Health Services
LOS ANGELES COUNTY

December 20, 2022

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"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.