

Nursing Facilities in California

The LTC Fundamentals series is produced by The SCAN Foundation to highlight and describe the organization and financing of long-term care (LTC) in California. This LTC Fundamentals brief provides a background on nursing facilities in California, including who uses them, what services they provide and by whom, and how these services are financed.

What are Nursing Facilities?

A nursing facility is an institutional care setting in which medical and supportive services are provided to people with significant functional and/or cognitive impairment.

Located in urban and rural areas across states, nursing facilities vary in size and operate either as part of a hospital or independently as for-profit, public, or non-profit entities. Most nursing facilities are certified to receive payments from the Medicare and/or Medicaid programs for those who meet both programmatic eligibility criteria and who have the appropriate level-of-care need to be served there.* In addition to Medicare and Medicaid, other payor sources include private pay, private long-term care insurance, and the Veterans Administration, among others.

In California, there are several types of facilities that are considered to be “nursing facilities.” Nearly all of these are “skilled nursing facilities”

that provide around-the-clock nursing and personal assistance services to individuals who are chronically ill or have a physical and/or cognitive disability. The other dominant facility type is the “intermediate care facility” that provides care to individuals who do not need continuous nursing care, but require supervision and personal assistance.¹ This brief focuses on skilled nursing facilities in California, as these facilities account for the majority (about 98 percent) of patients served and the largest share of financing.²

What Types of Services do Nursing Facilities Provide?

Nursing facilities generally provide short-term skilled care and long-term care. Skilled care consists of short-term rehabilitative services provided on a continuous basis by trained or professional personnel. This type of care can include physical therapy or intravenous injections that can only be given by a registered nurse or doctor.

* Medicare is the federally-run health insurance program that provides coverage for individuals age 65 years and older, individuals younger than 65 with permanent disabilities receiving Social Security Disability Insurance payments, and other select groups. Medicaid (called Medi-Cal in California) is the federal-state jointly funded program that provides medical and long-term care services for qualified low-income Americans.

Generally, skilled care is provided following an injury or hospitalization to improve a resident's condition within a predetermined timeframe or maintain and prevent their current condition from worsening.^{3,4} All nursing facility residents require some amount of skilled care, while others require long-term care in addition to these services.

Long-term care consists of assistance with personal care activities such as bathing, dressing, eating, and getting in or out of a bed or chair. It can also include assistance with incidental medical services that are typically self-managed, such as the administration of medications, the management of a colostomy or catheter, or testing for glucose levels. Long-term care tends to be provided for a longer duration than skilled care. Individuals residing in a nursing facility for less than 90 days are referred to as "short-stay" residents, while those residing for longer than 90 days are referred to as "long-stay" residents.^{3,4}

In addition to skilled and long-term care, federal law requires that nursing facilities provide "medically-related social services to attain or maintain the highest practicable resident physical, mental and psychosocial well-being".⁵ These services include counseling, assistance resolving disputes with other residents, assistance in contacting financial or legal professionals, and discharge planning.⁶ Additionally, some nursing facilities provide special care that is limited to residents diagnosed with Alzheimer's disease or AIDS, or to residents needing hospice care.⁷

Generally, an individual is eligible to receive services in a nursing facility if he or she has a physician's orders to receive this type of care. Beneficiaries of the Medicare and Medicaid programs have additional eligibility requirements. In addition to having a physician's orders, Medicare beneficiaries must require

nursing facility services following a hospital stay of at least three days and be admitted to a nursing facility within 30 days of discharge from the hospital.⁸ Medicaid beneficiaries must have a physician's order for services and have a condition which requires visits by a physician at least every 60 days and constantly available skilled nursing services. An individual may qualify for nursing facility services under Medicaid if they have one or more of the following conditions:

- A condition that requires therapeutic procedures, such as the dressing of post-surgical wounds, tracheotomy care, tube feeding, and training for bladder or bowel incontinence;
- A condition that requires continuous skilled nursing observation, such as the regular observation of blood pressure, pulse, breathing, or skin conditions;
- A condition that requires medications that cannot be self-administered; and/or
- A physical or mental functional limitation.⁹

Nursing staff in certified nursing facilities are mandated to use the Minimum Data Set (MDS) to determine the care needs of residents and to support care plan development. The MDS is an assessment tool that covers 17 domains, including clinical conditions, mood, behavior, and physical functioning. The MDS assessment is conducted for every resident, regardless of payor source, within 14 days of their entrance to a nursing facility and is repeated periodically (generally every 90 days or upon significant improvement or decline in condition) during the duration of a resident's nursing facility stay to determine whether care needs have changed and whether there is a need to revise the care plan.¹⁰

