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Health Services
LOS ANGELES COUNTY

December 20, 2022

313 N. Figueroa Street, Suite 912
Los Angeles, CA 90012

Tel: (213) 288-8050
Fax: (213) 481-0503

www.dhs.lacounty.gov

"To advance the health of our patients and our communities by providing extraordinary care"

TO: Supervisor Janice K. Hahn, Chair
Supervisor Hilda L. Solis
Supervisor Holly J. Mitchell
Supervisor Lindsey P. Horvath
Supervisor Kathryn Barger

FROM: Christina R. Ghaly, M.D.
Director

SUBJECT: **EVALUATING OPPORTUNITIES OF DISTINCT PART SKILLED NURSING FACILITIES (ITEM NO. 19 FROM THE OCTOBER 18, 2022 BOARD MEETING)**

This report back responds to an October 18, 2022 motion by Supervisors Kathryn Barger and Janice Hahn directing the Department of Health Services, in consultation with the Department of Mental Health, the Alliance for Health Integration, the Chief Executive Officer and County Counsel, to explore the feasibility of establishing distinct part skilled nursing facilities (DP/NFs) in Los Angeles County (LA County) and report back to the Board in writing in 60 days on their findings, including, but not limited to evaluating:

1. Best practices of DP/NFs operated by other California counties;
2. Projected patient population that could be served in these facilities;
3. Financial projections to operate a DP/NF, as well as state and federal funding streams and reimbursement structures to support these facilities;
4. Legal and regulatory limitations to operating DP/NFs; and,
5. Space and bed requirements to effectively establish a DP/NF, as well as county and non-county property options for housing these programs.

Executive Summary

The LA County Department of Health Services (DHS), in consultation with the Department of Mental Health (DMH), has begun evaluating whether it is cost-effective for LA County to open and operate a Distinct Part, or free-standing, Nursing Facility (DP/NF or SNF, respectively) compared to DMH operating an Institution for Mental Disease (IMD) alone. Key information that would allow DHS to present a complete analysis to the Board is pending a report from the State Department of Health Care Services (DHCS) on new DP/NF and SNF payment methodologies. Here, DHS provides a status update on other

important aspects of the analysis.

DHS preliminarily modeled costs of $90-180 million for constructing a 128-bed DP/NF on the site of a DHS hospital campus. DHS chose a facility of that size because DMH already has an active proposal 128-bed capital project at LAC+USC Medical Center (LAC+USC MC) with substantial information readily available that could facilitate the financial analysis and modeling for this project. If LA County were to move forward with a DP/NF in the future, additional work would be required to determine the ideal facility size. DHS estimated approximately that such a facility would have approximately $81 million in annual operating expenses, including staffing, facilities, and other operating costs. Medi-Cal revenues that might cover these costs are dependent on a report that DHCS is preparing for LA County on new payment methodologies for long-term care. Those methodologies vary by county, necessitating a unique report for LA County. Identifying an ideal mix of payers, short-stay vs. long-stay patients, and diagnoses will also be important factors in the revenue analysis in the next report.

To learn more about nursing facility best practices, DHS and DMH contacted hospital systems in Alameda, San Diego, San Mateo, and Riverside counties. Appendix A describes key takeaways from those conversations. The most relevant points are: (a) a DP/NF or SNF function best with their own specialized staff, management, billing department, and discharge unit; (b) a Medi-Cal only population, at least under the current reimbursement structure, is not sustainable – patients with other payors are important to cross subsidize Medi-Cal ones; (c) in one county's experience the current reimbursement structure is sustainable, their facility is utilized as a placement of last resort for clients with dual-diagnoses including physical and psychiatric conditions; and (d) while county-controlled DP/NFs and SNFs can be helpful in managing patient flow, logjams still occur.

Upon receipt of the DHCS report, DHS will revise its analysis to include revenues and refined patient population assumptions, make assessments compared to current options available, assess cost impacts to DMH and DHS, and provide its conclusions in a subsequent report back to the Board.

Background

LA eCounty is interested in exploring a DMH-DHS collaboration to meet a joint need to find medically appropriate places to discharge people from hospitals when they no longer need hospital (*i.e.*, acute) care, including more Medi-Cal supported placements for individuals suffering from mental illness. Patients who require nursing facility services are very sick yet require less intense care than patients needing acute hospital services. They may require such care for short periods of time, while recuperating from illnesses or medical procedures, or for long periods of time – even years. Across California, a shortage of private nursing facility beds has led to a bottleneck; patients who are not well enough to be discharged into the community, but who no longer need acute care, get stuck in hospital beds. Certain patients eligible for nursing facility placement, like those who suffer from mental illness or are at a high-risk due to other comorbidities (*e.g.*, those with substance use disorders or experiencing housing instability), are especially hard to place.

DHS and DMH primarily serve patients with health insurance coverage through Medi-Cal or who have no insurance. DHS does not own or operate any DP/NFs or SNFs; when it can find space, it places Medi-Cal managed care patients in SNFs operated in the community, paid for by Medi-Cal health plans (*e.g.*, Local Initiative Health Authority of Los Angeles County and Health Net, LLC). The way in which Medi-Cal managed care pays for skilled nursing care is undergoing significant changes that vary by county starting in 2023. DHS' uninsured population has fewer options – they stay in DHS hospitals until another placement is found or until they are ready for discharge.

For its part, DMH contracts with SNFs to provide nursing facility level care to patients who suffer from mental illness. Those SNFs are designated as IMDs. An IMD is a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and related services. Whether an institution is an IMD is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such. If the government designates a DP/NF or SNF as an IMD, none of the patients receiving care there will be eligible for Medi-Cal reimbursement.

In cooperation with DMH, DHS investigated the use of DP/NFs and SNFs for two key populations: one with substantial long-term physical health care needs, and the other for those with physical health needs who also require mental health care

Cost Analysis

DHS looked at three capital cost scenarios, direct patient costs, and overhead to develop a financial model. DHS preliminarily modeled costs of $90-180 million for constructing a 128-bed DP/NF located on a DHS hospital campus. DHS estimated such a facility would have approximately $81 million in annual operating expenses, including staffing, facilities, and other operating costs. DHS will need to further refine these preliminary estimates.

