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

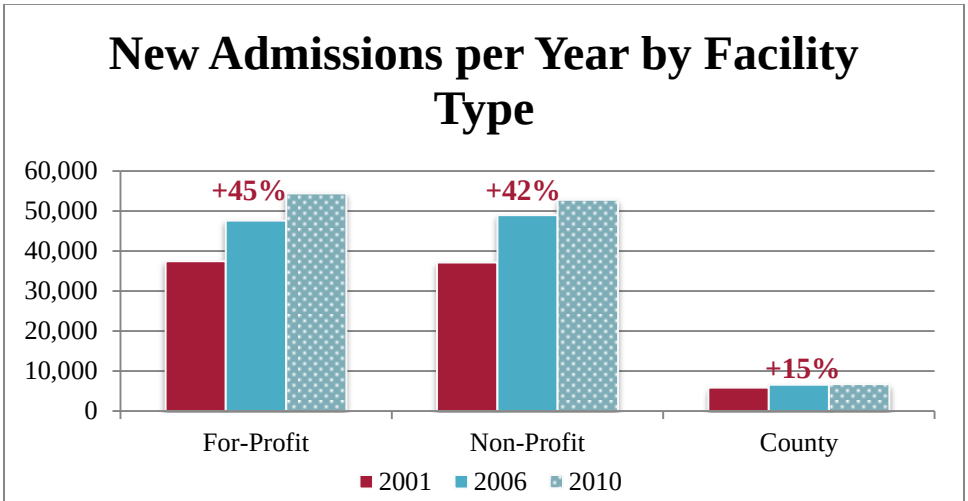
Over the past decade, the total number of nursing home admissions on an annual basis (admission date between January 1 and December 31 of the year, and not counting "carryover" persons already in residence at the beginning of the year) has increased substantially across all nursing homes statewide. Increasingly, 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



Source: NYS DOH Minimum Data Set (MDS 2.0) organized by LeadingAge New York
Note: CGR calculated 2010 full-year projections based on actual data for first 9 months of the year

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.

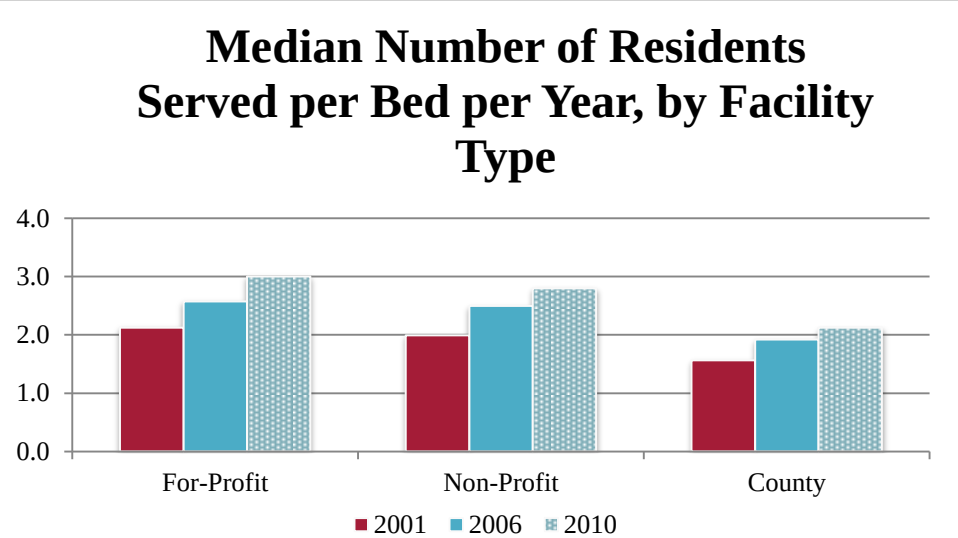
In effect, these data appear to reflect the fact that, even though county homes have increased rehabilitation services, and in many cases have expanded marketing efforts to attract more short-term rehab residents—and those efforts have led to increases in the number of short-term admissions to county 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



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

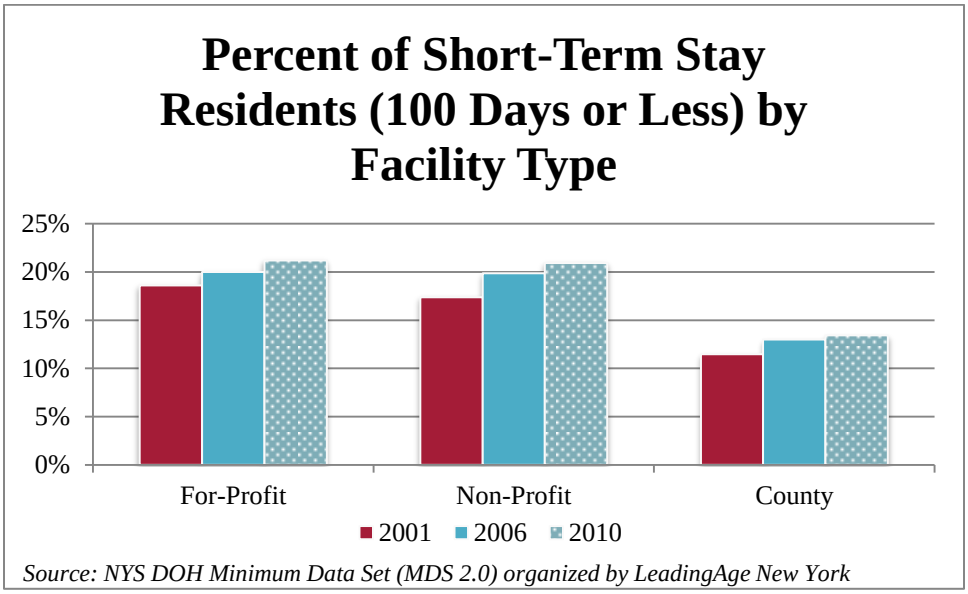
County nursing homes average about one less resident per bed per year than do for-profit and non-profit homes. Higher turnover in residents per bed typically translates into more revenues for non-county homes.