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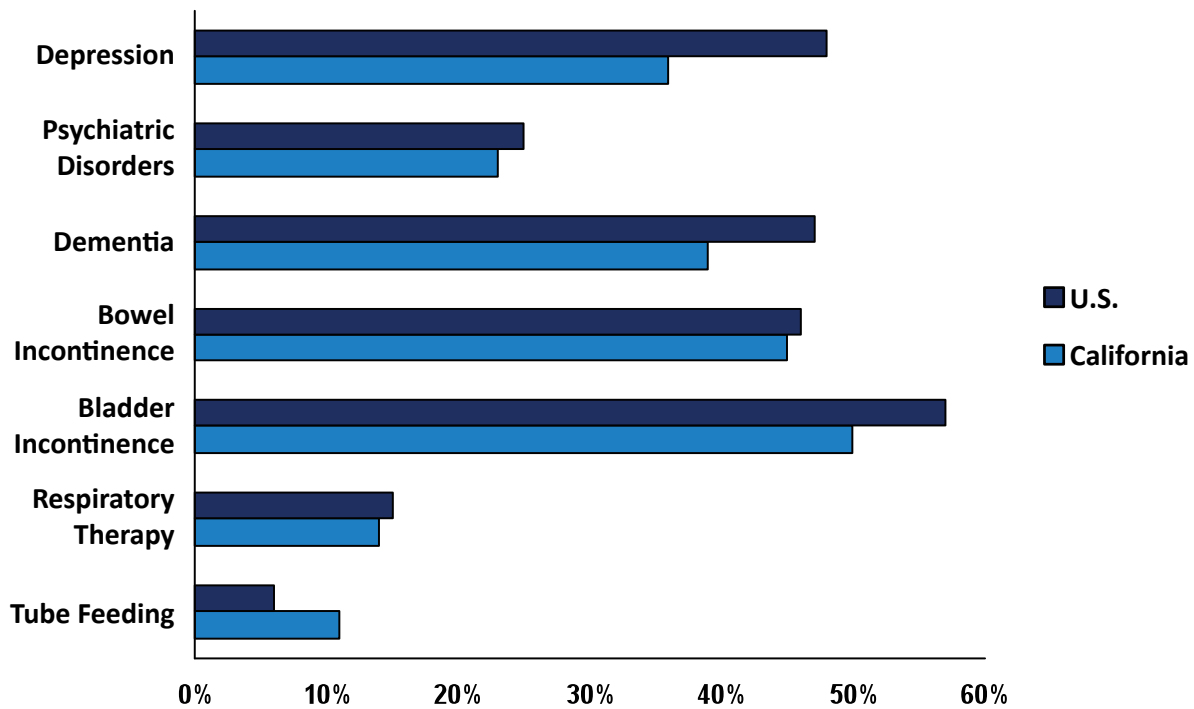
Characteristics of California Nursing Facility Residents

In September 2011, 102,591 individuals, or about 7 percent of the resident population in certified nursing facilities nationally, resided in California facilities.¹¹ Over 80 percent are age 65 or older and 64 percent are female.¹² Looking at California nursing facility residents by race, 65 percent are White, 11 percent are Black, 9 percent are Asian/Pacific Islanders, 1 percent are native American, and 16 percent are of other races. In addition, 16 percent of residents are of Hispanic ethnicity.¹² Almost 12 percent of residents are non-English speaking, compared to just over 3 percent nationally.¹¹ The average length of stay in a California nursing facility is less than three months for 80 percent of the residents discharged during the year, and less than 10 percent of residents remained in a nursing facility for one year or more.¹³ California nursing facility residents come from a variety of settings including their private homes, hospitals, and other locations, such as residential care facilities or board and care homes.¹⁴ Of the 300,000 nursing facility admissions annually, about 90 percent are directly from hospitals.^{13,15,16}

Nursing facility residents have a range of health and supportive service needs. For example, 39 percent of California nursing facility residents have dementia,

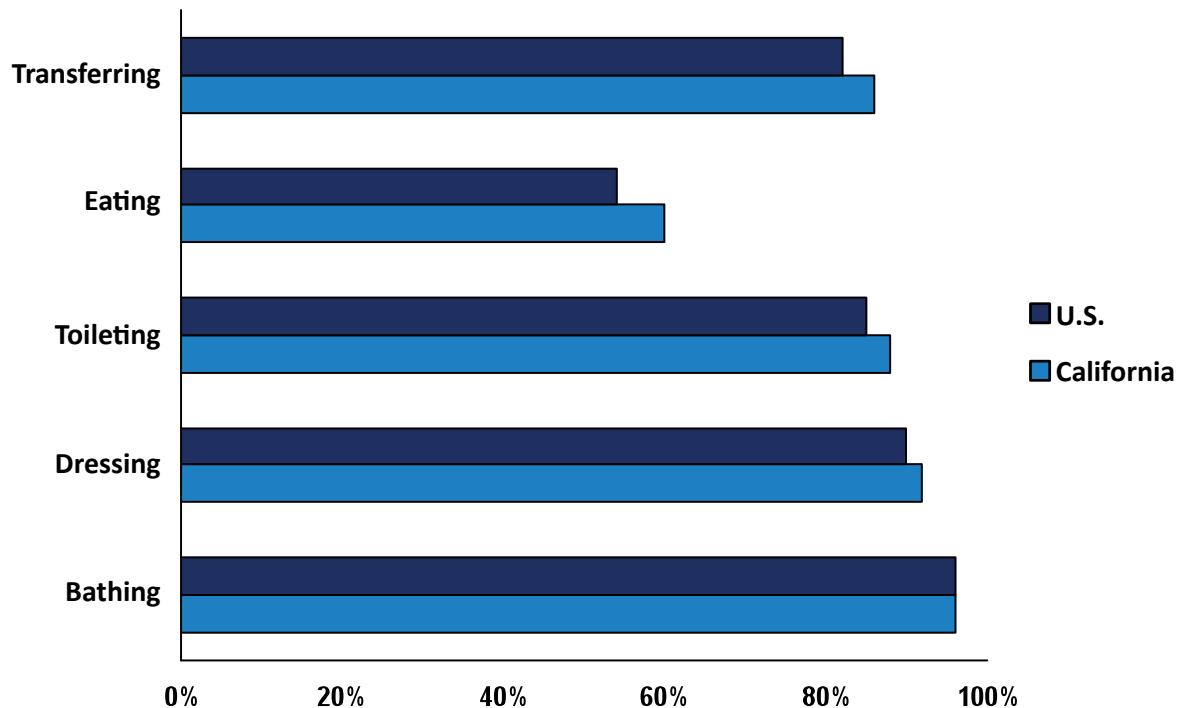
23 percent have psychiatric disorders such as schizophrenia and mood disorders, and 36 percent have depression (See Figure 1).¹¹ In addition, residents of California nursing facilities require tube feeding (11 percent), respiratory therapy (14 percent), and assistance with bladder and bowel incontinence (50 percent and 45 percent, respectively). The majority of residents require some level of assistance with activities of daily living, including bathing (96 percent); dressing (92 percent); toileting (88 percent); eating (60 percent); and transferring such as to/from the bed, chair, wheelchair or to/from a standing position (86 percent) (See Figure 2).¹¹ Almost 5 percent of residents are bedfast and about 56 percent are chairbound.^{7,17} It is estimated that almost 11 percent of California nursing facility residents have low care needs that could be met by services provided in their homes and communities. In comparison, the percentage across states ranged from about 1 percent to about 25 percent.¹⁸

