Disparities in Access and Use of Skilled Nursing Services by Income and Racial-Ethnic Status in California

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Background

Concerns about Disparities in Long-Term Care Services

The baby boomer generation began entering retirement age in 2011. About 10,000 people have turned 65 every day since then, and the trend will continue for the next nineteen years.[1] In California alone, the population age 65 and older is projected to double in the next two decades, from 4.6 million in 2010 to 8.9 million in 2030, with the largest increase in the group of oldest old—those 85 and older.[2] This sharp increase in the elderly population is generating an imminent need for long-term care services. The vital questions are: (1) who will offer these long-term services?; (2) who pays for these services?; (3) who currently uses these services?; (4) what gaps in services should be anticipated?; and (5) what are the consequences for low-income older adults?

Traditionally, nursing homes are the primary providers of long-term care services for elderly and/or disabled people. However, the long-term care delivery system has been undergoing a major transformation in the past decade. One change is the shift from public to private funding of long-term care services. Public sources such as Medicare and Medicaid/Medi-Cal are the primary payers for nursing homes, together comprising more than 77% of nursing home revenue in California.[3] Given the growing fiscal pressure on the federal and state governments, both public programs have been reducing or limiting their payments to providers. Nursing homes facing revenue shortfalls have had to either close or seek patients with more generous private insurance or cash out-of-pocket payments. The shift toward a more private market-based system suggests a potential redistribution of traditional nursing homes toward higher-income areas, which can lead to higher travel costs and monetary costs for skilled nursing facility (SNF) care.

Another major change is the shift away from institutionalization towards home- and community-based services.[4] Skilled nursing services are very expensive. An average day in a skilled nursing home costs over $200 in California.[5] Most older adults also prefer to "age in place," meaning to live more independently at home or in a residential setting in the community.[6] The result of this shift is an influx of new providers that offer alternatives to nursing homes, such as home health services and assisted living facilities.

However, Medicare pays for only limited short-term rehabilitation services at home, and Medi-Cal covers a limited subset of Medi-Cal beneficiaries for in-home support and services. This shift, too, suggests economic selection in who has access to preferred community-based long-term care arrangements and those whose only option for long-term care is a traditional nursing home.

This policy brief describes recent changes in the long-term care landscape with regards to the access to and use of a traditional skilled nursing facility. Data are drawn from the Office of Statewide Housing and Planning Department census of every SNF in California between 2001 and 2010, mapped by demographic and economic information from the U.S. Census Bureau for the zip codes and counties where SNFs are located.

Key Findings

- There has been an 8% decline in the overall supply of SNF beds, despite a 22% increase in the elderly population in California between 2001 and 2010.
- The decline in SNF beds has been greater in low-income than in high-income neighborhoods.
- There has been an important change in SNF residency. Hispanics, Asians, and African Americans are more likely to stay in SNFs while whites have decreased use.
- The growth of non-white racial and ethnic groups in SNFs is only partly explained by the current demographic composition of California.
- The growth of non-white racial and ethnic groups housed in SNFs may be related to the lack of alternative options in long-term care available to them.

Sharp Decline in the Overall Supply of SNFs

Between 2001 and 2110 the overall supply of skilled nursing care has declined sharply. During this period, the total elderly population (those age 65 and older) in California increased by 22 percent (see Table 1). In contrast, the total number of SNFs in California decreased by 7% from 1,244 to 1,157 facilities. In addition, the number of total licensed SNF beds in California dropped by 8% from 118,943 to 109,708. Normalizing SNF beds by elderly population provides a significant 24% reduction in SNF beds per 1000 older adults in California over the last decade. This sharp decline suggests a potential lack of access to skilled nursing services for some subset of the population, because older adults are unlikely to have improved their health or had access to other long-term care arrangements to completely offset the 24% drop in skilled nursing supply.

The sharp decline also indicates a potential SNF shortage of beds given the enormous demand growth from baby boomers that is already occurring.

Table 1: Increase in Older Adult Population and Decline in Nursing Home Capacity in California, 2001-2010

California	Elderly Population (millions)	Total SNFs	Total Licensed SNF Beds	Licensed SNF Beds per 1000 Elderly
2001	3.59	1244	118,943	33
2010	4.37	1157	109,708	25
change	22%	-7%	-8%	-24%

Low-Income Areas Saw Greater Decline in SNF Beds

The decline in SNF beds is not distributed uniformly across counties or within counties in California. Between 2001 and 2010, about 137 SNFs closed and 50 new SNFs opened. SNF closures were more likely to occur in zip codes of lower income neighborhoods, but new SNFs were more likely to be located in zip codes of higher income neighborhoods. High-income areas are defined as the top 25 percentile of zip codes in California by their median household income in 2000, and low-income areas as the bottom 25 percentile zip codes. Forty-six percent of new skilled nursing facilities opened in high-income areas, whereas 39% of skilled nursing facilities closed in the same areas. By contrast, 12% skilled nursing facilities opened in low-income areas, compared to about 17% of skilled nursing facilities that closed in these areas.

