Research to drive informed decisions.
Expertise to create effective solutions.

COUNTY NURSING FACILITIES IN NEW YORK STATE

CURRENT STATUS, CHALLENGES AND OPPORTUNITIES

Prepared for:

County Nursing Facilities of New York, Inc.

Donald E. Pryor
Project Director

One South Washington Street
Suite 400
Rochester, NY 14614
Phone: (585) 325-6360
Fax: (585) 325-2612

100 State Street
Suite 330
Albany, NY 12207
Phone: (518) 432-9428
Fax: (518) 432-9489

www.cgr.org

September, 2007

© Copyright CGR Inc. 2007 All Rights Reserved

County Nursing Facilities in New York State

Current Status, Challenges and Opportunities

September, 2007

Summary

County nursing homes have provided valuable services to residents throughout New York for many years. County homes have many significant strengths and attributes. They have a unique mission, and have provided needed long-term care services to many county residents who in all likelihood would not have been served by other proprietary or voluntary homes. County nursing facilities provide just over 10% of all nursing home beds in the state, and 14% of all non-NYC beds—and a much higher proportion of care for those considered hard to place and often with limited ability to pay for their services. County homes have also been an important contributor to the local economy in many counties. Nonetheless, county homes throughout the state are increasingly vulnerable.

Their future, individually and collectively, is jeopardized by increasing operating losses, reimbursement levels that fail to cover operating costs, declining intergovernmental transfer payments, and the need for increasing county subsidies.

County nursing homes consistently operate as a safety net, admitting residents that other facilities are reluctant or unwilling to admit—behaviorals, bariatric patients, those with Alzheimer's disease, adult protective cases, crisis admissions, etc.—regardless of their ability to pay. Examples of the extent to which county homes serve disproportionate numbers of "safety net, hard-to-place" residents include:

- Proprietary and voluntary facilities have cornered disproportionate shares of the market on relatively lucrative short-term sub-acute and rehabilitation residents. More than 55% of all discharges from voluntary and proprietary homes have short-term stays of 30 days or less, compared to 43% of those from county facilities. County home residents are twice as likely to stay three years or more, typically with reimbursement levels well below actual costs of services.

- County homes admit smaller proportions of residents from hospitals than do other types of homes, with resulting lower reimbursement levels.

- More than two to three times more new admissions to county homes enter on Medicaid from day one than is true in other types of homes, thus representing a revenue loss of well over $20 per day, compared to actual costs, for their entire stay in the facility.

- County homes are much more likely to serve higher proportions of younger residents requiring more staff time to address behavioral issues.

- County homes serve higher proportions of bariatric and "behavioral-problem" residents, at higher costs and staff time, and less reimbursement, than do proprietary or voluntary homes.

- The majority of county homes indicate that between a quarter and a half of all residents have low clinical complexity but high behavioral demands, adding to demands on staff and costs, with insufficient offsetting revenues.

- There is an increasing gap between typical county homes and other types of nursing facilities in the case-mix index, with lower resulting reimbursement and higher staff needs.

- The typical county home estimates that between 75 and 100 current residents (about 20% to 25% of all residents) would not be served by other nursing homes if the county home were to close.

Many of those served by county nursing homes receive reimbursement levels far below the actual costs of the services provided and the staff attention needed. The value of the county homes is typically recognized and appreciated by county officials, but the state and federal funding to cover their unique contributions has been dwindling, leaving it to counties to increasingly subsidize their homes, often at millions of local taxpayer dollars per year.

Key Challenges Facing County Nursing Homes

Because of their unique mission to provide high-quality services to those that voluntary and proprietary homes are less likely or unwilling to serve, county facilities face a number of challenges not faced, or faced to lesser degrees, by their competitors, including:

- Fewer lucrative admissions from hospitals, including sub-acute care and rehabilitation patients;
- Disproportionate Medicaid admissions, for which county homes lose money from day one;
- Disproportionate total resident days paid for by Medicaid, compared to Medicare and private pay, both of which are more lucrative and pay more of the bills at voluntary and proprietary facilities;
- Demographic profile of residents with disproportionately high behavioral demands and need for staff attention, but with insufficient reimbursement to cover the staff costs;
- Low case mix index compared to other types of homes;
- Rising staff costs, especially in benefits, mostly attributable to mandated increased pension/retirement costs passed on from the state to counties, and to increased health insurance costs;
- Limited county nursing home role in labor negotiations which directly affect their budgets and operations;

- Aging facilities;
- Increasing operating losses per bed;
- Rapid decline in IGT payments designed to compensate for unique costs and mission of county homes;
- Resulting increases in need for county taxpayer support of county homes.

