II. Framing the Discussion: Environmental Factors Impacting County Nursing Homes

A number of demographic, social, financial and political considerations shape the environmental context within which county nursing facilities exist and operate. It is important to note that many of these factors have significant impact on the broad nursing home landscape in general, to be sure. But several have particularly significant impact on county-owned-and-operated facilities. Despite the reality that many—perhaps most—of these factors are at least in part functions of circumstances and previous decisions largely beyond the ability of the facilities and counties to control directly, they nonetheless combine to limit the flexibility of current county home administrators and county governmental leaders. As such they have a major impact on both the current operations and financial condition of the nursing homes, as well as on the realistic viability of options which may—or may not— be available to county homes in the future.

Several environmental factors, some beyond current local control, have significant impact on the broad nursing home landscape, and several have disproportionate impact on county homes.

Even those environmental factors which can be controlled or influenced at least in part by county homes are often subject to local circumstances and/or political dynamics that may limit the number and nature of options realistically available to nursing homes or their county leadership. Certainly each county has its own distinct environmental realities to deal with, but the environmental factors that most significantly impact the future of county homes are not unique to individual homes or counties, but rather are pervasive and applicable at varying levels to virtually every county owning a nursing home, regardless of location in the state.

Together and individually, the factors referenced in this chapter establish much of the context for the discussions which follow in the subsequent chapters of this report. They provide an overview of the big picture trends impacting county homes and often their competitors; underscore why this study was initiated in the first place; help shed light on why the future of county nursing homes is in question in many counties throughout all regions of the state; and very much influence how county and state governmental policymakers are likely to think about the role and existence of county homes in the future.

Impact of Expanding Older Population

Across the state, the population is getting older. Between 2010 and 2030, the total NYS population is expected to grow by a modest 2%, according

While projected population growth in New York is expected to be relatively flat, those 75 and older and 85+ are expected to increase significantly by 2030 and especially 2040, reflecting the aging of the baby boomer generation.

to projections by demographers at the Cornell Program for Applied Demographics. But during that same period of time, the number of residents of the state who are 65 and older is projected to increase by 38%, and those 85 and older by 7%; moreover, reflecting the aging of the baby boomer population, the projections are that those 85+ will have increased much more dramatically, by 48%, by 2040.[7]

Of more direct relevance to this study, growth rates among the older population are expected to be even slightly higher within the 33 counties still owning nursing homes at the beginning of 2013, as indicated in Table 1 below.

Table 1

Projected Growth of Population 65 and Older in Counties Owning Nursing Homes

	2010	2020		2030		2040	
	population	population	change from 2010	population	change from 2010	population	change from 2010
65+	1,196,324	1,433,036	20%	1,676,147	40%	1,618,724	35%
75+	589,351	605,478	3%	767,755	30%	881,686	50%
85+	186,676	190,214	2%	204,629	10%	267,640	43%

Source: Cornell Program on Applied Demographics, produced September 8, 2011

Across the 33 counties, those 65 and older are expected to increase by 20% between 2010 and 2020, and by 40% by 2030, when projections are that there will be about 480,000 more residents 65+ than there were in 2010. After 2030, the growth rate among those 65 and older is expected to begin to decline somewhat, consistent with national projections.

In the 33 counties with their own nursing homes, there will be about 180,000 more residents 75 and older by 2030 than in 2010, and almost 300,000 more by 2040, a 50% increase.

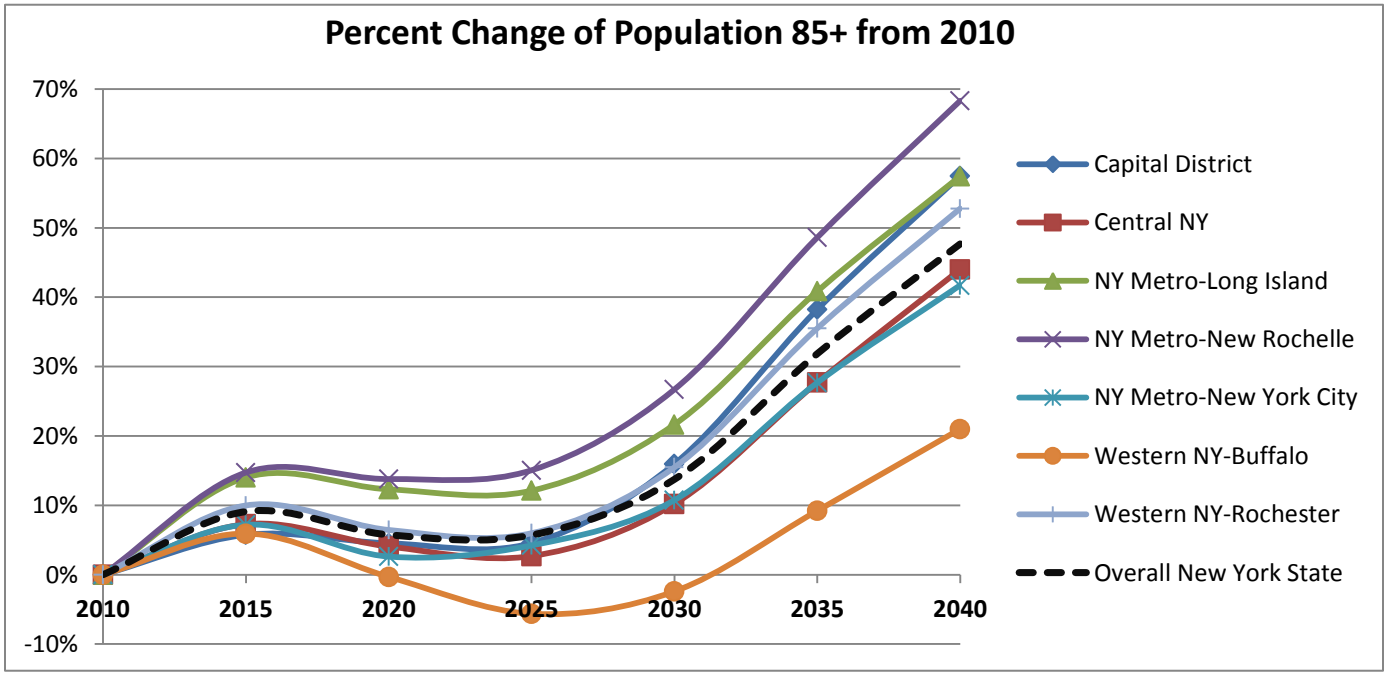
The baby boomer generation will begin to reach the age of 75 in 2021. Among the 75 and older group—the most significant subgroup in projecting the need for some level of long-term care—demographers anticipate an initial small increase in the 33 counties of 3% between 2010 and 2020, but with the impact of the boomer generation, the 75+ population is expected to be 30% larger in 2030 than it was in 2010 in those counties—almost 180,000 more than in 2010 (an average increase of about 5,400 per county). By 2040, the 75+ population is projected to have grown by an additional 114,000, to more than 880,000 residents 75 and older in the 33 counties with current public nursing homes—an increase of 50% in just 30 years.

