

California's Nursing Homes: A System in Trouble

July 2003

Background

Nursing homes fill a vital role in our society—caring for an increasingly frail population, especially for the indigent. About 98,000 mostly elderly Californians are cared for in more than 1,100 freestanding skilled nursing facilities (SNFs) at any given time. And demand for skilled nursing services will increase as baby boomers approach retirement age. California's age 65-and-over population is expected to grow by nearly 140 percent between 2000 and 2030. The state's 85+ population, which increased 42 percent from 1990 to 2000, will more than double by 2030 to more than 1 million residents.

California's \$5.2 billion nursing home industry is at a critical juncture. Revenue sources are being squeezed, costs are rising, and the quality of care is under scrutiny. Medi-Cal accounts for two-thirds of all nursing home patient days and more than half of all facility revenues. (In all, about 75 percent of SNF revenues are from government sources.) However, the state budget deficit has created immense pressure for cuts in the Medi-Cal rates paid to nursing facilities just as the federal government is cutting back on Medicare.

At the same time, the costs of providing adequate skilled nursing care are rising ahead of inflation, due in part to escalating costs of nursing salaries

and wages, employee benefits, temporary nurse staffing costs, liability insurance, and workers compensation insurance. A flat rate, prospective payment system for long-term care, introduced by the federal government in 1997 for Medicare and employed by the state of California for more than 15 years for Medi-Cal, has limited providers' ability to recoup these increased costs. Medi-Cal's prospective payment system also provides no incentive for capital investment or new construction of facilities.

These trends are fueling concerns over the quality of care across the industry. Poor quality care in California's nursing homes has been a persistent problem, according to a 1998 report by the U.S. General Accounting Office. They found that nearly one in three nursing homes in California had been cited by state inspectors for having "serious or potentially life-threatening care problems." California nursing homes had twice as many reported deficiencies in 1998 as the U.S. average.¹

This study seeks to provide an objective assessment of the financial performance of the skilled nursing industry in California and highlights some critical public policy issues confronting industry leaders, policymakers, and patient advocates.

Methodology

The study was conducted by Shattuck Hammond Partners for the California HealthCare Foundation. It focused on the performance of California freestanding skilled nursing facilities for the five-year period from 1997 to 2001, the most recent years for which data were available. Financial and operating data were primarily drawn from the California Office of Statewide Health Planning and Development's (OSHPD) Long-Term Care Facility Annual Financial Data files.²

The OSHPD data are based on mandatory annual cost and utilization reports filed by all skilled nursing, intermediate care, and congregate living health facilities licensed by the California Department of Health Services (DHS). Hospital-based skilled nursing units as well as intermediate care and congregate living facilities were excluded from analysis for this report. The OSHPD facility-level data files are available for five separate annual periods, from 1997 to 2001.

Data from four other sources have been matched to the OSHPD financial files:

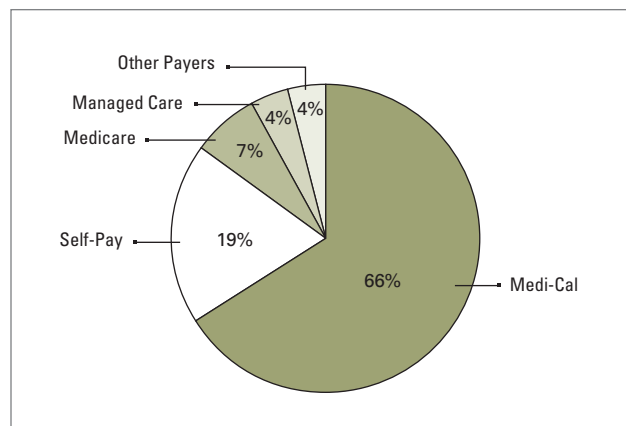
1. Mandatory annual utilization reports filed by all skilled nursing, intermediate care, and congregate living health facilities licensed by DHS.³
2. U.S. census data on the population, age distribution, and rural/urban status of each facility's county in 2000.⁴
3. Data from Shattuck Hammond's survey of the ownership and chain status of individual facilities. Based on OSHPD data, each facility was classified as for-profit or not-for-profit, and as a member of a national for-profit chain, other for-profit chain, or an independent facility.

