

The Future of County Nursing Homes in New York State

August, 2013

Prepared for:
New York State Health Foundation

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SUMMARY

Virtually all nursing homes across New York State—whether operated by a county, for-profit company, or non-profit operator—face wide-ranging, significant challenges. For county-owned homes, however, the future is especially troubled.

The Center for Governmental Research (CGR) of Rochester conducted a year-long, statewide study that focused on nursing homes owned by 33 counties, four homes sold by other counties since 2005, and two homes closed by counties in recent years. The study did not include nursing homes in New York City.

The New York State Health Foundation funded the study to identify key consequences of previous decisions to shift nursing home beds from the public to the private sector. The Foundation also supported CGR's goal to provide data-driven policy guidance to the state and to counties owning their own nursing homes.

CGR's analysis of relevant statewide datasets, case studies of county homes previously sold or closed, surveys of county officials and nursing home administrators, and interviews with stakeholders and industry experts, lead us to the following major conclusions:

1. The financial stability of county homes has eroded substantially over the past several years, as has the commitment of county officials to continue operating the facilities. In 2010, 92% of the county homes in the state lost money, with median losses per resident day doubling since 2006 and quadrupling since 2001. County homes are rapidly losing market share to non-public homes, particularly to for-profit providers.
2. A relatively recent, yet steady decline in New York counties owning and operating nursing homes could become a notable exodus in the near-term future. At least eight counties are currently in various stages of selling their homes, and at least five more have indicated that they are actively considering selling.

3. But many counties are currently planning to stay in the nursing home business. For them, continuing to conduct business in the future as they have in the past is unsustainable. County homes, county governments and the state must think strategically about their future.
4. Much of the annual operating deficit faced by the 33 counties that operate nursing homes is attributable to high costs of employee benefits, largely due to health insurance and pension costs. Median employee benefit costs per resident day in county-owned homes rose 181% in the 10 years ending in 2010. This is due in large part to long-ago negotiations by state and county elected officials, and union leaders. Without intentional, collaborative efforts by key stakeholders to address these issues and implement needed changes, most county homes have little chance to survive.
5. The results of recent sales and closings of homes are, to date, mixed. On the positive side, they have reduced costs to counties and in some cases facilities and care have improved. However, one of the four homes sold was later closed by the state due to poor performance, displacing more than 100 residents; and in some facilities staffing and quality of care have declined. For the most part, the oft-cited fear that “hard-to-place” residents would not be served if homes were sold has not been realized, as most new operators have admitted such residents.
6. Outright closure of existing county homes appears to have few, if any, real advocates among county leaders.
7. Decisions about the future of county-owned nursing homes are typically being made without a sufficient context. Few of NY’s counties have comprehensive long-term-care plans in place, despite projections that the state’s population is growing older and living longer.

In exploring the future of county nursing homes, county leaders must do due diligence, ranging from exploring ways of reducing internal costs and enhancing revenues to weighing the potential for selling the home, and if so, carefully considering to whom and under what conditions. The unique circumstances that exist in any county, and the variation in outcomes of previous sales, point to the need for counties operating homes to carefully consider their own situation and options. Key variables to consider include:

- ❖ The number of other nursing homes in the county;

- ❖ Whether the county has an overall surplus or shortage of nursing home beds;
- ❖ Projections of 75+ and 85+ populations over the next decade and beyond;
- ❖ Incidence of indigent elderly county residents;
- ❖ History of serving high proportions of Medicaid and other “hard-to-place” residents;
- ❖ Availability of long-term-care services other than nursing homes to county residents.

Specific recommendations for the state and also guidelines for counties weighing the future of their nursing homes are outlined in significant detail in the final chapter of the report. Highlights of those recommendations and guidelines are provided below.

State Recommendations

A key recommendation for NYS officials is to work with their federal counterparts to ensure the future availability of the Intergovernmental Transfer (IGT) Program. IGT, a federal initiative carried out in partnership with the state (and requiring a 50% match from a participating county) offers a needed source of revenue to county nursing homes.

Other recommendations include providing supplemental financial incentives to selected nursing homes that meet specific criteria (e.g., demonstrated need, significant admissions of “hard-to-place” residents); expanding partnerships with counties to thoroughly assess options for the future of their county homes; and providing incentives to help counties establish expanded community-based, long-term-care services that supplement institutional nursing home care.

County Guidelines

In addition to thoroughly exploring options for their homes before making decisions about their future, CGR’s recommended guidelines for county officials and nursing home administrators include developing county long-term-care plans and expanding community-based services; and strengthening working relationships between nursing home administrators, labor representatives and county officials to make county homes more financially viable.

For those counties that opt to sell their homes, the guidelines call for establishing clear county criteria and expectations for potential buyers to meet; and holding potential buyers accountable for meeting those expectations.

Study Website

CGR has created a special website where key findings, recommendations for the state, guidelines for counties, the full report, information on study partners, and more are posted. See: www.cgr.org/NY-county-nursing-homes.

Acknowledgements

Support for this work was provided by the New York State Health Foundation (NYSHHealth). CGR gratefully acknowledges the leadership of NYSHHealth in understanding the need for and potential value of this study, and in backing up that understanding by providing the financial resources to make the study possible.

The mission of NYSHHealth is to expand health insurance coverage, increase access to high-quality health care services, and improve public and community health. The views presented here are those of CGR and not necessarily those of the New York State Health Foundation or its directors, officers, or staff.

We could not have completed this study without the data analysis support, consultation, and substantive insights and advice of LeadingAge New York. We are especially appreciative of the contributions of Daniel Heim, Linda Spokane, Darius Kirstein and Zulkarnain Pulungan.

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Thanks also to the many county leaders and county nursing home directors who took time to complete detailed surveys, and to state and local officials, and nursing home residents, who shared their insights related to various aspects of the project.

Staff Team

Whatever criticisms are raised about this study should be directed to the project director. Whatever praise is associated with the report should be shared with a number of dedicated staff who provided significant contributions to many components of the study. First and foremost, Project Manager Erika Rosenberg was responsible for the case study/ impact of transfer of ownership portion of the study, and wrote the chapter detailing her findings, as well as playing key roles in survey design and other aspects of the project. Vicki Brown helped conceptualize the project from the beginning, and played the lead role in developing a wide range of

project deliverables apart from the report itself. Kent Gardner helped with project conceptualization and advice and final recommendations. Katherine Bell and Rachel Rhodes were instrumental in analyzing and making sense of the extensive survey findings, and following up with survey respondents to ensure that we received the most complete and accurate responses possible. Mike Silva worked his magic in making sense of voluminous data from LeadingAge New York, and converting the information into graphs that told a story more eloquently than the surrounding narrative. Eric Hepler provided important analyses of key demographic data at the county level. Scott Sittig helped with the case study analysis, and Dan Whalen provided data support early in the project. Jaime Saunders was also helpful early in the project in conceptualizing data organization and analysis and framing key issues to be addressed.

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I. INTRODUCTION AND CONTEXT

A steady decline in New York counties owning public nursing homes threatens to become a mass exodus in the near-term future, as numerous counties are in the process of selling or seriously considering sale of their homes.

Fifteen years ago, 40 of New York's counties outside New York City owned and operated a total of 44 nursing facilities¹. By the spring of 2013, the number of non-NYC county-owned nursing homes had declined by 20%, from 44 to 35. As shown on the map on the next page, by early 2013 only 33 of the original 40 counties continued to own a nursing facility (a 17.5% decline), as seven counties representing most regions of the state, from northwest to southeast and in between, have made decisions to opt out of public nursing home ownership.² Since the late 1990s, an average of one county nursing home has ceased to exist (either through transfer of ownership to a non-public owner or through closure) every two years.

This steady decline in recent years threatens to become a massive exodus from the public nursing home playing field over the next two to three years and perhaps beyond. As discussed in detail later in this report, at least eight of the remaining counties currently owning nursing homes have recently taken significant steps in the direction of selling their homes, and others are considering selling. So it is not unlikely that two or three years from now, the number of counties owning their own nursing facilities could well be 25 or even fewer.

Threats to the Future of County Nursing Homes

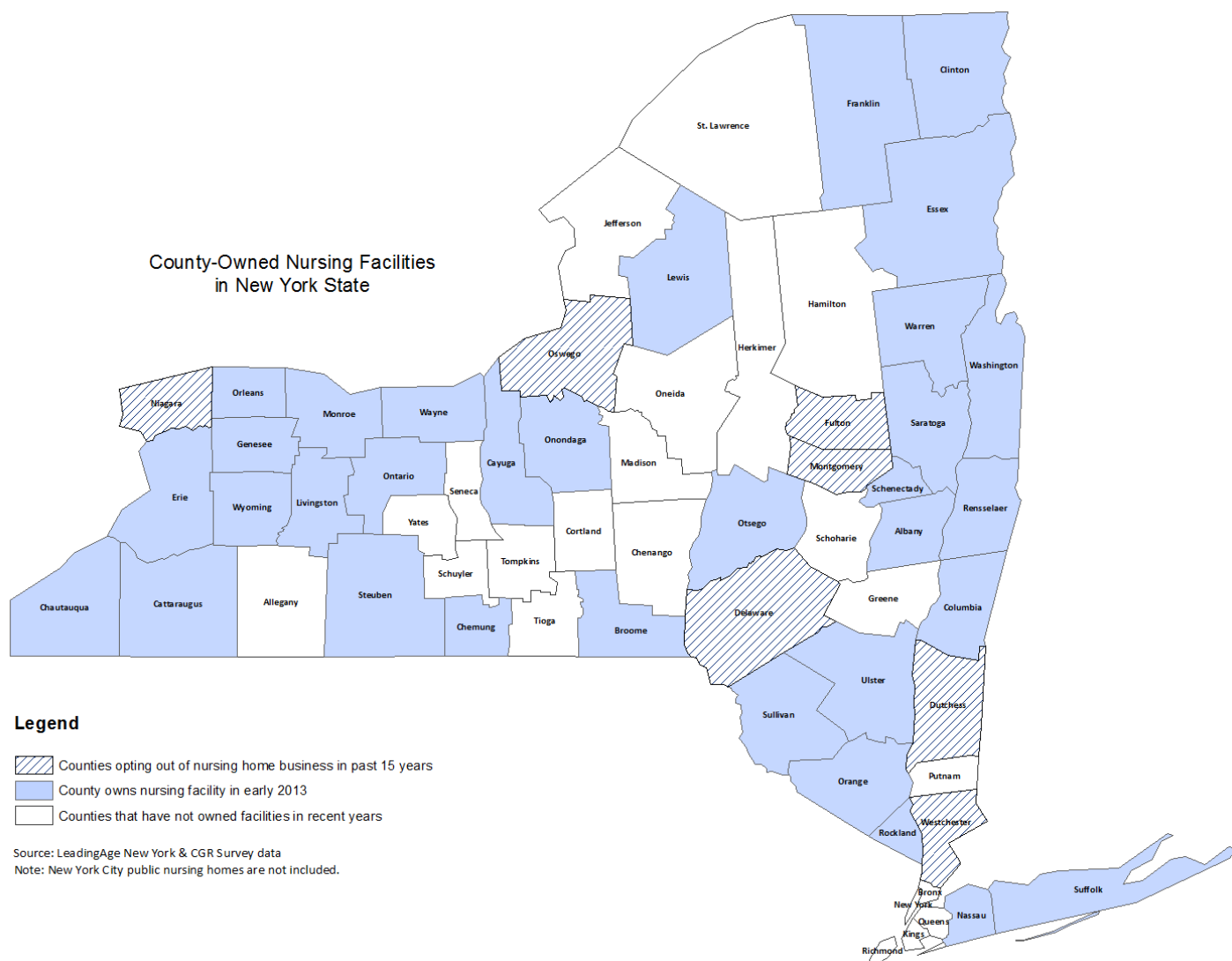
As recently as six years ago, in a statewide study of issues facing county nursing homes, about 70% of the county home administrators, while acknowledging various concerns about the future of their facilities, nonetheless indicated that they were not at that time feeling any "active encouragement" to consider sale or other dramatic alternatives for their homes' futures.³ So why this recent surge and heightened sense of urgency for counties to take steps to move away from their decades-long commitment to operating public nursing homes and their oft-stated commitment to serving "disproportionate numbers of often low-income, hard-to-place" county residents?

¹ Not counting an additional five public nursing homes in the NYC boroughs.

² In addition to the seven counties shown on the map that no longer own nursing homes, the counties of Albany and Livingston, which used to own and operate two facilities each, now each own only one home. Cattaraugus is the only county which continues to own two facilities; Erie also owned two until merging into a single facility early in 2013.

³ See CGR, *County Nursing Facilities in New York State: Current Status, Challenges and Opportunities*, September 2007.

Map 1



To be sure, even six years ago, there were beginning to be clear signs of vulnerability among some county nursing facilities. As stated in that 2007 report, the future of county homes even then was beginning to be endangered by increasing costs, reimbursement levels that failed to cover those costs, and resulting increases in operating losses, accompanied by the need for increasing county subsidies. *Since then, those initial warning signs have become a clear unmistakable trend in virtually all remaining county nursing homes.*

Reimbursement rates and levels have continued to decline; costs—some controllable by the homes, others affected by decisions not controlled by home administrators—have continued to escalate; and county officials have become increasingly alarmed at patterns of increasing county home deficits and their implications for increasing costs to taxpayers of continuing to own and operate the non-mandated county homes. Add to

that the uncertainty of the continuation of revenue sources such as Intergovernmental Transfer payments, the uncertain implications of health care reform and of the emerging trend toward managed care coverage, and the implications for counties of the New York State property tax cap—and a “perfect storm” of threats to the future viability of county nursing homes becomes clear.

A perfect storm of threats and barriers makes county nursing homes vulnerable, and yet many county leaders are reluctant to sell in the face of other competing realities.

Financial considerations are not all that is at stake, however. For example, county nursing homes typically have been in operation for many decades, and have been considered an important part of their county’s mission, often serving residents other non-public nursing homes are reluctant to serve. In addition, in several counties, few other non-county-owned nursing homes exist as viable options to offer long-term-care services to county residents, as discussed in more detail in the next two chapters. Moreover, the average county home serves more than 200 residents per day and employs almost 300 people.

So with hundreds of lives affected, and often one or more public employee unions involved, elected officials are understandably reluctant to alter the status quo. Thus tensions exist between these different and often competing realities, and *counties are increasingly faced with either needing to find ways to significantly reduce nursing home costs and/or expand revenues, or to consider alternatives to continuing ownership of their nursing facilities.*

Unknown Impact of Divestiture Decisions

The dilemma of whether or not to sell county nursing homes is exacerbated by the lack of documented evidence concerning what is likely to happen if a county gives up control of the future of its nursing facility. This study attempts to provide such information.

In addition to attempting to reconcile this climate of tensions between historic mission and worsening and uncertain financial realities, county officials seeking to make informed decisions about the future of their nursing homes are also confronted with uncertainty as to what is likely to happen should they decide to sell, close or otherwise dispose of their nursing homes. If they make a decision to divest from county ownership, and in so doing give up control over the future of the facility, what should they assume about the future of the facility, its employees and the current and potential future residents? What should they assume about the future impact on county finances? In short, what assumptions is it reasonable for county officials to make about the likely impact of their decision?

Unfortunately, beyond anecdotal information, to date there has been no systematic objective analysis of the consequences—positive and negative, anticipated and unanticipated—of closing or transferring ownership of county nursing homes and of shifting beds from the public to private sectors; of what impact such previous decisions have had on the “safety net” role often attributed to county homes and the vulnerable populations they serve; of what impact the decisions have had on employees of the county facilities; of how such decisions have impacted county government

and its financial profiles; and of whether and how state policy and reimbursement practices should be affected in the future. This study is designed to address these and related issues.

Study Focus and Purpose

The New York State Health Foundation agreed to fund this study to “identify the important consequences of shifting nursing home beds from the public sector to the private sector, in order to determine public policy implications for New York’s nursing home system.” The study was designed to document the tangible results of previous decisions to close, sell or maintain county nursing homes, in the context of a comprehensive analysis of the changing environment in which nursing homes in general, and county homes in particular, exist. This study’s focus on the impact of previous county decisions to sell or close their nursing homes, and the potential value of understanding such previous impacts in helping shape future decisions facing other counties—in combination with its comprehensive analysis of the current and evolving status and characteristics of, and challenges facing, county nursing homes—is unprecedented in New York. As such it is designed to provide objective data-driven policy guidance to the state and to counties deciding the future of their nursing homes in coming years.

The NYS Health Foundation funded this study to identify key consequences of previous decisions to shift nursing home beds from the public to the private sector, with results designed to provide data-driven public policy guidance to the state and counties deciding the future of their nursing homes.

It should be emphasized that this study is, by design, focused primarily on the historic and current status, and future, of *county/public* nursing homes and the public policy implications of support for such facilities. It also places those county facilities in the larger context of the nursing home industry in general, represented by the county homes’ competitors of for-profit and non-profit components of the nursing home business.

Who Did the Study

CGR (Center for Governmental Research) conducted this study. CGR is an independent non-profit with 98 years of experience as an award-winning provider of strategic research and analysis throughout New York and beyond. CGR has an extensive history of conducting high-quality work in the areas of health and human services, including a statewide and county-specific focus on long-term care issues. We have both a big picture perspective, and a more detailed understanding of the complex issues and unique characteristics, opportunities and challenges facing county-owned nursing homes. In addition, we have a clear understanding of the dramatically changing environment within which nursing homes operate, at federal, state and county levels. Our relevant expertise includes, but is not limited to, conducting two previous statewide studies of the challenges facing county nursing homes (1997 and 2007) and recently assisting nine counties in assessments of future options for their residential nursing facilities.

Most of the report's trend comparisons between county-owned, for-profit and not-for-profit nursing homes in New York were made possible by our collaboration with LeadingAge New York. Founded in 1961, LeadingAge New York (formerly NYAHS) represents not-for-profit, mission-driven and public continuing care providers, including nursing homes, senior housing, adult care facilities, continuing care retirement communities, assisted living and community service providers. LeadingAge New York's more than 600 members employ 150,000 professionals serving more than 500,000 New Yorkers annually. The organization is involved in advocacy, research, education, and consulting. LeadingAge New York monitors the pulse of state government, and is a respected force in helping shape long-term-care policies at the state and local levels.

In addition, the executive board members of County Nursing Facilities of New York, the statewide association of county homes, provided an important support role during the study.

The crucial funding partner for this study was the New York State Health Foundation (NYSHHealth). NYSHHealth is a private, statewide foundation dedicated to improving the health of all New Yorkers, especially the most vulnerable. Today, NYSHHealth concentrates its work in three strategic priority areas: expanding health care coverage, improving diabetes prevention, and advancing primary care. The Foundation is committed to making grants; informing health care policy and practice; spreading effective programs to improve the health system; serving as a neutral convener of health leaders across the State; and providing technical assistance to our grantees and partners.

Methodology

In order to carry out the purpose and goals of the project, the following primary research components were undertaken:

❖ **Case studies of counties that sold or closed their nursing homes.**

We conducted case study analyses of the impact of previous decisions of six counties that have made recent decisions to close or sell their homes, and compared their experience with comparable counties that, under similar circumstances, decided to keep their facilities, at least to this point. The case studies included the four counties that by 2012 had sold their nursing homes since 2005—Oswego, Delaware, Montgomery and Fulton—and the two counties that closed their only county home in recent years—Westchester and Niagara.⁴

⁴ Dutchess County also sold its county nursing facility in 1998, but that was too long ago for inclusion in our study, given the inability to track down relevant data and key persons knowledgeable about the transfer-of-ownership process conducted at that time.

We interviewed key officials of each county and the affected nursing homes who were familiar with the decisions made at the time, as well as others able to shed light on the current situation post-divestiture of the former county home (and comparable periods for the comparison counties which did not close or sell their homes). We also collected and compared various data concerning the affected facilities and counties prior and subsequent to the sale or closure decisions. We tracked the implications of the county decisions on “pre and post” county tax levies; staffing levels of facilities; case mix indices and other characteristics of residents of facilities; commitments to residents and employees of the county homes; employee retention and salary and benefit levels; changes in net operating gains or losses; indicators of facility quality of care; admission criteria and options available for difficult-to-place residents.

We also assessed “pre and post” changes in capital improvements in the facilities; perceptions of residents, family members and policy-makers concerning the quality of care and services offered; policy-maker post-mortem perspectives on the decisions made, and whether they accomplished what was intended, along with any unintended consequences. We assessed the implications of the decisions county by county, as well as in the aggregate, in order to assess the overall impacts of the decisions and their potential implications for other counties considering divestiture now and in the future.

- ❖ **Trend analyses of aggregate NYS nursing home data.** We placed the case study analyses in the context of a comprehensive analysis of a wide range of data about nursing homes in New York. As in two previous statewide studies done by CGR of county nursing homes,⁵ we conducted detailed trend analyses of aggregate NYS nursing home data, comparing public homes with for-profit homes and non-profits. Trends were compared over a 10-year period (2001-2006-2010—2010 was the most recent year for which most data were available). Major topics / questions addressed in these comparisons focused on such indicators as numbers of beds, staffing, occupancy rates, resident characteristics, quality of care data, payer sources, costs, revenues, net operating gains and losses, and county subsidies. The source for most of these analyses was the extensive historical database on nursing homes throughout the state maintained by LeadingAge New York, with which CGR was pleased to partner on this study. As in the

⁵ See CGR, *What Should Be Done with County Nursing Facilities in New York State*, September 1997, and CGR, *County Nursing Facilities in New York State: Current Status, Challenges and Opportunities*, September 2007.

previous statewide studies, *the focus of these data comparisons was on non-NYC nursing homes.*

- ❖ **Survey of county nursing facilities.** Key components of both this and the two previous statewide studies involved comprehensive surveys of each county nursing home. The administrator of each current county facility was asked to complete a comprehensive survey. Several of the questions in the current and previous surveys were identical, in order to facilitate comparisons of “then and now” responses where possible. A number of additional questions were added to the current survey to address new issues and changing needs affecting county facilities. The survey enabled us to obtain detailed information about various aspects of the county facilities which were not available from other data sources, including specific challenges facing county homes given their particular mission as public facilities, and relationships with their respective county governments.

Ten years of historical comparisons, along with high levels of survey completion by counties with nursing homes, and case studies documenting the impact of previous county home sales and closures, provide comprehensive findings and insights concerning likely implications of any future divestment decisions being considered by counties.

Surveys were obtained from 32 of the 35 non-NYC county nursing facilities, representing 31 of the 33 counties with one or more public nursing homes (a 94% response rate).⁶ Responses were representative of all types of county homes, including all regions of the state, large and small facilities, and urban, suburban and rural counties.

- ❖ **Survey of key county leaders.** In addition to the facility survey, we also surveyed key elected and appointed county leaders/decision-makers in the 33 counties which continued at the beginning of 2013 to own and operate their own nursing facilities. In each county, we attempted to obtain completed surveys from some combination of the following: the county’s elected county executive or appointed county administrator/manager, and the chair of its legislature or board of supervisors. We received survey responses from 29 of the 33 counties (an 88% response rate). In 21 of those counties, we received a single response (two-thirds of those from the county executive or administrator/manager), and in eight we received responses from both the executive/administrator and the legislative/board leader. In the latter cases, the responses were typically similar, but we presented the range of responses for the counties where there were differences in responses to individual questions.

⁶ We received a survey from one of the two Erie County facilities, but not the one that was in the process of being closed and consolidated into a single facility. Most facility surveys were submitted in complete form, but some did not answer a few of the questions. CGR added responses to some of those questions, where we had sufficient information and knowledge of the facility to do so. We are confident in the reliability and representativeness of the facility survey data presented throughout the report, unless caveats or cautions for specific data are explicitly cited in the text.

Whereas the nursing home administrator survey covered both perceptions as well as extensive factual information about each nursing facility, the county leader surveys focused more on the perceived value of the nursing home, and factors likely to shape decisions about the future of the county home. Many of the perceptual and future-oriented questions were similar or identical to those in the nursing home administrator survey, in order to facilitate comparisons where appropriate.

- ❖ **Presentation of preliminary data to County Nursing Facilities of New York (CNFNY) Fall Conference.** One of the initial deliverables in the project was a presentation to the Fall 2012 conference of CNFNY, the state association of county nursing facility administrators. At that conference we presented preliminary 10-year historical comparisons between county/public, non-profit and for-profit nursing homes, and in a follow-up discussion, received valuable feedback that helped shape our subsequent more extensive comparison analyses of the statewide aggregate data, as well as providing guidance concerning the design of the two surveys noted above.
- ❖ **Focus group discussions with county home administrators.** At the same fall CNFNY conference, CGR also facilitated three focus group discussions with administrators of about 20 county nursing homes. As with the survey, the administrators were representative of the variety of non-NYC county-owned homes throughout the state. The discussions were helpful in fleshing out issues and their implications in more detail than was possible with only the written surveys or aggregate data analyses. The discussions focused primarily on circumstances in the counties affecting the future of public facilities, perceived implications of continuing as public facilities versus potential county decisions to divest from future ownership, and information administrators believed was needed by county leaders to help inform their ultimate decisions about the homes' futures.
- ❖ **Coordination with project steering committee.** Throughout the project we had the benefit of input from a steering committee made up of the leadership of CNFNY, as well as consultation with our formal data partner on the study, LeadingAge New York. Their respective input and advice were especially helpful around issues of interpretation of data and reviews of drafts of surveys and of this report. This consultation did not attempt to influence our findings and conclusions, but proved helpful in making sure that key questions were raised during the study, and that our work was placed in the most

timely context possible. Supplementing our knowledge and contacts, we also consulted with our partners to monitor developments at state and federal levels concerning regulations, reimbursement rates, legislation and various policies affecting nursing homes in general, and public homes in particular.

The remainder of this report integrates the findings from the various study components into chapters focusing on the context or environmental factors impacting county nursing facilities; characteristics that distinguish county facilities from other types of nursing homes; challenges and opportunities facing county homes; impacts of previous county decisions to sell, close or maintain their nursing homes; and conclusions, implications and proposed next steps and recommendations for the future.

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.

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.

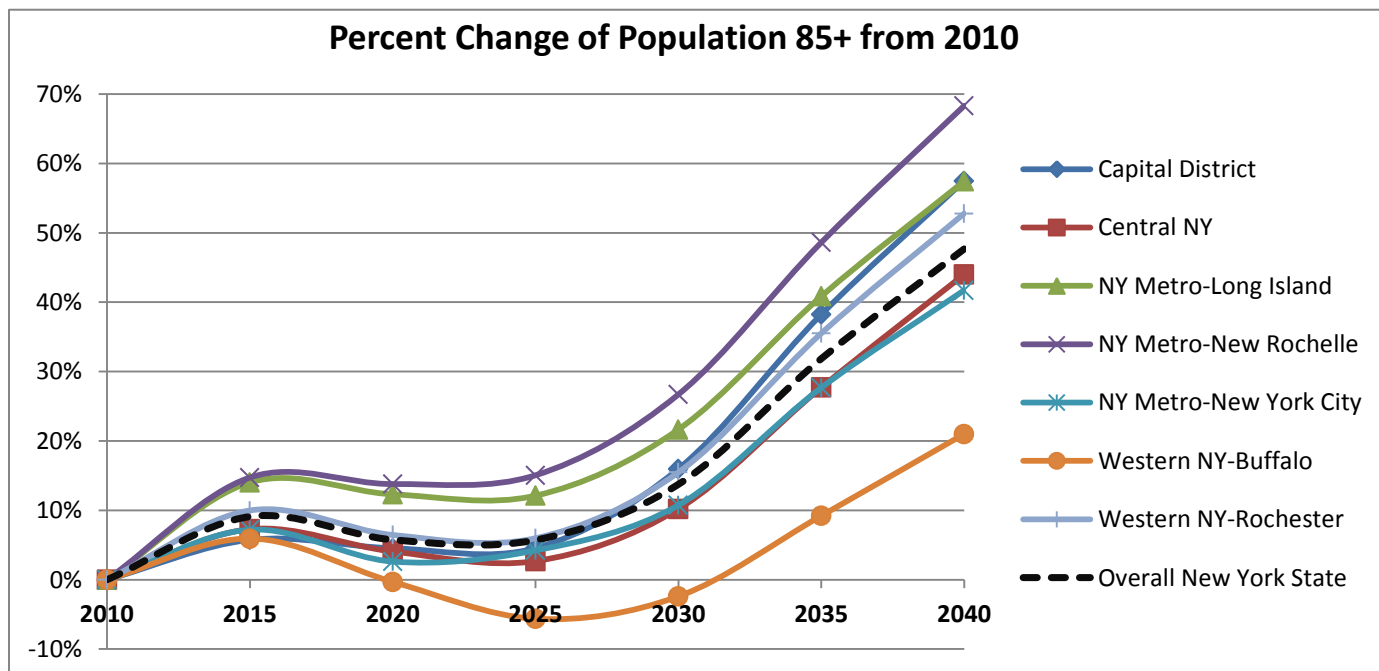
In the 33 counties with their own nursing homes, there will be about 180,000 more residents 75 and older by 2030 than in 2010, and almost 300,000 more by 2040, a 50% increase.

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 lives⁸—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

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

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.

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.

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.

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 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.

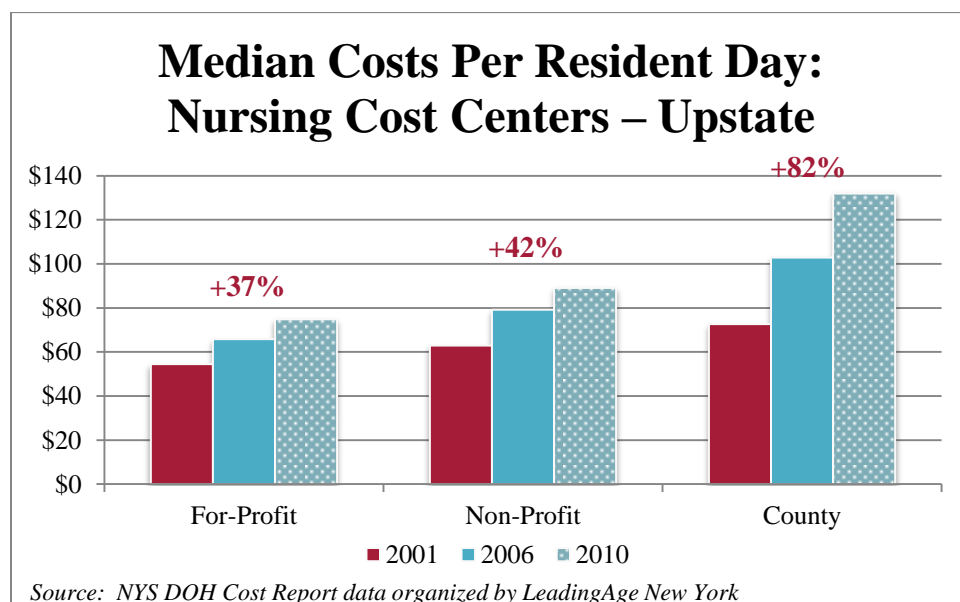
More resources are needed to support the projected growing demand for community-based long-term-care services at the local level.

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



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.

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.

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.

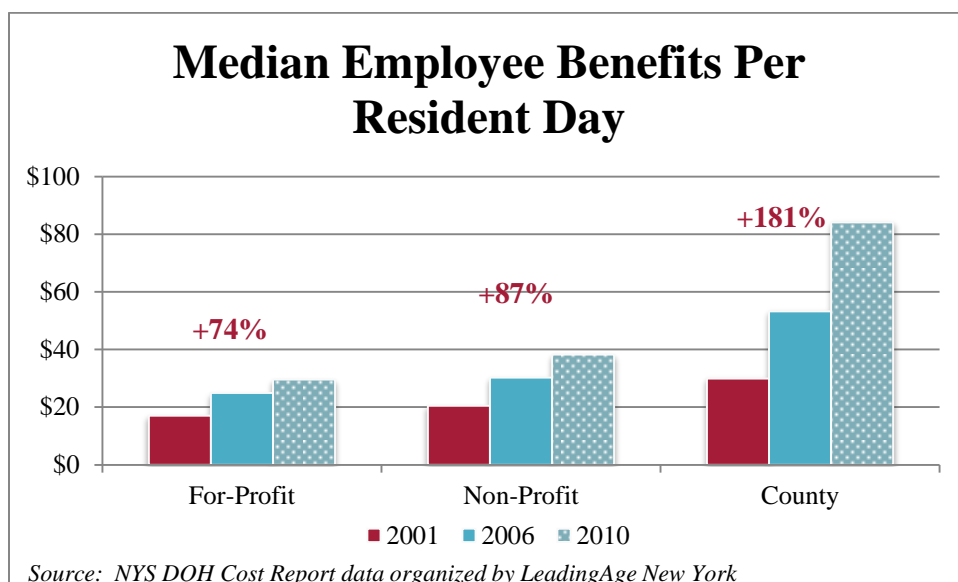
Costs in county nursing facilities consistently exceed costs in other types of homes in virtually all cost center categories. Of the 19 cost centers,¹⁵ the only exceptions in 2010 were in therapist and pharmacy costs in both upstate and downstate, facility administration in upstate and plant operations 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



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.

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.

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.*

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.

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

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.

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.

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.

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.

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.

III. DESCRIPTIVE PROFILE OF COUNTY NURSING HOMES

This chapter provides a descriptive profile of the number, size and other characteristics of county nursing homes; and an indication of how that profile has changed over time and of how it compares with the profile of other nursing homes throughout the state (for-profit and non-profit). As indicated in the Methodology, in most cases comparative data are trended over the past decade, using the years 2001-2006-2010. 2010 was the most recent year for which most data were available for comparison across types of homes. Where more recent data were available from the county home survey, they are included. As in previous statewide studies by CGR, and by previous agreement, *the focus of the comparisons is on all nursing homes outside New York City.*

Most nursing homes in New York are owned by for-profit or non-profit entities. For-profit homes are typically run by an individual or corporation. They function as commercial, for-profit enterprises and typically do not have boards of directors. Non-profit homes are owned and operated by not-for-profit entities, typically responsible to boards of directors. County homes, by contrast, are typically units of county government, and oversight is usually provided by an elected legislature or board of supervisors (except for two in New York that are currently operated as public benefit corporations).

Number and Size of Facilities: County Homes Losing Market Share

Table 2 provides a summary of the number of nursing homes and beds provided across all non-NYC counties in 2012. County facilities clearly represent a minority of all facilities and beds in the state. For-profit facilities account for almost half of all non-NYC nursing homes and beds.

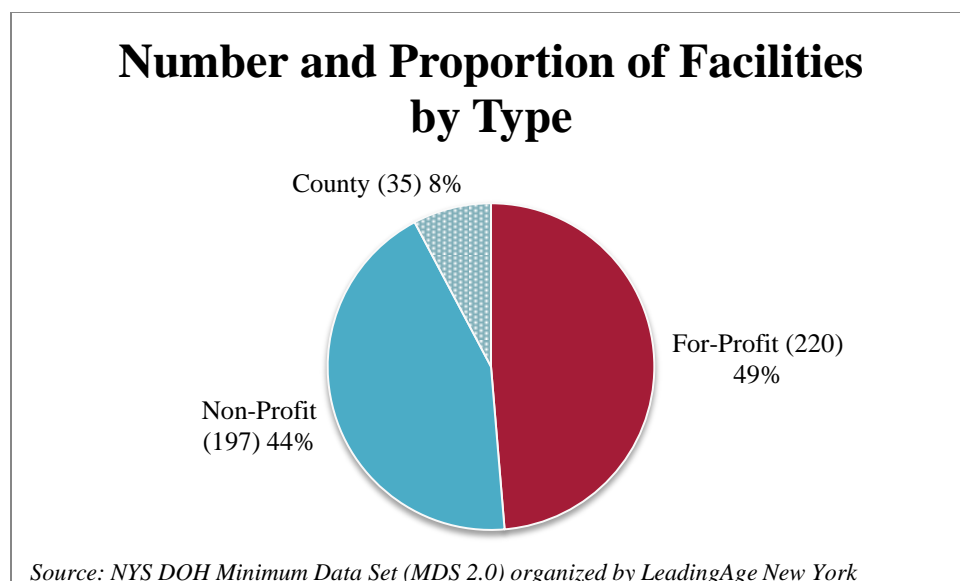
Table 2: Nursing Homes and Skilled Nursing Facility Beds in Counties Outside of NYC, By Type of Facility, 2012

Type Facility	# of Facilities	Total Beds	% of Beds
For-Profit	220	33,756	48.6
Non-Profit	197	27,852	40.1
County	35	7,856	11.3
Total	452	69,464	100.0

Source: Department of Health Cost Report and OSCAR Data, presented by LeadingAge New York. Note: Number of Facilities based on 2010 data.

As shown in Figure 4, county facilities account for about 8% of all nursing homes in the state. Because the typical county facility is larger than their typical for-profit and non-profit counterparts, county homes account for 11% of all nursing home beds, as reflected in Table 2.²⁰

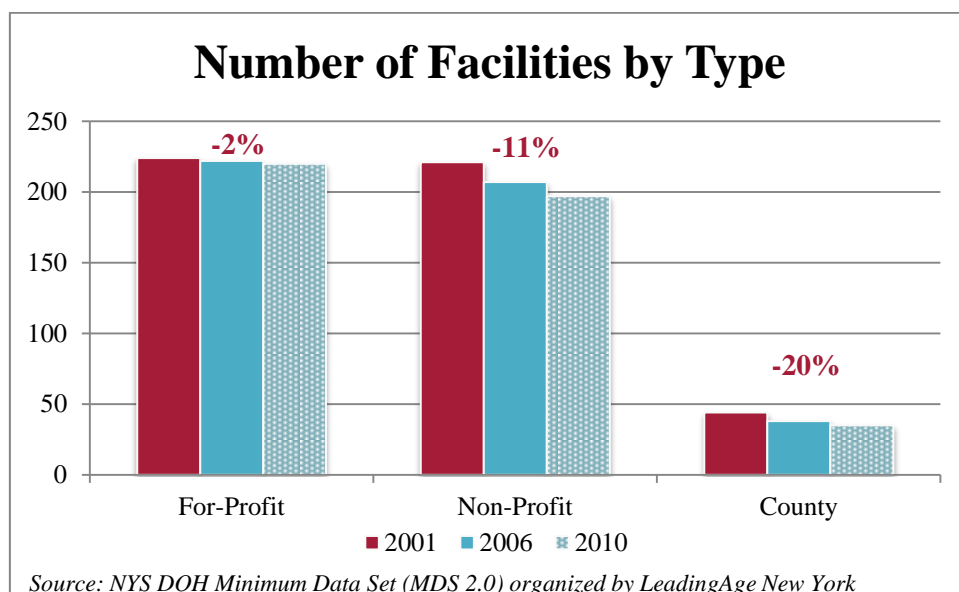
Figure 4



The relative impact and market share of for-profit facilities have been increasing over the past decade, over which time the numbers of county facilities, their beds and the numbers of residents served have all declined, relative to both for-profit and non-profit facilities. As indicated in Figure 5, the number of for-profit homes has remained relatively unchanged since 2001, while the number of non-profits has declined by 24—an 11% reduction. Proportionately, county homes have experienced the greatest decline, a 20% reduction since 2001, with more reductions in process, as indicated in Chapter I.

²⁰ Note that the source for the data in Figure 4 is the MDS data set. The full official citation for all subsequent graphs reporting MDS data is: “Minimum Data Set (MDS) data for all New York State Nursing Homes 2001, 2006, 2010 provided by LeadingAge New York under CMS DUA #08591 and NYS DUA #15407”. Rather than using this full citation, the shortened version of the source citation shown in Figure 4 will be used for all subsequent graphs reporting MDS data.