Strategies for the Future

A number of separate strategies or alternatives are available for consideration and action by county nursing homes and county officials. These are arrayed along a "degree of change" continuum and are available to counties depending upon their unique needs and circumstances.

As financial challenges increase, county homes are increasingly being forced to recognize the possibility that their future, individually and collectively, is at stake. In that context, it is important for county homes—and ultimately their oversight county governments and the state—to consider options available to them, and to plan strategically for their future.

The options that make most sense will vary from home to home and county to county, given circumstances unique to each. In addition, the viability of—and potential need for—various options will be determined to a great extent by funding and policy decisions made at the state and federal levels. But as those federal and state decisions are being made, counties can begin to determine for themselves which of various options would be logical and reasonable to consider under their distinct circumstances, and which should be discarded as untenable for various reasons.

As part of the consideration of options, county home administrators and county officials need to carefully consider the likely consequences of the possibility of closing their homes. In

most cases, best estimates are that between 20% and 25% of all current residents would be in jeopardy of loss of needed care, i.e., would not be served by other nursing homes, if the county facility were to close. There is even greater concern about who would provide the safety net function in the future for "undesirable" candidates for nursing home admission.

Recent state legislation offers the promise of a reimbursement mechanism and funding stream with the potential to meet the unique needs and mission of county nursing homes, reduce the need for excessive county taxpayer subsidies, and enable county homes and their governing counties to more effectively budget and plan for the future. It will be important to ensure that this legislation, currently beginning to be phased in, is fully implemented over the next few years.

Recommendations

The report concludes with several recommendations to the state and individual counties, including:

- The state should undertake a comprehensive review of the future role of county nursing homes. The current state legislation, expanding state payments to county homes to support their unique mission and implementing a new reimbursement methodology, should be fully implemented. The state should also sponsor a study of the impact of what happens when county nursing homes close or sell their facility to another nursing home. It should also work with the federal government to promote removing restrictions against public nursing homes offering assisted living programs, and work with counties to provide incentives to help make it feasible to establish expanded lower-level long-term care non-institutional services. The state and County Nursing Facilities of New York should also collaborate to assess the strengths, limitations and related implications of a Community Benefit Corporation concept.

- Counties and their nursing homes should actively explore the various options along the "degree of change" continuum to determine approaches appropriate for their distinct circumstances. Counties should place more focus where appropriate on opportunities to expand the numbers of non-institutional long-term care beds and program slots. County homes should more aggressively market their services and their mission to the public and to discharge planners in local hospitals. Nursing home administrators should be more routinely involved in contract negotiations in which decisions are made that affect the home's budget and future operations. And CNFNY and the counties should build on and expand current efforts to develop effective means of sharing experiences, rationale and decisions concerning acceptance or rejection of various strategies for the future.

TABLE OF CONTENTS

Summary .... **i**
Table of Contents .... **vii**
Acknowledgments .... **x**
I. Introduction **1**
Context: Threats to Existence of County Nursing Homes 1
Methodology 2
II. External Environmental Factors Impacting on County Nursing Facilities **6**
Demographic Changes 6
Growth in 75+ and 85+ Populations 6
Implications for Demand for Long- Term Care 7
Changes in Long-Term Care 8
Proposed Reduction in Nursing Home Beds 9
Increased Pressure on Nursing Homes to Diversify Services 9
Taxpayer and Political Concerns 11
III. Descriptive Profile of County Nursing Facilities **13**
Number and Size of Facilities 13
County Homes Larger Than Others, but #s and Sizes Declining 14
Few County Homes in Low-Population, Low-Density Counties 15
Distinct Mission of County Homes 16
Governance and Structure of County Homes 17
IV. Issues and Challenges Facing County Nursing Homes **18**
Perceived Strengths and Limitations of County Homes 18
Perceived Strengths 18
Perceived Limitations and Challenges 19
More County Home Admissions, but Fewer than Competitors 21
Fewer Admissions from Hospitals to County Homes 23
Declining Occupancy Rates 24
Payment Sources Disadvantageous to County Homes 25

