WHAT SHOULD BE DONE WITH COUNTY NURSING FACILITIES IN NEW YORK STATE?

Prepared for:

County Nursing Facilities of New York, Inc.

Donald E. Pryor
Project Director

Center for Governmental Research Inc.
37 South Washington Street
Rochester, NY 14608
(716) 325-6360

September, 1997

CGR Mission Statement

CGR is an independent, nonprofit research and management consulting organization that serves the public interest. By developing comprehensive perspectives on issues facing communities, CGR distinguishes itself as a unique professional resource empowering government, business and nonprofit leaders to make informed decisions. CGR takes the initiative to integrate facts and professional judgment into practical recommendations that lead to significant public policy action and organizational change.

CGR

WHAT SHOULD BE DONE WITH COUNTY NURSING FACILITIES IN NEW YORK STATE?

September, 1997

Executive Summary

Counties across New York State face the above question with each annual budget. Most of the 44 county-owned and operated nursing facilities lose money each year, and pressure from voters to hold the line on property taxes is stronger than ever. Many counties have considered selling their nursing homes, or other options, to reduce the burden on their taxpayers. Elected officials are asking fundamental questions about the county's role as a service provider: Should the county be in the business of operating a nursing home? If so, how should the county home react to a rapidly changing health care environment and position itself for an uncertain future?

The County Nursing Facilities of New York, Inc. (CNFNY), a statewide association of county homes and an affiliate of the New York State Association of Counties (NYSAC), commissioned the Center for Governmental Research Inc. (CGR) to probe these questions. In *What Should Be Done with County Nursing Facilities in New York State?*, CGR outlines the challenges facing county homes and investigates alternatives various counties have pursued or considered. The report does not recommend or advocate particular solutions for individual homes, but presents the array of options counties might consider for the future of their nursing homes.

The Changing Face of Long Term Care

A number of changes in the funding and delivery of care have profoundly affected the way all nursing homes do business. These changes will continue to compel nursing home administrators and operators to adapt and seek new opportunities. The principal developments affecting county nursing homes today include:

- State and Federal efforts to control Medicaid long-term care costs,
- the impact of managed care on long-term care delivery,

- a growing array of "lower levels" of care, and
- the possibility of publicly-traded corporations operating nursing homes in New York State.

Medicaid is the health care program designed for the poor and indigent, funded primarily by the Federal and State governments. In New York and other states, middle class elderly often rely on Medicaid to pay for the often prohibitive cost of nursing home stays. For this and other reasons, the cost of Medicaid has outpaced inflation for several years, and policy makers are now attempting to contain the costs.

Moreover, New York is one of few states to pass a portion of Medicaid costs to county taxpayers. The State Department of Health, which regulates all nursing homes, has responded to these pressures by adjusting the reimbursement mechanism to control costs and encourage homes to care for more physically infirm patients. These adjustments, many feel, have had a particularly adverse impact on county homes, which have unique costs not shared by their competition in the private sector.

Managed care is one avenue policy makers are using to control health care costs. New York State is continuing to enroll Medicaid recipients in managed care plans, but has yet to enroll long-term care recipients on a widespread basis. In anticipation of this likely occurrence, however, hospitals, nursing homes and other care providers are pursuing alliances and networks in an effort to become the low cost service provider with which the coming managed care organizations will want to contract.

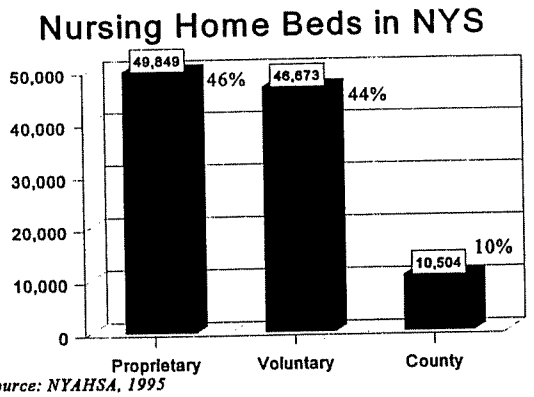
In response to the need for cost containment and to changing demands, a variety of long-term care options are emerging. The elderly today are making more use of options such as home care, adult day care, adult care facilities, assisted living and other models that are less medically intensive than the nursing home. These alternative services represent increased competition and promise to redefine the role of the nursing home in the future.

Currently, New York law prohibits publicly-traded corporations from operating nursing homes in the state. The state's nursing homes have to date been sheltered from competing with large national chains like Beverly and Marriott Host, but this could change. Many expect that NYS lawmakers will eventually pass legislation allowing these companies to operate in New York. Many small operators in the state will be hard pressed to compete with the chains because of their economies of scale. County homes are likely to

be in the poorest competitive position.

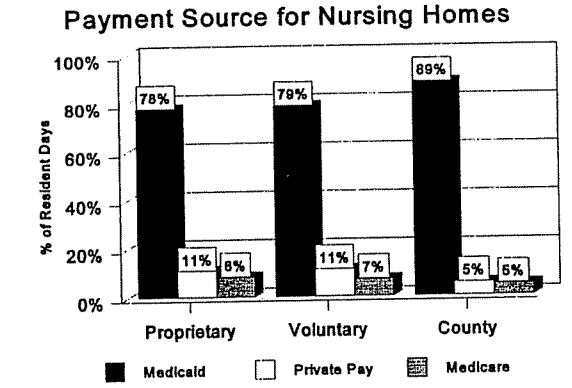
What Makes the County Home Different?

There are three kinds of nursing homes in New York State. Proprietary homes are run as businesses by private individuals or corporations. Voluntary homes are not-for-profit entities, often affiliated with religious organizations, and are run by elected boards. County homes are departments of county government and are ultimately governed by elected representatives. In New York, there are over 600 nursing homes and more than 100,000 beds. About ten percent of these beds are in county homes.



Source: NYAHSA, 1995

traditional mission is to care for poor and indigent elderly county residents regardless of ability to pay. Proprietary and voluntary homes, on the other hand, typically pursue persons with the greatest ability to pay. Nursing homes charge "private pay" residents at a rate higher than the State-determined rate for Medicaid residents. County homes typically do not compete for these private pays as aggressively as private homes do. On the whole, county homes have ten percent more resident days paid by Medicaid than do private homes, and have only half the rate of private pay resident days as do proprietary and voluntary homes.



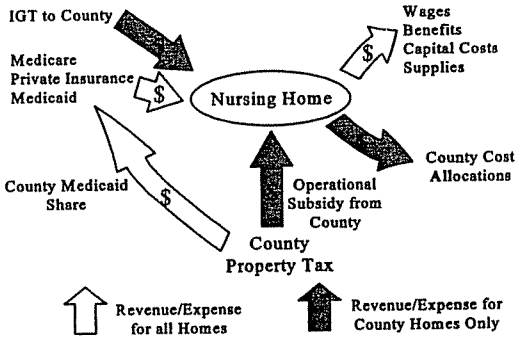
Source: NYAHSA, 1995

Several factors distinguish county homes from proprietary and voluntary homes:

- *County homes have a mission distinct from private sector homes.* Their
- *County homes can have difficulty competing for the Medicaid dollar as well.* Medicaid reimbursement is designed to increase with the intensity of a patient's medical needs, known as

the "case mix index." Many county homes see nearby private homes "cherry picking" residents with high case mix indices (CMIs) while their own beds fill with less reimbursable residents. Some relatively healthy patients have low CMIs but complex behavioral problems. These patients demand increased staff attention but carry no additional reimbursement. Some private homes have refused admission to such patients, who often ultimately end up in the county home. *CGR estimates that the typical county home would receive over $450,000 more in revenues each year if it maintained the same aggregate case mix index as the average private home.*

Nursing Home Revenue and Expenses



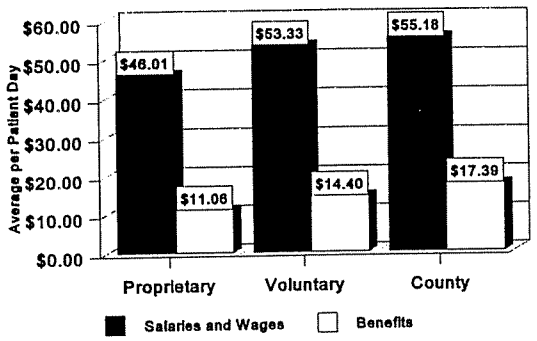
County nursing homes receive certain revenue and incur unique expenses because of their status as government entities. In addition to revenues from Medicaid, Medicare and private pay, which all homes receive, county homes benefit from inter-governmental transfers, or IGTs, from the Federal government. The total local share of IGTs for the 1997-98 State fiscal year will be over $63 million, and 20 counties will each receive over $1 million for their nursing homes. The future of IGTs is, however, uncertain.

Many homes also receive operating subsidies from the county when their expenses exceed their revenues. In 1996, counties contributed an average of more than $600,000 to the operation of their nursing homes.

Unlike proprietary and voluntary homes, county homes receive most administrative and support services from the county government. County departments provide services such as snow plowing and legal advice and charge the cost to the nursing home. While some of these cost allocations are for services a private home would obtain by contracting, many county costs allocated against the nursing home budget bear little relationship to the actual use by the home of the services; as such, they often artificially inflate the true cost of operation. These

county cost allocations are not, in most cases, calculated consistently from year to year within or across counties. CGR estimates that county homes had a total of $27 million in county costs allocated against them in 1996, an average of $627,000 per home.

Salaries and Benefits



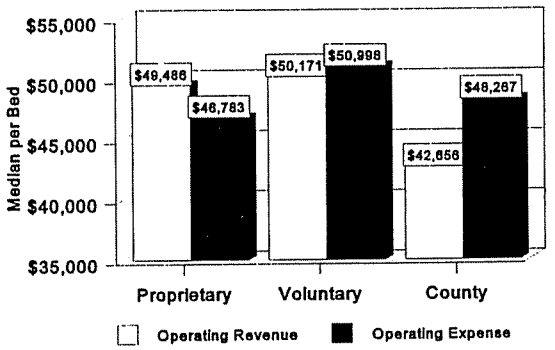
Source: NYAHSA, 1995

- *County nursing home employees are county employees and generally receive more generous wages, salaries and benefits than their counterparts in private homes.* More than 80% of county nursing home employees are represented by unions, compared to about 40% in other homes. Most are represented by the Civil Service Employees Association (CSEA) and are part of countywide bargaining units. The typical county nursing home administrator has almost no input in labor negotiations. By law, county homes must contribute to the State Retirement System on behalf of their employees. Payments range from 10 to 20% of salary and generally exceed pension benefits, where they are offered, in the private sector. The attached graph normalizes wages, salaries and benefits by patient day. With average benefits of 31% of salary, county homes are significantly more generous than proprietary and voluntary homes. Benefits in county homes exceed those in voluntary homes by 21% and proprietary homes by 57%.

- *While each county home has an administrator, policy and management decisions ultimately rest with the county legislature or board of supervisors.* Understandably, these policy makers are sensitive to numerous pressures, and the efficient operation of the nursing home is not always the top priority. For reasons both within and beyond the control of county policy makers, county homes generally spend more than they make each year. In CGR's survey of county nursing home administrators, many indicated that they had less flexibility in management decisions than their peers in private homes, and that they were relatively constrained in what they could do.

Many expressed interest in a variety of alternatives with the potential to make their enterprises more profitable and more able to meet the challenges of a changing health care landscape.

Revenue and Expenses



Source: NYAHSA, 1995

What Can Counties Do?

Counties will have an increasingly difficult time operating their nursing homes as if they were just another department of county government. If the Federal government should one day limit or eliminate IGTs, or if the State or Federal government seeks aggressive reductions in Medicaid reimbursements for long term care, counties will require huge increases in county taxpayer support to keep their homes open. The time to make informed policy decisions is now, before events force rapid and uninformed decisions with far-reaching consequences. Counties are considering a variety of approaches. Some of these may be appropriate for some counties and not others. Each county and its nursing home must examine its own unique situation and plan for its future with the necessary information and careful consideration.

In *What Should Be Done with County Nursing Facilities in New York State?*, CGR details various alternatives a county might choose to take, that follow three broad paths:

- Continue to operate the nursing home essentially as it is, but with individual reforms addressing cost and efficiency issues;
- Continue to operate with additional long-term care services beyond traditional nursing home care in order to be more competitive and cost effective; and/or
- Change the present relationship between the county government and the nursing home.

Each of these broad alternatives contains numerous options, which are not mutually exclusive, although some options call for the county to give up partial or complete control of the operation of the nursing home.

There are various ways counties can respond to the individual factors contributing to their higher costs. Many counties have, in fact,

attempted one or more of the following reforms:

- Counties can allocate funds for their nursing homes to market more aggressively. If the marketing effort results in even a few added private pay admissions, the investment should more than pay for itself.
- Some counties have effectively forged special agreements with labor unions outside of the countywide contract negotiations. Counties could also increase the involvement of their nursing home administrators in contract negotiations.
- While difficult to do, a county could create a separate bargaining unit for its nursing home employees. This would separate the home's interests from larger county issues.

Other options a county might consider are the use of private contractors and consultants for special services, merging with other county departments, and revisiting the cost allocations against the nursing home in an effort to make them more realistic reflections of actual costs.

In February, 1997, *Business Week* ran an article with the provocative title "Farewell to the Nursing Home" and a subtitle that read "a host of alternatives help the aging live independently." Health care providers and elderly customers are fueling the growth of lower levels of care that are generally less expensive than traditional nursing homes. Some counties have added services from a growing list of alternative long-term care models, and others are considering doing the same. These services include assisted living, adult day care, respite care, adult care facilities, early- to mid- stage dementia services, home health care, continuing care networks and continuing care retirement communities. There are both advantages and potential disadvantages to counties offering each of these and other services, which are discussed in greater detail in the report. While CGR does not recommend any specific services for county homes to offer, directly or in partnership, it is clear that their growth will reshape the role of the nursing home along the spectrum of long-term care.

More and more, counties are asking whether they should even be in the nursing home business. Because some, if not most, of the higher costs associated with county homes stem from the fact that they are units of county government, counties are looking into options that limit their role in the operation of the nursing home. Along a continuum ranging from the least limitation of the county's role to complete divestiture of responsibilities, options that counties have considered or tried include:

- *Contract for management services to operate the county home.* Under this option the county would retain ownership of the home, but contract out responsibilities for varying degrees of the day-to-day management of the home.
- *Sell licensed beds.* The county could transfer the license to operate some of its beds to a new operator. While the county would lose control of those beds, it would gain financially from the sale and could convert the sold nursing home beds into lower levels of care while retaining the remaining unsold beds for nursing home care.
- *Convert the home to a public benefit corporation.* The nursing home would become a quasi-governmental entity essentially divorced from the county, though the county could retain some control by appointing some members of the PBC board. Two counties in New York State are attempting to put public benefit corporations in place. This option frees counties from the responsibility of operating the nursing home and, depending on the enabling legislation, preserves civil service protections for employees.
- *Transfer the home to a not-for-profit corporation or sell to a proprietary corporation.* A county could transfer or sell the home to a newly created or already existing not-for-profit corporation or sell the home outright to a proprietary operator. In each of these scenarios, the county is freed from the costs and responsibilities of operating the home, but also loses control. Its ability to help assure a continuation of the home's historic mission will vary by the type of organization to which the home is transferred.

These and other alternatives to the existing relationship between counties and their nursing homes are discussed in greater detail in the report. While giving up ownership of its nursing home may save a county money, the county will also lose the ability to control the home's future and the extent to which the new owner maintains the home's historic mission. Many administrators expressed concern about what would happen to the county's more difficult-to-place patients; many were also concerned with job protection for their staff (an average of 300 employees per county home).

In the report, CGR details the points that county policy makers will need to consider as they grapple with decisions about the county home in a changing environment. The most appropriate options must be determined on a case by case basis, depending on the circumstances unique to each county.

Table of Contents

Executive Summary i

Table of Contents ix

Acknowledgments xvi

I. Introduction 1

II. External Environmental Factors: Why Should County Nursing Facilities Consider Alternatives to the Status Quo? 3

Demographic Changes 3

Taxpayer Costs and Political Concerns 4
- Taxpayer Subsidies to County Nursing Homes 5
- Responses to Taxpayer Concerns 6

Long-Term Care Systems and Service Delivery Trends 7
- Efforts to Control Long-Term Care Costs 7
- Impact of Managed Care on Long-Term Care Delivery 8
- Pushing for Lower Levels of Care 8
- Emphasis on Diversification of Services 9
- Increased Competition Facing Nursing Homes 9
- Expanded Emphasis on Specialized Nursing Home Programs/Units 10
- Changes in Resident Case Mix 11
- Changing Architectural Standards and Expectations 12
- Growing Impact of Publicly-Traded Corporations 12
- Absence of Long-Term Care Policies in State and Counties 13

III. What Distinguishes County Nursing Homes? 15

Revenues and Expenditures: County vs. Private Homes 15

Beds in County Nursing Homes 17

Mission of County Homes 17
Resident Characteristics: Method of Payment 18
Resident Characteristics: Case Mix of People Served by County Homes 19
Services Provided in County Homes 21

Labor 22

Plant and Grounds 23

County Cost Allocations 24

County Subsidies/Contributions to Nursing Homes 25

Intergovernmental Transfers 26

Capital Debts 27

Management 27

IV. SUMMARY: WHY SHOULD COUNTIES AND THEIR NURSING HOMES EVEN CONSIDER CHANGES? 29

V. ALTERNATIVES FOR CONSIDERATION: WHAT COULD BE DONE? 33

"Degree of Change" Continuum of Alternatives 34

Alternative 1. Continuation of the Status Quo 36
Perceived Advantages 37
Potential Concerns/Limitations 38
Potential Value of Option to County 40

Alternative 2. Continuation of County Homes with Various Reforms 41

Consider More Aggressive Marketing of the County Home 42
Perceived Advantages 43
Potential Concerns/Limitations 43
Explore Management Efficiencies and Contracting Arrangements 44
Perceived Advantages 44
Potential Concerns/Limitations 45
Engage Labor Unions in Discussions of Reforms 46
Perceived Advantages 47
Potential Concerns/Limitations 47
Consider Creation of Separate Bargaining Unit 47
Perceived Advantages 48
Potential Concerns/Limitations 48
Consider Implementation of "Eden Alternative" 48
Perceived Advantages 49
Potential Concerns/Limitations 49
Consider Renovation or New Construction 49
Perceived Advantages 50
Potential Concerns/Limitations 51
Consider Merging Nursing Home with Another County Department 51
Perceived Advantages 52
Potential Concerns/Limitations 52
Analyze Impact of Allocation of County Costs Against CNF 53
Perceived Advantages 54
Potential Concerns/Limitations 54
Potential Value of Alternative 2 Options to County 55

Alternative 3. Continuation of County Homes with Additional Long-Term Care Options 55

Non-Regulated Services 59
Perceived Advantages 59
Potential Concerns/Limitations 59
Potential Value of Option to County 60

Regulated Services 60

Social Model Adult Day Care 60
Perceived Advantages 60
Potential Concerns/Limitations 61
Potential Value of Option to County 61
Medical Model Adult Day Care 61
Perceived Advantages 62
Potential Concerns/Limitations 62
Potential Value of Option to County 63
Respite Care Social Model 63
Perceived Advantages 63
Potential Concerns/Limitations 64
Potential Value of Option to County 64
Respite Care Medical Model 64
Perceived Advantages 64
Potential Concerns/Limitations 65
Potential Value of Option to County 65
Enriched Housing (EH) Social Model 65
Perceived Advantages 66
Potential Concerns/Limitations 66
Potential Value of Option to County 66
Adult Care Facility (ACF) Social Model 66
Perceived Advantages 67
Potential Concerns/Limitations 68
Potential Value of Option to County 68
Early to Mid-stage Dementia Social Model 68
Perceived Advantages 69
Potential Concerns/Limitations 69
Potential Value of Option to County 69
Assisted Living Program (ALP) - New York State Defined 69
Perceived Advantages 70
Potential Concerns/Limitations 70
Potential Value of Option to County 70
Assisted Living (as defined in other states) 71
Perceived Advantages 71
Potential Concerns/Limitations 71

Potential Value of Option to County 72
Certified Home Health Agency (CHHA) 72
Perceived Advantages 72
Potential Concerns/Limitations 73
Potential Value of Option to County 73
Licensed Home Care Service Agency (LHCSA) 73
Perceived Advantages 74
Potential Concerns/Limitations 74
Potential Value of Option to County 74
Managed Care and Integrated Systems of Care 74
Program for All-Inclusive Care for the Elderly (PACE) 75
Perceived Advantages 75
Potential Concerns/Limitations 75
Potential Value of Option to County 75
Continuing Care Network (CCN) 76
Perceived Advantages 76
Potential Concerns/Limitations 76
Potential Value of Option to County 76
Continuing Care Retirement Community (CCRC) 77
Perceived Advantages 77
Potential Concerns/Limitations 77
Potential Value of Option to County 78

Subacute Care and Special Care Units 78
Perceived Advantages 79
Potential Concerns/Limitations 79
Potential Value of Option to County 80

Specialized Care of Geriatric Prisoners 80
Perceived Advantages 81
Potential Concerns/Limitations 81
Potential Value of Option to County 81

Alternative 4. Options for Limiting the County's Role in Nursing Homes 81
Management Contracts to Operate Nursing Homes 83

Perceived Advantages 84
Potential Concerns/Limitations 85
Potential Value of Option to County 85
Sale of Some Licensed Beds 86
Perceived Advantages 87
Potential Concerns/Limitations 87
Potential Value of Option to County 88
Establishment of County Public Benefit Corporations 88
Perceived Advantages of Nursing Homes as Public Benefit Corporations 89
Potential Concerns/Limitations 91
Nassau and Westchester Counties 92
Potential Value of Option to County 93
CNFs Become a State Authority 94
Perceived Advantages 94
Potential Concerns/Limitations 95
Potential Value of Option to County 95
Convert County Home to a Free-Standing Not-for-Profit Corporation 96
Perceived Advantages 97
Potential Concerns/Limitations 97
Potential Value of Option to County 100
Convert County Home to Existing Voluntary Corporation 101
Perceived Advantages 102
Potential Concerns/Limitations 103
Potential Value of Option to County 103
Employee Buy-Out (Employee Stock Option Program) 104
Perceived Advantages 104
Potential Concerns/Limitations 104
Potential Value of Option to County 105
Sell County Home to Proprietary Corporation 105
Perceived Advantages 106
Potential Concerns/Limitations 107
Potential Value of Option to County 109
Cease Nursing Home Operations, with No Transfer of Facility 109
Perceived Advantages 110
Potential Concerns/Limitations 110

Potential Value of Option to County 111

A Final Alternative: Long-Term Care Screening/Assessment 112
Perceived Advantages 113
Potential Concerns/Limitations 114
Potential Value of Option to County 114

VI. CONCLUSIONS 115

APPENDIX A: GLOSSARY OF TERMS 120

APPENDIX B: COUNTY HOMES IN OTHER STATES 124
Virginia 124
Illinois 124
Texas 125
Florida 125
Massachusetts 126
New Hampshire 126
Ohio 127
Michigan 128
Maine 128
Pennsylvania 129

APPENDIX C: CGR NURSING HOME ADMINISTRATOR SURVEY RESULTS 131

APPENDIX D: LIST OF COUNTIES/CHAAS 143

Acknowledgments

CGR gratefully acknowledges the leadership and vision of the County Nursing Facilities of New York, Inc. (CNFNY). CNFNY understood the need for this study, conceptualized it, and made it happen. Even though its members clearly have a vested interest in the outcome of the study, the organization from the beginning sought an objective assessment of the environment within which county nursing homes operate and of the options available to them and their counties, and its members at no time attempted to bias or influence either our approach to the study or our reported findings.

We are particularly appreciative of the guidance and support we received throughout the study from CNFNY's executive committee, which acted as the steering committee for the project. They and CNFNY's executive director were instrumental in orchestrating various aspects of the study, helping make arrangements for regional meetings, facilitating survey responses, offering constructive critiques of drafts of our report, and clarifying issues. They were unfailingly professional, friendly, cooperative, insightful and pleasant to work with. Our thanks and gratitude to Executive Director Katy Connolly, CNFNY Intern Tina Caballero, and CNFNY President Richard Maloney and Executive Committee members Bill Holt, Susan Keener, Joseph Manning and Jack Pease.

We are also appreciative of the New York Association of Homes and Services for the Aging (NYAHSA) for their cooperation during the study, and in particular for sharing with us their extensive database of nursing homes throughout the state.

Finally, our appreciation for the county nursing home administrators and their staff who took the time to talk with us and to complete the detailed survey that was an integral component of our data-gathering approach, and to the experts in New York and states throughout the country who graciously gave us their time, insights and suggestions. All of these inputs helped to shape and improve this report.

Staff Team

The Project Director's name is on the cover page of this report. However, this was clearly a team effort in which equal or greater contributions to the outcome of the study were made by David Bond and Jetson McCleary, each of whom did much of the research and shared in the writing of this document. Thanks also to Peter Young, Patty Malgieri, and Marty Croop for their significant contributions at key points in the project.

I. INTRODUCTION

Publicly-funded nursing homes (also known as nursing facilities or residential health care facilities) exist in 43 of New York's 62 counties. Excluding five public nursing homes which exist in three of New York City's five counties, the rest of the state contains 44 county nursing facilities (CNFs) in 40 counties. Together, these counties own and operate more than 10,000 nursing home beds in those facilities. This study focuses on those non-New York City facilities and their future.

The future viability of these 44 county-operated nursing facilities is increasingly in question. Although typically considered valuable assets in their respective counties, many of the facilities face threats to their future. Some face possible reductions in financial support from local taxpayers, while others face the possibility that their county government will decide to get out of the nursing home business. The current Resource Utilization Groups (RUGs) reimbursement system is perceived by many as having particularly adverse financial implications for county facilities, compared to voluntary (not-for-profit) and proprietary nursing homes. It is becoming increasingly difficult for county nursing facilities to compete with their proprietary and voluntary peers with a "business as usual" approach, given that county homes must contend with:

- their historical mission to serve anyone eligible for nursing home care, regardless of financial circumstances;
- fundamental changes in the economic and long-term care environment facing nursing homes in general and county facilities in particular; and
- the range of statutory mandates and circumstances peculiar to the public sector.

Public nursing facilities are often referred to as the long-term care "facilities of last resort." Historically, as part of county government's mission, these facilities have typically provided care for higher proportions of indigent elderly and disabled residents, and other persons considered "hard to place" for various reasons, than their proprietary or voluntary competitors. The costs of serving such persons have often exceeded the level of reimbursement available to pay for the services. The statutory mandates and decisions made by public sector officials over the years have driven up the costs of operating public facilities so that they are higher, on average, than comparable costs of their voluntary and proprietary counterparts.

As county nursing facilities face these daunting realities and face a future of growing numbers of elderly people--with the corresponding prospect of needing to increase tax revenue support to maintain fiscal solvency--county policymakers and nursing home administrators have increasingly been forced to explore various alternatives to current and historical ways of doing business. In this context, the County Nursing Facilities of New York, Inc. (CNFNY) issued a request for proposals seeking an objective analysis (1) of county nursing facilities and the circumstances under which they operate, and (2) of various options for counties and their nursing homes to consider as they face the future in the context of a rapidly-changing health and long-term care environment. The Center for Governmental Research Inc. (CGR) was selected to undertake the study. This report presents our findings.

The findings and conclusions are based on CGR's reviews of long-term care and nursing home practices and experiences around the country, as identified by literature reviews and extensive interviews with and surveys of officials of nursing homes and associations of homes throughout the United States. In addition to interviews with knowledgeable officials and experts in many states in all geographic sectors of the country, within New York we conducted an extensive survey of all county nursing facilities in the state, receiving completed surveys from all but two of the 44 county homes outside New York City. Survey results were supplemented by analysis of a comprehensive database of all nursing homes in the state, generously provided by the New York Association of Homes and Services for the Aging (NYAHSA). In addition, CGR, in conjunction with CNFNY, held three regional focus groups with administrators of more than 25 county nursing homes throughout the state, and conducted followup discussions by telephone with many administrators. We also spoke with other experts on long-term care in the Health Department, Department of Social Services, Health Services Agencies and other appropriate organizations at both the state and county levels.

This report summarizes what we learned and includes the following chapters: Chapter II discusses the environmental context that compels counties to consider alternatives to the county nursing home status quo; Chapter III profiles county nursing homes and discusses what distinguishes them from their competitors; Chapter IV summarizes reasons why counties are at a point where they must consciously and carefully consider the future of their nursing facilities; Chapter V delineates various alternatives and what could be done differently by nursing homes in the future; and concluding Chapter VI summarizes the types of circumstances under which counties should consider opting for various alternatives. (Survey findings are referenced throughout the report where appropriate and are summarized in more detail in the Appendix.)

II. External Environmental Factors: Why Should County Nursing Facilities Consider Alternatives to the Status Quo?

A number of social factors, coupled with a number of existing and emerging trends in ways in which health care and long term care are provided and funded nationally and in New York State, set the context for the discussion which follows throughout this report, and underscore why this study was initiated in the first place. These factors and trends are typically beyond the ability of nursing home administrators to control, but very much help control and shape the environment within which the county nursing facilities operate--and influence how county governmental policymakers are likely to think about their future.

Demographic Changes

Various projections indicate that the population of seniors 65 and older is likely to increase by more than 50% nationally over the next 25 years, from about 33.5 million in 1995 to more than 50 million people in 2020. The number of relatively "young elderly" (those 65-74) is actually expected to remain relatively constant for the next 15 years, followed by a rapid increase of more than 30% in New York between 2010 and 2020, as the "baby boomers" reach retirement age.

Not only are the numbers of older people growing dramatically, but they are also living longer. Thus, the number of persons 85 and older (those who are most likely to be housed in a nursing home) is expected to increase by more than 75% between now and 2020, to a projected 6.5 million people nationally. The 85 and older population has been the most rapidly-growing segment of the overall population in New York over the past two or three decades. Although that rate of growth is expected to decline in future years and to be less pronounced in New York than nationally, by 2020 there will be almost 100,000 more New York residents 85 and older than in 1995 (a projected 34% increase, to a total of about 370,000 persons 85+). This sustained growth in the number of older New Yorkers is likely to result in an unprecedented demand in future years for a wide range of services across all aspects of the long-term care system.

Those who will reach the age of 85 during the next 10 years typically entered the work force about the time of, or just following, the creation of the Social Security system, and were

the first generation to have widespread access to health insurance offered by employers. Thus this is an older generation with more financial resources than previous generations. This is even more true of those who will reach the age of 65 at some point over the next decade. The latter generation is, on the average, even wealthier, with less poverty and more assets, and is better educated than their parents' generation.