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

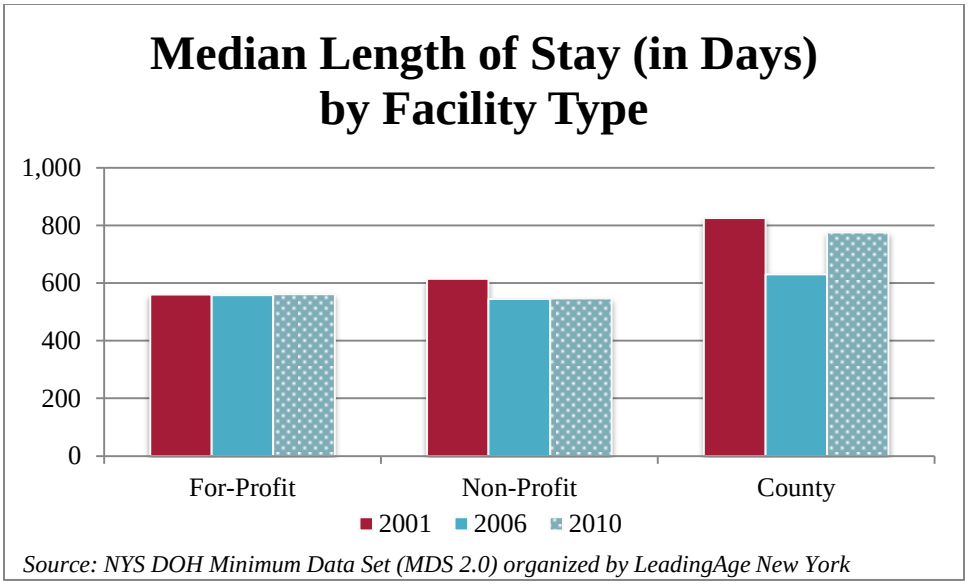


Source: NYS DOH Minimum Data Set (MDS 2.0) organized by LeadingAge New York

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



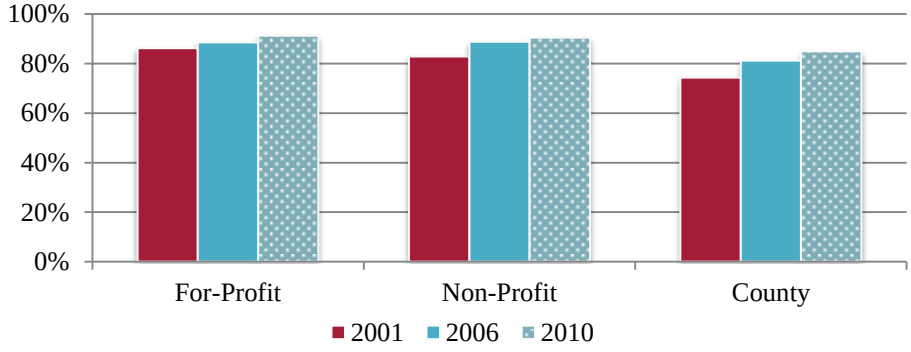
Source: NYS DOH Minimum Data Set (MDS 2.0) organized by LeadingAge New York

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



Source: NYS DOH Minimum Data Set (MDS 2.0) organized by LeadingAge New York

Negative Financial Implications for County Homes Start at Admission Intake

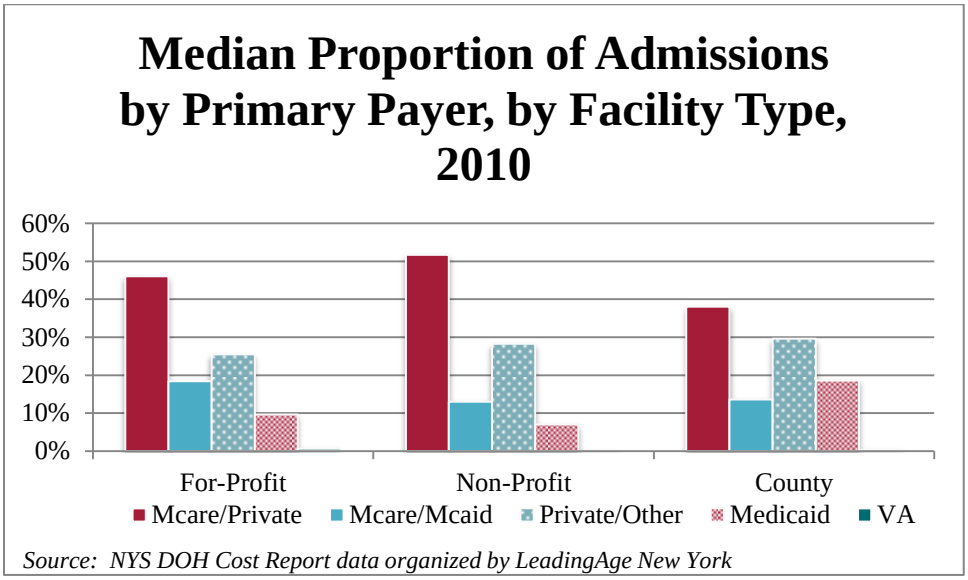
All of these differences have financial implications for the different types of homes, as typically the short-stay residents and those admitted from hospitals (often one and the same) come with higher initial reimbursement levels for their stays in the facilities than do the longer-stay residents. Thus 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