[7] See Cornell Program on Applied Demographics, data produced September 8, 2011, and LeadingAge New York, *Senior Housing in New York State*, February 2013, page 4.

The 85+ population is projected to increase 10% by 2030 and 43% by 2040 in counties with their own nursing homes. Based on current rates, this would translate to 10,700 more persons 85+ in nursing homes in 2040 than in 2010.

The 85 and older population—the subset most likely to need institutional care at that stage of their lives[8]—is expected to grow at a slower rate between now and 2030, increasing by 2% between 2010 and 2020, and by 10% by 2030, when there are projected to be about 18,000 more 85+ residents in the 33 counties than in 2010. With the baby boomers not beginning to reach 85 until 2031, the expansive growth in that population will begin to be reflected in the next decade, when the 85+ population is projected to have grown by another 63,000 persons in the 33 counties, to more than 267,000 in 2040 (43% more than in 2010). *Based on the 13.2% proportion of persons 85 and older now living in nursing homes, this would translate into almost 10,700 more 85+ residents in counties with nursing homes who would need nursing home care in 2040 than in 2010, if 2010 institutionalization rates were to remain consistent.*

LeadingAge New York presentations of statewide projected increases in the 85+ population show wide variations by region, topped by large projected increases in suburban counties north of New York City, on Long Island and in the Capital/Albany district, with much lower projected increases in the western/Buffalo region (see Figure 1 below).



Source: Program on Applied Demographics, Cornell University, graphed by LeadingAge New York, included in *Senior Housing in New York State*, February 2013, p. 4

[8] Based on a July 2010 snapshot, 13.2% of the NYS 85+ population resided in nursing homes at that time (from MDS 2.0 dataset, as reported to CGR by LeadingAge New York).

Focusing more explicitly on the 33 counties owning nursing homes, similar wide variations exist in growth rates for those 85 and older. Because decisions are currently being made by counties about the future of their homes, projections out as far as 2040 are less relevant to decision-makers looking at more immediate data and projections. Thus we focused greater attention on the 2020 and 2030 projections. Just over half of the 33 counties are projected to actually experience declines in their 85+ populations between 2010 and 2020, and even by 2030, seven counties will continue to have fewer 85+ residents than in 2010, before experiencing significant growth spurts during the next decade. At the other end of the growth spectrum, eight counties are projected to experience 85+ growth rates of at least 10% by 2020, and 16% by 2030, including eight counties with at least 30% increases in numbers of residents 85 and older by 2030.[9] County-specific data are provided in the appendix to this report.

Three of the four counties with double-digit projected declines in the 85+ population between 2010 and 2030 are currently actively considering sale of their nursing homes. On the other hand, so are seven of the eight counties with projected increases of 30% or more. Of the seven counties which have opted out of the nursing home business by selling or closing homes in recent years, most are projected to experience low or declining 85+ growth rates between now and 2030. The major exception is Delaware County, projected to experience 85+ growth rates of 47% by 2020 and 80% by 2030, with about 775 more residents 85 and older by 2030 than existed in 2010 (and an additional 700 on top of that by 2040).[10]

In virtually all counties with their own nursing homes, projections consistently suggest that there will be significant growth in demand for an array of long-term-care services over the next 15 to 30 years.

Projections are of course only that—projections—which can change dramatically as unforeseen events and realities intrude. But the number of elderly residents across the state and in most if not all of the counties currently owning nursing homes will almost certainly be significantly higher over the next 15 to 30 years, and these increasing numbers will have significant implications for an array of long-term-care services, institutional and community-based, for older citizens in the future.

It is worth noting that not only will there likely be a larger proportion of older people in the population, but they will also live longer and in many cases healthier lives. Research and federal and state policies suggest that there are clear preferences of older adults to remain in their homes and/or

[9] By 2040, all of the 33 counties are projected to have more 85+ residents than they did in 2010, with increases ranging from as low as 4% to a virtual doubling in one county. The median increase across all 33 counties by 2040 is projected to be 44%, with 12 counties experiencing increases of more than 55%, including eight with increases of 70% or more (the same eight with 30%+ increases between 2010 and 2030).