Capital costs

DHS has developed three preliminary estimates of capital costs for a potential 128-bed DP/NF at a DHS hospital campus to illustrate a range of options: (1) costs based on rehabilitating an existing building (2) a theoretical model for cost for new construction, and (3) a real-world estimate of cost for construction of a DP/NF-like project.

(1) Rehabilitation: In 2018, DHS engaged a construction cost management firm (O'Halloran Associates) to develop a conceptual cost model and a construction estimate for the development of a DP/NF in a vacant acute care building at Rancho Los Amigos National Rehabilitation Center (Rancho Los Amigos). The consultant's report projected that the cost to rehabilitate Building 900 (77,900 square feet) to create 100 DP/NF beds would be approximately $53 million, including all hard and soft costs. Because of the project's overall cost, DHS did not pursue the project further. Building 900 was later demolished and a recuperative care center, including both DHS and DMH facilities, was built on a portion of the site. The estimate in the table

below was adjusted to size it from 100 to 128 beds and to account for Construction CPI through November 2022.

(2) Real-world, theoretical, new construction: this estimate is based on an architect's informal estimate of $900 per Gross Square Foot, plus assumptions on soft costs and contingency.

(3) Real-world, actual construction cost: In 2022, DMH proposed to construct a 128-bed Subacute Facility at LAC+USC MC by DMH (including parking garage). That project reflects current construction/capital costs and soft costs, is located on a DHS hospital campus, and is sufficiently similar to a DP/NF. Variations between the DMH and DP/NF models require further analyses.

Capital Cost Estimates, DHS DP/NF	
Basis of Estimate	**Potential Cost (rounded to nearest $10m)**
(1) Rancho Los Amigos Building 900 Rehabilitation Estimate, Adjusted for Inflation, Size	$90,000,000
(2) Architect's Estimate of SNF Construction Costs	$160,000,000
(3) DMH Subacute Facility Construction Costs at LAC+USC MC	$180,000,000

Operating and Overhead Costs

DHS and DMH developed a preliminary operating cost and staffing model for a 128-bed DP/NF, based on staffing guidelines published by the California Association of Long Term Care Medicine, which reflect State and Federal staffing requirements for DP/NFs certified for Medicare and Medi-Cal patients. Final staff numbers and costs will vary, based on the count of filled beds, final decisions on DP/NF programming and other operating assumptions. Based on the assumptions outlined above, such a facility may have approximately $81 million per year in annual operating expenses, including staffing, facilities and other operating costs. The mental health staff expenses were provided by DMH and the other operating costs estimates were provided by DHS in the preliminary model. Both DHS and DMH need to further refine expense estimates.

Operating cost estimates include:

Item	**Amount**
I. Physical Health Staff Expense (1)	$33,546,000
II. Facility Overhead Expense (2)	$3,761,000
III. Mental Health Staff Expense (3)	$6,099,000
IV. Facility Operating Expense (4)	$37,605,700
Total Annual Operating Cost Estimate	**$81,011,700**

1. Staffing estimate based on industry practice.

2. Facility Overhead estimate.
3. Based on fully loaded IMD Rate of $392 / Day / Bed, assuming 1/3 of costs related to mental health staffing.
4. Operating Costs based on FY 21-22 Actual Expense for MLK Recuperative Care Center, escalated for Bed Count and increased supply and pharmacy costs.

Revenue Analysis

Revenues for a nursing facility could come from multiple sources, such as Medi-Cal managed care plan reimbursement, DMH, and potentially other payers. Anticipating that Medi-Cal managed care may be the most important source of funds, it is critical to describe the planned changes for reimbursement structures slated for 2023, which will change structures that have been in place in LA County since 2014.

In 2014, the DHCS implemented the Coordinated Care Initiative (CCI) to improve coordination of medical, behavioral health, and long-term care services for dual eligibles (people eligible for Medicare and Medi-Cal), and to make other Long Term Care (LTC) integration changes in Medi-Cal. The CCI was rolled out in seven counties, including LA. At the same time, DHCS carved LTC services into Medi-Cal managed care for all Medi-Cal beneficiaries in CCI counties, not just dual eligibles, and mandated that people needing long-term care enroll in managed care to receive those benefits in those CCI counties. LTC services that were carved into managed care included nursing facility care, In-Home Supportive Services (IHSS), Community-Based Adult Services (CBAS), and the Multi-Purpose Senior Services Program (MSSP). IHSS was removed from plan responsibility as of January 1, 2018. In CCI counties, managed care plans received a separate rate for LTC services from the rest of the standard capitation rate for all other health services.

More recently, the state has been working to align delivery systems to reduce variation across counties; these changes are broad and sweeping, involving multiple aspects of the Medi-Cal program including long-term care, and are broadly branded as “CalAIM.” For long-term care specifically, starting in 2023 the structures imposed by the CCI will change (the CCI will “end”), and statewide all managed care plans will assume risk for long-term care, starting with SNFs in January, and expanding to other post-acute settings in July. Because these changes will be felt most significant in non-CCI counties where long-term care is newly carved into managed care, most of the state’s policies have been focused on those counties; the corollary impacts on CCI counties like LA is still being determined by DHCS. These policies are critical to understand as part of an assessment of whether to open a DP/NF in LA.

For example, under Medi-Cal FFS today (i.e., for non-CCI counties), public hospitals that operate DP/NFs are paid a base rate from DHCS according to a fee schedule, plus an additional self-financed supplemental payment up to cost. This system will need to be “migrated” to managed care when all plans take skilled nursing responsibility (including for DP/NFs on January 1, 2023). To accomplish this, DHCS will build into non-CCI plans’ rates a temporary, 3-year transitional payment for existing public hospital DP/NFs to ensure they continue to be paid up to cost by the managed care plan. The state will pay for the non-federal share of the entire payment instead of just for the base rate.