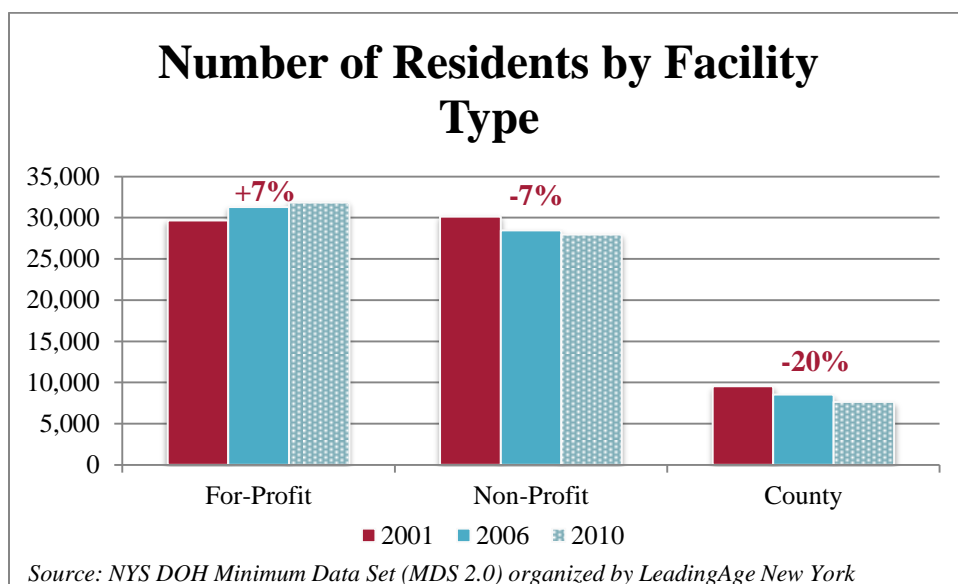
Figure 5



For-profit nursing homes account for almost half of all nursing home facilities and beds in the state, and for a growing market share of all residents served in nursing homes. By contrast, the numbers of county-owned nursing facilities, beds and residents served have all declined in the past decade.

Perhaps even more revealing are the data presented in Figure 6 below, indicating that for-profit facilities have been serving an increasing market share of all non-NYC nursing home residents (based on a snapshot of numbers of residents served in each facility as of the last Wednesday in July of each year). While the number of residents served in county facilities declined over the decade by 20% (a decline of almost 2,000 residents, to just over 7,650 in 2010)—consistent with the reduction in numbers of facilities—the *number of residents served in for-profit homes increased* by 7%, by more than 2,000 to its 2010 total of almost 32,000. In terms of market share, for-profit homes have grown from 43% of all residents in 2001 to 47% in 2010, while non-profits have declined from 43% to 41% and county facilities have declined from 14% to 11%.

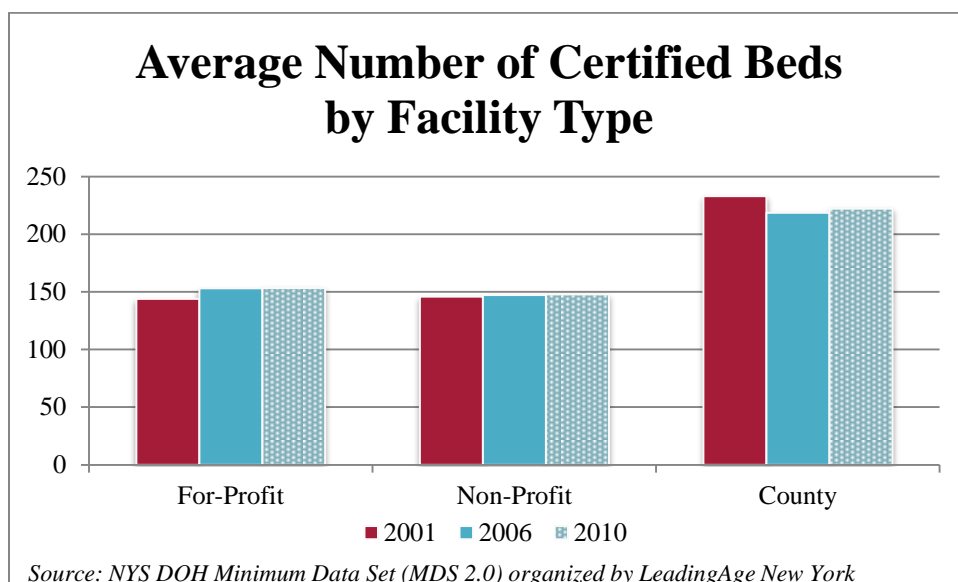
Figure 6



Marketplace shifts have been especially pronounced since 2006, fueled by changes in the numbers of beds across the state. Just since then, the overall number of nursing home beds outside NYC has declined by almost 3,800, including reductions of 14% and 10%, respectively, in county and non-profit beds. But in this time of overall decline, the number of beds in for-profit homes has *increased* by about 500 to its current 49% share of all beds. In addition to reductions in the number of county facilities, seven of the remaining 35 county homes experienced reductions in the number of beds during this time.

As noted earlier, county homes serve somewhat higher proportions of nursing home residents than would be predicted by the small proportion of all homes that they represent. This is a direct reflection of the fact that the typical county nursing home is considerably larger than the average for-profit and non-profit facilities. As indicated in Figure 7, the average county home of about 220 beds in 2010 was between 45% and 50% larger than the typical for-profit or non-profit home, respectively. Whereas a third of non-profit homes, and a quarter of for-profits, have fewer than 100 beds, only 14% of the county facilities are that small. Conversely, 43% of all county homes have more than 200 beds, compared to about a quarter of for-profits and non-profits. Indeed, eight of the 35 county facilities in 2010 had 300 or more beds, including four with more than 500.

Figure 7



Perceived Distinct Mission of County Homes

The historic mission of most public nursing facilities has typically included providing care for disproportionate shares of indigent elderly residents and those with disabilities, as well as other persons considered “hard to place” for various reasons (such as crisis admissions and adult protective cases).

County homes, with their typically larger facilities, have the reputation, often borne out in comments by many of their competitors, of serving higher proportions of “hard to place” residents—the so-called “safety net” role—than do most of their non-public competitors. From this perspective, the relatively small number of county homes tends to mask their significance as providers of service to higher proportions of lower-income, high-behavioral-problem, low-case-mix-index residents. Many of the concerns expressed by both county home administrators and county policymakers about potential consequences of selling their homes reflected uncertainty about what would happen to such individuals in the future, as noted in the previous chapter.

Historically, county homes have had the reputation, often confirmed by their non-public competitors, of serving disproportionate numbers of “hard to place” residents, often viewed as part of their historic mission. Profiles and characteristics of residents are outlined in more detail in the next chapter.

In many, and perhaps most, county nursing homes, over time the perception of the county facilities has evolved from a frequent label as the “home of last resort” (with the connotation that county homes only serve those without the means or the ability to go elsewhere) to facilities perceived as offering attractive, high quality services that are often highly regarded and sought out as the facility of choice by many residents with means and options available to them. Nonetheless, despite changing

perceptions, most county homes do view themselves—as do many of their competitors—as retaining a sense of mission that is not typically shared by for-profit, or even many non-profit homes.

Perhaps unfortunately for the future sustainability of county homes, the perception of the homes as an essential part of the county government’s mission seems to be eroding. When asked six years ago if the county government and its leadership view the county nursing home as “essential to the mission of local government,” a solid two-thirds of the county home administrators said yes, with only four saying definitively “no.”²¹ By contrast, in the current survey, only 47% of the administrators said “very” or “somewhat” essential, including 28% who indicated “very essential.” At the other end of the spectrum, eight (a quarter of the respondents) answered “not essential.” County leadership, when asked the same question, offered slightly more positive responses, with 57% indicating “very” or “somewhat” essential, including 25% saying “very essential,” with 14% saying “not essential.”

The issue of the profiles and characteristics of those served in county facilities is addressed in more detail in Chapter IV.

Governance and Structure of Nursing Homes

As noted above, the policymaking board of each county home is typically its county legislature or board of supervisors (with the exception of two counties, Erie and Nassau, which created their homes, that they continue to support financially, as public benefit corporations; in both cases, those homes are part of nursing home/hospital configurations that together make up the PBCs).²²

All but two of the 33 counties owning nursing homes at the beginning of 2013 owned and operated a single facility. Two counties owned two homes each, but that has now been reduced to a single county, as Erie combined its two facilities into one earlier this year—leaving only Cattaraugus, which continues to own two separate facilities in geographically distinct portions of the county. Both are overseen by a Director of Nursing Homes, who also serves as the administrator of one of the homes, while the other home has its own day-to-day administrator. The Director of Nursing Homes reports to a committee of the county

²¹ CGR, *County Nursing Facilities in New York State*, op cit., p. 62.

²² A third county created its home and hospital into a PBC in previous years, but the nursing home has subsequently been closed.

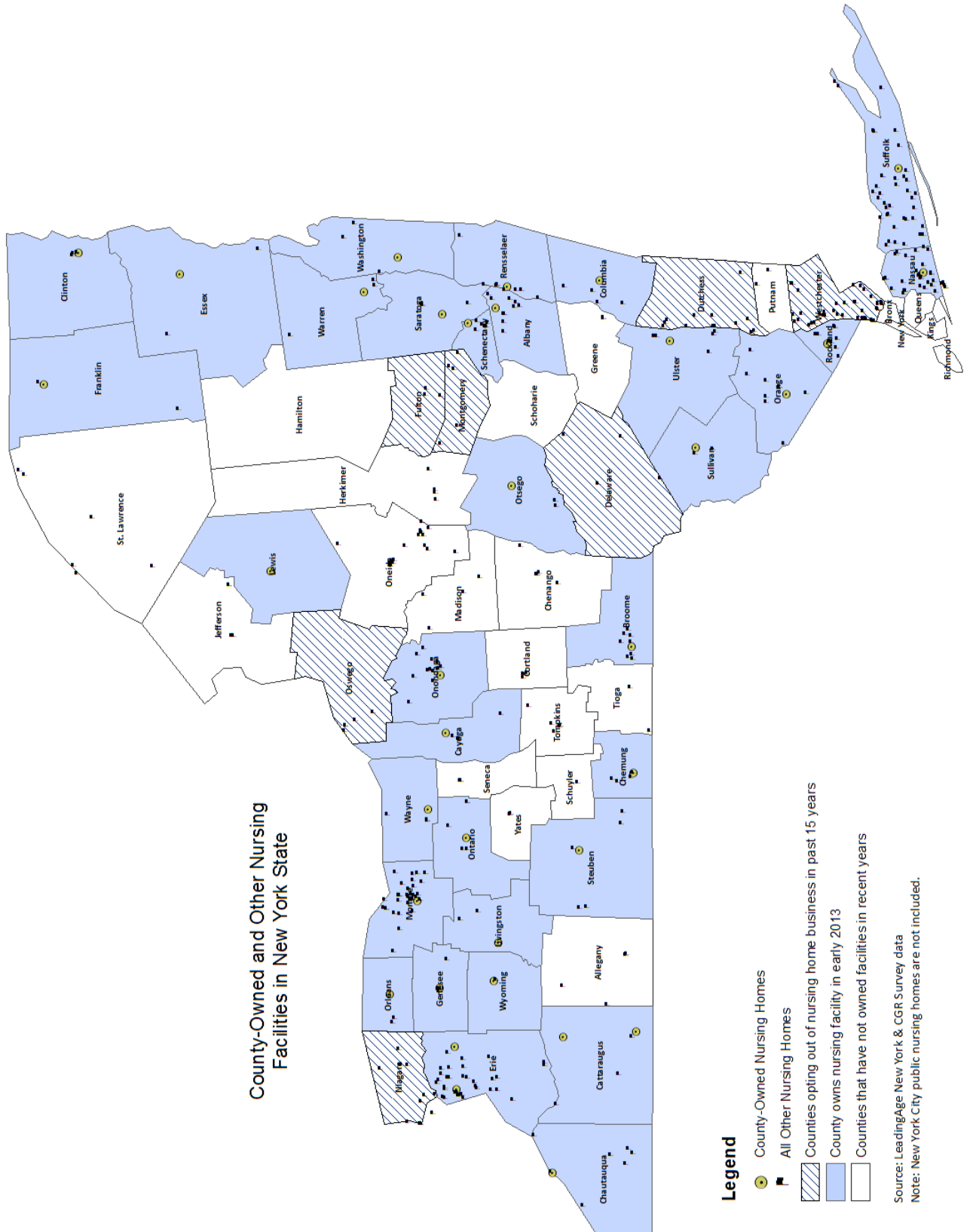
legislature and the County Administrator, similar to the reporting relationship of administrator of other county facilities.

The nursing homes in six counties, including the two PBC counties, are affiliated with a county hospital, and are thus considered to be hospital-based nursing homes. This represents 18% of all county homes. By contrast, cost report data indicate that only two hospital-nursing home structures exist among for-profit homes, but almost a quarter of all non-profit nursing homes (48 of 197) are hospital-affiliated.

Geographic Concentrations of County Nursing Homes

As indicated in Map 2, the bulk of the counties with nursing homes are concentrated in the western part of the state, the counties along and further to the south of Lake Ontario, counties along the northeast and eastern borders of the state, and counties in the southeast southern tier and southeast sector of the state encompassing the Hudson Valley and portions of the NYC suburban areas, including Long Island. By contrast, in the central and Adirondacks regions of the state (mostly counties with relatively small populations and/or large geographic areas with low population density), relatively few counties operate public nursing facilities. As shown in the map, most, but not all, of those counties without a public nursing facility have at least one and often two or more other nursing homes operated by for-profit and/or non-profit entities. The map also indicates the location of county-owned homes along with non-public homes in the 33 counties which had public homes at the beginning of 2013.

Map 2



In general, most large counties in the state offer public nursing homes, while few of the smaller counties do so—with a mixture in the counties in between the largest and smallest. Only five of the 17 counties in the state with populations under 55,000 currently operate their own nursing homes, and that number may decline in the next year or two. On the other hand, 14 of the 18 non-NYC counties with populations of more than 125,000 owned county nursing facilities at the beginning of 2013, as did 12 of the 15 counties with populations between 55,000 and 95,000. Only two of the seven counties with mid-range populations between 95,000 and 125,000 (and none of the three along the eastern edge of Lake Ontario) operate county homes. And those numbers notwithstanding, recent decisions and current discussions indicate that the numbers of counties owning public nursing homes in each of these population ranges will in all likelihood be declining within the next two to three years or less.

County Facilities: Age and Capital Improvements

County nursing facilities are often perceived to be older than the majority of their non-public counterparts. Unfortunately, good comparative data are not available to test this perception. However, data obtained through the county nursing home administrator survey sheds some light on this issue. Many of the homes have histories of more than a century: 43% of the responding administrators indicated that their homes were established well before 1900. Another 28% were established between about 1920 and 1967, with all but one of the rest established in the 1970s.

Two-thirds of the county nursing facilities moved into their current locations since 1970, including almost a third since 1980. Most counties have made major investments in their facilities in recent years: two-thirds have undergone major renovations of \$1 million or more since moving into their current location, with most of those since 2000.

But dates of establishment only tell part of the story. Many have moved into new locations since they were established. Just under a third of the county homes have been in their current location since the 1960s or earlier (the oldest being 1880 and 1933). Another 38% moved into their current locations during the 1970s, and 14% in the 1980s or 1990s. Seventeen percent moved into their current locations since 2000.

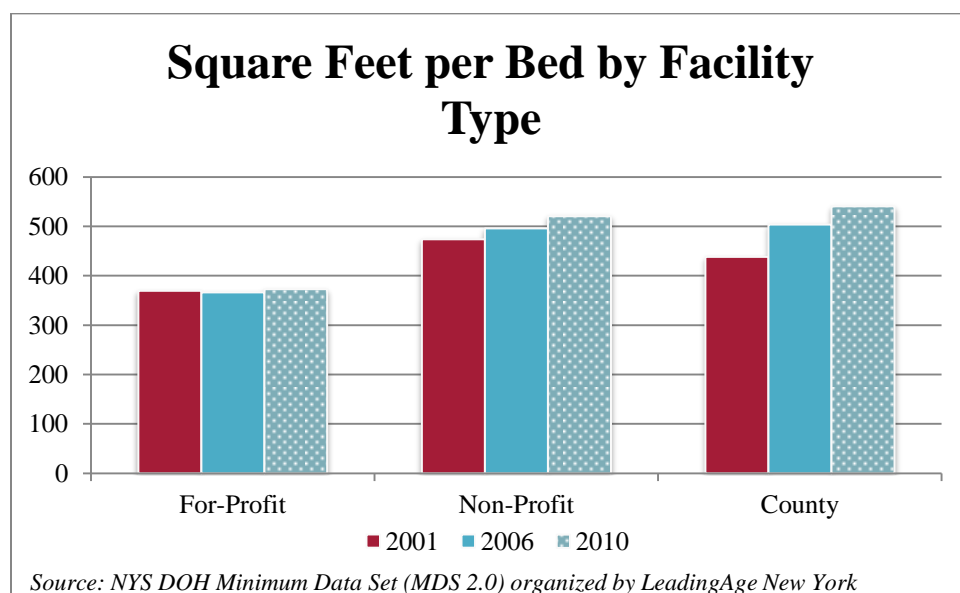
Since moving into their current location, two-thirds of the facilities have undergone major renovation projects, defined as renovations of \$1 million or more. Almost two-thirds of those have occurred since 2000, including 39% in the past five years. Another 26% occurred in the 1990s, and 9% before that. These “major renovations” were described as a new building (9%); building renovations, including “complete renovation” (56%); expansion (22%); and service additions (13%).

Thus, while many of the facilities have been in existence for many years, it appears as if counties have been willing to engage in at least some level of renovations and capital improvements in recent years.

Square Footage in Facilities

The size of the facility, as measured by square footage per bed, can provide an indication of the spaciousness and open space available in a facility, as well as a possible indication of the average room size and of “home-like” living environments available to residents, and the amounts of space that must be covered by staff within each facility. As noted in Figure 8, county facilities tend to be much larger in terms of floor space/square footage than the typical for-profit facility, and comparable to their non-profit counterparts.

Figure 8



Specialty Services

Data on specialty services offered by nursing home facilities were not readily available on a historical or comparative basis across different ownership types of nursing homes. However, data on specialty services currently offered by county-owned homes were available via the county home administrator survey.

The specialty services offered most frequently by county homes are rehabilitation and dementia/Alzheimer’s services, each of which was identified by between two-thirds and three-quarters of all county homes. In addition, about one-sixth of the county homes offer adult day care programs and traumatic brain injury services, with young adult, ventilator and dialysis services also cited by a handful of county homes.

Most county nursing homes provide dementia/Alzheimer's and rehabilitation/therapy services, and about a quarter of the homes indicated that their dementia services differ significantly from any other similar services in their counties. Many county homes offer dementia and rehabilitation units with designated beds. Concerns were expressed by several counties about potentially jeopardizing services to dementia/memory care residents if their nursing home were to be sold or closed.

Asked which if any of the specialty services the administrators considered unique to their facility, i.e., any that differed significantly from other programs offered by other non-public nursing homes in their counties, about one-quarter indicated their memory care/dementia services and about 10% noted their physical therapy/rehabilitation services.

Beyond the core services, the administrators were also asked if their home offered a dementia/Alzheimer's unit and/or a rehabilitation unit with designated beds.

About 60% of the administrators indicated that they do have a dementia/Alzheimer's unit with designated beds, including one about to be opened. The size of the bed units ranged from two with between 15 and 29 beds, nine with 30 – 44 beds, and six with 45 or more dedicated beds. One home reported that it was planning to expand the dementia services within the next two to three years.

Half of the administrators indicated that their home has a rehabilitation unit with designated beds, ranging from four with between 5 and 15 rehab beds, seven with 16 – 25 beds, and three with 26 or more designated beds. Three homes indicated plans to expand existing sub-acute/rehabilitation services, and two noted that they planned to add new outpatient therapy services within the next two to three years.

When asked their primary concerns if their nursing home were to be sold or closed, both nursing home administrators and county leaders frequently cited concerns about the continuing availability of care to certain subsets of the current resident population, and among the most-frequently-mentioned subsets were the dementia/Alzheimer's/memory care residents.

IV. PROFILE OF NURSING HOME RESIDENTS: IMPLICATIONS AND CHALLENGES

County nursing facilities appear to differ significantly from their for-profit and non-profit counterparts on a number of descriptive, demographic and personal characteristics that are likely to have staffing and reimbursement implications for the facilities. This chapter focuses on a descriptive profile of the characteristics of residents of county nursing homes, how that profile compares with those of for-profit and non-profit homes, and how each of these profiles has changed over the past decade. Implications and challenges of these profiles for the future of county nursing homes are addressed. As in the previous chapter, most of the analyses are based on historical comparisons made available by LeadingAge New York, supplemented by data from CGR's recent county home administrator survey. As throughout the report, the comparisons focus on all New York nursing homes outside New York City.

Admissions Increasing, but at Slower Rate in County Homes

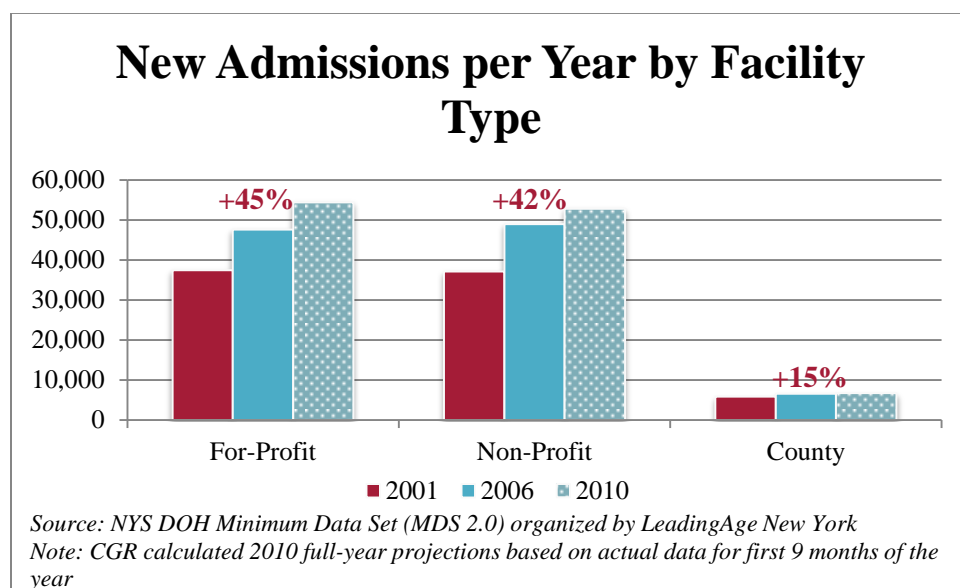
Over the past decade, the total number of nursing home admissions on an annual basis (admission date between January 1 and December 31 of the year, and not counting “carryover” persons already in residence at the beginning of the year) has increased substantially across all nursing homes statewide. Increasingly, nursing homes have been admitting higher numbers of residents needing relatively short stays for post-hospital, sub-acute care and rehabilitation services. Total new admissions in 2010 were an estimated 42% higher across the state than in 2001, up from about 80,000 to well over 113,000.²³ However, as shown in Figure 9, for-profit and non-profit homes reflected admission increases of 45% and 42%, respectively, during that time, while admissions in county facilities increased by a more modest 15%, to more than 6,700 in 2010.

The slower rate of growth in admissions to county nursing homes is consistent with the declining number of county facilities and beds, as referenced earlier in the report. However, even on a per-facility basis, new admissions in county homes are consistently lower than in for-profit

²³ 2010 admission totals are based on projections from 9 months of admission data. Data were available from LeadingAge New York through September, and CGR calculated projections for the full year from those data. The projections are reflected in Figure 9.

and non-profit facilities. For example, in 2010, projections indicated that the average non-profit nursing home admitted 267 persons during the course of the year, and the average for-profit facility had 247 new admissions during the year—compared with an average of 192 admissions that year in county homes. Such lower admission totals in county homes occur consistently despite the significantly higher numbers of beds in the typical county-owned nursing facility. Survey data for county homes for the last three years suggests that the average number of admissions may have increased in 2011 and 2012 to slightly over 200, although a handful of facilities did not provide such data. Since the latter were a mixture of large and small facilities, and since the survey 2010 average was identical to the average suggested by the data compiled by LeadingAge New York (presented below), even with the missing counties, we believe the estimate of about 200 new admissions per facility in 2011 and 2012 is realistic.

Figure 9



Annual admissions to all types of nursing homes have increased, due primarily to more short-stay admissions for sub-acute care and rehabilitation services. Rate of admissions growth has been slower in county homes, as for-profit and non-profit homes have garnered higher market shares of the financially-lucrative short-stay business.

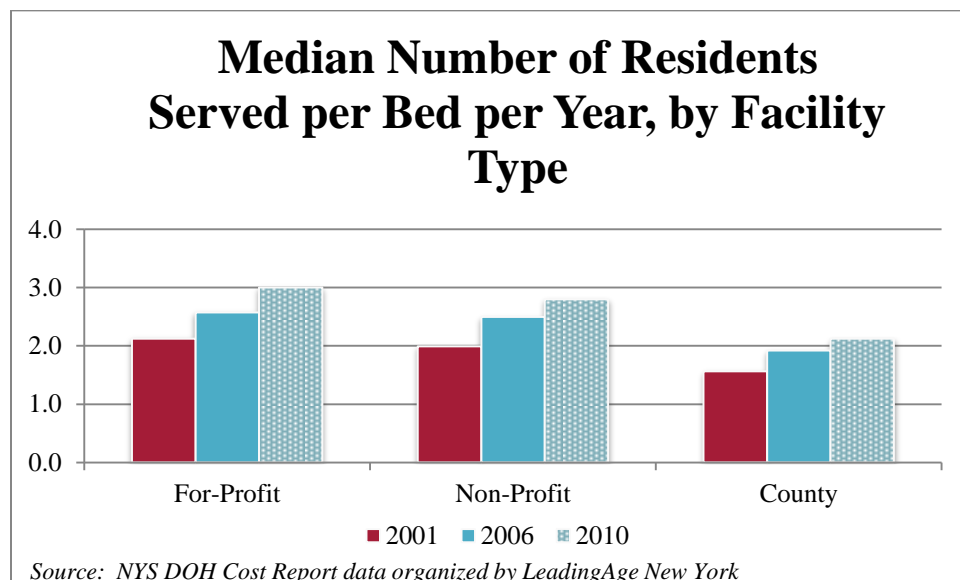
In effect, these data appear to reflect the fact that, even though county homes have increased rehabilitation services, and in many cases have expanded marketing efforts to attract more short-term rehab residents—and those efforts have led to increases in the number of short-term admissions to county homes—the reality is that for-profit and non-profit nursing homes have consistently garnered higher market shares of the financially-lucrative short-term sub-acute and rehabilitation business.

County Homes Admit Fewer Residents per Bed per Year than their Competitors

Another way of reflecting the increase in number of annual admissions is to compare the number of residents served in each nursing home per bed

during the course of the year—what might be thought of as the amount of “churning” or turnover of residents during the course of the year. The higher the number of new admissions, the higher the number of residents per bed during a given year. As indicated below in Figure 10, the turnover per bed has increased in recent years for all types of facilities, but the rate of growth among county facilities has been smaller than the growth rates for other types of facilities.

Figure 10



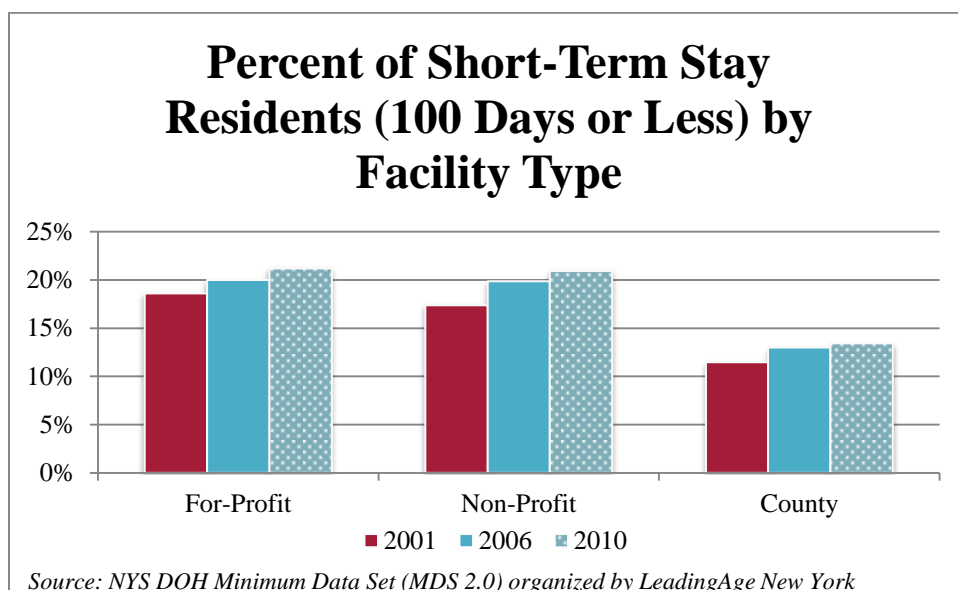
County nursing homes average about one less resident per bed per year than do for-profit and non-profit homes. Higher turnover in residents per bed typically translates into more revenues for non-county homes.

Even after the increases over the past decade among county nursing homes, the number of residents served per bed in 2010 had only reached about the same level (2.1 per bed) that non-county homes had reached a decade earlier. Non-county nursing homes now average about 3 residents per bed per year—essentially one more resident per bed per year than 10 years ago and almost one more than in typical county homes in 2010.

Residents in County Homes Typically Stay Longer than in Non-County Homes

Consistently over the past five years, about one of every five residents in for-profit and non-profit nursing homes have stayed for 100 days or less, compared to about 13% of county home residents, as indicated in Figure 11. And within that, just under 6% of the residents of county-owned homes stayed for 30 days or less, about half the proportion of their for-profit and non-profit counterparts.

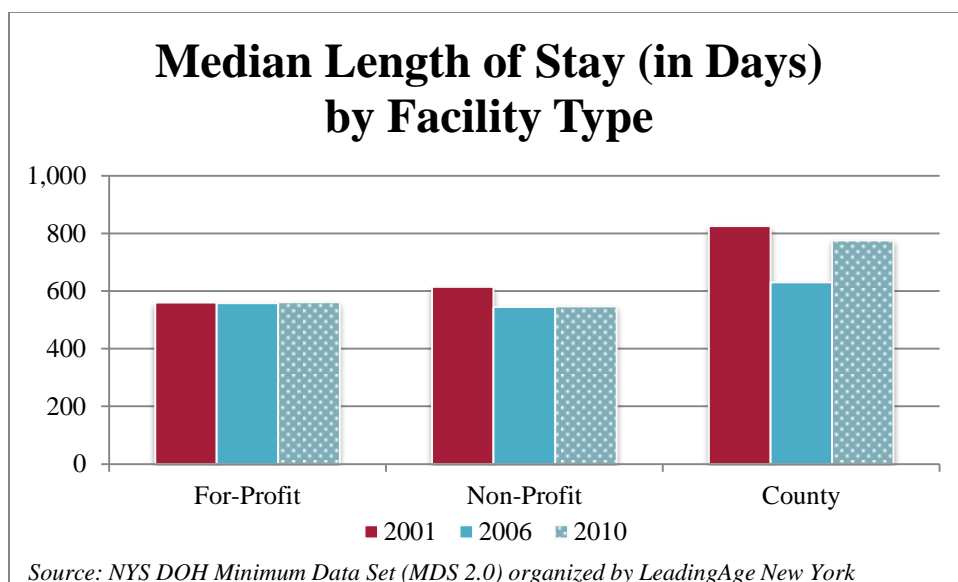
Figure 11



Residents in county homes typically stay much longer than residents in for-profit and non-profit homes. About 40% of all county home residents stay for 3+ years, versus about 30% for other types of homes.

At the other end of the length-of-stay spectrum, about 40% of all county home residents stay for three years or longer, compared to about 30% of all residents in for-profit and non-profit homes. Together, this combination of fewer short stays and a higher proportion of more lengthy stays by residents in county homes adds up to much longer typical stays among residents of county homes, as indicated in Figure 12. In 2010, the median length of stay among county home residents was more than 200 days longer than the comparable stays in for-profit and non-profit homes.

Figure 12

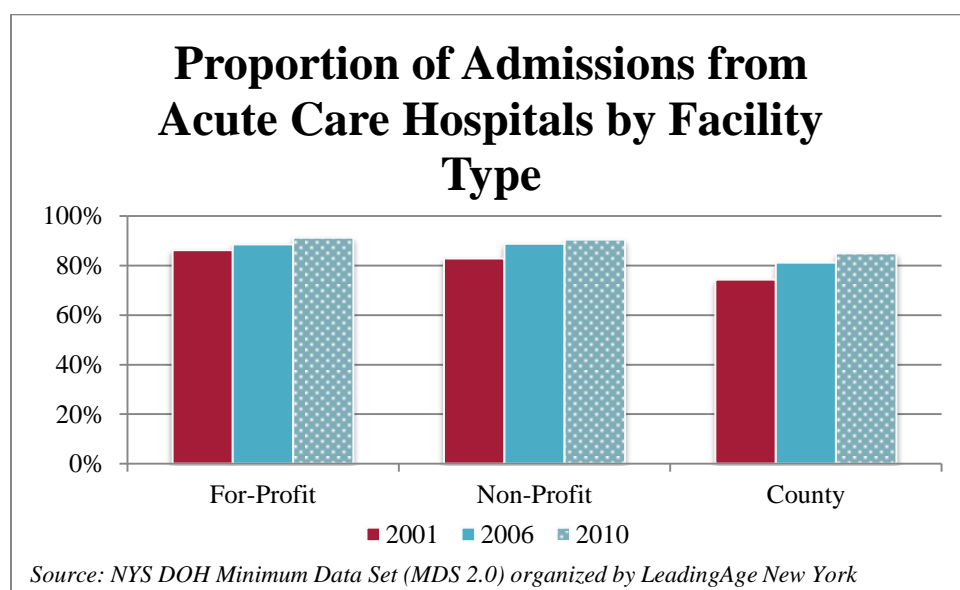


Fewer Hospital Admissions to County Homes

County nursing homes generally have fewer admissions from hospitals than their counterparts, which typically translates into reduced reimbursement levels for county homes.

Consistent with these changes in patterns of long-versus-short stays and of increased admissions and turnovers per bed is the increasing proportion of residents who are admitted to nursing homes from hospitals. For-profit and non-profit homes now obtain about 90% to 91% of their annual admissions from acute care hospitals, having gradually increased those proportions from the mid-80% range in 2001. As indicated in Figure 13, county homes have also increased their proportions of hospital admissions in the past decade, but they started at 74% in 2001 and have gradually worked their way up to 85% by 2010—basically the same level that their non-public counterparts were at a decade earlier. (Over the same period of time, county nursing home admissions from private residences have declined from about 13% to 8% of all admissions—which remains about twice the proportion of private home admissions to for-profit and non-profit nursing homes.)

Figure 13



Negative Financial Implications for County Homes Start at Admission Intake

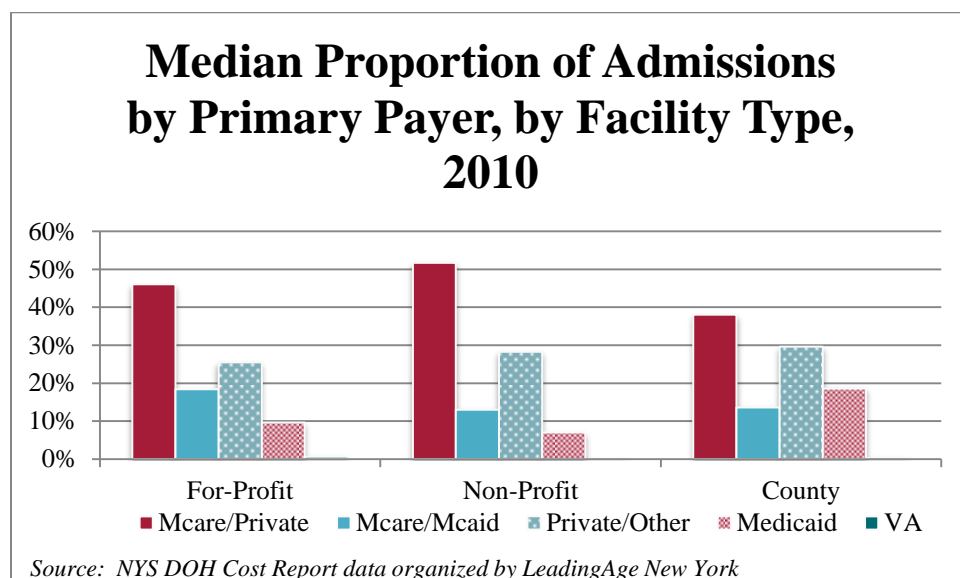
All of these differences have financial implications for the different types of homes, as typically the short-stay residents and those admitted from hospitals (often one and the same) come with higher initial reimbursement levels for their stays in the facilities than do the longer-stay residents. Thus in many cases the county nursing homes start with a revenue shortfall from day one, compared to their competitors, as a result of fewer

admissions entering with generally higher reimbursement levels from the time of intake.

County Homes Have Lower Proportions of Higher-Reimbursement Residents at Admission

As indicated in Figure 14, county nursing homes admit a much smaller proportion of residents entering with some level of financially-lucrative Medicare coverage than do non-public facilities. In 2010, just over half of all non-profit admissions, and 46% of for-profit admissions, were listed on cost report data as covered by Medicare/private pay, compared to 38% of county home admissions. With Medicare/Medicaid dual cases added, almost two-thirds of all admissions to non-county facilities have some level of Medicare coverage at intake, compared to just over half of those in county homes. Moreover, almost one of every five admissions to county nursing homes are Medicaid recipients from day one of their residence—more than twice the proportion in all non-county facilities.

Figure 14



If anything, these differences may be conservative in understating the county home proportions of Medicaid intakes and overstating the proportions with Medicare coverage, due to cost report category groupings. County home administrators suggest that the categories reflected in the cost report data, and thus in Figure 14, may include some Medicaid-pending cases in private pay and Medicare/private categories, thereby potentially overestimating the amounts of Medicare revenues generated by admissions and underestimating the numbers that will ultimately only be reimbursed at lower Medicaid rates from the time of admission. (Note: this may also be true for some non-public homes as

well, though it is not likely to change the overall pattern of differences between types of facilities.)

These anecdotal observations for county homes receive support from payer-at-admission data that were able to be broken out into more precise payer categories in the county home administrator surveys. Data in those surveys from 2010, 2011 and 2012 suggest that Medicare coverage may be closer to 45% than the 51% reflected in Figure 14, and Medicaid fee-for-service admissions hover between 21% and 23%, *plus* an average of 4% who are admitted to county homes with a Medicaid-pending designation. *Thus it seems reasonable to conclude that about one of every four admissions to the typical county nursing home is a Medicaid recipient, and receives reimbursement at Medicaid levels from the first day of admission.*²⁴

About one in four admissions to typical county homes are Medicaid recipients from day one. With fewer Medicare admissions and substantially higher proportions of admissions on Medicaid at intake, county nursing homes lose substantial revenues available to the typical non-county home from day one of admission. Those on Medicaid every day of their stay in the median county home receive reimbursement falling about \$100 a day short of covering facility operating costs every day they remain in the home.

These numbers have huge implications for the financial sustainability of county-owned nursing homes. As indicated earlier in the report, daily operating costs in the median county nursing home exceed the Medicaid rate by as much as an estimated \$100 per resident day. At an average of about 200 new admissions per county facility per year, if a quarter of those are receiving Medicaid reimbursement from their first day of admission, this means that *roughly 50 admissions per year per typical county nursing home receive reimbursement which falls significantly short of covering facility operating costs every day they are residents of the county home.*

By contrast, fewer than 10% of admissions to for-profit and non-profit nursing homes are on Medicaid throughout their stay in the homes. At an average of more than 250 admissions per year in those facilities, fewer than 25 admissions per year receive Medicaid reimbursement from intake forward, with most of the remaining admissions receiving more lucrative reimbursement rates for at least the initial days of their stay in the facilities, even if many ultimately are forced to convert to Medicaid over time. *Those initial days of higher reimbursement levels play a critical role in increasing the odds of financial sustainability for non-public nursing homes, compared to the current status of county homes.*

A statement made in CGR's 2007 study of county nursing homes rings as true today as it did then:

²⁴ It is also worth noting, in light of the earlier discussion on the implications of long-term managed care, that over the past three years in county facilities, more than 10% of all new admissions were enrolled in managed care programs at the time of intake. We have no information concerning how these data compare with earlier years.