[10] Analyses by CGR of projections by Cornell Program on Applied Demographics.

local community for as long as possible, and thus there will be increasing demands for community-based services to support the concept of residents wishing to age in place, delaying institutional care as long as possible. This suggests that there will be a growing need for expanding such community resources as affordable senior housing, assisted living, home care, respite and caregiver support services, personal care, meals on wheels, case management, and adult day care programs. [11]

Despite the projected future growth in the elderly population, the New York State Department of Health's (DOH) March 2010 update of nursing home bed needs by county reflects an estimated net excess by 2016 of more than 750 nursing home beds throughout the 33 counties currently owning nursing homes (estimates including *all* nursing homes, and not just county-owned facilities). On the other hand, it should be noted that those forecasts presumably do not adequately factor in post-2016 population projections such as those noted above. Such projections may suggest that the 2016 nursing home "excess" estimates may need to be reconsidered in terms of their applicability to future years.

Overall, data and projections show that most counties owning nursing homes have estimated shortages in nursing home beds in their counties, in addition to facing projected significant increases in their 75+ and 85+ populations over the next 15 years and beyond.

It should also be noted that, within those overall aggregate numbers, 13 of the 33 counties have 4,140 excess beds, according to the DOH estimates, with about 2,800 of those in three counties (Erie, Monroe and Onondaga). The other 20 counties with public nursing homes reportedly have cumulative nursing home bed shortages of 3,378, with more than 1,500 of those in Nassau and Suffolk counties. Excluding those five large counties, there would actually be a net *shortage* of about 500 beds across the remaining 28 counties—only 10 of which are listed as having excess beds, before factoring in post-2016 population projections.

Thus most counties currently owning nursing homes are facing projected significant increases in their 75+ and 85+ populations between now and 2030 and beyond, while most of those counties (20 of 33) are also facing estimated shortages in the total number of nursing home beds within their county boundaries.

Need for Comprehensive Long-Term-Care Planning at County Level

In the context of an expanding older population, of estimated shortages of nursing home beds in many counties, and of increasing desires and demands for various alternative levels of community-based, non-institutional long-term care, it is significant that most counties reportedly

[11] See, for example, LeadingAge New York, *Senior Housing in New York State*, op cit., pages 5 and 44.

have no, or at best partial, comprehensive long-term-care plans in place. The closest many come is to have a four-year County Office for the Aging Implementation Plan to outline selected goals and services, in some cases supplemented by varying degrees of implementation of New York Connects programs to help educate older people and their families about long-term care options and to help link people with appropriate services.

Decisions about the future of county nursing homes are typically being made in the absence of a comprehensive long-term-care plan. Despite shortages of nursing home beds, and likely increased demand for an array of long-term-care services (institutional and community-based), few counties have such plans in place.

Decisions about the future of publicly-owned nursing homes are typically being considered in most counties without the benefit of any context being provided by a long-term-care plan offering guidance concerning a comprehensive strategy for meeting overall long-term-care needs of the expanding older population over the next several years.

All counties have some combination of home health care programs, personal care services, senior centers, home-delivered meals, affordable senior housing, adult day care, and other long-term-care supports in place at some level. But few if any have enough, or have integrated these services into a comprehensive system based on any formal assessment of overall long-term-care needs of the population that links institutional and non-institutional needs and available resources to determine gaps and unmet needs going forward. Several years ago, the Commission on Health Care Facilities in the 21st Century (the "Berger Commission") emphasized the point: "We have too much institution-focused care and not enough home and community-based options."[12] That conclusion remains applicable more than six years later.

As the older population expands and lives longer, it is likely that the numbers of seniors living alone will also increase. In 2010, 30% of all those 65 and older in New York were living alone, and the proportion increases at higher age ranges.[13] Thus this particularly vulnerable subset of the older population is likely to continue to increase, as the number of 75+ and 85+ seniors expands over the next 15 to 30 years, adding particular stress on community-based services, if institutionalization is to be avoided or at least delayed for this growing subset of the older population.

As noted above, although research clearly indicates growing senior preferences for— and state and federal policies increasingly advocate on behalf of—increased provision of community-based long-term-care programs as alternatives to institutional care, the funds to support these directions appear to have typically not yet followed the policies and

[12] Commission on Health Care Facilities in the 21st Century, *A Plan to Stabilize and Strengthen New York's Health Care System: Final Report*, December 2006, p. 1.
[13] LeadingAge New York, *Senior Housing in New York*, op cit., page 6.

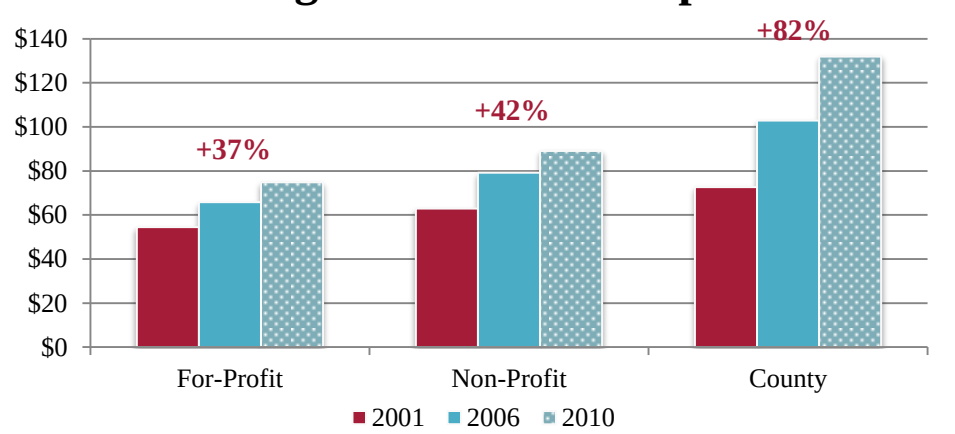
More resources are needed to support the projected growing demand for community-based long-term-care services at the local level.

desires into local communities to help such programs and services be created and expand to meet the demands. One possible source of at least some of these needed funds may eventually result from a NYS request to the federal government for a waiver to reinvest billions of dollars in federal savings resulting over five years from the state's Medicaid Redesign Team reforms. The waiver requests reinvestment of the funds in various efforts to restructure the state's health care system. If the waiver is approved and generates funds that can in part be directed to local communities to expand community-based long-term-care services, more comprehensive long-term-care plans and strategies may become possible at the local level, and expanded options may become more accessible to those in need.