How these policies apply to DP/NFs in CCI counties, and for new DP/NFs that open after January 1, 2023, has not yet been fully determined by DHCS. We know that state law today says in CCI counties, that plans must pay providers at least their FFS rate. Whether this means up to cost for any new DP/NF that LA County may open in the future in still unclear. Lastly, DHCS has not determined, and may not for some time, whether or how the state would impose minimum payment requirements to skilled nursing facility networks after this 3-year transition.

In addition, now that LTC rates will be fully incorporated into the plans' base rates, the ceiling that limits various supplemental payments relative to the total rates could potentially increase. Accessing those additional opportunities is subject to the state's discretion and Centers for Medicare and Medicaid Services (CMS) approvals, making it highly uncertain whether those resources could be relied upon to support a DP/NF in LA County.

Given these uncertainties, LA County requested a report from DHCS that would explain the application of these new policies for our county. This report is essential to completing the cost-effectiveness analysis for opening a DP/NF.

Cost-Effectiveness

Upon receipt of the relevant revenue information, DHS will perform a cost-effectiveness analysis that examines the net expenses for a DP/NF, after accounting for Medi-Cal revenues, compared to that of IMDs. Because SNFs and DP/NFs are eligible for Medi-Cal reimbursement and IMDs are not, the net cost for a SNF/DP NF bed may be lower than that of an IMD bed, even if gross costs for a SNF/DP NF bed are higher. This could make a DP/NF a more cost-effective solution than an IMD alone.

Additional Analyses

DHS has also investigated: the best practices of nursing facilities operated by other California counties; legal and regulatory limitations to operating DP/NFs; and space and bed requirements to establish a DP/NF, along with county and non-County property options for housing these programs.

Nursing Facility Best Practices

To learn more about nursing facility best practices, DHS and DMH contacted hospital systems in Alameda, San Diego, San Mateo, and Riverside counties. Appendix A describes key takeaways from those conversations. The most relevant points are: (a) a DP/NF or SNF function best with their own specialized staff, management, billing department, and discharge unit; (b) a Medi-Cal only population, at least under the current reimbursement structure, is not sustainable – patients with other payors are important to cross subsidize Medi-Cal ones; (c) in one county's experience the current reimbursement structure is sustainable, their facility is utilized as a placement of last resort for clients with dual-diagnoses including physical and psychiatric conditions; and (d) while County-controlled DP/NFs and SNFs can be helpful in managing patient flow, logjams still occur.

DHS' financial model was also informed by these conversations:

- Alameda Health System operates several DP/NFs, but does not own any of their facilities (the largest facility is owned by Alameda County, which is a separate legal entity from Alameda Health System).
- San Diego County operates one DP/NF. It occupies the bottom two floors of its county-run acute psychiatric hospital and runs at a profit. Each of the clients admitted to the DP/SNF has both a physical and mental health co-morbidity so that the county may capture the higher rate of revenue (for the higher complexity clients).
- San Mateo County Health operates two DP/NFs. The smaller facility is located in an unused county hospital building and the larger facility was acquired at no cost, through a partnership with the State of California.
- Riverside University Health System operates a behavioral healthcare facility at its main hospital campus, but does not operate a DP/NF.

Legal and Regulatory Analysis

Both DHS and DMH have worked with County Counsel and outside counsel to investigate the legal and regulatory contours of DP/NFs and SNFs. Three residual issues require greater exploration: (a) a proposed facility housing mental health patients in need of skilled nursing care may be deemed an IMD – thus jeopardizing Medi-Cal funding; (b) a nursing facility may not accept a mentally disordered patient who has an "identified program need" unless the nursing facility is licensed to operate as a Special Treatment Program (STP); and (c) if DHS wishes to establish a DP/NF in a location that is not part of a hospital campus, it may be reclassified as a SNF. A description of the issues and their relevance follows:

(a) Institutions of Mental Disease

As noted previously, an IMD is a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and related services. Whether an institution is an IMD is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, *whether or not it is licensed as such*.

If the government designates a DP/NF or SNF as an IMD, the patients will be ineligible for Medi-Cal reimbursement. This could occur during an audit, if auditors determine that more than 50% of patients have a primary diagnosis based on mental health and the entire DP/NF or SNF is a de facto IMD. Therefore, LA County must ensure the facility is not "primarily" engaged in care for those with "mental diseases." At a minimum, that means that DHS would need to maintain a greater than 50% portion of patients whose primary diagnosis not based on mental health – as assessed by auditors looking at patients treated. LA County would need to monitor patient flows and other factors to ensure that less than 50% of beds are occupied by mental health patients.

(b) Designation as a Special Treatment Facility (STP)

For NFs to accept patients who have significant mental health needs (in legal terms, patients who have an "identified program need"), they must be licensed to operate as a STP. An STP has the ability to serve patients with chronic psychiatric impairment and whose adaptive functioning is moderately impaired. DMH reimburses STP services in a nursing facility, so these services will have a different reimbursement and claiming process than most other NF/DP/NF services. So long as an STP is not designated as an IMD, patients may also be eligible for some Medi-Cal reimbursement.

(c) Choosing a DP/NF Location

To be designated as a DP/NF, the facility must be listed on the hospital license. The requirement that a DP/NF sit in "close proximity" to the main building of a hospital is ambiguous; risks of instead being considered a SNF increase with distance from the main hospital. More importantly, the level of reimbursement may fluctuate depending on whether or not the facility is a DP/NF or a SNF. Applicable regulations explain that a DP/NF may comprise one or more buildings or designated parts of buildings (that is, wings, wards, or floors) that are: In the same physical area immediately adjacent to the institution's main buildings; other areas and structures that are not strictly contiguous with the main buildings but are located within close proximity to the main buildings; *and any other areas that CMS determines on an individual basis, to be part of the institution's campus.* One county DHS consulted with a licensed DP/NF located approximately 1.5 miles from the main hospital campus.

In searching for locations, the LA County needs to better understand which ones are most likely to qualify for hospital licensure, assuming that a DP/NF and not a SNF is the preferred approach.