These growing numbers of older people are generally in better health than previous generations, and many have lifestyles, financial resources and personal expectations that will not only make possible, but also place increasing emphasis on, continuing to live in their own homes or other community, non-institutional settings for as long as possible. The average age of those residing in nursing homes is thus likely to continue to edge higher, as people enter at older ages, and as a result are less likely than in the past to be in good health and physical condition by the time they enter a home.

As the older population increases and places more of a burden on the resources of long-term care providers, large numbers of the children of the elderly will also be affected--some themselves in or nearing old age, and some part of the "sandwich generation" caught between caring for their parents and their own children. These growing numbers of children of the elderly will have their own needs for a variety of support services such as respite care and help in making decisions about the most appropriate level of care for their parents.

Taxpayer Costs and Political Concerns

As indicated, the growth in the numbers and life expectancy of older people is likely to fuel a dramatic growth both in future demand for and costs of long-term care services at both the nursing home level and at various lower levels of care, as described in more detail later in the report. Although much of this increasing demand is likely to be for services paid for by individuals' private resources and/or private insurance, much of the demand will place increasing burdens on the public sector and taxpayers.

Long-term care is the fastest-growing portion of Medicaid. Although the elderly and disabled account for only 27% of Medicaid beneficiaries nationally, they account for 68% of all Medicaid expenditures, according to the Urban Institute. And New York spends far more per person on long-term care than does the rest of the country, as emphasized in *Medicaid Cost Containment: Options for New York* (CGR and NYSAC, 1995) and in *Securing New York's*

Future: Reform of the Long-Term Care Financing System (Task Force on Long-Term Care Financing, 1996). The largest component of long-term care service costs is nursing facilities, and Medicaid spending per nursing home resident in New York, about $35,000 annually, is double the national average. According to NYAHSA, about 80% of all nursing home revenues in New York come from Medicaid, compared to about 50% nationally.

As nursing home and overall long-term care costs have increased over time, so have the specific costs to New York residents. Medicaid long-term care spending in New York almost tripled in the 10 years between 1983 and 1993, to almost $6 billion a year. According to survey data supplied by New York's county nursing facilities for this study, ***more than a half billion dollars were spent in 1996 to operate the 44 county-owned nursing homes outside New York City. Collectively, it is a big business.*** Of the 40 homes which reported annual operating "profits and losses" (not including county tax support or subsidies), an average of 22 homes each year reported losses between 1994 and 1996. The others reported either breaking even or showing a "profit" for the year. This represents an improvement from 1993, when 30 of the 40 reporting homes showed losses.

Taxpayer Subsidies to County Nursing Homes

The 40 county facilities which reported financial data in our survey indicated that a total of ***more than $90 million in local taxpayer subsidies was required in the three fiscal years between 1994 and 1996 in order to offset those nursing home "losses"*** (the excesses of expenditures over revenues received from such sources as Medicaid, Medicare, and private insurance). ***In 1996, this represented an average of almost $610,000 in county taxpayer subsidy per home*** *(down from an average of more than $800,000 in each of the two preceding years).* Nine of the 40 facilities were each subsidized/supported by more than a million dollars in local taxes in 1996. These figures do not include some additional unspecified draws against enterprise fund balances by some of the nursing facilities.

Moreover, the level of county support is over and above the roughly $35 million in additional intergovernmental transfer (IGT) funds received by the counties for 1995/96 and 1996/97. Even with the IGT payments, ***each year more than 2/3 of the county facilities draw upon county tax support (more if draws against fund balances are included).*** On the other hand, not counting the fund balance draws, an average of about 12 county facilities each of the last three years operated without need for a county subsidy--up from seven in 1993. *Eight homes*

reported no county subsidies for any of the last three years, including six which reported no county support for at least four years, and other facilities had a mixture of years when subsidies were and were not required.

As extensive as county taxpayer financial support for county nursing facilities has been in most counties, it is clear that it would need to have been even more extensive had it not been for the substantial infusion of IGT funds in the past two years. If this source of funds should disappear or be significantly reduced in future years, either the "hit" on local taxpayers will increase substantially, or added pressures will likely be placed on local officials to make other changes affecting the county nursing homes (see the next chapter for further discussion of this issue).

Responses to Taxpayer Concerns

In response to these costs to taxpayers, each level of government has attempted in various ways to control long-term care costs and revenues. For example, NYSAC and CNFNY have repeatedly raised concerns challenging New York's RUGs methodology and its perceived disproportionate adverse financial impact on county nursing homes. Other efforts have been discussed, and in some cases implemented, to control the growth of expenditures by restricting eligibility, emphasizing lower levels of care at reduced costs, maximizing reimbursements from private pay sources and Medicare (with no local share of costs), capping allowable costs, promoting managed care, limiting asset transfer limits, and so on.

Such efforts notwithstanding, taxpayer concerns continue. While the vast majority of county nursing facility administrators characterized their county officials as being generally supportive of the nursing homes and their roles in their respective counties, often that support was qualified and made contingent upon the future financial circumstances of the home. Many administrators indicated that there were maximum levels of subsidies that they thought their counties would be willing to tolerate in order to continue county operation of the nursing homes. The specific suspected maximum subsidy level varied considerably from facility to facility, and was often rather generous. Some administrators indicated that their counties might be willing to subsidize at a higher level than in the past under certain circumstances, although most suggested a maximum level of support reflecting some similarity to the historical pattern of county subsidies for their home. A few indicated that they expected pressures to bring down the

subsidy levels in the near future, and some which have not needed county subsidies in the past said that any change in that pattern could raise serious questions about the future of the home.

Overall, whatever the level of county financial support that would be tolerated in the future, it is clear in the majority of facilities that the administrators understand that there are limits on that support, even if those limits have not always been explicitly stated or tested in the past. Even administrators of most of the facilities where there has been strong historical county support for the home's mission tempered their positive statements with the reality that taxpayer concerns were an issue never far from the surface, and that alternatives to current operations were either already being considered or would be actively considered if financial considerations became more of a concern for the home in the future.

Long-Term Care Systems and Service Delivery Trends

A number of changes are occurring in the ways in which health and long-term care services are being provided and funded, new models of care are emerging, and demands are increasing for different types of services that enable older persons and persons with disabilities to remain in independent, community-based settings for longer periods of time. These trends and new directions have significant implications for the future of county nursing homes. They are summarized in no particular order below. Some of the new directions outlined here also suggest changes that may need to be considered by counties in the future, and as such are also subsequently described and analyzed in greater detail in the discussion of alternatives in Chapter V.

Efforts to Control Long-Term Care Costs

At both state and federal levels, policymakers are adamant about the need to reduce the upward spiral of Medicaid and Medicare long-term care costs. How this will be done, and with what degree of success, remains to be determined. However, the proliferation of Medicaid IGT funds notwithstanding, it is possible that the level of Medicaid/Medicare funding for county facilities, including the IGT funds themselves, could be reduced at any time in the future, with currently-unknown implications for not only the nursing homes but also other components of the long-term care service delivery system.

Impact of Managed Care on Long-Term Care Delivery

The growth in health care costs in recent years has led to increases in managed care programs and enrollment throughout New York and the nation, including managed care plans for Medicaid recipients. However, despite the fact that managed care programs were devised to help create cost savings, the most costly Medicaid populations in New York, including those needing long-term care services, have not to date been included among the state's Medicaid managed care programs. There are two initiatives in the state which offer limited managed long-term care--a social health maintenance organization (SHMO) for Medicare-eligible persons in Brooklyn, and two PACE (Program of All-inclusive Care for the Elderly) demonstration projects focusing on nursing-home-certifiable, dually eligible persons 55 and older in the Bronx and Rochester. However, both of these programs are limited in scope. Otherwise, New York's Medicaid managed care program does not currently focus on enrollment options for persons eligible for nursing home placements, for those using extensive long-term home health care services, or those dually eligible for Medicare and Medicaid benefits.

Despite the fact that New York lags behind many other large states in implementing managed long-term care, the extent to which aspects of managed care have already occurred--and the anticipation of its ultimate more widespread implementation--have already had a substantial impact around the state. Hospitals are aligning with each other and with other organizations and, as noted by NYAHSA, "Many long term care providers are forming alliances, both horizontally and vertically, with other health care providers in an effort to mitigate the loss of market share that could be created in a managed care environment" (NYAHSA, *"The Future of Managed Care"*). Such systems are all trying to control costs by offering services in ways that meet the managed care requirements for providing the most appropriate level of care in the most cost effective manner. The emergence of managed care has clear implications for nursing homes as they consider ways in which to position themselves to operate most cost effectively in the future.

Pushing for Lower Levels of Care

Partly as a result of the impact of managed care and related cost containment strategies--and partly in response to increased wishes and expectations of older persons (and expanded personal financial resources to make it feasible in many cases)--more and more seniors seeking long-term care arrangements are opting in the "younger elderly" years in particular for more

community-based living arrangements, rather than entering nursing homes. For the most part, such alternatives not only are more desirable from the consumer's perspective, but are also less expensive. Many also are primarily paid for by resources other than Medicaid, such as Medicare and/or private pay (personal out-of-pocket payments or third party insurance), and thus represent less of a drain on county taxpayers.

Emphasis on Diversification of Services

As increased emphasis is placed on lower levels of care to supplement nursing home use, there is more pressure on nursing homes to diversify their services. As described in more detail in the next section on the impact of increased competition, there are a number of ways in which services can be diversified, but the key is for nursing homes to realize that with the environment in which they operate changing, ***it may not be enough in the future to offer only traditional nursing home services and survive.*** It may become increasingly important for homes to offer directly, or at least have access to partners who offer, "one-stop shopping" access to a full continuum of long-term care services, at least some of which may be paid to a great extent by private pay resources.

Increased Competition Facing Nursing Homes

County nursing homes are increasingly facing, on a variety of fronts, competition to their traditional services. For example, many believe that the state has too many nursing home beds at this time, and that the system is "overbuilt" (although most CNFs remain at high levels of occupancy, based on reported 1994-1996 occupancy rates). Hence, there is a moratorium on new nursing home beds unless they offer specialized services. Others believe that even if there are too many beds at this time, it is a temporary situation, and that the beds will be needed in the not-too-distant future as the 85+ population continues to grow. Either way, many nursing homes are competing more aggressively with each other, scrambling in this more competitive environment to develop specialized programs and to establish niches to attract potential residents. In some cases, nursing homes are forced to compete with hospitals which are attempting to fill beds by developing various services, such as subacute or rehabilitation units, to attract persons who might otherwise enter a similar short-term unit in a nursing home.

At the other end of the continuum, nursing homes are competing with a broad array of community-based services. Nursing homes continue to be what most people think about when

they contemplate long-term care, and certainly nursing homes will continue to play an integra role in filling out a continuum of long-term care (especially at older ages, as noted above) Nonetheless, increasingly, emphasis is placed on such options as adult day care (both medical and social models), home care, and respite care for people wishing to remain at home while receiving support services. In addition, a variety of supportive or congregate housing options are available, including adult care facilities, assisted living, enriched housing, elderly apartments, ECHO housing (Elder Cottage Housing Opportunities), home-sharing and cooperative living.

All of these options offer the potential to be seen as threats, or competition for nursing homes, but they also offer *opportunities* for nursing homes to develop new services through various types of partnerships. Partnering could occur through integrated "vertical" continuum-of-care systems under one overall ownership or through affiliations, or through more informal "horizontal" partnerships or networks/affiliations in which cooperating provider organizations make referrals to each other and provide other complementary services as needed. Some of the options offer the opportunity for nursing facilities to actually convert existing traditional nursing home beds into other uses with different staffing and reimbursement patterns, as will be discussed in more detail in Chapter V.

Key assumptions underlying the pressures to diversify and to respond more aggressively to competition are that lower levels of care are increasingly likely to be demanded by both funders and consumers; that many of those alternative services can be provided at less cost than traditional nursing home services (and can often be reimbursed through private pay resources rather than public tax dollars); and that involvement with lower levels of care can help a nursing home establish relationships with consumers that will increase the likelihood that they will seek out the nursing home when ready and in need of that level of care.

Expanded Emphasis on Specialized Nursing Home Programs/Units

More and more nursing homes are emphasizing the creation of specialized programs and units within their facilities--often called special care units, or SCUs. Such units may include beds set aside for some combination of short-term subacute or rehabilitation care, rehabilitation units for stroke or neurological impairments, early dementia and/or Alzheimer's disease units, hospice care, respite care, HIV/AIDS, and the like. As hospitals are under pressure to release their patients from acute care ever more rapidly, and to provide more care on an outpatient basis, there are increasing opportunities in some communities for nursing homes to assume

responsibility for accepting subacute, post-acute discharges from the hospitals for particular types of care. Again, these changes in the long-term care and health care environment offer opportunities for nursing homes to think strategically about what future roles they wish to play to best meet needs in their respective communities. Some of these alternative specialized bed uses also have the added potential advantage of enabling the facility to maximize Medicare reimbursement, which pays for short-term rehabilitation and convalescent care and does not have a county payment component, thereby helping to create high bed occupancy while at the same time limiting the financial liability to county taxpayers.

Changes in Resident Case Mix

Changes in Federal and State regulations as part of the 1990 Omnibus Budget Reconciliation Act (OBRA) mandated the elimination from nursing homes of Health Related Facility (HRF) beds (representing lower levels of care similar to persons with low case mix scores), leaving nursing homes ostensibly strictly limited to higher-level Nursing Facilities (NFs) --also called Residential Health Care Facilities (RHCFs). Previously, most nursing homes had a mixture of NF and HRF beds, but under the new regulations they were required to retrofit or physically modify their facilities to remove the HRF-level beds. Some homes have been able to obtain approval to convert all beds to NF status, while others have needed to adjust service plans to remain competitive. In such cases, this has meant retaining more of the lighter-care patients who are technically no longer eligible for admissions to a nursing facility, but who have been allowed to remain in these NFs, as there have been no financial incentives for the State government to enforce full compliance with the OBRA legislation. Thus to a great extent the pre-OBRA case mix status quo remains in effect in many nursing homes.

Because of changes in the RUGs reimbursement formula, persons with relatively high case mix index (CMI) scores, i.e., those who are sicker and/or with higher service needs, who were often seen as undesirable under the previous formula, are now considered more desirable because they are reimbursed at a higher rate. Conversely, many persons with lower CMI scores are now viewed as less desirable by many nursing homes, given the fact that they receive lower levels of reimbursement and often have various behavioral problems which do not affect their score or reimbursement, but which require additional staff attention. Voluntary and proprietary nursing homes are believed to attempt, to the extent possible, to minimize the number of such low-CMI admissions, leaving higher proportions of such "less desirable" placements to the county facilities, thereby lowering a county home's overall case mix scores and contributing to

lower reimbursement levels than would occur under higher case mix scores. The extent to which competitors of county nursing homes are willing to take a broad range of "harder to place" admissions--and the extent to which county facilities are willing and able to aggressively compete for the more "reimbursably desirable" residents--can have a significant impact on how the county facility is perceived (and perceives itself) and ultimately on the extent to which it needs to rely on county taxpayers to compensate for any shortfalls in other forms of revenues.

Changing Architectural Standards and Expectations

A potential threat to county nursing facilities can be presented if those facilities are not maintained and upgraded, both in terms of modern and attractive buildings and modern equipment. Older facilities which have not been renovated are less likely to remain competitive as competitors build new facilities or renovate older ones with more amenities and more attractive living space. Many voluntary and proprietary nursing homes have undertaken substantial building or modernization programs, often leaving public facilities which have not kept pace in a less competitive position for the future.

Also, in terms of impressions people have of county nursing facilities, some have suggested that a facility name change can help convey a more positive image of the home, e.g., from County X Nursing Home to something more like the Continuing Care Center or other name that minimizes the county government role and any negative feelings that might exist around the concept of a nursing home.

Growing Impact of Publicly-Traded Corporations

A relatively new competitive force in New York is the entrance of out-of-state publicly-traded corporations (for-profit corporations typically involved in providing assisted living services). Although New York State government has yet to approve their operating in the state as part of the state's assisted living program, some have formed limited liability partnerships with existing developers and operators and have begun unofficially to function in the state, such as by purchasing adult care facilities. Such partnerships place limits on the extent of financial liability of any of the partners. These providers have significant resources, large systems with proven economies of scale, and the desire to grow. They are particularly desirous of claiming the private pay segment of the assisted living, adult care facility and/or early-to-mid-stage

dementia markets, and as such represent a significant threat to nursing homes also attempting to carve out such niches in their portfolio of services.

On the other hand, the arrival of publicly-traded corporations may be viewed as an opportunity by some nursing homes. The corporations will need to seek linkages for some of their care plans, including linkages with nursing home beds, so both the corporations and nursing homes may under some circumstances find mutual benefits to creating partnerships in which each is able to complement or enhance services they wish to emphasize by diversifying along the continuum of care.

If publicly-traded corporations are ultimately legally admitted to the state and become a viable presence, as could happen within the next two or three years (the State Senate previously passed a bill to authorize their presence, but the Assembly is thus far not supportive and the Senate did not repeat passage of the bill in the last legislative session), counties may be confronted by requests by the corporations to transfer some or all of their nursing home beds to the corporations. County nursing home beds could either be transferred through the sale of the entire physical assets--the building, beds and license--or by sale of the medical asset (license) alone. In the latter option, the buyer would be able in effect to relocate the purchased licensed nursing facility beds to a different location, but the seller (county) would retain the building and the ability to reconfigure the previous nursing home beds at the original location into a different use at a lower level of care, with proceeds from the sale available to pay for the transition. Although described here as part of the environmental context likely to influence what happens to county nursing facilities in the future, this issue is also discussed further in Chapter V under alternatives for counties to consider.

Absence of Long-Term Care Policies in State and Counties

The State Task Force on Long-Term Care Financing, in its 1996 report *Securing New York's Future: Reform of the Long-Term Care Financing System,* expressed its frustration with the lack of long-term care service options in the state and noted that "the current system is the result of the lack of a coordinated long-term care policy" at the state level. It went on to note that "the type and amount of long-term care provided in New York State has relied on the availability of public financing, especially Medicaid." The Task Force concluded that dollars alone, rather than any rational policy, have historically shaped long-term care provision in the state. With perhaps a few exceptions, similar comments can also be made about counties

throughout the state: ***very few counties have clear long-term care policies for the provision of services for their older and disabled residents.***

Thus county nursing homes tend to operate in a vacuum, with decisions about their status and future typically focused on broadly-stated missions and the financial "bottom line." Rarely does there appear to be explicit reference to how what happens in the county nursing facility should affect or be affected by--or coordinated with--such other county functions as, for example, DSS funding of personal care aides or an adult care facility, Health Department home health or Long-Term Home Health Care Programs, or the county's 10% share of Medicaid funding of non-county-operated (voluntary or proprietary) nursing homes. ***Decisions are typically made about county nursing homes without putting those decisions in the context of what other long-term care services exist or might make sense, and how resources should be allocated to assure that the most appropriate levels of care are being provided.*** Furthermore, in most counties, individuals and families make decisions about nursing home or other long-term care options with little or no overall discussion with anyone concerning "big picture" issues of most appropriate levels of care under certain circumstances, the relative costs of such care, and the resulting options that might make most sense, both short-term and long-term, for the individual and family. Some counties have mechanisms in place to offer such information and advice, though none are binding.

The net effect is that even those who are conscientious and want to make either smart policy decisions or smart individual decisions about county nursing homes and overall levels of long-term care typically must do so without the guidance of either a statewide or county policy perspective on long-term care, or the guidance of an objective set of guidelines concerning what level of care may be most appropriate for persons with particular characteristics, and the range of options that are available within the various levels of care. ***The absence in most counties of such guiding long-term care policies or principles is perhaps the most significant environmental factor limiting the ability to make sound future decisions about county nursing facilities.*** Without some such framework, the decisions that will need to be made about the future of each county nursing facility are far too likely to be made on an ad hoc basis, without adequate consideration of the county's overall needs and the combination of solutions with the best probability of meeting those needs.

III. What Distinguishes County Nursing Homes?

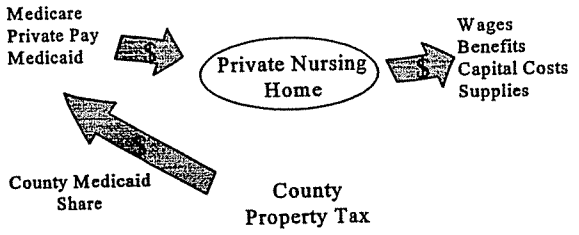
There are three kinds of nursing homes in New York State: proprietary, voluntary and governmental/public. Proprietary homes are run as businesses by private individuals or corporations. Unlike other states, New York currently prevents publicly-traded out-of-state corporations from owning and operating nursing homes within its borders. Thus the large chains, such as Beverly and Marriott Host, do not operate nursing homes here, although legislation to permit this has been proposed (but has not been passed by the legislature). Voluntary homes are not-for-profit entities and are often affiliated with churches or religious organizations. Governmental or county homes are units of county government.

The principal structural difference between county homes and others involves the governance structure. A typical proprietary home does not have a board and functions as a commercial enterprise. A typical voluntary home has an elected board of directors. The oversight of the county home, however, is provided by the county legislature or board of supervisors. These elected bodies vary in their experience and interests concerning health and long-term care and must of course deal with a wide range of priorities beyond just the nursing home. Other significant distinguishing features of county homes are summarized below:

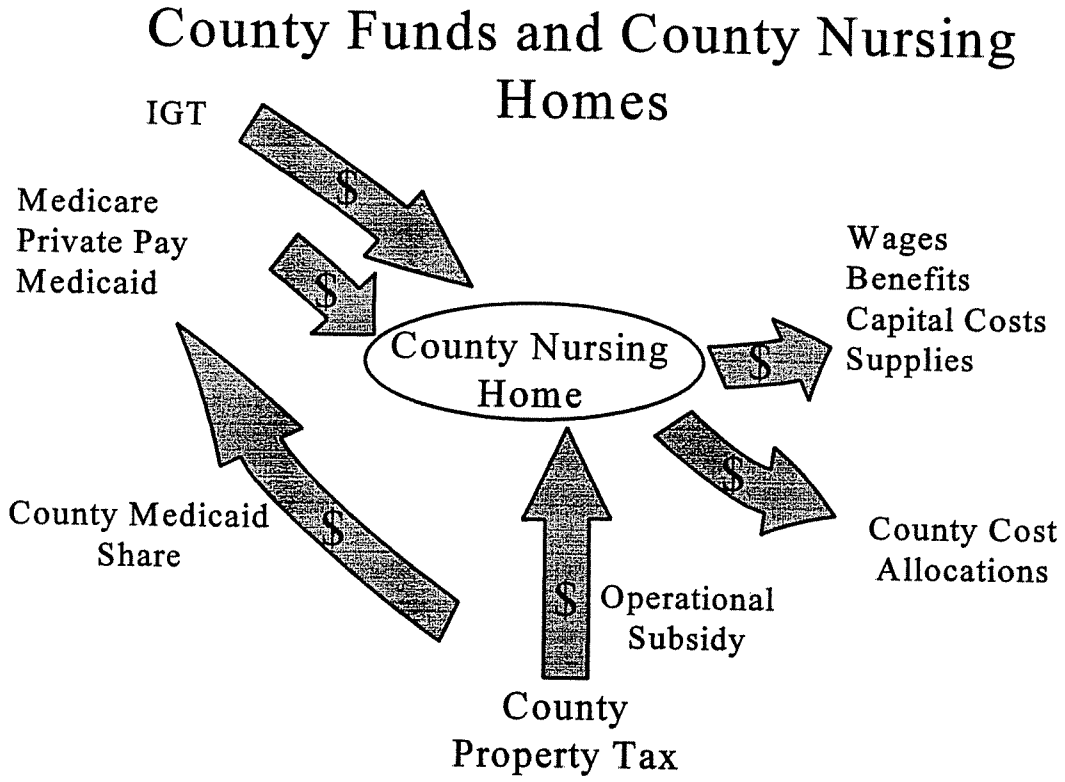
Revenues and Expenditures: County vs. Private Homes

The county helps fund the operation of *private* (voluntary and proprietary) nursing homes within its borders through county government's 10% contribution to the Medicaid share of nursing home revenues. Such funds come to the nursing home through the Medicaid reimbursement system (90% of which are paid by the New York State and Federal governments). The private nursing home receives its other revenue primarily from Medicare and private payments from residents and their third-party insurance payments. The major expenditures of the private nursing home include wages, benefits, capital costs and supplies.

County Funds and Private Nursing Homes



The revenue and expenditures of a *county-owned* nursing home are different in some important ways. As with the private nursing homes, county taxpayers pay for part of the cost of Medicaid. County homes also draw revenue from Medicare and private pay, and have major expenditures for wages, benefits, capital costs and supplies. But unlike private facilities, the county nursing facility (CNF) also receives revenue from intergovernmental transfers, or IGTs, from the federal government. County homes must also make up for any revenue shortfalls from the county property tax base in the form of direct operational subsidies (or draws from the nursing home's enterprise fund balance). As indicated in Chapter II, *all but eight county homes received county subsidies in at least one of the past three years.*



The expenditures a county facility has are also different from proprietary and voluntary facilities in some respects. County homes are required to contribute at specified levels to the State Retirement System for their employees, while private homes do not have such stringent requirements concerning pension contributions. Other benefits to employees of county homes, such as paid time off, sick time, and health insurance, typically exceed those in private homes. Counties also "charge," or allocate costs against, county nursing homes for services from other

units of county government, and these are included in the budget as county home expenditures. These services can include maintenance, snowplowing, data processing, legal services, purchasing and many others. Proprietary and voluntary homes often must provide or contract for some of these services. County homes, however, can also be charged for things like portions of the county executive's or legislators' salaries where there is no equivalent in the private sector; in addition, legitimate services rendered by county governmental units such as legal services or data processing are often charged against CNFs at amounts that exceed the actual market value of the services provided. County home administrators typically have no voice in determining the magnitude of these charges.

Beds in County Nursing Homes

Over 10,000 of the state's 107,000 licensed nursing home beds (licensed by the State Department of Health) are in county-owned facilities. Representing about 7% of all nursing home facilities in the state, county homes contain about 10% of the state's licensed nursing home beds. In many counties, the county home is one of the largest nursing homes in the area or perhaps the only one. On average, county homes tend to be larger than their proprietary and voluntary counterparts, and the average occupancy rate tends to be slightly higher.

Nursing Homes in New York State, 1995

	Number of facilities	Total Beds	Percent of Beds	Average Beds	Occupancy Rate
Proprietary	309	49,849	46.58%	161	96.82%
Voluntary	279	46,673	43.61%	167	97.51%
County	45	10,504	9.81%	233	98.20%

Source: NYS Department of Health, NYAHSA
Note: Oneida County is included in the county facility totals for 1995; however, it is no longer a county facility, having closed and converted to a voluntary facility during 1995.

Mission of County Homes

The historic mission of most county homes involves caring for the indigent and "hard to place," and many county homes are known as the "home of last resort." The growth of Medicaid has helped the county homes update their images and facilities and most are as

attractive as private homes and have the same or better quality of care. In many cases, the county home is no longer perceived as the home of last resort in the sense that only people without means or without the ability to go elsewhere would choose to go there. Many homes believe they are often the first choice of many of their residents.

Most county homes, however, do retain a sense of mission not shared by private homes. The mission of county homes usually involves:

- caring for residents without regard for ability to pay,
- limiting services to residents of the county, and
- accepting difficult-to-serve persons who might have no place else to go.

Some county homes, however, do not see themselves as having a unique mission distinguishing them from proprietary or voluntary homes. Others have a broader sense of their mission and actively seek to provide services to groups whose needs might not be met elsewhere, including AIDS patients and younger adults and children in need of long-term care.

Resident Characteristics: Method of Payment

Nursing homes receive reimbursement from Medicaid, Medicare, private insurance and direct payment from residents and their families. Medicaid rates (with their 10% county share) are fixed by the State Department of Health for each facility. Medicare rates are set by the Federal government and do not require a county share of the payment. It is the so-called private pay resident that is the most desirable from the nursing home's point of view, as it is free to set whatever rate it believes the market will bear for private pay residents. Long term care insurance policies typically pay the private pay rate for up to three years. Other benefit plans pay for some nursing home stays as well, and some private pay patients pay directly out of pocket.

Statewide, proprietary and voluntary homes attract people who have private resources at admission significantly more often than do county homes. While in some counties the county home is indeed the first choice for many, this is not universally true across the state. Compared with proprietary and voluntary homes, county nursing homes admit proportionally more people who are Medicaid-eligible at admission, without sufficient assets to require

spending down. This may be due to the admissions policies of county homes, many of which will admit on a first-come, first-served basis without regard for ability to pay.

Payment Source at Admission (% of Admissions for 1995)			
	Private Pay	Medicare	Medicaid
Proprietary	39.78%	32.08%	25.88%
Voluntary	48.88%	26.40%	24.25%
County	28.79%	34.47%	35.70%

Source: NYAHSA

After admission, many patients exhaust private resources and Medicare eligibility, and Medicaid becomes the source of most payments. Medicaid pays for the overwhelming share of all resident days (the number of residents times the number of days each spends in a nursing home) in the state of New York. ***Medicaid pays for about ten per cent more resident days in county homes than in proprietary or voluntary homes. Conversely, county homes have only about half the rate of private pay resident days as do other homes.*** Also, county homes have fewer admissions per 100 beds than do other homes, indicating that they typically admit fewer short-term Medicare patients needing rehab and sub-acute types of services. This is reflected in the fact that ***county homes also have fewer Medicare-paid resident days than do other types of homes.*** As noted above, counties do not pay any portion of the costs of Medicare coverage.

Payment Source for Nursing Homes (% of Resident Days for 1995)			
	Private Pay	Medicare	Medicaid
Proprietary	10.90%	8.38%	78.81%
Voluntary	11.14%	7.19%	79.37%
County	5.46%	4.78%	88.51%

Source: NYAHSA

Resident Characteristics: Case Mix of People Served by County Homes

While there is a difference in the mix of payors for county nursing homes, is there also a difference in the type of client they serve? CGR's survey of county home administrators

suggests that the mission of many county homes is not particularly consistent with being competitive with other homes, and that there are two primary areas of difference:

- County homes typically (though there are definite exceptions) have a difficult time attracting persons with more complex care needs and, consequently, higher Medicaid reimbursement rates; and

- Conversely, many county homes appear to serve as a "dumping grounds" for relatively healthy persons with behavioral problems who require significant staff time and attention--residents who receive lower Medicaid reimbursement rates.

The State Department of Health has established a system of reimbursement rates that increase with the needs of the resident. The index of patient acuity the Department uses is called the case mix index, or CMI. A higher CMI indicates the home serves relatively sick persons and/or those with high medical service needs. A person requiring more medical attention can raise a home's CMI, and a reasonably healthy person can lower it.

