indicate that California's hospital-based SNFs provide three times as many registered nurse hours and more than one and a half times as many licensed vocational nurse or licensed practical nurse hours as freestanding SNFs.⁹

Subacute-care unit patients are individuals who do not need acute care, but who are too ill to be cared for by most SNFs. Often, these individuals are ventilator-dependent or require frequent respiratory treatments. While subacute-care beds are licensed as skilled-nursing beds in California, they are reimbursed differently and are subject to additional patient and program requirements. Staffing levels within subacute-care units are required to be higher than in skilled-nursing units. Hospital-based subacute-care units must provide a minimum daily average of four licensed nursing hours per patient day and two certified nursing assistant hours per day, and freestanding subacute-care units must provide 3.8 licensed nursing and two certified nursing assistant hours per day.¹⁰ In comparison, non-subacute skilled-nursing units must provide a minimum of 3.2 nursing hours per patient day.¹¹

Hospital-Based SNFs Utilize Additional and More Highly-Skilled Nursing Staff

Chart 1: Percent of average nursing hours per resident per day by type of clinician



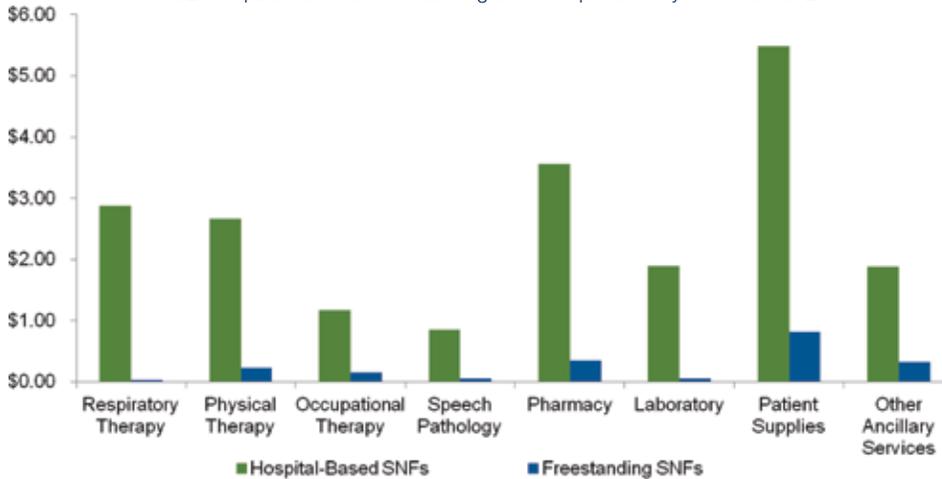
Source: Avalere Health analysis of 2010 Nursing Home Compare data.

Hospital-Based SNFs Provide Valuable, Tailored Services

In the San Francisco Bay Area, two facilities provide specialized care to the communities they serve. San Mateo Medical Center (SMMC) operates a total of 272 SNF beds on two campuses located in San Mateo and Burlingame. SMMC is the safety-net provider for seniors and disabled individuals in San Mateo County, and takes pride in providing all patients the right care at the right time. SNF care is overseen by hospitalists and includes on-site psychiatric support. To absorb the \$8 million loss it anticipates under the proposed cuts, SMMC will be forced to consider closing beds and cutting the very services that make its care so effective and valuable. Just 20 miles to the North in San Francisco, the Jewish Home provides a wide range of medical, social, cultural and spiritual services to its residents and the surrounding community. The Jewish Home's SNF includes specialized units for rehabilitation and Alzheimer's care. Waiting times for admission average 12 to 18 months. If the proposed cuts are implemented, the Home will likely close a significant number of the 420 beds it currently operates. The Home has already reduced staffing levels and stopped accepting long-term-care admissions. The vast majority of residents at both facilities are Medi-Cal beneficiaries. If the proposed cuts force these providers to close beds or reduce services, residents will lose access to facilities that are uniquely suited to meet their care needs.

Hospital-Based SNFs Use More Ancillary Services to Treat the Medically Complex Patients Served

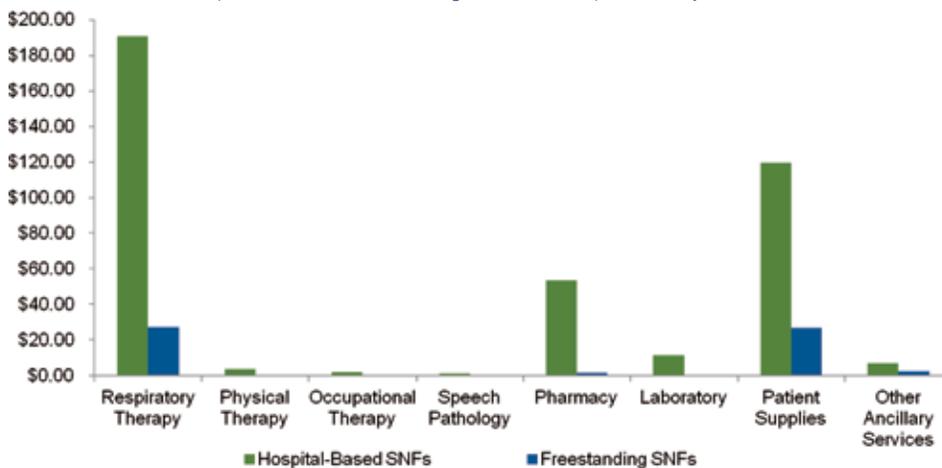
Chart 2: Hospital-based and freestanding SNF cost per diem by service line in 2009



Source: Clark, Koortbojian, and Associates (CKA) analysis of Office of Statewide Health Planning and Development (OSHPD) Annual Financial Disclosure Report, OSHPD Long-Term Care Facility Integrated Disclosure and Medi-Cal Cost Report, Long-Term Care Rate Tables and data collected by CKA from California hospital-based SNFs, July 2011.