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

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 <u>every day they are residents of the county home.</u>*

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

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.

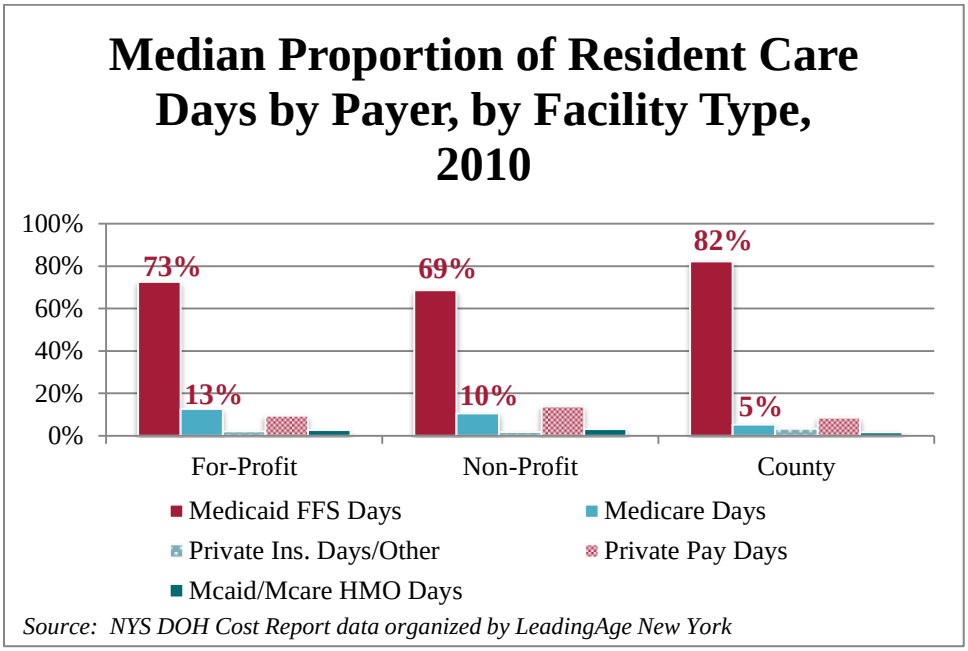
Even in for-profit and non-profit nursing homes, many residents who are initially Medicare or private pay admissions, other than very short-stay residents, ultimately wind up on Medicaid at some point during their stay in the facility. In the typical nursing home of all types over the past decade, slightly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

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



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

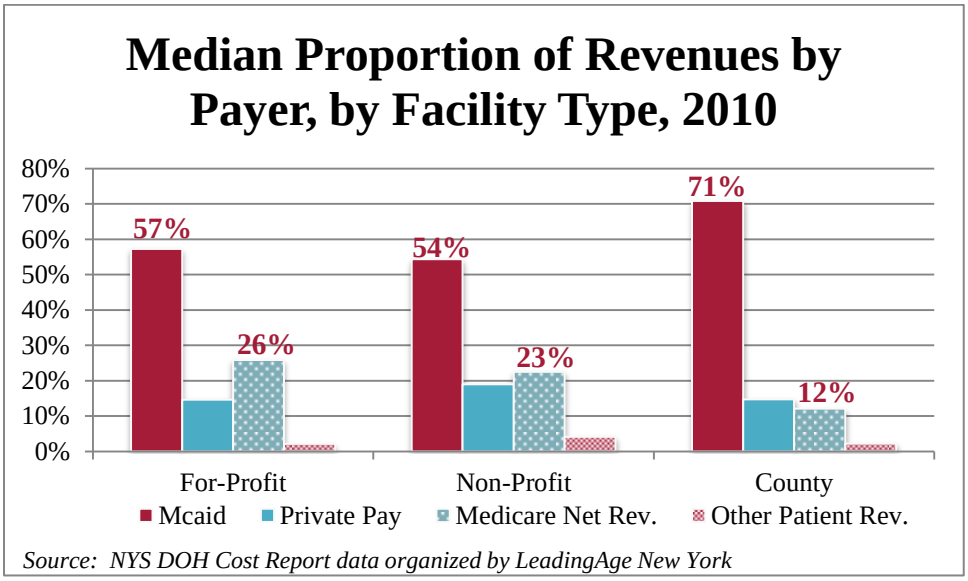
Medicaid Pays Most of Revenues

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.