Pressures of Escalating Employee Costs

Expenditures have increased across nursing homes of all types over the past decade, but particularly within the public sector, fueled largely by escalating health insurance and pension costs. Figure 2 provides an example of how total costs have increased in the single largest cost center of nursing homes—the nursing cost center (including nursing-related costs except for those of nursing administration, which are broken out separately).

Figure 2



Source: NYS DOH Cost Report data organized by LeadingAge New York

Nursing costs dwarf those of all the other 18 cost centers broken out in the cost reports summarized in the LeadingAge New York analyses. Whether upstate or downstate, for-profit, non-profit or county facilities, nursing cost center median costs per day are at least three to four times higher than the next-highest cost centers—overall facility administration and food

Nursing costs per resident day have grown at much higher rates in county nursing homes than within their competitors throughout the state, but especially in upstate counties.

services. And over the past decade, those nursing center costs have increased in upstate facilities by more than 80% in county homes, unadjusted for inflation—more than twice the rates of growth in for-profit and non-profit facilities.[14] Cost growth in the latter two home-ownership categories in downstate counties (Westchester, Rockland and the Long Island counties) over the past decade paralleled the growth in upstate counties, although downstate nursing cost growth in county-owned homes was somewhat less than in upstate—59%, still well above the rates of increase among other ownership types of facilities.

In nearly all 19 cost centers used to measure costs per resident day, costs in county-owned nursing homes consistently exceed those in for-profit and non-profit homes.

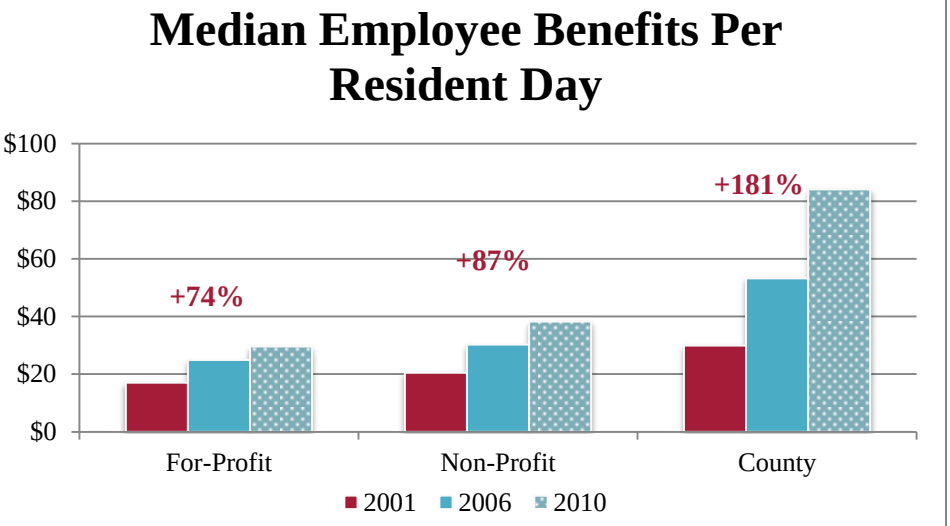
Costs in county nursing facilities consistently exceed costs in other types of homes in virtually all cost center categories. Of the 19 cost centers,[15] the only exceptions in 2010 were in therapist and pharmacy costs in both upstate and downstate, facility administration in upstate and plant operations downstate. In those categories, typical county homes spent less than did for-profit and non-profit facilities.

Overall wages have increased for all types of nursing facilities over the past decade, but their impact on the escalating costs of operating nursing homes is far outweighed by the dramatic increases in employee benefit costs. Wages paid per resident day across all facilities increased 37% since 2001, unadjusted for inflation, across the state, paced by the 45% increase among county homes. But during this same period, overall employee benefit costs were expanding by almost twice the wage rate, by 71%, across the state. As indicated in Figure 3, increases have been particularly dramatic within county facilities.

[14] It should be noted here, as it applies throughout our analyses, that medians indicate the central tendencies of each type of nursing home—the point at which half of the homes in each type are above and below the median figure presented. While those median numbers provide a solid basis for comparing *overall* differences between the three different types of homes, there are wide ranges of differences *within* each type home as well. Thus, for example, while the median county home may be well above the median for non-profit or for-profit homes on a particular measure, some individual county homes may be below the levels of some individual for-profit and non-profit facilities.

[15] The 19 cost centers are as follows: fiscal, administration, plant operations, grounds, security, laundry and linen, housekeeping, food, café, nursing administration, activities, social services, transportation, occupational therapy, physical therapy, speech therapy, pharmacy, CSS and nursing.

Figure 3



Source: NYS DOH Cost Report data organized by LeadingAge New York

Employee benefit costs in county-owned nursing homes have almost tripled in the past 10 years, mostly the cumulative result of historic agreements between employee bargaining units and local and state elected officials. Some willingness to reconsider some of these benefits may be critical to finding ways to reduce nursing home deficits.