Hospital-Based Subacute Units Use More Ancillary Services to Treat the Medically Complex Patients Served

Chart 3: Hospital-based and freestanding subacute cost per diem, by service line, in 2009



Source: Clark, Koortbojian, and Associates (CKA) analysis of Office of Statewide Health Planning and Development (OSHPD) Annual Financial Disclosure Report, OSHPD Long-Term Care Facility Integrated Disclosure and Medi-Cal Cost Report, Long-Term Care Rate Tables and data collected by CKA from California hospital-based SNFs, July 2011.

Hospital-Based SNFs Treat Efficiently and Effectively

Chart 4: Outcomes for hospital-based and freestanding SNFs

Measure	Hospital-Based	Freestanding
Average Medicare-Covered SNF length of stay	13.5 days	30.3 days
Percent discharged to the community	41.5%	24.9%
Percent with preventable readmission	8.2%	14.6%

Sources: Length of stay data were derived from Stearns et al. "Using Propensity Stratification to Compare Patient Outcomes in Hospital-Based versus Freestanding Skilled Nursing Facilities." *Medical Care Research and Review*, 2006 (63): 599. Discharge to home and readmissions data were derived from Min, Sung-Joon et al. "Trends in Risk-Adjusted Skilled Nursing Facility Rates of Community Discharge and Potentially Avoidable Rehospitalization," 2000 through 2008. MedPAC, June 2011.

In addition to higher nurse-staffing levels, hospital-based SNFs and subacute-care units provide significantly more specialized medical care and ancillary services. An analysis of the financial data of hospital-based and freestanding SNFs shows that hospital-based SNFs have higher ancillary costs for patient care services, including rehabilitative therapies (physical, occupational and speech therapy) and respiratory therapy. Similarly, the cost per day for patient supplies provided to individuals cared for in hospital-based SNFs is nearly six times greater than what is provided in freestanding SNFs.¹² This includes items such as specialized support surfaces (e.g., low air-loss mattresses) or other equipment necessary to meet the medical needs of patients. Like hospital-based SNFs, hospital-based subacute-care units also have higher costs per day than freestanding subacute-care units. The cost per day of pharmacy services for patients in hospital-based subacute-care units was more than 30 times greater than for patients in freestanding subacute-care units.¹³ This difference is likely related to the considerable intravenous drug services provided by hospital-based subacute-care units. Additionally, hospital-based subacute-care units had nearly six times more costs per day associated with respiratory therapy, which includes ventilator and tracheotomy care.

Despite the higher acuity of patients, studies show that patients in hospital-based SNFs have shorter lengths of stay and better outcomes when compared to freestanding SNFs, even when controlling for patient characteristics.¹⁴ One study found that hospital-based SNF patients have a shorter average length of stay, are discharged to the community at a higher rate, and are readmitted to the acute-care hospital less frequently.¹⁵ A study conducted on behalf of MedPAC in 2011 found hospital-based SNFs have a 16.6 percent higher rate of discharge to community, and a 9.6 percent lower rate of avoidable re-hospitalizations compared to freestanding SNFs.¹⁶ Patients in hospital-

based SNFs can be admitted and managed more efficiently due to their proximity to hospital services. The higher staffing levels and skill mix in hospital-based SNFs are also contributors to the favorable outcomes experienced in these SNFs.¹⁷

California's hospital-based SNF units provide essential transitional and rehabilitative care to individuals preparing to return to home and community.

Skilled nursing can be a necessary and beneficial step in supporting an individual's return to home and community following an acute-care hospitalization. In addition to medical supervision and nursing care, post-acute transitional care may include ancillary services such as rehabilitative therapies, wound care or IV antibiotics. In many areas of California, these services are available to Medi-Cal beneficiaries only in hospital-based SNFs.

“Over the last five years we have discharged over 1,200 residents to independent living or lower levels of care....The successful rehabilitation and community integration of our medically complex residents is a result of the specialized services we offer, many of which are not available in freestanding facilities.”

– Mivic Hirose, CEO,
Laguna Honda Hospital
and Rehabilitation Center

Successful Transition Back Home

Mr. M, a 54-year-old uninsured male living at home with his wife, was admitted to the acute-care hospital after suffering a stroke, cardiac arrest and respiratory arrest. Mr. M remained in the acute-care hospital for 32 days. He was then transferred to the hospital's subacute-care unit, the only facility of its kind in the community, for continued medical care including intensive respiratory therapy and nutrition through a feeding tube. During his stay, facility staff assisted Mr. M and his family in obtaining Medi-Cal coverage.



Mr. M was cared for on the subacute-care unit for 22 days. While his medical status improved during that time, he continued to require significant physical assistance for mobility and activities of daily living. Mr. M's wife, also ill, was physically unable to provide the level of care that he required. Mr. M would need additional care, including rehabilitative therapies (physical therapy and occupational therapy), in order to return home. The freestanding SNFs in Mr. M's community do not provide therapy services to Medi-Cal beneficiaries. If Mr. M was to have a chance of returning home, the only option was to transfer to the SNF operated by the hospital.

After nearly three months in the hospital-based SNF, Mr. M had made remarkable progress. At the time of his discharge, Mr. M was able to walk 50 steps with minimal support, mobilize in his wheelchair independently and complete most activities of daily living. No longer tube-fed, Mr. M was able to eat on his own. This level of independence allowed him to return home with his wife.

For Mr. M and many others like him, the continuum of care provided by the hospital-based SNF and subacute-care unit provides critical support for a successful return to home and community. Without access to these essential services, Mr. M would have likely remained in the hospital for an extended period of time before transfer to long-term institutional care.