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.

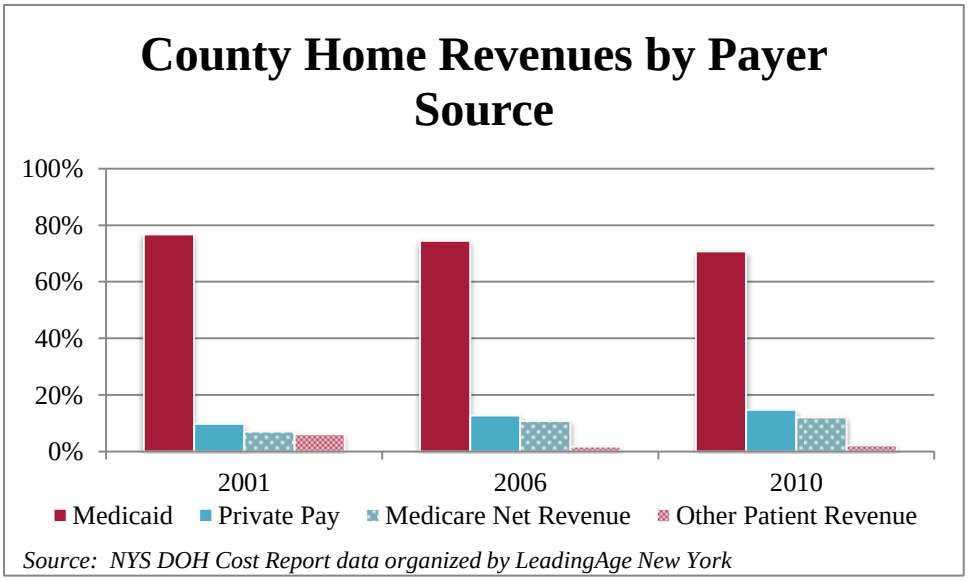
As indicated in Figure 16, the familiar patterns of county versus non-county facility differentials are clear in the revenue proportions. More than 70% of all revenues in county homes are paid by Medicaid, compared to an average of about 55% in non-county facilities. And the proportion of revenues from 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%.

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.

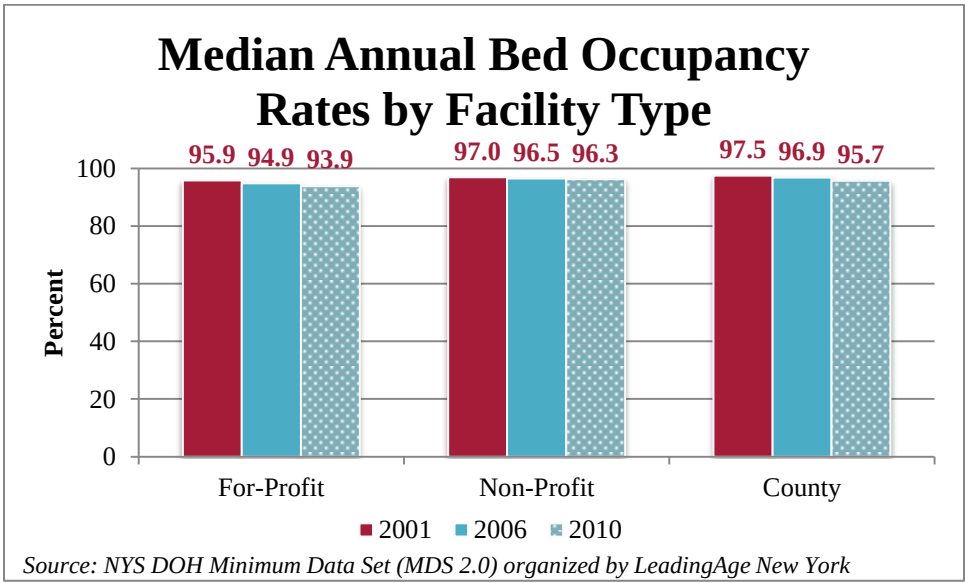
Figure 17



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



Source: NYS DOH Minimum Data Set (MDS 2.0) organized by LeadingAge New York

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.

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.