Primary Payer at Admission: Counties Often Lose Money from Day One 26
Most Resident Days Paid for by Medicaid 27
Factors Contributing to Low Medicaid Reimbursement Rates 28
Added County Home Costs Resulting from Resident Demographics 30
Age Profile Lower in County Homes 30
More Bariatric and Behavioral Beds in County Homes 31
County Homes: Many Residents with Low Clinical Complexity but High Behavioral Demands 32
Transfers and Discharges 33
Low Case Mix Index in County Homes 34
Higher Staffing Levels in County Homes 38
Rapidly Rising Staff Costs, Especially in Benefits, in County Homes 39
Salary Differential Actually Declining 40
Benefit Levels in County Homes Have Escalated Rapidly 41
Major Cost Differentials Among Nurse Aides 42
Growing Costs of Payments to Retirement System 43
Limited County Home Role in Labor Negotiations 44
Aging County Facilities 44
Outstanding Capital Debt of County Homes 45
County Costs Allocated Against Nursing Homes 46
The Impact of Competition on County Homes 48
Disproportionate Impact of Berger Commission Recommendations on County Homes 49

V. Financial Challenges Facing County Nursing Facilities 51

County Homes Increasingly Lose Money on Operations 51
Increasing Operating Losses per Bed 53
Nearly All County Homes Losing Money on Operations 54
Possible Sign of Improvement in 2006? 54
Ebb and Flow of IGT Payments 55
Rapid Growth, Rapid Decline in IGT Payments 56
Financial "Savior" of Homes, Followed by Rapidly Declining Impact 57
The IGT of the Future? 57
Increasing County Taxpayer Support of County Homes 59
Importance and Likely Maximum Value of County Subsidies 61

VI. Opportunities to Strengthen County Nursing Homes 62

Strong County Support for County Nursing Home Mission 62
Opportunities to Outsource Services 63
Opportunities to Streamline Purchasing 64
Opportunities to Expand Marketing 64
Opportunities to Strengthen Management Accountability 66
Other Perceived Opportunities 67

VII. Alternatives for Consideration: Possible Strategies for the Future 69

Options Chosen and Not Considered by Counties To Date 70

Continuing County Nursing Home Operations with Reforms 73

Expanding the Range of Long-Term Care Options Offered by the County 75

Limiting the County's Role in Nursing Home Care 76

The Future: What is Likely to Happen to County Homes? 77

Importance of Stable, Viable State Funds 78

Circumstances Under Which County Homes May Consider Closing 79

Likely Consequences of Closing County Homes 80

VIII. Conclusions and Recommendations 84

Recommendations with State and Federal Implications 86

Recommendations with County Implications 89

Appendix A: Survey Questions 93

Appendix B: List of County Nursing Facilities and Survey Respondents 104

ACKNOWLEDGMENTS

This report would not have been possible without several individuals who provided invaluable assistance and feedback on all aspects of the study. Special thanks to Richard Maloney and County Nursing Facilities of New York for envisioning the study and for their support throughout the process.

Steering Committee

The study Steering Committee assisted by reviewing preliminary drafts and presentations, hosting regional meetings, and sharing their expertise and thorough understanding of the County Nursing Home.

Richard Maloney, Executive Director, County Nursing Facilities of New York

Stan Wojciechowski, President, County Nursing Facilities of New York, and Administrator, Van Duyn Home and Hospital, Onondaga County

Diane Brown, Administrator, Maplewood Manor, Saratoga County

Doug Cosey, Administrator, Pleasant Valley, Washington County

Todd Spring, Executive Health Director, Monroe Community Hospital, Monroe County

Aldo Troiani, Administrator, Summit Park Nursing Care Center, Rockland County

Technical Assistance

Darius Kirstein, Senior Policy Analyst, New York Association of Homes and Services for the Aging, provided frequent and tireless assistance with issues related to data analysis.

Policy Assistance

Patrick Cucinelli, Senior Financial Policy Analyst, New York Association of Homes and Services for the Aging, and ***Tom Connolly***, Bolton-St. Johns, Inc., provided critical input on the legislative context of the county nursing home.

County Nursing Home Administrators

Special thanks go to all of the county nursing home administrators who gave their time in completing our survey and participating in regional meetings.

Staff Team

Maria Ayoob was instrumental in the successful completion of this project. Her extensive data analyses, thoughtful questions and insightful suggestions made the project and this report, as well as presentations along the way, possible. David Cohen and Susanne Morton also helped with specific analyses.

