CALIFORNIA HEALTH POLICY STRATEGIES, L.L.C.

Policy Brief

Requiring Access to Quality Report Ratings and Information for Long Term Care

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Executive Summary

In California, about 3 million individuals are discharged from hospitals annually and many need post-acute and long-term care services after discharge.[1] Hospital discharge plans often include placement options in skilled nursing facilities (SNFs) or other rehabilitation alternatives. Quality reports on long term care providers are available from several sources. However, there are no requirements that patients receive information about the quality of placement options that hospitals offer as part of the discharge process. This policy brief makes recommendations for legislation to improve access to quality reports during the hospital discharge planning process and for managed care plans to consider quality reports in establishing network providers.

Key Findings:

- Quality reports on long term care providers (nursing homes, home health, hospice and other services) are important tools for individuals, family members, caregivers, and providers to use when making hospital discharge decisions. The reports rate providers on various aspects of care such as staffing and regulatory violations and provide and an overall rating from low to high.

- Many people are not aware that there are reliable quality ratings and information available from government and independent non-profit organizations to aid in the discharge decision-making process and in establishing provider networks. Selecting high quality providers can result in better care outcomes and lower costs.

- Use of quality reports in discharge planning can reduce rehospitalizations, improve quality of care, and reduce costs. They are also valuable resources for managed care plans in establishing high quality provider networks.

- Requiring a directory of network providers with quality reports and the use of quality reports by managed care organizations can provide patients and their families with the tools they need to select high-quality long-term care providers, reduce rehospitalization and emergency visits, improve patient satisfaction, reduce hospitals stays, and lower costs

Recommendations: (1) Require hospitals, as part of the discharge process, to provide patients with quality ratings of nursing homes, home health, and hospice providers from reliable government and non-profit organizations sources; and (2) require managed care network directories to include quality reports; and require managed care plans to consider quality reports in establishing their long-term care provider networks.

Introduction

California hospitals admit and discharge about 3 million individuals annually. Many individuals need post-acute and long-term care services after discharge.[2] This includes nursing homes (including skilled nursing home and intermediate care facilities), home health agencies, hospices, and other supportive services. As the complexity of patient care needs has grown, discharge planning has become more challenging requiring:

- appropriate hospital discharge goals for post-acute and long-term care (LTC),
- selection of appropriate care setting(s), and
- selection of appropriate care providers.[3]

Hospital discharge planning decisions fall heavily on patients, families, and caregivers, often without adequate information about choices and options. Discharge plans and decisions are complicated by the stressful circumstances of hospitalization and discharge deadlines. Moreover, discharge planning processes are complex because many health plans and managed care organizations limit their LTC referral networks, often without regard to LTC provider quality ratings.

As part of the discharge process, the patient, family and caregivers, physicians and planners usually first determine the goals for recovery or care and whether a patient can safely return home with or without services. If the individual needs supportive services at home, they can be referred to a home health agency for skilled nursing or rehabilitation care, to a caregiving agency for basic care with activities or daily living, or to a hospice for end-of-life care. The discharge planner would typically provide a list of providers for the individual or family/caregivers to select for services in their area and then may contact the provider or ask the individual or family/caregivers to contact the provider to arrange services.

If a patient needs post-acute or long-term care in a nursing home or rehabilitation facility or an assisted living facility, the discharge planner would provide a list of facilities in the area near the patient's or the family/caregivers' home. The discharge planning may ask the family to choose a facility and assist them in contacting the facility to identify vacancies and arrange for admission or may ask the patient or family/caregivers to make their own arrangements for admission to a facility. Unfortunately, the patients and families may not be given information about the quality of the providers and sufficient assistance with the planning process.

This policy brief describes quality reports and their value to selecting high quality providers to reduce adverse outcomes, rehospitalizations, and costs. Discharge planning is more difficult for those who are dual-eligibles, racial/ethnic minorities, and those with dementia or complex illnesses. Planning is also more difficult when managed care plans have limited provider networks and fail to have high quality network providers. Finally, the policy brief makes recommendations for legislation to improve the use of quality reports by hospital discharge planners and by managed care plans.

Quality Reports Are Available and Valuable Tools for Discharge Planning

Many states, including California, require hospitals to provide assistance and resources for patients and families during discharge planning.[4] [5] Although LTC quality reports should be considered a first line tool in the discharge process, hospitals **are often not providing report ratings and information** to patients.[6] The California hospital discharge planning requirements **do not specify** that hospitals and health plans **must provide quality ratings** for post-acute and long-term care providers.[5]

California hospital discharger planners and patients have access to two sources of comprehensive quality reports on long term care providers.