FIGURE 1 Percentage of Nursing Facility Residents Requiring Assistance with Selected Medical Conditions in California and the U.S., September 2011



Source: LTC Stats: Nursing Facility Patient Characteristics Report, American Health Care Association, September 2011.

FIGURE 2 Percentage of Nursing Facility Residents Requiring Assistance with Selected Activities of Daily Living in California and the U.S., September 2011



Source: LTC Stats: Nursing Facility Patient Characteristics Report, American Health Care Association, September 2011.

Nursing Facility Workforce

Nursing facilities employ professional, paraprofessional, and supportive staff. Both federal and state laws specify requirements for certain nursing facility staff that facilities must abide by to remain in operation.

Federal Requirements

Every certified nursing facility is required to designate an administrator to oversee facility operations and ensure that employees are providing the highest quality of care to residents. An administrator is required to hold at least a bachelor's degree, pass a licensing examination, complete a state-approved training program, and pursue continuing education.¹⁹ Due to the medical nature of some of the services provided, nursing facilities are also required to have medically-trained professionals on staff, including physicians; physical, occupational and speech therapists; mental health providers; pharmacists; dietitians; and dentists.²⁰ Federal requirements specify that these individuals must be licensed, registered, or certified by the appropriate entities to be permitted to provide care to nursing facility residents. Nursing facilities are also required to designate a physician as medical director to be responsible for the implementation of resident care policies and the coordination of medical care in the facility.²¹

In addition, nursing facilities are required to employ nursing staff “to maintain the highest levels of physical, mental, and psychosocial well being of residents.”²¹ Nursing staff comprise the largest component of the nursing facility workforce.²² Required nursing staff consists of registered nurses (RNs), licensed practical nurses/ licensed vocational nurses (LPNs/LVNs) and certified nursing assistants (CNAs). There is no specific staffing ratio required by federal law,

but federal law does specify that a facility must provide these staff in sufficient numbers on a 24-hour basis to provide nursing care in accordance with resident care needs.^{21,23}

- **RNs** - manage the nursing care needs of residents and perform complex medical procedures. RNs must have at least a two-year degree and be licensed by the state. Federal regulations require nursing facilities to have a registered nurse on duty eight consecutive hours per day, seven days a week. Federal law requires that an RN be designated as a facility's Director of Nursing to oversee and coordinate the activities and duties of nursing staff.²⁰ For nursing facilities with less than 60 residents, the Director of Nursing can also provide direct resident care.²⁴
- **LPNs/LVNs** - provide routine bedside care, such as taking vital signs. LPNs/LVNs must have at least a 1-year degree and be licensed by the state.²⁰ In addition to the required RN, federal regulations require nursing facilities to have an additional licensed nurse on duty for 24 hours per day, seven days a week.²⁴
- **CNAs** - work under the direction of licensed nurses and are responsible for activities such as assisting residents with eating, bathing, and toileting. CNAs generally have more contact with residents than other staff and provide the greatest number of hours of care per resident per day.²⁰ CNAs that work in California nursing facilities must have at least 160 hours of training and have passed a competency exam.²⁵

State Requirements

In addition to federal requirements, nursing facilities in California are subject to state staffing requirements, which in some instances are more stringent than federal requirements. State requirements focus primarily on nursing staff and

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specify the types of staff that must provide continuous coverage in a facility depending on the number of beds it contains.²⁴

- Facilities with 1-59 licensed beds—must have an RN or LPN/LVN on duty 24 hours per day.
- Facilities with 60-99 licensed beds—must have a Director of Nursing on duty during the day and an RN or LVN on duty 24 hours per day.
- Facilities with 100 or more beds—must have a Director of Nursing and an RN on duty for 24 hours per day.

State requirements also specify that nursing staff must provide a total of 3.2 hours of care per resident per day.²⁶ As of September 2011, nursing staff in certified California facilities provided an average of 3.96 hours of care per resident per day, higher than the national average of 3.6 hours per resident per day and higher than the state requirement. The majority of these hours (2.63 hours per resident per day) were provided by aide staff.²⁷ Nursing staff turnover has been a major issue for nursing facilities, given its potential impacts on the quality of care provided to residents. The annual rate of turnover among nursing staff in California is almost 41 percent, compared to about 50 percent nationally.¹⁸

Nursing Facility Oversight

Nursing facilities must be both *licensed* to operate by the appropriate state agency and *certified* at the federal and state levels to receive Medicare and/or Medicaid reimbursement for services provided. In California, the Department of Public Health’s Licensing and Certification Division (L&C) maintains responsibility for the licensure of nursing facilities, ensuring compliance with both state laws and regulations. With regard to licensure, L&C requires a nursing facility to undergo annual inspections and pay a licensure fee, which for the 2011-12 fiscal year was \$297.14 per bed.²⁸ Licensure in California is governed by the California Code of Regulations (Title 22, Division 5 Chapter 3).²⁹ L&C will issue citations if a facility is found non-compliant with state regulations. Citations are classified according to their severity, with Class AA being the most severe. Class AA citations are for violations that are of direct proximate relationship to a resident’s death. Class A citations are for violations resulting in residents facing either an imminent danger of death, serious harm, or a substantial probability that death or serious harm could result. Class B citations are for violations that have a direct or immediate relationship to the health, safety, or security of nursing facility residents.³³