“Having even a few more private pay and Medicare residents at admission, even if for only a few days before they spend down to Medicaid eligibility, can make the difference between positive and negative operating margins for nursing homes. *The reality is that, with the significant proportion of admissions entering county homes as Medicaid residents, there is only limited opportunity to ever obtain full reimbursements for as long as they are in the facility. With low reimbursement rates for Medicaid residents, between 20% and 25% or more of all new admits to a typical county home are therefore considered money-losing residents for the entire time they remain in the facility.* [For-profit and non-profit] providers, without offsetting public subsidies available to county homes, simply cannot afford to provide services to many residents who do not bring at least a few days of other revenue sources with them at admission. County homes’ ability and willingness to accept high proportions of such persons is a prime example of the ‘safety net’ portion of their mission.”²⁵

County officials considering the future of their nursing homes need to consider ways of expanding the number of admissions that bring with them higher levels of reimbursement for at least a portion of their stays in the facility or, if they decide to sell, determine how comfortable they are with what is likely to happen to the Medicaid residents that county homes have historically admitted—but that non-public homes have been more reluctant to accept without some other form of reimbursement at intake.

Most Resident Days Paid for by Medicaid

Even in for-profit and non-profit nursing homes, many residents who are initially Medicare or private pay admissions, other than very short-stay residents, ultimately wind up on Medicaid at some point during their stay in the facility. In the typical nursing home of all types over the past decade, slightly more than 70% of all non-NYC nursing facility resident days each year were paid for by Medicaid.

Consistently over the past decade, more than 80% of all resident days in county homes have been paid for by Medicaid—about 10 percentage points more than in non-county homes. Proportions of days paid for by Medicare in county homes were only about half those in non-county homes.

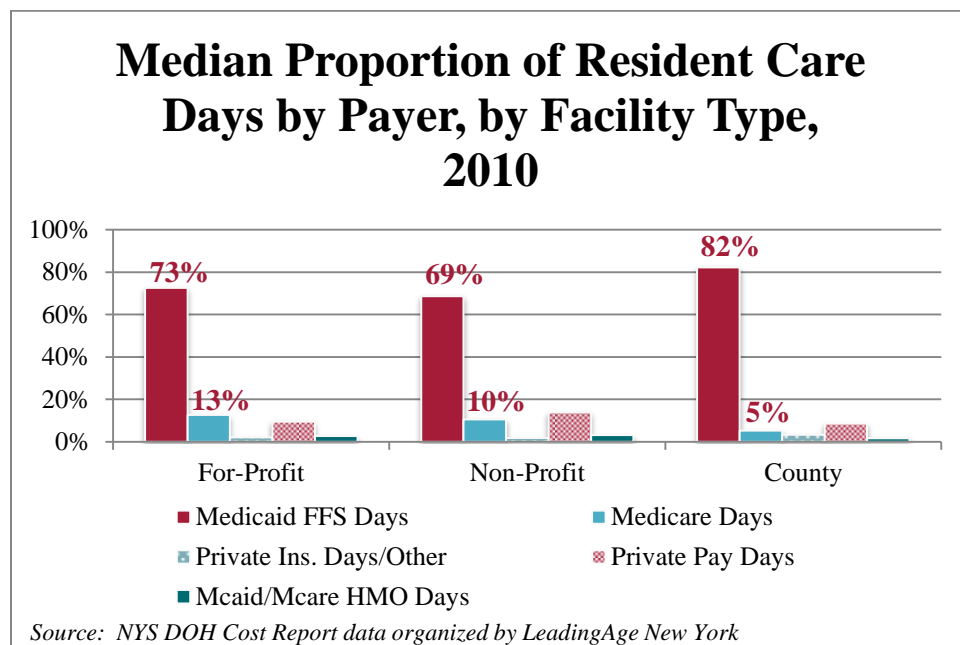
However, as indicated for 2010 in Figure 15,²⁶ primarily resulting from the disproportionate number of Medicaid days at admission in county homes, the overall proportion of *all* resident days paid by Medicaid is consistently several percentage points (about 10% or more) higher in the typical county home than in other types of facilities. Over the past decade, more than 80% of resident days in county homes have consistently been paid for by Medicaid. Conversely, smaller proportions of resident days in

²⁵ CGR, *County Nursing Facilities in New York State*, op cit., p. 27.

²⁶ Note that the 2010 data in the graph reflect similar patterns in earlier years as well.

county homes (typically about 5%) are paid for by Medicare—routinely less than half the proportions in for-profit and non-profit homes. *Those differences—when applied to all resident days across a facility—add up to significantly fewer days in county facilities being reimbursed at anything resembling full costs.*

Figure 15



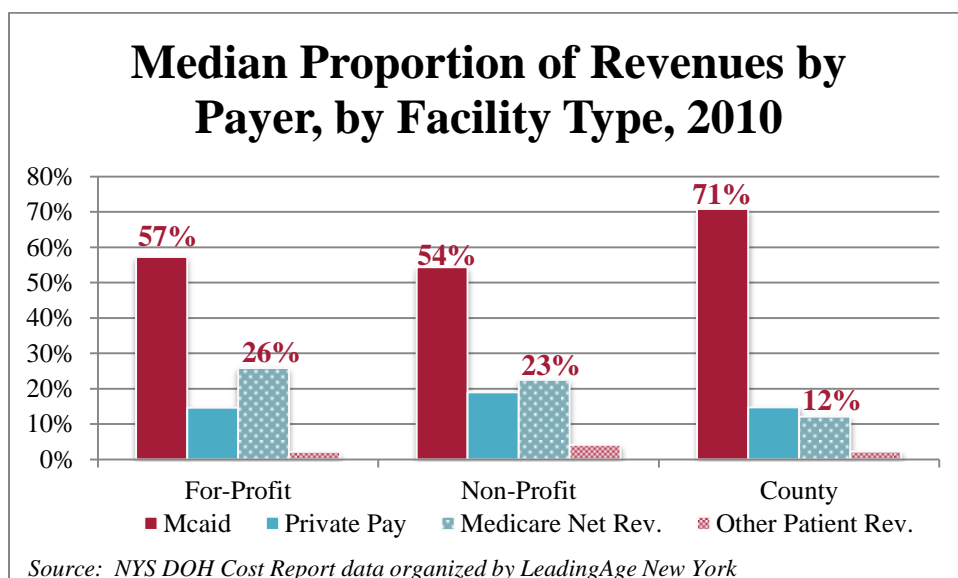
Medicaid Pays Most of Revenues

Not surprisingly, given the proportion of resident days paid by Medicaid, Medicaid is also the predominant overall payer of revenues in all three types of nursing homes, although the proportions of revenues paid are lower than the proportions of resident care days covered, due to the fact that the daily Medicaid reimbursement rates are so much lower than both other rates and actual costs. Thus, for example, in 2010 about 72% of all resident days in all types of nursing homes were paid for by Medicaid, but only about 57% of all revenues were attributable to that source. Conversely, about 11% of all resident days were paid for by Medicare, but twice that proportion of all revenues were paid for by that source.

As indicated in Figure 16, the familiar patterns of county versus non-county facility differentials are clear in the revenue proportions. More than 70% of all revenues in county homes are paid by Medicaid, compared to an average of about 55% in non-county facilities. And the proportion of revenues from Medicare in county homes has typically been less than half the proportion in for-profit and non-profit homes—12% in 2010 compared with about 25%.

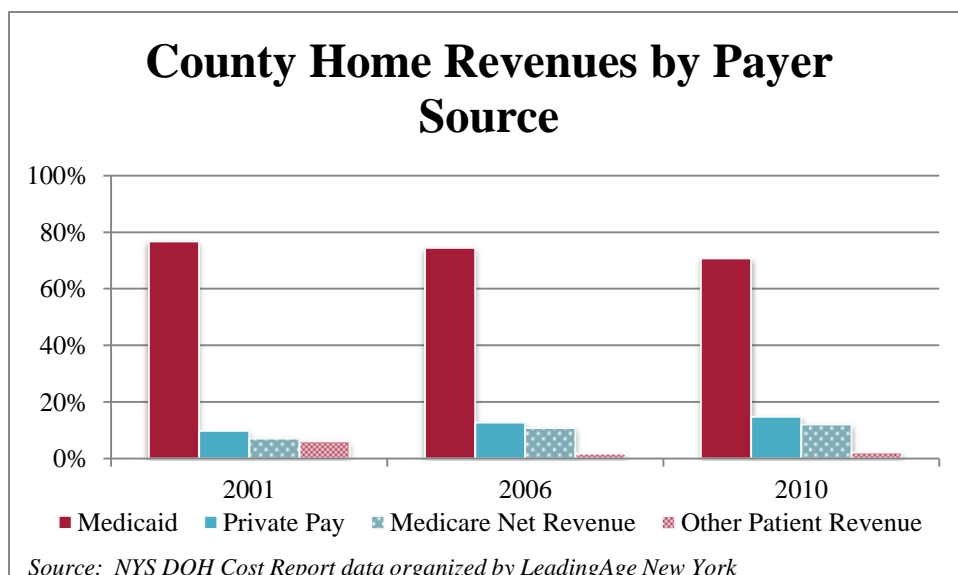
About 55% of all revenues in non-county homes in 2010 were paid by Medicaid, versus 71% in county homes. County homes receive less than half the proportion of revenues from Medicare than do non-public facilities.

Figure 16



Although county home revenue patterns over the years have clearly been detrimental to their financial sustainability, compared to their for-profit and non-profit competitors, the profile of proportions of revenues by source has gradually begun to shift in more beneficial ways for county homes in the past decade, as shown in Figure 17. The proportion of revenues from Medicaid has declined slightly, from 77% to 71%, and the proportions of private pay and net Medicare revenues have both inched upwards, each by about 5 percentage points between 2001 and 2010.

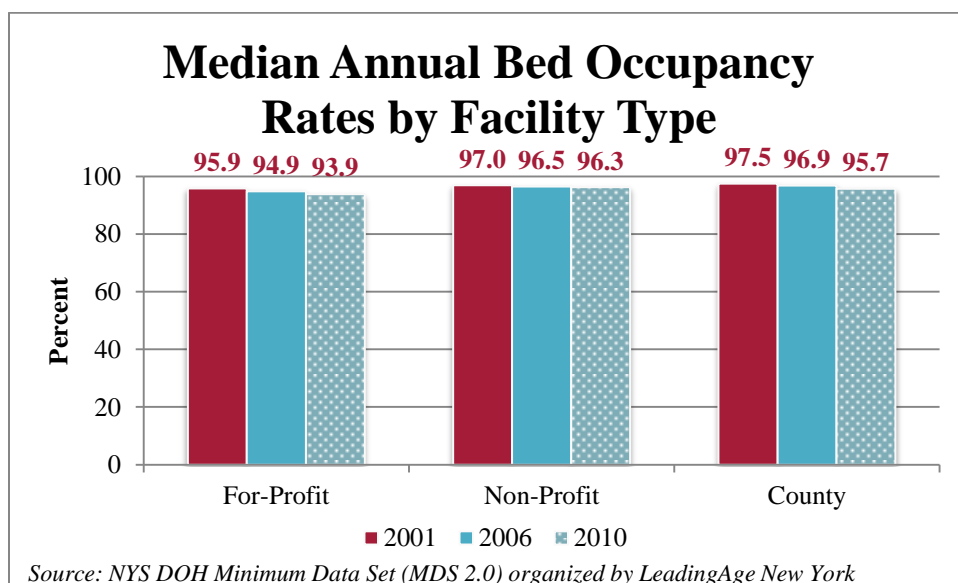
Figure 17



Slightly Declining Occupancy Rates

Over the past decade, occupancy rates in nursing homes across the state have declined slightly, perhaps in part as facilities experience more turnover in beds with the higher proportions of short-stay residents interspersed with days in between occupants. As indicated in Figure 18, the declines have been in the magnitude of one to two percentage points across each of the three types of facilities.

Figure 18



For-profit homes are the only ones in which the median occupancy rates have dropped below 95%: Occupancy rates in for-profit homes have declined by two points in the past decade, to about 94%. County facilities, which have historically had high occupancy rates compared to their competitors, have dipped by 1.8 percentage points since 2001, to just under 96% in 2010—slightly below the 96% level of non-profit homes, whose rates have remained the most stable, with a reduction of .7 percentage point since 2001.

Data from the county nursing home survey suggests that the county home median occupancy rate in 2011 and 2012 may have continued to decline slightly, to just above 95%, though a half dozen homes did not provide occupancy data. Most county homes have remained consistently well above 95% occupancy, with several at 98% or above. At the other end of the spectrum, two homes have been consistently below the 90% occupancy level, with another three or four occasionally at or below that level. Most county homes have remained relatively stable in their rates over the past three years, but nine facilities have experienced declines in their occupancy rates of between 5 and 9 percentage points each between

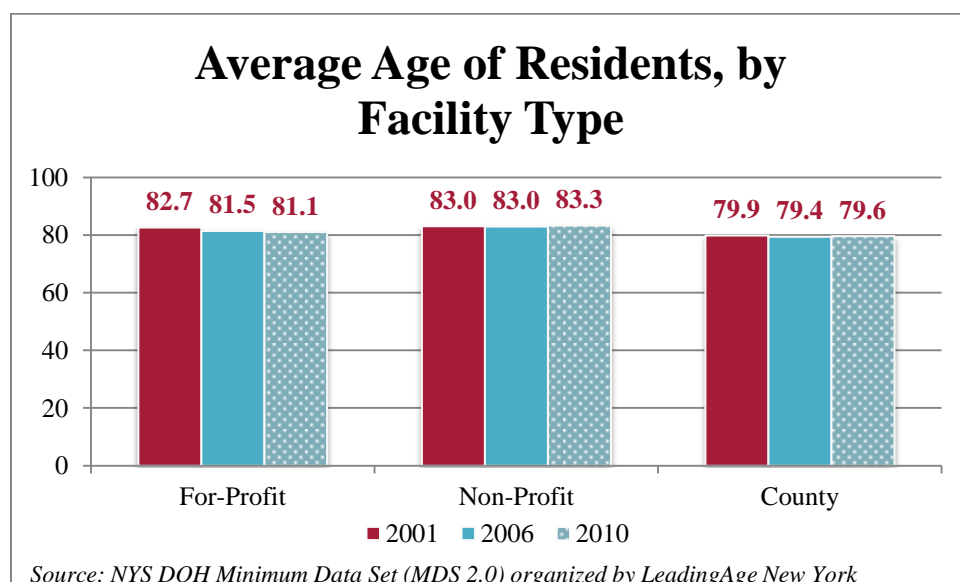
Overall nursing home annual occupancy rates have declined somewhat over the past decade in all types of homes. Rates declined in nine county homes between five and nine percentage points between 2010 and 2012—most in counties selling or actively considering sale of their homes.

2010 and 2012. Most of those are in counties either actively attempting to sell their home or in various stages of serious consideration of the possibility of selling.

Lower Age Profile in County Homes

As indicated in Figure 19, residents in county nursing homes have consistently over the past decade averaged about two to three years younger than their counterparts in for-profit and non-profit homes.

Figure 19

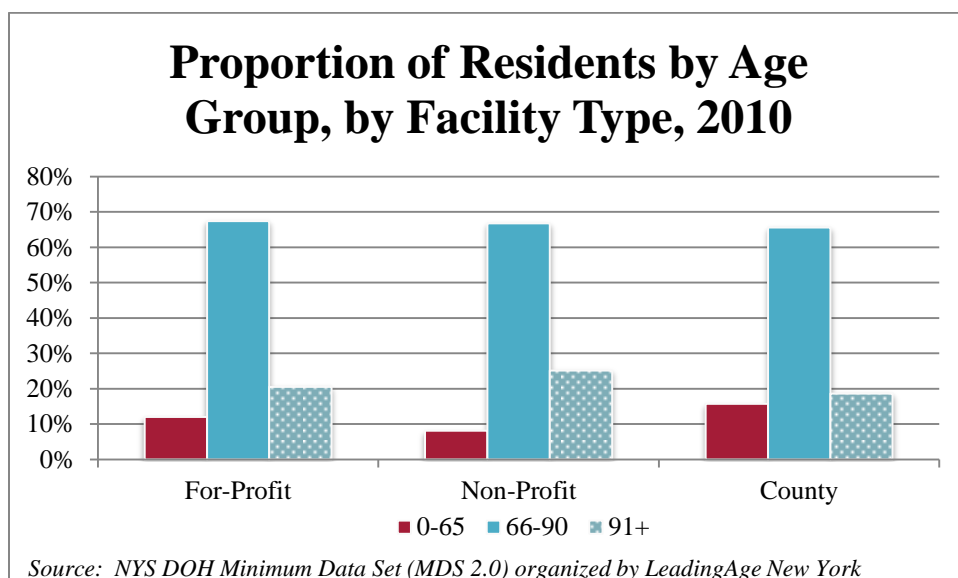


More specifically, county homes, particularly those in urban areas, have consistently had significantly higher proportions of residents 65 and younger, and lower proportions of residents over the age of 90, than have their for-profit and non-profit counterparts. As indicated in Figure 20, these patterns have held consistently in 2001, 2006 and 2010, and have been especially pronounced in comparison with non-profit homes.

Almost one in every six residents of county homes in recent years has been 65 or younger, much higher than the rate in non-county facilities. Young residents often have various issues that demand more staff time that is not sufficiently reimbursed to cover the full costs of the added service time.

The proportion of younger residents in the typical county home (almost one in every six residents in recent years has been 65 or younger) has consistently been about twice the proportion in non-profit facilities, and several percentage points higher than in the typical for-profit home. Those knowledgeable about nursing homes at least anecdotally suggest that these differences are significant in that younger residents, compared to average older residents, tend to have higher care needs; are often more disruptive; and tend to be more likely to have social, behavioral and substance abuse problems, have sexual needs, and to stay for many years. With higher proportions of such residents, there are likely to be higher demands on staff time in county homes, which in turn are less likely to be fully reimbursed for the costs of serving such residents.

Figure 20



County Homes Serve Primarily County Residents

Comparative data across types of facilities were not available on the geographic profiles of residents of nursing homes. But the county home survey shed some light on the geographic makeup of residents of county homes. Asked what proportion of their facility's residents had been residents of their county prior to being admitted to the nursing home, the median response was 86%. Twelve of the county homes indicated that 90% or more of their residents came from their home counties. A few homes, because of their location regionally, draw from a wider array of counties. Accordingly, about five of the homes reporting geographic data indicated that their proportions of county residents dipped below 80%, ranging in two counties as low as 70% in 2012.

Chronic Conditions and Diseases Increasing

Trend data reported to the state by nursing facilities indicate significant increases over the past decade in the proportion of nursing home residents across the state with depression, hypertension, diabetes mellitus and anxiety disorders. These increases have been pervasive across all three ownership categories of nursing facilities. More specifically:

- ❖ Hypertension has increased from a presence in just under half of all residents statewide in 2001 to being identified in about two-thirds of all residents in 2010. This pattern was virtually identical in all three types of facilities.

There have been significant increases in all types of nursing homes in the past decade in the proportion of residents with identified hypertension, depression, diabetes mellitus, and anxiety disorders. About half of all residents in all types of facilities are dementia/Alzheimer's cases, including 55% of all county home residents, just slightly higher than in non-county homes.

- ❖ The proportion of residents reported with depression has increased from about a third of all residents in 2001 to just under half in 2010; again, this pattern was consistent across each facility type.
- ❖ The proportion of residents with reported diabetes mellitus increased from a range of 21% to 23% in 2001 to 29% to 32% in 2010, depending on the type of facility.
- ❖ Those identified with anxiety disorders almost doubled from just under 8% in 2001 to just over 15% in 2010, again with very similar profiles across facility types.

The other major pattern observed in the data was the consistency in the prevalence of dementia/Alzheimer's cases across all three facility types. Consistently since 2001, about half of all residents in nursing homes across the state have been reported with some level of dementia/Alzheimer's. County homes have consistently been three or four percentage points higher than their counterparts, topping 50% each of the three years analyzed, and peaking at 55% of all residents in 2010. These figures are consistent with the reported substantial number of county homes which have established dementia/Alzheimer's units with designated beds for such residents.

County Homes Serving Residents with Low Clinical Complexity but High Behavioral Demands

County nursing home administrators and other advocates of public homes have long raised concerns about having to serve significant numbers of residents broadly defined as having “low clinical complexity but high behavioral needs/demands.” No formal definition of this group seems to exist, but the term resonates with nursing home officials, who indicate that they are comfortable estimating the proportions of their residents who fall into this somewhat amorphous category. When pushed to define it further, what emerges are definitions that include combinations of those with dementia or Alzheimer's disease who require substantial monitoring and observation; younger residents requiring substantial observation and often 1:1 staff time; and residents with particular behavioral issues needing special attention—with the further understanding that residents in each of these categories are in relatively good health from a clinical perspective, but require more attention than their health status would suggest.

Administrators note that additional staff time is typically required for such tasks as added supervision; additional social work; additional activities to keep residents occupied; and increased observation and monitoring to prevent wandering, aggressive behavior, and smoking or other safety

More than 35% of the county homes estimated that 20% or more of their residents have low clinical complexity but high behavioral demands, thus requiring more staff time and costs than health status alone would suggest. This appears to represent a decline in the size of this subset of residents from a 2007 state study, although the amorphous definition makes direct comparisons somewhat imperfect, and no comparisons are possible with non-county homes.

concerns. This group as a whole, because of its low clinical complexity, contributes to a relatively low case mix index, as discussed below, without any provision for added reimbursement to cover the additional staff time required to address the needs created by the behavioral issues.

The county home survey conducted as part of this study asked administrators to estimate what proportion of their residents have “low clinical complexity but high behavioral demands.”

Of the 27 county home administrators who responded to this question, the median response was 12%. Eleven said fewer than 10% of their residents would meet the definition, but another 10 (37%) estimated that the proportion would be 20% or higher, including seven who indicated that 30% or more would fall into the category. When the same question was asked in the 2007 survey, 72% said at least 20% of their residents fit that description, including just over half who indicated between a quarter and as many as half. Thus it would appear, even allowing for the lack of preciseness in the definition, as if the perceived magnitude of this issue may be declining over time, and therefore may be somewhat less of a drain on staff time than had been the case in the past.

Unfortunately, however, the absence of a precise definition of the term, and the fact that the extent to which comparable cases exist in non-county facilities cannot be determined, combine to make it hard to definitively determine whether there are in fact differential staffing and cost implications associated with this issue.

County Homes Serving the “Hard to Place”

As noted earlier, county homes are perceived by many, including competitors, as providing a “safety net” function of serving “hard to place” residents that for-profit and non-profit homes are often more reluctant to admit. It is difficult to definitively prove that county facilities are indeed more likely to admit such “hard to place” individuals than are their competitors, as there are no known data that objectively enable such comparisons to be made.

However, the data presented earlier about differences in proportions of younger residents and in admissions of low-income/Medicaid eligible individuals is at least suggestive, though such differences do not by themselves prove that county homes accept people that other homes reject or choose not to consider. And suggestions that county homes are more likely to accept those with memory issues would seem to be at least partially refuted by the similar proportions across nursing home types of residents with dementia/Alzheimer’s disease. On the other hand, representatives of for-profit and non-profit nursing homes interviewed for this and other studies are often outspoken in their appreciation for the

work county homes do in providing institutional care for people they acknowledge they would be reluctant or unwilling to serve.

As part of our county nursing home survey, we attempted to further clarify what county home administrators mean when they refer to the “safety net” and “hard to place” residents, and how many they believe they serve. About half the respondents included those with dementia, behavioral issues and mental illness issues as among the “hard to place.” About a quarter included low-income individuals and those with Medicaid or questionable payment sources within their definition. Persons referred from Adult Protective Services and those needing special services such as dialysis, brain trauma and ventilation services were also included by some in the definition.

The typical county nursing home indicated that about 15% of its current residents should be considered “hard to place,” and about 40% estimated the total could be 20% or more of all residents. Many concerns were expressed concerning what would happen to such individuals if the county home were sold, with a resulting need for counties to be diligent in determining whether to sell and, if so, to whom.

Thus there is no consensus around the definition of these terms. However defined, administrators were asked to estimate the proportion of their current residents who would qualify as “hard to place” residents that other homes would be unlikely to accept. The median number was 20 residents, equating to a median of 15% of current residents. About a third of the responding administrators indicated that they estimated that 10% or fewer of their residents would qualify, and about 40% provided estimates of 20% or more, including three larger homes estimating 50% or more.

Asked for their “candid assessment” of what they thought would most realistically happen to such “safety net” residents if their nursing facility were to be sold, 43% of the respondents suggested that those individuals would have a hard time being placed elsewhere; 30% said they thought they would be served in the current home under new ownership; and 30% suggested that they would be placed in a different home but outside the local community. Another 15% predicted a different home within the community, and about 15% worried that such residents would be kept in inappropriate hospital care. (Total responses equaled more than 100%, since more than one response was permitted.)

As noted earlier, the likely fate of current “hard to place” residents could be a concern for counties if a home is sold, though it is likely that most current residents would be able to remain in the nursing home under new owners, depending on terms reached between the county and the new ownership. *But the more important question concerns what is most likely to happen in the future as similar potential residents surface, if the county home and its “safety net” mission are not present to accept them. Judgments about what is likely to happen to such future individuals, and the extent to which counties attempt to build in protections for them in the future, are likely to have some influence on future decisions to sell or not sell county homes, and if so, to whom.* The effect of previous decisions to sell or close homes on such “hard to place” individuals is addressed in more detail in Chapter VII

County Homes Trail Other Homes in Case Mix Index

Given the resident characteristics discussed above, and the historical mission of most county nursing homes to provide a “safety net” function in the community—by serving the otherwise “hard to place” individuals that other types of nursing facilities tend not to admit—it is not surprising that the median county nursing home’s case mix index (CMI) is typically lower than that of other types of facilities.

Each nursing facility receives an aggregate CMI score based on the sum of individual resident acuity scores measuring degree of health/sickness, based on clinical status, functional impairments and various characteristics and needs as identified in a standardized assessment tool. The scores summed across all residents of a nursing home become the basis for the institutional case mix index, with higher CMIs indicating higher composite patient sickness/acuity and typically higher reimbursement levels.

As suggested above, county homes appear to often be adversely affected in the calculation of the index, since many appear to have disproportionate numbers of residents with various behavioral, Alzheimer’s disease or related circumstances that do not affect their facility CMI score or reimbursement level, but which do require additional staff attention. To the extent that for-profit and non-profit homes can minimize the extent to which they admit such individuals, and maximize those with higher acuity scores and lower demands for additional staff attention, the more they are able to maximize their CMI and related reimbursement levels.

County homes have significantly lower case mix index values than do their competitors, resulting in lower reimbursement levels and often increased staff time required to meet behavioral needs. Efforts to increase CMI scores do not seem to have changed the county home profile through 2012.

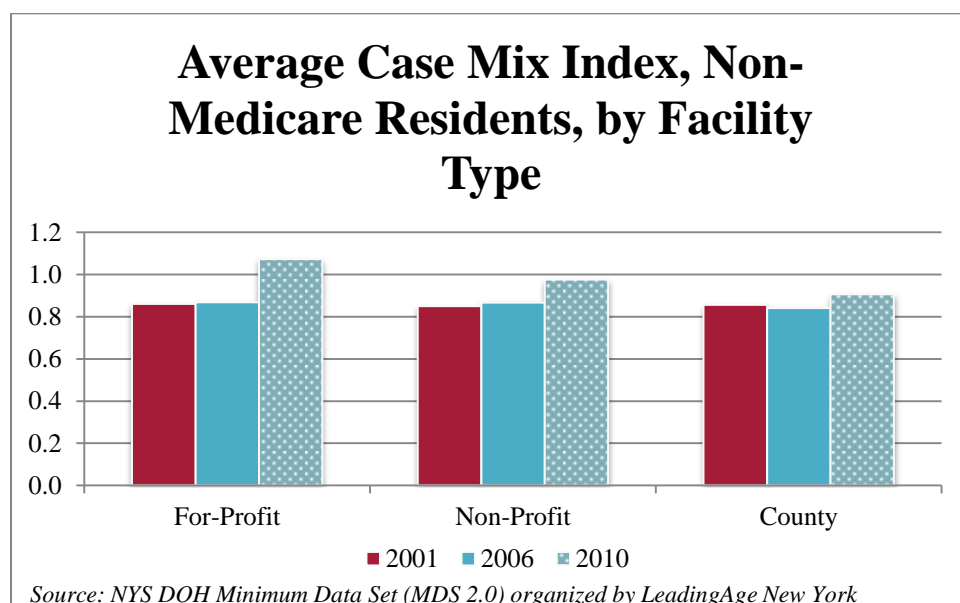
Using the average CMI for non-Medicare residents—the index most instrumental in determining reimbursement levels—this indicator of overall facility resident acuity was significantly lower in 2010 for county nursing homes than was the case in either for-profit or non-profit competitors, as indicated in Figure 21. Although all three types of homes had similar CMI levels in 2001 and 2006, by 2010 the typical for-profit home had increased its non-Medicare facility CMI by 25% to 1.07, and the average non-profit CMI had increased by 15%, leaving behind the typical county home, whose CMI level had increased by only 6% over that period, to .905.²⁷ These patterns suggest that the overall increases reflected in 2010 data resulted from changes in 2008-09 in the Medicaid

²⁷ The profile of *overall* CMI scores for *all* residents follows a similar pattern. Because Medicare scores are included, the overall CMI levels are higher for all types of homes, but the basic relationship remains the same, with the typical facility index levels highest among for-profits, followed by non-profits and by county homes trailing behind.

reimbursement methodology in New York. Furthermore, the differential growth rates suggest that county homes have not been as diligent or responsive to changes in Medicaid payment rules over this period as have non-profits and especially for-profit homes.

With significantly lower county nursing home CMI scores, compared to those of other facilities, and apparently higher proportions of “behavioral” residents, as noted earlier, county homes are typically disadvantaged in comparison with their counterparts in two significant ways: (1) they receive generally lower levels of reimbursement, yet (2) they have the potential for higher costs due to the higher staff time needed to provide the added attention demanded by many of the “low-acuity-high-behavioral-need” residents.

Figure 21



Most county homes are attempting to increase their CMI levels through expansion of short-term sub-acute care and/or rehabilitation services, and through more careful training of staff to more effectively use the scoring criteria that determine individual and ultimately institutional aggregate acuity scores, in order to maximize reimbursement potential. Indeed nearly all county homes indicated that they have assigned a person to oversee this role of maximizing allowable factors that enter into the reimbursement calculations. Nearly all administrators said they had assigned at least a full-time equivalent position to this function, with at least half indicating that 1.5 or more FTEs were focusing on this task. But based on 2011 and 2012 data from the county home survey, it does not appear that there has, at least to this point, been any growth in the typical case mix index for county homes since the 2010 level reflected in Figure 21.

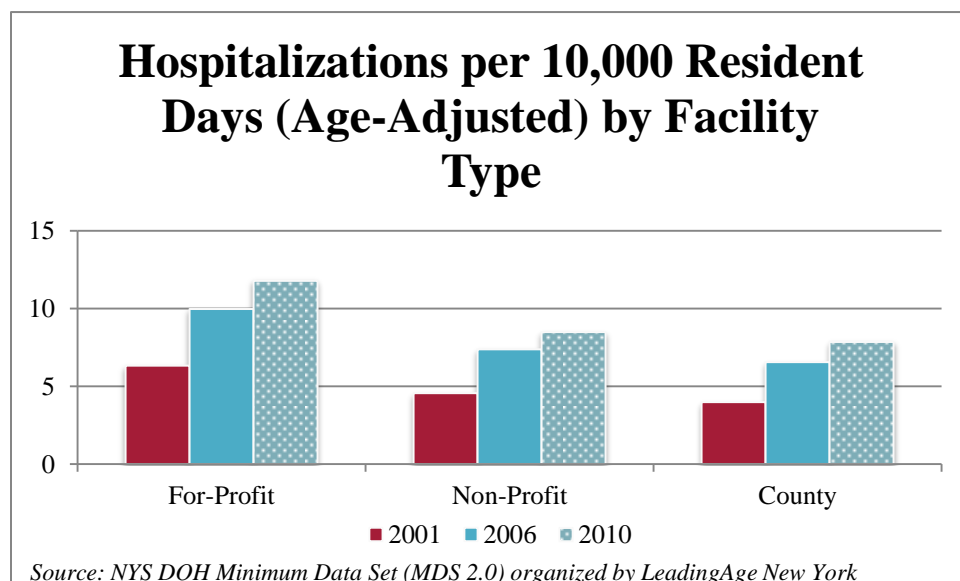
Differential Outcomes and Discharge Patterns

For-Profits Consistently have Highest Hospitalization Rates

Ideally hospitalizations of residents of nursing homes are kept as low as possible to avoid overall costs to the health care system, and as a partial indication of high quality care within the nursing homes. Realistically, hospitalization rates are also affected by many other variables, such as the acuity levels of the residents, amount of resident turnover and average length of stay among residents, proportion of clients receiving rehabilitation services, etc. Thus the interpretation of hospitalization rate data may not be conclusive, but they at least begin to raise questions for policymakers and administrators to consider.

As indicated in Figure 22, age-adjusted hospitalization rates per 10,000 resident days have been steadily increasing, almost doubling within the past decade across all three types of nursing facilities across the state. Throughout the period, for-profit homes have consistently had the highest hospitalization rates, and county homes have consistently had the lowest (county rates of 7.9 per 10,000 resident days in 2010, compared to 8.5 for non-profits and 11.8 for for-profit homes).

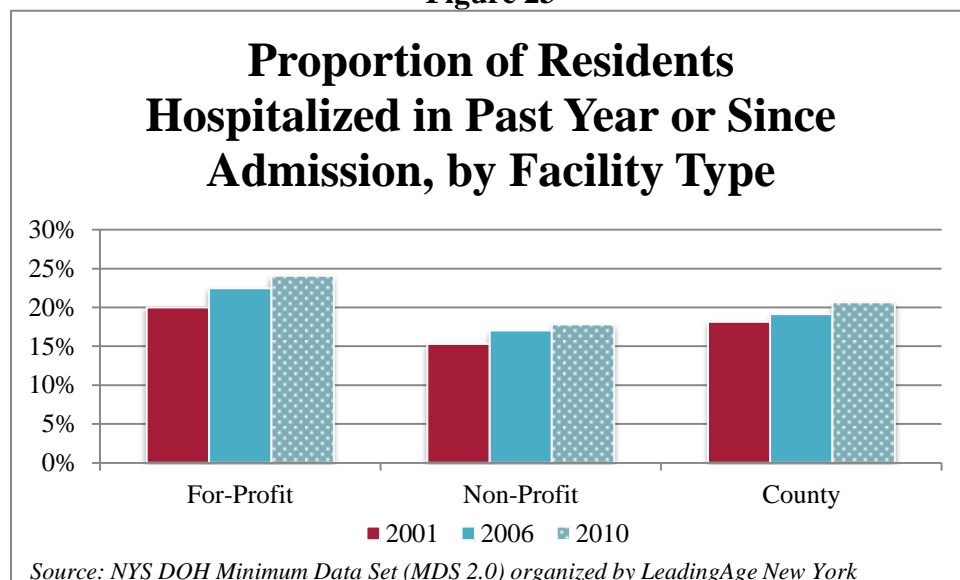
Figure 22



Another way of examining hospitalization rates is to measure the proportion of residents who have been hospitalized within the past year or since admission (whichever came first). As shown in Figure 23, those rates have also increased over time for all nursing home types, but at a

slower rate of increase than when measured per resident days. As in the first hospitalization measure, for-profit homes have consistently had the highest rates of hospitalization when measured as a proportion of residents (24% in 2010), but in this case, non-profits rather than county homes have consistently had the lowest proportions.

Figure 23



Under both measures of hospitalization rates for those in nursing homes, for-profit homes consistently have the highest rates; one in four residents of for-profit homes were hospitalized in 2010—rates that should at least raise questions by counties of a potential buyer with such high rates.

As noted throughout the report, there can be and often are wider variations *within* types of nursing homes than across types. Thus it would be a mistake to conclude that all for-profit homes routinely have worse hospitalization outcomes than other types of nursing homes, or that there are no rational explanatory factors underlying the higher rates. But *with one of every four for-profit residents hospitalized in 2010—and for-profits consistently having the highest rates of hospitalizations for both short-stay and longer-stay residents—there should at least be cautions raised by counties interested in potentially selling their home to a for-profit owner.* A recent report by LeadingAge New York raises similar concerns and quotes other research citing the relationship between for-profits and increasing likelihood of resident hospitalizations.²⁸ With a different perspective on the differential rates, a reviewer of a draft of this report raised a concern that some providers may “game” the system by consistently referring residents to hospitals for borderline reasons in order to have them return and qualify for a Medicare Part A stay, with resulting higher reimbursement levels. The data at least suggest the need for due diligence in terms of tracking performance and outcomes of any potential

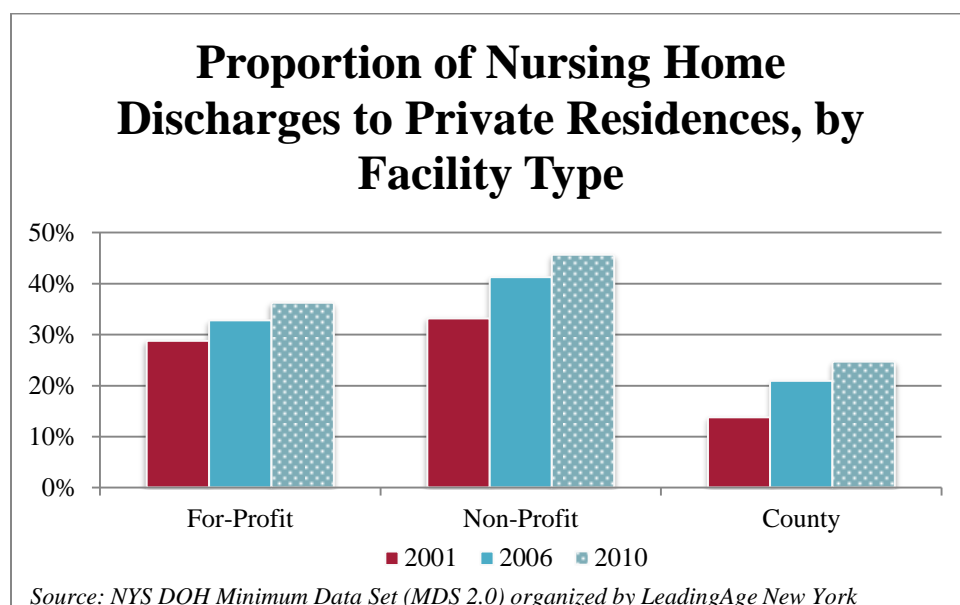
²⁸ LeadingAge New York, *New York State Nursing Homes: Sponsorship as a Defining Factor in Outcomes*, 2012, p. 21.

buyer concerning other nursing homes they may own, before any final sell decisions are made.

Changing Discharge Patterns from Nursing Homes

Patterns of destinations and reasons for discharges and transfers from nursing homes have changed significantly in the past decade. In conjunction with the increased number of nursing home admissions, coupled with increasing proportions of short-term stays and rehabilitation services, the proportions of nursing home residents discharged to their homes have increased substantially in the past ten years, across all types of nursing homes, as indicated in Figure 24. Statewide data indicate that 29.3% of all discharges from non-NYC nursing homes were to private residences in 2001, a proportion that had increased to 39.5% by 2010. Significant increases occurred across all three types of facilities.

Figure 24



However, distinctive differences remain in discharge patterns between county nursing homes and other types of homes. As indicated in the graph, despite the increases in recent years, county homes remain significantly less likely than their counterparts to have residents discharged to private residences. The median county home sent approximately one-fourth of its discharges in 2010 back to their community residence, compared to almost half of the discharges from the typical non-profit nursing home (45.6%) and 36.2% of for-profit discharges. These differences appear in large part to be a reflection of the fact that non-county homes remain significantly more likely to admit and discharge high proportions of sub-acute care and rehabilitation residents

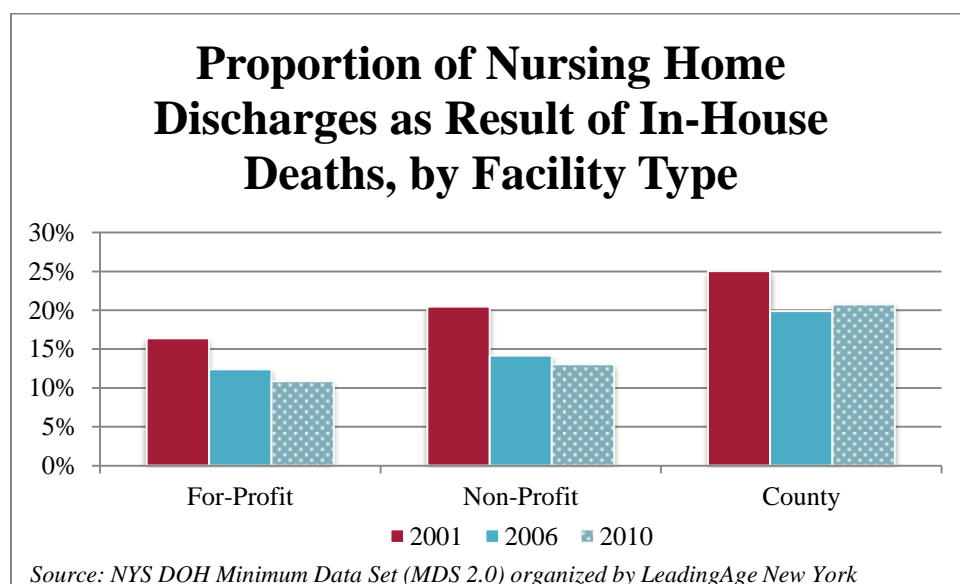
who then return to their homes following short stays in for-profit and non-profit nursing homes, versus county facilities which continue to have higher proportions of long-stay residents who are less likely to be returning to their homes.