More frail and sick patients help a home obtain higher rates. Consequently, they are more attractive financially to nursing homes, and proprietary and voluntary homes aggressively pursue referrals for such individuals. Most county homes say they are relatively limited in the resources they can devote to marketing, and some claim that they are actively discouraged by county officials from aggressively marketing/competing against proprietary, taxpaying competitors. Also, many facility administrators are concerned about accepting too many high case mix residents since this would have the practical effect of perhaps compromising the home's mission by limiting the numbers of admissions of relatively well but low-reimbursement residents, who might have nowhere else to go.

The case mix index is primarily based on physical indicators and does not accurately address the level of care needed by relatively healthy persons with complex behavioral problems. County homes claim they receive a disproportionate share of such persons without adequate reimbursement. While not as sick as other residents, these "behaviorals," as they are known, can demand considerable staff attention. It is the practice, we were told, of some proprietary and voluntary homes to refuse admission for such persons and even to "dump" such individuals in hospital emergency rooms. These persons often ultimately end up in the county home.

Given all this, the average case mix index for all county homes in 1995 was 1.03. For proprietary homes, the CMI was 1.16 and for voluntary homes it was 1.15. The practical financial impact of this seemingly small difference can be substantial. We were advised by knowledgeable nursing home fiscal experts that to estimate the impact this would have on an average home, we should assume that for each difference of .01 in the CMI, the marginal financial impact would be 1% of the direct rate portion of the facility's overall daily Medicaid reimbursement rate. Assuming an average direct rate of $45, the .12 difference in case mix between the average county and average voluntary home would translate into a $5.40 difference per resident day. Applying that figure to the number of annual resident days per average county facility (98.2% occupancy times 233 beds times 365 days), the annual difference would exceed $450,000. That is, ***if the average county nursing facility were able to maintain an identical case mix index to that of its competitors, it would bring in more than $450,000 in additional revenues per year.***

Services Provided in County Homes

Some county homes offer a variety of services, many unique in their area, while many offer little beyond traditional nursing home care. A few homes offer adult day care and respite care. Many county home administrators indicated a desire to add occupational, speech and physical therapy rehab services, and suggested that this was an area where they could be more competitive with the private sector. Moving in such a direction would have the added benefit of adding more short-term residents with Medicare reimbursement, which has the effect of saving the county the 10% share of the Medicaid rate which would apply if the same bed were filled with a Medicaid resident.

A few county homes, usually in larger communities, have been aggressive and innovative in adding services and catering to special populations. For example, some have special ventilator dependent units and serve a larger share of younger adult and pediatric long-term care patients.

Proprietary and voluntary homes are more likely to offer a wider range of services than county homes. Many are offering or considering offering lower level of care services that could establish feeder systems for their nursing homes. Many county homes indicated an interest in doing the same, though many of the administrators were skeptical since such initiatives would require the approval of the county legislature/board of supervisors, which may not always (1)

wish to approve the competition with other nursing facilities (especially proprietary/taxpaying homes), or (2) have the time to devote to understanding the issues and potential value of doing so.

Labor

With more than half a billion dollars in cumulative annual expenditures across the county nursing facilities, they represent a significant economic force in their respective communities. In some of the smaller counties, the county homes are among the larger employers in the area. Our survey indicates that ***the average county home employs more than 300 full-time and part-time people (mostly full-time), with a reported range from 80 employees in the smallest home to more than 1,000 in the largest facility.*** As mentioned earlier, labor, which accounts for the vast majority of the homes' overall costs, is one area in which county homes are distinguished from other homes. Unlike proprietary and voluntary nursing homes, only some of which have collective bargaining agreements, virtually all county homes are part of countywide labor negotiations and are subject to Civil Service Law provisions and protections. County nursing home employees typically receive the same wage and fringe benefits as other county workers. *Nursing homes are reimbursed for labor costs based on regional wage factors, and county nursing homes generally exceed them because of wage settlements negotiated by county officials, typically with little or no involvement from the nursing home administrators.*

Nursing homes are reimbursed based on their 1983 costs. The Health Department establishes a trend or inflation factor for labor costs to update them to the current rate year. Labor costs in county homes, however, generally go up by more than the trend factor because the employees are represented by countywide bargaining units. These bargaining units are typically stronger than those in proprietary and voluntary homes, many of which do not have unions to begin with. More than 80% of county nursing home employees are represented by unions, compared to about 40% among other homes.

By law, county homes must also contribute to the State Retirement System on behalf of their employees. These payments range from 10% to 20% of salary and typically exceed the pension expenses of proprietary and voluntary nursing homes. Where these costs exceed reimbursement, the burden falls on the county tax base.

Most county home administrators expressed the frustration that they were held accountable for the performance and financial well-being of their homes, yet were rarely allowed to be an active part of the decision-making affecting personnel costs. Most administrators argued in favor of creating separate bargaining units for county homes, though realizing the unlikelihood of realistically being able to do so.

Given the above, one would expect that the countywide bargaining units, most often represented by CSEA, would negotiate better terms for their employees than in the private sector, where many homes do not have unions. Indeed, county homes have fuller staffing relative to other homes, and in 1995 used 19% more staff time per occupied bed than employees in proprietary homes and 10% more than in voluntary homes. Wages and salaries, normalized by patient day, were 20% higher in 1995 in county homes than in proprietary homes and 3.5% higher than in voluntary homes. But it is in benefits that county homes are most generous relative to their competition. ***With average benefit rates of more than 30% throughout the state, employees of county homes receive 57% more in terms of benefits per patient day than do those of proprietary homes and 21% more than employees of voluntary homes.*** Although most argue that such figures reflect poorly on the competitive position of county nursing homes, others make the case that these homes attempt to pay fairer wages and benefits than their competitors and that by hiring more people for more pay and higher benefits, they make a contribution to improving the local economy.

Nursing Home Labor Statistics for 1995

	Staff Hours per Occupied Bed	Average Salaries and Wages per Patient Day	Average Benefits per Patient Day
Proprietary	1,369	$46.01	$11.06
Voluntary	1,483	$53.33	$14.40
County	1,632	$55.18	$17.39

Source: NYAHSA

Plant and Grounds

County nursing homes typically have more square footage and larger grounds than proprietary and voluntary homes. The previous reimbursement methodology used square

footage as an indicator of housekeeping and maintenance costs. The current reimbursement system does not consider the additional costs associated with a larger plant or campus. According to the New York State Association of Counties (NYSAC), county homes, on average, have 30% and 66% more square footage than voluntary and proprietary homes, respectively, and maintain 264% and 404% more square footage of grounds.

County homes in many cases are considerably older than other homes. Coopers and Lybrand figures indicate that in 1994, the average county facility was 16 years old, compared to about 10.5 for other types of nursing homes across the state. The Medicaid capital reimbursement system can make it difficult to maintain older facilities which are no longer being amortized. In previous years, the reimbursement formula paid a capital charge for every Medicaid patient based on average capital charges for the area, and homes used these payments for general upkeep. Today, the reimbursement formula pays capital charges only to facilities with outstanding mortgages; otherwise, Medicaid would be paying for the cost of construction more than once. This does, however, make it difficult for older facilities to compete with newer or renovated ones which benefit from increased reimbursement to help amortize the costs of the capital improvements. Counties are of course able to obtain such benefits if they choose to undertake nursing home renovation or new construction projects.

County Cost Allocations

As noted earlier, county nursing homes incur "charges" for services from other units of county government. For example, a county nursing home will often have expenses added to its budget for purchasing, legal, maintenance and other services provided by various county units. These cost allocations can be significantly more expensive than what a proprietary or voluntary nursing home will pay for comparable services. And in some cases the costs allocated against the county home's budget may bear little or no relationship to actual amount of use by the CNF of the central services. The previous Medicaid reimbursement system at least allowed county homes to be reimbursed for many of these costs. Under the present system, however, most counties receive more limited reimbursement, because high proportions of the allocated costs typically exceed the home's administrative cap. In such cases, the portion of these allocated costs that do not represent real services actually provided to the county home (a proportion not possible to calculate from reported data) artificially and inaccurately inflates the true costs of operating the home.

County cost allocations can vary from year to year. Some are not calculated consistently *within* a county--let alone *across* counties--thereby making it difficult for nursing home administrators to plan effectively (since they typically do not determine the allocations, which are generally calculated by county administrative officials) or to compare actual costs across facilities. As currently represented in nursing home budgets, it is not possible to know which allocated costs represent real services provided to the nursing homes and which are simply overall county administrative costs spread across agencies.

It is nonetheless instructive to realize that total county allocated costs to the 34 county homes which reported such figures in our survey were approximately $21 million in 1996. ***Reported average cost allocations increased from about $481,000 per nursing home in 1995 to $627,000 per home in 1996.*** In most county facilities, most of these allocated costs exceeded the administrative cap and therefore could not be used to claim reimbursement as part of the Medicaid or Medicare reimbursement formula. ***To the extent that they do not represent services actually performed that benefited the home, and to the extent that they exceeded the cap and cannot therefore generate reimbursement, these costs have the effect of making the county home's operating costs look artificially higher than they actually are, without the offsetting benefit of claiming revenues against them. This fact is not always made clear to the public or even to legislators/supervisors who must approve the county home's budget.***

County Subsidies/Contributions to Nursing Homes

As noted earlier in Chapter II, local taxpayers have contributed more than $90 million from local tax levies to the support of county nursing homes over the past three years (1994-1996). ***County taxpayer subsidies averaged almost $610,000 for each of the 40 homes which reported this information for 1996 (and the average had exceeded $800,000 in each of the two preceding years).*** Each of the last three years, between 2/3 and 3/4 of the county facilities have required county tax support, including nine facilities in 1996 which were each supported by more than a million dollars in local taxes. ***More than 80% of the county nursing facilities (all but eight) have received at least some county tax subsidies in at least one of the past three years.*** These figures do not include unknown numbers of facilities which draw additional funds from their respective enterprise fund balances.

Those fund balances themselves are substantial. Cumulatively, they total well over $90 million. Of the county homes reporting their fund balances, the average for each of the past three years has exceeded $2.6 million per facility.

Intergovernmental Transfers

Intergovernmental transfers (IGTs) have been used as a source of increased Medicaid reimbursement for county nursing homes in New York and other states (proprietary and voluntary homes are not eligible to receive the IGTs, which are intended to supplement revenues of only public facilities). IGTs allow the State government to claim matching Federal funds for local funds used to operate nursing homes, and a portion of those matching funds is returned to the counties. The amount of the IGT is determined by the State and distributed to the counties (and typically the county nursing homes) based on Medicaid resident days. IGTs represent a substantial additional source of revenues for the State and for the county nursing homes, resulting in increased Federal funding and decreased need for county tax support for the homes.

Over the past three years, the amounts of IGT payments directly to the county facilities have increased dramatically. ***Just since the 1995-96 fiscal year, the annual IGT allocation to nursing facilities statewide has increased by more than 650%.*** In the 1995-96 State fiscal year, county nursing facilities received as their share of the IGTs about $9.5 million. In 1996-97, the homes' share almost tripled, to $25.7 million, and the just-announced amount for 1997-98 has more than doubled again, to just over $63 million, including New York City facilities. For this most recent allocation, expected to be released to the counties during this calendar year, ***this represents an average of about $1.468 million for those counties with CNFs and about $1.3 million per facility. Twenty counties will each receive in excess of $1 million to apply to their county nursing facilities.***

Although many question how long such a transfer program so lucrative to the counties will remain in place, at this time at the Federal level, there appear to be no attempts to restrain states' use of IGTs. Moreover, during the just-concluded New York State budget negotiations, commitments were made to continue the IGTs at the level of the $63 million county facility share for each of the next two years. ***Although IGTs unquestionably represent a resource which can have significant implications for how counties think about the financial viability of their nursing facilities, counties should be extremely cautious in not planning too heavily on their future viability.*** Several officials during the study indicated that the IGT payments

certainly make the future of the county facilities appear more attractive, and that they may significantly reduce the number of counties which will need to use local tax dollars to support county homes over the next two years, or as long as the IGTs remain at current or greater levels. ***The question is to what extent this revenue source will continue, and if so at what levels, in subsequent years.***

Capital Debts

County homes were asked in our survey what was their outstanding capital debt. Of the 38 facilities which responded to that question, *almost 3/4 reported at least some outstanding debt, typically at least half a million dollars* (11 of the homes reported no outstanding debt as of 1996). *The total reported debt amounted to more than $220 million, an average of about $5.8 million per reporting facility.* A large portion of the total was accounted for by six facilities, each with reported debts over $10 million, including three in excess of $30 million. To the extent that any county facilities consider selling their homes or some of their bed licenses in the future, their outstanding debt could become an issue in the sale negotiations.

Management

The policymaking board of each county home is its county legislature or board of supervisors. While each home has its own administrator, ultimately policy decisions rest with the legislature/board. One would expect that it might be more difficult for a county home to function as profitably or efficiently as a private home, for many of the reasons suggested above. County policymakers have many issues to address, and are sensitive to various pressures that might preclude the most efficient course of action for the county home.

In measures of profit and loss, the relative inefficiency of county homes becomes apparent. As noted above, most county homes have reported annual losses (not including county tax support) over the past three years. Although the impact of the IGTs may change this in the future, county homes have historically lost money in the aggregate on a per bed basis. As shown in the table below, the differences in per bed profit and losses between the three types of homes in 1995 were dramatic:

Nursing Home Profit/Loss Statistics for 1995			
	Median Operating Profit (Loss) per Bed	Median Operating Revenue per Bed	Median Operating Expense per Bed
Proprietary	$2,703	$49,486	$46,783
Voluntary	($827)	$50,171	$50,998
County	($5,611)	$42,656	$48,267

Source: NYAHSA

Note: Figures do not include various non-operational revenues and expenses such as contributions to voluntary homes and county tax subsidies to county nursing homes.

In CGR's survey, county nursing home administrators indicated they had less flexibility in management decisions than their peers in the private sector and were relatively constrained in what they could do. Many would like to increase their reimbursement by offering services to treat higher acuity patients but feel constrained in moving forward. Additionally, only a few county homes reported having any aggressive marketing efforts in place, in part, the administrators suggested, because of the difficulty in obtaining legislative support for an adequate marketing budget. Nonetheless, most administrators characterized their county officials as being generally supportive of the county homes, and with the IGT payments offering at least temporary relaxation of some fiscal constraints, there may be opportunities to explore in a more strategic way, without as many day-to-day financial pressures, what the future of the county homes should look like.

IV. SUMMARY: WHY SHOULD COUNTIES AND THEIR NURSING HOMES EVEN CONSIDER CHANGES?

Before examining in the next chapter the relative merits and deficiencies of various alternatives to the current operations of county nursing facilities, it is worth reflecting briefly on why such an examination is even warranted. As indicated in the two preceding chapters, *a number of significant factors individually and collectively virtually compel counties to thoughtfully examine their CNFs and to make conscious, informed decisions about their future.* Those key existing and emerging factors include:

- an increasing focus through managed care and other efforts on containing long-term care costs;
- projected substantial increases in the numbers of elderly persons likely to need nursing home care, coupled with a growing demand for an increased provision of lower levels of long-term care in the community;
- emphasis of county taxpayers and elected officials on controlling costs of county government;
- a historical reliance in most counties by CNFs on county tax subsidies (historically averaging well over half a million dollars per facility per year);
- increased competition facing nursing homes, with pressures to diversify beyond traditional nursing home services;
- a growing potential threat from out-of-state publicly-traded corporations in the provision of long-term care in the state;
- the historical mission of most county nursing homes to care for residents without regard for ability to pay and to accept "difficult-to-place" county residents whom other nursing facilities are reluctant or completely unwilling to admit;

- a relatively high proportion of Medicaid residents and low proportions of Medicare and private pay residents in county homes, reflected in lower levels of reimbursement, compared with their voluntary and proprietary competitors;

- a relatively low case mix index, compared with competitors, resulting in substantial loss of revenues;

- a reluctance by a number of CNFs to aggressively "recruit"/pursue referrals for more reimbursable residents;

- the fact that CNFs represent a major economic force and employer in many counties;

- decisions made by elected officials that often negatively affect CNFs and their finances, but typically without the ability of nursing home administrators to control many of their costs, resulting in CNFs typically having higher labor costs than their competitors, which may contribute to the local economy but which also adds to the costs of county facilities;

- outstanding capital debts carried by almost 3/4 of all CNFs, typically amounting to at least half a million dollars, with an average debt of almost $6 million per facility;

- despite the outstanding debts, operation by many CNFs in older facilities with older equipment than is true for many of their competitors;

- the recent influx of a substantial new source of revenues, IGTs, which help make county facilities much more financially viable as long as they continue at their current substantial levels;

- the absence of guiding long-term care policies in most counties and statewide.

These factors push and pull in different directions. Some factors suggest that counties should get out of the nursing home business; others suggest that counties should continue their commitment to nursing homes and those they have historically served; and still others suggest staying in the business but only if changes are made in how the homes operate. ***But <u>all</u> compel, at the least, thoughtful, focused consideration by county officials of how to forge, out of these***

often-competing factors and trends, decisions that are in the best long-term interests of the counties and those they are responsible for serving.

County nursing facilities are at--or rapidly approaching--a crossroads. Their future, individually and collectively, is at stake. In the past, despite costs to taxpayers, changes in case mix and funding sources, and even in some cases changes in mission, most CNFs have survived and many have even flourished. And most counties' governmental bodies have been happy with the results, and thus have made implicit, "no decision" or "decision by inertia" determinations, with no real discussion of options, to continue public operation of their homes. After all, for the most part, the county nursing homes have:

- been viewed as fulfilling an important part of county government's mission;
- served an important component of the county's population; and
- been a significant employer of local residents in many counties.

As long as deficits and needs for county taxpayer support were kept in check (the definition and degree of tolerance of "kept in check" varies considerably across counties), counties have generally been happy to drift along in their support of the county homes, through either inertia or a positive sense of the home's value to the community--but either way, without a lot of conscious thought or reflection in most cases.

Now that ability to continue without careful, strategic thought is about to become a luxury of the past. Too many forces compel county officials, nursing home administrators and public employee union representatives to come to the table, to begin to plan for the future of the county homes. Ideally, the place to start is to develop a set of guiding principles in the form of a comprehensive long-term care policy for the county. But however the process occurs, it is important that it begin soon, and that a conscious effort be undertaken county by county to plan for the future of these important community resources and, more generally, for the broad range of long-term care services in each county. Otherwise, decisions will be made *for*, and not *by*, the counties and CNFs--or decisions will be made in a crisis mode when specific options are forced on the county for consideration. ***The time to plan and to make reasoned, informed, policy-driven decisions is now, before events force decisions and actions to be made too rapidly***

with too little information and too little time for adequate reflection on the likely consequences of various options.

By beginning to act now--before managed care has taken over the major decisions in a county, before publicly-traded corporations are on the county's doorsteps, before the huge increases in the elderly population occur--events and decisions can be shaped and controlled, rather than having outside influences become the controlling forces. But the window of opportunity is relatively narrow within which counties and their nursing facilities can exercise the control they need to make the best possible decisions. CGR believes that time is now.

Some county nursing facilities are already generating net "profits" and therefore are less likely to be under immediate pressure to consider alternatives to the status quo. On the other hand, circumstances can change rapidly, or a positive financial situation can be hiding problems likely to surface in the near future, so even positive situations can deteriorate, or at least be in need of constructive change. Thus even those homes that appear to be operating smoothly should be addressing the future now, in a positive environment, rather than waiting for a crisis to occur.

V. ALTERNATIVES FOR CONSIDERATION: WHAT COULD BE DONE?

Several counties have already acted in a variety of ways on a number of options. For example:

- Westchester and Nassau counties are in the process of establishing public benefit corporations for their nursing homes;
- several years ago Madison, and more recently Oneida, ceased to operate public nursing facilities and made arrangements to convert their operations to the voluntary sector;
- Chemung merged its nursing home administratively with its county health department;
- Niagara considered various options and ultimately made a clear decision to "stay the course" as a county facility, with the conscious support of public employee union leadership;
- many facilities have introduced a variety of internal management controls and efficiencies;
- expanded services have been put in place in some county nursing homes;
- Requests for Proposals have been issued to explore the level of interest in new ownership of nursing homes in various areas;
- some counties have conducted or begun to make plans to conduct some form of study or strategic planning process to examine future directions.

The point is not to push one alternative or another, or to advocate for one process for approaching the issues over another, but to simply illustrate that a number of counties have begun to explore options and to make a variety of decisions that seemed most appropriate for their circumstances. Several different solutions could probably be workable in any given community, yet no one solution is likely to be best across the board for every county. ***A variety of approaches may be appropriate for some counties and not for others. The point is that each***

county and CNF must examine its own situation and decide its future on a case-by-case basis. The options are many, with no clear definitive right or wrong answers. Any number of possibilities might work, with sufficient will and resources and creativity. The key is to start the process of deciding.

The remainder of this chapter is designed to provide the tools, in addition to what has already been said in the initial chapters, to help get the discussions started. Presented below are a range of options or alternatives that a county and its CNF might consider as they look to the future. For each alternative or set of related alternatives discussed, the option is described, followed by a summary of our assessment of the strengths and limitations of the option.

No specific recommendations are made concerning a given option, because what could work in one county facility may not make sense in another county with a different set of internal nursing home circumstances and external environmental factors in existence. However, we attempt to provide sufficient information about each option and how it might or might not be useful for consideration under various circumstances that a county and its CNF should be able to use what follows to at least begin the process of screening *in* a potential set of alternatives that may be appropriate for further consideration and more detailed analysis in their situation--and of screening *out* others that are not likely to work in their environment. Following the presentation below, Chapter VI draws some overall conclusions, suggests the types of questions counties and the CNFs should be asking themselves, and summarizes types of circumstances under which certain types of the alternatives discussed below might be most likely to work successfully.

"Degree of Change" Continuum of Alternatives

The alternatives discussed in the remainder of this chapter are presented in approximate order along a continuum of possible actions a county could take regarding the future provision of nursing home care. This "degree of change" continuum ranges at one end from the least change option of continuing to provide traditional nursing home services in county homes under current arrangements, to mid-range options that would maintain county operations of the homes but with various changes, to, at the most extreme end of the continuum, various options for severely limiting or even fully eliminating any direct county responsibility for future operation of nursing facilities. More specifically, the alternatives are summarized here, prior to a more detailed discussion of each:

1. **Continuation of the Status Quo**

2. **Continuation of County Homes with Various Reforms**

Several options are discussed, including

- more aggressive marketing of the county home,
- management efficiencies and contracting arrangements,
- efficiencies through labor reforms,
- separate bargaining unit for the county home,
- implementing the "Eden Alternative,"
- renovation or new construction,
- merging the home with another county department, and
- revisiting county cost allocations.

3. **Continuation of County Homes with Additional Long-Term Care Options**

Under this alternative, county nursing homes would continue, but would also add, directly or indirectly, one or more programs or services at different levels of care to enhance their core nursing home services. These could include a wide range of programs/services such as:

- home-delivered meals,
- adult day care,
- respite care,
- enriched housing,
- adult care facility,
- early to mid-range dementia services,
- assisted living program,
- certified home health agency,
- licensed home care service agency,
- managed care and integrated systems of care,
- continuing care retirement communities, and
- subacute care and specialized care units.

4. Options for Limiting the County's Role in Nursing Homes

Under this fourth broad alternative, counties would either place severe limits on the operation of their nursing homes or, under several options, completely terminate any direct ongoing responsibilities for operating the homes. Options would include:

- management contracts to operate nursing homes,
- sale of some licensed beds,
- establishment of county public benefit corporations,
- establishment of a state authority,
- conversion of county homes to free-standing not-for-profit/voluntary corporations,
- conversion of county homes to existing voluntary corporations,
- implementation of employee stock option (buy out),
- sale of county homes to proprietary corporations, and
- outright cessation of county nursing home operations with no transfer of the facilities.

More detailed discussion of each of these four broad alternatives and the various options under each follows:

Alternative 1. Continuation of the Status Quo

We begin with a discussion of the most basic option for consideration: continuation of county nursing homes and their traditional services, without substantive changes.

Within each county, discussion of alternatives would begin with an honest assessment of the nursing home as it is--its current mission, organization and staffing patterns, financial circumstances, physical plant, programs and services offered, who it serves, how its services are perceived by the public and residents, how it stacks up with its competition in the county, etc. Obviously, an analysis of each county facility would show different patterns of strengths and limitations, depending on the individual circumstances of each, but as an overview it is possible to characterize this status quo continuation option as having the following generalized advantages and potential concerns or limitations:

Perceived Advantages

- Existing facilities, programs and services, and staff are typically well-known in their respective communities; it is assumed that there is a general level of community familiarity and comfort with the existing home and services.

- Continuity of care and providers would be assured for residents, with no disruption of services for existing residents.

- No adjustments would be needed concerning existing certifications and licenses.

- The county can continue direct control over how nursing services are offered, and can assure that the mission of the facility is adhered to.

- If it chooses to do so, it can continue to assure that persons less likely to be acceptable for admission to other nursing facilities in the home's service area can continue to be admitted to the county facility, thereby providing direct assurances that even "hard to place" residents of the county will be served. Without such assurances, some of the residents may wind up receiving the more expensive alternative level of care (ALC) in hospitals. For such patients who receive Medicaid reimbursement, the county share of the costs would be 25% rather than 10% of lower per diem costs in a county nursing home.

- The facility would be able to remain a significant employer in the community.

- The home would be able to maintain whatever linkages it has made regarding services, referral patterns, etc.

- Counties may not wish to tamper with homes that have historically been able to bring in more revenues than expenditures.

- To the extent that the IGT payments continue to be substantial and that counties can count on them in the future, this could provide a financial incentive to maintain existing county homes, especially if the IGTs assure that there will be no need for county subsidies.

- Expected increases in the number of people 85 and older should assure a continuing market for many nursing homes, particularly at the older and sicker end of the market (which should help increase the case mix index and hence the level of reimbursement in the future).

- To the extent that a county has obligations to continue to pay nursing home retirees health insurance or other benefits (not all counties have such continuing commitments), it would continue to receive at least partial reimbursement for such expenses, as long as the administrative cap has not been exceeded. Otherwise, the county would lose such reimbursements if it no longer operated the home, but the expenses would continue.

- To the extent that a county receives at least partial reimbursement for any county government administrative or support service costs allocated against the CNF (not all counties obtain such reimbursements), it would continue to receive at least partial reimbursement for such expenses. Otherwise, the county would lose such reimbursements if it no longer operated the home, even if the county's administrative/ support expenses continued.

Potential Concerns/Limitations

- Most county facilities have continued to lose money annually and to need county financial subsidies to balance their budgets. Even with the current IGT payments, counties are vulnerable to changes in Medicaid and other reimbursement formulas, which means that even historically "profitable" county homes can make no assumptions about the future, especially in the context of managed care and a systemwide emphasis on reducing costs (and reimbursements).

- With increasing emphasis on lower levels of care and greater independence of older people, there may be a reduced overall demand, at least among the "younger old" population, for nursing home services. More of the demand in the future is likely to be among the frail elderly who are likely to be sicker and perhaps have dementia and other problems that require staff-intensive time (although this will have the effect of increasing the CMI and thus reimbursement levels).

- Counties may be less likely than voluntary and proprietary homes to spend the money necessary to retain modern facilities and equipment, thereby potentially eroding their competitive position. Counties with old facilities may find it difficult to compete for new admissions. (On the other hand, counties are able to receive 100% reimbursement for the costs of constructing new facilities if they choose to do so.)

- Managed care and other trends in the long-term care system increasingly emphasize the need for nursing homes to diversify and offer, directly or in partnerships, a greater variety of services that can help people remain longer in the community while at the same time creating a county home visibility and loyalty among a wider range of potential nursing home residents.

- Many county homes, given their historical mission, may find it hard to attract sufficient numbers of the high Case Mix Index residents necessary to assure "profitability" under current reimbursement formulas.

- Many county homes have not been encouraged, or have not chosen, to market their services aggressively, thereby limiting their visibility in the community, and reducing the likelihood of attracting private pay residents.

- The nursing home business is increasingly competitive, and many would argue that as long as there are sufficient nursing home beds and alternatives available in the community, the county may not need to maintain a presence in this level of care.

- County facilities typically have no ability to negotiate labor agreements on their own, and therefore are subject to agreements made by county officials that place them at a competitive disadvantage with their competition. Unless counties change the ways in which they enable their nursing homes to do business and negotiate labor contracts, and unless they expand the flexibility of homes to operate more efficiently and respond to changing opportunities, county homes may find it increasingly difficult to remain competitive in the marketplace.

- Counties may find it more financially attractive in the future to sell beds or their entire nursing facility to publicly-traded or other proprietary organizations that can entice

counties with fresh financial resources, in the process potentially overriding the long-term historical mission of county homes.

- Counties contend that Medicaid RUGs reimbursement formulas discriminate against county facilities. The reality appears to be that the formula is not likely to become any more favorable in the future (on the other hand, as long as the IGT payments remain in place at their currently-generous levels, that issue is somewhat neutralized).

- Unless county facilities explicitly offer services to attract higher proportions of private pay and Medicare residents, facility reimbursements will continue to lag, due to the need for counties to pay 10% of higher county facility costs for its predominant Medicaid residents, vs. paying no share of Medicare or private pay costs.

- By remaining a free-standing facility, as most county homes are, without partnerships and the ability to diversify, there are limits to a home's ability to create economies of scale, reduce staffing costs, etc.

Potential Value of Option to County

Under this alternative, a county maintains direct control over the provision of nursing home services and the ability to assure that "hard to place" county residents who need nursing home care will be served. As long as IGT payments remain in place at current levels, most counties may find the operation of nursing home facilities to be financially viable, at least in the short run. However, there are no guarantees that the IGTs will continue over the long run at their current levels, and a number of changes in the long-term care environment are likely to make it increasingly difficult for counties to continue to operate nursing homes as they have in the past, without incorporating one or more of the substantive changes discussed under other alternatives below.

In discussing other options that follow, many of the advantages of the status quo which were listed above become potential concerns or limitations for new alternatives, and concerns with the status quo may be addressed and become advantages with a new option. Each of the above advantages and concerns will not be repeated in the discussions of each of the options that follow below, but these core status quo issues, pros and cons, should be kept in mind as other options are reviewed.

Alternative 2. Continuation of County Homes with Various Reforms

Along the previously-described "degree of change" continuum of possible actions a county could take regarding the future provision of nursing home care--ranging from the least change/status quo option to the most radical change of complete divestiture of county responsibilities for nursing home care--the second basic option available to counties and county nursing facilities involves continuing to operate the home but with various reforms undertaken to address concerns about the home. Under this "close to status quo" option, the county would continue its responsibility for operating a nursing home, but with one or more significant changes made in its internal operations, the way in which it functions, and/or how decisions are made concerning its future operations.