Once a nursing facility is state-licensed, it can be certified to receive Medicare and Medicaid payments. Nursing facility certification is a shared responsibility of the federal government and states. The Centers for Medicare and Medicaid Services (CMS) defines the federal standards that facilities must comply with as a condition of participation in the Medicare and Medicaid programs. These standards are described in the Code of Federal Regulations (42 CFR 483). State agencies, in contract with CMS, conduct the periodic, on-site “standard surveys” of nursing facilities on which the determination to certify a facility is based. In addition to its responsibilities for licensure, L&C maintains responsibility for conducting

standard surveys in the state.^{29,30} Either CMS or the California Department of Health Care Services—California’s state Medicaid agency—determines certification, depending on whether the facility is state-operated and/or whether it participates in Medicare and/or the Medicaid programs (See Table 1).³¹ About three percent of nursing facilities in California are certified for Medicare only and about six percent are certified for Medicaid only. Approximately 90 percent of facilities are dually certified for both Medicare and Medicaid.²⁷ L&C also investigates complaints, as needed, by residents of certified facilities, their families, and others related to the quality of care delivered by a facility.

TABLE 1 Certifying Entity, by Type of Facility

Type of Facility	The Department of Health Care Services (DHCS)	Centers for Medicare and Medicaid Services (CMS)
State-Operated Facility		X
Non-State Operated Medicare-Participating Facility		X
Non-State Operated Medicaid-Participating Facility	X	
Non-State Operated Dually Participating Facility	X	X

Source: Centers for Medicare and Medicaid Services, Certification & Compliance: Nursing Homes.

During a standard survey, a team of surveyors assesses a facility’s performance on about 200 federal measures related to a number of areas of care including assessment and care plans, quality of care provided for specific needs, staffing, and disaster preparedness. Teams consist primarily of registered nurses and life safety code surveyors, but can also include other professionals such

as pharmacists, nutritionists, physical and occupational therapists, and infection control experts. Standard surveys are performed unannounced and include the inspection of all areas of the nursing facility, medical records, and other data; direct observations of resident care; and interviews with residents, family members, staff and/or other individuals. Standard surveys

are comprehensive and can last for several days. L&C is required to inspect nursing facilities at least once every 9 to 15.9 months. The statewide average is once every 12 months, and more frequently for poor performing facilities. In some instances, L&C will conduct the standard survey and assessment for licensure concurrently, though where state requirements are more stringent than federal requirements for certification, state requirements will be enforced. Complaint investigations consist of a more targeted review related to a specific allegation filed against a facility.²⁹

Deficiencies identified during standard surveys are cited according to their category, scope and severity. For standard surveys, deficiency categories include Residents Rights, Resident Behavior and Facility Practices, Quality of Life, Resident Assessment, and Quality of Care. The severity of a deficiency can range from those actions that have the potential for minimal harm to those that pose immediate jeopardy to resident health and safety. The scope of a deficiency is defined by the number of residents potentially or actually affected by the deficiency and can be classified as isolated, pattern, or widespread. A nursing facility is determined to be in substantial compliance with federal standards if it is found to be free of deficiencies or when all deficiencies cited have the *potential* for minimal harm and are isolated, pattern, or widespread.³² Substandard quality of care deficiencies are those that:

- fall under the categories of Resident Behavior and Facility Practices, Quality of Care and Quality of Life;
- are determined to cause minimal harm, actual harm, or immediate jeopardy; and
- depending on severity, are either isolated, pattern, or widespread in scope.³²

In 2010, about seven percent of certified nursing facilities, nationally, had substandard quality of care deficiencies based on federal standards. Additionally, about 23 percent of facilities received actual harm or immediate jeopardy citations in any deficiency category in 2010.¹⁷ In California, over three percent of certified facilities that year had substandard facility violations. About 11 percent of certified California nursing facilities received actual harm or immediate jeopardy citations that year.¹⁷ Based on state requirements, California issued 1,452 citations, deficiencies, and enforcement actions to nursing facilities in fiscal year 2009-10. Forty percent of these were directly related to resident health, safety, and security. About nine percent were either potentially or directly related to serious harm or death of a resident.³³

While L&C is the primary oversight entity, there are several other agencies providing oversight and inspections of nursing facilities, including: Medi-Cal Audits & Investigations, the Office of the Attorney General (including the Operation Guardians Program), Disability Rights, local law enforcement, and the Office of Statewide Health Planning and Development. In addition to federal and state agencies, the California State Long-Term Care Ombudsman Program provides some nursing facility oversight. The Ombudsman program is authorized by the federal Older Americans Act, as well as the state's Older Californian's Act to advocate for the rights of seniors age 60 and older that reside in long-term care facilities, including nursing facilities. One of the functions of the Ombudsman program is to investigate and endeavor to resolve complaints made by or on behalf of older adult residents related to issues including quality of care and abuse. Other services provided by the Ombudsman program include attendance at resident care planning meetings and witnessing the development of

advance directives. Ombudsman programs exist across all 58 counties within the state and are largely supported by volunteers.³⁴

Quality of Nursing Facilities

Nursing facility quality is evaluated using measures derived from the data that nursing facilities collect through the MDS assessment process. Quality measures are related to the management of care provided to both short-stay and long-stay residents and include elements such as whether residents have received flu shots, are in pain, are losing weight, or are increasingly depressed or anxious. The performance of California nursing facilities on quality measures relative to the nation is provided in Appendix 1. California performed better than national averages on certain measures, including the percentage of long-stay residents whose need for help with daily activities has increased (10 percent vs. 14 percent nationally) and the percentage of long-stay residents whose ability to move in and about their own room got worse (9 percent vs. 11 percent nationally). California performed worse than national averages on certain measures, including the percentage of long-stay residents who were physically restrained (5.1 percent vs. 2.6 percent nationally), and the percentage of low-risk long-stay residents who lose control of their bowels or bladder (58 percent vs. 51 percent).³⁵

“As of September 2011, there were 1,233 nursing facilities located across California, 91 percent of which were free-standing and the remaining 9 percent were hospital-based.”