Higher proportions of nursing home residents are returning home from their nursing home stays, and lower proportions are dying while still a resident in a home. Even though being part of those trends, county homes are still the least likely to discharge residents to their homes and still the most likely to have persons die as residents in their homes, given the longer lengths of stay by residents in the typical county home.

The reverse trend has occurred in proportions of in-house deaths (deaths while residing in a nursing home). With more “churning” being experienced in the resident population—with more admissions and discharges and people in and out of the facilities with short-term stays—the proportion of residents staying long enough to die as residents has declined over the past decade. In 2001, 19% of all discharges from nursing homes were the result of in-house deaths. By 2010, that proportion had been reduced by about a third to 12.5% of all discharges. As with discharges to private residences, this pattern of reductions has occurred in all three facility types, as reflected in Figure 25.

County homes, with their large proportion of long-stay residents, have continued to have higher proportions of residents die in-house than is true for the more shorter-stay non-county facilities. In recent years, about one of every five discharges from the median county home have continued to be as a result of dying as a resident of the home—about twice the rate for for-profit homes and also considerably above the 13% rate in 2010 for the typical non-profit home.

Figure 25

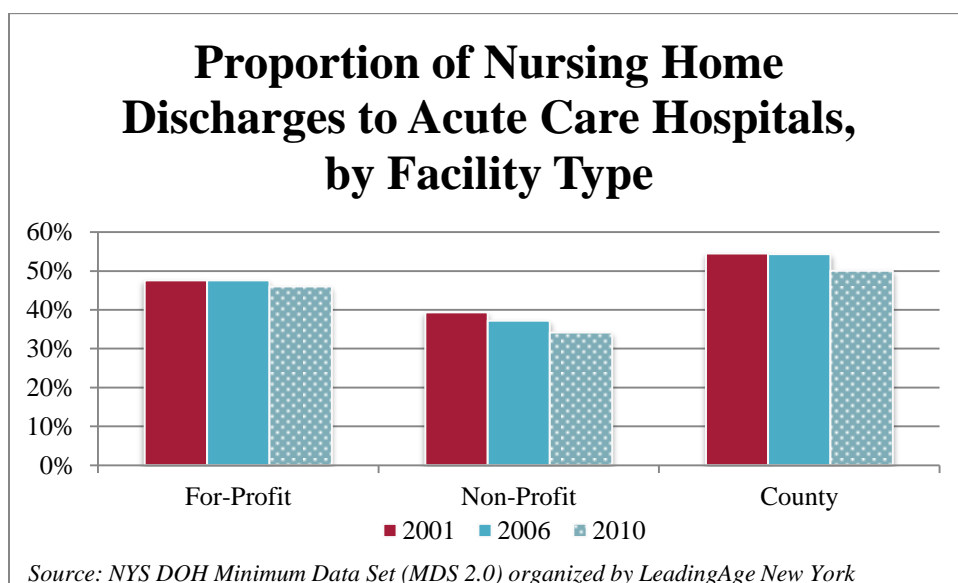


The third major category of discharge destinations from nursing homes—discharges to acute care hospitals—has remained the most stable of the three, as measured by proportions of all discharges. Across the state, the proportion of all discharges made to hospitals has dropped slightly over

Proportions of discharges to hospitals across all types of facilities have remained relatively stable over the past decade.

the past decade, from 44.6% to 41.1%. As shown in Figure 26, each of the facility types has experienced similar slight declines in proportions of discharges to hospitals, with declines ranging from about two to five percentage points. County homes have consistently maintained the highest hospital discharge rate, just above 50%, slightly higher than the typical hospital discharge rate of for-profit homes, which has consistently been just under 50%. Non-profit hospital discharges have declined to just over one-third of all their annual discharges.

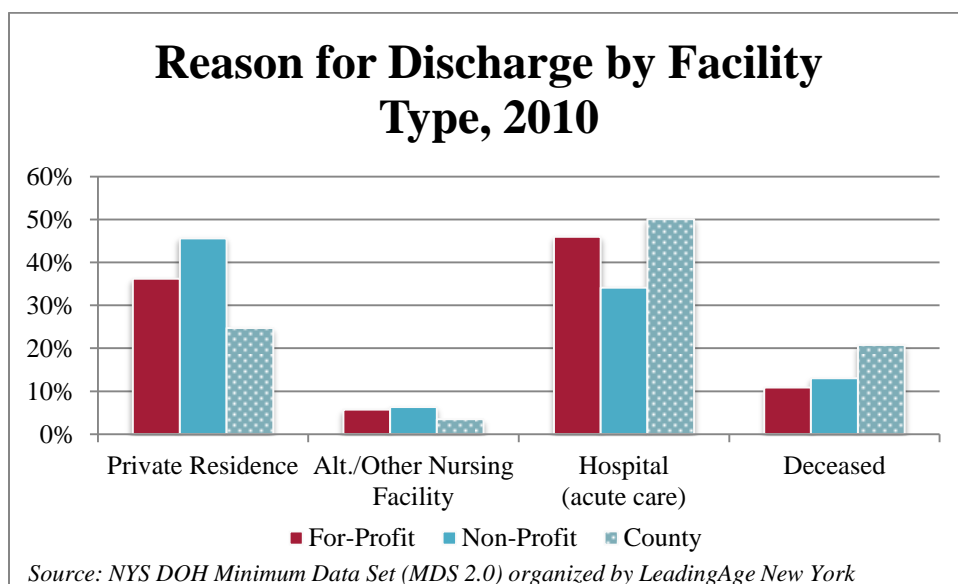
Figure 26



At first glance it may seem inconsistent and in error that county nursing homes could have both the lowest rate of hospitalizations per 10,000 resident days and at the same time the highest proportion of discharges to hospitals. But the rationale may simply be this: because of the large proportion of long-stay residents in county homes, hospitalizations are spread over a relatively large number of resident days, so the rate is relatively low. On the other hand, because there is less turnover of residents, the number of discharges is smaller than in shorter-stay homes, so that when a discharge to a hospital does occur, it represents a higher proportion of a smaller denominator than is the case with other facility types. However, it is worth noting that, even with the higher rate of short stays in for-profit nursing homes, the relatively high rate of for-profit hospitalizations noted earlier in this chapter is reflected in a for-profit hospital discharge proportion that is just below the comparable proportion of county homes.

Finally, Figure 27 provides a brief summary for 2010 of the patterns discussed above, reflecting the discharge patterns in that year for each facility type. These basic patterns are similar in the earlier years as well.

Figure 27

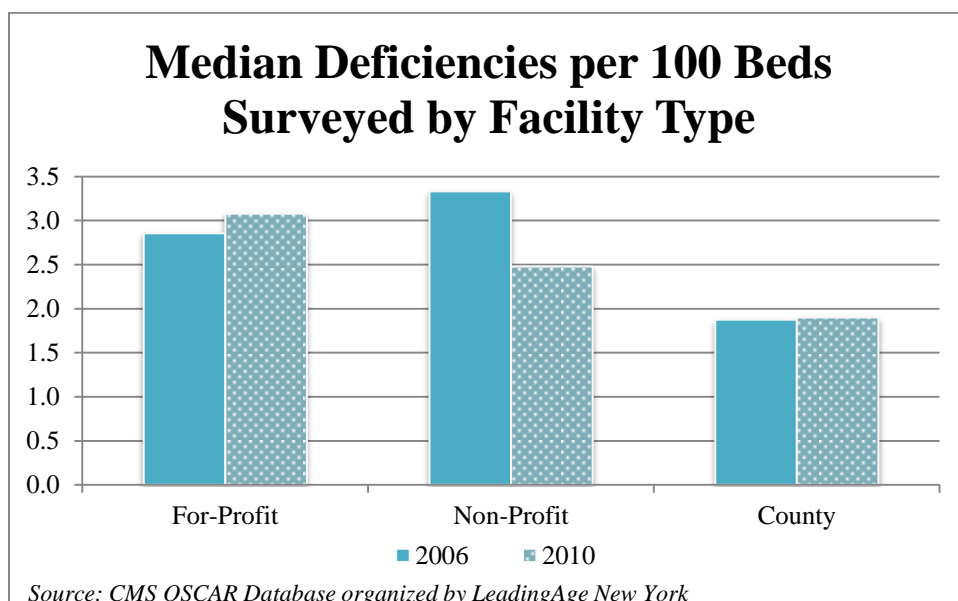


Quality of Care Indicators

Nursing homes must meet federal and state regulatory requirements to maintain their operating licenses. In New York, the State Department of Health is responsible for conducting inspections of each nursing home in the state on an annual basis, and more often if necessary. If certain regulatory standards are not met, the inspection team issues a deficiency citation which the facility is then given a certain amount of time to respond to in the form of a corrective plan. The state is currently implementing a new survey protocol, the Quality Indicator Survey. The data below, reflecting surveys from 2006 and 2010, report findings before the QIS was in effect.

The data summarized in Figure 28 indicate that the typical county nursing home in 2006 and 2010 was cited for significantly fewer deficiencies per 100 beds surveyed than were either for-profit or non-profit homes.

Figure 28

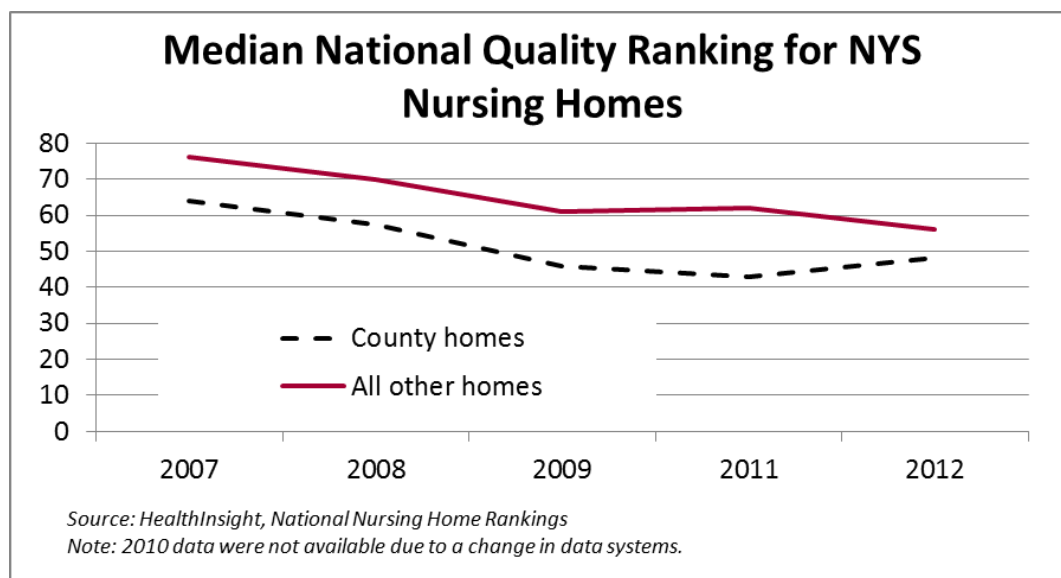


Quality of care measures present a mixed view of county nursing homes. Reported data on survey deficiencies suggest that county homes perform significantly better on this measure than do for-profit or non-profit homes, but a broader quality ranking focusing on 13 different long-stay measures suggests that overall quality of care in county homes may be declining over time, relative to rankings of homes nationally and statewide. However, these measures should be interpreted with caution, and suggest that there is no one definitive index of nursing home quality of care.

Because assessment of quality of nursing homes is more an art than a science, and because various factors besides just deficiencies are included in various assessments, we also present in Figure 29 data on quality from an additional source. HealthInsight compiles publicly-reported data obtained from the Centers for Medicare and Medicaid Services (CMS) website and translates them into national rankings (CMS long-stay quality measures as reported on Medicare.gov/Nursing Home Compare) for more than 14,000 nursing homes across the country. Thirteen measures focusing on care for long-stay residents are included in the rankings, with each weighted equally (see list in Footnote 33 in Chapter VII). The process has limitations, and the results should be interpreted with caution, as emphasized by HealthInsight's own statements and disclaimers.

Nonetheless, the data provide a balance to the deficiency data presented above. In 2007, non-public nursing homes throughout New York (for-profit and non-profit) had a median 76th percentile ranking, indicating that their average scores on the 13 long-stay quality measures exceeded three-quarters of the nursing homes nationally. County nursing homes in the state did not fare quite as well, with a median 64th percentile, but this composite median ranking remained well entrenched in the top half of all homes across the country. However, since then, both the non-public and county home rankings have steadily declined. Statewide, the non-public ranking has dropped from the 76th percentile in 2007 to the 56th percentile in 2012. Over that same period, the median county home percentile has dropped from 64th to below the 50th—fluctuating from 46 in 2009 to 43 in 2010 to the 48th percentile in 2012. Separate specific breakouts by non-profit and for-profit nursing facilities were not available.

Figure 29



V. NURSING HOME STAFFING AND COSTS: IMPLICATIONS AND CHALLENGES

County nursing facilities represent a significant economic force in their respective communities. This chapter focuses on profiles of nursing home staffing and costs, based on survey data, supplemented by comparison analyses made available by LeadingAge New York.

County Nursing Homes Have a Significant Cumulative Economic Impact

Including the six county nursing homes affiliated with hospitals, and the expenditures of the entire hospital-nursing home complex in those counties, county nursing homes are associated with more than \$1.8 billion in aggregate annual expenditures across 33 counties outside of NYC. It is not possible from financial statements to separate out the specific nursing home and hospital portions of the expenditures of the hospital-nursing home configurations. But even if most of the costs of the nursing home-hospital complexes are deleted from this total, leaving some reasonable estimates of the nursing home expenditure components of those operations, we conservatively estimate that the non-NYC county nursing home business, even without the hospitals included, accounts for more than \$800 million in aggregate annual expenditures across the 33 counties in which public homes operated at the beginning of 2013.

Together, county nursing homes are a big business. They employ about 10,000 employees (about 290 per facility), most of them full-time, and account for more than \$800 million in cumulative annual expenditures (more than \$1.8 billion if the six affiliated hospitals are included).

In some smaller counties, the county nursing homes are among the larger employers in the area. Our survey of county nursing home administrators indicates that the average county home employs about 290 staff, down from an average of about 320 in 2007. More than 70% of these employees are full-time (defined by about half the facilities as being 40 hours a week and by about half as either 35 or 37.5 hours per week). *Together, the county-owned nursing homes (including the affiliated hospital components) employ a total of about 10,000 individuals.*

In addition to the direct employment of county staff at the nursing facilities, most of the homes supplement their economic and employment impact by contracting out for various services, thereby expanding the numbers of individuals with at least partial employment impacted by the nursing homes. The nursing home survey attempted to obtain information on the specific number of jobs outsourced or contracted out, but the question was not answered consistently or thoroughly enough to provide reasonable estimates. However, the responses did provide indications of the numbers of facilities which contract out at least portions of certain

services and jobs. At least two-thirds of the county homes contract out for at least some of their therapists and physical therapist and occupational therapist aides. Well over half contract out for medical services. About half of the homes outsource at least a portion of their dietary/food services, and more than a third outsource some portion of their laundry services. About five of the homes outsource at least a portion of their maintenance and housekeeping functions.

Beyond what is currently being outsourced, about 40% of the homes indicated that they are considering outsourcing other functions, at least in part. The services most often noted as under consideration were laundry and housekeeping, food service workers, billing and maintenance.

At the same time as county homes provide substantial employment in their communities, staff reductions in recent years, as well as increased efforts to outsource various functions, attest to efforts by county nursing home administrators to reduce operating costs.

The extent to which outsourced services are currently in place and being considered not only reflects additional jobs created at least indirectly by the nursing homes, in addition to the roughly 10,000 direct employees, but also represents the extent to which many nursing home administrators are attempting to find ways to reduce the costs of operating their facilities. The fact that the average number of employees has also been reduced by an estimated 30 employees per facility over the past half dozen years is a further indication of efforts being made to reduce operating costs in many of the county homes.

Higher Direct Care Staffing Levels and Stability in County Homes

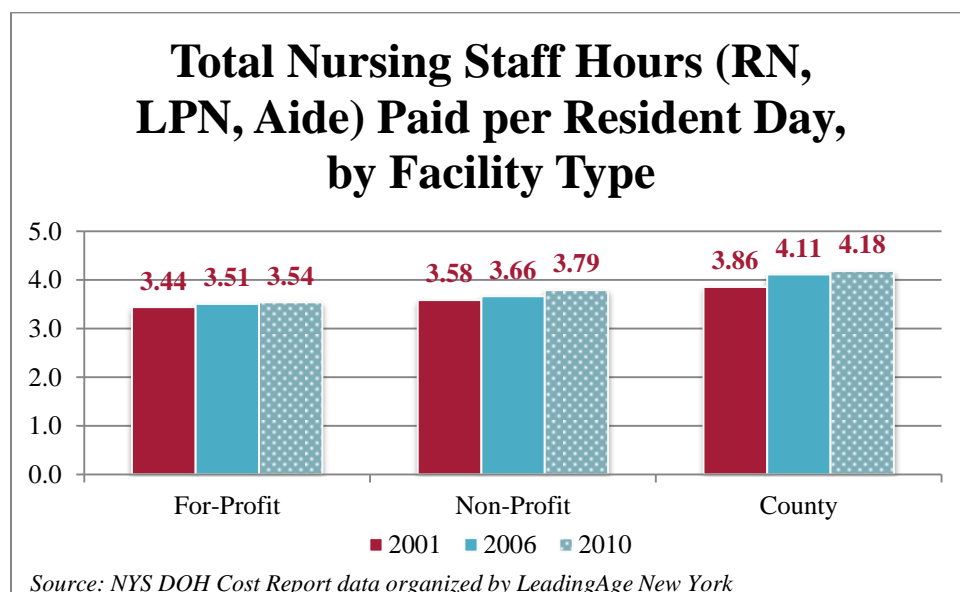
Many factors contribute to the care and ambiance of the nursing home environment, few if any more critical to the quality of care than the levels and stability of staffing responsible for the direct care of residents on the nursing floors. As shown in Figure 30, county facilities in the past decade have consistently maintained somewhat higher levels of nursing care (RNs, LPNs and aides combined) than have either their for-profit or non-profit competitors.

County homes provide about 40 minutes of additional direct nursing care per resident day than do for-profit providers, and about 23 minutes more than in non-profit homes.

While overall admissions per year have risen steadily in nursing homes over the past decade, especially in for-profits and non-profits, direct care staffing levels have remained relatively stable. For-profit total nursing staff hours (nurses plus aides) per resident per day have increased only from 3.44 to 3.54 during that time, while the typical non-profit home has increased by .21 hour, to 3.79 hours per resident day. Nursing time on the floor in county homes has increased a bit more, by about a third of an hour per resident day over that period. The net effect has been that direct care staff time in county homes, compared to time in for-profit homes, has grown from .42 hour more per resident day in 2001 to .64 hour more in 2010: 18% more staff time in county homes than in for-profits. That translates to almost an extra 40 minutes of direct care time per resident day in county homes than in for-profit facilities. Nursing time in county

homes also equates to about 23 minutes more per resident day than in non-profit homes.²⁹

Figure 30



One might have expected a higher level of nursing time/staffing in for-profit facilities given their higher average resident acuity, as measured by their significantly higher case mix index score in 2010, compared to the other facility types. Instead, county homes, with the lowest CMI levels, have had the higher staffing levels, perhaps to compensate for the reported higher levels of behavioral needs and issues noted in the previous chapter.

As indicated in Table 3, the differences in staffing levels between the facility types are primarily attributable to the difference in aide coverage, and to a lesser extent LPN staffing. There are essentially no differences across facility types in the amount of RN time on the floor. By contrast, county homes provide 14% more LPN time per resident day than do non-profits, and 22% more aide time. The staffing patterns reflected for 2010 in the table have been consistent over the past decade, except that LPN hours per resident day have increased somewhat across all facility types, and aide time has grown slightly in county and non-profit homes, during which time there was no change in aide coverage in for-profit homes.

²⁹ These reflect paid hours; actual hours worked are slightly lower, with the ratio of worked to paid hours virtually identical for all types of nursing homes. Thus the numbers of hours per resident day vary slightly between hours paid and actually worked, but the relationship as discussed in this section is identical whether using paid or worked hours.

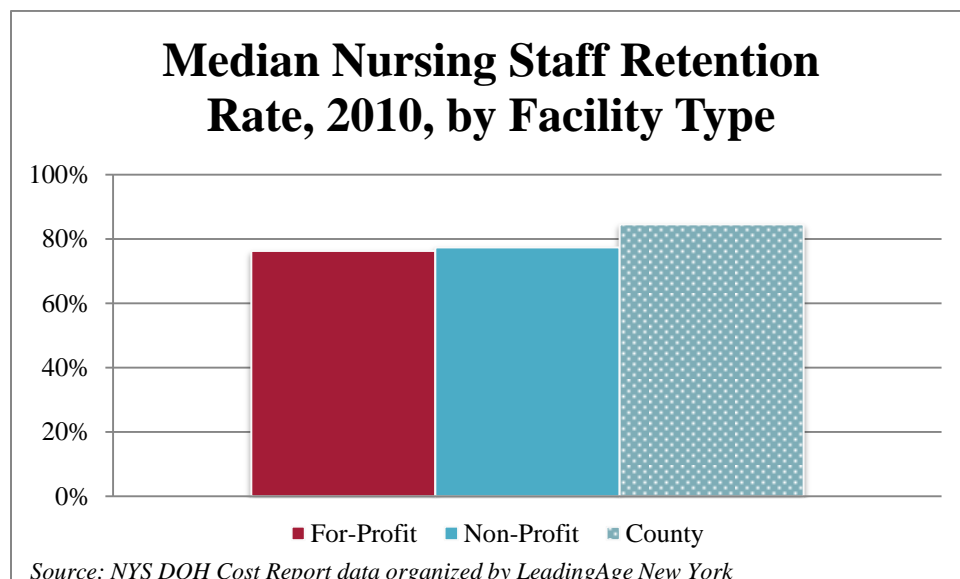
Table 3**RN, LPN, Aide Hours Paid Per Resident Day, 2010, by Facility Type**

	For-Profit	Non-Profit	County
RN	0.30	0.29	0.31
LPN	0.94	0.99	1.07
Aide	2.29	2.53	2.80
TOTAL	3.54	3.79	4.18

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

It is worth noting that over the years and across facility types, about two-thirds of the nursing hours devoted to direct care in the nursing homes statewide have consistently been provided by nursing aides. The ratio reflected in the data for 2010 was virtually identical for all facility types in both 2001 and 2006.

In addition to more staff time per resident day in county homes, county homes have also provided a bit more stability in staff coverage over time, with higher staff retention rates during the year, as reflected for 2010 in Figure 31 (85% for county homes versus 76% and 77% for their competitors). Such retention, if sustained year to year, is presumably reflected in a bit more continuity and stability in staffing on the nursing home floor, but also contributes over time to increasing salary and benefit levels that come with cumulative service.

Figure 31

Higher Costs of Other Cost Centers/ Functions in County Homes

Data were not available on comparative staffing patterns across facility types for functions other than direct care nursing staff. As an imperfect proxy for resources devoted to other functions, we provide a brief glimpse of the costs of selected other cost centers representing most of the major non-nursing functions provided in a nursing home. We recognize that the median costs of each cost center per resident day are a reflection of both resources devoted to the function, and also the salaries and benefits related to offering those services, and thus they are not a direct measure of resources alone. But with that caveat, it is worth commenting on a few of the cost center differences as a possible indicator of the differences between facility types in level of services offered.

To begin with, we have already seen in Chapter II that the costs of the nursing cost center are much higher in county homes than in other types of nursing facilities. We know that part of that added cost is due to the additional staffing levels just described above. We also know from other wage and salary data that typical salaries for RNs do not differ substantially between facility types, in either upstate or downstate nursing homes, but that the salary levels for LPNs and aides have been consistently higher in county facilities, both upstate and downstate. This combination of more and better-paid staff in county homes contributes to the dramatically higher median costs per resident day of the nursing cost center, reflected earlier in Figure 2 in Chapter II.

As noted earlier in Chapter II, county home costs per resident day were higher than in for-profit and non-profit homes in nearly all cost centers, in both upstate and downstate facilities. The extent to which those added costs reflect simply higher salaries and benefits, or higher staffing patterns and allocation of resources to improve the quality of services in the homes, cannot be determined definitively from the available data. But those caveats notwithstanding, some differences are worth noting.

- ❖ Costs per resident day of both housekeeping and food service are substantially higher in county facilities than in non-county homes in both upstate and downstate facilities. To the extent that these differences are not driven exclusively by salary and benefit differences (data were not available to determine this), the differences could suggest that more staff resources are devoted to these functions in county homes. Whether these translate into improved quality of life and care in the facilities cannot be determined by the available data.
- ❖ In less costly services, costs of providing social services, activities and laundry and linen services are also relatively higher per

resident day in county nursing homes than in their counterparts, again possibly suggesting that there may be differences in increased staff resources devoted to these services in county homes, depending on unknown salary levels.

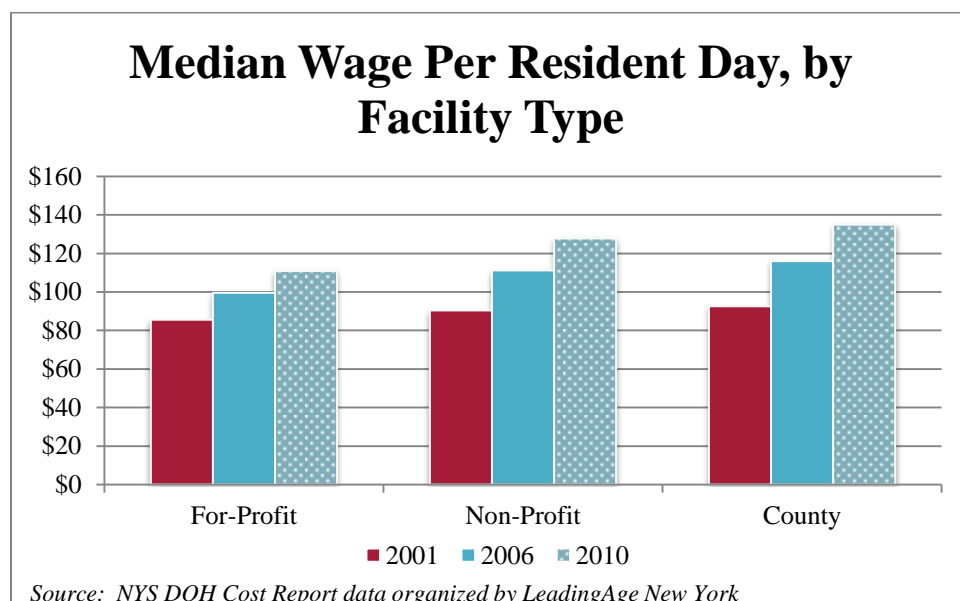
Rising Wages and Benefits in County Homes

Overall payroll costs of county homes significantly exceed those of their competitors. In 2010, the median cost of salaries plus benefits in a county home was about \$52 higher per resident day than in the typical non-profit home—and almost \$75 more per resident day than in the median for-profit facility. Median salary plus benefits, unadjusted for inflation, increased 75% in county homes between 2001 and 2010, compared with increases over that time of 49% in non-profit homes and 40% in for-profit facilities.

Median salary plus benefit levels increased 75% in county homes over the past decade, to almost \$75 more per resident day than in the typical for-profit home.

Wages were a significant contributing factor to these significant differences, as indicated in Figure 32. Wages paid per resident day increased 37% between 2001 and 2010 in all facilities, unadjusted for inflation, with county homes setting the pace with a 46% increase. But even with that level of increase, median wages per resident day in 2010 were only about \$7 higher in county homes than they were in non-profit homes (and \$24 per day higher than in for-profit homes).

Figure 32



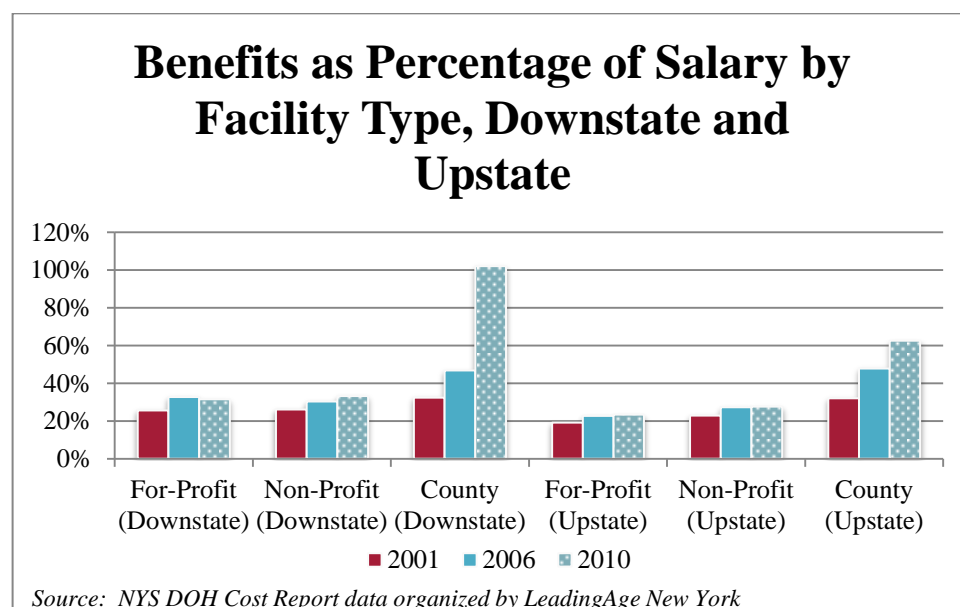
But the real issue is employee benefits, as emphasized earlier. Although average salaries are somewhat higher in county homes, the major contributor to the differential costs between types of facilities is the much

Employee benefit levels have increased 181% in county nursing homes in the past decade. The median county home benefit level is \$46 per resident day higher than in typical non-profit homes, and \$54 higher than in the typical for-profit facility. Benefits represent 63% of salaries and wages in upstate county facilities and 102% in downstate county homes. They primarily reflect increased payments to cover health insurance and employee pension programs.

higher employee benefits paid by public facilities. See Figure 3 in Chapter II as a reminder of the 181% increase in benefits per resident day between 2001 and 2010 in county homes. Over and above the relatively modest differences in median wages between county and non-county homes reflected in the graph above, employee benefit levels in the typical county home in 2010 were \$46 more than in the typical non-profit home, and \$54 higher than in the for-profit counterpart.

Another way of reflecting the disproportionate impact of benefits on the overall cost structure of county nursing homes is to demonstrate the cost of employee benefits as a percentage of total salary costs. As indicated in Figure 33, the typical benefits package for all types of homes was typically in the range of roughly 20% to 30% of salaries. That range has not changed significantly since 2001 for either for-profit or non-profit homes, either upstate or downstate. However, since then, county employee benefit rates have exploded—to 63% of salaries in upstate facilities and a remarkable 102% level in downstate facilities (defined as Rockland, Westchester, Nassau and Suffolk counties).

Figure 33



As discussed earlier, these increases in employee benefit costs reflect primarily increases in the costs of health insurance and especially of pension benefits and legacy costs due future retirees. These increases were set in motion by decisions made years ago by state and local policymakers, and the bill has come due.

Concerns about Employees in Decisions about Future of County Homes

With some 10,000 individuals employed by county nursing facilities in 33 counties outside NYC, and increasingly high wages and benefits allocated to them, a number of questions arise concerning their future as counties decide the fate of their nursing homes. Many of those issues were addressed in the surveys we conducted of nursing home administrators and of county government leaders in those counties.

Of most immediate concern is what to do to control those current costs. When asked the major challenges facing their nursing home, half of the administrators said the employee benefit costs and expressed frustration at the rapid increases in those benefit levels over the past three to five years. About a third of the administrators expressed concerns about the ability to continue to recruit and retain qualified employees. While making it a point to laud the quality of care and staff in their homes, most indicated they wish that they had more control over benefit and salary levels and raises, and that they could reduce or better control the amount of paid staff time off.

County nursing home administrators and county officials are seeking to control employee-related costs if the county continues to own the facility, and also to build in protections for current employees as much as possible if the home is sold.

Asked what changes they would like to see if their nursing homes were to continue to be owned by their counties, county government leaders addressed similar issues: 56% said there would be a need to reduce salaries and benefits, 40% said paid time-off days would need to be reduced, and about half said certain functions would need to be outsourced.

Asked their top concerns if their home were to be sold, 56% of the nursing home administrators specified the quality of care and staff levels in the future, and almost 40% expressed concern over the future of existing staff. Just over half of the county leaders listed the impact on current employees among their top concerns if the home were to be sold.

Should their nursing home be sold, nursing home administrators mentioned a number of things they hoped their county officials would do to protect the interests of existing staff, including negotiating continuation of employment for all who are interested; including provisions protecting staff in any sale agreement; providing other positions within county government as options for staff, to the extent possible; offering early retirement and severance/buyout options; and providing outplacement and training services for current employees. When asked directly, 92% of the county leaders said they should ensure that employment would be maintained as much as possible under the new owner; and about 20% indicated that salary and benefit levels should be maintained at least in the short term post-sale.

VI. FINANCIAL CHALLENGES AND IMPLICATIONS

As indicated in the previous chapter, county nursing homes outside NYC collectively make up an \$800 million-plus business in the 33 counties in which they were operating at the beginning of 2013 (not counting six county-owned hospital-nursing home complexes which would bring the total to more than \$1.8 billion in annual expenditures). They generate jobs employing some 10,000 individuals, the vast majority on a full-time basis. Annual admissions to these facilities are increasing. Yet the bottom line is that *nearly all of these nursing homes are losing a significant amount of money each year, and the financial condition of virtually all of the homes has worsened during the past decade*. This chapter uses survey data and historical comparison data made available by LeadingAge New York to focus on financial profiles of county nursing homes and how they compare with their for-profit and non-profit counterparts.

County Homes Increasingly Lose Money on Operations

As county nursing home expenditures have increased over the years, revenues have not kept pace. For example, cumulative data from audited financial reports for all non-NYC county nursing homes in 2010 indicated expenditures of \$1.834 billion (including six county-owned hospital-nursing home operations), which were only partially offset by \$1.633 billion in operating revenues. The operating revenues include primarily revenues generated by resident services, and do not include such additional non-operational revenues as intergovernmental transfers and local taxpayer subsidies (discussed further below). But the most fundamental measure of an organization's day-to-day financial health is its ability to take in enough operating revenues to cover or exceed its expenses in a given year, without the need for non-operating revenues which cannot necessarily be counted on from year to year.

County nursing homes reported a cumulative net loss of \$201 million in 2010, an average of \$5.9 million per home (\$6.2 million if hospital-affiliated homes are excluded). This is more than double the median county home loss of \$2.6 million in 2005 (unadjusted for inflation).

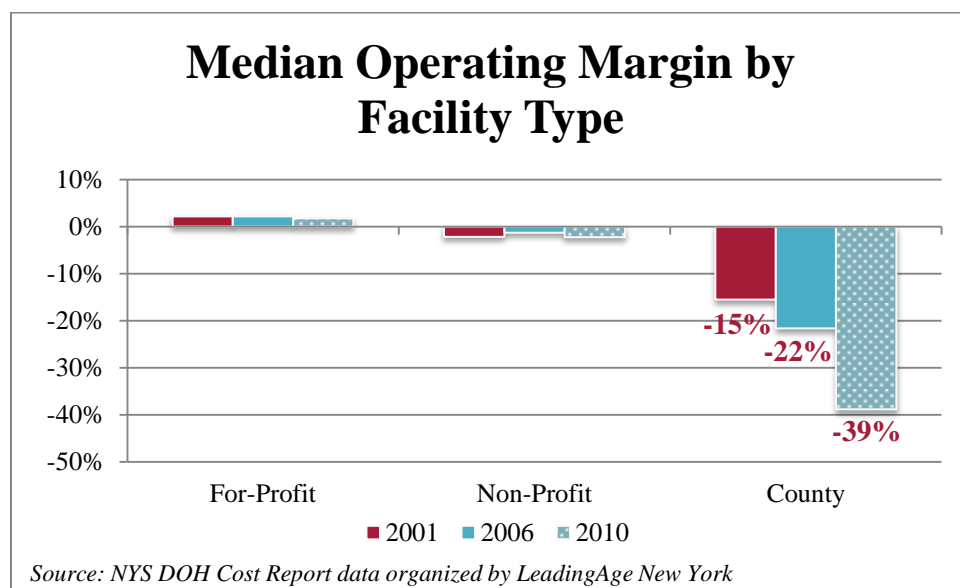
Using this fundamental yardstick of financial viability, the county nursing homes in 2010 reported cumulative net losses of about \$201 million. Thus total expenditures exceeded operating revenues by 12.3%. *The average county nursing home reported a net operating loss of about \$5.9 million in 2010.* (Available 2011 audited financial reports, with three missing, reflected similar results.) If the six hospital-nursing home complexes are excluded from these calculations, the remaining nursing homes suffered an

average net loss of about \$6.2 million in 2010. By contrast, the comparable reported median operating loss for county homes in 2005 was \$2.6 million.³⁰

Perhaps a better indication of the relative financial health of each facility is its operating margin, the ratio of net operating gain or loss to operating revenues. As shown in Figure 34, the operating margin has been relatively stable for non-county homes (a slight positive margin for for-profit facilities and a slight net loss for non-profits), but by contrast, the percentage amounts lost on operations in the median county home have gotten substantially worse over the past decade, especially since 2006. In 2010, operating losses in the typical county home were nearly 40% of the incoming operating revenues. Sixty-two percent of all county homes in 2010 had operating margins of -30% or worse, including seven homes with operating margins of -50% or worse. By contrast, only three of the homes had positive operating margins for the year (all three were hospital-affiliated).

More than 60% of all county nursing homes had a net operating loss in 2010 of -30% or worse. The typical county home's net operating loss has increased substantially since 2001, while net margins for non-county homes have remained relatively stable (slight median gains for for-profit homes and slight net median losses for non-profits).

Figure 34



In order to account for differential sizes of nursing home facilities, we normalized the data in Figure 34 by calculating the operating “gain or loss” per resident day.³¹ As shown in Figure 35, this provides a different way of emphasizing the dramatic downturn in the amount of operating losses in the typical county nursing home between 2006 and 2010, as the

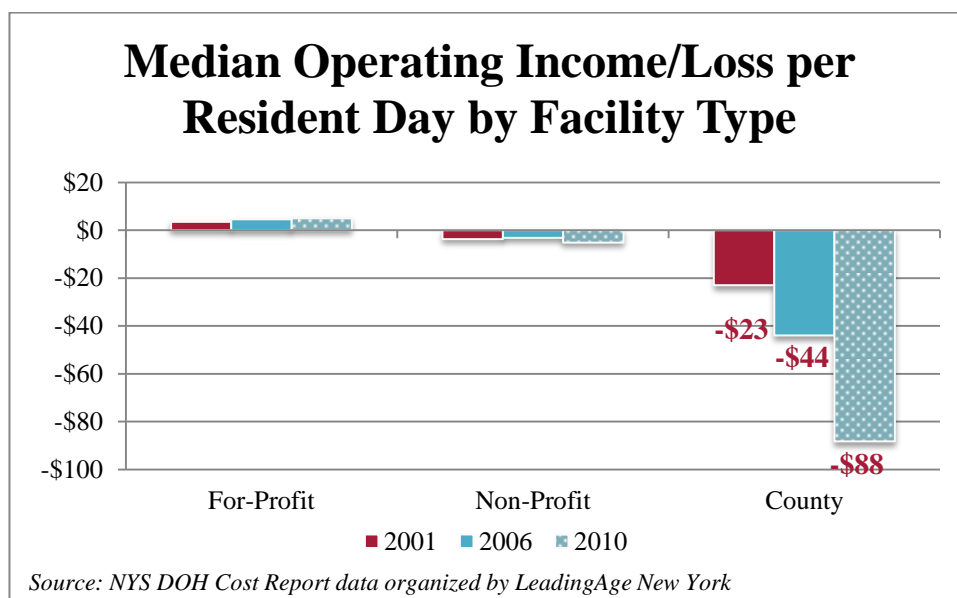
³⁰ CGR, *County Nursing Facilities in New York State*, op cit., p. 51.