The shift in the distribution of SNF beds may raise concerns about access for some populations. Alternatively, the shift in supply may simply reflect the change in demand for SNF care. To understand the relative change in SNF demand and supply conditions, we focus on Los Angeles County as an example. We approximate a market area for SNF at the 4-digit zip code level,* assuming people travel to a modest distance for SNF services.

*According to Bowblis and North (2011), the 75th percentile of a SNF market in California is about 7.8 miles. Categorizing at the 4-digit level yields 60 SNF markets in LA County. Source: Bowblis, JR & North, P. (2011). Geographic Market Definition: The Case of Medicare Reimbursed Skilled Nursing Facility Care. *Inquiry*. 48(2): 138-54.

Table 2 shows that total SNF beds declined more in low-income areas (-9%) than in high-income areas (-1%). Part of the greater decline in supply in low-income areas is explained by smaller growth in demand in these areas compared to high-income areas, as proxied by the percentage growth in the number of older adults age 65 and older (8% vs. 15%) and age 85 and older (24% vs. 42%). However, when we calculate the average number of SNF beds per 1000 elderly 65 and older, overall, low-income areas still saw a greater decline. In particular, SNF beds per 1000 elderly in low-income areas dropped by -17%, compared to -4% in high-income areas. At the same time, the number of discharges per 1000 elderly in low-income areas grew faster than that in high-income areas (17% vs. 10%). Taken together, a greater decline in supply (beds) with stronger growth in demand (discharges) may be related to shorter length-of-stay and potential barriers to access to traditional nursing home care in low-income areas.

Table 2: Change in SNF Bed Supply and Demand Conditions by Top and Bottom 25th Percentile of (4-digit) Zip Code Median Household Income in LA County, 2001-2010

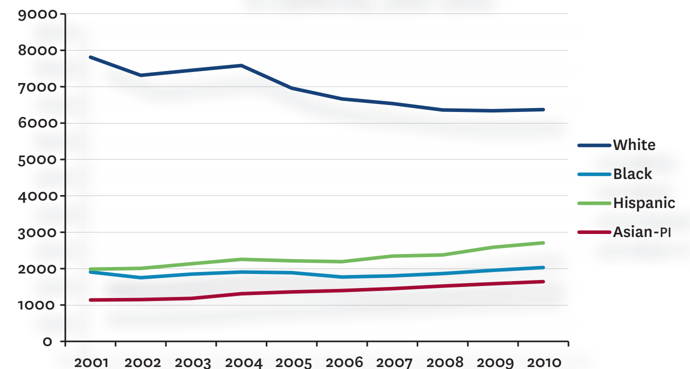
Category	Low-Income Areas			High-Income Areas		
	2001	2010	change	2001	2010	change
Total SNF Beds	720	657	-9%	319	318	-1%
Number of 65 and older	13806	14950	8%	8747	10054	15%
Number of 85 and older	1723	2130	24%	1028	1460	42%
SNF Beds per 1000 Elderly	63	53	-17%	31	29	-4%
SNF Discharges per 1000 Elderly	123	144	17%	61	67	10%
SNF Length-of-Stay in days	156	117	-25%	158	140	-12%

Hispanics, Asians, and African Americans are More Likely to Stay in SNFs

The differential decrease in SNF beds available to older adults suggests that who has access to and actually use SNF may be changing. The change in California SNF residents between 2001 and 2010 is plotted in Figure 1, which shows an important trend of changing ethnic mix in SNF residents.

While SNF residents are still predominately white, the number and proportion of white older adults in SNFs is decreasing over time while those of Hispanics, Asians, and African Americans are increasing over time. This general trend of the SNF resident census may reflect the changing demographics of California. Accordingly, this trend highlights the need for culturally competent SNF providers for the increasing ethnic diversity of SNFs.

Figure 1: Change in SNF Ethnic Composition in California, 2001-2010

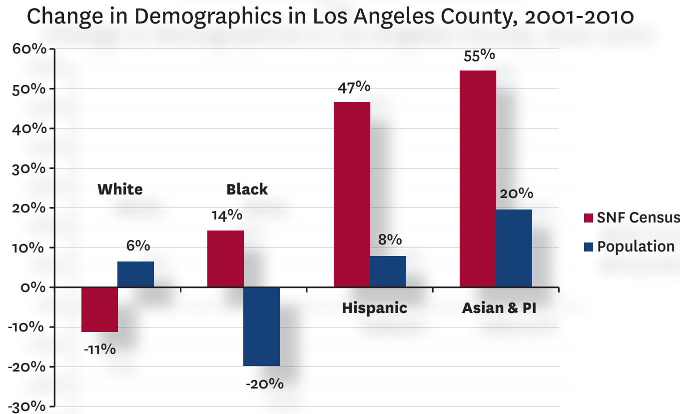


SNF Ethnic Composition is Only Partly Explained by Changing Composition of Los Angeles County

To understand whether the demographic change in SNF residents was due to the change in the racial and ethnic composition of the elderly population in Los Angeles County, the ethnic composition in SNFs to that of the county was compared. Los Angeles County may be a good lead indicator because it is leading other California counties in its rapid growth of non-white racial and ethnic populations.