Access to Beneficial Hospital-Based SNF Services Already Strained

During the past five years, more than 25 hospital-based SNFs have closed, representing a 15 percent reduction in hospital-based SNFs in California. At the same time, existing hospital-based SNFs are heavily utilized. A recent survey of hospital-based SNFs indicates an occupancy rate of 92 percent.¹⁸ Due to the high occupancy rates of hospital-based SNFs, these facilities often carry waiting lists. For example, the subacute-care unit of Alhambra Hospital Medical Center in Los Angeles County is perpetually full, averaging 99 percent occupancy, and currently has a waiting list

of 30 patients.¹⁹ In San Francisco, the Laguna Honda Hospital and Rehabilitation Center has an average occupancy rate of 98 percent and a waiting list of approximately 40 patients; 97 percent of its patient population are on Medi-Cal.²⁰ Although access is strained throughout the state, access to hospital-based SNF providers in rural areas is especially limited. Eastern Plumas Health Care's hospital-based SNFs, located in the rural cities of Portola and Loyalton in Northern California, carry waiting lists of four to six months.²¹

“Because of the already insufficient Medi-Cal reimbursement for the long-term care of medically complex patients, in the past five years there has already been a dramatic reduction in available capacity.”

– Conway Collis, Senior Counselor and Chief Government Affairs Officer, Daughters of Charity Health System

Medi-Cal beneficiaries have poor access to skilled-nursing services.

In a recent survey of California’s hospital case managers, 97 percent reported that they have difficulty finding beds in SNFs for Medi-Cal beneficiaries. Three-quarters of respondents reported that they encounter delays all or most of the time when attempting to transfer patients to SNFs, and 38 percent of these facilities reported average delays of more than seven days.²² These difficulties have increased in recent years; 94 percent of case managers stated that it has become much harder or somewhat harder to discharge Medi-Cal patients to freestanding SNFs over the past three years.²³

According to hospital case managers, patients with certain specialized needs are the most difficult to discharge to skilled-nursing services. For example, freestanding SNFs are often unable to accept patients who require dialysis or who are ventilator-dependent, or patients with specialized rehabilitation needs.²⁴ Patients with behavioral health needs, including mental illness or substance-use disorders, also have difficulty accessing skilled-nursing care. Additionally, hospital-based SNFs care for other types of patients who are often not accepted by other providers, such as homeless patients, bariatric patients and younger adults. In such cases, the hospital-based SNF is often the only provider willing and able to provide care.

Case Management Challenges: *Sharp Chula Vista Medical Center is a 343-bed hospital with the largest array of health care services in San Diego’s South Bay. Sharp Chula Vista also operates a 100-bed skilled-nursing unit, known as Sharp Birch Patrick. Case managers at Sharp Chula Vista Medical Center provide discharge planning for patients who no longer need acute care, but who require continued medical management and/or rehabilitative services, including skilled-nursing care. Case managers have great difficulty securing appropriate SNF care for patients covered by Medi-Cal compared to individuals covered by other payers.*

From January 1 through June 30, 2011, 1,114 of the 1,306 referrals made for SNF care for Medi-Cal beneficiaries were declined, a rejection rate greater than 85 percent. On average, 16 referrals were made for each Medi-Cal patient who ultimately transferred to SNF care. While reasons for not accepting the Medi-Cal beneficiaries were not routinely provided, roughly half of the time SNFs indicated they had no available beds. Other reasons given included “patient not eligible,” “insufficient funding” and “care needs exceed current capacity.” Approximately half of the Medi-Cal beneficiaries in need of skilled-nursing care were admitted to Birch Patrick, the hospital-based SNF.

By comparison, referrals for Medicare beneficiaries made during the same time period were declined only 25 percent of the time. An average of 2.4 referrals per patient was necessary to support admission to SNF care for Medicare-funded patients. Patients covered by private payers are discharged to SNFs at a much lower rate than Medicare or Medi-Cal patients overall, and available data is limited.

“As of August 18, 2011, we have had to turn away 67 Medi-Cal or Medi-Cal-pending subacute patients.”

– Marcia Hall, CEO, Sharp Coronado Hospital and Health System, San Diego, CA

Sharp Coronado stopped admitting patients to its subacute-care unit effective June 1, in response to the proposed Medi-Cal cuts.

Providing Specialized Care Comes at a Cost

Ms. D was a 48-year-old female with breast cancer who became eligible for Medi-Cal after losing her job. Unfortunately, chemotherapy and radiation treatments were not successful, and the cancer spread throughout her body. She developed acute pain and multiple wounds from her cancer while trying to continue to take care of her children. Ms. D is a single mom and, although she has many friends, no one could move in and provide the full-time care she needed at home. In total, she required over seven hours a day of skilled-nursing care to change the dressings and manage her wounds. She required an IV pump to manage her severe pain. Community nursing homes declined to admit Ms. D because her care needs exceeded the reimbursement that Medi-Cal would provide. Ms. D was admitted to a hospital-based SNF and remained 46 days until she died peacefully with her family at her bedside. The provider caring for Ms. D experienced a total loss of more than \$10,000 for her care.

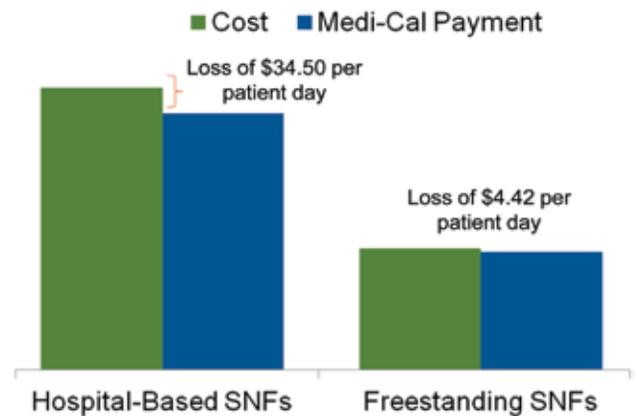


Low Medi-Cal reimbursement rates have jeopardized the safety net for beneficiaries.