I. INTRODUCTION

In 1997, CGR (Center for Governmental Research Inc.) conducted a study for the County Nursing Facilities of New York, Inc. (CNFNY) of the status of 44 county-owned and operated nursing facilities in 40 counties throughout New York (exclusive of five facilities in New York City). That study resulted in a report, *What Should Be Done with County Nursing Facilities in New York State?*, and a presentation to the 1997 NYSAC fall seminar, which presented factual information about the county facilities in comparison with proprietary and voluntary nursing homes throughout the state.[1] The report also outlined special circumstances and challenges facing county facilities, and presented an array of options counties might consider related to the future of their nursing homes.

Context: Threats to Existence of County Nursing Homes

Now, ten years later, 40 of the 44 upstate (non-NYC) facilities remain in operation in 37 counties. *Thus four county nursing facilities that existed in three counties ten years ago no longer remain as public facilities today.* One or two other counties are known to have seriously considered ending county operation of their public facilities.

As was true ten years ago, the future viability of many county-operated nursing homes remains in question. Most public nursing homes are considered valuable assets by county leaders because of their historic mission to serve any in need of residential nursing care, regardless of cost or ability of the resident to cover the costs of the services provided. Nonetheless, despite such praise and historic support, the reality is that many county facilities face serious questions about their future. Many of the potential threats that were noted ten years ago remain today. Some of those threats have become more pronounced and their negative impact on the

[1] See CGR, *What Should Be Done with County Nursing Facilities in New York State*, September 1997. The terms nursing homes and nursing facilities are used interchangeably throughout this report. They are also known as residential health care facilities (RHCFs).

homes exacerbated in the interim period, and other new challenges have arisen in the intervening years. Most immediately, the December, 2006, report of the Commission on Health Care Facilities in the 21st Century (the "Berger Commission report") has raised significant questions about the future of several of these county facilities, and nursing homes will sustain reductions in reimbursements as a result of passage of Governor Spitzer's first budget for fiscal year 2007-08.

With a new Governor and State administration in office since January, 2007 and in the context of a number of issues facing the nursing home industry, including those raised by the Berger Commission report and the Governor's proposed budget, CNFNY requested CGR to conduct an update of the 1997 study—*focusing on the current state of, and challenges and opportunities facing, county nursing facilities*—for consideration by the CNFNY membership, county officials, and ultimately for presentation to the new NYS administration and other key state policymaking officials. This report outlines our findings and conclusions.

Methodology

In order to compare the current status of county nursing facilities as directly as possible with the status of county homes ten years ago, CGR replicated as closely as possible the approaches and sources of data used in the initial study. Wherever possible, we made direct comparisons of 2005 and 2006 findings with historical nursing home profiles from 1995 and 2000. Wherever possible, we also contrasted characteristics and circumstances facing county facilities with those of proprietary (for profit) and voluntary (not-for-profit) nursing homes across the state. Our focus, as in the initial study and at the request of CNFNY, was on non-NYC nursing homes. The findings and conclusions presented in this report are based on the following research components:

- **Analysis of New York State Department of Health Cost Report Data on Nursing Homes in NYS.** The New York Association of Homes and Services for the Aging (NYAHSA) maintains an extensive database on nursing homes throughout the state, based on annual Medicaid Cost Reports compiled by

DOH, and it generously provided us with access to requested data from 1995, 2000 and 2005—as well as providing frequent substantial and insightful consultation to help us analyze and interpret the data. Trends in Cost Report data for county voluntary and proprietary nursing homes are presented throughout the remainder of the report, along with any caveats concerning interpretation of the data. The "Public" category in the Cost Report data includes both county-run facilities and facilities run by the Veteran's Health Administration. VA facilities have been excluded from the "Public" category in all analyses in this report. In most cases, unless otherwise noted, data for different types of facilities are reported in terms of median values, which are often the best indicator of central tendency in a series of numbers. The median is typically used instead of an average because it is less subject to influence by unusual extreme "outliers."

- **Survey of County Nursing Facilities.** Key components of both this and the 1997 study involved comprehensive surveys of each county nursing home. Many of the questions in both surveys were identical, in order to facilitate comparisons of "then and now" responses where possible. A number of additional questions were also added to the current survey to address new issues and changing needs affecting county facilities. The survey enabled us to obtain detailed information about various aspects of the county facilities which were not available from other data sources, including specific challenges facing county homes given their particular mission as public facilities. (A copy of the survey is presented in Appendix A.)