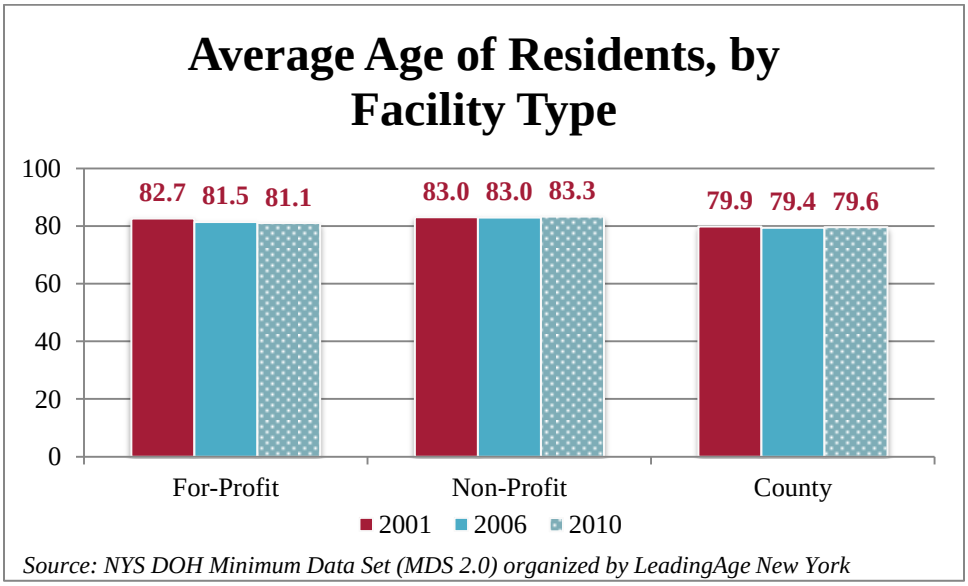
Data from the county nursing home survey suggests that the county home median occupancy rate in 2011 and 2012 may have continued to decline slightly, to just above 95%, though a half dozen homes did not provide occupancy data. Most county homes have remained consistently well above 95% occupancy, with 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

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



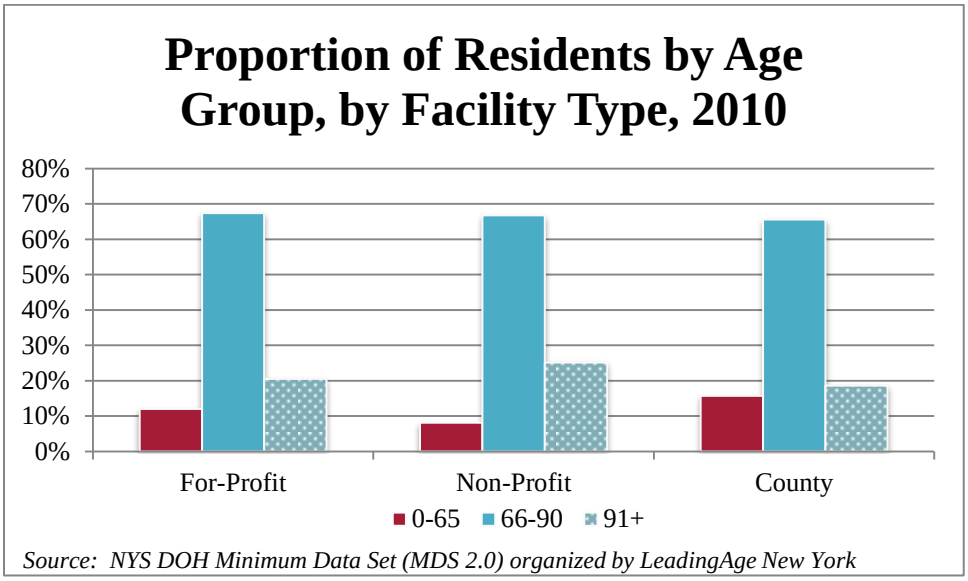
Source: NYS DOH Minimum Data Set (MDS 2.0) organized by LeadingAge New York

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



Source: NYS DOH Minimum Data Set (MDS 2.0) organized by LeadingAge New York

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

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.

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.

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.

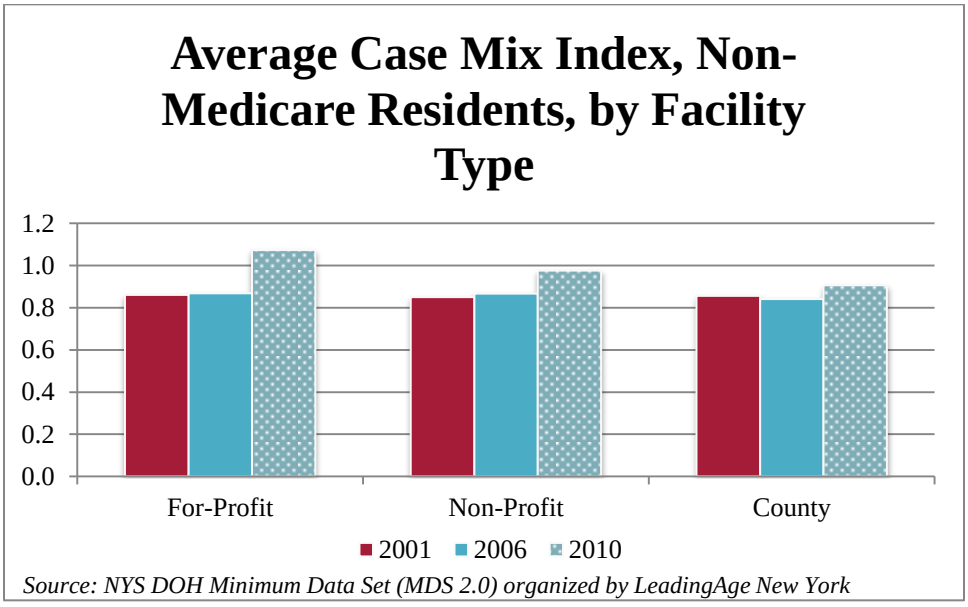
Using the average CMI for non-Medicare residents—the index most instrumental in determining reimbursement levels—this indicator of overall facility resident acuity was significantly lower in 2010 for county nursing homes than was the case in either for-profit or non-profit competitors, as indicated in 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



Source: NYS DOH Minimum Data Set (MDS 2.0) organized by LeadingAge New York

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.