Both the selectivity of freestanding SNFs and the limited availability of specialized services are the result of shortfalls in Medi-Cal payments. Hospital-based SNFs rely on Medi-Cal; however, payments are not adequate to cover costs. The average Medi-Cal shortfall between payment rate and allowable cost per day for all nursing facilities in California was projected at \$11.56 in 2010.²⁵ That payment shortfall amount is an average that includes both freestanding and hospital-based SNFs. A closer look at hospital-based SNF payment shortfalls reveals that the shortfalls are much greater for these facilities compared to freestanding SNFs. An analysis of 2006 data related to California hospital-based SNF payments in relation to the cost of care found that, on average, Medi-Cal payments cover just 84 percent of costs, and many facilities report greater shortfalls.

Hospital-Based SNFs are Not Adequately Reimbursed for the Complex Care they Provide

Chart 5: Hospital-based and freestanding SNF Medi-Cal payment shortfall relative to costs, 2008



Source: Clark, Koortbojian, and Associates (CKA) analysis of Office of Statewide Health Planning and Development (OSHPD) Annual Financial Disclosure Report, OSHPD Long-Term Care Facility Integrated Disclosure and Medi-Cal Cost Report, Long-Term Care Rate Tables and data collected by CKA from California hospital-based SNFs, July 2011.

Complex Patients Require Care Found Only in Hospital-Based SNFs With two hospital-based SNFs located in Poway and Escondido, Palomar Pomerado Health (PPH) provides complex medical care and other services that cannot be found in the nearby freestanding SNFs. Many PPH patients require ventilator and tracheotomy care, nutrition via tube feeding, specialty wound care, specialized surfaces and multiple IVs. These needs are increasing as PPH is seeing more high-acuity patients. Based on MDS data, half of the SNF patients are considered clinically complex. In addition, PPH is seeing an increase in younger patients. At one of PPH's two SNFs, 40 percent of patients are under the age of 65. PPH provides 24-hour nursing care and physician follow-ups to its patients; these services are not available anywhere else in the community. "[Our facility's] ability to admit these kinds of patients assists our hospitals with maintaining appropriate occupancies for acute interventional needs and other related emergencies. The ability to transfer patients, unacceptable to others, through the continuum, at the appropriate times, assists to control overall health care expense." –Steve Gold, Chief Officer, Senior Care and Support Services.

In California, freestanding SNFs participate in a statewide SNF Quality Assurance Fee and many receive additional funds that are of some assistance in mitigating payment shortfalls. However, this program is limited to freestanding SNFs and additional funds raised by this program are not available to hospital-based SNFs.²⁶ Medi-Cal payment shortfalls are further exacerbated by reductions by other payers, including an estimated average 11 percent reduction in Medicare payments for fiscal year 2012.²⁷

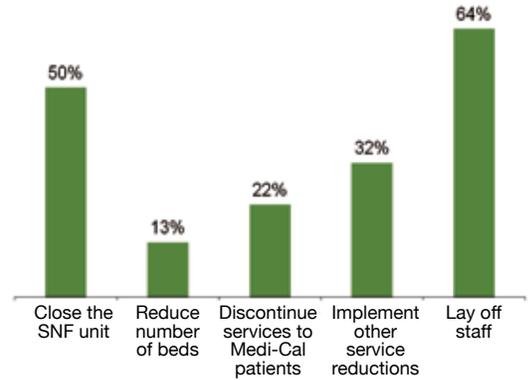
California Hospital-Based SNFs Threatened; Additional Reimbursement Cuts Will Decrease or Eliminate Medi-Cal Beneficiary Access to Hospital-Based SNFs and Subacute Care

The Budget Act of 2011, signed by Governor Brown on March 24, includes significant cuts to Medi-Cal reimbursement rates for hospital-based SNFs and subacute-care units. Medi-Cal rates for these facilities will be reduced to a level 10 percent below the rates they received in the 2008-09 rate year. For most facilities, this represents a cut of approximately 23 percent from current rates. If approved, these rates will be retroactively applied to all payments received on or after June 1, 2011. The total reduction in hospital-based SNF revenues is estimated to be at least \$236.8 million in 2011, including an estimated annual rate update that occurs August 1 of each year.²⁸ If the proposed Medi-Cal payment reductions are adopted, providers will be adversely affected. The most likely course of action for SNFs will be to close, reduce capacity, change admission practices and/or reduce certain services.

The proposed Medi-Cal reduction will lead to facility closures and reduced beds and/or services. A recent survey shows many hospital-based SNF providers will reduce the number of SNF beds or close SNF units entirely if the Medi-Cal cuts are approved. A survey of hospital-based SNFs showed that 50 percent of responding hospital-based SNFs would close if the proposed Medi-Cal cuts take effect.²⁹ Hospital-based SNFs' ability to place patients in freestanding SNFs will be further limited as those facilities respond to Medicare, as well as Medi-Cal, cuts by closing, reducing beds or becoming more selective about which patients they accept. Hospital-based and freestanding SNF closures and bed reductions will lead to a system-wide shortage in SNF beds for Medi-Cal beneficiaries, greatly exacerbating the current lack of access to skilled-nursing care.