This alternative presumes that a basic decision is made by a county to continue to operate a CNF, but that there is also a recognition that in order to remain competitive and cost effective, certain changes may be needed. This alternative makes the assumption that a county ultimately decides that continuing to provide nursing home services is a value consistent with the county's mission, and that it basically agrees with or accepts the rationale behind most if not all of the core advantages stated above for the status quo. However, it is assumed under this alternative that the county also recognizes the validity of the potential concerns and limitations of continuing to provide nursing home services directly and that it attempts to take actions to minimize or eliminate those concerns that can be addressed within the context of continuing to operate the nursing home, but short of engaging in fundamental reforms of the home's central character or core services. In effect, this alternative offers a variety of possible reform or restructuring options that range from relatively straightforward and easy to implement to more politically or economically difficult--but they all assume no fundamental shifts in what services or programs are provided by the county home (an alternative exploring such expansion of programs/services is discussed in the third basic alternative later in this chapter).

Under the broad rubric of this second overall alternative, CGR discusses the following options, in no particular order of importance:

- more aggressive marketing of the county home,
- management efficiencies and contracting arrangements,

- efficiencies through labor reforms,
- separate bargaining unit for the county home,
- implementing the "Eden Alternative,"
- renovation or new construction,
- merging the home with another county department, and
- revisiting county cost allocations.

These options are not intended to be all-inclusive, but are suggested as illustrative of steps that could be considered by counties and CNFs in response to some of the concerns raised earlier in the report. Unless otherwise noted, these options could be implemented without involvement or approval by other levels of government. Each is discussed briefly below, along with perceived advantages and possible concerns or limitations. Any of these could be implemented by themselves, or options could be implemented in various combinations, depending on the needs and circumstances facing each county and nursing home.

Consider More Aggressive Marketing of the County Home

Most administrators of county nursing facilities indicated that relatively little is done to formally market or promote their homes. Most indicated that they have limited budgets for marketing, and that other nursing homes in their areas typically invest more resources into marketing their facilities. Most indicated that they would like to be able to market more aggressively as a way of reaching more private pay individuals and more people with a more favorable case mix index score for reimbursement purposes. Others pointed out, however, that such promotion might mean that, if they were successful in attracting more of such "desirable" residents, they might have to turn away more of the "hard to place" persons that have historically characterized the mission of many county homes. Some indicated that county officials have actively discouraged the home from advertising, because of the belief that this could have a negative impact on competitors, with a particular concern about affecting proprietary homes which pay taxes.

It seems likely that more aggressive marketing of county homes could have a positive impact on future business and on countering the somewhat negative image that may exist of the county home as an agent of government that is only available for the poor and is not a desirable place to live. Some have suggested that such a marketing effort might be done in conjunction with a change in name as a means of improving the image of some county homes, perhaps even

by eliminating the word "county" from the facility's name altogether. Marketing could involve not only media advertising, but also efforts to promote the homes more effectively with such potential sources of referrals as physicians, senior centers, hospital discharge planners, pastors, and others who are likely to have significant contact with older people. In addition, finding ways to reach the children of seniors may also prove useful, as many of them are actively involved in the decisions about whether and where to place an older parent. There is nothing particularly noteworthy about this option, and many counties do much of this, even if informally, but it is clear from nursing home administrators that far more could be done to market the homes if this were to become a priority that had sufficient resources (financial and people) devoted to it. This represents a decision most nursing homes and/or county officials should be able to make relatively easily, at least in comparison with many of the other options that may need to be addressed in the future.

Perceived Advantages

In the increasingly competitive environment in which nursing homes exist, it may not be possible for a county home to thrive without becoming more aggressive in promoting itself. If homes are willing to accept people on a first-come, first-served basis, with heavy emphasis on accepting the "hard to place," marketing may not be as important, but if the CNF wants to intentionally target more private pay and higher acuity residents, more extensive marketing may be essential. With referrals in the future less likely to come primarily from hospitals, given reductions in staffing and extent of inpatient care, it is likely to become increasingly important in the future to find new ways to reach the primary target audiences. One home administrator spoke of a targeted media marketing effort, with a relatively limited budget, that in a short time yielded two private pay residents that almost immediately paid for the advertising expenses.

Potential Concerns/Limitations

The costs can be a drawback to an extensive marketing effort, although as noted, it may not take many successes to more than justify the expenditures. Also, county officials and home administrators must weigh the relative advantages of attracting a more diverse mix of residents against the potential for perhaps needing to compromise the home's mission by placing some restrictions on the numbers of Medicaid and other "hard to place" persons traditionally accepted as priorities by most county homes. County officials must also face the issue of how comfortable they are entering into more direct competition for potential residents with other

nursing homes in the area, particularly proprietary facilities which pay county taxes. On the other hand, county officials may need to make a conscious decision to let county homes compete more aggressively, or if they are unwilling to accept that, at least acknowledge that not doing so means an implicit agreement to support county subsidies to the home in lieu of seeking to attract more "reimbursably desirable" residents.

Explore Management Efficiencies and Contracting Arrangements

Many county nursing homes have conducted either internal or independent, third-party management studies to determine ways of creating labor- and cost-saving efficiencies and reorganizations of staff and functions. Other homes indicated that they could benefit from undertaking such formal analyses apart from the day-to-day management of their facilities. Several homes have entered into contractual arrangements with various firms to have selected functions (e.g., dietary, cleaning, maintenance, therapies, purchasing, etc.) performed more efficiently by private sector firms, thereby leading to cost savings and reductions in numbers of employees on the county work force. Management studies which examine the potential value of making various internal changes and/or of contracting out selected functions can provide useful insights for nursing homes in counties that have committed to continuing to provide traditional nursing services directly, but which at the same time want to investigate ways of making changes that can improve services and offer them more cost-effectively.

Perceived Advantages

Such management studies, particularly if they seek input systematically from staff at all levels of the nursing home organization, can often identify significant opportunities for making changes which improve the productivity and cost effectiveness of the organization. Often the best insights come from staff at all levels who have creative ideas for constructive change, and who are open to making changes if they are part of the process, but who have never been asked for their input, given the routine pressures of coping with each day's activities and assignments. By creating a process that forces people to back away momentarily from their routine tasks and asks them to think of how they and their units could operate more effectively, an organization can often obtain ideas worth far more than the value of the time devoted to the effort. Useful processes, with the right leadership, can operate effectively in generating such insights either when conducted internally or with the assistance of an outside consultant.

Contractual arrangements to purchase various services from private firms, rather than having those same services conducted by county employees, can have the effect of saving the county money under certain circumstances. Typically, nursing homes seek bids or issue RFPs to determine if private firms can provide the requested services more economically than could be done by county employees. Some firms have particular expertise in working with nursing homes throughout the state to provide purchasing services, dietary services, etc. for county homes. Experiences of some counties and CNFs indicate that in some circumstances such privatization of specific functions can work to the county's advantage, although each situation must be assessed on a case-by-case basis.

Potential Concerns/Limitations

One of the major impediments to engaging in a management study is the time involved in planning and implementing it, and the time staff must take away from regular assignments to participate. On the other hand, properly managed, interruptions of important functions can be minimized, and often the returns in improved performance, better morale, greater efficiencies and cost savings and/or revenue enhancements more than justify the efforts. Another major concern, especially if an outside consultant is being considered, is the cost. Properly planned, disruptions can be minimized, and savings and enhanced revenues resulting from such studies often more than pay for their costs within a year of their completion.

The management study approach to issues facing the nursing homes is seen by some as too limited in scope to address the major systems changes facing the homes. Some would see such studies, whether internal or external, as a waste of time and/or money unless they were part of a larger effort to focus on the broad range of options that could be considered by the county and the CNF, including the potential value of adding services/programs to the traditional nursing home functions and/or the possible implications of having the county divest itself of responsibility for direct provision of nursing home care (issues addressed later in the chapter).

Contracting out certain services, although offering the potential for saving the home and county money, can obviously have the effect of causing county employees to lose their jobs. This may have political consequences and could lead to labor union conflicts that may need to be skillfully negotiated. If a CNF and county are serious about examining the value of contracting out certain services, ideally these should include services such as data processing, legal services and others that may be provided by the county's central administrative staff. Some

counties may preclude such options from being considered, but if nursing homes are to be held accountable for being cost effective, they should be allowed to put all such options on the table for consideration. If they are not allowed to consider contracting out such services provided by centralized county staff, the implications of such decisions should be made clear to legislators/supervisors in the context of understanding the nursing home's budget and financial "bottom line."

Engage Labor Unions in Discussions of Reforms

Rightly or not, the role of public employee labor unions representing the county nursing home employees was frequently mentioned throughout this study as contributing disproportionately to the problems facing the homes. Realistically, labor unions can only negotiate agreements to which other parties, in this case county officials, also agree, so placing sole responsibility on one party for agreements perceived to be problematic seems inappropriate. Nonetheless, it is true that employee unions have certainly been instrumental in crafting agreements which have placed county nursing facilities at a competitive disadvantage in such areas as staffing, costs of wages and benefits, work rules, and the like. In several other states in which labor unions play a much more limited role in public nursing homes, those homes were perceived to be in a stronger competitive position with their nursing home competition than in New York, according to representatives in several other states interviewed as part of this study (see summaries of observations from other states in the appendix).

A few counties have been able to constructively engage union representatives in honest discussions about the future of the homes and the problems facing them, and to enlist their support in developing memoranda of agreements which have amended the basic collective bargaining agreement and crafted specific solutions to problems facing their nursing homes. *Other counties may need to engage in similar dialogue with union representatives to help develop compromise solutions concerning labor costs and productivity and efficiencies*--perhaps as part of a management study such as discussed above--which ultimately make it possible to enable the county home to function more competitively and thereby continue to stay in business in a way that is responsive both to the county's mission and the concerns of its taxpayers.

Perceived Advantages

As noted, there are examples of counties where successful negotiations outside the basic collective bargaining agreement have helped reach solutions to problems where both nursing home management and employees benefited. If a county is seriously considering closing a nursing home, or selling it or taking some other action which could jeopardize the jobs of employees, honest discussions with union representatives and other employees may help identify opportunities and solutions to problems which make it more feasible to remain in business. If they are unwilling to help craft workable solutions, they would then bear part of the responsibility for whatever more drastic solutions may result. On the other hand, if they can help develop solutions, the county home may be saved and taxpayer needs met at the same time.

Potential Concerns/Limitations

Relatively few counties reported success in negotiating changes with their unions which had the effect of making their nursing homes more competitive. In most cases, the nursing home administrator is not even an integral part of the process of negotiating the contract with the labor unions, and there is no separate nursing home union with which to negotiate separately. In most counties there appears to be relatively little history of successful mutual negotiations between union representatives and nursing home management upon which to build a more collaborative working relationship.

Consider Creation of Separate Bargaining Unit

County nursing homes in the state are all unionized, and virtually all homes are forced to engage in countywide public employee labor negotiations, rather than being able to negotiate separately with a union of nursing home employees. Typically the nursing home administrator is not part of the negotiations, and proposed nursing home positions which might help make county facilities more competitive with other homes in their respective areas are often ignored or receive little attention compared to broader countywide issues in the bargaining process. Nursing home administrators are held accountable for the performance and fiscal management of their facilities, and yet they often have little control over the issues and decisions that have the greatest impact on their ability to compete with other nursing homes and on their financial bottom line. Many county home administrators advocated strongly for the creation of separate

bargaining units for their homes, although few thought there was much chance of that ever happening.

Perceived Advantages

If the preceding option--to productively engage the existing unions in discussions of the types of reforms needed to make the nursing homes more productive and cost effective--were to prove successful, this option may not be necessary. However, if negotiating separate agreements outside the formal county collective bargaining agreement proves unworkable, counties may seek this option as a means of creating a union with interests specifically related to the nursing home, rather than having the home's interests submerged within larger county issues. Nursing home administrators believe that they could work out reasonable solutions that would be fair to both employees and the home's interests if a separate bargaining unit were in place.

Potential Concerns/Limitations

The major limitation to this option is that it is relatively unlikely to happen, unless the county's larger bargaining unit(s) are willing to agree to creating a separate union. Existing Taylor Law and Public Employment Relations Board (PERB) provisions make it difficult to create a separate bargaining unit for nursing home employees unless the larger county union is supportive. On the other hand, there is some limited precedent within the state for successfully petitioning PERB for separate unions if a commonality of interests and financial circumstances justifies the separation. If this cannot happen, then county officials must be willing to share responsibility with nursing home administrators for decisions made which limit the nursing home's flexibility to make certain decisions and its ability to compete costwise with other facilities. *Elected county officials must be willing to be held accountable for their decisions that affect the nursing home, and to take those decisions into account when analyzing the performance, efficiency, productivity and overall cost effectiveness of the home.*

Consider Implementation of "Eden Alternative"

Many nursing homes are considering, or have already begun to implement, approaches along the lines of the "Eden Alternative," which places emphasis within a nursing home on creating a caring environment incorporating visible examples of more home-like accoutrements

and activities, to reduce the institutional "feel" of the home. For example, plants, animals and children are intentionally brought into the home to provide a different ambience to the facility, and residents are often given greater autonomy in managing their activities.

Perceived Advantages

Such approaches have the potential to help neutralize or overcome the traditional "grey" image of many county facilities, and would provide highly marketable images to promote if a county opts to market its nursing home more aggressively (see above). Incorporation of such approaches may be necessary either to gain a competitive advantage over, or simply to keep up with, competitors serving the same geographic area as the county home.

Potential Concerns/Limitations

Movement in this direction may be seen as focusing on relatively "surface" issues, rather than addressing more substantive root cause problems a nursing home may have. On the other hand, such an approach may have sufficient appeal with those a home must attract that it can help overcome other problems. There are some risks in giving up a certain amount of autonomy to residents, and there would be some costs involved in moving in such a new direction, but these are likely to be relatively minor in scope, compared to the potential benefits that could result from implementing such an option.

Consider Renovation or New Construction

As noted earlier in the report, many nursing homes have undertaken substantial modernization or new construction projects, and more often than not, those projects have been undertaken by the county homes' competitors. The average county nursing facility is several years older than the facilities of their competitors, and relatively few of the older county facilities have received major renovation in recent years. As more competitors have more amenities and more attractive and/or modern facilities and equipment, the ability of county homes to compete is likely to be compromised in significant ways.

On the other hand, there are considerable costs associated with either renovation or new construction, and many counties have been unwilling to make such investments without being absolutely certain that there will be a continuing need for and commitment to a county facility

in the future. Nonetheless, *for several counties, perhaps the most significant option it must consider, if it intends to continue to provide nursing home services directly, is whether, and if so when, to renovate or replace its current facility.*

If a county were to decide to upgrade or renovate its existing nursing home facility, there is the possibility that the State might not approve the renovation. Depending on the age and condition of the facility, and the number of deficiencies in the State Fire Prevention and Building Code and the State Health Code, it is quite possible, based on previous experience with various facilities, that the State may not approve the renovation option. However, if it is approved, or if construction of a new facility were initiated, the county would need to put up a 10% down payment on the total cost of the project. The State will finance the remaining 90% of the costs, and will reimburse depreciation on 100% of the total costs, as well as paying interest on the portion that is financed.

Perceived Advantages

Upgrading existing facilities would send a clear signal that the county is committed to providing a quality, attractive nursing home environment for its residents. Depending on the extent of the renovations, the county would also be correcting some or all of any deficiencies that may have developed over the years as State codes have been revised, making it difficult if not impossible for facilities to remain in compliance at all times. If a new facility were to be built, it would obviously be built to State specifications, so compliance would presumably be 100% from the beginning.

Constructing a new facility, and perhaps even some renovation projects, could also lead to savings in subsequent annual operating costs for many facilities, depending on the configuration of the existing facility. Many county homes now have added staff requirements as a result of relatively few rooms per wing, and multiple-bed rooms (many rooms having four beds per room). Some administrators estimated that many older county homes could reduce their annual operational costs by as much as a third by building new facilities with more rooms per wing and fewer beds per room, thereby making the new facility more efficient to staff.

As noted, a county could build a new facility at little direct cost to county taxpayers. Even if it chose to finance 100% of the costs of the project, with no county down payment,

depreciation on 100% of the capital costs would be reimbursed by the State, and only the interest on the difference between 90% and 100% of the capital costs would not be reimbursed.

Potential Concerns/Limitations

If the county were to opt to renovate the existing facility, rather than building a new facility, the State may refuse to give its approval, depending on the age of the facility and the number and type of deficiencies. Even if it were to be approved, it is likely that some deficiencies would continue. Depending on the scope of the renovation efforts needed, there could also be substantial disruption to facility residents while the project was underway.

Alternatively, if the county were to decide to build a new facility, it should be done in conjunction with a clear long-term commitment to the county's role in long-term care provision. Ideally, a county should not simply decide in a vacuum whether or not to build a new nursing home or renovate its existing one, but it should make any construction-related decisions in the context of a more thorough assessment of what long-term care services at various levels of care are likely to be needed in the county in the future (see subsequent discussion of service/program needs). Thus it may be that a decision to build a new facility would incorporate not only a certain number of skilled nursing facility beds, but also, for example, a number of beds for one or more of such levels of care as dementia care, adult care facility beds, medical respite care, etc.

Consider Merging Nursing Home with Another County Department

Under this option, the nursing home could be administratively merged with one or more other existing county departments. For example, in Chemung, a new County Health Center has been created in the past year, under a Health Center Director, a new position involving consolidation of the Nursing Facility Administrator and Public Health Director positions. Restructuring and merging of other staff positions has occurred to strengthen the management oversight of various functions. Such a merger could be scheduled in conjunction with a planned retirement or related personnel moves, as happened in Chemung, so that reductions in staff could be accomplished wherever possible by attrition, rather than by layoffs.

Several counties have hospital-based nursing homes. Mergers of county-owned hospitals and nursing homes typically enable nursing homes to reduce their costs via various efficiencies, economies of scale, and reductions in equipment purchases/capital expenditures,

while at the same time also maximizing reimbursements through being affiliated with the hospitals.

An option rarely used, but with considerable potential, would involve integrating all long-term care units of county government under one overall administrative structure. Counties operating a nursing home, plus at least one other long-term care program such as an adult care facility, long-term home health care program, assisted living program, etc. may wish to consider establishing one overall long-term care administrative structure to save dollars and to help create an overall long-term care policy that best meets the needs of both those requiring such services and the overall taxpaying public.

Perceived Advantages

The primary advantage related to any such merger of responsibilities is the opportunity to save money through more effective deployment of staff. Depending on who the merger is with, it would ideally also enable the opportunity to forge more effective staff and service linkages between different operational units of county government. In the case of the potential integration of long-term care services, improved policies and service provision may also result.

Mergers of county hospitals and nursing homes can enable the cost savings noted above, while also making possible higher levels of reimbursement than might otherwise be the case. They also can help create a logical referral source and feeder pattern for the nursing home, as hospital discharges needing nursing home care can be readily referred to the county home.

Potential Concerns/Limitations

Among the concerns to be aware of in mergers of nursing homes with other departments is the danger of spreading persons and/or functions too thin, to the point that quality of services suffers. With strong leadership and the right people in place to make such a new operation work, there can be significant advantages, in terms of both savings and service improvements. However, planners considering such a merger must make certain before it is approved that standards of care and service provision, and understanding of nursing home operations and issues unique to the home, will not be unduly compromised as a result of the merger and consolidation of functions and positions.

With regard to potential nursing home/hospital mergers, there is the potential for disapproval by the State DOH. Despite efficiencies, the large administrative structure and resulting high costs of the hospital typically create higher reimbursement rates for nursing homes than would occur if a home were free-standing, thereby adding to the county home's Medicaid revenues, but also adding to the State's share of Medicaid costs (and to the total amount of the county's 10% share of the Medicaid reimbursement rate). The high reimbursement rates can also make private pay costs prohibitive for hospital-based county homes.

Analyze Impact of Allocation of County Costs Against CNF

As noted earlier, CNF expenditures typically are adjusted by county officials to include substantial costs of other county government operations allocated against the nursing home (and other departments). These allocated costs typically total $200,000 a year or more for most county homes, and in 1996 the reported *average* amount of county costs allocated against nursing homes was more than $600,000. Some of these costs represent actual services performed for the nursing home by staff in other county government units (e.g., legal, personnel, data processing, etc.), and thus may be legitimate charges against the home. However, *for many homes, it is not clear how even these direct service amounts allocated against their budget do or do not pertain to actual amounts of work performed.* Allocations are often based more on nursing home space/square footage rather than on use or value of the services received or tasks performed. Nor is it clear in many cases to what extent other county administrative costs are allocated for which no direct services were provided at all. There appears to be little consistency within counties in some cases, let alone between counties, as to how these allocated costs are derived and what they mean. Moreover, ***in most counties, high proportions of the allocated costs typically exceed the home's administrative cap, thereby limiting the county's ability to claim substantial reimbursement under existing formulas. Thus, these allocated costs can often be the difference, sometimes an artificial difference, between the nursing home appearing to "cost" the county money or actually break even or perhaps even "make money" for the county.***

In order for nursing home administrators and county legislators/supervisors to more clearly understand the realities behind these cost allocations numbers, it may be helpful for the counties to have their budget directors arrange to have joint presentations given on how these allocations are derived, including which portions are related to direct services and how they are costed out, and which are simply allocated regardless of services provided. *Such information*

may make it easier for both administrators and legislators to have a mutual understanding of what the cost allocation and overall budget numbers mean and of who should be held accountable for what portions of the nursing home expenditures. By breaking out such figures more precisely, it should also enable nursing home administrators to determine if it is possible for them to make separate arrangements for provision of certain services (e.g., data processing, purchasing, etc.) more economically outside county government than is possible by using county employees. If it is, then either they should be allowed to enter into such purchase of service/contracting arrangements and realize the savings in their budget, or if the county insists that the home must continue to use the county staff, then at least it will be clear in reviewing the budget who is responsible for certain costs, and where savings might have been introduced if allowed.

Perceived Advantages

The obvious advantage of conducting such analyses and presenting the information to both administrators and legislators (at least those with committee oversight for the nursing home) is that a clear understanding should result as to where accountability should lie for which portions of the nursing home budget. *If on the surface the CNF appears to be costing the county money overall, but that proves to only be true because of costs allocated to it but from which it did not benefit directly and/or could not receive reimbursement, then decisions about the home's future should be based only on the portion of costs and revenues over which it has direct control, rather than holding it accountable for "apparent losses" for which it had no responsibility.* Similarly, such an analysis may also point out opportunities for savings which may be possible if a home were allowed to contract for selected services outside county government.

Potential Concerns/Limitations

There are no logical reasons why such analyses should not be performed and distributed. However, it is recognized that cost allocations are widely used across county governments as a means of distributing the costs of various centralized administrative and service functions against various user departments, in order for at least some of those costs to obtain reimbursement for the county where possible. Thus this may be a sensitive subject for county officials who could see this as a threat to certain administrative functions or services. However, even if nothing is changed as a result of the analyses, simply having decisionmakers more knowledgeable about

the cost allocation concept and how it works, and what effect it has on a departmental budget, should justify the effort.

Potential Value of Alternative 2 Options to County

Counties which choose to continue to operate nursing facilities may wish to consider implementing one or more of the above options as ways of strengthening the facilities and helping to assure that they are responsive to needs of their residents while at the same time being more cost effective and less likely to need county tax support. The options could be implemented individually or in various combinations. Any of the options discussed above could be implemented by a county without fundamentally changing the core services or programs offered by the county home. On the other hand, they could also be implemented in combination with the addition of one or more new programs or services providing different levels of care than offered in a nursing facility. The potential implications of adding such services to those traditionally provided by a county home are discussed below.

Alternative 3. Continuation of County Homes with Additional Long-Term Care Options

Between efforts to control long-term care costs, the actual and anticipated impact of managed care, the need to maintain high nursing home bed occupancy rates, and the desires of older people and people with disabilities to remain in their homes and other community-based settings for as long as possible, more and more emphasis is being placed on offering lower levels of long-term care.

As county nursing facilities consider their current role and the extent to which they will need to change in the future, the third basic alternative involves adding various long-term care options to their core nursing home services. Many nursing homes already are beginning to respond in various ways by offering alternative levels of care directly or by arranging to make such opportunities available through various networks or partnership efforts. County homes will increasingly need to make conscious decisions about to what extent they wish to provide or arrange for one or more of a wide array of potential services or programs at levels of care below that of nursing facilities.

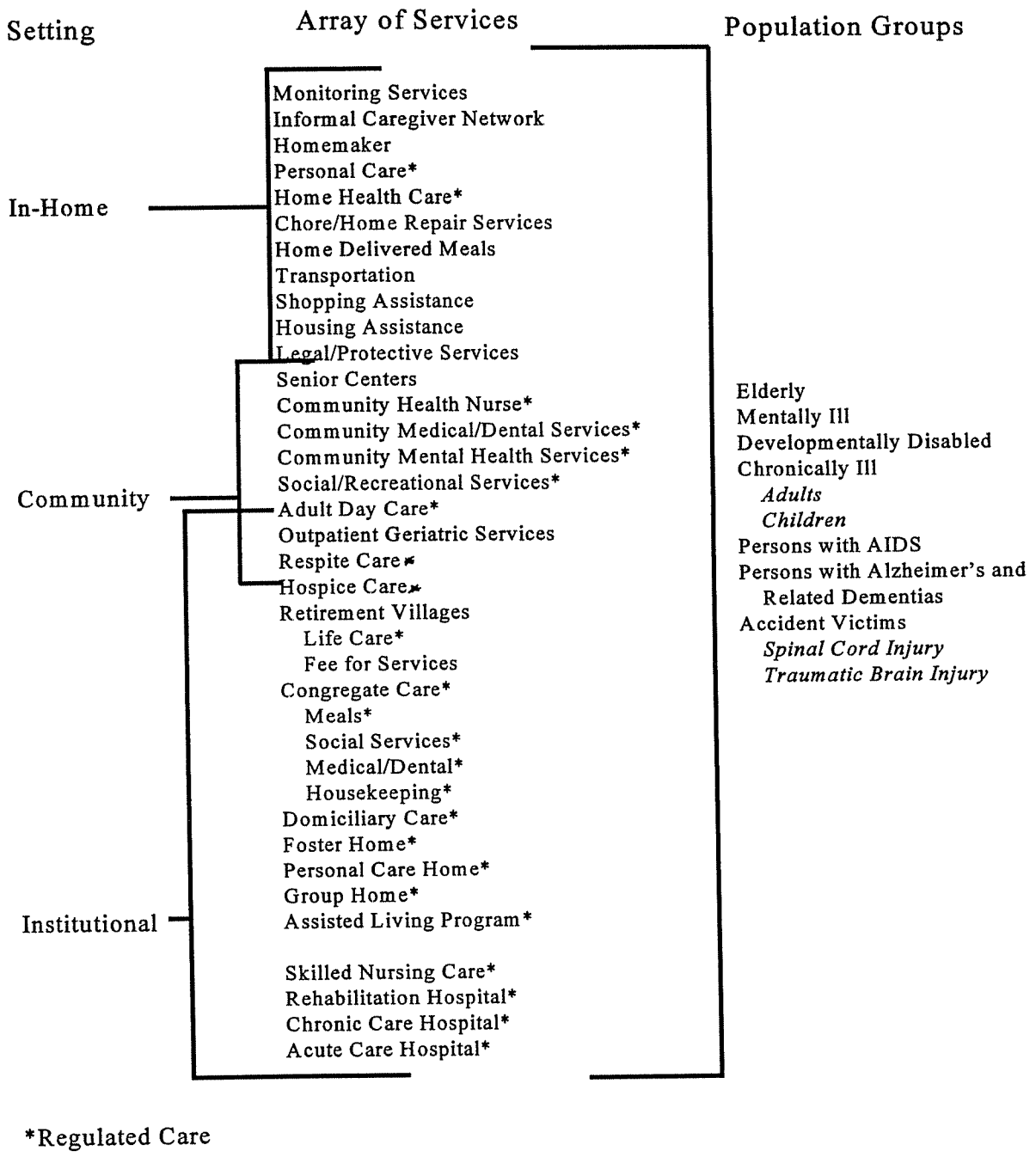
The assumption underlying this broad alternative is that the county nursing home would stay in business, but would at least consider the possibility of adding, directly or indirectly, one or more alternative level(s) of services to enhance the core nursing home services it would continue to offer. Homes may consider adding any one of these programs/services, or may consider adding a variety of services in various possible combinations.

The programs/services described below can be offered directly by a county nursing home, or can be offered in partnership with other service providers (e.g., other county government programs and/or programs offered by voluntary/not-for-profit agencies). Some of the services are not regulated and can be easily added to a nursing home's core services, although most of the additional services along a continuum of long-term care are regulated by the NYS Departments of Social Services and/or Health. In some cases, a county may wish to consider decertifying some of its nursing facility (NF) beds, especially if the nursing home is experiencing low occupancy rates, and converting those into lower level of care beds, such as at the adult care facility (ACF) level. Alternatively, a county may choose to maintain its existing number of nursing facility beds and create additional free-standing county-owned beds at a lower level of care, or to create a partnership with one or more other providers to integrate services.

As an example, one county nursing facility has an adult care facility as a key part of its care plan. This social model of care provides the CNF with a residential setting in which to place persons with low Case Mix Index scores, who don't yet need NF level care. The ACF can then be a feeder to the CNF in such a vertical integration of services. Through such an arrangement, a county could also create through the ACF additional service enhancements such as respite care, adult day care, early to mid-stage dementia care, and an assisted living program. Counties may also choose, alternatively, to add access to such services by integrating services horizontally by partnering with other service providers including an ACF. However created, these services can ultimately act as a feeder to the CNF. Such integrated systems can be attractive for a managed care model, if they can demonstrate flexibility and cost controls.

Although there is considerable overlap between some of the levels of care, they are described below along a rough continuum of care, from the lowest levels of care required (least intensive) to the highest. The chart on the next page shows how the various options fall along

Long Term Care



*Regulated Care

such a continuum. The chart first indicates an array of typically-unregulated services that can be created to offer to people in their own homes. By offering such services, a CNF can begin not only to offer needed services to the community, but also to create a feeder system that can ultimately lead to nursing facility services. The in-home and community services shown on the long-term care array of services are a blend of unregulated and regulated services available to people living at home as alternatives to more institutional care. The regulated services begin with those offered in the residential/social models under DSS and progress to those jointly regulated or offered by the State DOH. The institutional services shown on the chart involve provision of various services at a more congregate level, with people typically no longer living in their original, free-standing homes.

It should be noted as this is written that some of the distinctions referred to below between State Departments of Social Services and Health may in the future disappear, as some divisions of DSS are likely to be merged with DOH.