Figure 2 indicates a clear differential trend in SNF users by racial and ethnic background. White (non-Hispanic) older adults are becoming less likely to go to nursing homes, despite a small increase in their population overall. In contrast, African Americans are becoming more likely to enter a SNF, despite a decreasing population. The largest growth in the elderly population in Los Angeles County is among Hispanics, Asians and Pacific Islanders, and the percentage growth of SNF residents of those racial/ethnic groups exceeds their population increase. Using the growth in the elderly population as a proxy for demand, Figure 2 indicates that use of SNFs is now disproportionately higher among non-whites than among whites.

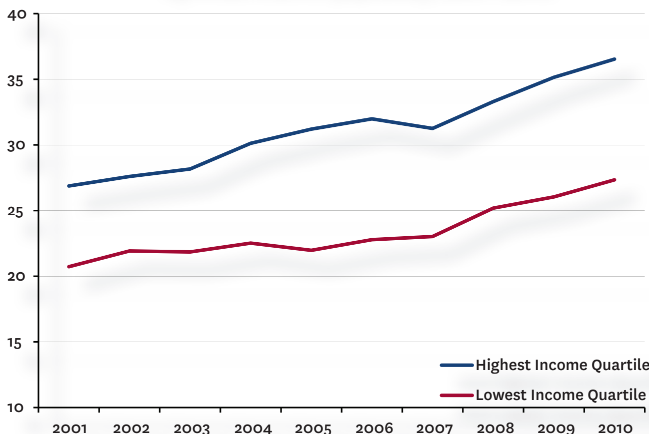
Figure 2:
Percent Change in SNF Residents
vs.
Change in Demographics in Los Angeles County, 2001-2010



Growth in the Presence of Non-White Racial and Ethnic Groups in SNFs is Likely Related to Lack of Options

The increasing reliance on SNFs by non-white populations suggests limited options for long-term care (LTC), other than traditional publicly financed nursing home services. Our tabulation of 2001-2010 data shows that SNFs are meeting a need for post-acute care after hospital discharge, and an increasing share of SNF patients are discharged home after short-term stays. Figure 3 shows that the probability of SNF patients to be discharged home is related to income. Ranked by the income of the zip code where a SNF is located, SNF residents are more likely to be discharged home in the highest income quartile areas than in the lowest income quartile areas. More importantly, this disparity has grown over the past decade. The trend of non-white racial and ethnic groups becoming more dependent on SNFs is suggestive of the lack of access to other LTC options faced by low-income populations.

Figure 3: Percent of SNF Patients Discharged Home by Area Income (zipcode), 2001-2010



Policy Implications

The past decade has seen a growing disparity in access to SNFs by income and racial/ethnic background in California. This trend reflects the shift from a publicly funded delivery system toward privately financed providers in higher income areas. It also reflects a change in the general perception and preference from institutionalization toward home and community-based long-term care services. For very poor older adults, access to traditional nursing homes declined substantially, and quality of these nursing homes is likely on the decline as well, as these providers typically rely on shrinking public revenues for the majority of their funding. In contrast, older adults with high incomes may still have robust access to higher quality nursing homes, as new homes being built in higher income areas attract better private reimbursements. Furthermore, for those who do enter nursing homes, poorer residents may have fewer options for care, while other more affluent older adults will be exiting after a short post-acute stay and move to a more preferred home- or community-based setting for long-term care.

The private market for long-term care insurance remains limited. The only attempt to restructure the long-term care insurance market was the Community Living Assistance Services and Supports (CLASS) provision under the Affordable Care Act of 2010, which would have allowed anyone to pay to obtain coverage for long-term care services. It was repealed in 2011. In lieu of CLASS or a program like it, older adults are faced with the continual proposals for, and implementations of, government budget cuts for long-term care services. For example, Medicare will reduce reimbursements to SNFs by $3.87 million, or 11%, in the 2012 fiscal year.[7] The recently enacted 2012-2013 California state budget also calls for cuts to In-Home Supportive Services (IHSS).[8] These trends financially squeeze low-income older adults, forcing them to rely on inadequate personal assets, and when these are depleted, turn to dual Medicaid/Medicare eligibility. Accordingly, key recommendations are to:

1. Pursue collaborative efforts to create public and private partnerships in restructuring the long-term care markets for low-income older adults and minimize gaps in access and quality of services.
2. Develop public policy that takes heed of trends in demand and supports viable payment mechanisms for different levels of care to assist low-income older adults.

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