  Completed surveys were obtained from 33 of the 40 non-NYC county nursing facilities, representing 31 of the 37 counties with one or more public nursing homes (an 84% response rate). Responses were representative of all types of county homes, including high proportions of completed surveys in all regions of the state, in both large and small facilities, and in urban, suburban and rural counties. Appendix B contains a list of all county facilities and which of those completed the survey.

- **Review of Relevant Berger Commission Information.** We reviewed the overall information and recommendations contained in the Berger Commission report, including conclusions concerning specific county nursing homes, for their relevance to this study.

- **Regional Meetings with County Home Administrators.** To supplement our analyses of survey results and Cost Report data, CGR facilitated three regional focus group discussions with administrators of about 20 county nursing homes. As with the survey, the administrators were representative of the geographic, size and urban-suburban-rural variety of homes throughout the state. At each of these meetings, administrators were able to respond to preliminary findings from the study. The discussions were helpful in fleshing out issues and their implications in more detail than was possible with only the written survey or Cost Report data analyses.

- **Analysis of Consideration and Actual Use by Counties of Various "Continuum of Change" Alternatives.** Various options were outlined in the 1997 report as possible alternatives to the status quo of current nursing home operations which counties may wish to consider (or may have already considered or even implemented). We updated our analysis of the extent to which various options are currently in use or under consideration (including changes implemented since 1997).

- **Coordination with a Project Steering Committee.** Throughout the study we had the benefit of consultation with a project oversight committee made up of representatives from CNFNY and from NYAHSA. Although they did not attempt in any way to influence the study's findings or conclusions, they were very helpful in providing guidance to CGR to ensure that study goals were met, that the key questions were addressed in the survey and by the various data analyses, and that the survey was completed in a timely fashion by the county home administrators.

The remainder of this report integrates the findings from the various study components into chapters focusing on external factors impacting on county facilities, characteristics that

distinguish county facilities from other types of nursing homes, challenges and opportunities facing county homes, and recommendations for the future. (Preliminary partial findings were previously presented at the 41st Annual County Finance School—the annual conference of county finance officers and related public officials—in May, and to the three previously-noted regional meetings of county nursing home administrators in June.)

II. External Environmental Factors Impacting on County Nursing Facilities

A number of demographic, social and political considerations impact on nursing homes in general, several with particular impact on county-owned-and-operated facilities. These factors establish much of the context for the discussions which follow in the remaining chapters of the report, and help underscore why this study was initiated in the first place. These factors and trends are typically beyond the ability of nursing home administrators to directly control or influence, but they 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

Demographic data and projections indicate that the aging of the "baby boom" generation and increases in life expectancy will lead to increasingly higher proportions of elderly in the NYS population than exist today. Adults 65 and older currently comprise about 13% of New York's total population, but this proportion is expected to rise gradually to 20% by 2030.

Growth in 75+ and 85+ Populations

Of greatest significance in forecasting future demands for nursing home care is the expected growth among those 75 and older and, within that group, especially among those 85 and older. Those 75 and older currently account for about 6% of the state's population, a proportion expected to increase to 10% by 2030. But that growth will be gradual over the next 10 to 15 years, before beginning to increase more rapidly between 2020 and 2025, with even more rapid growth after that. Depending on what projections are used,[2] the numbers of people in NYS 75 and older

---

[2] *Demographic Projections to 2025*, NYS Office for the Aging, May 1999; U.S. Census Bureau, Population Division, Interim Population Projections, 2005.

Those 75+ are growing steadily in NYS (especially those 85+), with several hundred thousand more 75+ expected by 2025.

in 2025 may range from about 1.4 million to as many as 1.7 million—up from about 1.17 million currently.