³¹ Gains are reflected as operating profits for for-profit homes and net gains for non-profit and county facilities.

amount of loss per resident day doubled in just those four years, while almost quadrupling since 2001. For each resident day spent in a county nursing home in 2010, the typical home lost \$88. By contrast, the typical for-profit home had a net gain of about \$5 per resident day, and the median non-profit facility had a net operating loss of about \$5 per resident day.

The typical county home lost \$88 for each resident day spent in its facility in 2010, compared to a net gain of \$5 per day in the typical for-profit home.

Figure 35



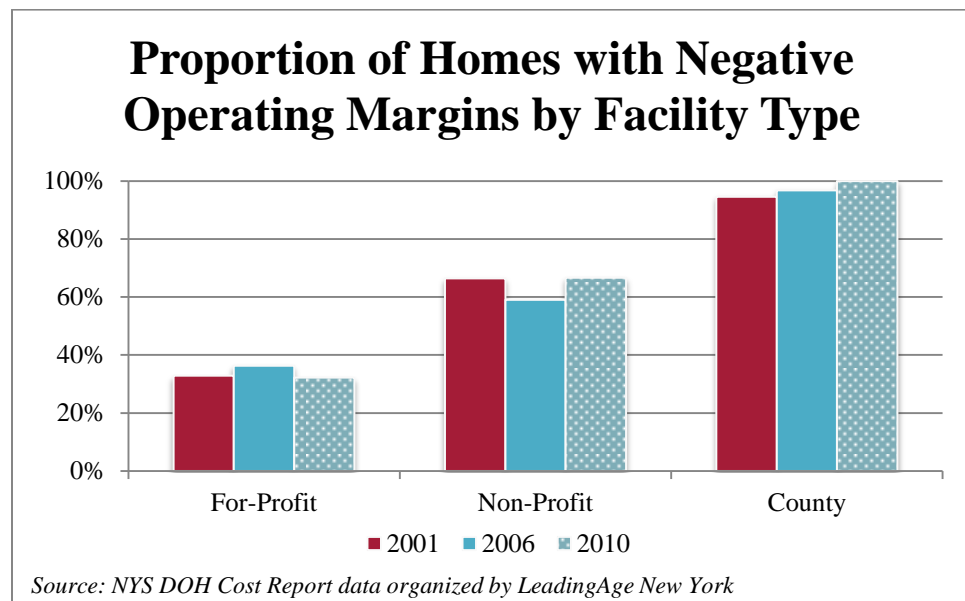
Nearly All County Homes Lose Money Each Year

Perhaps the most revealing statistic describing the declining financial conditions of county nursing facilities is the almost-universal number of individual homes losing money on operations. As shown in Figure 36, losing money is not unique to county homes, as *many nursing homes of all three types of facilities lose at least some money on an operating basis each year. But the proportions are dramatically different by ownership type. About a third of all for-profit homes in a given year lose money, as do roughly two-thirds of all non-profit facilities. However, consistently in nearly all county homes, expenditures exceed revenues.*

Indeed 100% of all stand-alone county nursing homes in 2010 suffered operating losses. However, it should be noted that three hospital-affiliated homes noted above did report net gains for 2010, but did not file cost reports and thus were not included in the LeadingAge New York data compilation reflected in Figure 36. With those homes included, the 2010 proportion for county homes would be 92%.

Nearly all county nursing homes consistently report net operating losses on an annual basis. In 2010, 15 of those losses exceeded \$5 million, including seven in excess of \$10 million. By contrast, a third of all for-profits and two-thirds of non-profits suffer operating losses each year, most involving much smaller loss amounts.

Figure 36



What is perhaps even more revealing than just the proportion of homes with operating losses is the magnitude of those losses. All but two of the operating losses in county facilities exceeded \$1 million in 2010. Moreover, 15 of the county facilities had operating losses exceeding \$5 million, including seven in excess of \$10 million. And these totals do not reflect additional costs to their counties (not reflected in nursing home enterprise fund accounting) of matching funds for IGT payments.

Signs of Revival?

On a more encouraging note, 2011 audited financial reports submitted as part of the county nursing home survey revealed that more than 60% of all county homes reflected improvements in the bottom line from 2010 to 2011, though most were of a modest nature. On the other hand, eight of these improved the operating bottom line by \$3 million or more, including three with improvements in excess of \$5 million from year to year. The number of homes with operating losses of \$5 million or more fell from 15 county homes to 11, though the number of homes with losses exceeding \$10 million increased by one to eight. Homes with positive changes in net assets increased from four in 2010 to 14 in 2011.

Overall, this reflects a more positive profile than has occurred in recent years. Although one should not put too much stock in comparisons from one year to the next (they may indicate only a one-year “blip” rather than an emerging trend), there may be reason for some level of restrained optimism in an otherwise bleak analysis of recent trends, and a similar

year-to-year comparison should be undertaken when 2012 financial reports are consistently available to see if these 2011 gains are sustained.

However, it has been suggested that a significant portion of this apparent upward movement may indeed be a one-shot fluctuation based on the retroactive rebasing payments and mitigation payments that occurred in 2011, which may account for significant Medicaid increases from 2010 to 2011.

There are some potentially encouraging signs in 2011 audited financial reports suggesting possible improvements in the bottom line of many county homes. However, this may be in large part a function of one-time retroactive rebasing and mitigation payments made in 2011. Whatever the reasons, whether this represents a one-year aberration or the beginning of a trend cannot yet be determined and needs to continue to be monitored.

Thus there is no guarantee that these data represent anything other than a one-time aberration. After all, our 2007 study reported a similar set of one-year improvements from 2005 to 2006, but data from subsequent years indicate that that one-year shift did not prevent the longer-term negative trend from resuming, as reflected in the graphs above. And even with this more encouraging sign, it is still the reality that the county homes continued to have an average operating deficit of about \$6 million dollars per facility in 2011, even with the year-to-year improvements from 2010.

But these changes from year to year could at least in part reflect an early indication of concerted efforts on the part of many counties to reduce costs and strengthen revenues in order to improve their homes' bottom line as they make decisions about their futures. *It would be worth finding a way to continue to track such data across county homes in the future to see if this one-year finding may be sustained and, if so, to explore the reasons behind any ongoing improvements in the financial operations of those county facilities—and their potential implications for the future.*

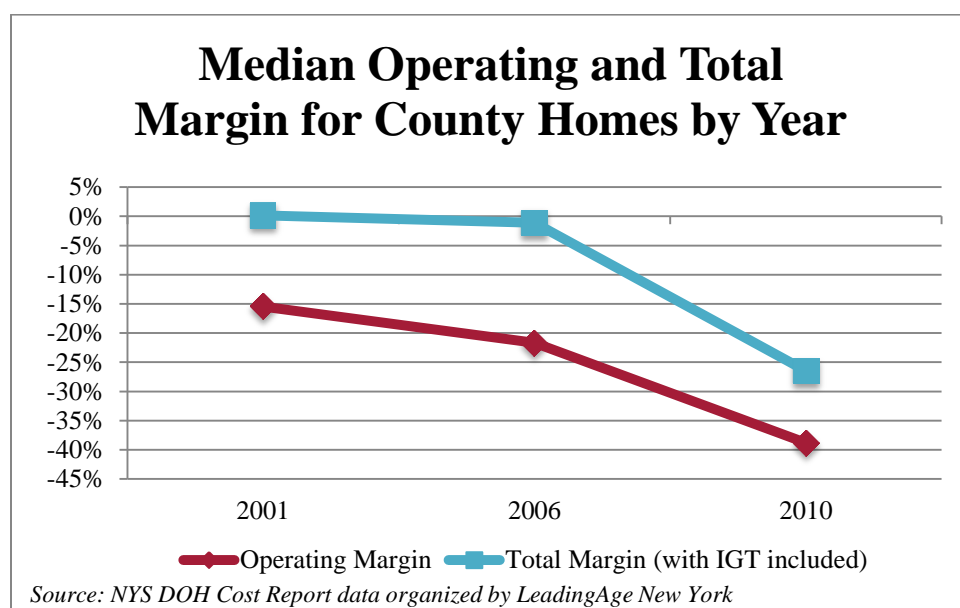
Dwindling Impact of IGT Payments?

Historically the existence of Intergovernmental Transfer (IGT) payments has made a significant difference in the ultimate year-end financial status of county nursing homes. But, as discussed in Chapter II, the timing and amounts of the payments are somewhat irregular, and payments do not always flow evenly from year to year, sometimes leading to no flow of IGT cash in some years and relative “windfalls” in others. Moreover, counties must provide a 50% match up front from the county general fund before any IGT funds can be accessed in any given year in which they are available. Some counties have begun to question paying at least some of the matching funds, thereby potentially reducing the full value of the IGT payment to their nursing homes. (IGT payments are not available to either for-profit or non-profit nursing homes.)

In this context, it is instructive to review the practical impact the IGT payments have had over the past decade, as summarized in Figure 37. At various points in the past, IGT payments have played the role of being the financial “savior” of county nursing facilities, making the difference in

many cases between an operating loss and a bottom line “surplus,” with the IGT factored in (*exclusive of any county matching subsidies*). For example, in 2001, IGT payments essentially made the difference between a median county home facility with a minus 15% operating margin (15% shortfall or loss) and a total margin median “virtual breakeven surplus” of +0.17% with IGT included. In nearly every county home, IGT payments improved the bottom line, at least reducing the amount of the facility’s net loss. And, for just over half of the facilities, the IGT payment pushed the home from an operating loss to a total net gain situation (see subsequent Figure 38 showing the homes remaining with a negative total margin, even after the IGT payments were factored in).

Figure 37



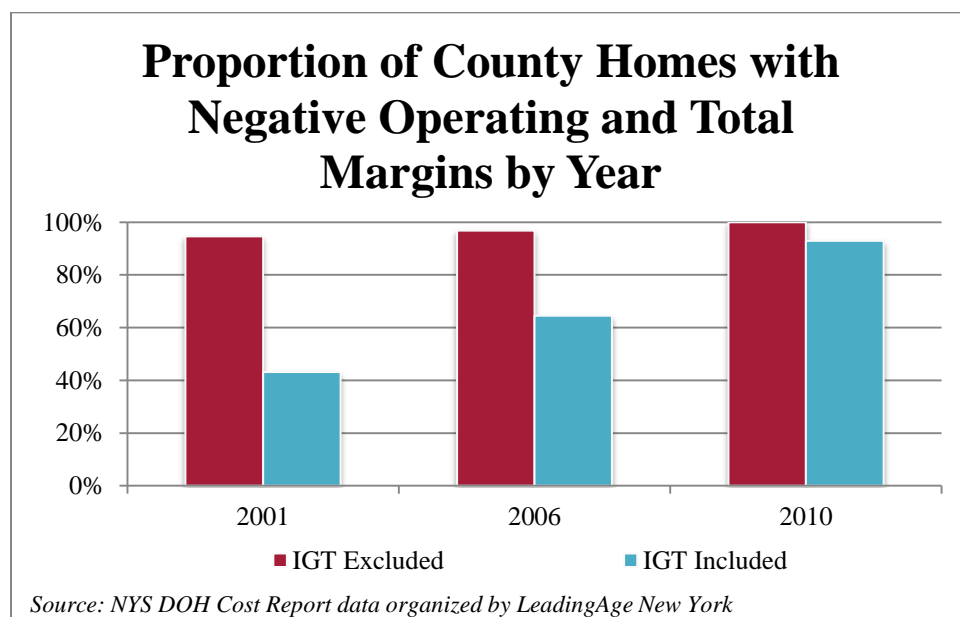
In 2006, the IGT payments continued to have an impact, virtually wiping out the gap between the -22% median negative operating margin and the total overall margin with IGT included. However, even though the IGT payments continued to improve the bottom line in virtually every county home, they were less of a force in pushing the bottom line from a net loss to a total net gain situation. Instead of making that difference for more than half the county homes in 2001, the IGT payments helped create a positive bottom line in the nursing home enterprise fund in about a third of the county homes in 2006 (see Figure 38).

By 2010, IGT payments had much less of an impact on the bottom line for most county facilities. With the larger operating losses in most facilities, they were simply too large for most IGT payments to overcome. Even though the IGT payments continued to reduce the median net margin—in this case from a minus 39% operating margin to a total margin or net loss of minus 26%—it was able to close less of the overall gap in the typical

county home. In many county homes in 2010, the IGT had no practical effect on reducing the operating margin. More to the point, in only two of all the county homes did the addition of IGT payments push the facility from an operating loss into a total net gain situation (see Figure 38).

Figure 38 summarizes the dwindling impact IGT has had over the past decade in moving county homes from a net loss to net financial gain situation.

Figure 38



IGT payments, once instrumental in reducing and even eliminating operating deficits in county homes, are increasingly less able to move the bottom line from a net loss to net gain position in most homes. While the IGT program is likely to continue to have a positive impact, its impact is likely to be reduced in scope if operating deficits continue to grow, as counties raise questions about the matching funds, and with the future of the IGT program itself uncertain in future years.

Furthermore, 20% of the county nursing home administrators said that in the most recent year for which their home received an IGT payment, their homes had not received the full IGT amounts for which they were eligible, because their county had not agreed to pay the full match from the county general fund. And, to that point, *any value the IGT payment has in reducing the county home's net deficit should realistically be discounted by the amount of the county matching contribution that must be covered by taxpayers from either the county tax levy or the general fund.*

Thus, as valuable and even essential as the IGT program is and will be to the future of county homes, to the extent operating margins continue to increase, and counties raise hard questions about providing the matching funds to access the IGT payments, especially when it may have an impact on pushing the county toward its property tax cap—and the existence of the IGT program itself remains somewhat uncertain in the future—it *becomes less and less certain that IGT payments will ever again be able to have the same level of impact on reducing or eliminating operating deficits in county homes as they had in previous years.* Furthermore, any

measure of the county-funded deficit should include the county's IGT match. Nevertheless, with these understandings, IGT can continue to be a strong economic factor supporting county homes, and homes are likely to continue to benefit from it as long as it remains in place.

Net Impact on Taxpayers

As county homes have increasingly suffered growing operating losses, the degree to which their county governments have needed to provide taxpayer subsidies to offset some or all of the losses has depended to a great extent on the availability of IGT payments and the extent and robustness of the county home's fund balance.

In reviewing data supplied as part of the survey process, including audited financial reports, it became clear that there were significant inconsistencies in terms of how county contributions to their homes were recorded, and the extent to which any contributions were made from a given year's tax levy, as opposed to contributions from the county's general fund. Furthermore, county matches for IGT funds were not recorded in any of the financial statements about nursing homes, since they came from county general funds and not the nursing home enterprise funds. Thus the combination of incomplete but mostly inconsistent data concerning direct county financial contributions to nursing homes makes it impossible for us to provide a definitive audited statement about the annual county contributions to, or subsidies of, their nursing homes.

One-fourth of responding county officials said their counties had provided no direct subsidy to their nursing homes in the past year; 29% reported subsidies of \$1 million or less; 29% between \$1 and \$4 million; and 17% up to \$7 million. Just over a quarter of the counties did not respond to this question.

However, we did ask county leaders to provide their best estimate of their county's 2012 subsidy to their nursing home, not including any IGT matching funds. Of the 24 counties responding to the question (73% of all counties owning homes), six (25%) said there was no direct subsidy. Seven (29%) reported subsidy amounts between \$500,000 and \$1 million; another seven said the amount was more than \$1 million and less than \$4 million; and four (17%) said the amount was between \$4 and \$7 million.

We also have nearly complete data from the audited financial reports on a useful proxy for annual total net costs of subsidizing the nursing homes: the annual net gain or loss in assets, and the impact that has on the nursing home fund balance. In most county nursing homes, even after IGT payments are factored in, and even if county subsidies are made in a given year, there remains a loss in net assets that is recorded against the nursing home's enterprise fund balance (in some cases homes are able to report net gains in net assets in some years after all other contributions are included). At some point, the taxpayers become responsible for payment of that fund balance. So even though county officials may choose in a given year to "charge" a nursing home shortfall in revenues against the nursing home fund balance, rather than against the county general fund or tax levy, at

some point the bill comes due to the taxpayers, as the fund balance becomes depleted.

Thus, it is important to note that, even after any often-substantial subsidies have been made by counties to their nursing homes in a given year to help offset operating losses, and after any IGT payments have been recorded, those were frequently not enough to move the bottom line of most county homes into a net asset gain for the year. Thus the resulting remaining deficits, or net losses of assets, wind up being reflected in changes from year to year in the net assets or nursing home fund balances available at the end of the year. In 2010, even with various subsidies already factored in, 27 of the 31 counties for which we had audited data reported an overall deficit or loss in net assets/fund equity for that year. In 2011, that number was reduced to 17, but still a majority of all county homes. In each of these two years, the county homes cumulatively accounted for more than \$178 million in net nursing home subsidies from their respective nursing home fund balances, over and above other county contributions and IGT matching funds that may have been provided.

Most county nursing homes reflect an annual deficit, or excess of all expenditures over all revenues, even after direct county subsidies and IGT payments have been applied. These are applied to the nursing home fund balance. Over half of these are currently negative fund balances, with eight having a cumulative negative fund balance of more than \$15 million. Obligations of taxpayers for county-owned nursing homes appear to be increasing.

Sixteen of the 31 county homes for which we had audited financial data reported negative *cumulative* nursing home enterprise fund balances at the end of 2011, with an average negative fund balance at that time across all homes of about \$13.1 million. Eight homes had a negative fund balance of more than \$15 million each. Of those with positive fund balances, most were relatively small: 11 of 15 had less than \$4 million in remaining fund balance assets against which to draw at the end of 2011.

Thus between specific-but-inconsistently-recorded county subsidies directly to nursing homes, the considerable matches from county resources that are necessary to access IGT payments, and the nursing home fund balances, which are ultimately county responsibilities as long as they own the homes, counties play a significant and increasing role in subsidizing the operations of their nursing homes.

County Costs Allocated Against Nursing Homes

Another way in which county taxpayers are affected by their nursing homes is through the concept of indirect costs allocated against the nursing home budget.

County nursing homes incur “charges” for services from other units of county government which are “allocated” as expenditures charged against the budget. In some cases these represent actual services provided, such as human resources/personnel, data processing and legal services—all of which any home (county, for-profit or non-profit) would need to provide directly or contract for. Often the chargeback allocations for such services

are accurate reflections of actual services and costs. However, even some legitimate services rendered to the nursing home by other governmental units can be charged against the home's budget at amounts in excess of the actual market value of the services provided. County homes can also be charged for portions of the salaries of legislators and county executive or county administrator where there is no equivalent in the private sector. Similarly, some of the costs of some services broadly provided by county government are in some counties allocated against the nursing home, whether the services are actually provided to the home or not. County nursing home administrators typically have no say in the inclusion or actual amount of the allocated charges.

Part of the rationale for this chargeback/allocations system is that at least a portion of these charges can be recovered through Medicaid and other sources of revenues that would otherwise have to be passed on to county taxpayers. However, because of upper payment limits and other administrative caps, in most counties many of these allocations are not currently reimbursable. In such cases, the portion of these allocated costs that do not represent real services actually provided to the home at fair market value artificially and inaccurately inflate the true costs of operating the home—and wind up being paid for by county taxpayers anyway.

As currently reflected in most nursing home budgets, it is not possible to determine which allocated costs represent actual services to the facility and which are simply overall county administrative costs spread across multiple county units including the nursing home. But with that caveat noted, it is nonetheless instructive to realize that the allocated amounts tend to be fairly consistent from year to year within each county home. In our nursing administrator survey, we asked for “the annual amount of general county indirect costs for such things as audit costs, personnel/HR support, legal service support, etc. which were allocated against your nursing home budget in the past three years.” We received reliable and consistent information for two of those years, 2010 and 2011.

The median for the 23 homes who responded to this question was about \$500,000 in each year. The maximum amount was \$1.46 million in 2010 and \$1.64 million in 2011.

To the extent that any of these costs represent services not actually performed for the home's benefit (or exceeded the real value of such services), and to the extent that the allocated costs are not able to generate reimbursement, allocated costs can have the effect of making the home's operating costs look higher than they actually are, without the offsetting benefit of claiming revenues against them.

We also asked about the practice in some counties of requiring their nursing homes to actually transfer funds from their enterprise fund to the

county general fund to cover some or all of these indirect charges. The responses were split, with 52% of the county homes saying that was the practice in their counties, and 48% saying it was not. Where that is the practice, the responses indicated that the entire allocated cost amount is typically included in the transfer of funds.

Outstanding Capital Debt

No comparative data were available on amounts of capital debt across different types of nursing home facilities. However, the survey of county homes asked what the amount of their outstanding capital debt was as of the end of 2012. Of the 24 facilities which responded to the question, five reported they had no outstanding debt. The total reported outstanding debt among the remaining 19 facilities was about \$191 million, an average of about \$10 million per facility, or about \$8 million across all reporting facilities (including those reporting no debt).

Three of the homes reported outstanding debt levels of \$1 million or less. Another six were between \$1 and \$5 million, with most of the rest reporting outstanding debt in excess of \$10 million, with a high of about \$34 million. It is not known how representative these totals are of the homes not responding to this question.

Likely Future Level of County Subsidies

Government leaders in counties owning nursing homes were asked their reaction to the level of financial support their county government is currently providing to their home. Leaders in just over a third of the counties indicated their current level of support was “about right.” Only one county said the current support level was “too low,” and just over half said the current level was “too high.” In three counties, responding leaders varied in their responses: in one county, responses ranged from too low to too high, and in two counties, the range was from about right to too high.

Both nursing home administrators and county governmental leaders were separately asked about the “tipping point” of county financial support (exclusive of IGT matching funds) at which the county would be likely to consider ceasing future ownership of its nursing facility. Administrators varied widely in their responses. About a quarter thought any county subsidy would be perceived as too much and would trigger a process to disengage from ownership; another 20% said the county might be willing to subsidize up to a half million dollars a year in the future; 29% suggested various subsidy levels between \$1 and \$3 million would trigger disengagement; and a similar number indicated that they thought the county would tolerate between \$5 and \$10 million annual subsidies before considering transfer of ownership.

County government leaders appear to have a relatively low level of tolerance for future levels of county subsidies they are willing to accept to maintain their county nursing homes.

County leaders who will actually make the decisions were less tolerant of future subsidies. Almost two-thirds said some combination of the following: the process to sell is already underway, or no subsidy is acceptable, or the current support level is already the point at which the county should consider selling. Another 20% indicated that some subsidies could be acceptable, with most of those suggesting a tipping point of around half a million to one million dollars a year and two going as high as \$4 or \$5 million. Thirteen percent were uncertain and unwilling to venture a specific estimate without further consideration.

VII. IMPACT OF RECENT OWNERSHIP TRANSITIONS

There is no single conclusion that says a sale of a county home is likely to result in a good or bad outcome for the county; the results are mixed. The process by which decisions are made becomes critical to the ultimate outcomes.

CGR conducted case studies of the experience in counties that have sold or closed their nursing homes, in order to provide local and state decision-makers with the benefit of their experience. These accounts include analysis of quantitative and qualitative data, historical information about the factors leading to the decisions to sell or close, comparisons to similarly-situated counties that have not yet sold or closed their homes, and our best estimates of the overall impact of these transitions—on residents, families, staff members, the larger long-term-care network and the broader community. In short, we talked to as many knowledgeable people as possible, and looked at as much relevant data as we could find, to tell as complete a story as possible about the experience in these counties and to share potential lessons from these experiences. *We find a very mixed picture, with both qualified successes and cautionary tales, suggesting that counties should pay very close attention to how they make these decisions and carefully consider who they wish to have in control of their nursing homes in the future.*

We begin this chapter with analyses of county nursing facilities that were sold, followed by a section on those that were closed.

County Homes that Were Sold

Oswego, Delaware, Montgomery and Fulton counties sold their homes between 2005 and 2012. Several others are in the process of selling, but for this analysis we focus on counties that had completed the transaction between 2005 and 2012, in order to provide some insight into the impact of sales.

Interviews with former and current nursing home administrators, county officials, nursing home ombudsmen coordinators and others, as well as available data, show that the outcomes of some sales were better than others. The most discouraging outcome was in Delaware County, where the state closed the home in 2012 because of poor performance six years after it had been sold to a for-profit start-up company. The owners have subsequently signed a contract to sell the home to a new operator, and the deal is under review by the state.

Sales in Montgomery and Oswego counties have had more encouraging outcomes. In Montgomery, resident care and the finances of the home have clearly improved, though there are some concerns that hard-to-place residents have less access to the home now than they did when it was county-owned. In Oswego, quality-of-care rankings have improved from

previously low levels. The impact in Fulton County is still unfolding—a New York City-based for-profit company just took over in 2012. But there have been concerns about increased admissions of younger residents with behavior problems, staff turnover and declines in the quality of care—all things the new owners say they are working to improve.

Factors Leading to Sales

Table 4

Counties that Sold Homes, at a Glance					
County	Year of Transition	Subsidy in Prior Year	Beds	Sale Price	Price per Bed
Oswego	2005	\$.4 M	89	\$.8 M	\$9,000
Delaware	2006	\$3.3 M	199	\$2.5 M	\$12,600
Montgomery	2007	\$2.7 M	120	\$.86 M	\$7,200
Fulton	2012	\$2-3 M	176	\$3.5 M	\$19,900

As shown in Table 4, the number of beds in nursing homes that sold homes between 2005 and 2012 ranged from 89 beds in Oswego to 199 beds in Delaware. Counties were making annual subsidy contributions to help make the homes whole financially, ranging from less than \$500,000 in Oswego to \$3.2 million in Delaware. Officials in Oswego decided to act before the financial picture worsened and thus became the first county in this century to sell its nursing home. The sale prices ranged from \$800,000 to \$3.5 million; on a per-bed basis, the homes were sold for between \$7,200 and \$19,900 a bed. *Sale prices—all less than \$20,000 per bed and two less than \$10,000—suggest that these counties derived the primary benefits of the sale from the future savings resulting from elimination of future nursing home deficits and from relinquishing themselves from the continuing operational burdens of ownership—more so than from the relatively small prices received from the actual sales of their homes.*

The four county homes all sold for less than \$20,000 per bed, suggesting that the benefits to the counties resulted from reduced operating deficits in the future, rather than from significant financial “windfalls” from the sale per se.

Several factors contributed to financial problems at the homes, which have already been discussed in detail earlier in this report. In these four cases, they include relatively low case mix index (CMI) figures prior to sale, ranging from 0.87 to 0.93, reflecting in part a dearth of short-term rehabilitation admissions. In at least two homes, administrators acknowledge that billing procedures weren’t sophisticated enough to capture all the reimbursement revenue the homes were due. Other inefficient practices were cited, including the use of expensive local vendors favored by county legislators. All of the county homes also had been paying relatively high wages and benefits, compared to non-profit or for-profit homes.

With one exception, the homes were not in serious trouble in terms of deficiencies at the time of sale, based on the available data. Data were not readily available for Oswego County, but the number of deficiencies in Delaware and Montgomery (3 and 5, respectively) in the year before sale, was not excessive compared to homes generally. The fourth county, Fulton, had more deficiencies, 10, in the year prior to its sale.

All four homes used a Request for Proposals process to solicit purchase offers for the homes. They each received between two and five proposals with, in most cases, a mix of non-profit and for-profit bidders. Generally, the counties used committees to review and evaluate proposals and narrow to a preferred buyer. One county (Oswego) sold to a non-profit current nursing home operator, and the other three sold to for-profit operators.

New Owners and Transitions

In Oswego, county officials rejected higher offers for the home in favor of a local non-profit nursing home operator with a good track record of providing care. Delaware County received only two bids for its home, and one of the bidders also wanted to buy the county's home health agency, which the county didn't want to sell. So Delaware sold to the remaining bidder, a start-up for-profit composed of three Herkimer County men with nursing home experience, including a CEO. Montgomery County sold its home to a small, new for-profit corporation, which moved quickly to improve its physical environment and staff culture. Fulton County sold its home in 2012 to a for-profit Bronx-based company that operates nursing homes throughout the state, selecting it over a local non-profit provider and two other for-profit bidders.

The transitions were difficult in each county for several reasons, including the length of time needed for the state to approve the sale, which ranged from about 12 to 18 months. During this time, home administrators had to manage the anxieties of staff and residents facing an uncertain future, which in some cases led to staff turnover and declines in the quality of care. (This was likely a factor in the 10 deficiencies cited in Fulton in 2011.) These challenges were mitigated somewhat in Oswego by allowing the new owner to come in to manage the home during the transition.

Detailed Case Studies

In the following section, we present detailed accounts of what transpired in each county that sold its nursing home, including the factors leading to the decision to sell, a brief outline of the process used to sell the home, the transition process and any challenges it presented, and the impact of the sale on nursing home residents and employees, as well as the broader community. We have compiled as much data and perspectives from as many reliable sources as we could locate to tell these stories as completely

and fairly as possible. Our efforts included interviews with county officials, nursing home administrators, union leaders, nursing home ombudsmen, administrators in neighboring nursing homes and hospital discharge planners. We also analyzed various datasets, including state data compiled by LeadingAge New York on nursing home finances and staffing, data on deficiencies from the NYS Health Department website, and quality of care data from HealthInsight, a non-profit community-based organization that works to improve health and health care.

These accounts of each county's experience are followed by an analysis of common themes and trends, and comparisons to similarly-situated counties which have not sold their nursing homes.

Andrew Michaud Nursing Home, Oswego County

Factors Leading to Sale

Oswego was the first county in New York in this new century to sell its nursing home, in 2005.³² The Andrew Michaud nursing home, which retained its name after it was sold, was not running large deficits by today's standards – annual losses covered by the county were less than \$500,000 (just 1% of its total tax levy of \$38.2 million). Yet county officials predicted that financial conditions would deteriorate and decided to solicit proposals for purchasing the home.

In the view of the home's administrator at that time, many aspects of its operation were "behind the times." It was not financially savvy and didn't capture all the reimbursement revenue to which it was entitled. Although it was attached to a hospital, almost all admissions were for long-term care rather than short-term rehabilitation. Union contracts contained wage scales that drove up compensation based on longevity without regard to job function. Housekeepers who had been at the home for years were making almost as much as RNs.

In addition, political concerns interfered with efficient operations. County legislators wanted to support local vendors even when they cost more, including local pharmacy providers. The administrator worked for years to get the county to solicit proposals for providing pharmacy services. Eventually, she was able to change providers and save about \$40,000. County officials, both elected and appointed, weren't familiar enough with the nursing home industry to be effective operators, she concluded.

³² Dutchess had previously sold its county-owned nursing home in 1998.

Sale Process

In 2004, the county issued an RFP inviting bids on the home. The RFP spelled out that the county sought to sell to a buyer committed to operating the facility as a skilled nursing home and accepting indigent and uninsured residents. It also said county officials would give favorable consideration to buyers that “positively address the continued employment of the facility’s current staff.” Although the county was interested in selling the home, officials wanted to make sure as much as possible that the quality of care would be maintained and that staff would retain jobs.

The county received five bids for the home, with purchase prices ranging from \$500,000 to \$2.5 million. The bidders were a non-profit hospital, a non-profit nursing home owner/operator, and three for-profit ventures, including two nursing home owners. They proposed a range of options for financing the purchase, including one in which the county would have retained ownership of the home and leased it to the buyer. Another bidder would have required the county to make it whole if the home suffered operational losses in the first two years.

A county committee reviewed the proposals and ultimately selected St. Luke Health Services, a non-profit that operates the St. Luke Health Services nursing home in Oswego, about 10 miles north of Michaud’s location in Fulton. St. Luke paid about \$800,000 for the 89-bed home. Although one bidder had offered much more for the home, county officials were concerned about its track record of providing care.

Transition

The county had St. Luke come in to manage the facility as the transfer of ownership was making its way through the state Health Department approval process. This provided some continuity for residents and staff and allowed St. Luke to begin learning the facility before it formally took control.

All existing employees could apply to work for St. Luke, and about 50-60% were retained. Most of the others had not applied for jobs. Staff who were hired kept their longevity, though compensation was generally lower, especially retirement benefits. Most of the front-line workers became members of Service Employees International Union 1199, the union representing workers at the St. Luke nursing home in Oswego.

St. Luke management in the first year addressed some “low hanging fruit” changes of bidding out laundry, pharmacy and therapy services to save money. They improved health information systems, introducing their own systems, and improved the documentation of care, allowing them to draw down more reimbursement revenue.

All current residents stayed at the home, and St. Luke managers met with them to try to address concerns and answer questions. Admissions to the home changed as St. Luke began taking more admissions from hospitals and providing more short-term rehabilitation, increasing that line of business by about 10%. This increased the case mix index and improved the finances of the home. The overall CMI increased from 0.88 in 2001 to 1.01 in 2006 and 1.07 in 2010, and the percentage of resident days covered by Medicare increased from 7% in 2004 to 16% in 2005 and 15% in 2006, before declining back to 10% 2010. While these changes raise the possibility that some lower income or hard-to-place residents were less likely to be admitted to Michaud following the transfer of ownership, CGR did not find any evidence in data or interviews proving that occurred.

St. Luke made over \$2 million in capital investments in the Michaud home to modify dining areas, improve security and purchase new mattresses and therapy equipment. The initial plan was to use non-recourse loans, but St. Luke in the end had to borrow against its assets. This was somewhat risky and shows the difficulty new owners may encounter in raising funds not only to sustain operations but also to make needed capital improvements. In some cases, this may be tougher for non-profit owners, who may have less access to capital.

Impact

The home's former administrator believes the quality of care has improved under St. Luke. When she visited a few years ago, she was impressed both with the physical changes at the home and improvements in two residents that she had known. She believes St. Luke was able to recruit better medical professionals and provide more continuing education.

Michaud has worked to address issues including pressure sores and ensuring that residents get proper medication. According to HealthInsight,³³ it ranked in the 45th percentile of homes nationally in 2012, down from 81st in 2011 but up from 9th in 2009.³⁴ Michaud in recent

³³ HealthInsight is a nonprofit organization working to improve health care and transparency that annually produces national nursing home rankings based on publicly reported data from the Centers for Medicare & Medicaid Services. The rankings are based on 13 quality measures for long-stay residents: % with pressure ulcers, % who lose control of their bowels or bladder, % given the pneumococcal vaccine, % given the seasonal influenza vaccine, % experiencing one or more falls with major injury, % with depressive symptoms, % who have/had a catheter inserted and left in their bladder, % who lose too much weight, % who received an antipsychotic medication, % who self-report moderate to severe pain, % who were physically restrained, % whose need for help with daily activities has increased and % with a urinary tract infection.

³⁴ HealthInsight rankings were not available before 2006.

years has had fewer deficiencies than average for nursing homes and none of the most serious types of deficiencies. Deficiencies had also fluctuated, overall falling from 13 in 2007 to 2 in 2011.

However, the home does have fewer nursing employees than it did when it was county-owned. In 2004, nursing FTEs (including RNs, LPNs and CNAs) numbered nearly 65, compared to 56 in 2010. During those years, the quality of care as measured by the national rankings fluctuated, so it is not clear what impact those declines had.

The overall impact on taxpayers was small: the total property tax levy increased from \$39.7 million in 2005 to \$40.7 million in 2006 before dropping slightly to \$39.2 million in 2007. But costs to the county would almost certainly have increased in succeeding years as pension and other expenses rose, had the county continued to own the nursing home.

Conclusions

Oswego County increased the community's comfort around selling its nursing home by choosing a local non-profit buyer, opting for avoidance of future annual subsidies rather than a high sale price. This appears to have been a relatively successful sale, with few negative consequences of significance.

The decision to sell the Michaud nursing home in 2005 saved Oswego County and its taxpayers from the escalating costs facing counties across the state. It occurred before the financial burden on the county was significant, and so was accomplished with less controversy and turmoil than has been the case in other places. By choosing a local, known non-profit as a buyer, the county eased some community fears about what would happen, though the transition was still difficult. As measured by quality indicators, deficiencies and interviews, the sale does not appear to have had a dramatic effect, positive or negative, on the home. Michaud remains in business and has been a stable community asset.

Countryside Care Center, Delaware County

Factors Leading to Sale

In Delaware County, financial pressures convinced county officials to consider marketing the Countryside nursing home, which kept the same name after being sold. The reported subsidy had grown from \$800,000 in 2001 to \$3.3 million in 2005, the last full year of county operation of the home, according to data compiled by LeadingAge New York. That was 15% of the total tax levy of \$22.2 million in 2005. The administrator at the time proposed replacing the existing building at an estimated cost of about \$20 million in order to gain higher reimbursements for care and to provide a more home-like environment for residents. But the county was facing a mandate to build a new jail and public safety building and constructing a new composting facility, and county officials were leery of taking on additional debt.

Sale Process

In 2004, the county issued a Request for Proposals to potential bidders for the home. The county received two bids for the home; one bidder wanted to purchase the county's home health agency as well, which the county was not interested in selling. So, in March 2005, the decision was made to sell the home to Leatherstocking Healthcare LLC, a new for-profit corporation formed by three individuals with previous experience in nursing home operations, including experience in human resources, maintenance and top leadership. The purchase price was \$2.5 million to buy the 199-bed home.

It took more than 18 months for the sale to be finalized; Leatherstocking did not take over the home until December 2006. The process was longer than expected both because of the time needed to obtain state Health Department approval and efforts to put together financing for the sale.

Transition

Staff had thought the transition might happen as early as January 2006, so the additional 12 months that elapsed presented a challenge for all parties, including existing management and the buyers. The buyers wanted to retain staff members but weren't able to guarantee them their jobs. Existing management needed to keep employees, but they faced an uncertain future. To try to retain staff, the county and union agreed that employees who stayed on would be paid out for accrued personal and vacation time at the time of the sale—a deal that cost the county about \$250,000.

After the state approved the sale, the buyers hired the existing administrator to continue in his job. He had about two weeks to interview existing staff and rehire employees whom he and the buyers wanted to retain—about 90%. Most of those who weren't hired back either retired or were rejected due to poor performance.

Initially, staff members were “held harmless” with regard to salary and benefits—they were maintained at the same level. This aided in the transition, and the staff began the new chapter under private ownership with good energy and a desire to prove themselves to the new owners and to the community.

However, within the year, financial pressures began to exact a toll. Starting salaries for new employees were reduced, pay for existing employees was frozen, and all employees began having to pay some of the costs of their health insurance. Although the employee union (CSEA) had lost a fight to continue representing employees at the time of the sale, employee discontent fueled two subsequent efforts to unionize, although

both ultimately failed. Following the last effort, the new owners granted retroactive pay increases.

Decisions at the state level made the financial picture even more difficult: a re-basing of Medicaid rates resulted in lower reimbursement rates for Countryside and required the home to repay about \$500,000. This scuttled the new owners' plans to add an adult day care program with 35 slots. The owners also spent money to fight the unionization efforts, another drain on resources. In addition, residents' Medicaid applications to the county were often not approved in a timely manner, according to one of the owners.

Although many nursing homes try to improve their financial picture by attracting more private-pay or Medicare-funded patients (including those needing short-term rehabilitation services), data on patient revenue sources show Countryside did not have increases in these areas. The percentage of patient days paid for by Medicaid increased from 70% in 2006 to 77% in 2010. The CMI was effectively unchanged: 0.84 in 2006 and 0.86 in 2010. Countryside did reduce annual financial losses from \$2.5 million in 2005 to \$22,000 in 2010.