4. Data on the Consumer Price Index from the U.S. Bureau of Labor Statistics used to convert all dollar amounts to constant year 2001 dollars.

Major Findings

Despite efforts by the state to promote long-term care insurance, the industry continues to rely heavily upon government as the principal payer (see Figure 1). This payer has made for a volatile financial and regulatory environment. Nursing home operators have faced a pattern of incremental rate increases (to cover at least part of the cost of government-mandated services), followed by deep rate cuts, depending on the vagaries of state and federal budgeting.

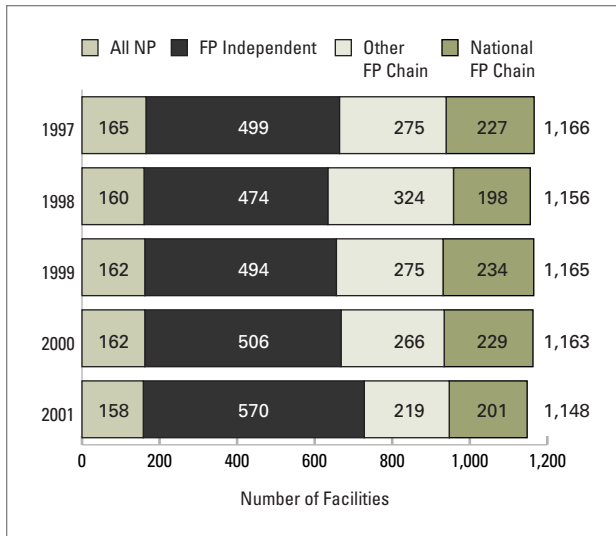
Figure 1. Payer Mix, 2001



Although the total number of facilities in the state has remained relatively constant, the patterns of facility ownership shifted between 1997 and 2001. The number of national and regional chain-affiliated facilities dropped significantly, from 43 percent of the total in 1997 to 37 percent of all facilities in 2001. Independent for-profits grew from 43 percent to nearly 50 percent of the total. Not-for-profits declined modestly in number. As of the end of 2001, more than 85 percent of freestanding SNF homes (and 90 percent of all beds) in

the state belonged to for-profit facilities (Figure 2). Due to inadequate reimbursement and rising liability risks, however, the larger for-profit operators may be exiting the California market. A growing number of not-for-profit providers, also under financial pressure, are likely to follow suit, and seek other ways of serving their communities.

Figure 2. California SNF Ownership Trends



In addition, today’s nursing home residents are far frailer, sicker, and more costly to care for than they were when the industry emerged in the 1960s and 1970s. With the advent of the Medicare prospective payment system in 1983, hospitals sought to discharge Medicare patients to lower-cost settings, including nursing homes, as soon as possible. Today the shift in the average acuity of nursing home residents continues, particularly as healthier (and often private pay) residents have been drawn away from the nursing home market to alternative care settings.