Employee benefit costs have risen steadily across all types of nursing homes, but they have almost tripled in county homes, paced by dramatic increases in the seemingly-uncontrollable growth in costs of health insurance and of pension benefits and legacy costs due future retirees. Much of these benefit increases results from the cumulative effect of decisions made over the years and enacted via state and local legislation and bargaining agreements at the local levels between counties and labor unions. *Even the most cost-conscious of nursing home administrators and current county officials seeking to operate nursing homes more cost effectively are limited in their efforts to find savings because of barriers created by these previous agreements and legislative acts—unless there is a willingness on the part of county and nursing home and union officials to begin to discuss ways of renegotiating aspects of previous agreements.*

Previous decisions resulting in escalating benefits that obligate current officials have significantly contributed to county decisions to shift from historic support of nursing homes to decisions to explore selling their homes.

These increases in employee benefit costs—more than any other factor on the cost side—have combined with reductions in revenues, as discussed below, to create the consistent pattern of county nursing home deficits requiring increasing levels of county subsidies/contributions—that in turn have fueled the perceptions of near-panic that are leading county after county to begin to actively explore options concerning the future of their nursing homes, and in many cases to jump from a history of leadership support of their facilities to a decision to explore selling.

Increases in costs and their implications are discussed in more detail in Chapter V, but this brief profile of expanding costs was presented in summary fashion at this point to indicate its importance as a critical factor in the environmental landscape that is increasingly shaping decisions being made about the future of county nursing homes throughout the state.

Uncertainty of State and Federal Funding

In the calculations of most county officials concerned about the future of their nursing homes, at least as, if not even more important than the trend of increasing costs is the recent pattern of declines in revenues and—perhaps even more to the point—the uncertainty about the future of such revenues.

Declining revenues—and especially the uncertainty about the future of state and federal sources of revenues—shape much of the thinking of policymakers concerned about the future financial viability of county-owned nursing homes.

The future of state and federal funding for long-term care in general, and nursing facilities in particular, is highly uncertain at best, and should probably most realistically be thought of as continuing in future years to trend downward (although how much, and at what points in time, remain highly speculative, even among "experts" in the field). That reality of uncertainty and the resulting perception of a potentially bleak future for non-county revenues—even more than the known increases in costs and levels of county contributions to underwrite the operating costs of county nursing homes—is what is increasingly cited by policymakers as influencing the decision-making concerning the future of their nursing facilities.

Among the revenue/reimbursement factors likely to affect funding of county nursing homes (and in several cases all nursing homes) over the next few years are the following:

Changes in Medicare and Medicaid Reimbursement Levels

- Effective October 1, 2011, all nursing homes experienced a reduction of 11% in Medicare Part A rates. An additional 2% reduction in those rates occurred April 1 of this year. Although applicable to nursing homes across the board, in some ways, this reduction has a greater impact on many non-public homes, because they typically admit more residents eligible for Medicare than do county homes. On the other hand, to lose this much revenue for those Medicare patients whom county homes are able to attract represents a significant loss, particularly at a time when many have been attempting to increase their short-term intakes, often with Medicare coverage at the time they are admitted.

- New York State imposed a global spending cap limiting total growth of Medicaid expenditures to about 4% initially, with annual changes to the global cap pegged to the 10-year moving average of the CPI-Medical Services index. At a time when costs continue to increase, especially among public facilities, a cap on revenues obtained through Medicaid has the practical effect in some nursing homes of a reduction in revenues. A national study estimates that Medicaid rates in nursing homes in New York fall about $42.50 short per Medicaid resident per

Medicaid rates in NYS nursing homes fall about $42 per resident day short of covering full costs of services, and estimates are that daily facility operating costs across all residents may exceed the Medicaid rate by as much as $100 per resident day in the median county nursing home.

day of covering full costs of services to those residents.[16] Moreover, officials at LeadingAge New York estimate, based on 2011 data, that daily facility operating costs are as much as $100 more per resident day in the median *county* nursing home than the Medicaid daily rate.[17]

Given these findings, the study conducted in 2011 for the American Health Care Association concludes: "Historically there has always been a major disconnect between what Medicaid pays for nursing home services and the cost of providing those services. That gap is rapidly expanding, leaving nursing homes with significant Medicaid volume little choice but to further constrain costs to survive. The challenge is not whether costs can be cut, but whether doing so will allow skilled nursing care providers to deliver the quality care and quality of life consumers expect and regulators demand."[18] This applies to all nursing homes, but is magnified in most county homes.

- Bed-hold modification (effective 7/1/12), limiting the ability to bill for bed-hold days for Medicaid recipients over age 21 to a combined 14 days annually for hospitalization and therapeutic leaves. Reimbursement levels for bed-hold days have been reduced to 50% of the full rate for hospitalization days and 95% of the rate for others.

New Statewide Pricing Methodology

After much uncertainty, a statewide Medicaid pricing and reimbursement strategy was approved by New York State, and implemented in 2012 following federal Centers for Medicare and Medicaid Services approval. The new pricing methodology is based on a statewide base reimbursement structure adjusted for such things as regional wage differentials, case-mix of residents and the size of the facility. It replaces a much-lamented reimbursement methodology that did not change for over 20 years and a base update that was accompanied by a subsequent series of rate cuts, thus making it very difficult for nursing home administrators to do realistic financial forecasting.