In 2010, Countryside's administrator was fired, and one of the owners temporarily took over operation of the home. The owners hired an administrator new to the field who then had some difficulty passing his licensing exam, though he eventually did pass. It was difficult to retain top staff, such as medical and nursing directors, and turnover in those positions was high. The financial strain was becoming obvious to employees—vendors that hadn't been paid began to refuse to provide supplies or services.

According to one of the owners, a key problem was their physical distance from the home. None lived in the community, and they saw the commute as too long for them to be on site every day.

Overall staffing at the home, measured by full-time equivalent employees, declined from 191 in 2005 to 179 in 2007, jumped back up to 204 in 2008 and then fell to 172 in 2010. The number of nursing FTEs followed a similar pattern but fell by a bigger percentage, declining 26% from 2008 to 2010, from 113 to 83. Hours of RN nursing care provided to residents fell from 0.2 hours per resident per day in 2005 to 0.17 in 2010, a decline of 16%.

Impact

As a result of all the turmoil, the care provided to residents began to decline, and Countryside started to rack up deficiencies in state surveys. Total deficiencies increased from three in 2006 to 10 in 2009 and 19 in 2011, according to figures from the state. In 2009, the home had four of

the most serious deficiencies (immediate jeopardy), and it had three in 2011. Countryside also fell in the national nursing home rankings developed by HealthInsight, from the 79th percentile in 2008 to the 35th in 2011.

Concerns about care had the nursing home ombudsmen at the home two to three times a week in 2011-12 responding to problems including medication errors, call bells not being promptly answered (including long waits for help to the bathroom), dietary problems (not following special diets), and incorrect documentation. During this time, rumors that the home would sell or be closed were prevalent among staff and residents.

Because of the issues with care, the state put Countryside on a special focus status, and in October 2012, the state forced Countryside to close, though the owners were in the process of trying to sell to a new owner. About 120 residents had to be moved to other facilities; because Delaware is a rural county with only two other nursing homes, many had to be moved to other counties, including Broome, Albany and Oneida.

The nursing home ombudsmen worked to notify other counties about the closure and transfers so that homes receiving Countryside residents could be on the lookout for “transfer trauma,” a potential side effect of being moved. Residents suffering from transfer trauma withdraw, stop socializing or, in extreme cases, eating, and their conditions deteriorate. Some of the former Countryside residents did show signs. And other residents were just angry and distressed about being moved. “A lot of them felt like they were being thrown away,” said one official who worked with residents.

In the flurry of activity closing the home, a few families had difficulty finding their loved ones, though eventually they were located. But there remain families who cannot visit their relatives because they were moved too far away, and some former Countryside residents are still trying to find a spot closer to their families.

The owners are still trying to sell Countryside, and in fact have signed a sale contract with a buyer which they did not want to identify. The potential sale is under review by the state.

The Delaware County Board chairman maintains that selling Countryside was the right thing to do for taxpayers. The property tax levy decreased from \$23.2 million in 2006 to \$22.5 million in 2007 and \$22.2 million in 2008, which the chairman attributed to the nursing home sale. The levy then began to rise again, reaching \$24.7 million in 2011, according to data from the Office of the State Comptroller.

The Countryside/Delaware County experience can be viewed as a cautionary tale for potential sellers of nursing homes: what can happen without a careful selection process and resulting comfort with the new owner. Inexperienced ownership led to poor quality care and ultimately closing of the facility and disruption to residents.

Conclusions

Countryside can be viewed as a cautionary tale. The county sold to its only viable bidder: a start-up with no institutional experience in taking over, or owning and operating, a nursing home. The result was years of turmoil, union/management struggles, top-level firings, staff turnover and declining care for residents, culminating with the state's closure of the home. While the county saved money (it could stop paying a \$3 million subsidy and the property tax levy declined for a few years), it seems likely that a more thoughtful, intentional approach toward marketing and selling the home might have produced more and higher quality bidders.

Montgomery Meadows/River Ridge, Montgomery County

Factors Leading to Sale

The deficits were also growing at Montgomery Meadows. In 2006, the year before the home was sold, Montgomery County provided a subsidy of \$2.7 million, more than 12% of its \$21 million tax levy. One county official speculated the county would have had to put \$4-5 million into the home by 2013 if the home hadn't been sold.

Sale Process

In 2005-06, the county issued an RFP and received several responses, narrowing the options to a handful and then to one. The new owners, who operate the home as a for-profit company, paid \$860,000 for the 120-bed home, including 25 acres of land. This represents the lowest price per bed of the four case study sales.

Transition

The new owners took over the home in January 2007 and renamed it River Ridge Living Center. To staff the home, they held a job fair at a local hotel. They had 150 positions, and the job fair attracted more than 300 applicants, including existing employees of the home. They hired about 40-50% of their staff from the pool of existing employees, but rejected the rest because they didn't meet their standards.

The new owners moved aggressively to improve the home's physical environment and culture/climate. They put in new floors, lighting, wallpaper, two fireplaces, a new roof, sprinkler system and renovated the dining room. Their [website](#) displays some before and after pictures highlighting the changes. They worked to instill a sense of professionalism and service among staff members, setting an example by helping keep the home tidy themselves. "We had to change the culture. Our people are very

professional. They're very friendly. The executives pick up garbage, so staff does too," one of the new owners said.

A new owner said they treat staff members well because "we want our residents treated well." That includes providing free lunches and paying 100% of the cost of health insurance (though that will be changing as federal health care reform provisions take hold).

The new owners also attracted more patients needing short-term rehabilitation, which can help to stabilize finances because the Medicare reimbursements for such care generally cover more of the cost than does Medicaid. Data show that River Ridge is serving more short-stay residents (21% in 2010, up from 14% in 2006) and that the Case Mix Index has improved (1.14 in 2010, compared with 0.87 in 2006).

Impact

Data show the quality of care and the finances of the home have improved. A thornier question is whether hard-to-place residents still have a place at the home.

The new owners said the only patients they do not accept are those with severe behavioral issues or who have to take very expensive medications. But the county's nursing home ombudsman said it has become more difficult to place residents with even mild behavior problems. As she explained, it is not uncommon for a patient with dementia or memory problems to become agitated and act out by swearing, resisting care or even hitting—even though such a person may not have persistent behavior issues. But even one incident is recorded in a resident's file and can require expensive, 1-on-1 supervision. River Ridge will sometimes admit such patients, but other times, depending on circumstances, will not, whereas its predecessor, Montgomery Meadows, like other county homes, consistently admitted such hard-to-place residents, according to the ombudsman. As a result, some residents with behavior challenges are now going to homes further away, such as places in Massachusetts that specialize in caring for these kinds of residents and are hungry for New York's level of Medicaid reimbursement.

The overall quality of care has improved—the national nursing home rankings placed River Ridge at the 22nd percentile in 2007 and the 84th percentile in 2012 (down slightly from 92nd in 2011). New York State surveys cited no more than 6 deficiencies at River Ridge in any year from 2007 to 2011, below state averages, though the home had 2 immediate jeopardy deficiencies in 2011. The new owner said these were related to a circuit box where a dead circuit was not plugged in, which she did not believe posed an actual danger to residents.

Financially, the home is in better shape, with annual losses of \$105,000 in 2007 and \$129,000 in 2010, much less than the millions the home was losing before the sale, according to data compiled by LeadingAge New York. River Ridge is attracting more private-pay and Medicare dollars: the share of overall patient days paid for by private-pay sources increased to 17% in 2010 from 10% in 2006; *the share paid by Medicare increased to 14% from 3%; and Medicaid-paid days fell to 66% from 83%. Data suggest that other nursing homes in the area may have had to pick up the slack; from 2006-10, they experienced an average 8% increase in the share of their resident days paid for by Medicaid.*

Staffing at the home has changed, returning to earlier levels after ballooning in 2005. The home had 160 full-time equivalent staff in 2001, including 77 nursing FTEs. By 2005, those numbers had increased to 219 and 135. In 2010, there were 137 FTEs overall and 72 nursing FTEs. Nursing hours have followed a similar pattern, with RNs providing 0.17 hours of care per day to each resident in 2001, a figure that rose to 0.49 in 2005 and fell back to 0.22 in 2010. Despite this decrease, the quality of care has remained high.

The impact on the county budget has been millions of dollars in savings, according to the county chairman at the time of the sale. In addition to avoiding annual subsidies, if the county had kept the home, it would have had to make physical improvements to the aging facility (as the new owners did). He speculated that the county would have exceeded its constitutional tax limit and had to raise property taxes above the state-imposed 2% cap had it not sold the home. Because of the sale, it was possible to stabilize the county budget.

The county's property tax levy declined in the years following the sale, going from \$27.4 million in 2007 to \$25.6 million in 2008, \$25 million in 2009 and \$23.5 million in 2010—savings perceived to be attributable at least in part to the sale of the home. In 2011, it went back up, to \$25.9 million.

This low-price-per-bed sale appears to have been successful against most measures, including quality services; an attractive facility; high quality ratings despite reductions in staff; and significant costs avoided by taxpayers. But the share of Medicaid residents has declined, with at least some picked up by other homes.

Conclusions

Montgomery County achieved savings to taxpayers and an increase in the quality of care provided to residents by selling its nursing home at a low per-bed price. The home is physically more attractive and the staff is praised for professionalism. However, the home is not as accessible as it once was to residents with behavior problems and Medicaid residents, and compensation to staff members is lower than it was when it was county-owned.

Fulton County Residential Health Care Facility

Factors Leading to Sale

In Fulton County, the subsidy required to keep the 176-bed home afloat had grown to more than \$2 million in the years before it was sold – about 7% of its total tax levy of \$27.3 million. Fulton County not only sold its nursing home but also divested itself of a mental health clinic and alcohol/addiction services, and sought to sell its community home health agency. But the county home was the largest of these – the biggest county department in terms of employees with about 300 workers.

Sale Process

The county used a traditional RFP process to solicit proposals for the home in 2010, and CGR was engaged by the county to help write and distribute the RFP, as well as to help evaluate responses. The county received five responses, four for the nursing home and one just for the Certified Home Health Agency. Of the four for the nursing home, one was from a local, non-profit nursing home operator and three were from out-of-town, for-profit operators.

A review committee of county officials evaluated each response, and narrowed the list to two. In 2011, the county selected Bronx-based Centers for Specialty Care (Centers) to purchase the home at a cost of \$3.5 million.

According to some accounts, the process of selling the home was made more difficult by a lack of transparency on the part of some county officials. Nursing home employees believed all options for the home's future were being considered, when in reality an RFP for the home's sale was being drafted. The home's administrator at the time floated other options, such as engaging with health care partners to have a broader discussion about the continuum of care needed to serve aging people in the county. But that was rejected as coming too late in the process.

Transition

The sale was approved by the state, and Centers took over the home in April 2012. Current employees were interviewed; about 80% were hired back and their wages were kept intact. Centers voluntarily granted recognition to the union in place, the Civil Service Employees Association, and a non-governmental CSEA unit took over representation of workers.

Shortly into the transition, however, staff began to feel that promises weren't being kept. The lower overall number of staff meant that everyone had to do more work, a change Centers maintains was justified. The former county home administrator acknowledged that as a county home, Fulton probably had more nurses than needed, but the changes were difficult for staff to adjust to. Also, benefit cuts took hold as employees had to pay more for their health insurance and new retirement plans were introduced with less generous provisions than government pensions.

At the same time, Centers began admitting different types of residents to keep the home full. Under county management, the home was often not full, with as many as 30 beds empty at times. Centers began targeting not only short-term rehabilitation patients but also bringing in residents from out of the area, some of whom had more severe behavioral or mental health issues than staff was used to seeing. These changes can be seen in the CMI, which increased from 0.83 in January 2011 to 1.21 in January 2013.

Centers said they have had to retrain staff in how to deliver proper care and how to document care so that the home can access full reimbursement. The former administrator acknowledged that documentation was an issue, saying the county hadn't wanted to invest in hiring a coding expert to ensure that the home was maximizing reimbursements.

A continuing challenge at Fulton has been staff turnover. Several sources said the home struggles to retain employees because of the working environment, which is more challenging and bottom-line driven. The new owners say they continue to lose workers who want to maintain public-sector wages and benefits to positions in the county as they become open.

Centers is making changes to address issues. They are not taking as many residents with behavior challenges, and they are working on an agreement with the union to increase wages. The home's current administrator is also suggesting adding a dialysis unit so that residents don't have to be transported for treatment.

The new owners are planning capital improvements to the home, including new furniture, floors and lighting, and they promise a full facelift sometime in the next six months. They are currently working to put cable TV and phones in all resident rooms.

Impact

The changes in the resident population, drawing more from outside the area, including the New York City area, has changed the climate of the home for the worse, according to some sources. Previously, it felt more

like a real home, and many staff members and residents were from the area and knew each other.

In a focus group, most residents said they were satisfied with their care. A few complained about the food at the home, more the lack of variety than overall quality. The residents weren't opposed to counties selling homes to private owners, and most said they understood that financial pressures were driving counties out of the business.

There are also concerns about the quality of care. In 2007, Fulton was in the 51st percentile in the national HealthInsight rankings. This fell to the 40th percentile by 2011 and dropped to the 2nd percentile in 2012. Deficiencies cited by the state have increased from 8 in 2010 to 10 in 2011 to 24 in 2012. (Note that the new owners took over in April 2012, so some of 2012's poor track record is attributable to the county.) The ombudsman's office has received more calls and complaints about the home in the last 12 months than it got in the prior 10 years about issues such as from pressure sores, toileting problems and resident privacy. The home's reputation has declined, and people don't want to go there, several sources report. However, the ombudsman did note that conditions seem to be improving, with staff becoming more responsive and gelling as a team.

The financial impact on the county has been positive, according to the county administrator, though he says it's too early to precisely quantify the savings. The tax levy did not decline after the sale, largely because sales tax revenues continue to decline. The county has saved money in indirect costs supporting the nursing home—e.g., the county did not have to replace a staff person in its personnel department, mostly due to nursing home sale.

Conclusions

The outcome of the Fulton County nursing home sale is a work in progress, with mixed results to date and problems being addressed about 15 months into the new ownership.

The Fulton County home has experienced significant tumult since being sold—with major changes to both the resident population and staff. Some 15 months after the sale, staff turnover continues to be a problem, and several outside observers say the home's reputation has declined. On the positive side, the county has been relieved of a \$2 million annual commitment to the home, and the home's new owners and administrator say they are committed to improving its operations.

Trends and Implications of County Home Sales

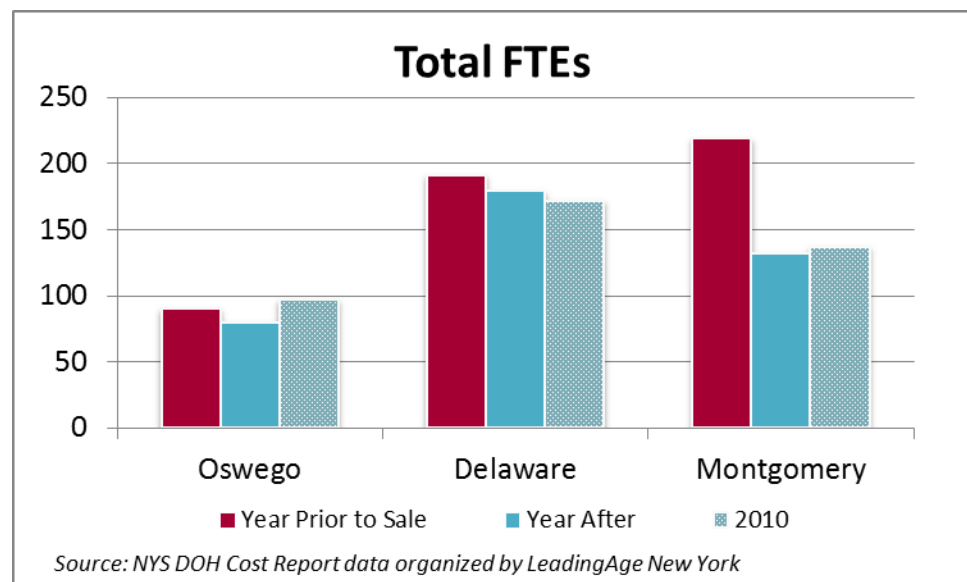
Having looked in some detail at a case study of each county that sold its nursing home, we now turn to a summary of overall issues across the four counties to discern common themes and trends, compare the experience in counties that sold their homes to similar homes in other counties that have

not sold, and seek lessons for counties contemplating the sale of their homes in the future.

Staffing

New owners retained roughly half or more of current staff, but at the two homes that have experienced more problems (Delaware and Fulton), staff turnover was or has been a recurring issue. As shown in Figure 39, overall staffing levels declined in two of the three counties, decreasing sharply in Montgomery³⁵, declining more gradually in Delaware and remaining fairly consistent in Oswego. (Note that meaningful data for Fulton was not available for the following several measures, since it was so recently sold.)

Figure 39



A similar pattern characterizes changes for nursing FTEs (see Figure 40). Hours of RN care, shown in Figure 41, provided per resident per day, fell sharply in Montgomery, dipped slightly in Delaware and also fell in Oswego, though this was due to a change in reporting rather than a true shift in staffing.

³⁵ 2005 data were used for Montgomery for the year prior to sale because 2006 data were not available. On several of the following measures, the data for Montgomery was especially high in 2005 relative to earlier years. The reasons are unclear, but the basic trends and conclusions remain the same, even if earlier years are used as comparisons.

Figure 40

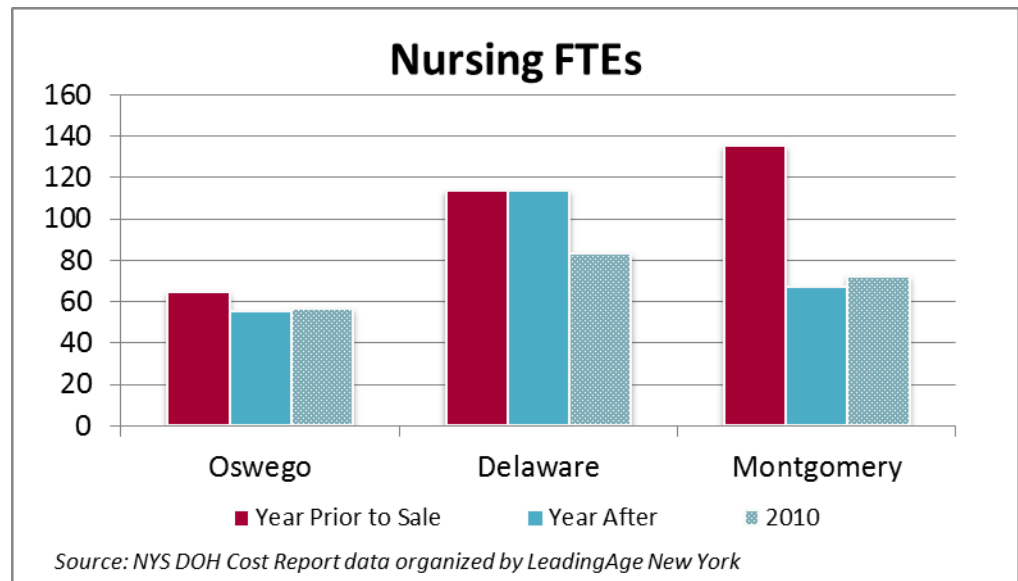
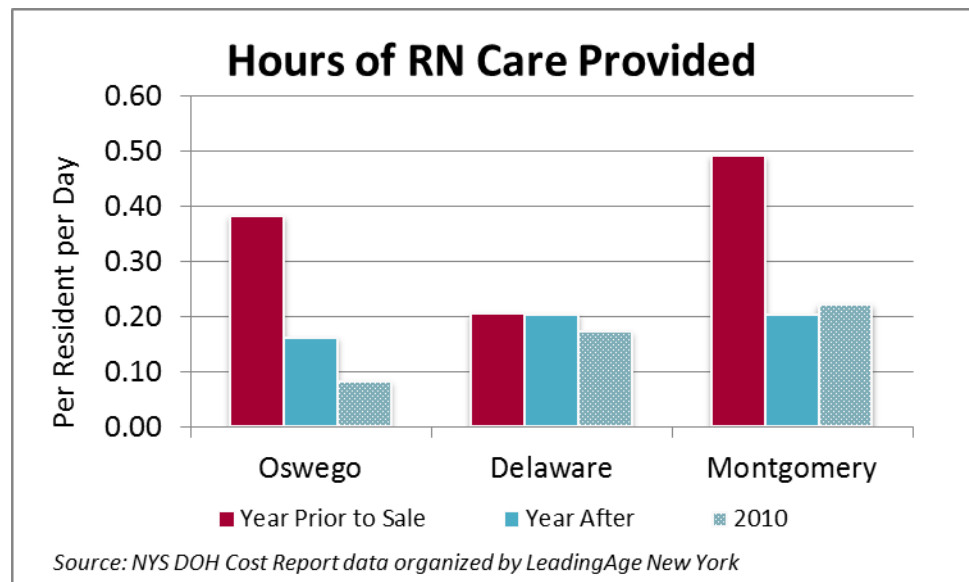


Figure 41

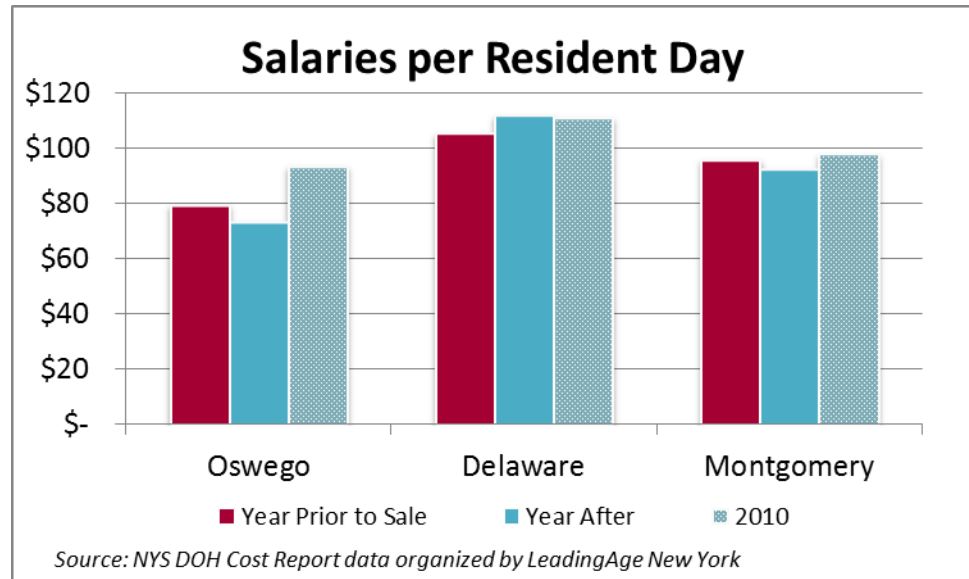


Based on these data and on interviews, it seems clear that some of the homes were overstaffed under county ownership. In Montgomery County, for example, staffing reductions did not have the effect of reducing the quality of care—in fact, the quality of care appears to have improved substantially in the last several years. However, staff reductions in Delaware County, along with financial strain and overall turmoil, likely contributed to declines in the quality of care.

Salaries and Benefits

Overall salaries paid to staff (Figure 42) did not change dramatically, though these figures have not been adjusted for inflation, so any declines or small increases may actually represent stagnation or reduced purchasing power. *In general, new owners tried to maintain salaries for existing employees who were hired back but reduced wages for new hires.*

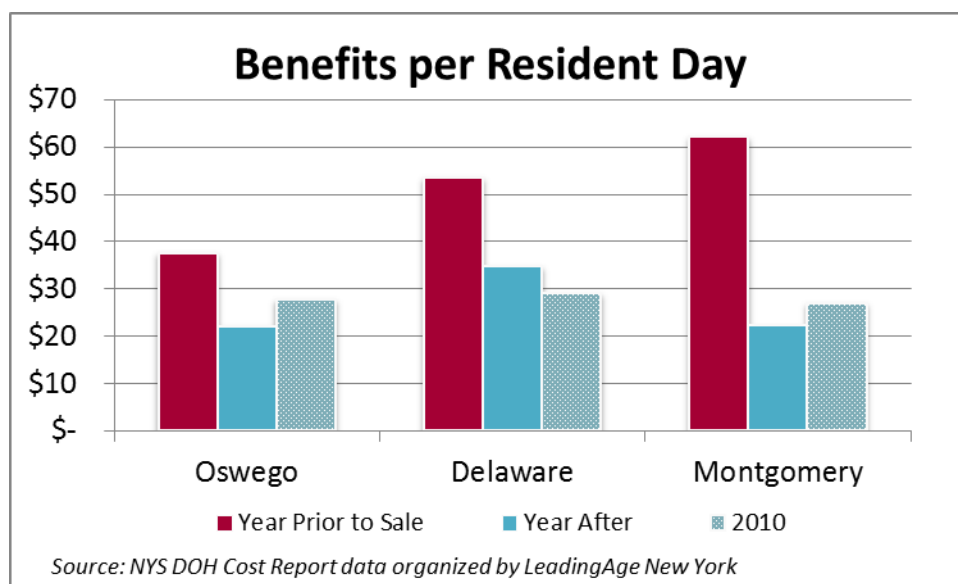
Figure 42



In contrast, as shown in Figure 43, *benefit levels declined in all three counties*. This reflects changes to both health insurance—usually requiring workers to pay more of their premiums—and retirement, where less generous plans replaced government pensions.

Two of the four homes retained union representation of workers. In Oswego, employees became part of the Service Employees International Union 1199 that already represented workers at the new owner's other facility. In Fulton, the new owners voluntarily granted recognition to a non-government unit of the existing union, the Civil Service Employees Association. In Delaware and Montgomery, workers were no longer represented by unions, though in Delaware, there were efforts to unionize workers, which ultimately failed.

Figure 43



Salaries have remained relatively comparable to pre-sale levels in most new-owner homes, at least for original county employees, with lower levels for new hires. Benefit levels have declined significantly in each sold facility.

The data show that reduced compensation (salaries plus benefits) for staff is a near-certain outcome of a county sale—no surprise given the financial condition of county homes. The biggest changes were seen in benefits, rather than wages. It is not clear what impact reduced compensation will have on a home's overall operation or quality, as we have examples of homes that have improved and homes that have declined.

Resident Population

There were clear changes in resident population as a result of the new owners taking over county-owned homes—but some changes were dramatic and others were more subtle. In three of the four counties where homes were sold, the new owners changed admission practices to try to attract more short-term rehabilitation patients in order to improve the home's financial stability and performance. However, this seems to have had a large and lasting effect in only one county, Montgomery. The share of resident days paid for by Medicaid declined and the overall CMI increased in Montgomery, as reflected in Figures 44 and 45. In Oswego, while the CMI has increased, the share of days paid by Medicaid dipped and then rose to previous levels. In Delaware, there were small changes in CMI and a down-and-up pattern in Medicaid days.

Figure 44

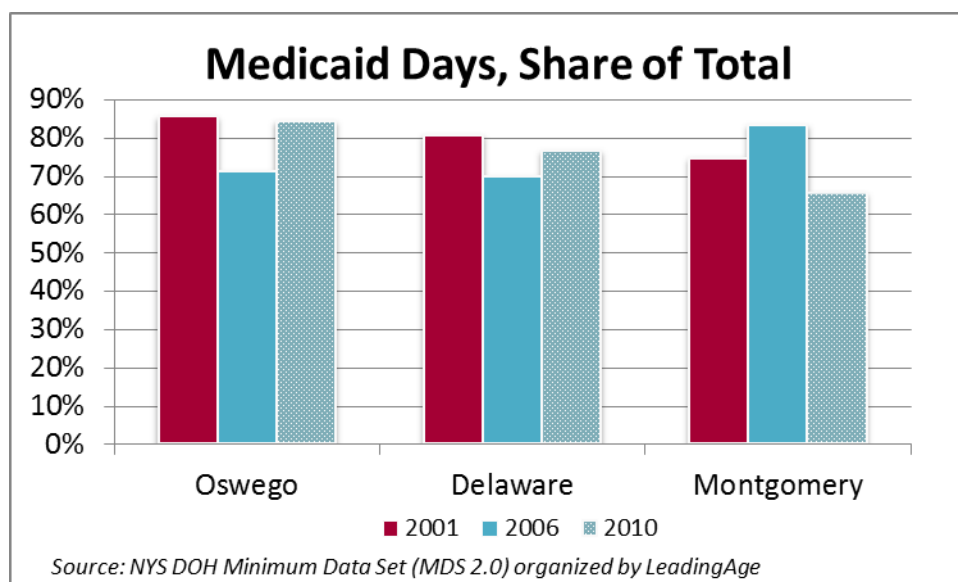
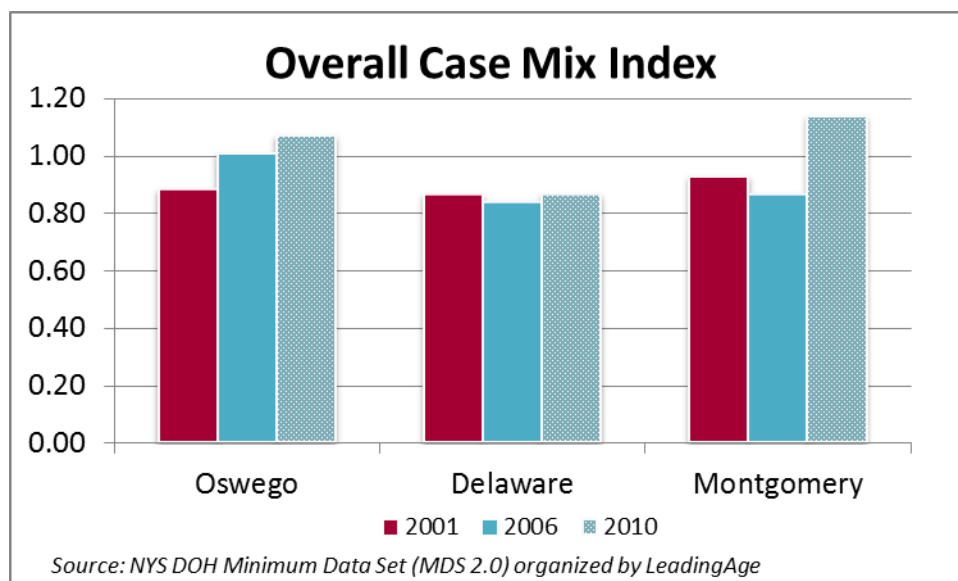


Figure 45



While we do not yet have post-sale data for Fulton, we know from interviews that new owners have tried to improve the home's financial condition through increasing the occupancy rate in part by accepting more difficult-to-place residents.

We can conclude that new owners may share the same goal—financial stability, if not profitability—but they may take different approaches to meeting that goal. While some may seek to be more selective in

There appears to be no overall evidence that low-income and other “hard to place” persons are not being served by new owners, with one possible exception—where other competitors may help pick up any slack.

admissions, others may be more flexible in order to keep the home full. And each approach may have its own up and down sides—a more selective admissions practice might help to improve overall quality as staff face fewer difficult challenges with residents, but hard-to-place residents could lose out. On the other hand, a more liberal approach to admissions might make the home more challenging for staff to manage, but access to care is preserved. Overall, to date, *the impact on access to care appears mixed across counties, with some of the new-ownership homes appearing to be relatively open to “hard to place” residents, while at least one appears to have been more resistant.*

Quality of Care

Available data and perspectives present a mixed picture on the quality of care in homes that were sold. Caution should be observed in using the quality data, but the two indicators used suggest generally consistent trends within each facility in the case study. Resident care clearly improved in Montgomery County, as evidenced by a higher national percentile ranking and a low number of deficiencies (see Figures 46 and 47). In Delaware County, the quality ranking declined as deficiencies soared, and in Oswego, both measures have been somewhat up and down since the home was sold in 2005—overall, quality appears to have improved in terms of fewer deficiencies, but with fluctuations in national rankings ranging from improvement from very low levels in 2007 and 2008, but at the 45th percentile nationally in 2012, Oswego’s home is currently ranked below the national median. Fulton had a low ranking and high number of deficiencies in 2012, but that is only partly attributable to the new owners, who took over in April of that year.

Figure 46

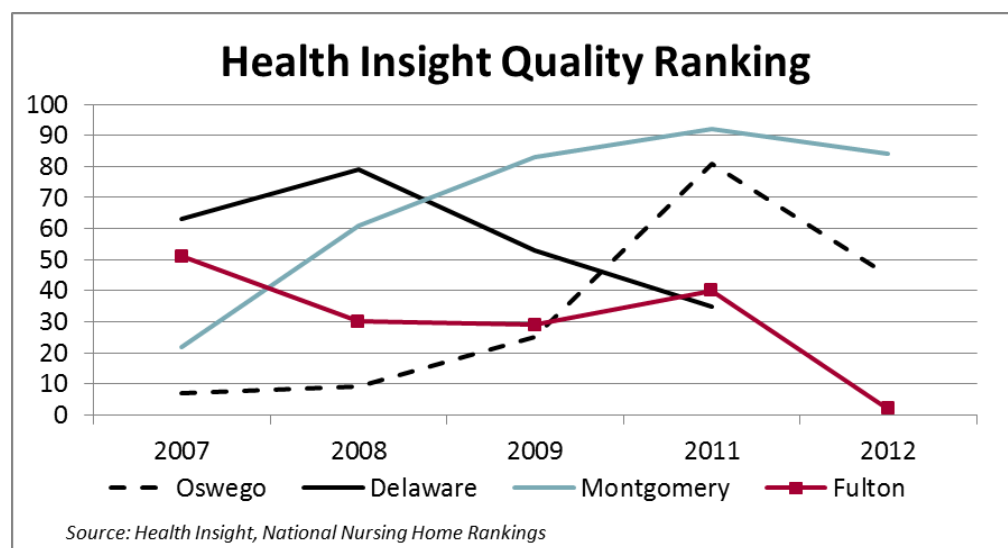
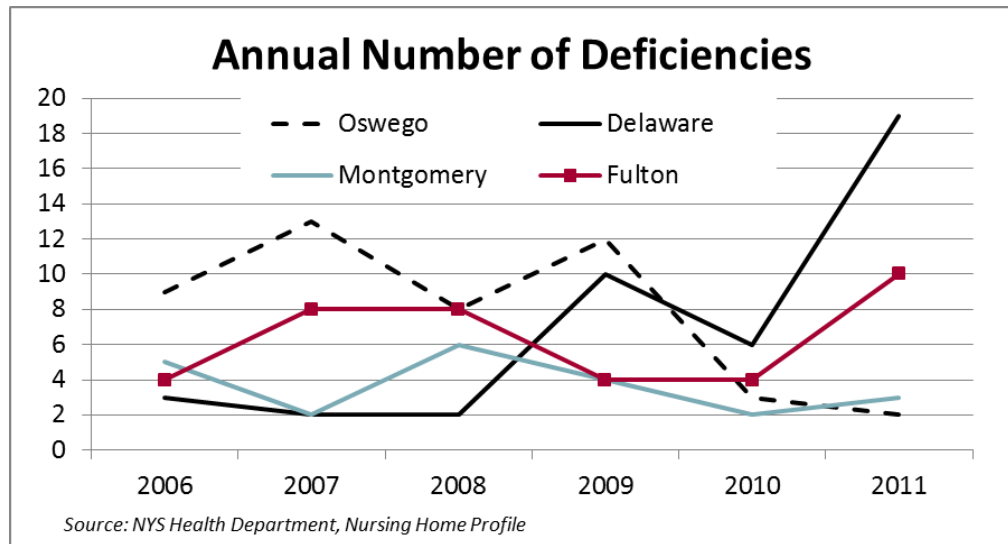


Figure 47



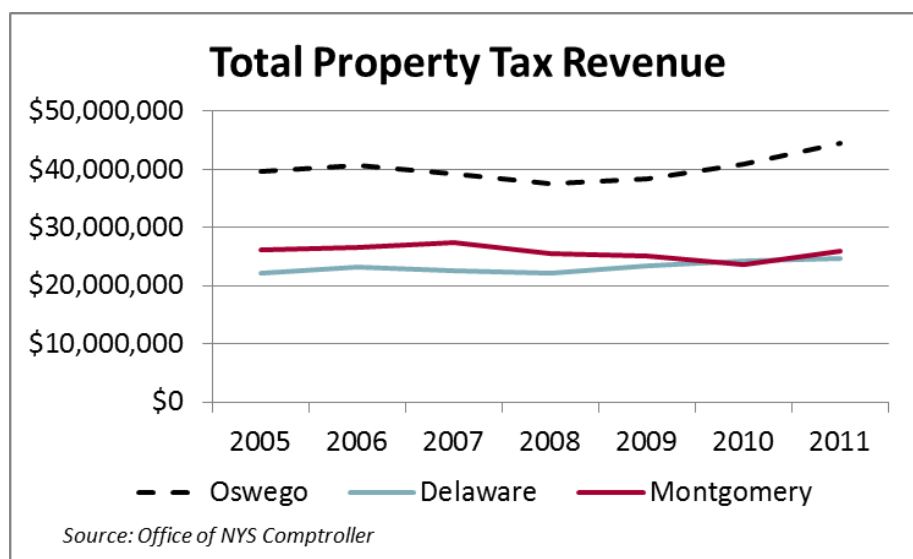
Tax Impact

All four counties achieved some savings by selling their homes, as they no longer had to provide operational subsidies ranging from \$500,000 to more than \$3 million. In some cases, these subsidies represented a significant slice of the property tax levy, at 12% in Montgomery and 15% in Delaware. In addition, counties that sold their homes saved the future costs associated with any mandated increases to staff wages or benefits and any capital investments needed in the homes. Overall property tax levies did not decline dramatically as a result of nursing home sales, as shown in Figure 48.

Sale of nursing homes appears to have had its primary financial impact on avoidance of future subsidy costs and taxes and/or freed-up resources for other government purposes.

While there were often decreases for a few years, as detailed in the case studies, other factors bearing on county budgets began to drive overall property tax collections back up after two or three years of declines. On the other hand, given the relatively small impact nursing homes in most counties have on the overall county budget and tax levies, one would not expect large overall impacts on the levies as a result of the sales. The real impact of the sales of the homes, from a future perspective, is in terms of subsidy costs avoided, thereby helping to avoid additional taxes, and/or freeing up additional resources for other purposes of county government.

Figure 48



Impact on the Long-Term Care Landscape

CGR conducted interviews with hospital discharge planners and nursing home administrators in the areas surrounding the homes that were sold, as well as analyzing available data, to gauge the impact of the sales on the overall network of long-term care. We did not find significant, measurable impacts, with two exceptions. Obviously, the closure of the former Delaware County home caused residents to be moved to other homes in Delaware and surrounding counties, but there was capacity to absorb them. Also, the efforts at the former Montgomery County home to recruit short-term rehabilitation patients, and to perhaps be more selective in admissions, seem to have affected other facilities. The overall CMI at Montgomery Meadows/River Ridge increased 0.27 from 2006-10, while nearby homes experienced an average decline of 0.05.

Comparative Analysis: How Similar County Homes Fared

While it is not possible to determine definitively what might have happened in these four counties if they hadn't sold their homes, it is feasible to compare homes in the sale counties with comparable homes in other counties.

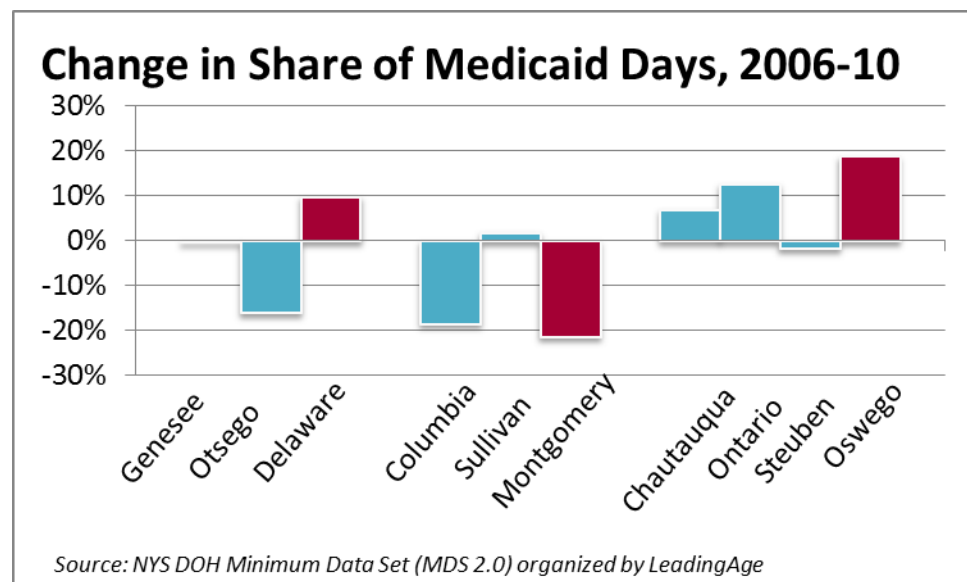
For this analysis, CGR matched homes that were sold with two to three similar county homes (matching on the basis of total beds, total population in the county, financial condition and share of resident days paid by Medicaid) and analyzed data for a few key variables. The matches were: Genesee and Otsego Counties for Delaware; Columbia, Washington and Sullivan for Montgomery; and Chautauqua, Ontario and Steuben for

Oswego. Once again, it was not possible to include Fulton in this analysis because of how recently the sale occurred.