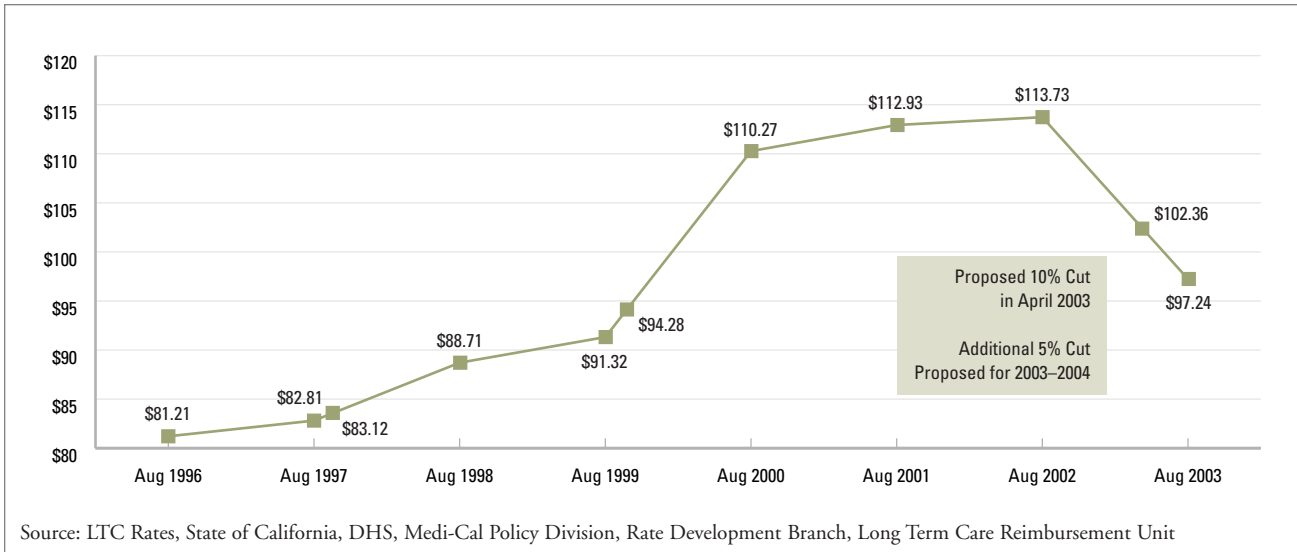
Revenue

Reflecting the volatile nature of the business, the five-year period studied was marked by ups and downs in

revenue. Medicare reimbursement, which historically helped subsidize state-controlled Medi-Cal rates, fell sharply from 1998 to 2000 (22 percent after adjusting for inflation), due to the effects of the Balanced Budget Act of 1997. Subsequent Medicare relief acts produced a modest 4 percent increase in Medicare revenue for 2001. However, these restored payments included sunset provisions, effective October 2002. They became known as the “Medicare cliff.” Congress did not extend these provisions when it adjourned in the fall of 2002, and additional sunset provisions scheduled for October 2003 will result in further cuts unless the federal government acts to extend these add-ons. Against this changing backdrop:

- National for-profit chain facilities rely to a greater extent on Medicare patients than do other facilities, though the lower paying Medi-Cal program is by far the biggest payer of services for the industry. However, not-for-profit facilities have a much lower proportion of Medi-Cal residents (less than 46 percent of patient days compared to 68 percent for the for-profits).
- The number of self-pay patient days, which generate significantly higher per-day revenue than Medi-Cal, declined more than 12 percent from 1997 to 2001, due in part to increased competition from assisted living facilities, home care, and other senior care alternatives.
- Net revenue from Medi-Cal rose 23 percent per patient day, adjusted for inflation, from 1997 to 2001, due in part to a sizable rate increase effective August 2000. This helped mitigate the loss of Medicare and self-pay revenue, but proposed rate cuts for 2003 could roll back almost 90 percent of the increase received since 1999 (see Figure 3).

Figure 3. Average Medi-Cal Reimbursement Rates for Freestanding Nursing Facilities



Overall, California nursing home providers have experienced an 8.8 percent increase in net patient revenue per patient day, adjusted for inflation, from 1997 to 2001. All ownership categories with the exception of the national for-profit chains (which already earned the highest revenue per patient day) experienced net revenue growth for the five-year period (see Figure 4).

Expenses

Total operating expenses for the industry rose a relatively modest 7.5 percent, adjusted for inflation, from 1997 to 2001. However, individual cost components grew far more dramatically. Routine patient care expenses, including all nursing services, as well as consultation and evaluation services, increased by 29 percent. These increases more than offset a dramatic reduction in ancillary services expense, and now account for more than 42 percent of nursing home costs (see Figure 5).