According to the state, the plan is designed to bring some much-needed stability and some degree of certainty to future Medicaid reimbursement levels. The new pricing approach is scheduled to be phased in over a six-

[16] Eljay, LLC for the American Health Care Association, *A Report on Shortfalls in Medicaid Funding for Nursing Home Care*, December 2011, p. 7
[17] Correspondence between CGR and LeadingAge New York, June 12, 2013. Note that this $100 "gap" is a median figure that varies from home to home. It compares the Medicaid rate to all facility costs across all residents.
[18] Eljay, *A Report on Shortfalls in Medicaid Funding for Nursing Home Care*, op cit., p. 19.

year period, with full implementation scheduled in 2017, with assurances built in that deviations from the 2011 Medicaid rates cannot exceed plus or minus 1.75%, 2.75%, 5%, 7.5% and 10% respectively each year between 2012 and 2016, leading up to full implementation the following year. The new methodology and limitations on annual rate adjustments are designed to provide a level of funding stability that allows nursing homes to identify and address financial concerns with some degree of assurance that they can develop business plans with some reasonable projections of revenues to work with (knowing that historically 80% or more of most county homes' resident days are paid for by Medicaid).

Even though the new statewide pricing methodology should provide some stability and increased ability to anticipate revenues with increased assurance, more than half of all county homes are projected to receive fewer Medicaid revenues over the next half dozen years than would have been the case under the previous Medicaid methodology.

Such relative stability should be a welcome development to most county home administrators. However, the stability in rates may be undermined in part by the Medicaid spending cap, which could potentially limit the total amount of available revenues against which to apply the new rates. Moreover, initial calculations based on the new plan's formulas and distributed by LeadingAge New York suggest that between 2012 and full implementation in 2017, 18 (just over half) of the 35 county nursing homes in operation at the beginning of 2013 were projected to realize less Medicaid revenues under the new plan than they would have received under the previous rebased Medicaid rate in place in mid-2011. In several of those county homes, the projected cumulative reductions over the six years would total well over a million dollars each, including about five where the plan could result in cumulative shortfalls of $3-4 million or more per facility.

It should be noted that as this is written, the question of the Medicaid global cap is being discussed by the State Department of Health, in conjunction with other key stakeholders. Some are suggesting that the cap may be adjusted in other ways through the influx of additional federal funding via the Affordable Care Act and as a result of initial reductions in Medicaid spending through various efficiencies resulting from the state's Medicaid Re-design Team. And ultimately all of the pricing discussions may be overtaken and replaced by new rates under managed care plans being discussed (see further discussion below).

Intergovernmental Transfer (IGT) Program

In recent years, in many cases how well county nursing homes have been able to cope financially with the fluctuations and uncertainties of reimbursements from their two leading sources of revenues for resident services (Medicaid and Medicare) has depended on the availability in a given year of Intergovernmental Transfer (IGT) funds. The IGT and its impact on county homes are discussed in more detail later in Chapter VI.

It is sufficient to say here that the IGT is a federal initiative carried out in partnership with the state, and that it is only available as a source of

revenue to public nursing home facilities (it is not available to non-profits or for-profit homes). The funds have helped offset some of the shortfall in Medicaid reimbursement rates and to recognize some of the particular burdens faced by public homes in terms of high benefit costs and the realization that these homes often will accept "hard to place" residents that other homes are reluctant to admit. In order to access available IGT funds, a county must first provide a 50% match out of the county general fund.

Although this funding source has been available for some 20 years, its existence from year to year has not always been assured, and even when funds have ultimately been released to county homes, the actual distribution has often lagged by more than a year from the time the county amounts were announced. With both the amounts and the timing of release uncertain, this important source of revenues for county homes has been one more source of uncertainty and frustration to county home administrators and to overall county leadership attempting to plan rationally in a climate with so much revenue uncertainty.

IGT funds often have a huge impact in determining the financial viability in a given year of county homes, but the existence and amounts of IGT funds fluctuate considerably from year to year, and the future of the funds is uncertain.

Earlier in 2013, the latest round of IGT funds (for the federal 2011-12 fiscal year) was made available and payments made to all counties that chose to provide the matching funds. In some of those homes receiving IGT payments in 2013, those revenues will make the difference between being in the black or red financially for this fiscal year. Available amounts ranged from about $1.1 million to as much as $11.1 million, with an average potential payment of about $3.8 million per county facility.

What remains uncertain at this point, however, is the future of the IGT funds going forward. Some sources suggest that they will continue to be available for the foreseeable future, and others expect them to remain available to counties at least until federal health care reforms begin to be fully implemented in 2014, with uncertainty after that. There is no current expectation that this funding source for county homes will disappear, but its future is simply unknown.

In addition to the core unknown about the future of this key source of funding for county nursing homes, another issue has been raised recently concerning whether, even if the IGT payments continue, they will be compromised by future shifts to managed care (see discussion below). The question has been raised concerning whether, for any future residents enrolled in Medicaid managed care, their resident days would potentially not count as Medicaid days, and might therefore jeopardize future IGT payments keyed in part to overall Medicaid fee-for-services revenues. This issue is just beginning to surface and has not yet been resolved.

Clearly, any assumptions about the future of IGT payments to county nursing homes should be made cautiously; but as of now, there is no indication that IGT will cease to exist at any particular time, although the

levels and timing of IGT funding remains uncertain. And even if IGT continues for the foreseeable future, it is important to note, as made clear by previous delays in payment dates, that payments are generally not received in the same year in which the funds are announced. Rather, there can be, and typically is, a significant lag time before funds are received at the county level. Also, it is important to remember that the IGT payments must be matched by each county from its general fund in the year in which any payments are made (as discussed in more detail in Chapter VI).

Managed Care

One of the major unknowns, and greatest perceived threats, concerning the future of all nursing homes, but especially county-owned facilities, is the pending expansion of Medicaid managed care. As an alternative to the current fee-for-service reimbursement model, managed care would be designed to pay set premiums to managed care plans, and nursing home providers (not just county homes) fear that the rates they will in turn be able to negotiate with the plans will fall short of current fee-for-service levels, even as their costs continue to rise. But nothing is yet certain as to the future of these approaches across the state.