The Proposed Medi-Cal Payment Reduction Will Erode Hospital-Based SNF Services

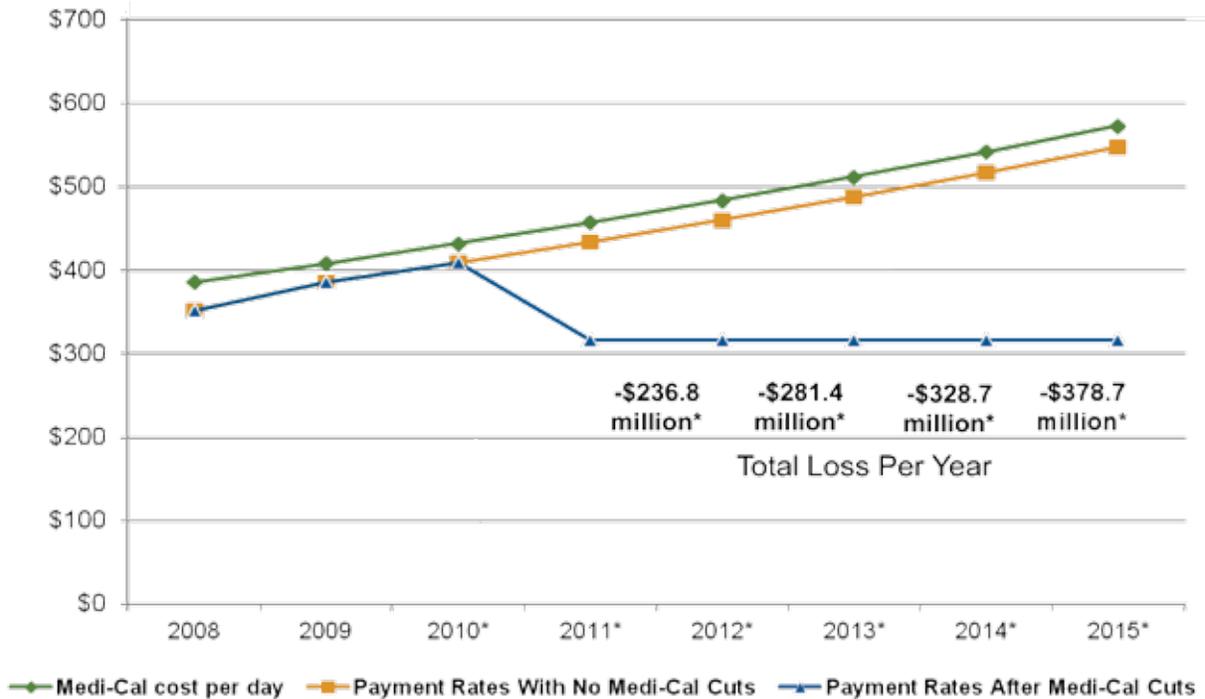
Chart 7: Percent of facilities responding that they would likely take the following actions



Source: California Hospital Association May 2011 survey of 108 California hospitals operating hospital-based SNFs or subacute-care units.

The Proposed Medi-Cal Cuts Will Have Significant Payment Impacts Over Time

Chart 6: Medi-Cal payment rates and hospital-based SNF costs per day



Source: * Projected. California Hospital Association analysis of California Office of Statewide Health Planning and Development data, and Clark, Koortbojian, and Associates analysis of data collected from California hospital-based SNFs, July 2011.

Some hospital-based SNFs, essential to hospital operations or mission, will remain open; however, services will be negatively affected. Some hospitals recognize that closing the SNF or sub-acute-care unit will impair their ability to effectively manage their acute-care facility, as patients will be forced to remain in costly acute care or even ICU beds. As community-based facilities, some hospitals will keep their SNFs open, as there are no other facilities or programs to accept these patients.

Rural hospital-based SNF closures will leave many rural Californians without access to skilled-nursing care.

Approximately 710,000 people, or almost one-fifth of Californians age 65 and over, live in rural areas.³⁰ These seniors have higher rates of heart disease and repeated falls, and are more likely to be low-income than urban or suburban older adults, a factor that exacerbates many health conditions.³¹ The Medi-Cal cuts will disproportionately affect those living in rural areas and in need of a SNF level of care.

In many rural areas of California, hospital-based SNFs are an integral part of the health care system and provide essential infrastructure to the overall hospital operation. For example, Surprise Valley Hospital, a Critical Access Hospital (CAH) in Cedarville, operates a 24-hour emergency room with physicians on standby 24 hours a day. The hospital stabilizes patients who must be flown to other larger hospitals that can be hundreds of miles away. Surprise Valley has one acute-care bed, three swing beds and a 22-bed SNF unit. Reimbursement for individuals cared for on the SNF unit provides essential support for the operation of the hospital as a whole. The reduction to SNF payments will undermine the financial viability of the hospital. The closure of small and rural hospitals, such as Surprise Valley, will result in a loss of access to essential hospital inpatient and outpatient care, as well as SNF care, for the residents of the community.

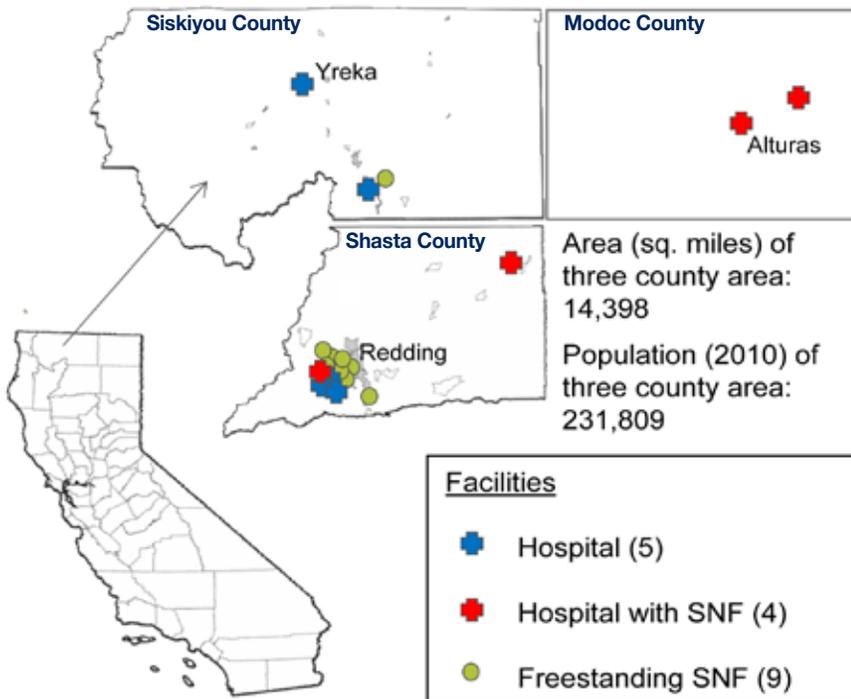
If existing hospital-based SNFs close, long-term-care residents will either remain in acute-care beds or will need to be relocated. Many Medi-Cal beneficiaries will be transferred to SNFs that are significantly farther away, perhaps even out of state, causing additional burden on relatives and impacting care outcomes.