- The Centers for Medicare & Medicaid Services (CMS) established a web-based nursing home and rehabilitation facility information system called Medicare Nursing Home Compare which has a "five-star" quality rating system for all US facilities. The website provides ratings on California nursing homes including information on facility characteristics, deficiencies, staffing, and resident quality indicators.[7] CMS also has website called Medicare Home Health Compare and a Medicare Hospice Compare website with quality ratings.[8] [9]

- California also has an integrated single-portal LTC consumer information website called Cal Long Term Care Compare that includes all licensed LTC providers including nursing homes, home health, hospice, and residential care/assisted living

facilities (https://callongtermcarecompare.org.) This website, tailored for California and operated by a non-profit organization, uses unbiased public information from federal and state sources and a five-level quality rating.

Lack of Knowledge About Quality Reports and the Wide Variations in Quality

Although these LTC quality reports are highly valuable, patients/families and the public are often unaware of their availability and how to access quality reports. The public is also frequently unaware of the wide variations in LTC provider quality. For example:

- Of the 1,163 California nursing homes, 36% percent had low ratings of 1 or 2 stars out of 5 stars, indicating poor quality in July 2025.[7]
- Some nursing homes do not meet the state's minimum staffing requirement of 3.5 hours per resident day.
- Total nurse staffing hours (average 4.5 hours per resident day) ranged from below 2 hours to over 11.5 hours per resident day.
- Registered nursing hours ranged from 0.2 to 5.9 hours per resident day. Overall, 132 facilities were cited by the state for abusing residents.
- Federal nursing home regulatory violations range from zero to over 95 deficiencies (average of 16) with a scope and severity ranging from minor with no harm to widespread harm or jeopardy to residents (including deaths).[7]

These quality data are important for individuals and families to know when making discharge decisions, yet they are generally not provided by hospitals.

Discharge Planning Is More Difficult for Selected Patients

Nursing homes, residential care/assisted living facilities, home health, and hospice providers are allowed to select patients that they can care for appropriately. Unfortunately, some providers prefer: (1) Medicare patients over Medi-Cal for low-income patients (which pays lower rates than Medicare), (2) white patients over patients from racial or ethnic minorities (even those this is not allowable by law); and (3) patients with fewer health care conditions or complex care needs.

Research shows that individuals eligible for Medicaid (Medi-Cal in California) and those who are dually eligible for Medicaid and Medicare are the most likely to be living in nursing homes with low quality scores.[10] Compared to Medicare-only patients, dual-eligibles are:

- more likely to be discharged to nursing homes with low nurse-to-patient ratios and

- are more likely to become long-stay nursing home residents if treated in facilities with low nurse-to-patient ratios.[11]

There are two other high-risk groups for poor quality of care:

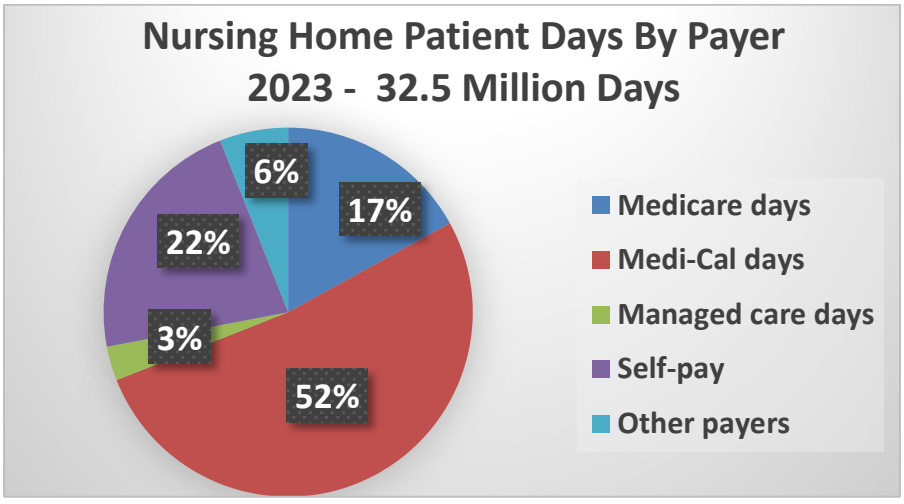
- Nursing home care remains highly segregated. Compared to whites, racial/ethnic minorities tend to be in facilities with **low clinical and financial resources, low nurse staffing levels, and with poor quality.**[12] [13]

- Recently, individuals with Alzheimer disease and related dementias (ADRD) were found to have a lower probability of discharge to high quality nursing facilities.[14]

Because of the biased selection process, discharge planners, patients and family/caregivers may find that it takes additional time and effort to find high quality providers and to complete the discharge planning process.