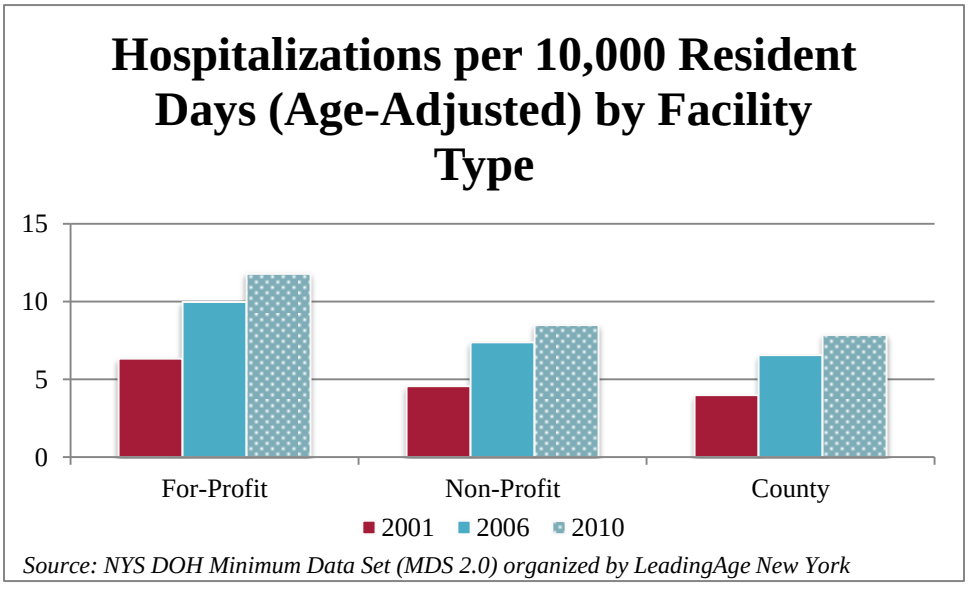
Differential Outcomes and Discharge Patterns