A Moral Obligation Kaweah Delta Healthcare District, located in Tulare County, operates an acute-care hospital, a hospital-based SNF and a 30-bed subacute-care unit. As a health care district, Kaweah Delta is the safety-net provider for the surrounding community. None of the freestanding SNFs in Tulare County accept complex patients, even after repeated requests from Kaweah Delta staff for assistance in caring for them. Patients requiring skilled nursing, and particularly subacute care, are dependent on the district's facilities as they have no other options for care in their community. To control costs, Kaweah Delta has already implemented a salary freeze and capital expenditure reductions, and cut some services needed for the community's poor. "The care requirements of our community's most vulnerable do not go away because the funding has gone away.... We have a moral obligation to assure these patients receive the treatment they need to address their significant health issues." – Karrie Decker, Director of Skilled Nursing, Home Care Services and Palliative Care

Currently Limited Access to Rural SNF Care Could Become Non-Existent Mercy Mount Shasta, a CAH in Siskiyou County, was recently forced to close its hospital-based SNF because it was no longer financially viable. Within Siskiyou County (population of 44,900, over an area of more than 6,300 square miles), there are no hospital-based SNFs and only one freestanding SNF. The next nearest SNF is 70 miles away. In the neighboring county of Modoc, the access picture is even bleaker: in more than 4,200 square miles there are no freestanding SNFs and no home health agencies. The two CAHs in the county, Modoc Memorial and Surprise Valley, operate hospital-based SNFs, but both are faced with the likelihood of closing their SNF and/or the hospital itself.

In Some Counties, Access to SNF and Hospital Care Is Extremely Limited

Chart 8: Hospitals and SNFs in Modoc, Shasta and Siskiyou Counties



Source: California Healthcare Atlas. California Office of Statewide Health Planning and Development (OSHPD). Accessed on August 16, 2011.

Cuts to Hospital-Based SNFs Are Cuts to Hospitals and Jobs Located in rural Plumas County, Eastern Plumas operates a small 10-bed CAH and two hospital-based SNFs for a combined 66 beds. The approval of proposed Medi-Cal reductions would result in the closure of both hospital-based SNFs, as 85 percent to 90 percent of the patients they see are on Medi-Cal, creating a loss of more than \$1 million annually. The hospital-based SNF closures would lead to a 24 percent reduction in Eastern Plumas' total staff, creating significant job losses that would add to the county's high unemployment rate of 16.8 percent annually.³² Like Eastern Plumas, Hazel Hawkins Memorial Hospital provides needed care to the residents of the rural community surrounding Hollister, California. A part of the San Benito Healthcare District, Hazel Hawkins operates an acute-care hospital, as well as two hospital-based SNFs, rural clinics, home health care and other services. Hazel Hawkins' 127 SNF beds represent the only SNF beds in San Benito County. If the proposed Medi-Cal cuts are approved, at least one of Hazel Hawkins' two SNFs will no longer be able to accept Medi-Cal patients and would attempt to relocate its current SNF residents. The estimated \$2.7 million annual impact of the cuts would jeopardize the financial stability of the entire district; force the elimination of home health services; and exacerbate the county's already high unemployment rate, which was 17.6 percent in 2010.³³ With no SNF beds for discharge, the acute-care facility could become full and have to cease accepting and admitting patients to the emergency department, the only one in the county.

Access to subacute care will be reduced if the proposed Medi-Cal cuts are approved.

As subacute-care units close, patients who cannot be cared for in the home or other community-based settings will need to be placed in an ICU or other acute-care beds. As a result, access to acute care will be compromised.

Loss of Hospital-Based Subacute-Care Beds Will Strain Hospitals

Integrated Healthcare Holdings, Inc. (IHHI) operates two hospital-based subacute-care units in Southern California. These subacute-care units are two of just three hospital-based subacute-care units located in Southern California's Orange County and are extremely dependent on Medi-Cal payments due to a disproportionately poor patient population. Per-capita income in Santa Ana, IHHI's primary service location in Orange County, is 49 percent below the California average, and all of IHHI subacute-care patients are Medi-Cal beneficiaries. The proposed Medi-Cal cuts would represent an 18 percent to 24 percent reduction in payment rates, a figure that IHHI cannot absorb. If the Medi-Cal cuts are adopted, IHHI plans to close both of these subacute-care units, and in fact has already stopped admitting new patients. Facility staff estimate it will take 12 to 18 months to place current residents due to medically complex needs. Many of IHHI's subacute-care patients are ventilator-dependent and have needs beyond the capabilities of freestanding subacute-care units in and around Orange County. IHHI is committed to finding an appropriate setting in which to

Continued on Page 10

Continued from Page 9

transfer these patients, but believes it will force patients to be moved between 50 and 100 miles away. Even if IHHI's subacute-care units close, Orange County's acute-care hospitals' ICUs will continue to admit patients who often eventually require skilled-nursing or subacute care. Without the benefit of the hospital-based SNF and distinct-part subacute unit, patients will remain in the acute-care hospital longer, adding greater costs to the health care system than the dollars saved through the proposed cuts.

A shortage of hospital-based SNF care is likely to decrease quality of care while increasing inpatient costs to public payers.

Research suggests that when hospital-based SNFs close, beneficiaries and health care spending are negatively affected. A national study of Medicare claims found that hospital-based SNF closures that occurred between 1997 and 2001 were associated with increased spending on hospital care and a small, but statistically significant, increase in acute-care hospital length of stay. The study's authors state that the increased spending was likely due to a decrease in early transfers rather than an increase in outlier payments, underscoring SNFs' key role as facilitators of care transitions.³⁴ If more of California's hospital-based SNFs close, medically complex patients will remain longer in hospitals or be discharged to other institutional post-acute-care settings, which could lead to increased costs. Medi-Cal patient outcomes could be adversely affected as the onset of therapy and other treatment is delayed while they wait longer in the acute-care hospital to be placed in SNF beds.