Space and Bed Requirements; Property Options

As with attempting to assess costs, DHS used the DMH Subacute facility at the LAC+USC MC and assumed 128 beds for its model. It assumed that a newly built or rehabilitated structure on LA County property would be superior to an off-site location were the project to move forward. DHS met with its own Capital Projects division and estimated that, based on the space needs for a DP/NF, it would take a minimum of four to six years to have a new building open for service.

The requirements for space, and parking, would vary depending on the size of the facility, whether and where administrative offices were kept, and other key features. The size of the facility will partly depend on the reimbursement structure associated with different types of patients.

Next Steps

DHS' feasibility evaluation hinges on the State's new reimbursement approach. It is awaiting DHCS guidance within the next two months. The new guidance will provide greater detail on claiming and reimbursement, particularly for the Medi-Cal managed

care population. DHCS has communicated to DHS that it will be issuing unique information on how Medi-Cal reimbursements will work in LA County.

Once DHS receives DHCS information it will work with the state, DMH, and other LA County departments to conduct a financial analysis of whether a DP/NF or SNF would be cost effective. After fine tuning assumptions associated with our model, DHS will provide options for the Board to consider.

If you have any questions, you may contact me or your staff may contact Allan Wecker, Chief Financial Officer, at awecker@dhs.lacounty.gov.

CRG:aw

c: Chief Executive Office
County Counsel
Executive Office, Board of Supervisors

Appendix A

Nursing Facility Best Practices

- Because SNFs and DP/NFs are administered differently from hospitals, it is best to hire separate specialists to manage them (including medical directors, nurses, *etc*.).
- Nursing facility rehabilitation is distinct from hospital rehabilitation, and different teams are preferred.
- Billing and claiming are also different, and a separate billing staff can be useful.
- DP/NFs tend to be better resourced than freestanding SNFs because of their integration with hospitals.
- Under State law, placement into a DP/NF first requires attempts to secure a patient bed in a freestanding SNF. Integrating placement attempts and recordkeeping for patient screening is essential for annual audit and compliance reviews.
- One system had to build out a more robust electronic medical record system specific to its nursing facility needs, which may be necessary for DHS.
- In DP/NF and SNFs, many patients leave within a few days, others remain for months or years. To avoid bed blockages one county ensures that its intake allows for a mix of both types of patients. That keeps at least some beds available to aid in patient flow to lower levels of care.
- Building new facilities can lead to new logjams within months, because of demand for services and lack of additional lower level of care placements.
- During the pandemic, one county rented a SNF and staffed it with hospital nurses on contract. It concluded that the approach was inefficient.
- Another county said the way to sustain its facility and enhance cost-effectiveness was to hire a private operator.
- One county has found success with utilizing its DP/NF as a facility of last resort for clients with physical and mental health co-morbidities.
- Contractors who are heavily involved in managing operations should be integrated into meetings regarding the entire system.
- Counties also described the need for a payor mix that extended beyond Medi-Cal and the uninsured. Medicare and commercial insurance pay more – functioning to subsidize the indigent population.
- Several counties indicated that having control of lower level of care facilities did help manage hard to place populations – like undocumented people and those with behavioral health issues.
- A strong discharge team is essential in moving patients out of nursing facilities.

Health Services
LOS ANGELES COUNTY

January 18, 2024

313 N. Figueroa Street, Suite 912
Los Angeles, CA 90012

Tel: (213) 240-8050
Fax: (213) 481-0503

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TO: Supervisor Lindsey P. Horvath, Chair
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Supervisor Janice K. Hahn
Supervisor Kathryn Barger

FROM: Christina R. Ghaly, M.D.
Director

SUBJECT: **REPORT BACK NO. 2: EVALUATING NURSING FACILITIES OPPORTUNITIES STATUS UPDATE**

By motion approved by the Los Angeles County Board of Supervisors (BOS or Board), Supervisors Kathryn Barger and Janice Hahn directed the Los Angeles County Department of Health Services (DHS), in consultation with the Department of Mental Health (DMH), the Alliance for Health Integration, the Chief Executive Office, and County Counsel, to explore the feasibility of establishing distinct part skilled nursing facilities (DP/NFs) in Los Angeles County (County). The impetus for the BOS' motion was the long-term care (LTC) bed shortage in Los Angeles County for both physically and mentally ill patients. Due to the regulatory limitations associated with DP/NFs, the scope of the investigation expanded to encompass free-standing skilled nursing facilities (SNFs).

DHS drafted the first report, "Evaluating the Opportunities of Distinct Part Skilled Nursing Facilities," in consultation with DMH. That report provided the initial evaluation of whether it would be cost-effective for the County to open and operate a DP/NFs and SNFs (collectively, "Nursing Facilities") compared to DMH's operating an Institution for Mental Disease (IMD) alone. DHS modeled the costs of owning and operating a Nursing Facility on the site of a DHS campus and identified several factors impacting the ability to reliably model revenues. At the time the State of California was creating a new framework for LTC —including skilled nursing facility– with payment methodologies that would vary by county. The report highlighted the State Medicaid agency's intention to release L.A.-specific information separately.

This second report highlights the implications of new and proposed Medicaid policies to the County's approach to Nursing Facilities. The federal agency known as the Centers for Medicare and Medicare Services (CMS) is currently overhauling Medicaid financial and reporting regulations. To follow suit, the State of California's Department of Health Care Services (DHCS), which administers California's version of Medicaid (Medi-Cal), is working to harmonize its regulations with those changes. Both efforts are a work in

progress. The new policies, whether proposed or finalized, revolve around the appropriate roles of managed care plans and providers within Medicaid and how each is funded. They reinforce some of DHS' earlier conclusions and have profound ramifications for DHS both within and beyond the scope of skilled nursing care. Essentially, CMS and DHCS seem to be settling on the perspective that health plans should insure patients and coordinate services while providers should care for patients, with little latitude for either to parade on the other's turf.