Finding Appropriate Discharge Options

Discharge planners, patients, and families must be persistent in seeking high quality providers rather than accepting the first facility that agrees to accept a resident. Although nursing homes prefer short-term patients paid by Medicare (because it pays the highest rates), almost all nursing homes accept Medi-Cal.



California data shows that Medi-Cal paid for 52% of all days and Medicare only paid for 17%, while Medicare and Medi-Cal managed care paid for 22% for the over 325,000

residents admitted to nursing homes.[15] California nursing homes only have an 85% occupancy rate, showing unused capacity for residents.

Although individuals on Medi-Cal and those with complex medical conditions may have fewer discharge options of providers than other patients, these individuals have a right to know the quality ratings and to participate in discharge planning to find high quality providers.

Consequences of Inadequate Discharge Planning

Inadequate discharge planning, especially for post-acute and LTC, is an important contributor to adverse events and subsequent high rates of rehospitalization and emergency care visits.[16] [17,18] These events result billions in unnecessary costs annually.

- In 2024, 363 California hospitals had 2.9 million discharges,[19] with **avoidable hospital readmission rates of 14.5%.**[20]

- California nursing homes had an **average of 22.7% short-stay residents readmitted to hospitals** that could have been avoided. This rate is slightly higher than the national average of 21.2% and 29% more readmissions per 1,000 population than the national average.[21]

There is strong evidence that nursing home readmission rates along with hospital costs can be reduced using a variety of methods, including improved discharge planning.[22]

Using Quality Reports Improves the Planning and Selection of Quality Providers

Because insurers and health plans set limits on the length of hospital stays, hospitals are concerned that using quality reports will delay the discharge process. However, the availability of web-based quality information now allows discharge planners to quick access quality information. We estimate it takes an additional minute to provide a patient with a written and digital link to these websites.

Rather than extending the decision-making time and the length of stay in hospitals, the use of quality reports **can reduce hospital length of stay and reduce hospital costs**.[23] Quality reports improve the identification of the most appropriate providers and settings and allow choice among providers.

After establishment of the CMS Nursing Home Compare rating system, nursing homes improved their scores on certain quality measures and consumer demand significantly increased for the best (5-star) facilities and decreased for 1-star facilities.[24] [25]

A clinical trial using a personalized version of Nursing Home Compare in the hospital discharge planning process found:[23]

- greater patient satisfaction
- patients being more likely to go to higher ranked nursing homes
- patients traveling further to nursing homes, and
- patients having shorter hospital stays compared to the control group.[23]

Overall, use of LTC quality reports may reduce adverse events, rehospitalizations, and emergency visits and lower the costs of care described above.

Health Plans & Managed Care Plans May Fail to Consider Quality Reports

California had 138 health plans with 26.5 individuals enrolled in commercial plans and 17 million individuals in government plans in 2024.[26] Health plans establish networks of LTC providers and these networks must be taken into account in the discharge process.

A study of 17 Medi-Cal managed care organizations (MCOs) participating in a California integrated long term care demonstration found that these MCOs established broad networks of nursing homes but **only half of the MCOs considered quality in developing contracts**. As a result, **MCO network nursing homes had lower quality than community nursing homes**.[27] MCOs should consider quality reports in establishing LTC networks.

If MCOs used high quality LTC network providers, it is likely they can reduce hospital length of stay, hospital readmission rates, and improve patient and caregiver satisfaction with the discharge process. LTC network quality ratings should be given to patients and families to offer choices within networks.

Discussion of Recommendations

We recommended legislative changes to: *Require hospitals, as part of the discharge process, to provide patients with quality ratings of SNFs and alternative placement options from reliable government and non-profit organizations sources;.*

Current Federal and State Hospital Discharge Planning Requirements

Current federal law 42 CFR 483.43(a)(8) requires that:

> The hospital must assist patients, their families, or the patient's representative in selecting a post-acute care provider by using and sharing data that includes, but is not limited to nursing facilities, long term care hospitals, inpatient rehabilitation facilities, and home health agencies data on quality measures and data on resource use measures. The hospital must ensure that the post-acute care data on quality measures and data on resource use measures are relevant and applicable to the patient's goals of care and treatment preferences.