Reductions to Key Services Will Hinder Care Transitions Facilities that provide additional care to beneficiaries in the interest of navigating them through the care continuum as smoothly and quickly as possible may have to discontinue those services. In Northern California, Sutter Health's hospital-based SNFs provide needed therapy to Medi-Cal beneficiaries, despite the low reimbursement rates, in order to effectively move patients throughout the care continuum. To further assist in transitions, Sutter provides complex care interventions, such as IV and wound care, that require more staff hours than are mandated by regulations. Substantial payment reductions associated with the proposed Medi-Cal cut will make it impossible for facilities to put resources toward care coordination and transition activities that are minimally or not reimbursed, but are essential to the provision of high-quality care. In Southern California, Palomar Pomerado has a readmission rate of 9.4 percent compared to the national average of approximately 20 percent.³⁸ Some of services that Palomar Pomerado staff credit for these low rates will be reduced or cut if the Medi-Cal reductions are approved. A likely contributor to the low readmission rates is the relatively high level of staffing, which will be jeopardized by the Medi-Cal reduction. Palomar Pomerado SNF facilities provide 5.0 staff (total, including RN and aide) hours per patient day for skilled-nursing patients, compared to the freestanding SNF requirement of 3.2 hours, and 7.8 hours per patient day for subacute-care patients. Similarly, Sutter Health will have to make adjustments to its staff hours in order to cope with the impact of the proposed Medi-Cal cuts. Reductions in staff and services that now ease care transitions will negatively impact patient care.

Research has consistently shown that level of reimbursement is positively associated with staffing, and in turn that level of staffing is positively associated with patient outcomes.³⁵ Moreover, states with relatively higher Medicaid nursing home payments have fewer hospital readmissions.³⁶ The proposed Medi-Cal cuts will possibly lead to staffing reductions in hospital-based SNFs, which are typically staffed far above the state requirement of 3.2 hours per patient day. Such reductions may affect the quality of patient care and drive up readmissions to acute care. Increased readmissions would in turn result in higher Medicare and Medi-Cal inpatient hospital spending. Readmissions from SNFs in California accounted for more than \$425 million in Medicare costs in 2006.³⁷ Reducing readmissions is in the

interest of patients and payers; however, facilities must be adequately reimbursed to implement programs to achieve this goal.

Reductions to hospital-based SNFs will also mean reductions to affiliated services and facilities. Hospital-based SNFs are often part of a larger network of providers that offer services in addition to acute hospital care. These systems often include home health agencies, rural clinics, and other types of providers and services. In response to the proposed Medi-Cal reductions, some health systems that operate hospital-based SNFs will reduce or eliminate other services. Health systems facing multiple payment reductions may be forced to discontinue services that assist in transitions back to the home.

Medi-Cal Cuts Will Lead to Cuts to Services for Vulnerable Children

Located in San Diego, Rady Children's Hospital is the largest children's hospital in California, providing a broad range of services for nearly 150,000 children in a variety of settings in 2010. Rady Children's operates a 59-bed pediatric SNF, including a subacute-care unit that is made to feel like a home where 24-hour care is provided to medically fragile and developmentally disabled kids, 98 percent of whom are Medi-Cal patients. Each day, Rady Children's staff makes up to 20 specialized baby formulas for children with special nutritional needs. The goal of Rady Children's SNF is to stabilize patients, wean them off of tracheotomies, and transition them to community-based care settings. Unfortunately, this is extremely challenging as many residential-care units and freestanding SNFs are unable to provide services that would meet the needs of a pediatric patient, especially those requiring ongoing respiratory therapy care. The recent reductions in funding within the local mental health system also add to Rady Children's difficulties in transitioning patients to community-based settings. One of the key tools Rady Children's uses to ensure smooth transitions is home health care, but these services are likely to be cut to keep the SNF's doors open. Since there are no pediatric subacute-care SNF units in the surrounding areas, Rady Children's will not close their hospital-based SNF, but will be forced to cut other services.

Med-Cal cuts across the continuum create ripple effects on an already weakened long-term-care service and support system.

The reductions in funding to other public programs that support long-term-care providers, such as adult day health care (ADHC) and mental health programs, are eroding the safety net and putting increased pressure on hospital-based SNFs. The deep budget cuts enacted in 2009 ended or dramatically diminished many programs that promoted and supported community-based long-term care. This reduction in services affected primarily poor Californians; many of the program cuts disproportionately affect low-income and/or Medicaid-eligible seniors. The In-Home Supportive Services Program (IHSS) program provides personal care and essential services in the home for Medi-Cal eligible seniors who need

assistance to complete those tasks. The ADHC program provided supervised care, including medical monitoring and rehabilitation, to Medi-Cal beneficiaries with long-term-care needs. The IHSS program underwent significant benefit reductions and the ADHC benefit has been eliminated entirely. Additionally, some counties have implemented cuts to mental health services for these populations.³⁹ Individuals who relied on these programs to maintain their independence in the community are being forced to give up that independence and attempt to seek placement in increasingly unavailable institutional care settings, like SNFs. The safety net of medical care, as well as long-term-care services and supports for California's most vulnerable Medi-Cal beneficiaries, is already strained and the proposed Medi-Cal cuts will further erode it.

Conclusion

The proposed Medi-Cal cuts to hospital-based SNF payments will have a devastating impact on Medi-Cal beneficiary access to hospital-based SNF care, and, in some cases, would limit access to hospital, home health and other services. The lack of access to SNF care will in turn force higher inpatient costs and break down critical-care transitions. These impacts work against federal health care reform initiatives, which emphasize improved care coordination and transitions as a way to improve outcomes, reduce readmissions and reduce health care spending overall.