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

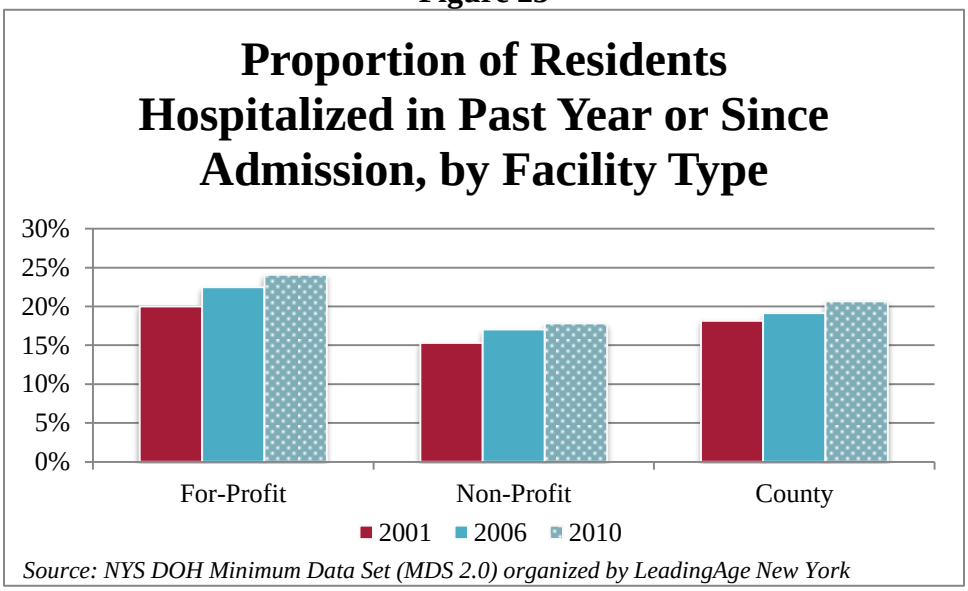


Source: NYS DOH Minimum Data Set (MDS 2.0) organized by LeadingAge New York

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



Source: NYS DOH Minimum Data Set (MDS 2.0) organized by LeadingAge New York

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

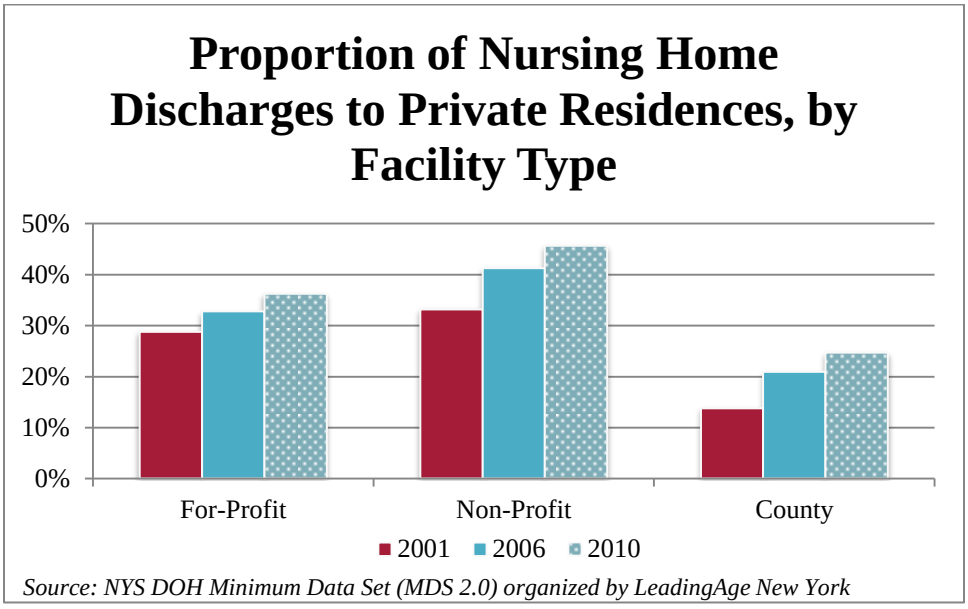
[28] LeadingAge New York, *New York State Nursing Homes: Sponsorship as a Defining Factor in Outcomes*, 2012, p. 21.

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



Source: NYS DOH Minimum Data Set (MDS 2.0) organized by LeadingAge New York

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

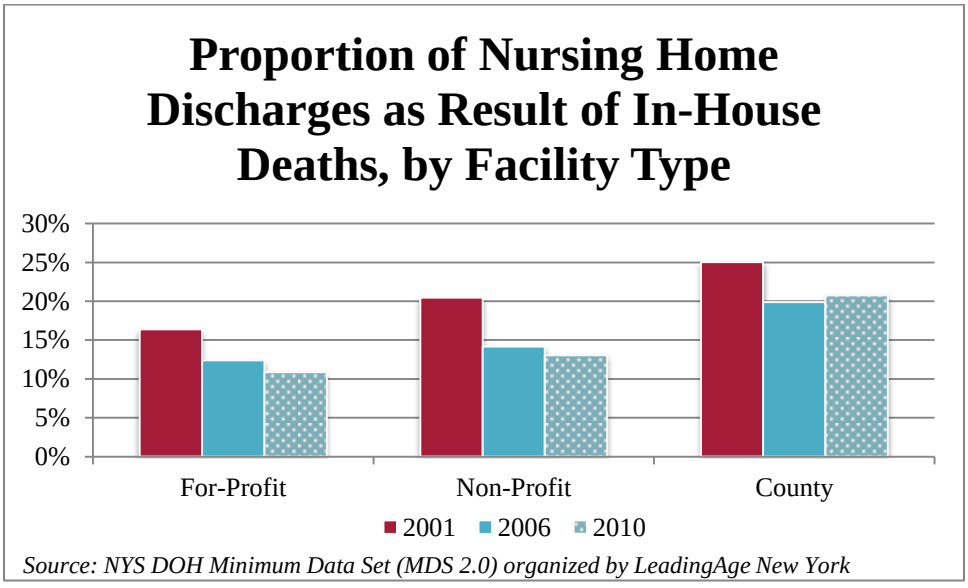
who then return to their homes following short stays in for-profit and non-profit nursing homes, versus county facilities which continue to have higher proportions of long-stay residents who are less likely to be returning to their homes.

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



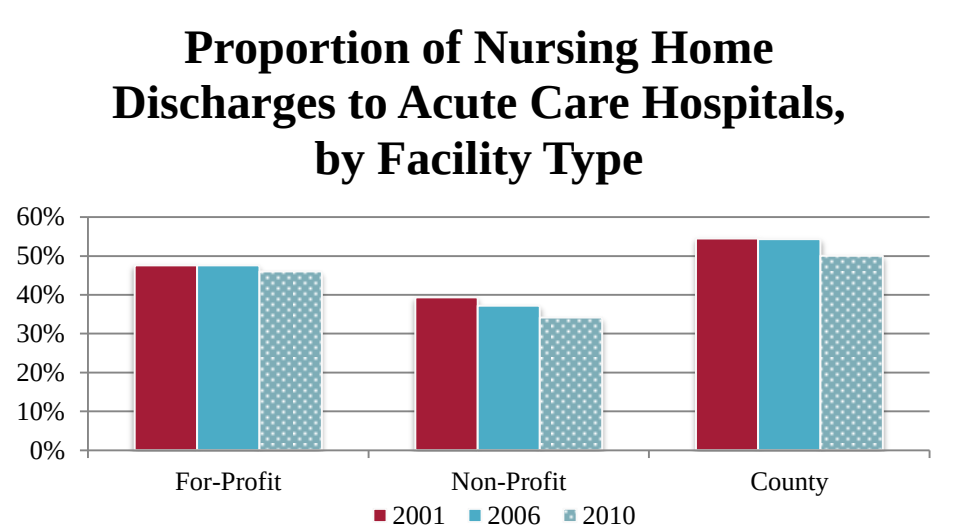
Source: NYS DOH Minimum Data Set (MDS 2.0) organized by LeadingAge New York