I. Executive Summary

This report incorporates new information about pending managed care regulations and future financing opportunities into the feasibility and cost-effectiveness assessment. First, we conclude that the possibility of DHS' contracting with a third party to provide skilled nursing services is not feasible. Such an arrangement would increasingly make DHS' operations, which are all in-house, converge on that of a health insurance plan—operating through a network of contracted entities. If the State were to designate DHS as a health plan, it would impose new and significant regulatory and financial requirements such as State oversight into how revenues are spent, and fiscal stability controls. Such fiscal oversight could also result in DHS' foregoing existing payments, making DHS worse off than it is today. For these reasons, we advise against pursing a contracting arrangement for skilled nursing services.

We also examine the potential cost-effectiveness of a Nursing Facility that is owned and operated by DHS. We conclude that while it is possible to do further exploration, whether such an endeavor is financial feasibility is currently highly speculative. A cost-effective, county-owned Nursing Facility would need supplemental payments to be viable given meager Medi-Cal managed care base rates that have resulted in the existing supply shortage. However, the federal rules regarding supplemental payments are being called into question: a recent proposed rule by the federal Medicaid Agency (the Centers for Medicare & Medicaid Services or CMS) contemplates placing limits on directed payments out of concern for recent growth and total size of such programs. CMS would need to publish a final rule, and implementing guidance, for the County to better predict opportunities for supplemental Nursing Facility payments. Other state policy planning efforts could push the consideration or approval of such payments until sometime in 2026, when the state will be solidifying future of long-term care payment policy for the next iteration of federal Medicaid approvals slated to launch in 2027. We therefore conclude that it would be appropriate to continue to study the feasibility until there is better information about these major regulatory policies, and that moving forward with concrete plans to build a facility is not advisable at this time.

Finally, the path for DMH's Mental Health Plan (MHP) is more favorable. DMH has now contracted with approximately ten (10) third-party skilled nursing service providers in settings where the MHP can appropriate leverage federal dollars under Medi-Cal.

II. Two Scenarios

A. To Make or Buy Nursing Facilities

To provide skilled nursing care, the County could hypothetically pursue one (or both) of two strategies. Both assume a key shift in responsibilities. At present, health plans are financially

responsible for LTC and maintain a network of third-party Nursing Facilities in which to place their enrollees. In the new world, DHS would begin by contractually assuming the responsibility for providing skilled nursing services—at least for its own patients. From there it would need to develop new patient care sites using:

1. The Make Scenario: The County owns the facility and its employees or contractors provide medical and psychiatric on-site services to DHS and DMH patients; or

2. The Buy Scenario: The County contracts with a private third party to provide beds to county patients (from both DHS and DMH) at a negotiated rates.

DHS' first report focused on a financial model of the Make Scenario. Its approach not only allowed DHS and DMH to leverage existing information for an expedient report back, as will become clear, it accounted for myriad issues associated with outsourcing. Below we address both scenarios, revisiting costs, then illuminating key finance and regulatory issues.

III. Revisiting the Cost Models of Make v. Buy

1. The Make Scenario

In the first report back, DHS preliminarily modeled the cost of constructing a 128-bed DP/NF located on a DHS hospital campus at $90-180 million. The report emphasized that the size of the facility modeled was not an indicator of an optimal size, but rather an example for which there was readily available data. The broad range of capital costs reflects differences in approach. The cost of rehabilitating an existing building falls at the low end compared to new construction at the other extreme.

In addressing the operating costs for staffing Nursing Facilities in its first report, DHS found the costs to be much higher than that of the IMD baseline provided by DMH. DHS estimated nearly $80 million in annual operating expenses, including staffing, facilities, and other operating costs. The variations in staffing costs between IMDs and medically-focused NFs were attributable to differences in the level of medical care patients require. To be placed in a nursing facility a patient would ideally need intensive medical services (skilled nursing care). A patient in an IMD may not have similar medical needs. The staffing costs of the proposed facility—which offers some mental health care, and uniformly requires intensive medical care—will be higher due to being staffed by doctors and nurses in prescribed ratios as opposed to IMDs that, depending on need, may be staffed with mental health professionals such as social workers.

In addition, the DHS staffing model incorporated the use of County staff, with fully-loaded benefits and overhead. Those costs are generally higher than when using contracted-out services. For non-employee providers working at DHS facilities, staffing and operations could cost less, but the county would maintain the responsibility of contracting and quality oversight. DHS would need to determine the best approach for non-County employees to document services and how DHS would bill certain payors under its licensure.

2. The Buy Scenario

The cost of the Buy Scenario depends heavily on those market conditions that would incentivize a community provider to accept a Medi-Cal-insured patient over other higher reimbursing insurers like Medicare or commercial insurance. As the BOS emphasized, there is a bed shortage. That shortage is partly a consequence of Medi-Cal's relatively low reimbursement amounts. Therefore, a reasonable cost model would need to include not just the cost of displacing other patients, but also the cost of incentivizing new beds.

The Buy Scenario does not remove DHS from the picture entirely. DHS must exercise contracting and quality oversight of its third-party contractors. The precise cost of those functions would depend on negotiations with the third-party provider, the level of oversight required by DHS' health plan agreements, and the costs of County personnel.

Finally, costing out the Buy Scenario must incorporate a mental health component. A third-party serving Medicaid patients would be taking on a population with unique needs. Such care may require a premium payment whose structure would need to incorporate two features of mental health reimbursement. First, under Medi-Cal, DMH is the payor for specialty mental health care under the MHP. Therefore, DMH might need its own contract with the third-party provider for specialty mental health services. Second, recall that, if the third-party were found to be primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, it would be reclassified as an IMD and lose its ability to receive Medi-Cal reimbursement altogether if the facility were greater than sixteen (16) beds. These factors would likely contribute to additional costs that are difficult to estimate in advance.