Because the sales all occurred from 2005-07, we looked at percentage changes since 2006 to 2010 in share of resident days paid by Medicaid and overall case mix index, as well as changes in national quality rankings from 2007 to 2012 (the span of years available).

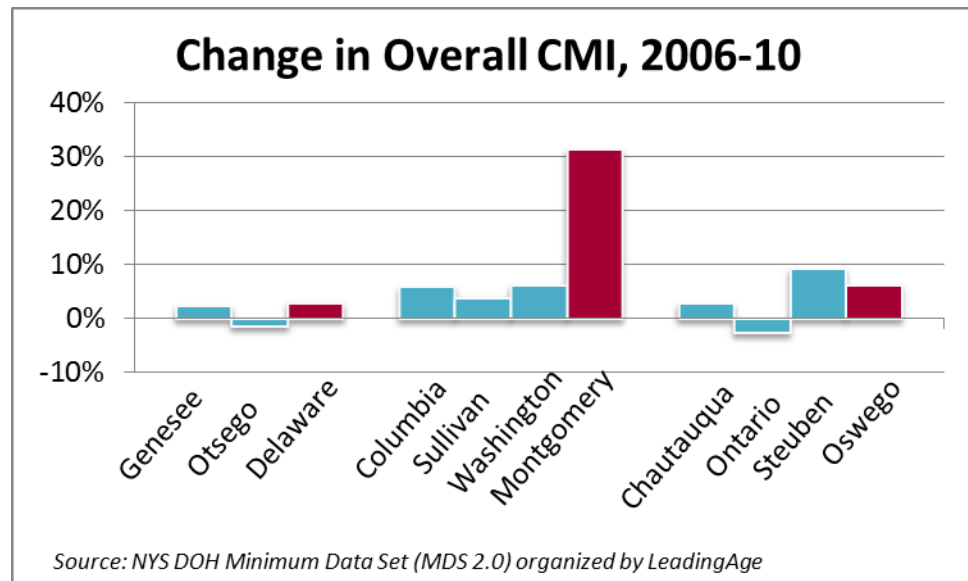
As indicated in Figure 49, compared to similar homes, the formerly county-owned homes in both Delaware and Oswego had larger increases in the share of resident days paid by Medicaid between 2006 and 2010, while the former county home in Montgomery had a larger decline than its comparison homes.

Figure 49



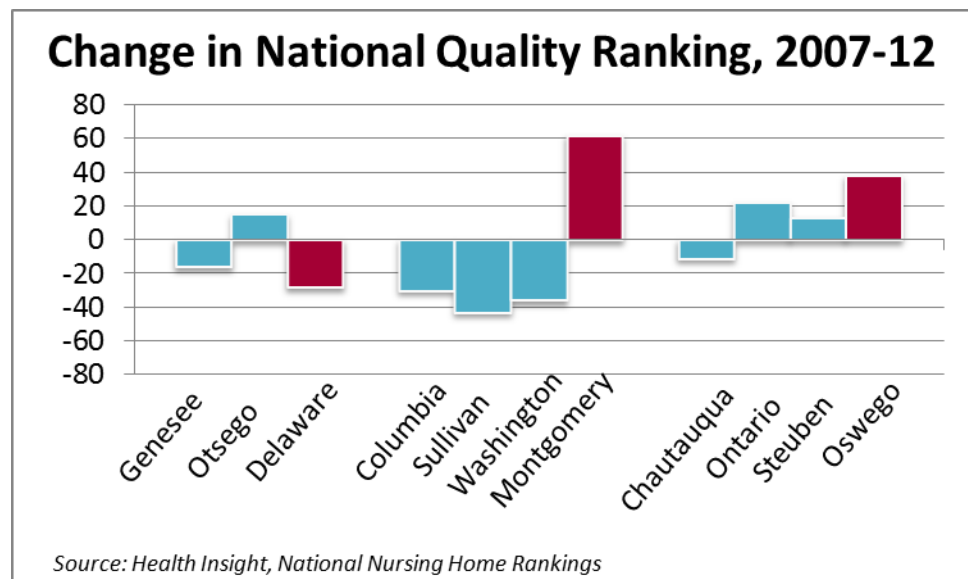
As shown in Figure 50, most of the homes in the analysis saw only small increases in their overall CMI, but the former county home in Montgomery had a large increase, far outpacing its comparison homes.

Figure 50



Compared to similar homes, the former Montgomery County home had a much larger increase in its national quality ranking (62 percentile points) between 2007 and 2012. Oswego also had a larger increase, 38 points, than its comparison homes, while Delaware before it closed in 2012 had experienced a greater decline, falling 28 points by 2011.

Figure 51



Summarizing the impact of what happens when a county nursing home is sold, the most realistic statement may be “it depends,” as there is evidence suggesting either success or problems can occur. Much depends on the due diligence process used to determine what is important to each county pre-sale, and carefully selecting a buyer able to meet those expectations.

These comparisons do not yield a neat, consistent story about what is likely to happen when a county home is sold. More than similar homes in other counties, Montgomery County’s home increased its CMI and quality ranking while decreasing reliance on Medicaid as a payer source. But homes in Oswego and Delaware counties had more subtle and inconsistent changes and did not depart as much from their comparison homes. *Like much of the other information gathered for this analysis, and as summarized in Table 5, these comparisons suggest that the outcome of a sale is very much dependent on who takes over the home and how they approach the challenge of making the home financially stable while maintaining or improving care to residents.*

Table 5

Summary of Impact of Sales of County Homes				
County	Oswego	Delaware	Montgomery	Fulton
Year of Transition	2005	2006	2007	2012
2012 Quality Ranking	45	35	84	2
2011 Total Deficiencies	2	19	3	10
Admission Practices	Attracted more short-term rehab patients.	No major changes.	Attracted more short-term rehab patients; more selective about behaviorally challenged residents.	Tried to increase occupancy by garnering more out-of-area residents, some with behavior challenges. Also attracted more short-term rehab patients.
Hard to Place Residents	No evidence they are not admitted.	No evidence they were not admitted.	Some evidence to suggest they are not as frequently admitted.	No evidence they are not admitted.
Change in FTEs	-11%	-6%	-40%	NA
Change in Salaries	-8%	6%	-4%	
Change in Benefits	-41%	-35%	-64%	
Staff Union	SEIU 1199	None	None	CSEA non-govt unit
Tax Implications of Sale	Tax levy declined 4% and 5% for 2 years, then began to rise.	Tax levy declined 3% and 1%, then began to rise.	Tax levy declined 7%, 2% and 6%, then began to rise.	Tax levy has not yet declined, in part because sales tax revenues are down.
Notes: Delaware quality ranking change is for 2011, as home was closed in 2012. Ranking is on 100-point percentile scale. Changes in FTEs, salaries and benefits presented for one year post-sale. Salaries and benefits represent total per resident day.				

Potential Lessons from Sale Counties

The varying outcomes of sales in the four counties don’t point directly to selling or retaining a county-owned home as the best option. Instead, they suggest that the outcome of a sale hinges largely upon who buys the home,

Careful due diligence in terms of whether to sell or continue to own its nursing home, and a careful selection process IF the decision is to sell, are critical to successful decisions about the future of a county's home.

and that therefore how the buyer is selected, if the decision is made to sell, is critically important.

Based on the two more successful sales in Oswego and Montgomery, the failed experience of Delaware and the mixed initial outcomes in Fulton, we suggest counties considering selling their homes pay close attention to the following recommendations, IF the decision is to sell.

Thoroughly research potential buyers, finding out not only about the track records of any current nursing home operators but also about their financial backgrounds and available resources. Selling to an organization with thin financial resources, or a poor track record of providing quality care, is likely to lead to serious problems in the long run.

Consider more than just the sale price in choosing a buyer. A big dollar figure is surely appealing to a financially strapped county looking to divest itself of a nursing home. But that should be balanced with the needs of residents and their families to see the best possible new operators take over the home. In addition, county officials should decide what pre-conditions they might want to attach to the sale, such as providing preference in admissions to county residents; continuing to admit low-income, uninsured or behaviorally difficult residents; or giving preference to existing staff members in filling positions. This can be done by spelling out requirements in a Request for Proposals and/or through follow-up interviews and conversations with bidders.

Put time and thought into the process, involving stakeholders as much as possible, and being honest with them about what is happening. In counties where employees felt officials weren't forthright about their intentions to sell, new owners had more trouble establishing good working relationships. Dealing as much as possible with objections in an upfront way can set the tone for open, productive relationships among staff, residents and new owners.

Consider ways to provide as much continuity as possible through the transition. These might include entering into a management contract with the buyer before a sale is finalized, as was done in Oswego, or requiring the buyer to retain a certain percentage of existing staff members to help residents adjust to the change.

Consider whether county officials can or would like to be involved in an oversight role following the sale. In one of the sale counties, a committee of county officials and the home's buyers and administrator was set up to meet periodically and discuss the home's operations. While this structure wasn't well implemented in this county, it could potentially help maintain a county's interest in seeing the home succeed under new ownership.

The experiences of two county homes that were closed is likely to have limited relevance to most counties that are or may be considering selling their nursing homes, as the circumstances of those two homes and counties were significantly different from most counties currently contemplating sales.

County Homes that Were Closed

Two counties, Niagara and Westchester, have closed nursing home facilities in the last several years. These counties are distinct from those that sold their homes in that they are in larger, more metropolitan areas than most, and they were determined by state officials to have an excess of nursing home beds when the state conducted an in-depth analysis of health care facilities in 2006, as described in more detail below. For these reasons, the following accounts of these closures may not have as much relevance to the counties currently considering the future of their nursing homes, which for the most part appear to have little or no interest in closing their homes.

Mount View Health Facility, Niagara County

Niagara County closed its Mount View residential health facility in December 2007. The County had operated it as a skilled nursing facility with a 25-slot adult day health care program. Closing the home was the culmination of a multi-year process in which the County had deliberated on whether to try to operate it more sustainably or privatize and get out of the business. Formal discussions about transitioning the facility off of the County's books began in earnest in 2003 coinciding with the hiring of a new county administrator and a mandate from the County Legislature to find solutions for the nursing home.

Factors Contributing to Closure

Niagara County hired a new administrator in May of 2003. For several years prior, Mount View Health had not been covering its costs and was consistently using tax revenue to subsidize its operation. The new administrator had previous experience in privatizing a nursing home, and was hired in part because of the Legislature's interest in developing a plan to fix the imbalance in revenues and expenses for the nursing home. Upon being hired, the administrator was charged by the Legislature to find solutions to make the nursing home become self-sustaining.

At the time of hire, the Legislature in the County was relatively evenly divided along partisan lines, though Democrats held a slight edge and thus narrow control of the governing body. The Democratic faction was supportive of the nursing home, though pragmatic about the need for the nursing home to be self-sustaining. Democrats were also supportive of the unions representing nursing home staff. The early charge from the Legislature was not to close the facility, but to develop solutions to the problem of sustainability.

The primary issues facing the home at the time were low occupancy rates, changing demographics with low income populations requiring increasing levels of care, and low reimbursements, largely from Medicaid, that fell short of covering costs. With authorization from the Legislature, the new

administrator began in late 2003 to negotiate with the two unions (AFSCME and CSEA) that represented the majority of the workforce for the nursing home. The goal was to obtain salary and benefit concessions that could balance the nursing home budget over a multi-year period. After significant negotiations over several months, it became apparent that the unions were not going to make any concessions. The stumbling block was not their awareness of the need, but that they were representing multiple departments within the County. AFSCME and CSEA were reluctant to make concessions for nursing home staff that would negatively impact the membership in other county departments unrelated to the nursing home.

A significant shift occurred in the politics of the County in the fall of 2003. Republicans took control of the Legislature by supporting Democrats who agreed to caucus with them. What had been a narrow majority for Democrats became a sizable majority for Republicans. With the shift in control, the goal of finding a sustainable solution for the nursing home shifted to a formal mandate to find a private buyer for the facility and get the county out of the business of running a nursing home.

Based on his previous experience in privatizing a nursing home, the administrator issued a Request for Qualifications (RFQ) to determine if parties would be interested in purchasing the home. The only offer received by the county in 2004-05 was considered too low and rejected by the administrator and the Legislature. The RFQ was reissued in 2005-06 and one buyer was identified. The bidder was determined not to be a perfect fit, but the administrator decided it was worth entering into negotiations. Around the same time, the New York State Commission on Health Care Facilities in the 21st Century (a.k.a. Berger Commission) was developing its final report for the State. There were several uncertainties regarding final recommendations and how they would impact Niagara County.

Negotiations with the potential buyer continued throughout 2006, though they were difficult and proceeding slowly—without significant progress as of the end of the year. A potential contract developed at the time included a provision that the sale of the home would become null and void if the findings of the Berger Commission included specific recommendations that impacted the Mount View facility. The Berger Commission report was released in December 2006 and contained specific recommendations regarding Mount View. Once the report was public, the potential buyer of Mount View walked away from the deal and the county began deliberating over the findings of the Berger Commission.

The formal recommendation of the Berger Commission was that the Mount View Health Facility should downsize all 172 nursing home beds (due to over-capacity in the region), rebuild a new facility on its existing

campus, and add assisted living, adult day services and possibly other non-institutional services. The Berger Commission report cited several factors that contributed to its recommendations for Mount View, including:³⁶

- A very low occupancy rate of close to 75% (97% is considered ideal for viability – 95% is acceptable);
- An old/outdated building;
- An uncertain financial viability.

The facility was losing approximately \$2.5 million annually, and required subsidization from Niagara County, which the taxpayers could not afford indefinitely. The administrator and Legislature reevaluated their plan for privatization. Since there were no longer buyers at the table and privatizing was not an option, they considered whether they could repurpose the existing facility according to the vision of the Berger Commission Report. Since the new facility required substantial investment, there was no guarantee of money to support the transition and officials viewed the venture as risky, the Legislature determined in early 2007 to close the facility.

Closure Process

The county filed a lawsuit with the state soon after the findings of the Berger Commission because officials realized the burden of eliminating the beds could have left them on the hook for a facility with high costs of closure and no associated revenue sources. The state offered Niagara County about a quarter of the estimated closure costs, around \$8 million of the \$28 million total, to help with closing the facility. The nursing home administrator at the time was subsequently offered another job, leaving the county administrator to oversee the transition. In spring 2007, the administrator hired a person to facilitate the closure process. The official decision to close occurred in early July 2007, and the facility was finally closed at the end of December 2007.

The closure plan was regulated by New York State to ensure the well-being of residents met high standards. Under the direction of the transition leader, the county developed a plan using Microsoft Project identifying the tasks required for closure, regulatory requirements, and responsibilities to families and other stakeholders. Employees were given layoff plans, though few actually lost their jobs; most were redeployed to other areas of the county workforce. The county also developed a job

³⁶ Berger, S. (2006). *A Plan to Stabilize and Strengthen New York's Health Care System*. New York: Commission on Health Care Facilities in the 21st Century. Retrieved from <http://www.nyhealthcarecommission.org/docs/final/commissionfinalreport.pdf>

retraining plan for all redeployed workers. Each resident of the home had a transition plan and was assigned a social worker. Each individual transition plan was overseen by the state with regular outreach to families from social workers and from staff of their new nursing homes.

At the time of the Berger Commission report, there were 125 residents in the 172-bed facility. However, by the time the closure process was in full swing that number had dwindled considerably. Residents began moving out on their own and finding alternative placements. The county maintained its full operation throughout the closure process to assure there was no loss of service or continuity of care. All residents found an alternative placement if they required one. Almost all found placements in Niagara County, though a few went to Orleans or Genesee counties.

The county maintained ownership of the physical facility, though it was essentially mothballed. At the time of the writing of this report, the facility had a suitor to develop a Medicaid-eligible assisted living facility.

Impact

Though few if any counties seem to be seriously considering closure of their nursing homes, the experience in Niagara County of closing Mount View seems to have been reasonable in light of its unique circumstances.

Though the decision to ultimately close the facility was driven largely by the findings of the Berger Commission, it was clear for many years that the Mount View facility was not self-sustaining and was costing taxpayers millions of dollars to operate. Those interviewed for this report believe to a person that closure was ultimately the right decision for the County. Not only did it stop the bleeding in regards to the operational losses, it also saved millions of dollars to the County that was ultimately repurposed in other areas of the budget. The transition process was not easy, particularly for the frailest individuals. Closure of any facility must be done with the utmost care and sensitivity to the people who are being served. In the case of Mount View, there seem to be few if any major complaints with the transition.

Taylor Care Center, Westchester County

Multiple attempts to contact individuals with direct or historical knowledge of the closure of this facility were unsuccessful. Information that follows is from CGR awareness and newspaper articles from the time of the closure, in addition to the findings of the Commission on Health Care Facilities in the 21st Century (Berger Commission).

The Taylor Care Center (TCC) was operated by the Westchester Public Health Corporation, which also operated (and currently still operates) the Westchester Medical Center. TCC was originally a 321-bed residential health care facility which provided baseline services, including a 27-bed ventilator-dependent care unit and a 42-bed unit providing distinctive sub-acute care for individuals with complex medical needs. This unit received referrals from Westchester Medical Center, St. John's Hospital, White Plains Hospital, Montefiore Hospital, and Columbia-Presbyterian

Hospital. Beyond those two units, TCC was licensed for an additional 252 skilled nursing beds, but staffed only 156 at the time of the Berger Commission report, which cited TCC's low occupancy level as support for downsizing. TCC had a high case mix index (1.25), and provided solid quality of care. TCC at some point housed 10 uncompensated residents, adding to the county costs of operating the facility. Very few nursing homes, even county-financed homes, have more than one or two residents on charity care at any point. Due to its high-intensity care and several uncompensated cases, TCC operated at a significant loss of \$6 million per year, which was down from as much as \$13 million in previous years.³⁷

The Berger Commission report determined that there was a significant excess of residential health care beds in Westchester County. This led to low occupancy rates county-wide among all nursing homes. The report recommended that Taylor Care Center downsize by approximately 140 beds to approximately 181 residential health beds. That reduction was achieved in 2007. In 2008, the Westchester Medical Center received approval from the NYS Department of Health to further reduce its number of residential health beds by 90, leaving it with 91 residential health care facility beds.

In 2009, the Westchester Medical Center received the second of two drastic fiscal year cuts in Medicaid funding. Nearly \$75 million was cut over the course of two fiscal years, forcing a layoff of nearly 10% of the workforce. Leadership then determined that the TCC did not fit with the core mission of the Medical Center and was costing too much money and decided to pursue closure. Closing the facility was estimated to save the Medical Center approximately \$8.5 million and determined to be a benefit to all the nursing homes in the region. *Since there was substantial capacity in other facilities (394 of 6,815 available beds), there was little concern that the 96 remaining residents would have any trouble finding placement in other locations.* The other goal at the time was to find placement for as many of the 195 staff of the TCC as possible within the Westchester Medical Center. The TCC was slated to close in spring 2009. It is not known how many personnel were ultimately transitioned.

³⁷ Berger, S. (2006). *A Plan to Stabilize and Strengthen New York's Health Care System*. New York: Commission on Health Care Facilities in the 21st Century. Retrieved from <http://www.nyhealthcarecommission.org/docs/final/commissionfinalreport.pdf>

Potential Lessons from Counties with Nursing Home Closures

Closure of county homes can make sense, but primarily in special circumstances: For example, in areas with low occupancy rates and excess nursing home beds, cases in which it may not only be possible to save money for counties but also to help streamline the overall health care system, as the state's Berger Commission envisioned. Nonetheless, care should be taken to transition residents to appropriate nearby facilities, and staff members and the larger community should be involved in discussions about the home's future and kept abreast of decision-making.

VIII. COUNTY RELATIONSHIPS WITH THEIR NURSING HOMES: PREPARING FOR THE FUTURE

The premise from the beginning of this study is that county-owned nursing homes are in jeopardy, for reasons spelled out throughout this report, but that nonetheless, in most counties a wellspring remains of good will toward, and support for, the historic mission of these facilities. Many counties find themselves at the intersection of these competing forces, facing difficult decisions about the future of these longstanding institutions that for years have been part of the infrastructure of their respective communities.

Facing these realities, as discussed in the previous chapter, several counties in recent years made the decision to sell or close their nursing homes, with varying results—some satisfactory, some mixed, one ultimately leading to displaced nursing home residents, one currently in the process of struggling through the early stages of the transition to new ownership. Other counties have more recently made arrangements to sell their homes, and still others are in various stages of discerning their options or engaging in the process of testing the market for selling. And there remain a number of counties owning nursing homes which, at least for now, seem content to continue with something resembling the status quo, with no present plans to investigate divesting ownership.

In this context, this chapter focuses on what counties owning nursing homes are thinking about the future of their homes, what is shaping their thinking, the existing relationship between the counties and their nursing facilities, what options have already been considered, and realistic prospects for the future. Findings presented in this chapter are based almost exclusively on surveys of county nursing home administrators and of leadership in counties owning nursing homes. Survey responses were received from 32 nursing home administrators and from 29 of the 33 counties owning nursing homes at the beginning of 2013. Some surveys did not address specific questions, as noted in the discussion that follows.

Level of County Cooperation and Support for Nursing Homes

Most nursing home administrators and county officials indicated that there are high degrees of cooperation between county government and their nursing homes. Just under 80% of the leadership of the counties owning nursing facilities characterized their relationship with their homes as being “very” or “somewhat” cooperative, including about 70% who indicated

“very cooperative.” Only one county raised a serious question about the relationship, suggesting that it was “somewhat adversarial.” Most of the nursing home administrators were also pleased with the level of cooperation, though a few had misgivings: More than 70% characterized the relationship as cooperative, including 53% who said “very cooperative,” while almost 20% said it was “somewhat adversarial.” None of the county leaders or nursing home administrators checked the option of “very adversarial.”

However, despite the generally positive working relationships, when asked how essential the nursing home is to the mission of county government, a slightly lower level of support was indicated. As noted in an earlier chapter, 61% of county leaders said the home is very or somewhat essential, with 25% saying “very.” Another 20% were neutral on the question, and 14% indicated their home is “not essential” to the county’s mission. Nursing home administrators, asked to characterize their government leaders’ perspective on the same question, were somewhat more skeptical: 47% said leadership would say very or somewhat essential, with 28% indicating “very,” while a quarter of the administrators indicated that their county leadership would view the home as “not essential.”

Most counties and their nursing homes have good reported relationships. But perceived high county subsidy levels have reduced the level of support for many county homes going forward.

The most direct and tangible evidence of county support for the nursing homes is expressed by financial subsidies, and the promises of future financial support. Counties have provided significant evidence of that support over the years, both through direct county subsidies, staff support through indirect allocation lines, matching funds from the county’s general fund to access Intergovernmental Transfer payments, and support evidenced indirectly through de facto subsidies in effect funneled through the nursing home enterprise fund balance. As indicated in Chapter VI, leaders in two-thirds of the counties with nursing homes suggested that those subsidy levels may have reached their maximum acceptable level, while another third are either open to additional subsidies up to some specified level or remain uncertain as to future subsidies.

Current and Perceived Future Status of the County Homes

In the context of current levels of support for the county homes, county leaders were asked whether they believe the county needs to consider alternatives for the future of their respective homes, and how they would assess the existing status of their facilities. Nursing home administrators were asked the same questions.

Asked about alternatives that should be considered, the primary responses fell into two groupings—one involving improvements and efficiencies designed to strengthen the existing facility, and a more external focus on

selling the home. More than one option could be selected. Responses were as follows:

- **Consider management and operational/cost savings efficiencies:** 37% of the counties in the county leader survey and 36% of nursing home administrators selected this option.
- **Consider selling the facility:** 56% of the counties and 39% of the home administrators said this option should be a priority.

It should also be noted that closure of the facility was also an option for consideration. Only two county leaders and one nursing home administrator believed that any consideration should be given to that possibility. More specifically, survey respondents were asked to assess the current and likely future status of their nursing home. The responses are presented in Table 6 for those responding to this question.

Table 6

Assessment of the Status of the County Nursing Home		
Status Option	% of County Leaders (N=26)	% of Home Administrators (N=32)
Decision has been made to sell the facility	31%	25%
Decision has been made to close the facility	0%	0%
Decision to sell under active consideration	16%	16%
Decision to close under active consideration	0%	3%
Uncertain; discussions are ongoing	23%	25%
No active consideration of sale or closure; continue as county home for foreseeable future	31%	31%

Source: CGR County Leader and County Nursing Home Administrator surveys conducted first quarter of 2013

There appear to be eight of the counties with nursing homes that have made decisions to sell, some of those already far into the process, with at least another five under active consideration. Just over half of the 25 counties responding to the question suggest it is likely that their home will be sold in the next two to three years (one-third say “highly probable”), while just over a third say a sale is unlikely during that time.

County leaders and nursing home administrators seem to have similar understandings of the current realities in their respective counties. Both groups indicate that eight counties have apparently made the core decision to sell their nursing home, or at least to explore the option by testing the market. In addition, a decision to sell appears to be under active consideration in another five counties (leaders in four counties indicated such a decision, but a home administrator in a fifth county, which did not respond to the leader survey, also indicated that this option was under consideration). There appears to be little if any serious interest in the possibility of closing any facility. In just under a third of the counties, there appears to be no active consideration of anything other than continuing ownership of the county home, and in another roughly quarter of the counties, there are ongoing discussions about the future of their homes, but with no apparent predispositions in any particular direction.

Asked the probability of their home being either sold or closed within the next two to three years, more than 90% of both survey groups said slight to no probability of closing the home (75% of both said virtually no chance that would happen). Consistent with the status question on potential sale, responses were split on the odds of a sale occurring within that period of time. Just over half of the 25 counties responding to this question and just under half of the home administrators believe that it is fairly or highly probable that a sale would occur (about a third of each group indicated it was “highly probable”). Almost half of the administrators suggested that there was only a slight, or almost no, probability of a sale within the next two to three years, compared with 36% of county leaders. About 12% of the counties and 6% of the administrators rated the odds as 50-50.

Circumstances That Could Change the Odds?

The die appears to be cast in favor of nursing home sales in a substantial number of counties currently owning nursing homes, with Ulster having just completed its sale, and several other counties in various stages of the sale or state review process, and others well on the way toward such a decision. But several others seem to have no such inclination, and others are uncertain, with discussions concerning the future fate of their homes ongoing with no clear direction yet established. For those counties where decisions are not yet cast in stone, are there things that can be done to help strengthen the odds that a county nursing home will remain under county ownership in the future? We asked several questions along those lines.

We asked both county leaders and nursing home administrators what circumstances might make it more likely that the county would continue ownership of the home, and the responses were predictable. Nearly all

revolved around reducing county costs, improving Medicaid reimbursement rates and increasing the certainty of IGT funding at enhanced levels.

Potential Local Changes

Asked about the challenges and opportunities facing their homes, administrators emphasized the revenue/reimbursement concerns as well as the rising employee benefit costs, which they perceive to be beyond their control. Beyond those issues, they focused on the difficulty in uncertain times of recruiting and retaining high quality staff and of maintaining high occupancy rates. They also expressed concerns about labor contracts and related work rules and associated costs, and some spoke of opportunities to negotiate contractual changes with their labor unions (see below for further discussion of this issue).

About a third of the administrators also noted opportunities to expand or add new services in response to new demands (hopefully with positive revenue implications), and others noted the need to increase fiscal efficiency and reduce costs in various ways throughout their facilities. Others expressed doubt that there was anything they could do to turn things around. For counties that have already made up their minds, that may well be true. But for others, there may still be time and the opportunity to engage in processes that can make facilities more cost effective. *Opportunities have been identified in several county facilities around the state for significant cost reductions and revenue enhancements with the potential for millions of dollars in facility deficit reduction, for counties and facilities willing to engage in such processes.*

Opportunities exist to reduce costs and enhance revenues in county homes that could significantly reduce annual deficits, including new approaches to negotiating union agreements, for counties willing to engage in the process.

If their county were to continue to own its nursing home, county officials and home administrators were asked if there were provisions in their current labor agreements affecting the home that they would like to change. Both groups expressed strong support for finding ways to negotiate some type of salary and benefit relief/reductions in order to make future ownership of the public homes more feasible. Both groups also expressed the need to find ways to reduce paid time off and modify other work rules and scheduling issues that pertain specifically to a 24/7 operation that do not apply to most other county workers in other functional units. County leaders also expressed strong support for more outsourcing of various functions and trying to enlist union support in that endeavor. Several administrators also mentioned the desirability of separating contract negotiations for the nursing home from more general county negotiations, because of circumstances unique to such operations.

Although there is considerable variation across counties, many nursing home administrators report that they are rarely part of overall union negotiations—and rarely have opportunity to negotiate benefit levels, or

other conditions affecting their home and its sometimes distinct circumstances, separately from agreements that are reached on behalf of all county employees. Many of the administrators reflected frustrations that they are held accountable for the performance and financial well-being of their facilities, but without opportunity to fully impact those circumstances.

Requested State Changes

County leaders were asked about changes needed at the state level that might make it more feasible to continue to own and operate a county nursing home. The following issues received substantial support:

Changes and increased assurances at the state level are likely to be needed to reassure county officials open to retaining their county homes.

- ❖ Increases in Medicaid reimbursement levels – 81%;
- ❖ Assurances that funding sources such as IGT will continue consistently in the future – 77%;
- ❖ Relief from mandates driving up employee costs – 73%;
- ❖ More timely, complete and accurate information about how managed care will affect their nursing homes in the future – 69%;
- ❖ Relief from mandates related to patient care – 35%.

And What if the Decision is to Sell?

If the decision by a county ultimately is to sell its nursing home, administrators and county officials were asked what would be their top concerns that would need to be addressed. Both groups placed their primary focus on the items in the list below:

- ❖ Ensuring high continuing quality of care for all residents, including reducing the strain on residents and families during ownership transition period;
- ❖ Concern for the employees of the home and their future under new ownership;
- ❖ Future assurances of availability of care to various vulnerable subsets of the resident population.

If the home were to be closed, rather than sold, that list would be supplemented by concern for the displacement of existing residents and working to ensure employment for the displaced workers, related to the impact of the closing on the local economy.

Protections for Residents, Current and Future

More specifically, administrators and county leaders were asked what should be done by their county, if the home is sold or closed, to protect the interests of current residents and potential future persons in need of the nursing home's services. The following received strong support, particularly from county leaders:

- ❖ Ensure that current residents can remain in the home;
- ❖ Ensure that new owners will serve historically-needy populations, protecting the “safety net” function of the home;
- ❖ Ensure that the new owners will provide certain types of care appropriate to needs of each facility and geographic area (e.g., bariatric, memory care, rehabilitation, dialysis);
- ❖ Negotiate transitional documents with provisions protecting residents;
- ❖ Perform due diligence to ensure that the home is sold to a quality operator.

Officials expressed concerns that in any sale, protections be built in for current residents and to ensure “safety net” provisions are in place for potential future residents.

Concerns were expressed not just about what would happen to existing residents of facilities, but also about people in the future with similar characteristics. In fact, many were at least as worried about future populations as about current residents. Their expressed rationale was that *as time goes on and new applicants for admission appear, the county will have lost any leverage to ensure that the safety net provisions in place while the county home is open will be respected by the new owner or other nursing homes in the future, thereby potentially leaving many people unserved within their respective counties in the future.*

Protections for Current Employees of the Home

Similarly, each survey group was asked what should be done by the county, if the home is sold or closed, to protect the interests of the home's current staff. The following received support, with the first item the predominant focus:

- ❖ Ensuring/negotiating that their employment can be maintained as much as possible (this received support from more than 95% of the county leaders);
- ❖ Ensuring that the salaries and benefits are maintained at least in the short run (second highest level of support from the leaders, but this received consideration from only about a fourth as many of the counties as did the continuing employment issue);

Counties wish to ensure as much employment of current employees as possible under new owners.

- ❖ Including these provisions protecting staff interests in any sale agreement;
- ❖ Providing other county government employment options as much as possible for those wishing to remain with the county.

Options That Have Been Selectively Explored

Before getting to the point of making final decisions about the future of their nursing homes, many counties have already explored, or are in the process of exploring, a wide range of options. Those options are presented in Table 7, along with indications of the extent to which counties owning nursing homes have previously considered such options (including considering and rejecting them), may currently be considering various options, or may have already implemented (or be in the process of implementing) certain ones. These options, and the extent to which they have or have not been addressed before by the counties, are offered as both a historic roadmap of what options have been considered, and also as a guide to those counties which, as suggested above, may be looking for options and ideas to help guide their due diligence review process as they consider future options.

The alternatives were grouped into three broad categories of possible options, defined as follows:

- ❖ **Limiting the County's Role in Nursing Home Care** – Options in this category would significantly limit or even fully eliminate direct county responsibility for future operation of nursing facilities. The options in this category include, among others, the possible sale or closure of nursing homes.
- ❖ **Continuing County Nursing Home Operations with Reforms** – These options assume the continuation of the provision of traditional nursing home care under current arrangements, but with some internal reforms or new initiatives, including such things as management efficiencies and outsourcing.
- ❖ **Expanding the Range of Long-Term-Care Options** – This set of options would maintain county operation of its home but with various service expansions and modifications designed not only to potentially enhance the nursing home surroundings, but also expand counties' long-term-care options in general. Options include such services as adult day care and respite care.

Table 7

Status of Consideration of Nursing Home and Long-Term-Care Options by Non-NYC Counties with Nursing Homes, as of Spring 2013: Nursing Home Administrator (and County Leader) Responses

	Not Considered	Considered and Rejected	Currently Being Considered	Has Been or is Being Implemented
Limiting the County's Role in Nursing Home Care				
Sale of licensed beds	65% (58%)	3% (13%)	23% (17%)	10% (13%)
Establishment of public benefit corporation	64% (60%)	21% (32%)	4% (4%)	11% (4%)
Establishment of local development corporation	74% (52%)	6% (16%)	10% (20%)	10% (12%)
Conversion to freestanding not-for-profit / voluntary corporation	71%	10%	19%	0%
Conversion to existing voluntary corporation	83%	3%	13%	0%
Employee buy-out	90%	7%	3%	0%
Sale of County home	42% (31%)	10% (8%)	35% (42%)	13% (19%)
Partnership with organization outside of County government	68%	10%	23%	0%
Closure of County nursing home	80% (79%)	7% (13%)	13% (8%)	0% (0%)
Continuing County Nursing Home Operations with Reforms				
Management contract to operate nursing home	77% (56%)	17% (20%)	7% (16%)	0% (8%)
More aggressive marketing	37% (43%)	10% (0%)	23% (26%)	30% (30%)
Management efficiencies	27% (25%)	0% (0%)	30% (21%)	43% (52%)
Outsourcing selected services/functions	17% (21%)	7% (4%)	17% (25%)	60% (50%)
Efficiencies through labor reforms	43% (22%)	3% (13%)	37% (39%)	17% (26%)
Separate bargaining unit for County home	57% (65%)	30% (4%)	10% (13%)	3% (17%)
Renovation or new construction	41% (39%)	7% (13%)	10% (8%)	41% (39%)
Merging the home with another County department	87%	3%	7%	3%
Revisiting County cost allocations	79%	3%	7%	10%
Expanding the Range of Long-Term Care Options				
Non-regulated services (e.g., home delivered meals, transportation)	63%	7%	7%	23%
Social Model Adult Day Care	77%	13%	7%	3%
Medical Model Adult Day Care	47%	27%	10%	17%
Respite Care Social Model	87%	3%	0%	10%
Respite Care Medical Model	63%	10%	7%	20%
Enriched Housing Social Model	93%	3%	3%	0%
Adult Care Facility Social Model	87%	3%	3%	7%
Early to Mid-Stage Dementia Social Model	77%	3%	0%	20%
Assisted Living Program	67%	20%	13%	0%
Certified Home Health Agency	77%	13%	0%	10%
Subacute Care and Special Care Units	33%	13%	7%	47%
Expanded therapy / rehabilitation services	23%	10%	23%	43%

Source: CGR County Leader and County Nursing Home Administrator surveys conducted first quarter of 2013

Note that in the table we have presented two sets of percentages: the first (and in some cases the only) number refers to the proportion of 31 nursing home administrators who checked the status of consideration or implementation in their respective counties of each of the listed options. The second number (noted in parentheses where there are two) refers to the proportion of the 25 counties whose leaders provided their perspectives on what had been done with these options in their counties.

In options where only the first number appears, that particular option was not included in the county leader survey.

In general, the administrators and county leaders had similar perceptions about the general status of the extent of consideration given to various options in their counties, but the specific proportions differ for various reasons, including the fact that 31 counties are included in the administrator numbers and only 25 in the analyses of the county leader responses; and different levels of understanding of issues by county leaders and nursing home administrators, each of whom may be aware of some things of which the other is not cognizant.

The options that make most sense for a given county to consider will vary from home to home and county to county, given circumstances unique to each. Counties have begun, or can begin to determine for themselves which of various options would be logical and reasonable to consider under their distinct circumstances, and which should be discarded as untenable for various reasons. Indeed most counties have begun to undergo such a process, at least informally, while others have done so more formally and have even made specific decisions to adopt or reject certain options, as summarized in Table 7.

Options to Limit the County's Role in Nursing Home Care

Counties considering options in this category need to be comfortable that new ownership arrangements will continue to meet county goals and expectations for nursing home operations.

Counties choosing options in this category would in some cases fully eliminate any future direct responsibility for the operation of the current county nursing facilities. In most of the options, the county would get out of the nursing home business entirely, while in others it would continue to play some reduced role. But in each of the options (with the possible exception of the sale of licensed beds, depending on the number sold), the county government's day-to-day responsibility for managing and operating the county nursing home would be significantly reduced, if not eliminated. *Thus counties need to be careful about considering their comfort level ceding future decisions related to the nursing home to other providers; make certain that they have carefully thought through what expectations they have of the new circumstances; and that they are comfortable with any new ownership arrangements, including the specific new providers, that may emerge from the process.*

As indicated in the table, the options in this category, with the exception of the potential sale of the nursing home, have either not been considered, or have been considered and rejected, by the vast majority of counties with nursing homes. None of the options has been implemented to date by more than about 10% of the counties, though that is beginning to change with the sale option and to some extent the creation of local development corporations to help facilitate the sale of nursing homes in some counties.

Options to Continue County Nursing Home Operations with Reforms

The range of possible options outlined in this category implies an ongoing commitment to have the county continue to operate and support the public nursing home, but with one or more significant changes made in its internal operations or facilities, the way the home functions, and/or how decisions are made concerning its future operations. Although none of these are necessarily easy and without controversy to implement, on balance they represent arguably easier choices to make than most of those in the other two categories of possible options.

Many counties have not explored a number of potential revenue-enhancing or cost-reduction potential options. Other counties have proven the value of a variety of ways of creating options that save significant dollars and/or increase revenues, and enhance services, if the will is there to address difficult issues.

Thus, it is not surprising that several of these options, as shown clearly in Table 7, are among the most frequently-implemented alternatives available to counties and their nursing homes (or are under the most active current consideration). Nonetheless, it is striking that many of the implementation proportions are as small as they are. For example, it seems surprising that only 30% of the administrators indicate that they have engaged in more aggressive marketing efforts, and that only 43% have implemented management efficiencies—and that 27% have never considered this option. And despite the talk of working more effectively with labor unions around issues unique to nursing homes, and the need for addressing issues with unions related to future cost-savings and revenue-enhancing options, relatively little has been done on this front.