As federal reform efforts focus on improving the care continuum as a whole, California is attempting to achieve budget savings at the expense of the continuum, a decision that could have considerable ripple effects across the health care system. Payment shortfalls have and will continue to threaten the viability of hospital-based SNFs, which at the same time are facing increased demand due in part to the aging of California's population and the increasing prevalence of disability among those under age 55.⁴⁰

While federal and state programs aim to transition patients out of institutional long-term-care settings and into community settings, the community setting is not appropriate for all patients and the need for SNF care will remain. As a key provider of skilled-nursing care, hospital-based SNFs must receive sufficient reimbursement to continue to deliver high-quality, efficient care to California's Medi-Cal beneficiaries.

Endnotes

- 1 California Health Care Almanac: Long Term Care Facts and Figures. California Healthcare Foundation. November 2009.
- 2 Subacute care is a level of care provided to patients who do not need acute care, but who are too ill to be cared for by most SNFs. Subacute-care facilities are subject to different staffing and reimbursement policies than SNFs.
- 3 Clark, Koortbojian, and Associates analysis of OSHPD Annual Financial Disclosure Report, OSHPD Long-Term Care Facility Integrated Disclosure and Medi-Cal Cost Report, Long-Term Care Rate Tables and data collected by CKA from distinct-part nursing facilities, July 2011.
- 4 Office of Statewide Health Planning and Development. LTC Facilities Annual Financial Pivot Profile, 2009.
- 5 Report to the Congress: Medicare Payment Policy. Medicare Payment Advisory Commission. March 2011.
- 6 Avalere Health analysis of 2010 Medicare Nursing Home Compare data.
- 7 *Ibid*
- 8 Liu, Korbin and Jones, Emily. Closures of Hospital-Based SNF Units: Insights from Interviews with Administrators, Discharge Planners and Referring Physicians. Urban Institute. March 2007
- 9 Avalere Health analysis of 2010 Medicare Nursing Home Compare data.
- 10 Facilities that do not utilize CNAs must provide 4.8 actual licensed nursing hours per patient day.
- 11 California code of regulations 22 CA ADC § 51215.5.
- 12 Clark, Koortbojian, and Associates analysis of OSHPD Annual Financial Disclosure Report, OSHPD Long-Term Care Facility Integrated Disclosure and Medi-Cal Cost Report, Long-Term Care Rate Tables and data collected by CKA from distinct-part nursing facilities, July 2011.
- 13 *Ibid*
- 14 Stearns, Sally et al. Using Propensity Stratification to Compare Patient Outcomes in Hospital-Based versus Freestanding Skilled Nursing Facilities. *Medical Care Research and Review* Vol. 63 No. 5. October 2006.
- 15 *Ibid*
- 16 Min, Sung-Joon et al. Trends in Risk Adjusted Skilled Nursing Facility Rates of Community Discharge and Potentially Avoidable Rehospitalization. University of Colorado, June 2011.
- 17 Report to the Congress: Medicare Payment Policy. Medicare Payment Advisory Commission. March 2010.
- 18 California Hospital Association survey of 108 California hospitals operating distinct-part SNFs or subacute-care units, May 2011. Occupancy rate calculated on number of staffed beds
- 19 Letter sent from Alhambra Hospital Medical Center to the Centers for Medicare & Medicaid Services, July 28, 2011.
- 20 Letter sent from Laguna Honda Hospital and Rehabilitation Center to the Centers for Medicare & Medicaid Services, July 26, 2011.
- 21 Avalere Health interview with Tom Hayes, CEO of Eastern Plumas Health Care on July 18, 2011.
- 22 California Hospital Association survey of 160 California hospital case managers, May 2011.
- 23 *Ibid*
- 24 California Hospital Association survey of 160 California hospital case managers, May 2011.
- 25 A Report on Shortfalls in Medicaid Funding for Nursing Home Care. Eljay LLC, December 2010.
- 26 California Health and Safety Code, Sections 1324.20-1324.30.
- 27 Department of Health and Human Services. Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities for FY 2012. Federal Register, Vol. 76, No. 152. August 8, 2011.
- 28 California Hospital Association analysis of the impact of proposed Medi-Cal payment cuts based on current payment rates, 2011.
- 29 California Hospital Association survey of 108 California hospitals operating distinct part skilled nursing facilities or subacute care units, May 2011.
- 30 Wallace, Steven P. et al. California Budget Cuts Fray the Long-Term Care Safety Net. UCLA Center for Health Policy Research, October 2009.
- 31 *Ibid*
- 32 U.S. Bureau of Labor Statistics' Local Area Unemployment Statistics (LAUS) program data, 2010.
- 33 *Ibid*
- 34 White, Chapin and Seagrave, Susanne. What Happens When Hospital-Based Skilled Nursing Facilities Close? A Propensity Score Analysis. *Health Research and Educational Trust*, Vol. 40 No. 6, 2005.
- 35 Tong, Patricia. The Effects of California Minimum Nurse Staffing Laws on Nurse Labor and Patient Mortality in Skilled Nursing Facilities. *Health Economics* Vol.20, July 2010.
- 36 Mor, Vincent et al. The Revolving Door of Rehospitalization from Skilled Nursing Facilities. *Health Affairs* Vol. 29 No. 1: 57-64. January 2010.
- 37 *Ibid*
- 38 *Ibid*
- 39 Amaro, Yesenia. Mental health agencies struggling: Budget and staff cuts force innovation to serve county's expanding need. Sacramento Bee, February 12, 2011, and Robertson, Kathy. California makes largest mental health cuts. The Sacramento Business Journal, March 9, 2011.
- 40 Rethinking the Nursing Home: Culture Change Makes Headway in California. California Healthcare Foundation, December 2008.



California Hospital Association
1215 K Street, Suite 800
Sacramento CA 95814
916-443-7401
www.calhospital.org



Avalere Health LLC
1350 Connecticut Avenue, NW
Suite 900
Washington, DC 20036
202-207-1300
www.avalerehealth.net