IV. Key Financing and Regulatory Issues

Today the risks associated with skilled nursing services reside with managed care plans (MCPs) like L.A. Care, Health Net, and Molina. MCPs contract with DHCS to receive premium payments for all Medi-Cal Managed Care covered services. They use that money to insure their Medi-Cal populations through third-party skilled nursing contractors. MCPs pay their providers in one of two ways—*via* fee-for-service (FFS) or capitation. DHS receives payments primarily through capitation, an ongoing monthly payment that on average covers the costs of providing care to its patients. Providers, including DHS, only receive capitation payments for the services they are responsible for providing. DHS is not responsible for skilled nursing care, so it doesn't receive payment to do so. DHS refers patients who need skilled nursing care to the relevant health plan, which arranges and pays for care with a private nursing facility in its network. While there is some financial risk to DHS that patients will stay in the hospital longer than necessary awaiting placement, the risk is relatively small compared to that of accepting responsibility for the cost of providing adequate access to nursing facility care for DHS patients under the Make or Buy models. As insurers, MCPs bear the financial risk for overutilization or see profits for underutilization, as all insurers do. The MCPs are regulated as insurance companies. To mitigate risk, MCPs must be properly licensed by the California Department of Managed Health Care (DMHC) under the Knox Keene Act and, where applicable, the California Department of Insurance. MCPs must comply with a plethora of laws and regulations, including those ensuring their solvency.

DHS' assuming financial risk and operational responsibility for coordinating (in the case of the Buy Scenario) or directly providing (in the case of the Make Scenario) skilled nursing would constitute a tectonic shift in its overall risk profile, both in terms of cost and regulatory oversight responsibilities.

A. The Impact of Make v. Buy on the Medical Loss Ratio Calculation

The Medical Loss Ratio (MLR) is a feature of health insurance regulation under both federal and state law and factors into whether and how DHS should enter the nursing facility market. The MLR is the percentage of the total adjusted Medicaid premium payments that a health plan expends on medical care, quality improvement, and fraud detection (Non-Administrative Functions) as opposed to administrative functions. [1]

By law, health plans must use eighty-five percent (85%) of the funds they receive from the State for Non-Administrative Functions like direct patient care; only the remaining fifteen percent (15%) may be used to cover administrative costs associated with the plan itself.[2, 3] MCP's must calculate and report their MLR to the State annually. And when administrative expenditures exceed 15%, the funds must be paid to providers or returned to the State (with the federal portion remitted to the federal government).

The implications of the MLR for selecting among the Make or Buy Scenarios are dramatic—and weigh heavily in favor of Make. Providers are not subject to MLR limitations and reporting requirements when spending on administrative functions related to the direct provision of Medicaid services through their own employees (i.e., the Make Scenario); however, when providers start to act like health plans and subcontract services to *other* vendors for those same services (i.e., Buy Scenario), CMS and DHCS treat them like health plans and incorporate provider administrative costs into MCP MLRs.

DHS relies on both basic capitation payments and supplemental payments to support its patient care. If DHS assumes the financial risk for long term care and then contracts for skilled nursing facility services, rather than providing those services directly, it may lose money that the State wants to use to support public hospital provided skilled nursing services. To avoid the loss, DHS could either expend the supplemental payments to the contractors or remit the supplemental payments to the State. The latter option (remittance to the State) would be more appealing to DHS because DHS would be able to keep the non-federal portion of the Medicaid payments. The net effect would be a reduction in federal dollars to the County's nursing facility programs.

The State has yet to release final guidance on how to incorporate provider data into MLR reports, but it is actively addressing the issue. It is required to do so under the terms and conditions of the California Advancing & Innovating Medi-Cal (CalAIM) waiver. According to the State's

[1] 42 C.F.R. § 438.4(b)(1).

[2] Cal. Welf. & Inst. Code § 14197.2.

[3] 42 C.F.R. § 438.8(b).

workplan, MLR reporting in 2023, and with the implementation of subcontractors' remittances by 2025.

B. The Impact of Make v. Buy on the Potential Need for a Knox Keene License

The more DHS behaves like a health plan, the greater the possibility that the State will determine that it needs to be licensed as a health plan. While it would likely be faster for DHS to contract out nursing facility services than build new ones, DHS faces regulatory risks in doing so. Combining the assumption of financial risk for providing LTC to patients with an outsourcing strategy for the provision of patient care makes DHS look a lot like a plan. Already, DMHC has proposed regulations that treat entities that engage in those activities together as a plan. While those proposed regulations were revoked during COVID-19, it's not clear whether they will be re-introduced. *A licensure requirement for DHS would have ramifications for the entire DHS system not just LTC operations. For example, it would have to take on the administrative functions of a plan and, potentially, would be subject to new financial requirements.* Therefore, this issue too heavily favors DHS' directly providing skilled nursing care, if it determines to do so at all.

C. To Provide Skilled Nursing Care, DHS will Need to Renegotiate its MCP Contracts

To assume financial and operational risk for providing skilled nursing services to its patients, DHS will have to amend its health plan agreements. Exactly what responsibilities it accepts and how much money it receives to do so will be the subject of negotiation with each individual MCP. Both the federal government and State of California use actuaries to develop reimbursement rates for covered services. They do so based on a constellation of data and assumptions about costs and utilization. To that end, DHS would benefit from the input of actuaries knowledgeable about Medicaid's financial underpinnings. DHS has begun the process of procuring an actuary to aid in its research and, potentially, to assist with contracting.

DHS will also need to identify the types of delegated authority it needs to manage Nursing Facilities. For example, ordinarily, MCPs pay providers directly and process claims (similar to invoices) that providers submit to them. MCPs can delegate that right to others. If DHS decides on the Buy Scenario, it needs "claims processing" delegation from the health plan so it can pay third-party providers. In that sense, DHS would be wading into the role of a health plan or functioning as an administrative middleman to pay the direct care provider. If DHS elects the Make Scenario, it will not have to process claims because it will be providing the services directly.