Early mandatory expansion is being tested initially in the New York City area, involving dual-eligible (Medicaid and Medicare) individuals 21 and older who need community-based long-term care services for 120 days or more. Most nursing home residents are specifically excluded from being enrolled in Medicaid managed care at this point. Phase-in of this model is being expanded to other regions of the state between 2013 and mid-2014, but there are signs that this timeline is already being pushed back. Successful implementation partly depends on having sufficient managed care plans engaged in a region, and having a network of service providers sufficient to respond to the needs.

A new era of managed long-term care appears on the horizon, with unknown implications for nursing homes of all types. No one yet knows the financial implications for nursing homes, though the general expectation seems to be that reduced revenues will result. The timing of long-term-care implementation remains uncertain, especially for upstate counties, though it may begin sooner than initially anticipated.

The state is currently planning to phase enrollment of the nursing home population into managed care beginning as early as January 2014. Exactly when and how, and with what impact, remains very much unknown. October 2013 is scheduled as the startup for statewide enrollment for Medicaid-only persons, although it seems likely that there will be some type of phased rollout across the state, over a period of time and geographic areas yet to be determined. The state is also envisioning enrollment of the dual-eligible nursing home population into dually-capitated managed care plans beginning as early as October 2014 under a proposed demonstration Fully Integrated Duals Advantage (FIDA) program.

And while the general expectation is that significant expansion of the managed care model will lead to reductions in revenues for nursing homes, others are not so sure, and expect little or no net reduction in

revenues, depending on market conditions, the extent to which community-based alternatives exist in each county, what levels of quality care are provided and how facilities perform on quality measures yet to be determined. Skills in negotiating rates and conditions with insurance companies may become critical in the process if nursing homes are to survive and thrive in the future.

Uncertainties notwithstanding, *there seems to be little real doubt that managed care is on the horizon, and eventually will become a key factor in how nursing homes are funded and conduct their business. The question is how soon, and with what impact.*

At one time the "conventional wisdom" suggested that it may have taken perhaps as much as four to five years before managed care would make major inroads into nursing homes in western NY. More recent estimates suggest that the state is now envisioning Medicaid managed long term care enrollment of new upstate nursing home residents beginning as early as 2014.

Conclusions Concerning Non-County Revenue Sources

Making realistic assumptions about the future of various state and federal sources of revenues, and about the future of long-term managed care, will be instrumental in county decisions concerning the future of their nursing homes.

So many uncertainties face county officials concerned about the future of their nursing homes—including such things as the future implications of the Affordable Care Act, the future of Intergovernmental Transfer (IGT) funds to county nursing homes, new statewide Medicaid funding approaches, reduction in Medicare reimbursements, and the timing of likely expansion of managed care. Certainly any county that is pondering its options, including consideration of staying in the public nursing home business, should be realistic in its assumptions about the availability and levels of future non-local revenue sources, and how well it would be able to function if those levels decline significantly in future years.

NYS Property Tax Cap Adds Pressure

In 2011, New York State enacted the "Real Property Tax Levy Cap and Mandate Relief Provisions" law (known alternatively as the "property tax cap"). Beginning with the 2012 fiscal year, local municipalities and school districts are not authorized to increase the property tax levy by more than a set percentage, after applying several exemptions such as pension and health benefit costs.[19] While the cap is commonly viewed as a 2% limit, in practice the allowable amount may range above or below this

[19] The property tax cap includes a multi-step formula to determine the permissible amount of increase, which varies for each municipality.

figure. Local governments can surpass the tax cap only if the governing body, or in some instances the public, approves overriding it with a minimum 60% vote.

On top of cost increases, reductions in revenues and uncertainties about their future, and increases in needed county subsidies, the property tax cap rounds out the "perfect storm" of barriers facing those seeking to make county nursing homes financially sustainable in the future.

The tax cap in some ways represents the "final straw" for those seeking to find ways to make county nursing homes viable and sustainable in the future. With increasing nursing home costs, uncertainties about future revenues, and increasing county subsidies needed to sustain county homes, the addition of the property tax cap further limits the degrees of freedom available to county officials, and puts added pressure on municipalities to find cost-cutting and/or new revenue-generating opportunities, particularly in non-mandated service areas such as county nursing homes.

County Government Barriers to Nursing Home Operating Efficiencies

The institution of county government itself is often part of the environmental context that makes cost-effective sustainability of public nursing homes so difficult. As noted above, decisions made, often long ago, by elected officials in conjunction with public employee bargaining units at state and local levels have contributed to the financial burdens now exacerbating the financial status of the public home institution. These decisions—both financial in the case of salary and benefit levels, and operational in the case of decisions affecting working conditions, filing of grievances and various other protections for workers—have typically been made with the best of intentions to protect the well-being of public employees.

Some past decisions about wages and benefits, and about various protections for workers, typically made with the best of intentions for the good of nursing home workers, have unwittingly combined to limit current management flexibility and financial sustainability in many county nursing homes.

But in difficult financial times, many of these decisions have unintended consequences in terms of financial and operational management of nursing homes that make cost-effective, financially-sustainable management and ownership of such public facilities very difficult—especially in contrast to many of their competitors in the for-profit and non-profit sectors, which typically have fewer financial and management constraints, thus enabling them to operate at substantially lower costs. Whatever the implications of these contrasting approaches from the standpoint of employee well-being, types of care provided, and types of residents accepted (all issues addressed in more detail in subsequent chapters), the reality is that these government-made decisions over time have made the future sustainability of public nursing homes more in question.