To help consumers and their families compare the quality of nursing facilities, CMS developed the Five Star Quality Rating System, which takes into account facility performance on MDS quality measures, performance on standard surveys, and staffing levels. Each facility is given a star rating of 1 to 5 on each of these three aspects, as well as its performance overall. Nursing facilities with five stars are considered to provide higher than average quality care and facilities with one star are considered to provide care that is well below average. For nursing facilities nationwide, these quality ratings are maintained on CMS’ Nursing Home Compare website (www.Medicare.gov/NHCompare/Home.asp).³⁶ For California-specific facilities, this information is also maintained on the CalQualityCare.org website (www.CalQualityCare.org).³⁷

Distribution and Capacity of Nursing Facilities in California

As of September 2011, there were 1,233 nursing facilities located across California, 91 percent of which were free-standing and the remaining 9 percent were hospital-based (compared to about 94 percent free-standing and about 6 percent hospital-based nursing facilities, nationally).²⁷ Approximately 81 percent of facilities in California are for-profit, while 15 percent

are non-profit and about 3 percent are government-owned. In comparison, about 68 percent of facilities nationally are for profit, while about 25 percent are non-profit and almost 6 percent are government-owned. Additionally, 51 percent of nursing facilities in California are part of multi-facility chains (compared to about 54 percent nationally).²⁷

There were 120,715 beds located in California's nursing facilities and the number of beds per facility ranges from 6 to 765.^{2,27} About 98 percent of these beds are located in urban areas, compared to about 75 percent, nationally.¹⁵ Considering the distribution of certified nursing facility beds across the population of older adults, there are 28 beds per 1,000 seniors age 65 and older in California, compared to about 42 beds per 1,000 seniors, nationwide.^{27,38}

Figure 3 shows the number of certified beds per 1,000 seniors in California by county in 2011. During this year, Tulare and Modoc Counties each had 43 beds per 1,000 seniors, the highest of all counties and slightly higher than the nationwide average. Trinity, Siskyou, and Mariposa Counties had less than 10 beds per 1,000 seniors, with Mariposa County having 4 beds per 1,000 seniors, the least of all counties.^{38,39}

From 2001 to 2011, California saw declines in the number of nursing facilities, beds, and nursing facility

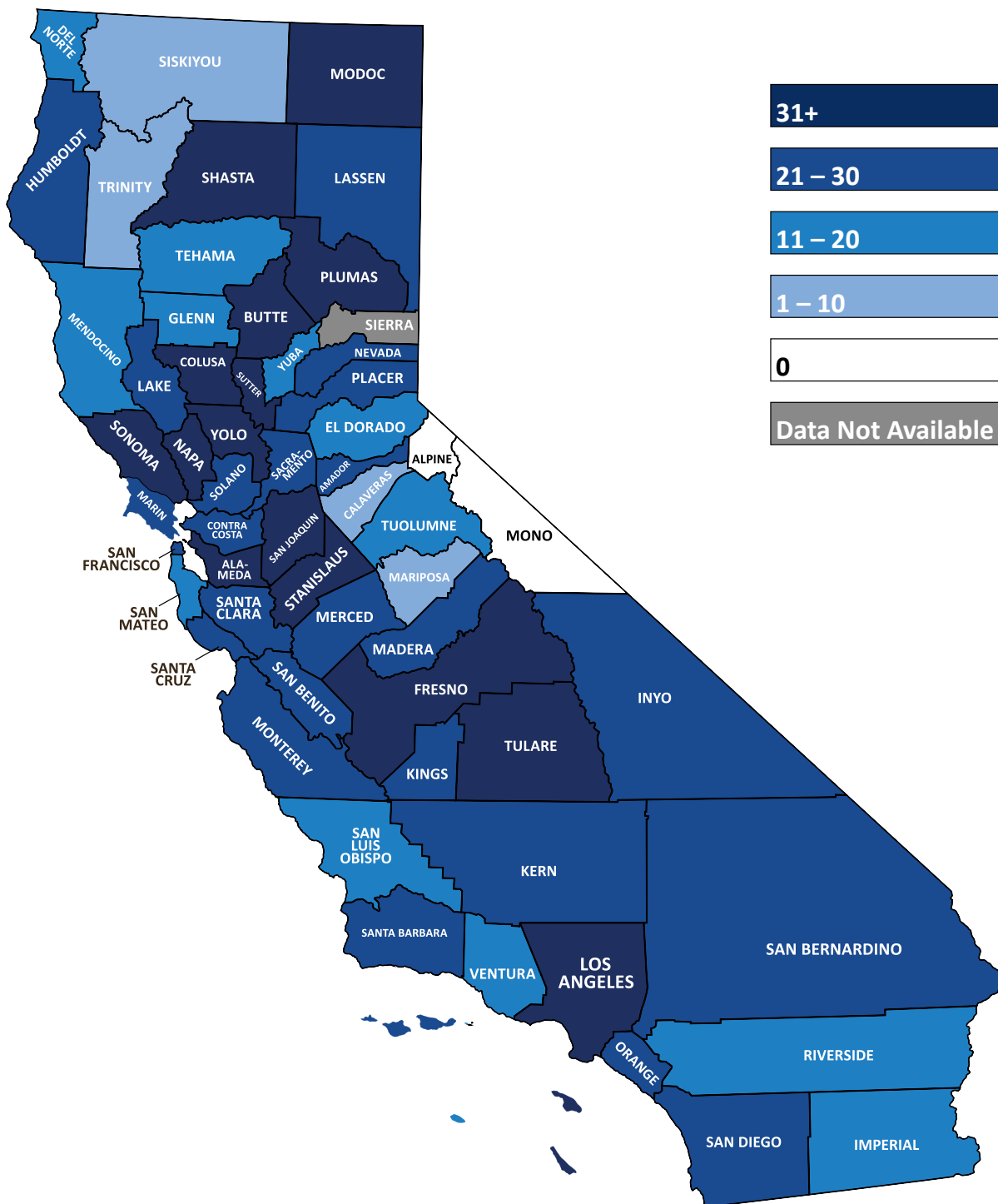
residents. During this period, the number of facilities in California declined by about eight percent, slightly larger than the decline observed nationally (five percent). The total number of nursing facility beds declined in California and across the U.S. by about 12 percent and 6 percent, respectively, though the number of certified beds in both areas declined by 2 percent. The number of nursing facility residents in certified beds declined by almost three percent in California and five percent nationally.^{27,41} Average occupancy rates per facility are about 85 percent in California and about 83 percent nationally.²⁷