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

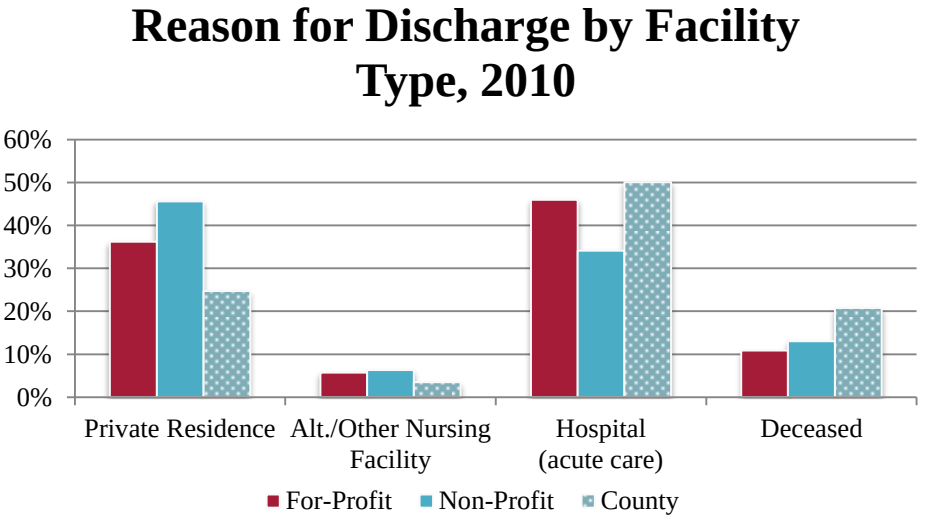


Source: NYS DOH Minimum Data Set (MDS 2.0) organized by LeadingAge New York

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



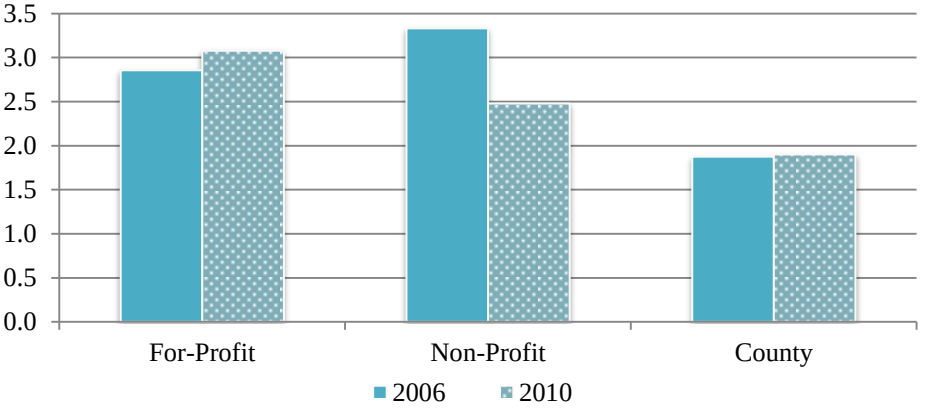
Source: NYS DOH Minimum Data Set (MDS 2.0) organized by LeadingAge New York

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



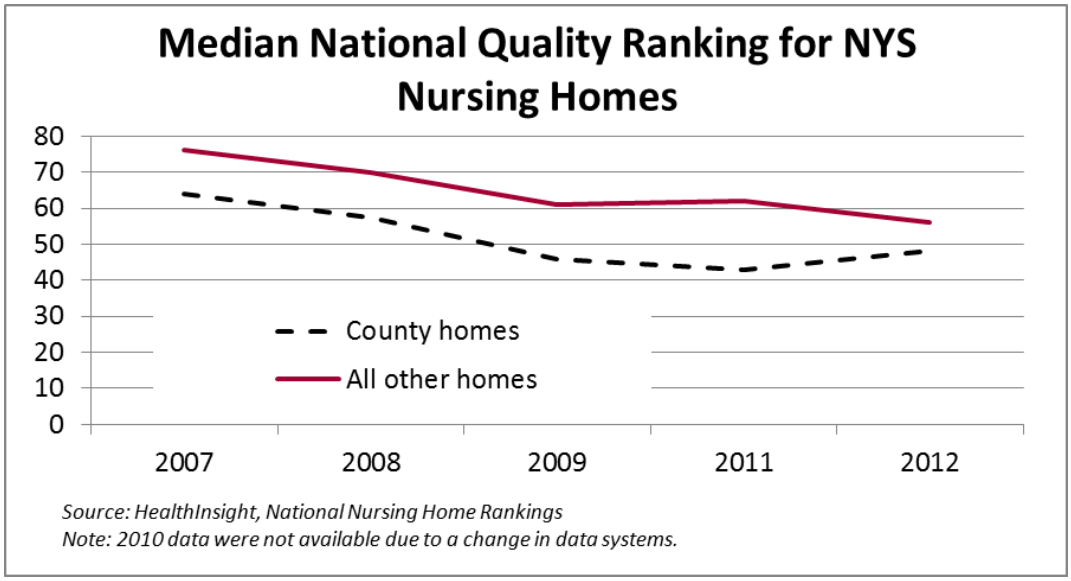
Source: CMS OSCAR Database organized by LeadingAge New York

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



Source: HealthInsight, National Nursing Home Rankings
Note: 2010 data were not available due to a change in data systems.