Increased life expectancy is also contributing to the growth in the older population. Thus, the numbers of people living to be 85 and older—those who are most likely to be in need of nursing home care—are expected to grow even more rapidly than the "younger olds." From about 310,000 people statewide in 2000, the numbers of 85+ NYS residents is expected to exceed 425,000 by 2010, and to reach almost 550,000 by 2025, with further growth in subsequent years.[3]

Implications for Demand for Long-Term Care

This sustained growth in the numbers 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 continuum. Much of this demand may well impact directly on nursing homes. On the other hand, older people today report themselves on average to be in better health than in previous generations, to have fewer disabling conditions and less functional loss, and to have different attitudes and preferences concerning health care services. *They are more likely to value independence and to resist institutional care arrangements for as long as possible.*[4]

Thus the sheer increase in the numbers of older persons in the state is likely to have a significant impact on demand for health services and long-term care options, including nursing home care. *But what proportion of the additional several hundred thousand residents 75 and older who will be living in New York by 2025 will choose, or need, to live in a nursing home setting—as opposed to seeking out other less-restrictive, non-institutional settings—remains to be determined.* The potential for

[3] Ibid

[4] See, for example, Commission on Health Care Facilities in the 21st Century, *A Plan to Stabilize and Strengthen New York's Health Care System: Final Report*, December 2006, p. 47. See also Richard Dietz and Ramon Garcia, "The Demand for Local Services and Infrastructure Created by an Aging Population," Upstate New York Regional Review, Volume 2, #1, 2007 (Federal Reserve Bank of New York, Buffalo Branch).

Demands for long-term care are likely to increase significantly in future years. Much of that is likely to be for non-institutional settings. Offsetting factors make the level of demand for nursing home care difficult to forecast.

increased demand for nursing home beds in future years is substantial, given the aging of the baby boom generation, but much of that potential may be siphoned off into other, non-institutional care alternatives. On the other hand, data reflecting growing proportions of racial minorities among the state's elderly population and the rapid disproportionate growth among women 75+ and 85+—many living alone and with serious health problems and functional impairments—may suggest growing demands for publicly-funded nursing home care in future years.[5] The implications of these demographic changes and the likely shifts in preferences and needs for varying levels of care and services will be addressed in more detail later in the report.

Changes in Long-Term Care

A number of changes are occurring in the ways in which long-term care services are being provided and funded and, as noted above, demands are increasing for different types of services at lower levels of care 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.

The Commission on Health Care Facilities in the 21st Century (the "Berger Commission") emphasized the following in its recent report on reforming the health care and long-term care system and facilities in NYS: "We have too much institution-focused care and not enough home and community based options….A growing percentage of nursing homes are losing money from operations….Hovering over the instability of our hospital and nursing home providers is a growing problem of affordability."[6]

---

[5] Commission on Health Care Facilities in the 21st Century, *Planning for the Future: Capacity Needs in a Changing Health Care System,* February 2006, pp. 7-14.

[6] Commission on Health Care Facilities, *A Plan to Stabilize and Strengthen New York's Health Care System: Final Report*, op cit, p. 1.

The Commission's report goes on to document that despite "crippling" and "unsustainable" growths in Medicaid expenditures, the majority of nursing homes in the state operate at a loss and have limited ability to reinvest in their systems and physical plants. In response the Commission recommends that the state (1) "undertake a comprehensive review of reimbursement policy and develop new payment systems that support a realignment of health services delivery" and (2) "undertake a comprehensive review of the future role of county-owned and operated nursing homes. A clear policy should be developed to guide decision-making about county nursing homes and to protect indigent residents."[7]

Proposed Reduction in Nursing Home Beds

The Berger Commission recommends eliminating about 3,000 nursing home beds in NYS, with disproportionate cuts in county homes.

In the meantime, the Commission also made a number of recommendations to "rightsize and reconfigure" hospitals and nursing homes throughout the state. Those recommendations would affect nine county nursing facilities in eight counties—six involving downsizing the number of nursing home beds, and three involving both downsizing and proposed mergers that will affect public nursing facilities in two counties. The proposed downsizing would reduce the number of nursing home beds throughout the state by about 3,000, including about 1,750 in county facilities. *Thus almost 60% of the proposed reduction in nursing home beds would occur in county nursing facilities, although only about 10% of all current nursing home beds in the state are in county facilities.*

Increased Pressure on Nursing Homes to Diversify Services

Both the Berger Commission and the Governor, in his proposed 2007-08 budget, were attempting to find ways to contain the upward spiral of Medicaid long-term care costs, while also rationalizing the reimbursement system such that payments more accurately reflect actual costs of care. At the same time, they emphasized the need for an increased focus on lower levels of "non-institutional services," thereby at least implicitly increasing pressure on nursing homes to diversify their services—which would be consistent with the apparent increased public demand

[7] Ibid, pp. 9, 10.

for such lower-care-level services (see above). These alternative levels of care tend to be less expensive, and many are not covered by Medicaid, which would help reduce the Medicaid burden on taxpayers. On the other hand, to the extent that lower-level-of-care services require private pay and are not covered by Medicaid, they may not be affordable to many potential residents unless covered by third-party insurance.