The most significant of the alternative-level-of-care services, from the perspective of how they might be used to enhance a county nursing home's existing operations, are summarized below, along with their potential strengths and limitations. They are presented and discussed in the following order:

- Non-Regulated Services
- Regulated Services
  - adult day care (social and medical models)
  - respite care (social and medical models)
  - enriched housing
  - adult care facility (ACF)
  - early to mid-stage dementia social program
  - assisted living program (ALP)
  - certified home health agency (CHHA)
  - licensed home care service agency (LHCSA)
  - managed care and integrated systems of care
  - continuing care retirement community (CCRC)
- Subacute Care and Special Care Units
- Specialized Care of Geriatric Prisoners

Non-Regulated Services

There are a number of services that can be offered to the public that are not regulated by the Department of Social Services (DSS) or the Department of Health (DOH). These "hands off" services are early interventions for services needed by the elderly to help them continue to live at home. Some examples include: home-delivered meals, shopping services, chore and home repairs, transportation services and durable medical equipment such as personal monitoring equipment. If a CNF decides to offer one or more of these services, it can help establish itself as a known and competitive provider. When persons who have received such services ultimately need nursing home care, the CNF would be in a strong position to acquire them as residents. Providing such services permits nursing facility staff to assess those clients' future needs and market its services. They can be a valuable source of future referrals to the home. This can be an opportunity to market also to any assisted living program, retirement centers/apartments and senior centers operated by the county. The nursing home and the county would typically have the trained staff and for the most part the equipment to provide such services directly or on a joint venture basis.

Perceived Advantages

- The county nursing facility can begin to offer such services at anytime, with no applications, and no decertification of nursing home beds needed.
- Adding one or more of these services increases the array of services a CNF can offer the public.
- The CNF can establish the rates, so there should be no issues of inadequate reimbursement, and those receiving the services would typically be private pay individuals.
- Such services are currently being offered by few nursing home providers.
- Adding such services would require very little new staffing; considerably less staffing would be needed than the existing NF care staffing plan.
- When clients need nursing home care, they are likely to trust the CNF recommendations.

Potential Concerns/Limitations

- Offering such services may have the effect for some people of increasing the time they are able to remain in the community and outside the nursing home. However, this is a

desirable overall objective and, moreover, most of those seeking such services are not likely to be ready to enter a nursing home at that time anyway. The CNF would be able to establish a reputation for good services with the individuals for future reference.

- There may be only limited reimbursement for low-income county residents in need of such services.

Potential Value of Option to County

These services could become a source of net immediate income for a county home, as well as a source of future referrals for the nursing home itself.

Regulated Services

In licensed services such as adult day care and respite care there are both *social models* regulated under the State DSS and *medical models* under the State DOH. Social models under DSS will require an application process. Medical models under DOH will require a Certificate of Need. Again, some of these current distinctions may ultimately disappear, depending on the final resolution of proposed DSS/DOH mergers.

Social Model Adult Day Care

The DSS-regulated adult day care social model is provided in a more residential setting, compared with its medical model counterpart. It offers supervision and socialization through structured programs, meals, and some personal care (it does not include medication management). The program is normally offered up to six days a week and is patterned after a traditional work day. A nursing home could offer the program either on-site if space is available or at a different location; either way it would not affect the number of nursing facility beds already provided by the county home. This would require an application to DSS which primarily includes disclosure statements on the provider's character and competence. This application process may take nine months to a year before approval is officially granted.

Perceived Advantages

- This could increase the array of services a CNF can offer the public.

- The CNF is already offering, and is familiar with, most program requirements such as supervision, structured programs, and meals.
- The program would require a small new investment in staff and equipment--considerably less staffing than the NF care plan, as no evening or night staff would be required.
- The program would permit staff the opportunity to evaluate the client's needs, which may lead to another level of care or services in the future.
- Primarily services would be provided for private pay individuals; rates typically range from $7.50/hr. to $10.00/hr.
- Some health insurance and long term care insurance will pay for services if there is a Registered Nurse (RN) on site, rather than just on call.

Potential Concerns/Limitations

- Space requirements may exceed the CNF's current social program space and therefore may require rental or purchasing of an off-site facility.
- Bathroom requirements may exceed the CNF's current accommodations.
- The program would require hiring program-specific staff: a program coordinator, RN and recreation staff.

Potential Value of Option to County

A social model day care program's costs should be more than offset by sufficient revenues to make it a net revenue generator, as well as a future feeder to the county nursing facility.

Medical Model Adult Day Care

The Department of Health-regulated adult day care medical model is provided in a medical setting. If a CNF were to offer such services, it could do so either on-site--if there were sufficient existing space and/or if some nursing home beds were decertified to create added space --or in a separate site from the nursing home location. It would provide supervision; socialization through structured programs; meals; and nursing facility services such as: medication management, clinical dietetics, medical social work, recreation, occupational and physical therapy, speech and language pathology, and medical services. The program is

normally offered up to six days a week and is patterned after a traditional work day. An interested CNF would have to submit an application to DOH in the form of a "Certificate of Need," which would describe the program; its location; staffing schedules; services provided; audited financial statements; financial schedules of the anticipated source and application of funds; and other related exhibits. The process may take nine months to a year.

Perceived Advantages

- This would increase the array of services a CNF can offer the public.
- The CNF is already offering most program requirements, such as supervision, structured programs, meals, NF services, medication management, occupational therapy, physical therapy, speech therapy, and language pathology and medical services.
- The program would require a relatively small new investment in staff and equipment. There would be less staffing than in the NF care plan (no evening or night staff needed).
- The program would permit staff the opportunity to evaluate the client's needs, which may lead to another level of care or services in the future.
- Rates range from about $12.00/hr. (Medicaid rate) to about $16.00/hr. (private pay rate), typically for five or six hours of service per person per day.
- Some health insurance and long-term care insurance will cover costs of this program.

Potential Concerns/Limitations

- Space requirements are likely to exceed the CNF's current social program space. Most nursing home providers therefore would presumably need to rent or purchase space off-site.
- Bathroom requirements may exceed the CNF's current accommodations.
- The program may have the effect of increasing the time the client is able to remain outside the nursing home. However, this is an intended goal of the program, which the nursing home should encourage and recognize that it would at the same time be establishing a link with a future resident if quality services are provided at this level.
- The determination of need must be based on the number of approved slots by the DOH.

Potential Value of Option to County

This could be a revenue-positive program that could help a CNF capture a market niche for the future.

Respite Care Social Model

Regulated by DSS, as offered in an Adult Care Facility (ACF) setting as an enhanced service, respite care offers the ability to provide short term care in a residential setting for up to six weeks in any one year. The consumer must be suitable for the adult care level (not needing nursing facility care). This program offers respite to the caregiver and to the client. It is like the social model adult day care on a 24-hour basis. Respite care permits the facility to assess the customer's needs and evaluate the possibility of permanent residency, and the consumer and caregiver are able to evaluate the facility's services at the same time. The clients can use the program without making any permanent changes in their basic living accommodations.

In order for a county to offer the social model of respite care, it must do so as part of an ACF. The county would need to create or purchase an adult care facility, decertify some of its nursing home beds and convert them to ACF beds, or decide to partner with an existing ACF. This would provide a county home with a lower level of care that would also act as a feeder to the CNF in the future. As an ACF, the process would require filing a waiver request to DSS.

Perceived Advantages

- Again, this would increase the array of services a CNF can offer the public.
- The uniqueness of the program is that respite service may be offered in any adult care facility beds (up to five beds) in any location that is available within the ACF facility. The ACF facility would not need to set aside specific ACF beds and keep them for respite only. That is, respite beds could be used as they are available. So respite services may be offered as resident occupancy fluctuates, as a way of keeping beds full and exposing people to the facility.
- The ACF requires less staff than a nursing facility care plan, and no additional staff are required to add respite care services.
- Permits the staff the opportunity to evaluate the client's needs, which may lead to another level of care or services in the future.

- Private pay can be charged at a premium rate, ranging from $75 to $85/day for respite care, compared with a range of $60 to $72/day for private pay residents of the ACF.
- Some health insurance and long-term care insurance will pay for ACF custodial care, including respite.

Potential Concerns/Limitations

- To offer this program, the nursing home would have to decertify some of its nursing home beds and have them converted to adult care facility beds, have access to its own separate ACF, or partner with one.
- No additional reimbursement is available for respite care for low-income recipients receiving Public Home Care or SSI reimbursement, over and above the basic ACF rate.

Potential Value of Option to County

If a county has an ACF, this option offers the opportunity for revenue enhancement while simultaneously creating a potential source of future referrals to the CNF.

Respite Care Medical Model

This service would permit a nursing home to offer respite services that can fill a marketing niche that is often not available. It could provide respite care in a medical setting, such as recovery from a hospitalization prior to returning to the consumer's home. It could also give primary caregivers needed respite when the client isn't suitable for a social model. In contrast to the respite care social model, this medical model service could be provided directly by a nursing home, although it would have to set aside specific beds to be used exclusively for this purpose.

Perceived Advantages

- This would also increase the array of services a CNF could offer the public.
- All program requirements are already offered by a CNF, such as supervision, structured programs, meals, NF services, medication management, OT, PT, ST and language pathology and medical services.
- Little new investment would be needed since staff and equipment are already available.

- The program would permit the staff the opportunity to evaluate the consumer's needs, which may lead to another level of care or services in the future.
- This model is currently being offered by few facilities.
- The county home can ask for a premium rate from the private pay client. For example, the nursing facility rate can be exceeded for this premium service.
- Some health care insurance and long-term care insurance will cover the cost of the respite care.

Potential Concerns/Limitations

- For each bed to be used for respite care services, a nursing facility bed must be taken off line and labeled just for respite services only. It could no longer be used for regular CNF residents, even if the bed were not being used for respite care at a particular time.
- The home would need to heavily pre-market and continue to market the service in order to assure that any respite beds would be fully utilized. If not appropriately marketed, the potential for lost revenue exists, since the bed cannot be used for an NF resident.

Potential Value of Option to County

This option has the potential to generate revenue for a home if it is properly marketed, and to create the potential for full-time residents to be cultivated by the service; however, there is the potential for beds staying empty if not aggressively marketed.

Enriched Housing (EH) Social Model

Enriched Housing (regulated by DSS) provides 12 hours of supervised care in an apartment-like setting with cooking facilities. The program offers at least one meal a day; personal care; housekeeping; case management; and socialization. A county nursing home may decertify beds, create new construction, or partner with another organization in order to offer this lower level of care, which can serve both private pay and Public Home Care/SSI residents. Application is to DSS, involving proof of need and disclosure of the provider's character and competence. The process may take nine months to one year.

Perceived Advantages

- Increases the array of services a CNF can offer the public.
- This service is currently being offered by very few nursing home facilities.
- If a CNF creates an enriched housing site, it then can create a Licensed Home Care Service Agency (LHCSA) and may apply for an Assisted Living Program (ALP).
- The program could create a feeder to the CNF.
- A low staffing pattern would be required for the program.
- There could be few capital expenses if existing structures can be rented.
- Private pay rates are set at what the market will bear.
- Some health insurance and long-term care insurance will cover basic program costs.

Potential Concerns/Limitations

- There would be a need for strong marketing efforts to draw private pay residents to a county program, as this program would need a high proportion of private pay residents to be successful.
- The program would come under both DSS and DOH regulations.

Potential Value of Option to County

A predominantly-private pay program could be a revenue producer, though it may require considerable marketing effort to make that happen.

Adult Care Facility (ACF) Social Model

The DSS-regulated Adult Care Facility (ACF) provides 24 hours of supervised care in a congregate residential setting with three meals a day and snacks; personal care; housekeeping; case management; and recreational programming. This social model of care would provide the CNF with a residential setting in which to place persons with relatively low case mix scores similar to the now-defunct HRF level of care who do not need nursing facility care. The ACF can also enhance its services to include one or more of the following: respite care; adult day care; early to mid-stage dementia care; and an assisted living program.

A county nursing facility could create a free-standing ACF or decertify some of its existing nursing home beds, which could in turn be converted to ACF beds by the county. Another alternative would be to partner with an existing ACF or purchase its business. The application is to the DSS, involving proof of need and disclosure of provider's character and competence. The application process may take nine months to one year.

At this point, only one county has both a CNF and an ACF operating under one overall administration. Another county has a CNF and an ACF, but under separate administrations that do not function as a team. The only other four counties owning ACFs do not also have county-owned nursing homes.

Perceived Advantages

- Increases the array of services that can be offered the public.
- Low staffing pattern for an ACF compared to a nursing facility.
- This can be of value as a program by itself, or it can be a building block making possible the integration of a core of lower-level long-term care services. For example, the ACF basic care plan can be enhanced by offering social models in respite care; adult day care; early to mid-stage dementia; licensed home care service agency (LHCSA); and may create an assisted living program (ALP).
- If a CNF applies to create its own LHCSA, it can provide home care services to all but its NF patients.
- This level of care is becoming a replacement for the old Health Related Facility care provider in a residential setting.
- This can be a very effective feeder to the CNF.
- Capital expenses would be relatively small if an existing CNF structure is renovated to offer an ACF program.
- Private pay rates are set at what the market will bear, and not determined by DOH. The range is likely to be between $60 and $85/day. There is the potential to attract enough private pay patients to make ACFs a profitable venture.
- Some health insurance and long-term care insurance would cover basic program costs.

Potential Concerns/Limitations

- The level of reimbursement for low-income ACF residents only covers about half the actual costs of providing the care, as the county must cover the other half under the Public Home Care (PHC) reimbursement formula. Although there are many other advantages to creating an ACF, the reimbursement formula creates a disincentive for a county, unless it can be offset with a high proportion of private pay residents. Financially, a county may be in a stronger position if it can partner with an existing voluntary ACF and thereby avoiding paying any county share of reimbursement for low-income residents.
- Publicly-traded corporations are beginning to purchase and create some ACFs in NYS, so this may become a competitive program area.
- Ideally, any county-operated NFs and ACFs would be under a single long-term care administration within a county, but there is currently little precedent for such coordination of services and policies.

Potential Value of Option to County

The ACF level of care is now serving those who were previously in a nursing home health-related level of care. The ACF level is positioned to grow and add services, as stated above. It has significant potential as a source of future referrals to a county nursing home. Financially, partnering with an existing voluntary ACF may be an attractive option for a county, unless the State government changes the PHC reimbursement formula to create greater incentives for county ownership of ACFs. If an assisted living corporation were to subsequently purchase an ACF owned by a county, the county would be likely to return a significant profit.

Early to Mid-stage Dementia Social Model

By creating a free-standing adult care facility (ACF), purchasing or partnering with an ACF, or decertifying NF beds to retrofit a county nursing facility to support an ACF, a county home can apply to DSS through a waiver process to create an early to mid-stage dementia social model. Based on a household design, a dementia care plan can be established by enhancing the CNF staffing pattern and training. The resulting program can be an excellent feeder to a nursing home skilled dementia program. A nursing home may also wish to add adult day care for dementia to create a continuum of dementia care.

Perceived Advantages

- Increases the array of services that can be offered the public.
- Currently being offered by few facilities, though becoming more popular.
- Lower staffing pattern needed than in a nursing facility.
- Private pay rates are set at what the market will bear: the current rates range from $95 to $135/day. There is a high demand for these services.
- Some health insurance and long-term care insurance cover the basic program costs if the person was insured prior to dementia.

Potential Concerns/Limitations

- Such a program would primarily need to be dependent on a private pay market to be financially successful.
- This may become a highly-competitive service. A publicly-traded assisted living corporation has already begun to make inroads in NYS to capture a portion of this private pay early to mid-stage dementia market.

Potential Value of Option to County

This type of program can be a good income producer, compared to its costs. At least one CNF has already begun to pursue the establishment of these services. However, this may rapidly become a highly-competitive market in some areas of the state.

Assisted Living Program (ALP) - New York State Defined

Regulated by both DSS and DOH, this limited NYS program is designed as an enhanced social model. The ALP is a combination of supportive housing and home care services to individuals who have historically been placed in nursing homes for social rather than medical reasons. Both enriched housing (EH) and adult care facilities may apply for a limited supply of existing ALP beds. An EH program or an ACF must apply in conjunction with a Certified Home Health Agency (CHHA) and a Licensed Home Care Service Agency (LHCSA) to create the ALP. This is a form of an integrated delivery system. This limited program is in theory available to a CNF by creating a free-standing ACF or enriched housing site, purchasing an ACF or EH

site, or decertifying NF beds to retrofit the system to support ACF level beds. A nursing home can apply through an application process through DSS, and it takes at least one year.

However, the practical reality at this time is that CNFs currently need not apply. Out of a limited number of 4,200 ALP beds initially available in the state, only 357 remain as this is written, with 27 active provider applications with requests totaling some 880 beds. Thus there is currently little likelihood of counties being able to be successful in submitting new applications for ALP beds, unless and until the supply expands. The development of legislation to expand the supply of ALP beds is currently under consideration.

Perceived Advantages

- This option potentially increases the array of services that a CNF can offer the public.
- Currently being offered by few facilities.
- Lower staffing pattern required than in a NF.
- Could assist in improving a nursing home's Case Mix Index (CMI), as lower scoring clients could be cared for in the ALP.
- A CNF could apply to create its own Licensed Home Care Service Agency (LHCSA) and provide home care services to all but its nursing facility patients.

Potential Concerns/Limitations

- Few ALP beds are still available, so there is little or no opportunity for CNFs to apply at this time.
- ALPs are likely to become a highly competitive program area, with the expected future involvement of publicly-traded out-of-state corporations.
- The program would come under both DSS and DOH regulations.
- While the main advantage to a county nursing facility is to acquire an ACF and create an LHCSA, the net effect of just the limited State government-defined ALP beds may be income-neutral or even negative for a county.

Potential Value of Option to County

This alternative might better serve a county that has an overbedded nursing facility situation and desires the ALP and related programs to expand services to utilize space.

Realistically, this option will only become a viable one for counties if new legislation creates expanded ALP opportunities in the future.

Assisted Living (as defined in other states)

While Adult Care Facilities and Enriched Housing are very close in concept to Assisted Living as defined in other states, with their assistance provided with activities of daily living and similar services, New York State, through DSS, at this time will only recognize their 4,200-bed limited ALP service as assisted living. On the other hand, similar "look-alike" programs have been created with independent living apartments that use a Licensed Home Care Service Agency to assist the residents with their home care needs. Moreover, changes being considered in NYS statutes may expand ALP opportunities in the state and create more inviting future opportunities for counties to become viable providers of such services.

Perceived Advantages

- Increases the array of services that can be offered the public.
- Utilizes a Licensed Home Care Service Agency, which a CNF could apply to create. This would give a county home the flexibility to self-serve any apartment residents, or other social models of care that it may create.
- This would involve a lower staffing pattern than a nursing facility.
- Little capital expenses would be needed if existing structures can be rented.
- Private pay rates are set at what the market will bear.
- This program is consistent with current trends, as people seek to delay or avoid going to a nursing home.
- Some health insurance and long-term care insurance cover some forms of assisted living.

Potential Concerns/Limitations

- Marketing for Assisted Living is highly competitive and a county nursing home will have to overcome any negative image that it may have.
- There is currently a lack of official standards for "out of state models" of Assisted Living in New York State.

- Assisted living model programs will be highly competitive, especially with out-of-state assisted living corporations moving into the state in the future, assuming they are legally allowed to do so (perhaps within the next two to three years).

Potential Value of Option to County

Depending on future legislation, this may represent a new market trend that will reward those that capture this marketing niche. County homes may be desirable sources of beds among publicly-traded corporations which may wish to purchase beds from nursing homes and convert them into ALP beds.

Certified Home Health Agency (CHHA)

Currently there may be an opportunity to bid on a new CHHA, as the State Hospital Planning Review Committee and the DOH are considering allowing for the creation of 52 additional CHHAs in certain counties around the state (see the appendix for a list of the potential counties and the number of possible CHHAs in each). A CHHA can bill for both Medicare and Medicaid and provide an extensive array of home care services. Also, a CHHA includes in its array of services its own Licensed Home Care Service Agency (LHCSA). Application would be to the DOH through a Certificate of Need (CON) process which will describe the program; its location; staffing schedules; services provided; audited financial statements; financial schedules of source and application of funds; and other related exhibits. The process may take at least a year.

Perceived Advantages

- Increases the array of services that can be offered the public.
- Being offered by few nursing home facilities.
- Private pay rates are set at what the market will bear.
- Most health insurance and long-term care insurance cover services.
- Can bill for Medicare and Medicaid.
- Can sub-contract with other LHCSAs for additional business, as LHCSAs need CHHAs in order to bill for Medicare.
- Specific niche programs are possible for Maternal/Child Care, Psychiatric Home Care Program, Orthopedic Pre-Screening, Wound Care, and Cardio-Pulmonary Care.

Potential Concerns/Limitations

- This would only make sense for a county to consider if it currently has no county government CHHA already in existence.
- Market penetration can be difficult as start-up includes gaining both market share and recognition.
- Staffing a CHHA is an ongoing process, as there is considerable competition for well-trained staff and thus often high turnover.
- A CHHA cannot refuse to provide care, including to those who cannot afford the full cost of care.
- A new agency will lack economies of scale and may encounter significant start-up costs.
- A county may choose not to get into a CHHA which might have to compete with existing CHHAs from which it is seeking referrals to its CNF.
- The State Hospital Planning Review Commission and the DOH have yet to reach a decision to open the bidding for the 52 potential new CHHAs.

Potential Value of Option to County

A well-marketed CHHA can be a good revenue producer and enhance a CNF's role in the county. It can also be a good source of referrals when the CHHA's clients begin to need more services than home care can justifiably provide. On the other hand, other lower levels of care may be easier to establish, and still accomplish the objective of creating new sources of revenues and marketing opportunities for the county nursing home.

Licensed Home Care Service Agency (LHCSA)

Home care is among the most rapidly growing services in long-term care. Home care is an integral part of most of the integrated delivery systems that are being created. An LHCSA can provide most of the services of a CHHA, except that it cannot bill for Medicare services. It provides skilled nursing services to persons in their homes. CNFs could create ACFs which in turn could set up LHCSAs. The application process is through DOH. The Part I Application focuses on disclosure of character and competence; staffing plans; budget; and schedules for quality assurance. The Part II Application is the development of policy and procedures; training schedules; corporate resolutions; and operational schedules.

Perceived Advantages

- Increases the array of services the CNF can offer the public.
- Allows for enhancement of services.
- Can serve both non-NF program clients and others in the community.
- Permits the staff the opportunity to evaluate the client's needs which may lead to another level of care or services.
- Private pay can be charged at a premium rate.
- Can bill Medicaid.
- Most health insurance and long-term care insurance will pay for services.

Potential Concerns/Limitations

- From a CNF perspective, the program may have the effect of increasing the time the client is able to remain outside the nursing home.
- Market penetration can be difficult.
- Staffing an LHCSA is an ongoing process, as there is competition for well-trained staff and resulting high turnover.
- An LHCSA cannot bill Medicare directly.
- If additional CHHA slots open up, there will be even more competition to acquire or create LHCSAs.

Potential Value of Option to County

If the additional CHHAs do not materialize, the LHCSAs remain the only viable option for county nursing homes to add home care to their services.

Managed Care and Integrated Systems of Care

Managed care systems are being created to save Medicaid dollars. Models are built on integrated systems of care, with networks and collaborative efforts between different providers offering different levels of care. Two examples are provided below of how such networks can work, and how county nursing facilities might have opportunities to become involved in the future.

Program for All-Inclusive Care for the Elderly (PACE)

PACE is a model of managed care, overseen by DOH, that integrates the delivery of acute and long-term care services under a capitated pay system. Like the Assisted Living Program plan, it targets individuals who are eligible for nursing home placement. Services include primary and specialty care, adult day health care, home care, acute care and nursing home care as needed. Two sites in Rochester and New York City are about to be joined by a third PACE pilot program in Syracuse. In the Rochester area, longterm housing options are also provided to some of the participants.

Perceived Advantages

- Increases the array of services that can be offered the public.
- Allows for enhancement of services.
- Creates an integrated delivery system.
- Attracts foundation support as a new program designed to save Medicaid costs.
- Most health insurance and long-term care insurance will pay for services.

Potential Concerns/Limitations

- From a CNF perspective, the program may have the negative effect of increasing the time the client is able to remain outside the nursing home.
- Program depends on federal waivers.
- High utilization of transportation and related expenses.
- It is a relatively new program with a limited track record.
- The program is currently located in only three sites, serving a relatively small number of participants.
- There is a PACE application process that will evaluate the possibilities of any new demonstration models. PACE programs are built on proposed cost saving models. Applicants would need to be flexible enough to control costs and offer integrated systems or be willing to partner to create those systems.

Potential Value of Option to County

There is the potential to establish a rural PACE model, as the coordinator has expressed interest in such a program. A PACE model would be a good feeder for a CNF. However, the

PACE model may be income neutral for a nursing home, depending on the ability to control costs, and the volume of business may also be relatively low coming from the local PACE site.

Continuing Care Network (CCN)

This is a PACE modified program, overseen by DOH, that can also partner with a social model of care, an Adult Care Facility. This is a program for dually-eligible Medicaid and Medicare individuals who enroll in a managed care plan that provides them with a primary care physician and combines home care, adult day care, adult care facility, mental health, skilled nursing care, and hospital care. This model is part of a Federal Waiver Program and its goal is the control of costs. This program follows all the application and operational steps of the PACE model. Also, it then can receive prospective payments.

Perceived Advantages

- Hospital provides primary care physicians.
- Increases the array of services provided to the public.
- Allows for enhancement of services.
- Attracts foundation support as a new program designed to save Medicaid costs.
- Most health insurance and long-term care insurance will pay for services.
- The integrated delivery system promotes quality care in the least costly settings.

Potential Concerns/Limitations

- From a CNF perspective, the program may have the effect of increasing the time the client is able to remain outside the nursing home.
- The program depends on federal waivers.
- This remains a new program with a limited track record.
- As with PACE, applicants would need to remain flexible enough to control costs and offer integrated systems or be willing to partner to create those systems.

Potential Value of Option to County

A CCN model would be a potentially good feeder for a county nursing facility. However, it may be income neutral, depending on its ability to control costs.

Continuing Care Retirement Community (CCRC)

Such programs have grown in popularity in other states, though regulatory requirements and financing limitations have limited their development in New York, where CCRCs are just beginning to be offered. They are primarily for upper income elderly who can afford an entry fee of from $100,000 to $300,000. There are also monthly fees associated with this type of care plan. The CCRC offers multi-levels of care beginning with housing and services through nursing home care when needed. Depending on how large the entry fee, the full cost or a portion of the nursing home fee may be covered as residents move from level to level as their health changes. At the present time there are only two CCRCs operational and a third is under construction in Rochester.

Currently there are three levels of CCRCs. The first level is referred to as Life Care or an extensive model. The upfront entry fees are the most expensive in order to provide applicants with prepaid nursing facility (NF) care whenever it becomes needed. As with the other two levels, there are also monthly fees for any services required prior to admission into the NF level of care. The second level is referred to as a Modified Care Plan. It requires less expensive upfront entry fees, as the NF prepaid care is limited to a range of 15 to 20 days per month. Any additional NF days are on a fee-for-service basis. The third level is referred to as Fee for Service and has the smallest upfront fees, with all nursing home services paid for as they occur.

Perceived Advantages

- Increases the array of services offered the public.
- Most health insurance and long-term care insurance will pay for services.
- Allows for a seamless integrated delivery system.
- Is in demand for those with relatively unlimited funds.

Potential Concerns/Limitations

- Program is costly to set up, demanding very extensive insurance reserves.
- It can also be expensive to administer.
- Extensive marketing campaign would be needed.
- Would challenge the county nursing homes' mission.

- Along with existing NYS providers and developers that are planning to offer a CCRC, or a CCRC "look-alike" (without the life care contract), out-of-state publicly-traded long-term care corporations are also planning to search for CCRC market share in NYS.

Potential Value of Option to County

County nursing facilities may find an opportunity to partner with, sell to, or sell selected NF bed licenses to other providers, both NYS and out-of-state corporations, when they come into NYS and need access to nursing home beds as part of their continuing care communities. Such opportunities may also create conflicts for counties and their nursing homes, as they weigh the opportunities involved in enhancing short-term capital vs. their mission and the long-term needs of the residents of the areas they serve.

Subacute Care and Special Care Units

At the high end of the service array for county nursing facilities is the emerging subacute care focus, which is also lumped together here under the broader category of special care units. These offer a variety of specialized, high intensity services for people with special needs, usually offered over relatively concentrated periods of time. Special care units may include such units and types of residents as: physical rehabilitation, stroke and other neurological impairments, Alzheimer's disease, HIV/AIDS, subacute or convalescent care, young accident and brain trauma victims, spinal cord injuries, ventilator dependent patients, hip replacements, etc.

The first premise behind the potential expansion of such units is that the need is increasing, as pressures are placed on hospitals to discharge patients who at one time would have stayed as inpatients to deal with most of those issues, but who now are being forced to leave the hospitals and seek lower, less expensive levels of care. The additional premise, from the perspective of the nursing homes, is that these specialized services, while less expensive to provide in a nursing home than in a hospital setting, can nonetheless be a lucrative source of income for the homes, since reimbursement for such services typically exceeds reimbursement levels for other types of care provided in the homes.

Subacute and most if not all of the other specialized types of care typically require skilled care for patients with complex needs. The services are sometimes labeled "Medicare high-end skilled care" or "heavy care skilled," higher acuity patients, who have complex or intensive

needs requiring skilled care, often for relatively short periods of time. Subacute care has grown through the efforts of managed care providers to find more cost-effective types of care, the implementation of new Medicare payment policies applicable to acute and post-acute care providers, and changes in patient preferences. Medicare's payment systems for acute care have led to increased demand for post-acute, subacute care services. The development of such specialty units could in some geographic areas be established on a regional basis.

Perceived Advantages

- Many Medicare managed care plans offer incentives to shift beneficiaries to NFs.
- In selected areas, county facilities could respond to unmet needs by increasing the array of services needed to address special rehab and related medical needs for care. Specialty units address growing needs with targeted services.
- Growth of managed care and related pressures create a growing demand for such services. Nursing homes can demonstrate through such services their ability to compete in a managed care environment, either by themselves or as part of managed care partnerships.
- County facilities should be able to increase revenues by focusing on such patients who have higher case mix acuity scores and who receive higher reimbursement rates.
- In most cases, this focus should enable homes to increase the proportions of residents who are reimbursed by Medicare, at 100% Federal reimbursement, and to decrease the proportions covered by Medicaid, for which counties must pay 10% shares.

Potential Concerns/Limitations

- There will be substantial competition from other nursing facilities to find a responsive, financially stable niche in this changing marketplace.
- There will be added costs up front to develop the subacute care plan, increased staffing, training, equipment, possible therapy specialists, etc.
- Publicly-traded corporations may increasingly compete in this market, with the efficiencies they are able to bring to these units.
- Larger chains may be better prepared than county facilities to develop subacute care programs based on their ability to access capital markets, achieve economies of scale and operating efficiencies, develop integrated post-acute networks, hire specialized staff, and provide higher-margin ancillaries through their own related organizations.