Unfortunately, this federal requirement does not appear to be followed in California.

California hospitals are required to meet state requirements for the discharge planning process.[28] The Health and Safety Section 1262.5 requirements include:

> (h) A hospital shall provide every patient anticipated to be in need of long-term care at the time of discharge with contact information for at least one public or nonprofit agency or organization dedicated to providing information or referral services relating to community-based long-term care options in the patient's county of residence and appropriate to the needs and characteristics of the patient. At a minimum, this information shall include contact information for the area agency on aging serving the patient's county of residence, local independent living centers, or other information appropriate to the needs and characteristics of the patient.

Recommendations for Hospital Legislative Changes. A new section of the California Health and Safety code should add the language of the federal law 42 CFR 483.43(a)(8) that:

> *The hospital must assist patients, their families, or the patient's representative in selecting a post-acute care provider by using and sharing data that includes, but is not limited to nursing facilities, long term care hospitals, inpatient rehabilitation facilities, and home health agencies data on quality measures and data on resource use measures. The hospital must ensure that the post-acute care data on quality measures and data on resource use measures are relevant and applicable to the patient's goals of care and treatment preferences.*

In addition, the Health and Safety code should require that:

Each hospital must specifically provide written and digital information on access to the CMS Medicare Nursing Home Compare, Medicare Home Health Compare, and Medicare Hospital Compare quality ratings and reports as well as the Cal Long Term Care Compare website quality ratings and reports for long term care providers. This shall be provided to every patient and his family and caregivers at the beginning of the discharge planning process.

Managed Care Organizations Requirements

We also recommend legislative changes that: *require managed care network directories to include quality reports on long term providers; and require managed care plans to consider quality reports in establishing their long-term care provider networks*

Current Managed Care Requirements

Existing federal Medicaid law requires the state to publish an online directory of physicians and, at state option, other providers, as specified. Existing state law sets forth Medi-Cal managed care provisions relating to a Medi-Cal applicant or beneficiary being informed of the health care options available regarding methods of receiving Medi-Cal benefits, including through certain provider directories. The state has created an online provider directory through an internet website known as Medi-Cal Managed Care Health Care Options.

California passed Senate Bill 250 Medi-Cal: provider directory: skilled nursing facilities and it was signed by the Governor in October 2025. The bill adds Section 14197.8 to the Welfare and Institutions Code, relating to Medi-Cal, to require the following:[29]

(a)(1) As part of the health care options information posted by the department, in the provider directory that lists accepted Medi-Cal managed care plans, through the Medi-Cal Managed Care Health Care Options internet website and any other applicable mechanisms, the directory shall include skilled nursing facilities as one of the available searchable provider types.

(b) The department shall annually update the provider directory described in subdivision (a) to ensure that information is accurate and readily accessible to the public.

Recommendations for Managed Care Legislative Changes:

Section 14197.8 should be amended to:

(1) require that the provider directory that lists accepted Medi-Cal managed care plans and the Cal Medi-Cal Managed Care Health Care Options internet website and any other applicable mechanisms, shall include all LTC providers including: skilled nursing homes, intermediate care facilities, rehabilitation facilities, home health agencies, and hospices as part of the available searchable provider types.

Second, Section 14197.8 should add a requirement:

T*he provider directory and Managed Care Health Options internet website shall annually provide links to the Centers for Medicare & Medicaid Services website quality ratings and the Cal Long Term Care Compare website quality ratings for each LTC provider including: skilled nursing homes, intermediate care facilities, rehabilitation facilities, home health agencies, and hospices.*

Finally, a new Section 14197.9 should be added to require:

All Cal Managed Care Plans must take the Centers for Medicare & Medicaid Services quality ratings and the Cal Long Term Care Compare website quality ratings into account in order to ensure access to quality LTC providers when establishing network arrangements and referrals to: skilled nursing homes, intermediate care facilities, rehabilitation facilities, home health agencies, and hospices.

About the Author

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About California Health Policy Strategies (CalHPS), LLC

- CalHPS is a mission-driven health policy consulting group based in Sacramento. For more information, visit www.calhps.com

Endnotes

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