Clearly the changing preferences of older people for non-institutional levels of care, combined with increasing public calls for such diversification of long-term care services, add to competitive pressures facing nursing homes. Not only are many competing with each other for nursing home residents (see discussion of occupancy rates in Chapter IV), but they are also increasingly competing for the attention of seniors who may prefer lower levels of care, especially at the "younger old" ages, if they are affordable. Increasingly, people wishing to remain at home while receiving support services are considering such viable options as adult day care, home care and respite care, in addition to a variety of supportive or congregate housing options such as adult care facilities, assisted living and enriched housing.

All of these options offer the potential to be viewed as threats or competition for nursing homes, but many also offer potential *opportunities* for homes to develop new services on their own or in various types of partnership with other providers. Among the assumptions underlying pressures to diversify are that lower levels of care are increasingly likely to be requested and demanded by both consumers and funders; that many 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 offering lower levels of care (e.g., reaching persons at younger ages and when they are in relatively good health) can help a home establish a relationship with consumers around other services that can increase the likelihood that they will seek out the home when ready for and in need of

higher level nursing home care. (Such options are discussed in more detail later in the report.)

Taxpayer and Political Concerns

As noted above, the Berger Commission and the new Governor have expressed strong concerns about the increasing costs of nursing home care, with particular focus on the continually escalating costs of Medicaid, despite the gap between nursing home costs and the levels of reimbursement provided by Medicaid, as discussed in more detail in Chapters IV and V.

Counties outside of NYC contribute well over $70 million a year in financial support for county nursing homes, based on 28 reporting facilities. The amount would be much larger, probably close to $100 million, if all public facilities had reported.

Beyond Medicaid expenditures, which account for more than 75% to 80% of all nursing home revenues in the state, local tax dollars increasingly provide substantial support to county homes, helping to offset operating losses[8] experienced by the vast majority of county nursing homes throughout the state. As discussed in more detail later in the report, counties outside of New York City contribute well over $70 million a year in financial support for their nursing facilities, an average of more than $2.5 million per home (based on 28 reporting facilities; if all county homes, including those in NYC, had reported their contributions, the statewide total amount would have been considerably higher, and probably approaching $100 million).

As county support levels rise, nursing home administrators express concerns about the level of county financial support that will be tolerated in the future. As discussed in more detail in Chapters III and V, despite strong county support reported by administrators for the nursing homes in most counties, most also report feeling some pressures to constrain costs and/or increase non-taxpayer revenues in order to at least limit the growth of required county revenues. Even administrators of facilities with a history of strong county support for the home's mission indicate that taxpayer concerns are never far from the surface, and that alternatives to

[8] Operating losses represent the excess of expenditures over revenues received from such sources as Medicaid, Medicare, private pay and private insurance, but not including county taxpayer subsidies.

current operations are either already being considered or would need to be actively evaluated if financial considerations become more of a concern in the future. These and other statewide efforts to maximize non-county revenues are discussed in more detail later in the report.

III. Descriptive Profile of County Nursing Facilities

County nursing facilities provide just over 10% of all nursing home beds in the state, and 14% of all non-NYC beds—and a much higher proportion of care for those considered hard to place and often with limited ability to pay for their services. Across the state, including NYC, about 90% of all residential health care facility beds are located in either a proprietary or voluntary facility. Proprietary homes are typically run by an individual or corporation. They function as commercial, for-profit enterprises and typically do not have boards of directors. Voluntary homes are not-for-profit entities, typically responsible to boards of directors. County homes, by contrast, are typically units of county government, and oversight is typically provided by an elected legislature or board of supervisors (except for three in New York that are currently operated as public benefit corporations).

Number and Size of Facilities

According to Cost Report data, there were 650 licensed nursing homes in New York in 2005—310 proprietary homes, 291 voluntaries, and 49 public facilities (including NYC but not counting three V.A.-operated public nursing homes). Together, they contained more than 115,000 residential health care facility (RHCF) beds, with about 53,000 of those in proprietary facilities, just under 50,000 in voluntary homes, and just over 12,000 in public facilities. Since our focus was on non-NYC nursing homes, Table 1 summarizes the breakdown of homes and beds for all non-NYC counties.