Moreover, the interests and unique concerns of a nursing facility that operates on a 24/7 basis are very different, from both a management and employee perspective, than are the interests and concerns of management and employees in most other county departments. The absence in most counties of a separate bargaining unit for their nursing homes that can

address those unique concerns has been viewed by some as creating significant management challenges for the administration of those facilities, and has helped contribute to the large number of call-in absences many experience each day, and to the difficulty of developing either effective disciplinary practices or incentives to address this and other issues unique to nursing homes. Some have argued that the lack of a separate bargaining unit puts some county nursing homes at a distinct disadvantage relative to its competitors and acts as a barrier to the facilities being able to live up to county government expectations of running like a mission-oriented business.

Finally, the often-complex decision-making process inherent in most county governments often works against efficient operations of county nursing homes. The need to bring both legislative bodies and elected executives or appointed administrators together on both budgetary and operational decisions concerning both day-to-day and longer-term issues—compounded by the need in many counties to receive time-consuming approval by more than one committee for often-mundane matters to proceed—can make even the most efficient nursing home administrator appear indecisive and unable to effectively manage and control his/her facility. Delays of a month or even longer in receiving approval for routine staffing or other requests affecting the well-being of residents and the financial well-being of the facility are not uncommon in some counties.

Decisions about the future of county nursing homes can also become bogged down in lengthy discussions between committees and branches of government. Those debates are often part of healthy processes inherent in a democracy, but are also used in some counties as justification for streamlining decision-making processes concerning potential sale of nursing homes, by creating local development corporations for the purposes of expediting the process of transferring ownership of the county home, and bypassing many of the steps and potential barriers built into county government deliberations. Some counties refuse to abdicate their governmental responsibility to carry out all aspects of decision-making concerning the future of their nursing homes, while others, once a core decision has been made to sell, seem happy to turn over the final process of finding a buyer to others, under the rationale of expediting the process, and in so doing saving the county money by reducing the length of time it will need to continue to own a financial liability.

Nursing Home Competition

The final environmental factor to be discussed is the degree to which county nursing homes face competition in their counties and surrounding regions.

In 15 of the 33 counties owning nursing homes at the beginning of 2013, there were three or fewer non-county (for-profit or non-profit) nursing home competitors within county borders, including one county with no other nursing home competitors, another with a single alternative within the county, five with 2 competitors, and eight with 3. Another five counties had 4 or 5 other non-county-owned nursing homes; seven had 6 to 9; two had 10 to 14; and four large counties had more than 30 other nursing facilities spread within their county boundaries. Most of the counties had a mix of for-profit and non-profit competitors; only eight of the 33 had either no competitors (one) or only one or the other (three counties with only for-profit competition and four with only non-profits). For a graphic depiction of the distribution of nursing homes in these 33 counties, along with nursing homes in other counties of the state as well, see Map 2 in the next chapter.

In considering the future of county homes and what would be likely to happen if they were no longer owned by county governments, decision-makers need to factor in not only the number of other nursing homes in a county, but also the number of beds represented by those facilities. As noted earlier, 20 of the 33 counties have overall shortages of nursing home beds through 2016, based on calculations by the State DOH.

Taking such factors into consideration, county nursing home administrators and the key county leaders/decision-makers in each county with a public nursing home were asked by CGR about the impact of competition on options their county may consider about their home's future, and about the viability of alternatives if the county were to no longer own its nursing home. Nineteen of the home administrators indicated that they believe they had three or fewer "primary competitors," including six who felt they had no primary competition. The most-cited characteristics that they perceived distinguished their county homes from their primary competitors were: reputation for quality care, quality of staff, the facility itself, facility location, special services offered, and willingness to admit persons other facilities are reluctant to admit.

When asked what impact their competition has on options their county may consider, almost 40% said the other existing homes would have little or no impact on any future decisions, while 27% said the lack of competition would make the continuation of the home under the county essential; another 12% said strong competitors in the region have the effect of reducing the need to continue as a county-owned operation.

Asked to select their top two from a list of possible concerns should their county home be sold, just over 80% of the county leaders cited continuing the quality of care provided to residents, and 26% indicated continuing availability of care to certain subsets of the population. Reported concern

for availability of care to specific subsets was even more prevalent (58%) if the county were to actually close, rather than sell, the home.

With those concerns in mind, 70% of the county leadership said there were reasonable alternatives available to current and potential future residents if the county were to no longer own its nursing home, including a handful who thought the new owners could be counted on to meet those concerns, regardless of other options available in the community; another 22% said there were no reasonable alternatives; and in 9% of the counties, the leaders expressed differing views. Asked the same question, the administrators of the county homes expressed a range of perspectives: more than a third of those responding indicated confidence that a new owner would be able to provide continuing high quality of services to all in need; 13% expressed confidence that other homes in the area could perform similar services; and about a third said other homes could provide reasonable alternatives for most, but expressed some concerns that some of the neediest may not be served and/or that the quality of care may suffer under new ownership. About one sixth of the administrator respondents expressed concerns that there were insufficient beds in the area to absorb any future potential residents whom new owners may be reluctant to admit.

The amount and nature of nursing home competition in a county can help shape what decisions are made about the future of county homes, particularly the extent to which potential new owners or other homes in the county could be expected to absorb "safety net" or "hard to place" residents in the future.

Pushed for their assessments of what would most likely happen to "safety net" or "hard to place" residents if the county home were to be sold to a new owner, almost 45% of county home administrators expected that at least some of the residents would have a hard time being placed elsewhere, and 30% expected that some residents would have to be placed in a home outside the area.

Counties contemplating the possibility of selling or closing their nursing homes will need to decide how much consideration to give to these factors as they consider their options. Perceptions of home administrators and county leaders, and how various factors help shape county decisions, are addressed in more detail in Chapter VII.