- Some have raised the concern that setting aside beds for special units may compromise the mission of some nursing homes, by potentially denying services to traditional nursing home residents while responding to the higher end needs.

Potential Value of Option to County

This new trend of care has both high start up and risk costs, as well as high potential rewards for county homes. The CNFs will need to network, be very flexible, and increase their operating efficiencies to be a viable partner in managed care systems and in responding to such special needs. Subacute and specialty care offers large incentives and, if successful, will provide increased Medicare reimbursement and a good referral system that should combine in most cases to raise the CNF's case mix index and reimbursement levels.

Specialized Care of Geriatric Prisoners

A National Criminal Justice Commission study shows shrinking space in prisons and jails, and most prisons and jails are not equipped to function as a nursing home. The cost for incarcerating state inmates 55 and older is estimated to be about $69,000 per year. That is three times the normal cost of an adult inmate. The primary cause is the cost of medical care. Many State and Federal prison administrators are experimenting with privatization and forms of managed care and contracting with outside agencies to provide health services. Some offenders that have no families to support them, when released, are placed on public assistance or transferred to State run convalescent or nursing homes. When there is a relocation of an older prisoner to such a public facility, the annual cost of care is reduced to approximately $36,000 per person in New York--a substantial reduction from the $69,000 geriatric incarceration costs.

Some CNFs may wish to pursue the possibilities of a special locked unit for the care of geriatric prisoners. County nursing homes could consider the delivery of services to a modified site at a prison. With NYS currently concerned with the costs of prisons and the need for more space within them, this may be an appropriate time to explore a partnership between selected county nursing homes and State and/or Federal prisons within their geographic areas.

Perceived Advantages

How counties would benefit is unclear at this point, but this may provide an opportunity to provide selected services on a contractual basis that could prove mutually beneficial at several levels of government. This may be especially worth exploring if some CNFs have unused space or are facing the likelihood of such space in future years. The potential for total public cost savings (across all levels of government), and for the possibility of increased revenues within selected counties, may make at least an initial exploration worthwhile.

Potential Concerns/Limitations

There are many uncertainties about this "virgin territory," so counties would need to explore this area with extreme caution. There is the legitimate concern that movement in this direction could negatively impact at least the *perception* of nursing home safety and security, and hence the marketing of any other new CNF services, as well as existing core nursing home care.

Potential Value of Option to County

This type of joint venture could receive strong support of county, State and Federal governmental levels in order to save taxpayers considerable money overall. With appropriate safeguards, some counties could also find this a source of income in future years. On the other hand, the numbers of counties likely to be affected would appear to be small, and a considerable amount of developmental effort would be needed to make this concept work and to overcome potential marketing concerns and perceptions of lack of adequate safety and security.

Alternative 4. Options for Limiting the County's Role in Nursing Homes

The alternatives for county nursing facilities which have been considered to this point have all assumed that the county homes would continue to exist. Those alternatives have ranged from (1) maintaining current nursing home operations (the status quo) to (2) continuing the homes with various internal reforms to (3) continuation of core nursing home operations, but with one or more additional long-term care services or programs added. Despite major differences in the implications of each of those alternatives--and the various subsets of options

under the second and third broad alternatives--all have a major connecting thread: in each, the county government would continue to own and directly operate the county nursing home.

By contrast, this fourth and last broad alternative along a "degree of change" continuum would involve the greatest change in governance or oversight responsibility for the nursing homes. Counties opting for this alternative to the status quo would severely limit, if not fully eliminate, any direct responsibility for the operation of their nursing facilities. In most cases, this would mean that the county would get out of the business entirely, while in others the county would continue to play some reduced role, but *in all of the options discussed below, the county government's day-to-day responsibility for managing and operating the county nursing home would be at least significantly reduced, if not eliminated.*

Various options are explored below, some of which have overlapping features, strengths and limitations. For each of the core options discussed explicitly, there are multiple permutations and hybrids limited only by circumstances in each county, the imaginations and creativity of those creating the new solutions, and relevant legal restrictions. But at least these core options appear to be worth consideration for those counties which are contemplating the possibility of limiting their involvement in, or getting completely out of, the nursing home business. ***Decisions as to what a county should do when faced with a decision to stay in or leave the nursing home business are rarely clear-cut and unambiguous, and can only be made after careful consideration of all relevant factors on a county-by-county, home-by-home basis.*** But the core options discussed below at least lay out the framework for change that should be considered.

Options are presented along a rough "degree of county disengagement" continuum, ranging from options which would *limit* a county's operational responsibilities for, and financial commitment to, its nursing home--but while still maintaining overall county control over the home--to options which would result in *complete divestiture* of the county's responsibilities for the home. The most realistic options for county consideration are as follows:

- management contracts to operate nursing homes,
- sale of some licensed beds,
- establishment of county public benefit corporations,
- establishment of State CNF authority,
- conversion of county home to free-standing not-for-profit corporation,

- conversion of county home to existing voluntary corporation,
- employee buy-out (employee stock option program),
- sale of county home to proprietary corporation,
- cessation of nursing home operations without transfer of facility.

Those options are summarized below, along with their potential strengths and limitations:

Management Contracts to Operate Nursing Homes

At one end of the "degree of county disengagement" continuum is the option whereby the county would contract with a management firm to operate the facility on a day-to-day basis. Under such an option the county would retain overall responsibility for setting policies affecting the nursing home and for budgetary oversight. Policymakers concerned about giving up too much control over the facility and its programs, but also concerned about running the home as efficiently as possible, would be able to help assure that the overall mission of the home was not compromised, while simultaneously also receiving assurances that the home is under the day-to-day administration of a firm presumably specializing in nursing home administration and therefore able to maximize the home's fiscal condition. (This management contract option involves oversight of the *entire* nursing home operations, as distinct from the earlier discussion under Alternative 2 of more limited contracting out on a fee-for-service basis of selected functions or services within a home.)

Such management contracts could occur at different levels. Under one scenario, the management contract could function almost like a consultant arrangement rather than a true takeover of the management and day-to-day responsibilities of running the home. Under the consultant arrangement, current county staff would remain in place within the nursing home, with outside management experts providing advice and consultation, and perhaps in some cases direct "hands-on" management and decisionmaking.

In a very different scenario, a management firm could be hired to take over virtually all aspects of operating the nursing home, with existing county staff relegated to support roles or, in the most extreme case, actually losing jobs in favor of the staff team brought in by the management firm. In the latter case, the management firm would bring in staff with specialized expertise in various aspects of operating and financing a nursing home and entrust them to carry out the needed functions within the home.

A third variation of the management contract option would be to have specific aspects of the nursing home contracted out to a management firm with specialized expertise in those areas. For example, it might make sense to contract out responsibility for operations of a new special care unit, such as a subacute unit or dementia unit.

To the extent that New York county nursing homes have experience with management contracts, they appear to most closely resemble the first option, with aspects of the second, but without actually replacing county employee nursing home staff with staff employed by the management firm.

One set of circumstances under which a county might consider contracting out the management of a nursing home would be in a situation in which the county home has a history of operating at a deficit, and serious consideration is being given to closing the county facility. A management firm--in this case perhaps more of the consultant relationship--could be brought in and given a specified period of time within which to get the home back on a sound financial and management footing. Once the work is done, the county could determine whether to continue the management arrangement, revert back to straight county operation of the facility, or decide that the best solution would involve the county's getting out of the business entirely.

Perceived Advantages

The overall benefits of the management option would depend on the nature of the management arrangement, and how well the contracts are negotiated and monitored. In some situations, a management firm with specialized expertise in particular areas could help improve efficiency in those areas. Such firms could also help a CNF address long-range planning issues by helping it anticipate changes and develop strategic plans to adjust to those changes. A firm could help save money and improve the quality of care for residents of the home. An ideal management firm may be able to use its expertise and experience in other locations to bring the best practices from other homes into the county facility and help implement such practices.

The advantages of such expertise could be maximized in some situations in a short-term management arrangement, whereby a firm is hired as a consultant for a fixed price to recommend changes, but the overall management responsibility on a permanent basis remains with the county employees. In that case, a consultant would be expected to generate permanent savings and revenue enhancements on an annual basis that would far exceed the one-time costs

of the management contract. On the other hand, in more ongoing management contractual arrangements, the contract could involve hiring a firm to replace at least some of the county home's workforce, thereby potentially reducing the county payroll and saving wages and benefits on an annual basis (depending of course on the terms of the contractual agreement between the county and the management firm).

Any of the contractual arrangements would have the advantage of enabling the county to continue to remain in control of the ultimate destiny and mission of the home, without giving up that responsibility to any other organization, as would happen under several of the other alternatives discussed below.

Potential Concerns/Limitations

The primary concerns about the various management options revolve around the potential loss of the county home's historical mission under a bottom-line oriented management, and the potential loss of jobs by county employees under the more extensive and long-term management team approach. The fear is that in the interests of saving taxpayers dollars, more emphasis would be placed on cutting costs and compromising quality of services, and on assuring the most reimbursable residents, possibly at the expense of serving some of the more "hard to place" individuals that have characterized the missions and actual residents of various public nursing homes around the state.

Administrators of county homes have also expressed concerns that some management firms do not adequately understand the reimbursement formula and other special circumstances affecting county homes in New York, and that, unless firms are very carefully selected, some can cause more problems than they solve. Other administrators expressed the concern that some such firms have a vested interest in "getting their foot in the door" and using the opportunity to promote particular options from which they are uniquely positioned to profit if they are implemented in the future.

Potential Value of Option to County

For counties wishing to continue to directly provide nursing home services in the public sector and which do not want to give up control over the mission and policies of the nursing home--but which want to exercise greater control over the management and cost effectiveness

of the overall operation--this option may offer the appropriate mixture of responsibilities and protection of county employees, especially under the management contract scenario which does not lead to wholesale replacements of county staff. Under this option, counties must be diligent in selecting management firms which do not have vested interests in the outcomes of their actions and recommendations.

Sale of Some Licensed Beds

A second option whereby the county can continue to operate a nursing home, but with limits placed on the relationship, involves the sale by the county of the licenses or medical assets of selected, limited numbers of its nursing home beds to another organization for its use. This scenario is most likely to occur in the context of a sale of bed licenses to a publicly-traded corporation. Under this option, a holder of current licensed nursing facility beds may transfer one or more of those licensed beds to a new owner, through a "transfer of ownership," as long as the sale is approved through a CON process by the State DOH. Such sale can either involve the sale of the entire physical assets--the building, beds and licenses--or only one or more of the medical assets--the actual licenses for the nursing facility beds. If only some of the licenses or medical assets are sold, the original seller retains the actual beds and the building.

In this limited sale example (sale of the entire facility is discussed separately below), the buyer now has access to the license to provide nursing home service for as many licenses as purchased. For example, if a county has a 100-bed nursing home and sells licenses for 25 of those beds, the buyer can now provide nursing home care for 25 residents at any new location approved by DOH. On the other hand, the county retains the original facility, the 75 unaffected NF beds, and 25 of the original 100 beds which can now be converted into new uses other than nursing facility beds. That is, the same 25 beds whose licenses were sold can now in effect be multiplied by two--to create 25 new nursing home beds for use by the new buyer, and the 25 original beds which can now be used by the county to convert to some other lower level use. Those beds can be retrofitted for any subsequent use, as long as it is at a lower level of care than the NF level, and as long as it is approved by the appropriate regulating body (often DSS, as indicated earlier in the chapter).

In this option, the county may ultimately profit directly by using the proceeds of the sale of the bed licenses, which can be substantial for each licensed bed, to pay for any costs of creating a new use for the existing beds, thereby potentially earning a short-term profit from the

sale, while also in effect multiplying the total supply of long-term care beds available in the community.

Perceived Advantages

Under this option, the county clearly would continue to retain direct operating control over a number (albeit a dwindling number) of nursing facility-level beds, while at the same time retaining control over a potentially wider array of beds which can be used to offer lower levels of long-term care. Moreover, under this option the county would receive funds from the sale of the bed licenses which can be used to aid in the conversion of those beds into other uses to meet the community's growing need for lower levels of care. Thus the county would have earned money which can be used to expand the net number of long-term care beds in the community as a whole. Such a scenario may well become a more likely one over the next few years if organizations from outside the state (especially publicly-traded corporations) attempt to buy up as many existing beds as possible, or at least the licenses to those beds, for use in making major inroads into the direct provision of care in locations throughout the state. Counties and other owners of existing nursing home beds can exact a high price from those buyers if they choose to do so, and if beds are sufficiently in demand, and can then use proceeds from any sales to reinvest into expansion of the overall number of service beds for community long-term care use. In addition, any ongoing profits generated by the corporation on an annual basis would generate taxes for the counties in which they operate.

Potential Concerns/Limitations

Although having the positive effect of helping to increase the net total number of long-term care beds available in the community, counties selling off some of their nursing home bed licenses need to consider the overall impact of what they are doing when they sell these licenses. Some fear that "consorting with the deep pockets corporate devil" may be a dangerous precedent, as it would help give the large, for-profit, corporations (in the future often likely to be from out-of-state) an important assist in establishing a firm foothold as competitors in the state. Those fears are that with their extensive resources, these publicly-traded corporations will play an increasingly significant role in the provision of long-term care in the state, and that with their emphasis on profit, the overall quality of care provided in the community will erode over time. Moreover, there is the concern that any profits from their efforts will go outside the state,

although that would be partly offset by taxes paid from those profits to the State government and counties.

Potential Value of Option to County

A county which may already believe it has more nursing facility beds than it needs, but which does not want to remove itself from the nursing home business, can reduce its number of vulnerable beds, make a one-time profit from selling some of those bed licenses, and use the proceeds to invest in expanding the community's supply of lower-level long-term care beds. In turn, the county should assure itself and its constituents that it is entering into such a sale of licenses with a clear objective in mind, has thought through the consequences of giving up control over the "mission" of the sold bed licenses, and is not simply "blinded by the dollar signs."

Establishment of County Public Benefit Corporations

The traditional purpose of public benefit corporations or authorities (many of which carry the title "authority," "commission," "district" or other names) is to construct, operate, and finance a specific type of improvement. The number of state, regional and local authorities has exploded since 1956, when only 90 existed in the state. Today there are about six hundred in operation around the state, and their missions include construction, operation or financing, or combinations of the three. Functions of statewide or regional authorities include operating the State Thruway or regional transportation systems, regulating rivers, constructing facilities for colleges and hospitals and urban development. Local authorities have been created to help meet communities' needs for housing, parking, water supply, sewage treatment, and industrial and community development.

Public benefit corporations (PBCs) are often created to provide a more flexible administrative entity than a local government for the operation of a public enterprise. The corporation can operate the service without many of the limitations and constraints of local government and behave like a commercial entity. Public benefit corporations can be free from many of the constitutional and statutory restraints faced by county governments:

- PBCs are free from debt limitations, except for those in their enabling legislation.

- Public benefit corporations are not required to follow the provisions of the Civil Service Law in the hiring and promotion of officers and employees.
- PBCs are not bound by public bidding requirements faced by counties.

However, while it is possible for a public benefit corporation to operate with these freedoms, most are created with legislation requiring them to comply with many of the same restrictions faced by counties. Most PBCs, for example, are created to comply with public bidding provisions and the Civil Service Law. They can only be created with special acts of the State Legislature, even if their jurisdiction is exclusively local.

Public benefit corporations are normally created for a limited purpose, which nearly always expands. They tend to take on additional obligations, leading some to oppose their use. The total indebtedness of all State, regional and local authorities is approximately $13 billion. This ability, however, is part of the single greatest advantage of public benefit corporations--their autonomy from State and local government. Their autonomy makes them relatively efficient and able in some cases to accomplish more than a county government, for example, but creates a condition where an entity can incur public debt with relatively little public oversight.

Perceived Advantages of Nursing Homes as Public Benefit Corporations

Could a county benefit by turning the responsibility for its nursing home over to a newly-created public benefit corporation? What would be the advantages of doing so?

- From the point of view of many county legislators and executives it would be a relief to hand off the responsibility for managing the nursing home.
- Nursing home administrators value autonomy. A public benefit corporation would increase their autonomy in the operation of their nursing homes.
- A nursing home does not necessarily benefit, in any obvious way, by having a county management structure layered on top of its own management structure.
- Fiscal decisions at the nursing home would not be as closely tied to the county budget cycle.

- The nursing home would have an appointed board, presumably with more long-term care related experience than their county legislators or supervisors have. Legislative representatives could be appointed to the board to provide some direct, though limited, country input and control over the PBC's actions.

- The corporation would have a greater degree of flexibility and would be free, subject to board approval, to enter into managed care contracts, add additional services, enter into networks with other health care providers and make other decisions that are more difficult to effect as part of county government.

- While it is unlikely that any county could create a public benefit corporation that is exempt from the Civil Service Law, the employees of the corporation need not necessarily be part of the countywide bargaining unit, even though they can still be represented by CSEA. This creates the opportunity to negotiate contracts more suited to health care services.

- The PBC can be created to include other county health care services and be designed with the potential to serve as an integrated services network.

- The county can reduce its county payroll, and can reduce or *eliminate*, if it chooses in determining the terms of creation of the PBC, all county tax subsidies for the nursing home.

- Employees of the home would continue to be part of the State retirement system, at least initially, although future employees may be treated differently, depending on PBC board actions.

- The PBC could continue to be eligible to receive IGT payments.

- County cost allocations for the nursing home would be discontinued. To the extent that the county nursing home currently creates demands on the county's support services (e.g., legal, personnel, maintenance, purchasing, etc.), those demands and time requirements would be eliminated under this option, thereby freeing up staff in those county operations for other tasks or, depending upon how much work they currently are

doing for the nursing home, perhaps even resulting in some reductions of staff and costs in those areas in the future.

- The nursing home administration under a PBC would have more control over the purchase of administrative and support services previously provided by county government and allocated against the nursing home. This may result in a reduction in the actual costs of such services. Also, as a separate corporation with its own board and independence, it is likely that over time, new salary and benefit plans and staffing configurations would be put in place that may ultimately result in lower operational expenses for the home. In the long run, if such savings in personnel costs and costs of support services result, this would save taxpayers money, as the county's 10% share of Medicaid rates would be 10% of a lower total figure than under the CNF operations.

Potential Concerns/Limitations

What are the potential concerns for a county creating a public benefit corporation for its nursing home?

- In some counties, turning the nursing home over to a public benefit corporation would cause the legislature/board to lose direct control of a large portion of its budget. In spite of the operational efficiencies a public benefit corporation could achieve, it could be difficult to convince a legislative body to surrender control of the historical service mission of a nursing home representing a significant share of the county's operating budget.

- Public benefit corporations are designed to behave more like commercial entities than county governments. If a county nursing home has a unique mission that taxpayers are willing to subsidize, there is the potential that a corporation might not maintain this mission if the opportunity cost is too high.

- The public benefit corporation would be free to incur debt, modify the structure and mission of the nursing home, and even sell or transfer the nursing home without voter or legislative approval.

- There may be some initial uncertainty as to how the PBC will cover all its costs, especially if the county no longer agrees to subsidize any shortfalls. Careful understandings should be worked out as part of the agreement to create the new PBC mechanism.

- By losing access to the county's various support services and liability insurance coverage, and without the existence of comparable support services that would likely be available within a larger existing service-providing agency, this option may force the new corporation to have to purchase various support services and insurance on the open market, with additional direct expenditures of cash, rather than more indirect costs and "paper transfers" levied against the county home's budget. On the other hand, as noted above, the PBC may be able to purchase such services at less actual cost than was previously allocated, or charged against the CNF budget.

- To the extent that a county government has been able to receive at least partial reimbursement for any of its administrative or support service costs allocated against the CNF (not all counties obtain such reimbursements), it would lose those reimbursements once it no longer operated the nursing home, even though the administrative/support expenses may continue.

Nassau and Westchester Counties

Two counties in New York State, Nassau and Westchester, are scheduled to transfer their nursing homes into public benefit corporations effective January 1, 1998. Nassau County's A. Holly Patterson Geriatric Center has 869 beds and had an occupancy rate of 99% with a case mix index of 1.115 in 1995 and Westchester County's Ruth Taylor Geriatric Rehabilitation Institute has 400 beds with a 1995 occupancy rate of 93% and a case mix index of 1.19. In 1995 Medicaid paid for 89% of resident bed days in both facilities.

Both public benefit corporations were created with similar legislation signed by the Governor in 1997. The two corporations share several features:

- Both the Nassau and Westchester public benefit corporations include the county hospitals, the Nassau County Medical Center and the Westchester County Medical

Center, respectively. The Westchester corporation also includes a county-operated psychiatric hospital and a mental health services provider.

- Both are in the process of appointing boards and are scheduled to be operational January 1, 1998.

- Both facilities will remain eligible to receive IGT funds owing to special language in the State budget.

- Both facilities remain free-standing nursing homes and neither becomes a hospital based nursing home as a result of forming the corporation.

- The formation of the corporation does not result in a rebasing of the Medicaid cost year.

- Both corporations are subject to the Civil Service Law.

- Current collective bargaining agreements (employees of both facilities are represented by CSEA) remain in effect, but employees will not be part of a countywide agreement in future contract negotiations.

- County cost allocations against the nursing homes will be discontinued.

In both Nassau and Westchester, it would appear that the hospital and not the nursing home was the primary motivation in creating the public benefit corporation. Many of the Public Medical Institutions (municipally owned nursing homes) in the state of Massachusetts became authorities years ago in response to the presence of nursing home chains in the state. Authority status allowed them to enter into strategic partnerships without the oversight of a local government and gave them increased flexibility to deal with increased competition.

Potential Value of Option to County

This option would technically accomplish the goal of getting the county out from under the burden of being responsible for the financial well-being of the nursing home, while at the same time maintaining an "arms length" continuing concern for and active interest in the facility. From the employees' perspective, most if not all would be able to retain their jobs, at least

initially, and they would remain public employees subject to Civil Service protections, and could maintain union connections and support. On the other hand, the public benefit corporation could make any changes it chose to make to create a more efficient operation in the future, so there would be no future guarantees as to the mission of the home or protections for either employees, residents or future "hard to place" individuals in the community. The county would be represented on the board of the PBC to help assure that such issues continue to be addressed.

CNFs Become a State Authority

If individual county nursing homes can become public benefit corporations, could some or all county-owned nursing facilities join in some way to become a statewide authority? This would represent a major shift in the county's role. Each county would effectively cede control of its nursing home to the newly created authority. The new authority would provide some sort of administrative oversight for all member homes, including, perhaps, personnel, purchasing and capital improvements planning. Staff in each home would be employees of the authority and not the county. Presumably, this authority could be structured to eliminate county subsidies and maintain IGT payments.

Without question, it would be extremely difficult to make this happen. Numerous acts of State and county legislation would be required. However, several administrators found the concept of a statewide authority for government nursing homes intriguing for several reasons.

Perceived Advantages

- A State authority would have one combined bargaining unit representing employees of all member homes and only employees of member homes. The authority would likely be in a better position to set reasonable wages and work rules than individual counties.

- This option would allow for the consolidation of various functions, such as staffing, purchasing and contracting, in a central office. Under the right circumstances, this would greatly reduce the administrative burden on individual homes.

- The authority, rather than individual counties, would be responsible for decisions to renovate, build or close homes based on statewide and/or regional needs and interests. These decisions would no longer be based on individual county concerns and political

considerations. The decision to renovate a home, for example, would be balanced against the needs of other homes across the state and not other demands on specific county budgets.

- If structured properly, a State authority could function as a nursing home chain and be in a better position to compete with corporate nursing home chains, if and when they are allowed to operate in New York.

- A State authority would be in a better position to enter into managed care contracts and other network arrangements than an individual county home.

- A State authority could be designed to be free from public bidding requirements and Civil Service laws, reducing the cost of care.

- The authority could incorporate a mission similar to county homes into its charter.

Potential Concerns/Limitations

- State authorities are often a few steps away from government oversight. Without proper oversight, there is the potential for an authority to become a patronage vehicle with the potential for financial mismanagement.

- The county would lose control over its nursing home. Decisions to expand, modify, or close homes would be made by the authority.

Potential Value of Option to County

While offering potential advantages to the overall "system" of public nursing homes, the difficulties in obtaining agreements across numerous governmental entities may make this option a long shot at best. Counties would need to develop some core understandings in the near future as to whether there is sufficient interest in pursuing the concept, and whether it is sufficiently feasible from a practical point of view, to justify devoting energy to the possible creation of such an authority. In a very real sense, counties may need to determine whether to focus attention on creating solutions at a county-specific level, or whether to work to create a statewide mechanism.

It seems likely that most counties and their nursing home administrators cannot realistically be expected to have the time to focus creatively on both possibilities simultaneously.

Convert County Home to a Free-Standing Not-for-Profit Corporation

Under this option, a not-for-profit 501c(3) corporation would be created to own and operate the previously county-owned nursing home. In effect, ownership and operation of the facility would be transferred or sold to the newly created not-for-profit corporation. Services and programs previously provided by county employees would in effect be transferred from the county to the new corporation. The services and programs would likely remain virtually identical to existing services, at least initially, although the county could determine whether to make some adjustments as the transition is made (e.g., adding additional services along the long-term care continuum). It is assumed that existing nursing home employees at the time of the transition would transfer to the new agency, or would at least be given the opportunity to do so.

Staff would no longer be included as employees on the county payroll, and would no longer be eligible to receive county benefits. Salary levels and benefit packages could be identical or at least similar initially, or they could become something quite different, depending on agreements worked out in advance between the county and the new corporation. The corporation would have its own board of directors which would make subsequent decisions about the corporation's affairs. The county could choose, in helping to negotiate terms of the new corporation, to have automatic representation on the new corporation's board as a way of confirming the county's continuing commitment to the home, although under this arrangement the county would no longer be liable for the financial well-being of the nursing home. Other than paying the county's 10% share of Medicaid patient rates, the county would have no ongoing fiscal responsibilities with the new corporation.

Establishment of a new corporation, as opposed to selling the county nursing home or converting it to an *existing* not-for-profit or voluntary corporation, would enable the county to control to the extent possible the type of services that would be provided, while at the same time building in as many protections as possible for existing staff and residents. At the same time, by freeing the nursing home from the county, it would help create a number of options and a degree of flexibility it would not be likely to duplicate as a county agency.

Perceived Advantages

- This option would retain many of the strengths of the existing county-operated nursing facility, including the public's comfort and familiarity with existing programs, staff and location (assuming the corporation would remain in the same location, although this option could also be combined in some counties with the construction of a new facility if one is needed).

- Continuity of care and providers would be maintained, at least initially, with minimal disruption of services to current residents. By essentially transferring existing services and programs to a corporation it helped design, the county could help assure the continuation of the county home's mission.

- From the county's perspective, it would be able to eliminate the nursing home positions from the county payroll, thereby saving the salaries and benefits currently paid.

- From the employee's perspective, this option would make it relatively easy to combine "privatization" of services with some reasonable assurances of employee protection, at least initially--e.g., transferring most if not all jobs to the new corporation, likely maintenance of most benefits, etc. On the other hand, as a separate corporation with its own board and independence, it is likely that over time, new salary and benefit plans and staffing configurations would be put in place that may ultimately result in lower operational expenses for the home. In the long run, if such savings result, this would save taxpayers money, as the county's 10% share of Medicaid rates would be 10% of a lower total figure than under CNF operations.

- The county would no longer be liable for any subsidies in years when the home was not "profitable," thereby further saving taxpayers dollars. By the same token, to the extent that the nursing home's revenues in a given year exceed expenditures, there would of course be no direct benefit to taxpayers.

- To the extent that the county nursing home creates demands on county government's support services (e.g., legal, personnel, maintenance, purchasing, etc.), those demands and time requirements would be eliminated under this option, thereby freeing up staff in those county operations for other tasks or, depending upon how much work they

currently are doing for the nursing home, perhaps even resulting in some reductions of county staff and costs in those areas.

- The nursing home would gain some flexibility and ability to respond to changing service requirements and administrative needs as a result of the removal of the home from the county bureaucracy and restrictions imposed by Civil Service, union/contractual agreements and Taylor Law restrictions. Also, the nursing home administration would have more control over the purchase of administrative and support services previously provided by county government and allocated or charged against the nursing home's budget. This may result in a reduction in the actual costs of such services.

- As the new corporation develops its own board of directors, an opportunity would be created to expand the county's constituency for long-term care by appointing knowledgeable persons committed to the home and the need for strong long-term care services in the community.

Potential Concerns/Limitations

- No matter what agreements are made initially and how much the new corporation is designed to continue the concern for county employees and the historical mission of the county home, over time the independent board may have to make decisions that may appear to undermine the historical commitments. The county will have forfeited any direct control over the home, and its ability to influence what happens under the new governance structure will be limited to any effect its representative(s) on the board may have, and the power of public persuasion.

- The home under this structure would no longer be eligible for the generous IGT payments now available to public nursing facilities. On the other hand, it may have fewer expenditures over the years that are associated with public facilities, thereby minimizing the need for such a supplemental revenue source.

- If the new corporation is a stand-alone agency, it may still have some of the problems an unaffiliated county home would have in facing the changing systems realities, reimbursement mechanisms and service-provision changes that are shaping the delivery of long-term care services. Thus, the new corporation may still need to create the kinds

of partnerships and consider expanding services in various ways, as discussed above. On the other hand, as a free-standing corporation no longer tied to government, it may have more flexibility to move decisively when new directions are needed (as noted above under "perceived advantages").

- A new voluntary corporation may not have the kinds of deep financial resources necessary to make the kinds of capital investments in facilities and equipment and new staff that may be called for both for the nursing home and other potential service enhancements. Therefore, the protections that such a free-standing corporation could provide may be offset by significant restrictions on resources at the disposal of the new corporation, unless it is well financed from some source (including the county, should it decide to make such a commitment, at least in the short-term transition period). On the other hand, newly-passed State legislation may provide at least a partial solution here, as construction and renovation projects of not-for-profit nursing facilities may now be funded for up to $15 million through local Industrial Development Agencies (IDAs).

- To the extent that a new facility may be required, whereas the county could finance 100% of the costs if it chooses, a voluntary corporation would need to come up with at least 10% of the costs up front, which could be a problem for a small voluntary corporation in its early stages of existence. (Again, the new IDA legislation may help here.)

- To the extent that a county has obligations to continue to pay nursing home retirees health insurance or other benefits (not all counties have such continuing commitments), the net county costs of paying those obligations could increase if it no longer owns the nursing home. If it has been reimbursed for such expenses (and the administrative cap has not been exceeded), the county would lose such reimbursements once it no longer operates the home, although the expenses would continue.