Figure 4. Operating Revenue per Patient Day by Ownership Type

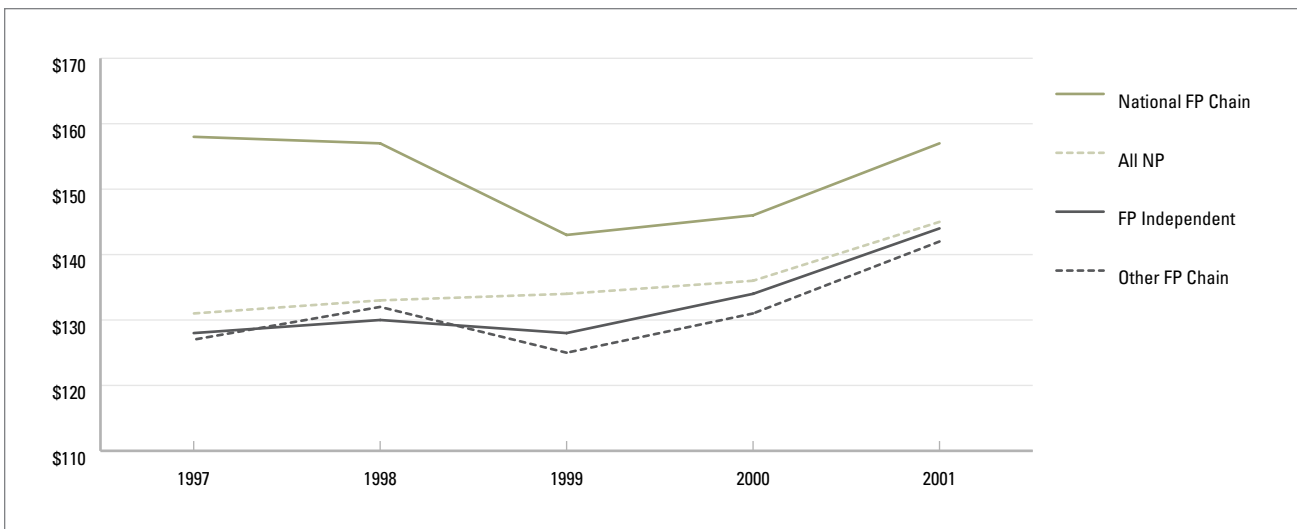
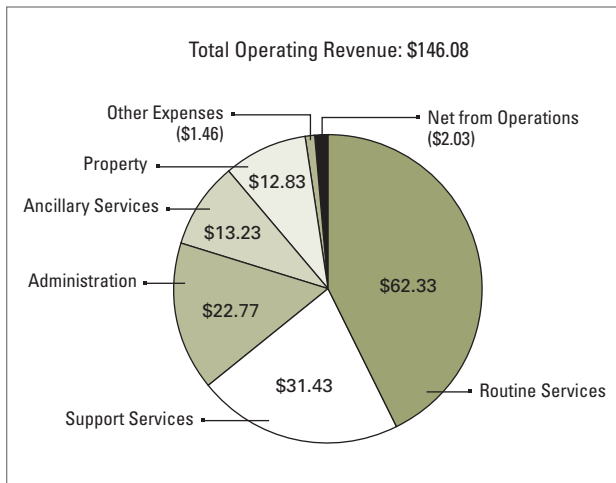


Figure 5. Average Revenue and Expenses per Patient Day, 2001



In addition the study found:

- Salary and wage expenses, representing nearly half of total operating costs, rose 17 percent over the period, adjusted for inflation, driven by 36 percent increases in the costs of both LVNs and CNAs. Temporary staff costs rose six-fold during the period, and at an average of \$1.21 per patient day in 2001, consumed more than one-quarter of the average facility's net income for the year.
- Not-for-profit facilities have had the highest costs per patient day, with total expenses for these facilities rising 10.1 percent adjusted for inflation since 1997. National for-profit chain facilities, with a higher mix of Medicare patients (who tend to be sicker), had the second-highest costs for the period. However, as a group they were most adept at reducing ancillary costs, and have reduced their overall operating expenses by 1 percent since 1997.
- Administrative costs rose more than 17 percent over the period, due in part to the increased cost of general and professional liability insurance. Annual premiums have risen from roughly \$300

per bed in 1999 to \$1,350 per bed for 2002–2003, according to one industry report, and are expected to reach \$3,000 per bed by 2006 in the absence of legal reforms. In addition, workers' compensation insurance expense per patient day has shown dramatic swings over the five-year period, dropping 15 percent from 1997 to 1998 and then jumping 12 percent in 2000, followed by a 23 percent increase in 2001.