1. DHS and the MCPs will need to review the Overall Division of Financial Responsibility

The portion of health plan-provider agreements that delineates who bears financial risk for the benefits covered by Medicaid is called the Division of Financial Responsibility (DOFR). In considering whether to accept LTC-associated financial risk, DHS will also need to ensure that the allocation of all the risks that it has taken on harmonize with its new responsibilities. It is possible that, in addition to LTC risk, DHS will have to take on others. DHS' managed care contracting team would work with each plan to determine what sets of responsibilities should be bundled together and reallocated.

2. DHS and the MCPs will need to Agree on an Appropriate Payment Structure

Plan-provider negotiations would need to determine the form of payment (*e.g*. FFS, episode-based payments, or capitation), and how that form might vary depending on whether the patient is "assigned" to DHS for primary care. The combination of these terms determines how much risk DHS has for long-term care costs. Again, these terms would need to be established separately with each of the three plans, aiming for consistency across them.

There are two main populations that MCPs might be interested in contracting for. The first is for patients assigned to DHS, for which DHS responsible for providing certain services as needed in exchange for a risk-based capitation payment. The second are patients that impact DHS because they are receiving services at DHS hospitals, but DHS is not financially responsible for all of their primary and specialty care. MCPs pay FFS for these latter patients. It is also possible that DMH's MHP will be responsible for certain payments that are not DHS assigned—some of whom it will want to place in the DHS nursing facility. DHS and DMH will need to work together to understand the payment system for different populations that might gain access to the Nursing Facility.

Based on DHS' current understanding, if the County opened its own Nursing Facility and had FFS agreements with MCPs, it would generally be a losing proposition from a financial perspective. While there might be some small gain in being able to discharge certain FFS patients from DHS hospitals more quickly, since most of DHS' costs and revenues are fixed, small changes in variable costs and revenues have little impact on the overall system. The only meaningful gain would be to improve DMH's access to such services outside of IMDs, assuming it also did not have a negative financial impact on DHS.

D. Revenue Opportunities

1. New Revenue: Base Payments for Nursing Facilities in Medi-Cal Managed Care

The first report back noted that DHCS was undertaking significant policy changes to the managed care delivery system with respect to LTC services, including payments for Nursing Facilities. These policies were expected to vary by county, necessitating specific information on LA that was not yet available. The report described that it was uncertain how the state would interpret a requirement that plans pay Nursing Facilities in Los Angeles at least their "FFS rate" (which could mean up to cost for DHS, or could mean just the state's fee schedule), or whether new Nursing Facilities in LA would be eligible to receive budgeted supplemental payments. DHCS has recently clarified that:

- MCPs in Los Angeles will be required to pay nursing facilities at least at the Medi-Cal fee-schedule rate, not DHS' costs, though they are permitted to pay more.

- There will be no near-term pass-through supplemental payments or incentive program payments available for Nursing Facilities in Los Angeles County. The budgeted pass-through payments are designed to assist providers in counties that historically excluded skilled nursing from Medi-Cal Managed Care. Because the County participated in the

Coordinated Care Initiative (CCI) before CalAIM, and under the CCI, Medi-Cal Managed Care plans have received state payments for long-term care services for many years, Los Angeles County providers are ineligible.

As a result, the County's near-term opportunities to receive payment for MCP-covered services will be limited. Reimbursement will primarily derive from MCPs through negotiation. The State-directed minimum rate would cover only a fraction of actual costs and negotiations with health plans alone would not likely make up the difference. The anemic rates Medi-Cal pays for nursing facility care are legendary. As mentioned in the first write-up, most private facilities limit their volume of Medi-Cal patients for this reason.

Under payment reform for DMH, DMH will receive a fixed payment amount per service from DHCS, and will be responsible for contracting for or directly providing those services within that budget. DMH is at risk for the cost per unit of service, but not the volume of services, under this FFS approach to payment (MCPs, under capitation, are at risk for both price and service volume). Whether DMH could afford an adequate payment rate to cover costs under the Make scenario would need further analysis. However, if a joint DHS-DMH nursing facility could ensure that all beds were eligible for payment compared to operating an IMD alone, the net benefit to the County would depend on whether the average operating loss per bed day is less than the loss of running an IMD at full County expense.

The implication of these base payment structures is that DHS would have to pay the market rate to find a willing contractor under the Buy Scenario, and that cost would be far more than DHS could hope to receive from the MCP. Under the Make Scenario, the outstanding question is whether the County could recoup its costs for directly operating services. In all cases, the rates would be subject to negotiation with MCPs and with DMH.

2. Potential New Revenue: CMS and DHCS May Create Supplemental Payments

The State could develop additional Medi-Cal payments to supplement low MCP base rates. At present, there are no firm proposals that would apply to DHS. Still, DHS and DMH could approach the State with ideas.

- Directed payments: DHCS has expressed openness to generally growing existing directed payment programs like the Enhanced Payment Program (EPP), and such program can be used to support objective like expanding access to post-acute care. Such programs must be tied in some way to the services the county provides for the county to receive the payment, and these payment streams are typically county-financed. Self-financed payments by their nature can never fully cover costs and have been receiving increased scrutiny from CMS. In fact, CMS proposed placing limits on the total amounts of funding that can flow through directed payments earlier this year. DHS is leery of further leveraging the current Medi-Cal model of combining low base rate payments with proportionately high directed payments. It is actively working to decrease its reliance on that approach.

  In terms of timing, DHCS likely would not entertain a payment change until the 2025 rate year at the earliest, and more like 2027 when the temporary pass-through payments for non-CCI counties expire and a new unified payment structure across all counties could be

created. Thus, the county would not know for a few years how much such a payment could be worth, and whether it would make a Nursing Facility cost effective.

- Plan incentive payments: DHS could work with DHCS to find other incentive opportunities for plans to increase rates for Nursing Facilities. The development of such structures would take time to negotiate with DHCS, making the amount and nature of any such arrangement unknown for cost-effectiveness purposes. In addition, plan payments would be run through the MCPs and subject to negotiation in the same manner as rates. MCPs would likely want to use such payments to address access broadly across a number of different providers, potentially diluting the direct financial benefit for the County.

- Other DMH opportunities: Other similar opportunities for incentives may exist within payment reform for county mental health plans.