- By losing access to the county's various support services and liability insurance coverage, and without the existence of comparable support services that would likely be available within a larger existing service-providing agency (see option below), this option may force the new corporation to have to purchase various support services and insurance on the open market, with additional direct expenditures of cash, rather than more indirect costs and "paper transfers" levied against the county home's budget. On the other hand, as suggested under "perceived advantages" above, the corporation may be able to

purchase such services at less cost than was previously allocated, or charged against the CNF budget.

- To the extent that a county government has been able to receive at least partial reimbursement for any of its administrative or support service costs allocated against the CNF (not all counties obtain such reimbursements), it would lose those reimbursements once it no longer operated the nursing home, even though the administrative/support expenses may continue.

Potential Value of Option to County

This option would allow the county, if it chose to, to divest itself of responsibility for providing nursing home services directly, while at the same time building in as many protections as possible to assure continuation of the county home's mission, and protections at least in the short run for current residents and employees. The county would no longer be required to commit taxpayers dollars to subsidies for the home, and if the home is able to lower its overall costs, the county share of Medicaid dollars spent on nursing home care may also decline over time. On the other hand, there are no guarantees that the county's mission to the "hard to place" will continue to be met in future years--and if not, the costs associated with expanded alternate level of care hospital backups could increase (for example, the county would have to pay 25% of the higher hospital costs of Medicaid patients, rather than 10% of lower costs in the nursing home setting)-- nor are there assurances under this model that the necessary financial resources will be in place to meet any needs for substantial capital expenses (though the recent IDA legislation should help reduce that concern).

Convert County Home to Existing Voluntary Corporation

This option would have many of the positive features of the previous option, with the added potential benefits of converting the home to an *existing* voluntary organization with presumably more stability and resources than a newly-created organization would have. Under this scenario, the county would decide to divest itself of the ownership and operational responsibility for the county home, and would either select a local hospital or other not-for-profit/voluntary organization to negotiate a takeover, or would issue a Request for Proposals (RFP) to interested organizations in the community. The RFP would ascertain the extent to which there would be sufficient interest, willingness to respond to designated mission, and

ability and resources to satisfactorily operate the home under terms acceptable to the county. The focus of this option is to explicitly sell or transfer ownership of the home to a voluntary corporation in order to enhance the likelihood of finding a new owner which would be open to, and compatible with, the core historical mission of the county home. (See option below which would involve sale of the facility to a proprietary corporation, where there may be less likelihood of such compatibility.)

Such a transfer of responsibility would require approval from the State Department of Health. As with the previous option, the county would no longer have any direct responsibility for the home, and would have no responsibility to subsidize any of the costs of operating the facility. The terms of the agreement could either include the transfer of the *current facility*, which would be operated by the voluntary organization that assumes ownership of the home, or they could include an understanding that a *new facility* would be built, to be owned and operated by the 501c(3) organization. In the latter case, the county could agree to purchase the new facility (with its ability to finance 100% of the costs), or the voluntary could agree to obtain the construction and equipment financing, as happened in the recent transfer of ownership from a county home to a not-for-profit hospital in Oneida County.

If an existing facility is to continue to be used after the transfer, rather than a new facility being built, the county would need to determine whether it would actually sell the facility, or whether in effect to simply divest and transfer ownership to the new voluntary corporation without an actual financial transaction being involved. In some cases, the county may be so happy simply to get out of the nursing home business and be willing to have the responsibility for running the home transferred to another operator with a compatible mission that it is willing to forego any actual payment for the home; in some cases, the voluntary may only be able to take over the home under such circumstances. In other cases, an actual purchase may be arranged, depending on the financial circumstances and needs of both the county and the prospective new owner.

The county would need to be explicit under this option about the terms under which it would be willing to transfer ownership of the home. For example, either in the negotiations (if with a single organization) or in the RFP, the county needs to stipulate clearly what expectations it has, and what it expects to hold any new owners to, concerning such issues as protection of current residents of the home, preferences given to county residents in the future, protections or preferences given for current employees, future assumptions about case mix and whom the new

home owners will admit under what assumptions (and what guarantees it is willing to make concerning "hard to place" individuals), etc.

Under this option, it is likely that terms could be negotiated that would provide at least reasonable protections that the core mission of the home would be continued, that current residents would be guaranteed continuity of care, and that current employees would be at least given first preference for jobs under the new employer, if not actually directly transferred into the new owner's payroll. However, the key test becomes what happens over time after the agreement has been forged and the voluntary corporation, with its independent board, takes over. How binding are any agreements over what period of time? What assurances can be offered by the new provider that the county's historical mission will be continued? What levels of assurances are sufficient for the county to feel comfortable relinquishing control over the facility? How these and a series of related questions are answered will determine whether this option ultimately proves to be a viable one or not for specific counties.

Perceived Advantages

- The county would no longer subsidize the nursing home operations in years where it was not "profitable" on its own, and it would be able to eliminate the nursing home positions from the county payroll.

- The new nursing home organization would gain flexibility and the ability to respond to changing service requirements and administrative needs as a result of the removal of the home from the county bureaucracy and the restrictions imposed by Civil Service, union/ contractual agreements and the Taylor Law restrictions.

- Any current demand on the county's support services would be eliminated.

- An existing corporation would presumably bring greater resources to the agreement than a newly-formed voluntary corporation, and therefore may have more options available to it concerning purchasing of needed equipment, capital improvements, adding new services and/or levels of care, adding staff as needed for potential new services, etc. In addition, it may be able to absorb responsibility for providing some of the support services previously provided by central administrative units within county government, without having to contract out for provision of such services.

- Should the county and/or the new owner choose to do so, the new governing body could ultimately provide an umbrella corporation for other health and long-term care organizations.

Potential Concerns/Limitations

- As with the previous option, offsetting the ability of the county to get out from under the burden of responsibility for owning and operating the nursing home is the fact that the county would forfeit any opportunity to exercise any future control over the facility and its future once the transfer has occurred.

- There are no guarantees under this option of the county's ability to provide nursing home care for the "hard to place," unless there are agreements with the new owner and/or other nursing homes in each area to absorb their "fair share" of that subset of the population. Even such "agreements" would be hard to enforce. Without resolution of the "hard to place" issue, there is a risk of increases in alternate-level-of-care cases in hospitals, with the county paying 25% of the higher hospital costs of Medicaid patients rather than 10% of lower costs in the nursing home setting.

- Unless counties are able to find potential new owners for their nursing homes that have the financial wherewithal to purchase existing facilities, counties may not be able to realize any immediate financial benefits from the sale of the property; instead, the benefits to the counties in such situations would result exclusively from any potential savings in future years.

- As with the previous option, to the extent that a county government has been able to receive at least partial reimbursement for any of its administrative or support service costs allocated against the CNF, it would lose those reimbursements once it no longer operated the nursing home, even though the administrative/support expenses may continue.

Potential Value of Option to County

Under this option, the county would be able to save money and remove itself from the responsibilities of operating its nursing facility in the future, thereby protecting itself from any

unknowns that may arise with changes in the health and long-term care systems in the future. It may or may not be able to make money from the direct sale of the home, depending on the terms of the agreement reached with the new owner. In exchange for the benefits, the county gives up the ability to control what happens to the home and its mission in future years.

Employee Buy-Out (Employee Stock Option Program)

To date, there has been no implementation of such an option in New York in the long-term care field. Nor is there any significant body of literature or experience in the field at the national level, although some interest has been expressed in exploring the concept. It is not clear how this would be made to work, but the employees would somehow buy the nursing home and become employee-owners. This would give all employees a vested interest in the efficient operation of the nursing home and take it out of the hands of county government.

Perceived Advantages

- An employee-owner is generally assumed to be highly motivated to be a conscientious, cost-conscious employee. Staff at the nursing home under this option would likely be more motivated as employee-owners.

- The nursing home would be in a better position to network and modify the services it provides.

Potential Concerns/Limitations

- Would employee-owners sacrifice the traditional mission of a CNF for the "bottom line," especially if it means more compensation for them?

- The nursing home business in New York State is increasingly risky. With the rise in alternatives to nursing home care, managed care and other developments, the would-be employee-owners would need to understand the risks involved.

- The nursing home would probably lose county support and IGTs.

- This option would reduce the size of the county bargaining unit and might meet with resistance from CSEA.

Potential Value of Option to County

This is an option that could be pursued if there is a strong commitment from nursing home employees to try to work out a satisfactory arrangement, but without such a commitment and support for the idea, it is not likely to go very far.

Sell County Home to Proprietary Corporation

One of the options presented above involved the sale by the county of the licenses for a selected number of its nursing home beds, thereby enabling the county to continue to control the remaining beds and the overall county nursing home operations while at the same time providing funds from the proceeds of the sale that could be used by the county for various purposes. Further along the continuum of county disengagement from nursing home operations is the option whereby the county would sell the *entire nursing home facility* to a proprietary corporation. Such a corporation could be either a private, for-profit corporation licensed to operate long-term care facilities in the state, or, with possible changes in state legislation in the future, a publicly-traded corporation (typically based outside New York). Such publicly-traded corporations cannot currently own or operate nursing home beds in New York, but that may change, as legislation authorizing such a role in the state has previously received support in the State Senate, albeit not in the Assembly and not even in the Senate in the past legislative session.

As noted earlier, some view these publicly-traded corporations as a competitive threat to existing nursing homes and especially to the public homes with their "mission" to serve those whom other facilities may be reluctant to admit. Others, however, view the potential arrival of such corporations as an opportunity for county facilities. The corporations will need to seek linkages for some of their care plans, including linkages with nursing home beds. As such, some counties may be confronted by requests to transfer some or all of their nursing home beds to one of these corporations, particularly to the extent that any of the county homes may be perceived to be "vulnerable" politically within their counties. County nursing home beds could either be transferred through the sale of the license for specific numbers of beds (as described above) or by the county's selling the entire nursing home and all its physical assets--the building, beds and license.

Under this latter option, the county nursing facility would be sold to the new corporate owner through a "transfer of ownership," which would have to be approved by the State Health Department. The county would reap the one-time profits from the negotiated sale of the facility and would no longer have any say in any decisions concerning the facility's operation. In theory at least, a county could negotiate an agreement with the corporate purchaser concerning what would happen to the residents and employees of the home, and what the new owner's obligations would be in the future concerning admission policies, but there would be little the county could do to enforce such agreements once the sale had taken place. The county would be free to use the proceeds from the sale to invest in other needed long-term care services, or it could make the decision to use the proceeds for one or more of a variety of purposes having absolutely nothing to do with long-term care.

Perceived Advantages

- The county would be able to immediately effect a significant reduction in the size of the county payroll, by eliminating the sizeable number of employees for the home, along with responsibility for meeting the home's payroll and payment of benefits.

- The county would no longer have any direct responsibility for subsidizing the home in any years where there was a shortfall of revenues. Other than paying the county's 10% share of Medicaid resident reimbursement to the new proprietary home, the county would have no ongoing fiscal responsibilities with the new corporation.

- Any current demand on the support services of county government would be eliminated.

- The new corporately-owned home would typically have more flexibility than the county to respond to changing service needs and requirements, to add services and equipment, and to make capital improvements as needed.

- Assuming that the new corporate structure would institute various changes that would lower the annual operating costs of the facility in the future, the county's 10% share of Medicaid payments to cover costs of Medicaid residents of the corporate facility would be reduced, although that share in the future would be going directly into corporate coffers.

- Corporate ownership of the nursing home would be paying taxes to the county, rather than taxpayer subsidies being required in many counties.

- The county could reap a substantial one-time source of income from the sale of the property, which it could choose to use in a variety of ways. If it chose to do so, the county could increase the net total number of people able to receive long-term care in the county by investing some or all of the proceeds into the establishment of expanded long-term care services at a lower level of care than the nursing facility level, to the extent such services are needed. Such services could be provided either directly by the county or on a contractual basis by voluntary agencies in the community.

- To the extent that counties were to sell their homes to publicly-traded out-of-state corporations doing business in New York, the proceeds from the sale and the ongoing taxes paid would represent an influx of new revenues from outside the state. (On the other hand, annual profits would in effect leave the state.)

Potential Concerns/Limitations

- As noted earlier, by selling to large, for-profit corporations, counties may help such corporations establish a firm foothold as competitors in the state. Some fear that with their extensive resources and emphasis on profit, publicly-traded corporations may play an increasingly-significant role in the provision of long-term care in the state, and that the overall commitment to quality of care in nursing homes may erode over time as their role expands.

- The county would no longer have any direct control or influence over the nursing home and its mission. It would have no direct ability to affect what happens to current county home residents or employees, other than through any agreements worked out as part of the sale, and would have no direct ability to affect future admission or employment practices. There would be no guarantees that county residents and/or "hard to place" residents would receive priority attention as they do in most county homes.

- Several counties have expressed concern that increased nursing home beds controlled by proprietary owners concerned primarily about profits may reduce the likelihood that the overall nursing home system will admit hard-to-place, "reimbursably unattractive"

people who might otherwise cause an increase in the backup in hospitals of patients awaiting admission to nursing homes. Such alternate level of care (ALC) Medicaid patients represent higher costs to the county than if they were placed in a nursing home: each one costs the county 25% of a higher hospital reimbursement rate, compared to 10% of lower nursing home rates.

- To the extent that a county has obligations to continue to pay nursing home retirees health insurance or other benefits (not all counties have such continuing commitments), the net county costs of paying those obligations could increase if it no longer owns the nursing home. If it has been reimbursed for such expenses (and the administrative cap has not been exceeded), the county would lose such reimbursements once it no longer operates the home, but the expenses would continue.

- As noted above, to the extent that homes were sold to publicly-traded corporations from outside New York, any profits in future years from operation of those proprietary homes would leave the state and go to those out-of-state corporations.

- Assuming that these corporations would operate nursing homes in the future with reduced staffing, there would be a net loss of long-term care jobs in the county as a result of the sale of county homes--unless the county were to reinvest the proceeds in the creation of additional long-term care programs and services which would hire equivalent numbers of staff or more (and/or unless the proprietaries themselves added other types of services that expanded job opportunities throughout the long-term care system). Counties may wish to consider the probable "big picture" employment implications associated with the sale of the home before entering into a final agreement.

- As indicated in several other options above, to the extent that a county government has been able to receive at least partial reimbursement for any of its administrative or support service costs allocated against the CNF, it would lose those reimbursements once it no longer operated the nursing home, even though those administrative/support expenses may continue, in part at least.

Potential Value of Option to County

A county with potentially more nursing home beds than it needs, and/or that is finding it more and more difficult to maintain high occupancy levels, and/or that is under pressure to reduce high levels of county subsidies to its nursing home, may find this an attractive option. The county may well save money annually, and it can make a one-time profit from selling the facility. If it chooses, it can invest all or at least a portion of the proceeds in the development of expanded long-term care options at lower levels of care, thereby helping to increase the numbers of elderly county residents able to receive services needed to maintain independent living within the community at less cost than in a nursing home setting. On the other hand, counties contemplating such a sale should be cautious about the potential implications of such a decision on the ability to ensure that "hard to place" county residents needing nursing home care in the future will be able to find a facility willing to admit them--an assurance counties have little or no control over once they no longer operate a nursing home.

Cease Nursing Home Operations, with No Transfer of Facility

This alternative would represent the most extreme, and perhaps most unlikely, scenario along a "degree of county disengagement" continuum. Under this option, a county would simply determine that it was no longer in its best interests to continue to operate a nursing home, and that circumstances had reached the point where it would be preferable to close the facility, even if no other sale or transfer options were feasible, than to continue its operation. The county would have to give 90 days notice of its intent to close the facility, and it would have to receive approval from the State Commissioner of Health. It would be responsible for arranging for the discharge or transfer of all current residents prior to closing the facility, and for notifying the appropriate next of kin and/or responsible person and the physician of each resident.

Responsibility for caring for those historically served by the county facility would need to be assumed on a shared basis by the remaining nursing home operators in the county and/or surrounding area. The extent to which those operators would make such a commitment could not be guaranteed. Depending on the size of the county facility and the occupancy rates of the various nursing homes of all types in the county, it is possible that the other homes would simply not have sufficient capacity to accommodate the loss of beds from the county facility. Even if sufficient capacity were present, there would be no firm assurances that "low reimbursable" Medicaid and/or other "hard to place" county residents would receive sufficient priority from

other nursing homes to assure that they would be admitted in the future. This would clearly be the most disruptive of the various options which counties could consider for disengaging from the nursing home business.

Perceived Advantages

There would appear to be relatively few advantages to the county under this alternative, compared to the various other options available to it. Presumably the only circumstances under which a county would even consider such an option would involve a political judgment that the county nursing home had become a substantial continuing (and unacceptable) drain on local taxpayers, coupled perhaps with a declining occupancy rate and the prospects for a continuing downward spiral--with no viable prospects for sale or transfer of the facility to any other provider. The only apparent advantages to the county under this scenario would be some of those noted under other options, along with one possible additional value:

- the ability to reduce the number of employees on the county payroll;
- the elimination of county taxpayer subsidization of the home;
- the elimination of the home's demand on county government support services;
- the possibility that the nursing home facility could be converted into alternative uses of value to the community, such as lower levels of long-term care, senior housing, other forms of federally-subsidized housing, etc.

Potential Concerns/Limitations

- There would be major disruption to the residents of the current county nursing home who would be dislocated.
- There would of course be a significant reduction in the number of nursing home beds available in the county. Unless the county has a major oversupply of beds and high vacancy rates in the use of its existing beds, the elimination of substantial numbers of beds is likely to cause shortages in the future, unless other long-term care alternatives are put in place.

- There could be significant economic hardship within the community, as employees of the home would suffer dislocation. Although it is likely that some of the employees would be able to find employment within other nursing homes in the area or within other units of county government, it is likely that substantial numbers would wind up unemployed for some period of time, perhaps costing the county unemployment insurance payments, as well as costs associated with any severance arrangements.

- The county would of course no longer be able to exercise any direct control over who is admitted to nursing homes in the future. It is unlikely that there would be adequate assurances that "hard to place" county residents in need of nursing home care would be absorbed by the remaining nursing home providers in the community.

- It is unclear what would happen to the nursing home buildings and grounds under this scenario. Even though there is the potential for alternative uses, as suggested above, there is also the potential under this "closedown" alternative for the county to have a large unused facility on its hands.

- In the final analysis, it is not clear whether this alternative would receive the approval of the State Health Department.

- As with other divestiture options, the county may lose reimbursements for county expenditures that would continue even though it would no longer operate the nursing home.

Potential Value of Option to County

Of all the options considered for limiting or eliminating a county's role in providing nursing home care in the future, this would appear to offer the fewest benefits to the county. And its residents. Other than the possible advantages of eliminating the ongoing costs and responsibilities of operating the home, the county would appear to gain little from implementing this option, while potentially setting in motion a number of disruptions and dire consequences for the overall long-term care delivery system in the county.

A Final Alternative: Long-Term Care Screening/Assessment

Counties which own and operate nursing homes are both providers of and payors for nursing home care. As such, they have dual responsibilities to various constituencies: both to assure that the mission of the home to provide high quality services to those in need is consistently met and at the same time to assure county taxpayers that long-term care services are being provided as economically and cost effectively as possible. Stewardship of the nursing home and broader stewardship of overall public resources can be mutually consistent, but can also come into conflict with each other. For example, a goal of maintaining high occupancy levels at the county nursing home and even having the home be "profitable" may conflict with opportunities to provide less costly services at a lower level of care for many potential nursing home residents, thereby providing the most appropriate levels of care in settings that foster individual independence while also potentially saving the county taxpayers money. Currently most counties have no mechanism for making such determinations, either at the broad policy level, or at the level of individual decisions being made about most appropriate levels of care based on individual and family circumstances.

However, some counties in New York, and some states, are beginning to address this issue by developing long-term care policies and/or units of government to oversee long-term care services and expenditures. Often at the core of such efforts is the creation of long-term care assessment or screening units, sometimes known as long-term care access programs. Such screening programs typically have dual goals of both (1) containing long-term care costs and (2) improving the delivery and quality of long-term care services and assuring that those services are provided at the most appropriate level, given individual and family needs and preferences.

Screening programs are not viewed as fitting neatly along the continuum of alternatives previously described throughout this chapter, but rather cut across all the four broad alternatives discussed above and summarized earlier near the beginning of Chapter V. Regardless of what choices a county ultimately makes along that continuum, a long-term care screening or access program can provide valuable information both to individuals and their families and, in the aggregate, to county policymakers as they attempt to make informed decisions about long-term care policies, programs and expenditures for the county as a whole.

Most such screening programs are voluntary, although some are mandatory for all persons seeking nursing home placement, regardless of payment source. For example, the State of Maine has recently enacted such a mandatory screening program, although ultimate choices remain with individuals, once they have been screened and educated about the alternatives available to them. The programs often involve coordinated staffing from departments such as DSS, the Health Department and the Office for the Aging, and typically provide a central access point, or a form of "one stop shopping," for information about the range of long-term care services available in a county, and the level of care that appears most appropriate in light of an individual's needs, financial circumstances and preferences.

Individuals' needs and appropriate levels of care are typically assessed by a nurse. Immediate needs and placement opportunities are usually addressed, but individuals and families can also receive information to begin to plan in a non-crisis mode for the future, based on objective information about levels of care and what resources exist within each of the various levels. In some cases, screening programs also help individuals with necessary paperwork and application forms. Actual choices are left to the individuals and their families/caregivers, but experience in various settings to date suggests that people tend to act responsibly on the information they are given to make appropriate choices which are both in their interests and, in the long run, are also most cost effective both for them and for taxpayers as a whole.

Perceived Advantages

There is evidence in the areas where such long-term care assessment initiatives have been implemented that they have been instrumental in:

- improving access to various levels of long-term care;
- educating individuals and families to help them better meet their long-term care needs in the short run as well as planning for the future;
- improving coordination between various services and departments of county government; and
- providing appropriate quality services at the most cost effective levels.

Reports on some such programs have documented their impact in reducing costs, especially in the expenditure of Medicaid dollars, and in expanding use of community-based programs and services at lower levels of long-term care than more expensive institutional care. The initiation

of such screening programs can be an important step in creating a consistent and coherent long-term care policy and set of programs for a county, and in helping assure that the county strikes the correct balance between quality, appropriate level, and cost effectiveness of long-term care services.

Potential Concerns/Limitations

Many counties have resisted the establishment of such programs for a variety of reasons. In some cases, there has been a fear of giving them too much power in determining who obtains what levels of care. In some cases there have been concerns about which department(s) of county government will oversee the screening process. There are also concerns expressed by some nursing home administrators that such screening efforts will lower their occupancy rates and add to their revenue problems. Others have at least raised the possibility that by providing the public with more information about long-term care alternatives, public costs in the long run may go up, as people previously able to function on their own without supportive services become more aware of the services and decide to take advantage of them, at public expense.

Potential Value of Option to County

Properly implemented, a long-term care assessment program can help a county assure that the most appropriate and least costly levels of long-term care are being offered consistent with its citizens' needs and preferences. From a nursing home perspective, there is a legitimate concern that it may lose some business as people who would have become nursing home residents wind up receiving other levels of care, at least initially. On the other hand, by emphasizing the importance of planning for and making informed decisions about long-term care options, such assessment programs may in the long run help create future referrals to the home. Moreover, data obtained from the assessments may help provide the documentation needed for a county to determine which transitions, if any, may be needed to some of the lower levels of care referenced earlier in the report. In short, such screening programs can help a county establish a coherent approach to long-term care which balances its "big picture" responsibilities as both a provider and funder of long-term care services.

VI. CONCLUSIONS

County nursing homes have provided valuable services to residents in more than 40 counties in New York over the years. They have provided needed long-term care services to many county residents who in all likelihood would not have been served by other, private nursing homes; and in many of those cases, the persons ultimately served in the county homes would have been forced to remain for a period of time in more costly hospital beds, with the county paying a larger share of the costs than in the nursing home setting. County nursing facilities (CNFs) have also been an important contributor in many counties to the local economy. All of these statements remain true today, and these CNF attributes are enhanced in some counties by the fact that some CNFs have contributed a net "surplus" to the annual county budget--and the total of such counties may increase in future years, as long as the current levels of intergovernmental transfer (IGT) payments remain in effect.

County nursing homes indeed have many significant attributes. However, county homes throughout the state are nonetheless increasingly vulnerable. Even the substantial IGT payments are viewed by many as being a relatively short-term source of revenues that may not last; *counties are cautioned not to base decisions on the future of their nursing facilities on an assumption that IGT payments will continue, at least at their current substantial levels.* In addition to the uncertainty of the IGTs, a number of other factors combine to leave county homes at a crossroads, under increasing pressures from taxpayers and county officials. These factors include:

- decisions made (or not made) over the years by county governments, over which the homes often had little or no control, that have had often adverse impacts on the CNFs;
- changing circumstances and pressures in the health care and long-term care environments over which the homes have little or no control;
- current and likely future increases in competition from lower levels of long-term care and from other nursing homes (and particularly from proprietary homes, increasingly likely in the future to be out-of-state publicly-traded corporations); and
- deficits faced by most CNFs in most years.

Given these and related factors, the futures of county nursing facilities, individually and collectively, are at stake.

The County Nursing Facilities of New York, Inc. (CNFNY) recognized the variety of competing factors--historical, current and emerging--that push and pull county nursing homes and county officials in various directions. It requested this study to help define the current status of county facilities in the state, and to educate administrators and policymakers about the options available to them. Although in conducting this study CGR was specifically asked not to make specific recommendations, but rather to present viable options in an objective fashion, a few concluding comments are appropriate.

First, it seems clear to CGR that ***few if any county nursing homes can afford in the future to continue to conduct business as they have in the past.*** Even where such approaches have been effective in the past (a statement that applies to many county facilities), changing circumstances simply eliminate the status quo option as a viable approach in the future. ***Homes that continue to operate as they have, with no efforts to respond aggressively to changing realities, will simply be left behind, often at significant costs to taxpayers at all levels of government.*** The substantial IGT payments of recent years, as long as they continue, will make it easier for many CNFs to continue to operate in the good graces of county policymakers, at least for the time being, but there are no guarantees that such payments will continue indefinitely, and even if they do, they should not obscure the fact that changes will be needed for county nursing homes to survive in the future.

Nonetheless, despite such a dire forecast, the future of county facilities need not be as bleak as the "business as usual" scenario would suggest. Indeed, this report has pointed out numerous options available to county nursing homes that could brighten their future considerably. Without revisiting them in detail, suffice it to say that ***there are a number of reforms or internal changes county governments and their nursing homes can undertake, and there are numerous possibilities for expanding the services and levels of care they provide, or link with, that individually or in combination could make the future of many county homes quite viable.*** We are very optimistic that the future of many county homes can indeed be bright and financially viable, consistent with the traditional missions of the homes, if counties and their nursing home administrators work collaboratively, constructively and creatively to implement some of the options discussed throughout this report, and to tailor those options to the unique circumstances of their particular homes.

On the other hand, there are likely to be counties in which even the implementation of internal changes or the expansion of long-term care services may not be enough to guarantee

a viable future for their CNFs. Other counties may decide that, even if their homes could survive and even prosper in the future, they will not be needed and the private system would be sufficient to meet the public's nursing home needs in subsequent years. After all, 19 counties presently have no county nursing homes (most, but not all, with county populations under 60,000). ***In counties reaching conclusions that the future of their county homes is in question, various options are available which would limit or completely terminate the county's future role in operating a nursing home.***

Which scenario a county chooses, if it should decide to scale back its role or get out of the business completely, will be in large part dependent on what competition and other resources currently exist in the county, and on what choices a county makes concerning attempts to assure that the mission of the county home will continue as much as possible in the future, vs. attempts to make any divestiture as financially lucrative for the county as possible. Various options along a continuum provide each county with a number of choices and opportunities to balance those competing interests and values.

Even if we had been asked to make specific recommendations as to what counties and their CNFs should do, there would be no blanket, "one solution fits all" recommendations possible. ***There is simply no one set of solutions that will universally work for every county, or even all counties of similar types.*** Conversely, several combinations of options could work for a number of counties. But the reality is that *each county on a case-by-case basis must make its own decisions as to which option or combination of options will best address the particular set of circumstances unique to it.*

But whatever decisions are made county by county, we are convinced that there are sufficient options available to each county and CNF, and that there are already sufficient strengths existing within each CNF, to virtually guarantee that ***each county should be able to make decisions concerning the future of its nursing home that will result in a positive resolution for the county. That is, virtually every county should be able to craft a solution or set of solutions that would either enable the CNF to remain in business, at little or no costs to county taxpayers, or to responsibly divest itself of responsibility for nursing home services in a way that eliminates future county financial subsidies of nursing home care (other than the 10% share of Medicaid costs).***

In the final analysis, the decision for a county and its nursing home to make can probably be stripped down to a deceptively simple, basic choice: either be willing to commit to the home and its future and to doing what is needed to make its future a viable one, or decide to eliminate the county nursing home from the county government's functions.

The key decision for a county to make, if it decides to divest, then becomes the balance it decides to strike between the extent to which it wishes to profit from the divestiture and the extent to which it wishes to attempt to assure at least some vestiges of the county home's historical mission once the county can no longer directly control that mission.

On the other hand, if the choice is to remain in the business, county officials should be willing to commit to doing what is necessary--depending on the needs of the home, the competitive pressures it faces, and its financial circumstances--to assure that the home can remain competitive, true to its mission, and financially viable. Such a decision may mean that the county must in turn commit to one or more subsequent decisions, such as expanding services, directly or in partnership with other providers, along the long-term care continuum; investing in renovating an old facility or building a new one; aggressively marketing the CNF; allowing the nursing home administrator more control over direct costs; entering into agreements with nursing home employees to do what is necessary to make the home more financially viable; etc.

If the county is willing to make the types of decisions necessary to assure a viable future of the home under changing competitive conditions, then it should probably continue its commitment to the nursing home, its constituency and its mission. If unwilling to make these types of commitments to the home's future, the county should probably begin to take steps to disengage from the nursing home business under terms that best protect the future interests of the county and its constituencies.

Two final thoughts for consideration by State governmental officials that could have substantial bearing on what counties may decide to do with their nursing homes in the future:

- It may be in the State's interests to provide financial incentives for counties to establish new long-term care services at lower levels of care than provided in nursing facilities. For example, if a county decides to decertify nursing home beds and convert them into provision of lower levels and less expensive forms of care--which would lower the State's level of Medicaid expenditures--it may make sense for the State to share some of

its savings as incentives 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 conversion.

- The State may wish to adopt Maine's initiative to enable counties to "bank" nursing home beds. Under such an arrangement, a county hesitant to decertify any of its nursing home beds in order to convert them into lower levels of care could decertify the beds, maintain them in a pool of "banked" beds, and reactivate them as nursing home beds if future needs warranted doing so, under an expedited and simplified Certificate of Need approval process.

APPENDIX A: GLOSSARY OF TERMS

Activities of Daily Living - The activities usually performed in the course of a normal day in the resident's life, as eating, dressing, toileting, washing, or brushing his teeth.