Cost & Financing

In 2011, the median annual cost of care in a California nursing facility was almost \$78,000 for a semi-private room and over \$91,000 for a private room. In comparison, the median annual cost of care in a nursing facility, nationally, was about \$70,000 for a semi-private room and about \$78,000 for a private room during that same period.⁴² The cost of nursing facility care is financed through a variety of sources (See Figure 4). Medicare and Medicaid are the primary public funders of these services and reimburse facilities at specific rates for the care they provide to beneficiaries. Other sources of financing include long-term care insurance and personal income and assets.⁴³ In 2010, California nursing facility revenues equaled more than \$8 billion.⁴⁴

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FIGURE 3 Number of Certified Nursing Facility Beds per 1,000 Seniors Age 65 and Older in California by County, 2011



Source: The SCAN Foundation’s analysis of the number of certified nursing facility beds by California county from the Center for Medicare and Medicaid Services’ Nursing Home Compare website as of November 2011 and county population data from the U.S. Census Bureau’s 2010 Summary File: Age and Sex.

“In 2010, Medicaid accounted for about 49 percent of California nursing facility revenues.”

Medicare, specifically Part A, covers beneficiary costs for up to 100 days of skilled care in a benefit period if it is required following a hospital stay of at least three days and an individual is admitted to a nursing facility within 30 days of discharge from the hospital. A Medicare beneficiary can have an unlimited number of skilled nursing benefit periods as long as they qualify (e.g., have a hospital stay of at least three days, etc.).^{8‡} During the first 20 days, Medicare covers the full cost of care. During days 21 through 100, the beneficiary is required to pay a copayment, which in 2011 was \$141.50 per day.⁴⁵ Some beneficiaries have Medicare supplemental insurance that helps them pay for these copayments as long as Medicare is providing some coverage for the services.⁴³ In addition, Medicare Advantage plans provide coverage for nursing facility care if medically necessary.⁴⁶ Care needs beyond the 100-day limit are financed through other means. In 2010, Medicare accounted for about 33 percent of California nursing facility revenues.⁴⁴

Medicaid covers the costs of both skilled and long-term care provided in a nursing facility for individuals with low income and assets. The coverage of nursing

facility care is an entitlement under federal Medicaid law, meaning that coverage for these services must be provided to anyone who satisfies financial and clinical eligibility standards.⁴³ In addition, Medicaid supplements Medicare coverage of these services for individuals eligible for both the Medicare and Medicaid programs (“dual eligibles”). Payment for dual eligibles is covered under Medicare Savings Programs, with the level of support varying by an individual’s level of income and assets.²⁷ In 2010, Medicaid accounted for about 49 percent of California nursing facility revenues.⁴⁴

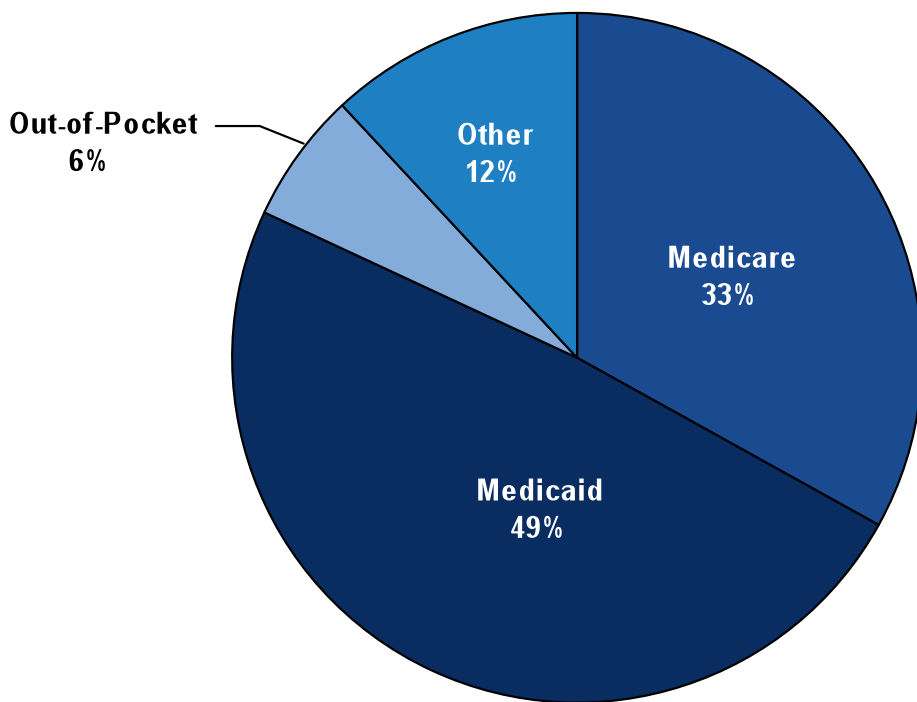
For individuals who have exceeded the limits of their skilled benefit coverage under Medicare and those who are not eligible for Medicaid, nursing facility services can be financed through private sources, including one’s personal resources as well as private long-term care insurance (LTCI). Private long-term care insurance policies generally cover both skilled and custodial care provided in a nursing facility. LTCI policies typically require a monthly premium based on the individual’s age and health condition when purchased. Payments begin only after a waiting period or when the company considers that the care