Additional payments would be key to DHS' nursing facility efforts to succeed under either the Make or Buy Scenario, but the timing and value of these payments is unclear. Furthermore, the structure of the Buy Scenario could jeopardize the County's access to those funding sources as CMS and DHCS are likely to be more skeptical of Medicaid payments to local governments leaving public hospitals and reimbursing third-party providers in the future.

3. DHS' Current Structural Deficit

It's important to consider DHS' current financial position in light of the uncertainties regarding whether new revenues and supplemental payments will be sufficient to make County-owned Nursing Facilities self-sustainable. As it noted in its recent Fiscal Outlook, DHS has an ongoing structural deficit. It estimates that its fund balance will decrease by over $1 billion between now and the end of calendar year 2026. DHS' current surplus stems from several one-time positive adjustments (e.g., COVID-19 funding, the resolution of long-term receivables). By fiscal year 25/26, there are no further positive adjustments. DHS forecasts the available fund balance for that year at $167.2 million. The current financial system for public hospital systems is not capable of solving DHS' structural deficit.

Statewide redetermination of patient Medi-Cal eligibility is exacerbating DHS' woes. During COVID-19, Medi-Cal managed care enrollees stayed on health plan member roster due to regulations that suspended beneficiary eligibility evaluations. The number of DHS-assigned patient grew and so did DHS's corresponding capitation payments. With the end of the pandemic, entities have resumed eligibility review. Because many of DHS' patients are difficult to locate and have been default assigned to its system, DHS has been especially hard hit. Over the past few months, the State estimates that Los Angeles County (countywide) has lost over 6% of the Medi-Cal population. When DHS loses members, it loses the associated capitation payments from MCPs.

The financial impact of DHS' assuming responsibility for nursing facility services is more likely to exacerbate its ongoing structural deficit. DHS' material fixed costs will not be reduced by promoting patient placement in lower-level beds. It will still have to support most costs of what it would have had to if a patient remained in the hospital—those related to salaries, benefits, and the

facilities themselves. DHS will have new abilities soon to analyze such interactions with its new cost accounting system. Nevertheless, DHS anticipates that skilled nursing facility costs will accrete onto the current ones.

V. Conclusion

The rules associated with Medicaid financing are changing rapidly. CMS has proposed or imposed rules to tighten how local governments may fund their share of Medicaid dollars, limit the proportion of dollars that may flow to providers as directed payments, and restrict how providers may expend the gross receipts. DHCS is moving from cost-based reimbursement models to risk-based ones, funded in-part by intergovernmental transfers (IGTs) from localities. This transformation has happened most recently in the mental health arena where DMH's MHP is using IGTs to pay for services and is becoming pervasive. The County should incorporate these factors when planning future health care investments.

Whether the County should pursue building and operating a Nursing Facility requires further analysis based on emerging guidance from CMS and DHCS. The County should have a reasonable ability to project revenue prior to making decisions about major capital investments and long-term financial obligations; therefore, the timing of when supplemental payment discussions could produce results important. Because supplemental payments will be critical to the success of such venture, it will be key to have ongoing conversations with DHCS about the possible amounts, timing, and mechanisms available to create such opportunities. More information about CMS' stance on supplementals may become available in 2023 and 2024. DHCS will be more heavily focused on LTC financing structures that can launch in 2027 year – that is the year that the transitional payments to non-CCI counties will expire. New payments that are ready to launch in 2027 would need to be redesigned with discussions starting perhaps in late 2024.

Relatedly, the CalAIM waiver, which has major components focused on managed long-term services and supports, sunsets in December 2026. DHCS has indicated that successor programs would have a more robust benefit structure that would support the entire LTC continuum more fully that exists today. The next two years will be a critical period for research around local feasibility as well as dialogue with the State about building future systems that support access to services that we know are in short supply. DMH has similar considerations in the context of available funding for specialty mental health services.

Considering the direction policymakers are pushing Medicaid and the fact that, unlike DMH, DHS is not a health plan (nor does it aspire to be one), DHS recommends against a skilled nursing model that relies on contracting with third-party facilities. CMS and the State of California are increasingly skeptical of arguments that providers behaving as plans should not be regulated as plans. Moreover, the federal government intends for most Medicaid money to care for patients, not support excessive administrative costs. The attenuated connection between payors and direct care providers not only loses money at each step, it makes quality oversight more challenging. DHCS has personally communicated that for at least one service, a California Medi-Cal Managed Care plan has up to seven or eight entities interposed between the plan, who receives the funds, and ultimate provider—it is clearly evaluating the wisdom of the *status quo*.

Despite lingering uncertainty, DHS will continue to analyze potential costs and revenues with the help of actuarial expertise. The analysis will entail better understanding the appropriate size of a facility based on DHS and DMH patient population risk profiles and volumes, likely health plan revenues, and assessment of possible payment arrangements. Other important steps to take include identifying spaces where such a facility could be located, continuing discussions with DMH to deepen collaboration, and working with DHCS about access to supplemental payments. These efforts should bring more clarity to the cost-effectiveness analysis.

In addition, given State and Federal governments' trajectory, the County should approach the MCPs, and, DMH should continue to use its MHP to increase the number of Nursing Facility beds in Los Angeles. If only insurance plans may sit at the epicenter of providers, the County should engage the plans. Greater collaboration between the mental health and physical health payors could lead to more appropriate rate development and care settings. DMH has added ten (10) third party skilled nursing facility providers whose settings enable it to leverage federal money, along with additional resources to expand and improve coordination and communication with the payors. DMH's collaboration with the payors is continuing to grow and will further enhance in the coming years. For the time being, its efforts to find third party providers will be most fruitful. DHS will continue to monitor this issue and, if the State develops funding mechanisms and policies conducive to building maintaining nursing facilities, will revisit it with the Board.

If you have any questions, you may contact me or your staff may contact Allan Wecker, Chief Financial Officer, at awecker@dhs.lacounty.gov.

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c: Chief Executive Office
County Counsel
Executive Office, Board of Supervisors