Options to Expand the Range of Long-Term Care Alternatives

Given efforts to control long-term-care costs, the need to maintain high bed occupancy rates in nursing homes, and the desires of more elderly people and people with disabilities to remain in their homes and other community-based, less-institutional settings for as long as possible, more and more emphasis is being placed on offering lower levels of long-term care. And yet few counties, as noted earlier in the report, provide systematic approaches to the delivery of a range of long-term-care options. This set of options involves the possibility of having nursing homes add various long-term-care options to their core nursing home services and/or for counties to explore how these options might be expanded in their communities, with or without the nursing home involvement.

The assumption underlying this set of options is that the county nursing homes could or could not stay in business, but they and their counties would consider the possibility of adding, themselves or in partnership with others, one or more alternative levels of services to enhance the community's core long-term-care services. Many of these options would require approval by a state agency and ongoing state regulation. Most would have the potential to generate revenue for a nursing home, while at

A number of relatively unexplored options exist for enhancing a county's long-term-care portfolio.

the same time creating potential for recruiting future nursing home residents.

Many of these options have received little attention to date by their counties or nursing homes. The most frequently-implemented options to date are rehabilitation services and various sub-acute and special care units, consistent with data presented earlier in the report. Several other options have been implemented by as many as about a fifth of the counties, while several others have yet to be implemented by a single county.

IX. WHAT NEXT? CONCLUSIONS AND RECOMMENDATIONS

Times are bleak for county nursing homes. Virtually all are losing money, with the amounts of loss steadily increasing over the past decade, and county subsidies increasing as a result. Yet the future is not without hope, depending on how counties choose to face it.

About 80% of all resident days in county homes are paid for by Medicaid, and those payments fall an estimated \$100 per resident per day short of covering facility operating costs. Intergovernmental Transfer (IGT) payments have historically been instrumental in closing many county nursing home operating deficits, but increasingly in recent years those payments have been insufficient to fully cover operating losses. And the amounts of the true shortfalls are even greater with the 50% match from county general funds (required to access authorized IGT payments) factored in. Indeed, a number of counties are beginning to raise questions about paying the full 50% match, which potentially restricts the deficit-reducing role of the IGT funds even further.

Meanwhile, costs of operating county homes continue to escalate, particularly benefit costs associated with health insurance and pensions, and this upward trajectory is likely to continue. Add to this the uncertainty of future funding and reimbursement sources, formulas and levels, and uncertainties associated with long-term managed care programs coming at some point with their unknown reimbursement levels.

Finally, add property tax caps to the equation, and these factors combined comprise a “perfect storm” of difficult realities faced by counties and their nursing homes. The net effect of all this appears to be an unsustainable model for the continuation of most county-owned homes, *at least in their current configurations*.

Many of these concerns and uncertainties also impact for-profit and non-profit nursing homes, albeit typically to a lesser degree. But the focus of this study by design was on the small number of county/public nursing facilities, and the public policy implications of future support for such homes.

The seemingly unsustainable current model of public nursing homes is what increasingly informs and influences the conclusion of many counties—counties that have historically considered public nursing homes to be an important part of their mission and which as recently as six years ago appeared solidly in support of continuing county ownership. As financial realities have gotten worse, however, and the need for substantial

county subsidies has increased, county commitment to continued nursing home ownership has dwindled. Per our survey data, at least eight counties have recently decided to sell their nursing homes, and are well into the process of exploring the market (including a few that have either just consummated the sale process or are awaiting final approval of the terms of sale from New York State). Several other counties are leaning strongly toward selling.

Yet at the same time, many counties have a different perspective. Just over half of the 33 counties owning homes at the beginning of 2013 appear not to be as far along on the “sell” continuum—including (a) about a quarter that are uncertain and in various stages of ongoing discussions about the future of their homes, with no apparent predisposition as to the outcome of those discussions, and (b) almost a third of the counties that appear to be content with current realities and willing to continue their support for their nursing homes—and that apparently are not engaged in any substantive discussions of divesting, at least at this time.

In this rapidly-evolving environment, what can we conclude from our statewide research, and what are the implications for the state and for those counties—wherever they are in the process—as they face and make their decisions about the future of their nursing homes and who will own them in the coming years?

Wherever counties are in their thinking about the future of their nursing homes, it is our hope that the clarity and urgency brought to the issues facing them by this report will prove a useful tool, encouraging and enabling counties to think strategically in a way that will ultimately preserve these community assets and the care they provide well into the future—regardless of whether they or someone else ultimately owns and operates them.

Conclusions and Implications

This section summarizes some of the major conclusions that emerge from the earlier chapters of our findings—conclusions that we believe have implications for policymakers at both state and county levels as they make decisions concerning future provision of institutional as well as other levels of long-term care.

- ❖ County nursing homes have provided valuable services to residents throughout New York for many years. County homes have many significant strengths and attributes, and have provided needed long-term care services to many “hard to place” county residents, regardless of their financial situations, many of whom in all likelihood would not have been served by other for-profit or non-profit homes.

- ❖ In recent sales of county nursing homes, the evidence suggests that generally low-income and other “safety net” individuals have not “fallen through the cracks” or been forced to go outside the community for nursing home services. With some important partial exceptions to that statement, in general it appears that transferring ownership from a county facility has not to date borne out the worst fears of some that “hard to place” residents would find it hard to find admission in local nursing homes once the county was no longer involved as a provider. However, this needs to be monitored and receive careful attention in the process of selecting a new owner, to help ensure that persons considered “hard to place” will not be ignored under new ownership and/or that other community providers will be available to pick up any slack. The number and nature of other nursing homes in the county can also influence how well these individuals are covered by the system in the future.
- ❖ Many of those served by county homes receive reimbursement levels far below the actual costs of the services provided and the staff attention needed. With Medicaid reimbursement rates falling an estimated \$100 per day short of covering operating costs, and county homes accepting disproportionate numbers of residents on Medicaid from the day they are admitted, the ability of most county homes to be financially sustainable without subsidies is severely compromised compared to non-county homes, under current admission policies and practices. County homes admit fewer new residents per year—including fewer Medicare, short-term and rehabilitation admissions—thereby having fewer opportunities for admitting residents with higher reimbursement levels from day one of residency.
- ❖ As financial challenges increase, few if any county homes can afford to continue to conduct business in the future as they have in the past. It is important for county homes—and ultimately their county governments and the state—to think strategically about their future and the numerous options available to them, including (a) ways of increasing revenues and reducing costs internally, as well as (b) consideration of divestiture options.. Historically, relatively few county homes have systematically explored and compared the service and cost-benefit implications of a range of options before making decisions about the future of their nursing facilities. Experiences in several counties indicate that in many county homes, there is the realistic potential to reduce nursing home deficits by several million dollars through revenue enhancements and management efficiencies/cost reductions if there is the serious will to explore them, but many counties have thus far not aggressively pursued those options through careful study and/or discussions with employees and union officials.

- ❖ County nursing facilities have been an important contributor to the local economy in many counties. Statewide, county homes employ about 10,000 people (an average of about 290 per facility, down 9% from 2007), and account for about \$800 million in expenditures annually (\$1.8 billion if six county hospital-nursing home affiliations are included). The value of the county homes is typically recognized and appreciated, but increasingly must be assessed in the context of increasing contributions needed by county taxpayers to subsidize increasing operating deficits of the homes.
- ❖ In the past decade county homes have accounted for a dwindling share of the nursing home market, with reductions in number of homes, beds and residents served. For-profit homes represent a growing share of the market.
- ❖ Much of the annual operating deficit faced by county homes is attributable to high costs of benefits, and decisions about work conditions and worker protections, negotiated by state and county elected officials, in conjunction with union leaders, years ago. The cumulative effect of decisions made over the years limits the options available to current nursing home administrators and county leaders in their efforts to reduce deficits. These realities should at least be recognized and acknowledged in debates about the spiraling deficits faced by many county homes, rather than pointing fingers at current administrators and employees as the immediate cause of the deficits, as too often happens in many counties.
- ❖ At the same time, current leaders find it easy to become paralyzed by the combined effects of these previous decisions, seemingly precluding negotiations that could begin to modify previous agreements in ways that could enable nursing homes to operate in more streamlined, cost-effective ways. Without intentional efforts to address and overcome the effects of these past decisions, most county homes have relatively little chance to survive. Most counties talk about the need to work with nursing home management and employees and their union representatives in a collaborative process to address many issues related to wages, benefits, work rules, paid time off, scheduling issues and various other concerns unique to a 24/7 institutional setting that are distinct from circumstances that apply to other county employees—but there is little evidence in most counties of substantive efforts to engage productively in such discussions, leaving most of these issues unresolved, and costs continuing to escalate.
- ❖ The future of Intergovernmental Transfer (IGT) payments is uncertain, and even if one assumes they continue, unless the payment levels increase dramatically, they are unlikely to be large enough to be able

to cover the increasingly large typical county home operating deficits in the future, to the extent they once were able to do. The continuation of IGT payments is considered essential to the future financial sustainability of county homes, but it is increasingly unlikely, as currently constituted, to be *sufficient* as a financial “savior” of county homes.

- ❖ Nearly all counties with nursing homes are facing substantial increases in their 75+ and 85+ populations over the next 15 to 30 years, with potential major implications for the future demand for nursing home care and various lower levels of long-term-care services. Most of the counties with their own nursing homes are also in areas with projected shortages of nursing home beds needed for the future. In the short run, however, the baby boom generation will not be entering nursing homes in large numbers for another decade or so (beginning in the 2020s), and low birth rates during the Great Depression years will keep the rapid expansion of the nursing home market somewhat on hold over the next few years. Thus planners have both short-term and longer-term horizons to consider as they make decisions about the future of nursing facilities.
- ❖ Despite the projected shortages of nursing facility beds and the increases in the older population that will be needing and demanding more beds and more long-term-care options, few counties have long-term-care plans in place, and many lower levels of long-term care have received little active consideration in most counties.
- ❖ Counties need to be careful in doing due diligence in making decisions about whether or not to sell their nursing home, and if so, to whom and with what conditions. The recent history of sales and closures indicates that under the right circumstances, and perhaps some good fortune, sales can work out well in meeting community needs and sustaining a well-run, quality nursing home in the for-profit or non-profit sector in place of the former county home. But that history also raises cautionary tales, as one recent sale can fairly be characterized as a failure, and there have been specific concerns about others that potentially could have been avoided or at least minimized with a more careful review and assessment process in place. Selling a facility does not automatically create a good outcome for the future of the community and its residents, nor does it automatically mean a decline in the quality of the nursing home. The outcome largely depends on how the process of making decisions is conceptualized and carried out, and the care with which options are vetted, compared and analyzed.
- ❖ Recent sales of county homes seem to have had some impact in reducing taxpayer costs, at least in the short run, and have certainly helped avoid some costs that would otherwise have occurred.

Residents at the time of sale have been well taken care of and generally, with some exceptions, county nursing home employees seem to have been fairly treated and absorbed into the new owner workforce as appropriate, typically with reasonable wage levels but anticipated sharp reductions in benefits.

- ❖ Sale of homes has typically resulted in staff reductions, with mixed results in terms of quality of care. Quality seems to have improved or at least remained at comparable levels in some homes with new owners, while declining in others.
- ❖ Despite a frequent assertion that county homes typically offer the highest possible quality of care, the data are mixed on this, depending on different quality measures used. One measure suggests that county homes on balance surpass their for-profit and non-profit counterparts, while another suggests that quality of care has been declining and in the aggregate falling behind that of non-county homes in recent years. This possible decline seems to coincide with reductions in staffing in many county facilities. Whether those staffing reductions contribute to reductions in quality of care cannot be determined by this study, but the relationship should be monitored by state officials in the future.
- ❖ Outright closure of current county nursing homes seems to have few if any advocates. Evidence suggests that it makes sense only in the few situations where there is a combination of low occupancy rates in the county home, combined with an excess of nursing home beds in the county.

Recommendations

The findings and conclusions throughout the report and summarized above have implications for both state (and to some extent federal) and county policymakers. To effectively address a number of the issues raised by this study, parallel and complementary actions will need to be taken at both state and county levels. In order to clarify responsibilities, we have chosen to break out the recommendations that explicitly apply to each, even as we understand the need for collaborative approaches that will involve both levels.

General Findings and Recommendations

First, some overriding findings and general recommendations:

- ❖ **Before making a determination about the future of its nursing home, each county should engage in a careful due diligence process of examining a range of options concerning the future of its home.** Following such a process, some are likely to opt to remain a county facility, while others will choose to divest from ownership.

Because of the uniqueness of each county and county home situation, there is no clear predisposition to conclude that one approach is better than the other in general. The preponderance of circumstances in some counties may argue for continuing to own their facilities, while in other counties the evidence will suggest selling. The findings in this study do not lead to a conclusion that any one approach is always better than another, because too many variables are at play from county to county.

- ❖ **On balance we conclude that it is generally better for a county to sell its nursing home than to either close it or continue to lose significant amounts of taxpayer money, *as long as it is able to sell to a responsible buyer meeting various criteria and expectations important to the county.*** At some point, whatever the legitimate arguments over the special mission of county homes and other related issues, it may become more important to ensure that the services and jobs are continued than to insist that they must be provided by county employees. That decision will and should be made county by county, with many deciding for rational reasons to continue with their homes, but our research has concluded that it is possible to provide quality services via different types of owners and not only through the public sector, *IF key expectations are met.* That is discussed further below, and our findings make clear that this assurance will not always be met, so the due diligence process again becomes critical in making such decisions.

We are not necessarily concluding that most county homes will eventually need to be sold. What we *are* saying is that, absent proactive attention to the challenges described, this may increasingly become the default result. But it is not a foreordained conclusion. Counties will make those decisions, and the comprehensiveness and thoughtfulness of the process they use in making their decisions will be determinative.

- ❖ **Given all this, we expect that over the next five years there will continue to be counties owning and operating their own nursing homes, but that number will be considerably smaller than the number existing in 2013.** We believe some of our recommendations, if adopted, will help counties follow a rational process leading to decisions that will determine what that number will eventually be. In turn, that smaller number may make it easier to implement some of the other recommendations, especially those affecting the state.

Recommendations with State Implications

Recommendations that follow pertain primarily to county-owned nursing homes, but they also have broader implications. Some pertain to nursing

homes in general, and others to more comprehensive long-term care issues involving levels of care below the nursing home level. They are numbered for convenience, but not necessarily in any particular order of priority.

1. **New York State should work closely with the federal government to obtain assurances concerning the future availability of Intergovernmental Transfer (IGT) funds for county nursing homes.** At this point, the future status of IGT funding is uncertain, making it difficult for counties and their nursing homes to make any realistic future financial assumptions about their homes, and what resulting implications are likely for county finances. The sooner the state can provide realistic information to the counties concerning future years' existence of the IGT funds, and the likely amounts of those funds, the better counties will be able to make more realistic plans about the future of their facilities.
2. **The state should consider supplemental financial support for selected county homes that meet specified criteria.** Those criteria might include such factors as being a public facility in a county with few other nursing homes, in a county with a shortage of nursing home beds, with rapidly growing projected 75+ and 85+ populations and a high indigent elderly population, as well as being a county home with a demonstrated history of serving a disproportionately high population of Medicaid residents and residents with low clinical scores but behavioral issues with staffing implications. The rationale here is that the county homes meeting such criteria are playing an especially critical role in their communities by serving residents who may not otherwise be served in their counties, some of whom may be confined to hospitals if they were not served by the county home, or need to find nursing care away from families outside the county. Such supplemental financial support might include development of a formula to cover added costs of residents with behavioral issues not addressed through the RUGS/Case Mix Index formula. Another approach could be to provide a supplement to the basic Medicaid rate that would enhance revenues for residents who enter the facility on day one at the lower Medicaid rate, and who therefore lose an estimated \$100 per day for the facility every day they are in the home, from day one forward. *Such an approach, spread across a relatively small number of remaining county nursing homes, would have little impact on the state budget, but could help reduce the operating deficit for these counties and ensure that critical services remain.*

Parenthetically, it should be noted that this recommendation is consistent with a recommendation in the 2006 Berger Commission report that “a clear policy should be developed [by the state] to guide

decision-making about county nursing homes and to protect indigent residents.”³⁸

3. **As a further incentive for any nursing home to admit more low-income, Medicaid residents, the state might wish to consider providing supplemental financial support for *any* home that admits residents on Medicaid at the time of admission.** The previous recommendation focuses attention on county homes only, to help provide relief for those homes that admit disproportionate numbers of residents paid for by Medicaid from day one, but if the state decides that it wishes to incentivize other homes as well to accept higher proportions of Medicaid residents, and thereby make them less dependent on county facilities, some broader version of such a supplemental Medicaid rate for such admissions might be worth considering. One possible approach that might be used in this context is the state’s Vital Access Providers (VAP) initiative, designed to provide support for continued access to vital health care services such as nursing homes for the uninsured, Medicaid and other vulnerable populations. This initiative might have applicability for either this or the previous recommendation, or both.
4. **The state should consider making an exception to the property tax cap for counties with nursing homes meeting criteria outlined above, in order to provide them with additional flexibility if needed to cover county subsidy or matching IGT funds.** Not only are counties concerned about the increased subsidies many of them are having to pay to support their nursing homes, but they are also concerned about the potential for that support, combined with the need for IGT match money to come from the county general fund, to push their counties over the tax cap and/or force other priority items to be cut to avoid that happening. Having some such level of tax relief—for such counties that meet specified criteria demonstrating the value of the county homes in those communities—could help create more flexibility for any counties wishing to explore such a level of nursing home support.
5. **Any supplemental support from the state should be tied in some way to accountability of the homes for provision of quality care.** The types of supplemental support suggested above, including the exception to the property tax cap, should be linked to some agreed-upon quality measure(s), so that such support is only provided as long as consistent evidence of quality levels of care exists. The key to the

³⁸ Commission on Health Care Facilities, *A Plan to Stabilize and Strengthen New York’s Health Care System: Final Report*, December 2006, p. 10.

success of this recommendation would be to agree upon a consistent quality measure to apply to all nursing homes, based on some type of rolling three-year average for something like Medicare.gov ratings, or number of deficiencies compared to state average, etc. This could also be linked to something like the DOH Quality Pool. A three-year average is suggested to avoid the potential for single one-year fluctuations in ratings that can happen to any institution without being indicative of fundamental declines in quality.

6. **The state should take responsibility for reviewing existing measures of quality that compare nursing homes, and for making recommendations as to which should be used consistently in the future, or to initiate the development of a new measure if necessary to enable consistent, reliable comparisons to be made.** Each of the variety of measures currently in existence appears to have significant drawbacks, including lack of comprehensiveness and consistency of measurement, often subject to considerable fluctuation from year to year. The state should consider ways of merging the best attributes of different measures into a more universal measurement of quality that can have more value for comparison purposes in the future, and which can provide a more accurate basis on which to hold facilities accountable for some of the support recommendations offered above. If that is not possible from existing measures, the state should consider developing a more comprehensive comparative measurement approach to be used with all nursing homes in the state.
7. **The state should be more pro-active in working with counties interested in undertaking comprehensive due diligence assessments of options for the future of their nursing homes.** As counties seek to discern the most appropriate future directions for their nursing facilities, the state should be willing to provide guidance and support upon request from the counties, including offering technical assistance, consultation, relevant data, and perhaps financial support for counties seeking outside consultation. Such support should be offered on a prioritized basis for counties meeting particular criteria, such as suggested above.
8. **As part of the state's process of reviewing applications for transfer of ownership of nursing homes, it is recommended that the Department of Health reviewers become more active partners with the counties to help ensure that thorough proper vetting and review of potential buyers takes place. Counties have not always been as careful as they might in making decisions about potential new owners, and the state has considerable experience which should be tapped that could help counties feel more comfortable and informed about their decisions concerning potential buyers.** Ideally this would mean having the state engaged with counties earlier

in the process to provide support in the early vetting stages. State reviewers would provide advice based on previous experience about pitfalls to avoid, types of issues to be concerned about, types of questions to raise, types of information to request from potential buyers, etc.

9. **The state should offer financial incentives for counties to establish new lower-level long-term-care services not now provided in county nursing homes.** The intent would be to consider a form of financial incentive that may make it easier for counties to consider converting nursing home beds, or adding new beds, to meet increasing demands for lower levels of care. For example, if a county wishes to decertify some of its nursing home beds and convert them to a lower level and less expensive form of care—and in the process reduce the state’s level of Medicaid expenditures, for example—it can make financial sense for the state to share some of its savings as a financial incentive for the county to undertake the necessary conversion expenses and/or to help subsidize any loss of revenues the county might experience as a result of the transition. Such incentives should also be more generally available for the creation of a wide range of community-based long-term-care services, whether related to conversion of nursing home beds or not, as part of a state focus on creating incentives for communities to establish long-term-care plans to meet the needs of the expanding older population.

As suggested earlier in the report, 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. 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. The state may also consider offering such supports as technical assistance to local communities and grants for pilot projects to help establish new initiatives.

10. **As part of a review of long-term-care policies, the state should lobby the federal government to remove its restrictions against public nursing homes offering assisted living programs.** This issue was raised in the 2007 statewide study, and it has received no traction in the meantime. A number of county nursing homes have consistently raised the issue of providing an assisted living option, indicating that it would be a more appropriate level of care for some of their residents. But federal regulations continue to restrict counties from investing in this alternative level of care for Medicaid residents. The rationale behind these restrictions should be reviewed, and changes in the

regulations should be considered. One approach might be to consider providing such care through Medicaid waivers. Short of obtaining relief from this archaic restriction, it may be possible for a county to pursue such an option on a collaborative partnership basis with a non-public service provider.

11. **The state should be as clear and informative as possible about its plans concerning the statewide rollout of managed long-term-care programs, including the timing for various parts of the state, and their direct applicability to nursing homes and long-term care in general.** There is considerable confusion about the plans for implementing managed care initiatives and what impact they are likely to have, and when and where, on nursing home residents, including the impact they are likely to have on the establishment of broader long-term-care service networks in counties throughout the state. Nursing home administrators and counties owning nursing homes are particularly concerned about how these plans may affect eligibility for nursing home services compared with other long-term-care programs, and the impact managed care will have on the revenue profile of the homes. The state should engage in a carefully-designed education effort to help all who are involved in the provision of long-term care understand what is coming when, and what implications this new direction will have for residents and for revenue expectations.
12. **The state should solidify and expand its support for New York Connects, or a variation thereof, to strengthen programs at the county level which help the elderly population and their caregivers make well-informed decisions about the level of long-term care they need.** While these programs are not mandatory, and residents are not obligated to follow the advice of the program, they can provide an informed and educational focus on available options and how those might apply to an individual or family's circumstances and needs.

Recommendations with County Implications

Counties often face a very difficult choice between stanching the financial bleeding in a very difficult environment, or disposing of a community asset affecting hundreds of people in order to save what in most counties amounts to a relatively small share of the county's overall budget or tax levy. As one of the few services counties provide that isn't mandated, a financially hemorrhaging nursing home is an understandable target for cost-cutters. **But the key for any county, as suggested earlier, is to implement not just a careful review of potential buyers of the nursing facility, but well before that to engage in a thoughtful, comprehensive process of reviewing a range of options involving possible continuation of the facility as a county operation on through a continuum of change with divestiture of the facility at the other end.**

If the decision is ultimately to sell, it has been and will continue to be tempting for financially-strapped counties to focus on getting the highest purchase price possible, without providing a careful vetting process to ensure as much as possible that key county needs and expectations are met. Our case studies show that the consequences of a poor selection of a new owner can be devastating for current residents, families and staff members, and for those who may need nursing home care in the future.

The recommendations that follow incorporate improved processes at the county level.

Comprehensive Review of Options

1. **Counties and their nursing homes should actively explore the various options outlined in Table 7 and the discussion in Chapter VIII.** The fact that many of the options outlined in Table 7 have not been seriously considered by most counties or their nursing homes suggests that there may be significant untapped beneficial opportunities waiting to be explored. Ideally, as part of any decision about the future of a county's nursing home, a comprehensive process should be undertaken by counties, involving a variety of inputs from county officials, employees, union and community leaders, and others as appropriate, to analyze and compare relevant options from that list. Each county should select those options it considers most relevant and pertinent to its needs and resources and assess the potential for developing new cost-effective solutions internally (through revenue enhancements and cost reductions) before considering divestiture options. *Such a due diligence process can help county leaders bring the public along on whatever decision is ultimately made about the future of the facility, based on careful documentation of selected options and their respective pros, cons and net cost and revenue implications.*
2. **Counties should create more comprehensive long-term-care plans, and explore opportunities to expand the provision of lower levels of long-term care by expanding the numbers of non-institutional beds and program slots.** In some cases this could involve choosing to decertify a number of underused nursing home beds and convert them to other types of service provision. Or it may not involve conversion of existing beds, but rather expansion of other more community-based lower levels of care, which may help address unmet needs in a county. It may also help create links to individuals and families for subsequent admission to the nursing home when that level of care is needed. Either way, the key is for counties to begin to create the more comprehensive long-term-care plan that most do not currently have in place, despite the likely increased demand in future years for a wider array of long-term-care programs in the community, below institutional levels of care.

3. **Counties with sufficient nursing home beds should begin to explore downsizing or decertifying beds in a portion of their home, and potentially converting them to assisted living beds to be leased by community partners.** Although the counties are not legally able to provide such services directly for Medicaid recipients, they could potentially develop partnerships with non-public-sector entities to help make this level of service available in counties where the need exists.
4. **Counties should improve their efforts to inform people interested in long-term-care options about what is available and provide advice as to the best options for their circumstances. This may mean strengthening NY Connects programs or equivalent central intake programs.** This recommendation is consistent with the earlier recommendation to the state to strengthen support for such programs. Properly used, they can provide helpful advice to seniors and family members concerning a variety of long-term-care options before they make a decision to choose one, where they have the flexibility to choose.

Internal Improvement Options

1. **Counties interested in potentially continuing to own their nursing homes should more aggressively market their services and the quality of their care.** County homes throughout the state have very different approaches to marketing, and different perceptions of its value. Some counties are at least implicitly encouraged to downplay marketing because of the potential negative impact on taxpaying private nursing homes. Nonetheless, especially if county homes begin to more aggressively expand services and levels of care, marketing and expanded communications with the public, hospital discharge planners, physicians, social workers, senior centers and other service providers working with older citizens may become especially important, especially to the extent that homes consciously attempt to attract more Medicare and private pay residents to supplement the Medicaid/safety net core of the clientele of most county homes.
2. **Counties should strengthen working relationships between nursing home management, labor representatives and county officials to help resolve issues to make retaining county homes more viable in the future.** County leaders and nursing home administrators in their surveys expressed support for finding ways to bring key groups together to find mutually beneficial solutions in the interest of more sustainable future operations. But despite much talk of working more effectively with labor unions around issues unique to nursing homes, most counties appear to have talked about doing this more than they have actually made it happen.

3. **Counties should consider establishing separate bargaining units involving nursing home employees and/or include nursing home administrators more directly and substantively in labor negotiations.** This happens now in some counties, but in most, the special 24/7 and related circumstances associated with managing a nursing home do not get adequately factored into the broader county contract negotiation process. Often decisions are made (or not made) as a result that have direct—and often negative—implications for the cost effectiveness and performance of, and overall ability to manage, the county home. If county home administrators are to be held accountable for the performance of their homes, counties should consider ways to give them more management flexibility, with fewer limitations on what they are and are not allowed to do under terms of a contract which they may have had little say in shaping.
4. **For counties that decide to continue to own and operate their nursing home, a number of options should be considered to increase revenues and reduce costs. Among specific revenue enhancement opportunities would be to provide more education on Minimum Data Set (MDS) coding to ensure accuracy in capturing resident conditions that impact reimbursement; improved billing practices; and expansion of the number of short-term residents at higher reimbursement levels.** The practical implications of such opportunities should be carefully explored, and the potential revenue implications of each analyzed and monitored to determine the potential implications for reducing the county home operating deficit.

Consideration of Divestiture Options

Our research on the impact of selling or closing nursing homes (see Chapter VII) suggests that the outcomes that result from a sale hinge primarily on the process used by the county in making its decision, the thoroughness with which the process is undertaken, the breadth of factors considered in the decision (going far beyond just the sale price), the expectations of the county and the extent to which they are met by the potential buyer, and the extensiveness of the owner vetting process. In short, *who* buys the home, and *how* the buyer is selected, are keys to how well the decision holds up over time. Such a thorough process is at the heart of the following recommendations.

1. **Establish a clear set of the county's criteria and expectations that a potential buyer should meet to be selected, including future expectations of admission policies and approaches to "safety net" candidates for admission in the future.** Such a delineation of expectations and review of proposals for how well they are met can be supplemented by reviews of data about other facilities owned by each potential buyer, by field visits to facilities and by reference checks, as

well as through interviews. It should be noted that there is no clear right or wrong way to handle the criteria/expectations issue. Some counties prefer to be very explicit and attempt to pin down applicants in their initial proposals concerning how they would handle certain situations, while others prefer to be more general, at least initially, raising broad issues but without attempting to force specific types of responses, preferring instead to see what potential bidders offer in a more unstructured way, and becoming more precise as the process moves forward with selected “finalists.” This latter perspective also is based in part on not wanting to turn some potential buyers off by overly detailed initial requirements. Each county will need to find its comfort level with these types of issues and how and when they get addressed.

2. **Consider more than just the sale price in choosing a buyer.** A big dollar figure is obviously appealing to a county looking to divest itself of a nursing home. But that should be balanced with the needs of residents, their families, employees and the larger public to ensure that the best possible new operators take over the home. As suggested in the previous recommendation, county officials should decide what pre-conditions they want to attach to the sale, such as providing preference in admissions to particular subgroups of residents; continuing to admit low-income, uninsured or behaviorally difficult residents; giving preference to existing staff members in filling positions; potential protections concerning wage structures for employees; etc. This can be done in part by spelling out requirements in a Request for Proposals as well as through thorough follow-up interviews and conversations with bidders.
3. **Thoroughly research and vet potential buyers.** This includes finding out not only about the experience of any current nursing home operators in other facilities but also about their financial backgrounds and available resources. Selling to an organization with thin financial resources, or a poor track record of providing quality care, is likely to lead to serious problems in the long run. Indeed, there is evidence from our case study for this project, as well as examples in other counties, where the failure to carefully vet potential buyers against criteria or expectations set by the county led either to unfortunate outcomes post-sale, or to the sale not being consummated because decision-makers were ultimately not convinced the preferred buyer would be able to meet county needs and expectations over the long haul.
4. **Counties should test building protective language into the terms of agreement to sell or lease that provides options should the terms of sale not be met (e.g., party breaks lease arrangement, becomes financially unable to sustain operation of the home).** It is difficult to

build in iron-clad, legally enforceable protections, but a county may wish to attempt to include language along the lines of providing right of reversion back to the county if conditions are not met by the successful buyer or leaser of the nursing home, while recognizing enforceability of these provisions may be challenging. At the same time, establishing test cases for building in such protections would appear to have little risk, other than potentially being fought by potential buyers, in which case this would need to be negotiated as part of the terms of sale, and the county would need to determine how strongly it felt about sticking to its intentions, and where the compromise point might occur.

5. **If a county is not satisfied that any specified conditions can be successfully met by the successful bidder, it should not enter into an agreement to transfer ownership.** As difficult as this may be after a thorough process and the time invested in it by many people, experience suggests that it is better to walk away up front from a potential deal that has remaining unresolved issues than to enter into it with misgivings and risk problems in the future.
6. **Ensure an open, transparent process involving key stakeholders throughout the process.** Involve stakeholders as much as possible and be honest with them about what is happening. In counties where employees felt officials weren't forthright about their intentions to sell, new owners had more trouble establishing good working relationships. Dealing as much as possible with objections in an upfront way can set the tone for open, productive relationships among staff, residents and new owners—as well as providing early indications before a sale is finalized of how well the potential new owner relates to various constituent groups.
7. **Provide as much continuity as possible through the transition.** This might include entering into a management contract with the buyer before a sale is finalized, as was done in Oswego County, or requiring the buyer to retain a certain percentage of existing staff members to help residents adjust to the change.
8. **Assess the extent to which county officials can or want to be involved in an oversight role following the sale.** In one of the case study counties, a committee consisting of county officials and the home's buyer and administrator met periodically and discussed the home's operations. While this structure wasn't well implemented in that county, some similar process could potentially help maintain a county's interest in seeing the home succeed under new ownership and hold it accountable.

9. **Counties should consider using a portion of sale proceeds to invest in the development and expansion of community-based levels of long-term care to meet demands in their communities.** Where this is possible, it would represent a commitment to the importance of developing a strong network of long-term-care programs below the institutional level, hopefully to be supported as well with funds from the state.

APPENDIX: ELDERLY POPULATION PROJECTIONS FOR COUNTIES OWNING NURSING HOMES, 2013

County	Age	2010 Population	2020 Population	Change from 2010	2030 Population	Change from 2010	2040 Population	Change from 2010
Albany	65+	42,314	52,905	25%	61,222	45%	58,414	38%
	75+	21,670	21,636	0%	29,125	34%	32,723	51%
	85+	7,100	7,078	0%	7,464	5%	10,257	44%
Broome	65+	32,844	37,197	13%	41,269	26%	37,832	15%
	75+	17,176	16,738	-3%	20,306	18%	22,412	30%
	85+	5,637	5,722	2%	5,848	4%	7,460	32%
Cattaraugus	65+	12,419	15,183	22%	16,615	34%	14,911	20%
	75+	5,881	6,313	7%	7,990	36%	8,484	44%
	85+	1,691	2,005	19%	2,174	29%	2,820	67%
Cayuga	65+	12,235	14,664	20%	17,179	40%	15,964	30%
	75+	6,043	6,039	0%	7,651	27%	8,720	44%
	85+	2,074	1,935	-7%	2,011	-3%	2,602	25%
Chautauqua	65+	22,381	25,269	13%	28,084	25%	25,356	13%
	75+	11,256	10,539	-6%	12,775	13%	13,846	23%
	85+	3,544	3,268	-8%	3,170	-11%	3,951	11%
Chemung	65+	13,943	15,696	13%	17,249	24%	15,652	12%
	75+	7,102	6,617	-7%	8,096	14%	8,623	21%
	85+	2,240	1,921	-14%	1,873	-16%	2,340	4%
Clinton	65+	8,403	10,514	25%	16,338	94%	15,334	82%
	75+	5,051	5,129	2%	6,565	30%	7,870	56%
	85+	1,152	1,214	5%	1,449	26%	1,877	63%
Columbia	65+	11,463	14,896	30%	17,286	51%	15,945	39%
	75+	5,264	5,944	13%	7,823	49%	8,708	65%
	85+	1,581	1,879	19%	2,125	34%	2,793	77%
Erie	65+	144,364	159,498	10%	176,236	22%	159,567	11%
	75+	74,435	68,390	-8%	80,749	8%	87,551	18%
	85+	23,607	22,605	-4%	21,396	-9%	25,893	10%
Essex	65+	7,143	8,280	16%	9,368	31%	8,843	24%
	75+	3,378	3,397	1%	4,145	23%	4,636	37%
	85+	995	1,070	8%	1,126	13%	1,429	44%
Franklin	65+	6,880	8,459	23%	10,199	48%	9,819	43%
	75+	3,134	3,065	-2%	4,001	28%	4,666	49%
	85+	843	794	-6%	801	-5%	1,045	24%

County	Age	2010 Population	2020 Population	Change from 2010	2030 Population	Change from 2010	2040 Population	Change from 2010
Genesee	65+	9,390	10,969	17%	13,037	39%	12,291	31%
	75+	4,608	4,862	6%	5,976	30%	7,024	52%
	85+	1,487	1,428	-4%	1,559	5%	1,980	33%
Lewis	65+	4,076	4,805	18%	5,681	39%	5,234	28%
	75+	1,980	1,945	-2%	2,420	22%	2,796	41%
	85+	544	609	12%	606	11%	776	43%
Livingston	65+	8,985	10,272	14%	11,915	33%	10,985	22%
	75+	4,256	3,946	-7%	4,876	15%	5,571	31%
	85+	1,288	1,101	-15%	1,073	-17%	1,372	7%
Monroe	65+	103,594	127,958	24%	147,142	42%	139,655	35%
	75+	51,523	55,093	7%	71,539	39%	80,161	56%
	85+	17,444	17,896	3%	19,817	14%	26,323	51%
Nassau	65+	204,681	228,514	12%	258,900	26%	249,149	22%
	75+	106,374	99,888	-6%	120,531	13%	136,082	28%
	85+	34,057	33,846	-1%	34,081	0%	43,399	27%
Onondaga	65+	65,578	78,025	19%	90,143	37%	85,407	30%
	75+	33,633	32,578	-3%	41,805	24%	47,278	41%
	85+	12,987	10,636	-18%	10,777	-17%	14,246	10%
Ontario	65+	16,612	20,150	21%	23,662	42%	23,196	40%
	75+	7,777	8,142	5%	10,482	35%	12,196	57%
	85+	2,565	2,490	-3%	2,767	8%	3,696	44%
Orange	65+	40,985	55,325	35%	71,289	74%	75,070	83%
	75+	18,531	21,747	17%	30,741	66%	38,704	109%
	85+	5,588	5,986	7%	7,345	31%	10,632	90%
Orleans	65+	6,178	7,718	25%	8,968	45%	8,256	34%
	75+	2,832	3,298	16%	4,186	48%	4,760	68%
	85+	854	972	14%	1,126	32%	1,462	71%
Otsego	65+	10,281	12,095	18%	13,503	31%	12,545	22%
	75+	4,831	5,145	6%	6,335	31%	6,987	45%
	85+	1,529	1,506	-2%	1,669	9%	2,137	40%
Rensselaer	65+	21,607	27,024	25%	31,892	48%	30,861	43%
	75+	10,457	10,639	2%	14,324	37%	16,465	57%
	85+	3,275	3,142	-4%	3,400	4%	4,714	44%
Rockland	65+	41,841	50,424	21%	58,779	40%	60,439	44%
	75+	19,525	22,503	15%	28,198	44%	33,094	69%
	85+	5,696	7,226	27%	8,560	50%	11,332	99%
Saratoga	65+	29,994	41,611	39%	52,352	75%	53,687	79%
	75+	13,275	16,256	22%	23,287	75%	28,296	113%
	85+	4,041	4,381	8%	5,482	36%	7,871	95%
Schenectady	65+	23,083	28,176	22%	34,343	49%	34,883	51%
	75+	12,390	12,493	1%	16,581	34%	19,973	61%
	85+	4,400	4,390	0%	4,751	8%	6,567	49%

County	Age	2010 Population	2020 Population	Change from 2010	2030 Population	Change from 2010	2040 Population	Change from 2010
Steuben	65+	14,718	19,021	29%	21,716	48%	20,367	38%
	75+	7,498	7,403	-1%	9,542	27%	10,469	40%
	85+	2,160	2,130	-1%	2,172	1%	2,855	32%
Suffolk	65+	201,793	247,572	23%	301,758	50%	304,620	51%
	75+	93,810	106,350	13%	135,253	44%	163,207	74%
	85+	27,841	31,639	14%	36,855	32%	48,403	74%
Sullivan	65+	11,455	15,062	31%	18,589	62%	18,202	59%
	75+	4,767	5,506	16%	7,499	57%	8,927	87%
	85+	1,266	1,290	2%	1,538	21%	2,125	68%
Ulster	65+	27,044	34,809	29%	40,836	51%	38,945	44%
	75+	12,580	13,964	11%	18,557	48%	21,176	68%
	85+	3,826	4,384	15%	5,000	31%	6,756	77%
Warren	65+	11,247	14,664	30%	17,458	55%	16,706	49%
	75+	5,290	5,799	10%	7,893	49%	9,087	72%
	85+	1,612	1,699	5%	1,927	20%	2,658	65%
Washington	65+	9,707	12,142	25%	14,934	54%	14,424	49%
	75+	4,499	4,895	9%	6,363	41%	7,521	67%
	85+	1,297	1,545	19%	2,011	55%	2,319	79%
Wayne	65+	13,363	16,839	26%	19,703	47%	18,170	36%
	75+	6,008	6,488	8%	8,542	42%	9,672	61%
	85+	1,698	1,685	-1%	1,863	10%	2,483	46%
Wyoming	65+	5,723	7,300	28%	8,502	49%	7,995	40%
	75+	2,517	2,731	9%	3,599	43%	4,012	59%
	85+	757	742	-2%	813	7%	1,067	41%
New York State	65+	2,617,943	3,115,588	19%	3,618,598	38%	3,569,981	36%
	75+	1,257,341	1,296,814	3%	1,630,159	30%	1,863,746	48%
	85+	390,874	389,166	0%	418,616	7%	543,452	39%
Total for all 33	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%