Margins

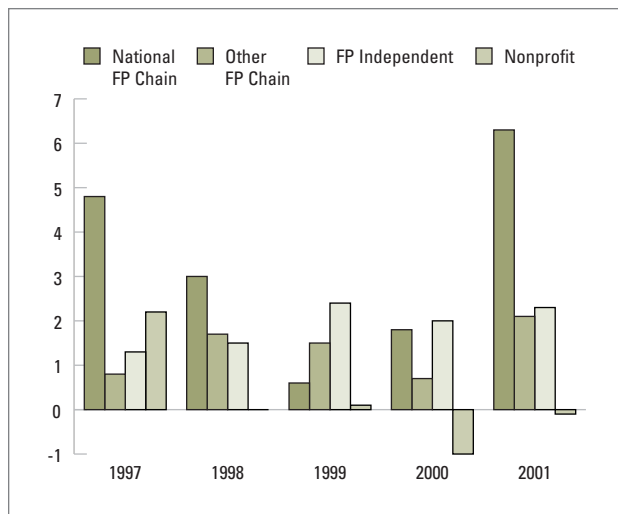
A first look at an income statement for the industry, comparing operating revenue to expenses, might suggest reasons for optimism. As Table 1 shows, net income per patient day increased significantly from 2000 to 2001, thanks to a \$10.11 increase in operating revenue per patient day versus an increase of only \$7.36 in operating expenses. As a result, after three years of declines, average margins rose to nearly three percent in 2001. However, looking only at average performance misses much of the picture. As shown in Figure 6, the different ownership types varied widely in performance. In fact, the study found that 34 percent of all facilities in the state had negative margins in 2001, including 51 percent of nonprofits.

While all the for-profit groups improved their margins, on average, during the five-year period, not-for-profits' margins have declined, with net losses in both 2000 and 2001. Not-for-profit facilities typically relied upon donations and endowment funds to subsidize their operations. Alarmingly, their non-health revenue, including charitable contributions, dropped 27 percent in 2000. The following year, not-for-profits as a group reduced their net loss, thanks to a partial recovery in charitable contributions and improved reimbursement rates.

Table 1. Per Patient Day Revenue, Expenses and Net Income (Constant Year 2001 Dollars)

	1997	1998	1999	2000	2001	% Change
Total Operating Revenue	\$134.25	\$136.33	\$131.37	\$135.98	\$146.09	8.8%
Medicare	31.78	31.68	24.07	23.77	26.86	- 15.5%
Medi-Cal	59.61	60.79	63.66	67.89	75.32	26.3%
Self-Pay	29.32	28.56	28.69	27.96	27.49	- 6.3%
Other Payer	13.01	14.81	14.39	15.78	15.84	21.8%
Other Operating Revenue	0.53	0.49	0.56	0.57	0.58	9.4%
Operating Expenses	133.96	136.80	131.65	136.70	144.06	7.5%
Net from Operations	0.29	- 0.47	- 0.28	- 0.72	2.03	589.8%
Nonhealth Revenues minus Expenses, Income Taxes, and Extraordinary Items	2.48	2.59	2.18	2.57	2.24	- 9.5%
Net Income	\$2.77	\$2.12	\$1.90	\$1.85	\$4.27	54.1%

Figure 6. Total Margin Trends by Ownership Type



Given the high proportion of facilities with negative margins, it is surprising that more facilities have not closed. Certainly these findings help explain why so many facilities have changed hands in recent years, and why the operators of national and regional chain-affiliated facilities appear to be pulling away from the California market.

Proposed budget cuts would be a further blow to the industry. The authors' analysis, based on 2001 OSHPD data, suggests that:

- If each facility's reported 2001 Medicare net patient revenue were reduced by 10 percent to reflect the impact of the Medicare provisions that expired in October 2002, and if Medi-Cal net revenue were reduced by 15 percent to reflect the originally proposed rate cuts for 2003, average margins for the industry would drop from the 2001 figure of +2.9 percent to -7.4 percent.
- The proportion of all facilities with a negative total margin would jump from 34 percent to more than 72 percent.
- If operating expenses continue to grow at the rate they increased from 2000 to 2001 (7.7 percent before adjusting for inflation), 97 percent of all facilities would lose money.