Adult Care Facility (ACF) - An ACF is a residential care facility which provides custodial and domiciliary care to generally well elderly persons who, because of age or infirmity, cannot, or choose not to, live independently. ACFs provide room, board, supervision, and assistance in activities of daily living, as well as minimal medical care.

Adult Day Health Care - Social, recreational, and/or limited health care services provided to frail elderly persons in a group setting during daytime hours. Medical day care programs focus on health and personal care. Social day care programs focus on social/recreational activities.

Alternate Level of Care (ALC) - Designation of patients in the hospital awaiting placement elsewhere.

Alzheimer's Disease - An irreversible dementia, causing a loss of nerve cells in those portions of the brain essential to memory and thought processes.

Ambulatory Care - Services provided on an outpatient basis in hospitals, physicians' offices, clinics, or community health centers.

American Association of Homes for the Aging (AAHA) - AAHA is a national non-profit organization representing not-for-profit nursing facilities, housing, and community services for the elderly.

Ancillary Services - Services other than physicians' services and room and board.

Assisted Living - An enhanced package of health services which, in the New York State model being developed, will be delivered to individuals residing in a supportive environment. Services may include acute and long term home health services and may be delivered to individuals residing in adult care facilities or other specified senior housing which offer supportive services.

Case Management - A system of coordinating health and/or supportive services which meet the needs of the patient. Most often a lead service agency or individual is identified as the coordinator of all health and/or supportive services a patient may require. Typically, case managers play a role in certifying and arranging payment for services.

Certificate of Need (CON) - Process by which the applications by providers for new or expanded health facilities, services, or equipment are approved or denied by state agencies (mandated by Article 28 of the New York State Public Health Law of 1965).

Co-Payment (also called Co-Insurance) - Amount a policyholder must pay directly per physician visit, prescription, clinic visit, and hospital stay; the remaining balance is covered by insurance.

Community Services - A range of services which includes acute care, long-term care, and hospice, as well as a wide variety of supportive services delivered in the patient/client's home. Typical community services extend from programs such as meals on wheels to visiting nurse home care to adult day care.

Continuing Care Retirement Communities (CCRCs) - Retirement communities which guarantee they will provide supportive services in addition to shelter on a continuing basis for a long period of time, sometimes for life, as residents age and their needs change. There are usually a variety of accommodations ranging from completely independent apartments to assistance with daily living in resident's own apartment to nursing home care.

Deductible - Amount the policyholder must pay before insurance benefits begin.

Dementia - A progressive mental deterioration due to organic disease of the brain.

Diagnosis Related Groups (DRGs) - Patients are classified according to diagnosis, and the hospital then receives a fixed payment from Medicare based on that diagnosis, no matter how long the patient stays or how many services are provided.

Enriched Housing - A program designed primarily for persons aged 65 years and older who need some assistance with activities of daily living in order to live independently. Persons

requiring continuous medical or nursing care are not eligible. Programs are either located in freestanding buildings or within private or publicly subsidized housing.

Fee-for-Service - Payment of a fee established by a provider for a specific service.

Health Maintenance Organization (HMO) - Organization or insurance program which provides complete medical services through a network of hospitals and clinics for a fee fixed at the time of enrollment. Doctors and other providers are hired on a salaried basis.

Hospice - A program for the terminally ill, which is multidisciplinary and includes home visits, medical support, teaching, and emotional support of the family, and physical care of the client. Hospice assists the client to be comfortable and maintain a satisfactory lifestyle through the terminal process of dying.

Intermediary - An organization which processes Medicare claims.

Long Term Care - Relates to services given to people in need of care for lengthy periods of time; can be within a nursing facility, adult care facility, housing, or in-home care: generally chronic care is needed and is for the elderly population.

Long Term Home Health Care Program (LTHHCP) - A program that has been established to support those persons who wish to and are able to remain at home rather than enter a nursing facility. Reimbursement for this program is capped at 75 percent of nursing facility's daily rates within a region in New York State. (Also called "Nursing Home Without Walls.")

Medicaid (Title XIX) - A jointly administered Federal-state program designed to finance health care for certain low-income individuals, including elderly persons who meet certain income asset criteria.

Medicare (Title XVIII) - The primary Federal funding source for financing health care services to individuals over age 65. Part A provides in-patient hospital coverage, and Part B provides for physician care and other related costs.

Minimum Data Set (MDS) - Federally required information that must be collected on all nursing facility residents as part of the OBRA-mandated resident assessment process.

Minimum Data Set + (MDS+) - New York State's form that must be used to fulfill the resident assessment criteria mandated by OBRA.

Nursing Facility - Once referred to as a skilled nursing facility or health related facility, this is what is commonly called a "nursing home." Residents require 24-hour nursing and custodial care and are considered to be the frailest of the elderly population.

Omnibus Budget Reconciliation Act - OBRA is a Federal law, also referred to as the Nursing Home Reform Act, which required nursing facilities to become more uniform across the nation by standardizing approaches to nurse aide training and establishing a national registry for nurse aides; by removing inappropriately placed mentally ill or mentally retarded persons who needed active psychological services from the nursing home setting; and by setting standards for screening procedures for potential nursing home residents. Additionally, OBRA was responsible for what is called the "collapse of care." Prior to the effect of OBRA on October 1, 1990, nursing facilities in New York State could have two levels of care: skilled nursing facility (SNF) for higher care patients, and health related facility (HRF) for lower care patients. As of October 1, 1990, however, the SNF and HRF levels were combined into one category: nursing facilities.

RAPs (Resident Assessment Protocols) - Federally developed outlines that must be used in identifying clinical approaches and care planning in nursing facilities.

Resource Utilization Groups (RUGs) - RUGs refers to New York State's case-mix reimbursement system for nursing facilities which analyzes each individual resident's abilities to perform the activities of daily living (ADL) and attempts to measure resources used to provide care for an individual. There are 16 different RUG categories. Each resident's number is then compiled into a total, which is averaged to determine the facility's overall case-mix number.

Respite - A short-term program (usually 30 days or less) designed to assist/relive the caregivers of non-institutionalized aged and infirm. Respite may occur in the institutionalized setting or with 24-hour help in the home.

APPENDIX B: COUNTY HOMES IN OTHER STATES

As a part of this report, CGR interviewed officials in other states about the role played by county or government nursing homes and the issues they face. Summaries of these interviews are included here.

Virginia

Virginia has 257 nursing homes, about 30% of which are not-for-profits, and only a few county homes. Many of the proprietary homes are owned by corporate chains and about half of the not-for-profits are in integrated health systems networks. The county homes are well respected in their communities and not seen as second class or last resort. They offer assisted living and other services, including child care. They tend to have a larger share of Medicaid residents than Virginia's other homes. There are no unions in any of Virginia's nursing homes.

Illinois

Illinois has about 20 county homes, half of which are larger and located in urban areas and do not receive county subsidies. The other half are smaller, rural and subsidized by their counties. Some of these rural homes have been sold or are working with management companies in preparation for sale.

The rural homes are more often seen as the homes of last resort. The larger, urban homes often have over 50% private pay patients. The Medicaid rates in Illinois are low, and some homes are developing "Medicaid wings," separate units within the same facility for Medicaid patients.

The larger urban homes offer a broader range of services. A few of these homes have formed foundations, and undertaken new projects such as constructing Alzheimer's wings.

The county homes report to their legislatures and about half are unionized, but not civil service. The staff are not paid more than in proprietary and not for profit homes, but there is a retirement contribution from the county and the state. There is some public interest in keeping the rural homes open, but an association representative felt that about half would go under within five years.

Texas

Texas has a few government homes, 10 of which are members of the not-for-profit nursing home association. The homes are run by hospital districts, entities which include multiple counties and are responsible for health care services planning for their districts. The hospital districts have taxing authority. The districts have elected boards and the boards hire the nursing home administrators.

Most of the government homes are rural. They are considered to offer quality care and are not seen as homes of last resort. Most are the results of community decisions and are relatively new, not older than proprietary homes in their area. Districts which include hospitals offer different services than those which do not. Districts without hospitals may choose to offer certain services and therapies themselves while other districts would use the hospital for such services. The more rural homes are less affected by managed care than those near population centers but all homes are affected by assisted living, as Texas is implementing a program to encourage the use of alternatives to nursing home care.

The government homes are not unionized and there is no pension contribution. Medicaid reimbursement rates are low in Texas, and there is no adjustment for high cost areas. Rural homes, consequently, fare better than their urban counterparts in this regard, but often have problems attracting professional staff.

Florida

Out of 660 nursing homes in Florida, only six are county owned and operated. Although the county homes report to legislators, they are generally as profitable as proprietary homes.

There are no union employees in Florida homes. The employees in Florida's county homes are not part of a civil service system and are hired by a private management company. The homes themselves are financially stable, and none have been sold recently and they are not looking at any particular options.

Massachusetts

The state of Massachusetts has 14 public medical institutions, PMIs, that are all not-for-profit and run by cities or towns. Historically, their rates were determined using a separate rate group consisting exclusively of PMIs. The state Medicaid commissioner lowered the rate ceiling and then rolled eleven of the PMIs into the larger pool of private nursing homes over a three year period. They have all survived with the lower rates, and the state is planning to put the remaining three PMIs into the larger pool.

Massachusetts homes are unionized and have the same benefits packages as the local municipality, which can be very generous. Their contracts generally specify staffing patterns. The PMIs offer the same quality of care as private homes and have a slightly higher Medicaid residency rate. Some homes are "last resorts" in the sense that they operate in remote, sparsely populated areas where a private home would be unlikely to locate.

Massachusetts has a case mix system with ten rates. There is some competition for patients with the higher rates, but the state also has a minimum utilization factor of 96% which encourages homes to maintain high occupancy. The state is also providing incentives for home and community based services. The PMIs have been slow to offer other services, mostly due to the time it takes for municipal governments to act. Many PMIs have become authorities and are not under the direct control of municipal government. The main advantage of authority status, according to one home administrator, is that it allows homes to network.

New Hampshire

There are 11 county homes in New Hampshire. Most are predominantly Medicaid, one we interviewed was 95% Medicaid. The counties in New Hampshire pay for 31% of Medicaid long term care costs (the state portion is 19%) and also subsidize the homes. The county homes are pushing the state to cover assisted living to reduce the overall cost of long term care. The county homes have also been working with the state to tighten criteria for Medicaid nursing home admission.

County homes claim to provide care to more difficult patients, private homes disagree. New Hampshire has one reimbursement rate for all patients and no regional differential rates.

In 1995, the reimbursement rates were frozen for all nursing homes and in 1996 the county homes were treated as a separate group by the state for rate determination.

Six of the county homes are unionized with public employees unions, but not all are part of county-wide bargaining units. All homes are part of the state pension plan, which has a 3% employee and a 5% county contribution. Staffing is generally higher in county homes, and they claim this is due to higher acuity patients. County homes in general have good reputations and good relations with their legislatures.

Many county homes provide services along the continuum of long term care, including elderly housing, home health services, and behavior modification. Some have considered becoming public benefit corporations, but at least one has met resistance from the county legislature. The administrator felt the county was unwilling to lose control of the home because its budget was 40% of the county's operating budget.

Ohio

Ohio has about 50 county homes remaining out of 88 twenty years ago. The county homes themselves have been around for 150 years. In the mid 1970s, about half of these homes modernized and became Medicare and Medicaid certified nursing homes. The rest remained uncertified and under the regulation of the county health department. Most uncertified homes are group homes for the indigent. Some of them would like to be licensed, but do not qualify because of the age of the structure and physical plant. Furthermore, Ohio has a moratorium on nursing home bed construction.

Before Medicaid, county homes were supported entirely from the county tax base. County homes typically do not have more Medicaid patients than private homes. Their rates are generally lower and they have good reputations.

Only a portion of county homes are unionized but all county homes contribute to the retirement system. Some counties are deciding they do not want to be in the business of long term care and are selling and leasing beds. Beds have sold for over $100,000 each.

County homes must diversify and become parts of networks with hospitals and other organizations to survive, according to an association representative. No homes are closing at the

moment, except for uncertified homes whose beds have no value. Some homes are being sold, more to local hospitals than corporations.

Michigan

Thirty seven of Michigan's 442 nursing homes are county owned. They range in size from 65 to 220 beds. There are some chains operating homes in the state, but they do not have a large presence.

Managed care will have a profound affect on the county homes, according to one county home administrator. Presently, they are reimbursed at the "Class III" rate, or about $15-$20 a day more than the private homes. Managed care organizations have not penetrated the Michigan market, but the county homes are especially vulnerable once they arrive because of their higher staffing ratios.

Historically, county homes cared for the indigent. Today the county homes offer rehab, therapies, respite stays and subacute care. The county homes have more Medicaid (85-90%) than the privates (65%) and they would argue the acuity level of their residents is higher.

Most county homes are unionized with AFSCME or 1199 and offer wages and benefits comparable to the county. Michigan has a generous wage pass through: homes can be reimbursed up to 50 cents an hour for wage increases annually (this is true for private homes as well) and the legislature may raise this to $1 an hour.

Michigan homes have had IGT for 4 or 5 years. The state recovers about $90 million each year and shares that with the homes. There is strong support for the county homes. In one county, the millage rate, the property tax rate necessary to support the county home, is put on a periodic referendum and recently passed by a 2 to 1 margin. Homes are free to offer services without legislative approval and go to the ballot for large expenditures.

Maine

The state of Maine has a policy initiative in place to encourage the use of Assisted Living as an alternative to early placement in a nursing home. Maine's legislature has put a system in place that tightens admission requirements for new and existing nursing home patients. The

system mandates that nursing home residents must require assistance with at least three activities of daily living to receive Medicaid benefits and those who do not will be placed in alternative care facilities.

The state's initiative has resulted in reduced nursing home occupancy. Several nursing homes have converted some of their beds to less restrictive and less expensive forms of care. More elderly are using home care, adult day care and respite care programs as well. Maine has also set up a universal pre-admission screening for all nursing facility applicants which gives families information about all service options. Since implementing pre-admission assessments Medicaid now pays for only 65% of nursing home resident days compared to the 81% prior to the Pre-admission requirements.

Pennsylvania

Just over 40 of Pennsylvania's 67 counties have county owned and operated nursing homes and the state has over 800 total nursing homes. Counties are required by state law to care for the indigent in Pennsylvania and many of the county homes were known as poor farms before becoming nursing homes. While some county homes are modern facilities and are many residents' first choices, county homes overall have about 90% Medicaid occupancy while Medicaid occupancy statewide is 67%.

In 1996, Pennsylvania initiated a new case mix system for Medicaid patients and eliminated the county home peer group for Medicaid rate determination. Prior to 1996, county homes were in one of two peer groups, one for larger and one for smaller homes, and their Medicaid rates were generally higher than private homes. The change has prompted many homes to actively market their services and has resulted in competition for higher acuity patients.

The state health department shows an excess of 5,600 skilled beds statewide and some county homes have declining occupancy rates. Nursing homes are seeing increased competition from hospitals, many of which are adding their own skilled nursing sections. The nursing homes claim the hospitals retain nursing home patients until their Medicare runs out and then transfer them out. While the state is pushing for greater use of home and community based services, it has not defined or regulated assisted living. The service falls under the Department of Public Welfare and is not covered by Medicaid.

County homes are unionized, but many are not part of countywide bargaining units. A pension contribution by the home is mandated by state law. Voluntary and for profit homes are not unionized to the same extent as county homes and, by and large, their employees enjoy less generous wage and benefit packages than county home employees.

Counties in Pennsylvania pay 5% of Medicaid long term care costs. Pennsylvania has received IGTs for eight years. Some county homes are subsidized, but many have stopped requesting subsidies in recent years.

Five of the county homes have privatized over the past several years. All have become not-for-profit homes and most are managed by an outside company. In an effort to ensure service to the indigent, some of the homes' contracts stipulate that they will maintain a certain percentage of Medicaid admissions. Overall, county homes are slower than private homes when it comes to marketing and adding services, but many are offering new services and many are considering such options.

APPENDIX C: CGR NURSING HOME ADMINISTRATOR SURVEY RESULTS

This is a summary of responses from CGR's survey of county nursing facilities. We received responses from all but one facility.

1. How many beds are in your facility and what has been the average annual vacancy rate over the past three years?

   There are 9,722 total nursing home beds in the 43 facilities responding to our survey. Only one facility did not respond. (NYASHA reported 10,504 beds in 45 county facilities for 1995, but one of those homes, in Oneida County, has since converted to a voluntary facility.) Responding facilities vary in size from 62 to 889 beds and the average bed size for respondents was 226 beds. The average reported vacancy rate has been about 1.3% for each of the past three years.

2. What percent of resident days for the past year were private pay? What percent Medicaid? What percent from other sources? (Please indicate source.)

   The average private pay percentage among respondents for 1996 was 7.57% and the average Medicaid rate was 84.01%. (NYAHSA's 1995 proportions varied slightly.) Fifteen counties reported 10% private pay or more and the home with the highest private pay had 16%. Eight homes reported 90% Medicaid or more, with a maximum of 95%.

3. How would you describe the mission of your facility? (Please feel free to attach your mission statement.) Do you see your home as the "home of last resort?" Please explain why or why not.

   The homes described their missions in various ways but a few common elements emerged: 1) County homes are not "homes of last resort" in the sense that no one would choose to go there if they had the means to go to another home. The quality of care in the responding homes is thought to be as good or better than other homes in the area. 2) County homes are the homes of last resort in that they tend to take all comers. County homes will admit without regard to the patient's case mix index or ability to pay. 3)

County homes typically give preference to county residents. 4) County homes claim they tend to end up with more difficult to serve patients with lower reimbursement than their competitors.

4. How does the mission of your home compare with others in your area? How is the population you serve different from other homes? What services do you offer? Is this different from other homes in your county?

   The answers generally overlapped question 3. Some homes offered more services to younger and special populations.

5. Do you offer any unique services in your area? Have you considered adding any? Could you realize a higher level of reimbursement for these services if you were not a County facility?

   Some homes offer adult day care and respite services. Other services offered by at least one home: peritoneal dialysis, IV services, and hospice care. Many counties are considering adding one or more of the following services: dementia, short term rehabilitation and sub acute care. At least one county is considering decertifying beds for assisted living.

6. Are you a stand-alone nursing facility or are you affiliated with a hospital or other organization? Please indicate which one and also indicate if this has changed within the past ten years. What do you consider the pros and cons of your current arrangement?

   Several respondents are hospital based, but the vast majority are free standing. The pros of being hospital based include availability of ancillary services. Many administrators in free standing homes cited their autonomy as a positive.

7. What has been the range of your case mix over the last three years? What case mix do you aim for? What do you do to achieve the desired case mix?

   Many respondents admitted to aiming for a high case mix and some to aggressively seeking out rehab patients. Several noted they had little control over admissions. See text for further discussion.

8. How many unions are present in your facility? Which ones and what staff does each represent?

The predominant union in most homes is CSEA, though some are represented by other public employees' unions. Non-union positions are the exception and not the rule. In many homes, only the administrator and one or two management staff are the only employees that are not part of the bargaining unit.

9. What is your involvement with contract negotiations? Do you think your role should be different?

Typically, the nursing home administrator is not involved and nursing home employees are part of a countywide bargaining unit. Most administrators would like very much to be more involved in negotiations.

10. Are there any separate provisions for CSEA employees in your home? Have you attempted to negotiate or obtain any exceptions to the county contract for your employees through memoranda of understanding or other negotiations? Are there any particular contract provisions you would like to change?

Most have few or no separate provisions. About twenty homes reported some (usually very limited) provisions relating to: holiday time, safety and attendance, working hours and uniform, shift differential and pay for certain positions.

11. Which functions or services are outsourced? How much money has outsourcing saved the County annually? How many County government positions have been eliminated by contracting out certain services?

Nine respondents reported that they have no outsourcing nor plans for outsourcing. Among the services homes have outsourced: laundry, pharmacy, housekeeping, food services, therapists, physicians, dietary, environmental services and security. Some administrators report unspecified cost savings and staff reductions, though the results are somewhat mixed.

12. Do you belong to a purchasing consortium? Which one? What kind of savings have you realized by participating? If you belong to a consortium or not, what is the dollar amount of in-state purchases you have made for each of the last three years?

Twenty-eight respondents reported being in Iroquois, Gulf South, Seagate, or some other purchasing consortium. Most estimate substantial savings from these memberships and report that purchasing is also easier. A few administrators responded that their counties had discouraged them from joining a consortium.

13. Please describe any marketing efforts for your home. If you had funding allocated, what kind of marketing would you like to be able to do?

Responses were varied. Some homes do not market because they have high occupancy rates and do not need to advertise. Some might like to advertise but have no funds allocated to do so. Among those homes that do have some form of marketing effort, it is generally limited to having a brochure and perhaps a booth at community events. Only a few reported anything more extensive, such as newspaper ads, and only one made use of television. Most thought these kinds of marketing efforts had been successful. Several said they needed more emphasis on marketing to be successful in the future.

14. What is your annual operating budget and annual payroll for each of the last three years?

Based on 36 answers to this question, CGR estimated the total annual operating budget for CNFNY members was $524 million in 1995 and $548 million in 1996 and payroll was $283 million in 1995 and $287 million in 1996. Respondents' operating budgets varied in size from $3 million to over $60 million.

15. What costs has your County government allocated against your budget over each of the last three years? Please itemize those allocations for the most recent budget year. How much of the allocation was recovered through reimbursements?

Respondents indicated that cost allocations have been rising in each of the last three years. CGR estimates the cost allocations (not all respondents answered the question) for all homes to be $15 million for 1994, $21 million for 1995 and $27 million for 1996. The average allocation per home for 1996 was $627,000.

16. How much IGT did you receive in 1995-96 and 1996-97? How are IGT dollars allocated in your county (e.g. nursing home, general fund, etc.)?

Allocations vary, but usually ten percent of the IGT goes to the nursing home. Actual county nursing home shares for 1997-98 have been set at about $63 million statewide, up from $9.5 million in 1995-96 and $25.7 million in 1996-97.

17. How much revenue have you received from grants or contributions for each of the last three years?

Twelve homes reported receiving some sort of grant or contribution in one or more of the last three years. Typically the reported amount were relatively small.

18. For each of the last three years, what has been the annual operating profit or loss for your home, not including County subsidies?

Annual Operating Profit(Loss) for County Homes, Exclusive of County Subsidy			
Year	1994	1995	1996
Responses	35	39	40
Total Profit(Loss)	($13,106,068)	($14,538,848)	($11,806,245)
Average Profit(Loss)	($374,459)	($372,791)	($295,156)

See report text for further discussion.

19. For each of the past three years, what was your County subsidy and fund balance?

See report text for further discussion. Data are summarized in the following table.

Annual County Subsidy and Fund Balance			
Year	1994	1995	1996
Responses	36	40	40
Total Subsidies	$30,411,087	$35,269,025	$24,397,963
Average Subsidy	$844,752	$881,725	$609,949
Total Fund Balance	$88,476,841	$91,386,090	$88,565,208
Average Fund Balance	$2,681,116	$2,687,826	$2,604,859

As enterprise funds, most nursing homes are allowed to build fund balances in some years by their legislatures and in other years must dip into their fund balance to offset the needed county subsidy. See report text for further discussion.

20. Could you operate without a County subsidy? What changes would need to occur for you to do so?

Eight homes said they could and have been operating without county subsidies. Several more said they could with certain qualifications, mostly the continuance of IGTs. Many noted that fundamental changes (discontinuing cost allocations, more control over labor negotiations and a change in mission) would need to occur if they were to operate without a subsidy.

21. What is your outstanding capital debt?

Thirty eight respondents reported a total of $221 million in capital debt. The average debt per home is $5.8 million, the median is $662,000. Six homes have over $10 million in debt and eleven homes reported no debt.

22. Is your base year for Medicaid and Medicare reimbursement 1983? Have you attempted to appeal your rates? If so, what is the amount of outstanding appeals?

Everyone has a 1983 base year for Medicaid. Twenty have received appeals or have appeals outstanding.

23. How would your facility be affected if you had a 1996 cost basis?

Seventeen administrators thought a change in the base year would have a positive effect, two thought the impact would be negative. Two thought there would be little or no impact and the rest were not sure.

24. How would you characterize your relations with your County's elected officials and policy makers? Do they understand your operations and concerns?

Sixteen administrators wrote that relations with County elected officials were very good or better and many cited their officials for their active support and efforts taken to understand their operations. Fifteen described relations as good or at least not bad, often because some officials were supportive and some not, or officials were generally supportive but did not understand health care. Six described relations as less than good, where they receive little or no support and officials have no understanding of health care and are said not to be particularly concerned.

25. Are County officials supportive of the county home and the services you provide? Under what circumstances will the County continue to support the home? Are any officials actively pushing you to consider alternatives for the future of the home?

Most respondents characterized their legislatures as supportive, some with the qualification that the supportiveness depends on how big a subsidy they receive. Some wrote that there was no push to consider any management alternatives at this point. In many counties, there are periodic efforts, often led by individual legislators, to investigate privatization.

26. In your opinion, what is the maximum subsidy the County will provide on an annual basis for the continued operation of the county home?

Respondents gave few numeric answers, two about $1 million, ten or so between $100,000 and $250,000. Some pointed out that the County's willingness to provide a subsidy depends on the County's overall fiscal condition and that past subsidies are not good indicators of what the County might be willing to pay in the future.

27. How many other nursing homes are in your county (or immediate area) and how many beds do they have? Are they proprietary, voluntary or other government homes? What is their approximate annual vacancy rate over the past three years?

Naturally, responses varied. Only one reported being the sole provider in the area. Several reported being one of five or less providers. Vacancy rates were similar between county and private homes.

28. What impact do other nearby nursing homes have on your operations, your case mix and your profitability? How does your competition affect options you might consider for the future of the county home?

The majority of administrators said that competition from other homes hurts their ability to attract private pay and high CMI residents. This seemed to be especially true when the competition was a hospital based home with the ability to offer more services and sub acute care. Some, mainly in rural areas, wrote that other homes had minimal impact on their operations. Several administrators noted the relative flexibility of many of their competitors to control costs and respond to changes.

29. What concerns do you have if the county home were to go out of business? Are there circumstances under which the County should get out of the nursing home business? If the County were to get out of the business, are there reasonable alternatives available to your clientele elsewhere? Are there people who would not be served by other nursing homes? About how many?

The main concern administrators have is the placement of difficult to serve Medicaid patients. Since the county home takes many residents no one else wants, sometimes by

design, often by default, there would be a number of people at risk if the county home went out of business. Administrators were concerned that some would be passed over by private homes and left in hospitals, with a higher county Medicaid share, or unsafe home situations. Another concern was unemployment of staff and the lack of comparable paying jobs in the community.

30. If the County home were to go out of business, what should your County government do to protect the interests of your clientele and staff?

Most administrators agreed the County should take steps to ensure residents are placed in appropriate settings, although some admitted it would be difficult to make this work. Most also expressed concern for the staff but were divided on what kinds of protection, if any, they should receive.

31. How many staff are in your home? Please list (or attach) job titles and range of salary or wages for full and part time staff.

As one would expect, staff size varies from home to home, from about 80 to over 1,000. Average staff size across all county nursing facilities is more than 300, with the vast majority of those being full-time employees.

32. What are benefits as a percent of salary? Are benefits uniform with other County employees?

Benefits varied from 21% of salary to 50% of salary. The average (unweighted) benefit level was 31%. All but two administrators said benefit levels were comparable with benefits for other county employees.

33. Do you consider your staff to be receptive to change?

A few administrators thought yes, more gave a qualified yes for a response. Many said their staff members were resistant to change.

34. Do you have any managed care contracts? Have you considered contracting with a managed care organization? Please describe the actual or potential contracts, the services covered and any advantages or disadvantages to the contracts.

Nine reportedly have or are considering managed care contracts. Many say that nothing is in place yet in their areas.

35. Have you sold or leased any beds in your facility? Has this been considered or attempted?

Only three counties have even considered this option and none reportedly have actually sold or leased beds.

36. Have any particular alternatives for the future of the county home been discussed in your county? Please indicate if any of the following have been considered in your county and tell us about the status of the ideas, if they are under active consideration or if they have been rejected, and what you see as the pros and cons.

Conversion to not-for-profit status

Four administrators said their counties were considering this option, one had considered and rejected it and one has an RFP out to possibly do this. All other respondents either left this blank or said there was no serious consideration at this time.

Sale of the county home

Twenty one administrators reported that this had been considered to varying degrees in recent years. In most cases it was dismissed, but in several counties this issue comes up over and over again. In at least one county, the executive has said the county would sell the home if it requires too much support.

Closing the county home

Three counties considered this, presumably as a part of a larger conversation involving selling the home. All rejected closing, either because it was too expensive or too much of a political issue.

Combination or consolidation with other County agencies or institutions

Nine administrators reported their counties had considered or tried this. Of the counties that have combined or consolidated with other county agencies, one has consolidated with the CHHA, one County home combines bids for services with other departments, and another shares certain support services with other departments.

Partnership with organizations outside County government

Only a handful of administrators reported considering this option and one has consolidated with a local hospital. The organizations they considered partnering with were all local hospitals.

Contracting outside the county for management and other services

Three counties have some sort of management contract in place, three counties have considered but rejected the idea and several others have contracts for laundry, dietary and other services.

Diversifying operations to include other services along a continuum of long term care alternatives

Fifteen respondents either have other services in place or are actively considering adding them. Services include assisted living, Alzheimer's care, adult day care, adult care facilities, respite care, home health and outpatient physical therapy. Ten said they were not considering adding any services and the rest did not answer.

Conversion of the county home to a public benefit corporation

Beyond the two facilities discussed in the report, four others reported considering this option.

Becoming part of a state wide authority for government operated nursing homes

No county reported having formally discussed this option.

Implementing an employee buy out

Some early indications of interest, but no formal actions to date.

Other alternatives (please specify)

Alternatives suggested included adding services, selling a part of the campus and combining with other homes on a regional basis.

37. Are there any other issues you would like to raise with us? Feel free to do so here, in an attachment or by telephone.

No issues raised.

If you have any annual reports, consultant reports or other statements that you think might be helpful, please send them to us.

Thank you very much for your help. We appreciate your input and the time you have taken to complete this survey.

APPENDIX D: LIST OF COUNTIES/CHHAS

New DOH data methodology indicates the following opportunities for a Certified Home Healthcare Agency (CHHA). Still under discussion, expected to be finalized this year, 1997.

Broome	1
Cayuga	1
Chautauqua	2
Chemung	1
Columbia	1
Dutchess	2
Erie	8
Nassau	10
Niagara	3
Orange	3
Oswego	3
Otsego	1
Rockland	1
St. Lawrence	1
Saratoga	1
Steuben	2
Suffolk	3
Ulster	3
Warren	1
Westchester	3
New York	1
	52