[‡] For nursing facility coverage, a benefit period begins on the first day a resident enters the facility and ends when either of the two events occurs: a) when the resident leaves a nursing facility and has not received this care for 60 days in a row; or b) when a resident currently in a nursing facility has not received skilled care for at least 60 days in a row. Once the 100 days of Medicare covered nursing facility care have been used, the current benefit period must end before nursing facility coverage under Medicare can be renewed. There is no limit on the number of benefit periods an individual can have, however, each one must be preceded by a 3-day hospitalization and the individual must continue to meet Medicare eligibility requirements.

is needed according to the particular rules set out in each policy.^{47,48} Some individuals will use their income and assets to finance their care. This can include drawing on savings, cashing out a life insurance policy, or using annuities.⁴⁷ After these funds are exhausted, many of these individuals become eligible for and finance their care through Medicaid.⁴³ In 2010, median annual nursing facility costs for a “private pay” resident as a percentage of median household income for individuals 65 and older ranged from

166 percent to 444 percent across states and 224 percent in California specifically.¹⁸ In addition to out-of-pocket spending and LTCI, other sources of financing for nursing facility care include managed care insurance plans, as well as other third party, state, and local programs. In 2010, out-of-pocket payments accounted for about 6 percent of California nursing facility revenues, while other payers accounted for about 12 percent.⁴⁴

FIGURE 4 California Nursing Facility Financing, by Payer, 2010



Source: Office of Statewide Health Planning and Development, State of California. LTC Facilities Annual Financial Pivot Profile, FYE Jan 1 2010 to Dec 31 2010. Revenues represent those for freestanding nursing facilities only and equaled \$8.14 billion in 2010. The “Other” category includes payors such as managed care and private health insurance.

Federal and State Policy Related to Nursing Facilities

The current framework for nursing facility operations in California has been driven by policy both at the state and federal levels. One of the most important pieces of federal legislation related to nursing facilities is the Omnibus Reconciliation Act of 1987 (OBRA 87), which was responsible for revamping the oversight of these facilities and addressing major quality concerns. OBRA 87 and subsequent federal regulation changed nursing facility operations in a number of ways. It defined specific resident rights that included freedom from abuse, mistreatment, and neglect and the ability to voice grievances without fear of discrimination or reprisal. The Act also created a uniform certification process for Medicare and Medicaid participating facilities with more stringent standards than were previously used, as well as an enforcement system for poor-performing facilities. In addition, OBRA 87 instituted a standardized assessment tool—the Minimum Data Set—for use across nursing facilities in order to develop individualized care plans for residents, provide data to evaluate quality of care provided to residents, determine case-mix reimbursement rates for Medicare-funded skilled nursing stays, and determine reimbursement for services provided to Medicaid beneficiaries in some states.[§] The law also upgraded staffing requirements for nursing facilities.⁴⁹ Nursing facility operations as described throughout this brief reflect the improvements made as a result of OBRA 87.

In October 2010, CMS implemented a new version of the Minimum Data Set – MDS 3.0 – designed to improve the reliability, accuracy, and

usefulness of the tool and include resident input into the care planning process. A key component of MDS 3.0 is the revised “section Q,” which elicits whether a resident would like to receive care in their home or community versus remaining in the nursing facility. If a resident expresses an interest in transitioning from a nursing facility to the community, the facility is required to refer them to a designated local state agency to provide the resident with information and options to return to the community.⁵⁰

State-level policy over the years has addressed nursing facility operations, including deficiencies in the Department of Public Health’s oversight of these facilities as mentioned earlier in this brief. One of the more recent state policies related to nursing facilities is AB1629 (Frommer, Chapter 875, Statutes of 2004), the intent of which was to increase access to quality care for Medi-Cal beneficiaries, ensure a stable nursing facility workforce, increase provider compliance with state and federal requirements, and improve administrative efficiency. AB 1629 aimed to accomplish this by establishing a system in which freestanding nursing facilities are reimbursed by Medi-Cal for the actual cost of care provided to beneficiaries. Prior to AB 1629, these facilities were paid a flat rate per Medi-Cal resident, depending on the size of the facility and its geographic location. This rate was less than actual care costs and provided little incentive to provide quality care to these individuals. AB 1629 also permitted the state’s Department of Health Care Services to collect a quality assurance fee from each facility to generate funds to support the revised reimbursement methodology.⁵¹ Under AB 1629, the quality assurance fees collected were to be used to provide increased reimbursements to facilities, as well as increase the amount of

[§]Some states have adopted case-mix reimbursement methodologies based on the Minimum Data Set. California is not one of those states.

federal dollars that flow to the state, given that state Medicaid programs are reimbursed by the federal government for the costs of care provided to beneficiaries.