Conclusions and Implications

Unquestionably, the California skilled nursing industry is in a financially fragile state. Dramatic and sometimes sudden changes in Medicare and Medi-Cal payment levels impede facility operators' ability to provide high-quality care. If the Governor's 2003 proposed budget cuts are implemented, and the financial cushion once afforded by higher Medicare payments is not restored, the historic shortfall between allowable costs and Medi-Cal reimbursement rates (reported at \$180 million for California SNFs in 2000) will loom large.

Given these uncertainties, policymakers, SNF operators, and patient advocates face a number of policy questions. These include:

How can the skilled nursing industry be insulated from the extreme volatility of recent years? History suggests that public monies will always be insufficient to pay for the state or federal government's own definition of quality care. This suggests that public policymakers should develop funding streams that combine third-party and private resources with available public funds. Proposals for mandatory long-term care insurance and limitations on transfers of wealth by those seeking nursing home care are ripe for public debate.

Who will pay for the subacute and long-term care services that will be required by our growing elderly population? It appears that the federal government is losing its appetite for subsidizing Medicaid/Medi-Cal's long-term care programs with Medicare funds. And, in any case, perpetuating a system in which one program relies on cross-subsidies from another can only serve to delay a lasting solution. On the one hand, California seems committed to paying adequate rates for the care of Medi-Cal residents. On the other hand, it is difficult

to see how the state can fulfill this commitment in the face of the current budget crisis and the competing demands of other social programs for limited state resources.

Who will operate nursing care facilities in the future?

Trends suggest that the larger, better capitalized national and regional operators are beginning to leave the state, and are being replaced by smaller providers, who may lack resources to weather the ongoing volatility of the industry. Not-for-profit owners represent only a small and modestly declining percentage of industry capacity, and the mission for many of these facilities is to serve their own religious or ethnic communities rather than the Medi-Cal population at large.

What kind of payment system should Medi-Cal or other governmental payers use to reimburse nursing homes for the care they provide? Would replacement of California's flat-rate reimbursement system provide better incentives to meet public policy objectives? Under state law, DHS is required to develop and implement by August 2004 a facility-specific Medi-Cal rate-setting system that "reflects the costs and staffing levels associated with quality of care for residents in nursing facilities." As the state and other industry constituents work toward a new reimbursement model, they should consider a few key principles suggested by this study. A new reimbursement system should include:

- Incentives for capital investment and new construction to replace aging physical plants and accommodate design innovations in elderly care.
- Incentives for new construction in underserved markets.

- A mechanism that insulates facilities from extreme reimbursement swings caused by budgetary and economic cycles.
- A reporting mechanism that accurately tracks the costs of providing care to Medi-Cal residents, and rates, either prospectively or retrospectively set, that adequately cover the costs of quality care.
- A means for private and third-party payments to be used in combination with publicly funded reimbursement.

Some have questioned whether there will be a place for traditional nursing homes in the future. Indeed a few states, most notably Oregon, have banned construction of new nursing homes and moved instead to promote development of assisted living facilities and other care alternatives. But given the high occupancy of today's homes, the higher acuity of California nursing home residents, and the general aging of the population, there seems little doubt that a strong network of skilled nursing facilities will be needed. However, Californians should not take for granted that these facilities will always be available. A clear understanding of the finances, utilization, and operations of California's nursing homes can help policymakers ensure that quality facilities are here for those who need them.

ENDNOTES

1. U.S. General Accounting Office. *California Nursing Homes: Care Problems Still Persist Despite Federal and State Oversight*. GAO-HEHS-98-202. Washington, D.C.:GAO 1998.
2. California Office of Statewide Health Planning and Development, Long-Term Care Facilities Financial Data Archive (<http://www.oshpd.cahwnet.gov/HQAD/HIRC/ltc/finance/archive/index.htm>).
3. California Office of Statewide Health Planning and Development, Long-Term Care Facilities Utilization Data Archive (<http://www.oshpd.cahwnet.gov/HQAD/HIRC/ltc/util/archive/index.htm>).
4. U.S. Census Bureau, State and County *QuickFacts* (<http://quickfacts.census.gov/qfd/states/06000.html>).