AB 1629, originally scheduled to expire in July 2008 was reauthorized several times, most recently in 2010 to expire in July of 2012. The reauthorization of the legislation included additional mechanisms to provide the state with a greater ability to provide incentives and enforce penalties related to the quality of care provided in nursing facilities. It allows the Department of Health Care Services to assess financial penalties for non-payment of quality assurance fees and also to use these fees to provide facilities with incentive payments for performance on specific quality indicators. These indicators will be drawn from MDS quality measures, quality measures required by Patient Protection and Affordable Care Act (ACA), and other measures required by the Department of Health Care Services. The provisions of the law are scheduled to be fully implemented by 2013.^{22,52} As part of his budget proposal for 2012-13 released on January 5, 2012, the governor proposed to permanently extend the rate methodology and nursing facility fee initially established by AB 1629.⁵³

In March 2011, the California Legislature approved a 10 percent payment reduction in Medi-Cal rates to nursing facility providers (\$471 million over a 14-month period) expected to become effective (retroactively) for services provided from June 1, 2011 through July 31, 2012.⁵⁴ The governor's proposed budget for 2012-13 includes funding to restore the 10 percent provider rate reduction and also includes supplemental payments) for nursing facilities.⁵³

Additionally, CMS released a final rule in August 2011 announcing an 11 percent reduction to Medicare reimbursements to nursing facilities for FY 2012 equal to about \$3.87 billion in order to better align Medicare reimbursements with costs. These cuts could potentially have a negative impact on the quality of care provided in these facilities.⁵⁵

Future Policy Opportunities for Nursing Facilities

Federal and state policy has done much to improve nursing facility operations, but there is still more to be done. New federal opportunities look to further the progress made to date. The ACA requires a number of changes to improve the quality of care and the transparency of information provided by nursing facilities, including the development of a quality assurance and improvement program for these facilities, additional requirements for the reporting of staffing information and expenditures, and requirements for dementia and abuse prevention training.^{||}

In addition to the ACA, other opportunities include the reauthorization of the Older American Act (OAA), the federal law that funds State LTC Ombudsman programs, as well as other services to older adults provided through the aging network. In fiscal year 2011, over \$21 million of the almost \$2 billion appropriated to OAA programs was for programs to protect vulnerable older Americans (Title VII), which includes the Ombudsman program.⁵⁶ The OAA expired at the end of FY 2011 and is up for reauthorization. In its budget request, the Department of Health and Human Services requested an additional \$5 million for the

^{||} For additional detail on these provisions, see Policy Brief No. 2: A Summary of the Patient Protection and Affordable Care Act (P.L. 111-148) and Modifications by the Health Care and Education Reconciliation Act of 2010 (H.R. 4872), produced by The SCAN Foundation at: http://www.thescanfoundation.org/sites/default/files/PolicyBrief_2.pdf.

“The challenge facing policymakers in California and at the federal level will be to ensure that all individuals have access to quality long-term care services in the setting of their choice.”

Ombudsman program for FY 2012. In addition to increased funding, it proposed an expansion of eligibility for Ombudsman services to formally include individuals under the age of 60 years. Appropriation requests for OAA are currently making their way through the federal budget process.⁵⁷

Conclusion

Nursing facilities play a significant role in the continuum of care for seniors and people with disabilities. They serve as both rehabilitation providers for many and supportive care providers for some of the most vulnerable individuals. Although

services are costly to public and private payers, nursing facilities draw down a substantial amount of federal funding and are major employers in their communities. Future growth of the aging population and the projected need for long-term services and supports mean that nursing facilities will likely continue as a source of long-term care, even though challenges in care quality remain despite federal and state improvement efforts. The challenge facing policymakers in California and at the federal level will be to ensure that all individuals have access to quality long-term care services in the setting of their choice.

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APPENDIX 1 Nursing Facility Performance on Selected MDS Quality Measures for California & US, 2011

Measure	California Average	U.S. Average
Long-Stay Residents		
Percent of long-stay residents who have moderate to severe pain	4%	3%
Percent of high-risk long-stay residents who have pressure sores	12%	10%
Percent of low-risk long-stay residents who have pressure sores	2%	2%
Percent of long-stay residents who were physically restrained	5.1%	2.6%
Percent of long-stay residents who are more depressed or anxious	9%	15%
Percent of long-stay residents who lose too much weight	7%	8%
Percentage of long-stay residents whose need for help with daily activities has increased	10%	14%
Percent of long-stay residents whose ability to move in and about their own room got worse	9%	11%
Percent of long-stay residents who have/had a catheter inserted and left in their bladder	4%	5%
Percent of long-stay residents with urinary tract infection	8%	9%
Percent of low-risk long-stay residents who lose control of their bowels or bladder	58%	51%
Percent of long-stay residents who spend most of their time in bed or in a chair	5%	4%
Percent of long-stay residents given influenza vaccination during the flu season	88%	92%
Percent of long-stay residents who were assessed and given pneumococcal vaccination	87%	90%

Short-Stay Residents		
Percent of short-stay residents with delirium	1%	1%
Percent of short-stay residents who had moderate to severe pain	22%	19%
Percent of short-stay residents with pressure sores	17%	12%
Percent of short-stay residents who were assessed and given pneumococcal vaccination	82%	85%
Percent of short-stay residents given influenza vaccination during the flu season	82%	84%

Source: Centers for Medicare and Medicaid Services, Nursing Home Compare, 2011.

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