Table 1: Nursing Homes and RHCF Beds in Counties Outside of NYC, By Type of Facility, 2005

Type Facility	# of Facilities	Total Beds	% of Beds	Average # Beds
Proprietary	214	32,016	44.2	149.6
Voluntary	212	30,433	42.1	143.6
Public	44	9,905	13.7	225.1
Total	470	72,354	100.0	153.9

Source: Department of Health Cost Report Data Note: Does not include 3 V.A. public nursing facilities. Since 2005, three of the 44 public facilities have gone out of business and two have merged into one facility.

County Homes Larger Than Others, but #s and Sizes Declining

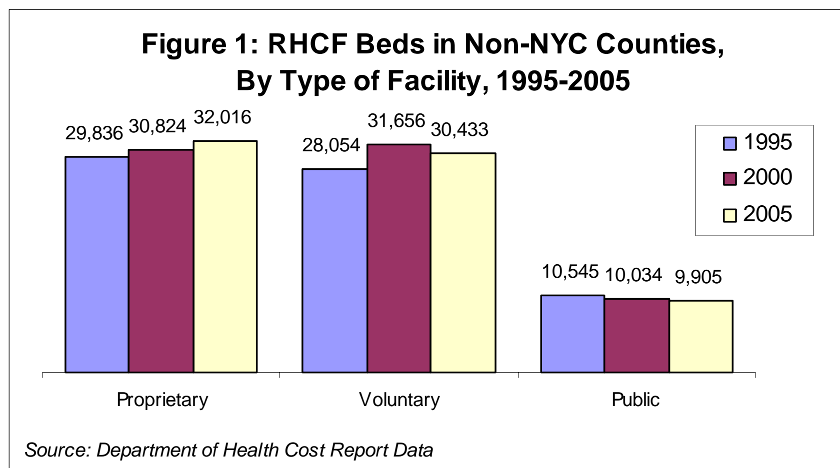
The mission and importance of county nursing homes far exceed their numbers, given those they serve.

Of the more than 115,000 RHCF beds in the state, about 63% (more than 72,000) are in counties outside New York City. About 9% of all non-NYC nursing homes are county-operated. But the relatively small number of homes masks their greater significance. *The county facilities represent an especially important component of the nursing home service system because of whom they serve*, as discussed in more detail below. Moreover, although representing only 9% of the homes, they account for about 14% of all non-NYC nursing home beds (compared to about 10.5% of *all* beds statewide, including NYC homes). This is due to the fact that the average public/county home contains about 50% more beds per facility (225 in 2005) than the average proprietary or voluntary home.

The average county nursing home is 50% larger than other types of facilities, but there are fewer county homes and beds than 10 years ago, while proprietary and voluntary beds have increased.

As indicated in Figure 1, proprietary and voluntary homes both contained more RHCF beds in 2005 than in 1995, while county facilities contained fewer beds. Between 1995 and 2005, the number of proprietary beds increased by 2,180 (up 7%), while voluntary beds increased by 2,379 (an 8.5% increase). The number of beds in county facilities during that period declined by 640 (a 6% decrease). The growth in proprietary beds is primarily a reflection of expansions in existing facilities, as the average number of beds in non-NYC proprietary facilities increased from 137 to 150 since 1995. Among voluntaries, most of the growth was accounted for by the fact that there were 11 more non-NYC voluntary facilities in existence in 2005 than in 1995. Among

public nursing homes, the decline in beds was a function of slight reductions in both number of facilities and average beds per home. *Further reductions of one or two public facilities and about 1,750 beds could occur if the Berger Commission recommendations are fully implemented.*



Few County Homes in Low-Population, Low-Density Counties

The bulk of the county nursing homes in the state are concentrated in the western part of the state, the counties along and further to the south of Lake Ontario, counties along the northeast and eastern borders of the state, and counties in the southeast southern tier and southeast sector of the state encompassing the Hudson Valley and NYC suburban areas. By contrast, in the central and Adirondacks regions of the state (mostly counties with relatively small populations and/or large geographic areas with low population density), relatively few counties operate public nursing facilities.

Relatively few counties with low populations and/or low population densities provide public nursing homes. Nearly all larger counties provide public homes.

In general, most large counties in the state offer public nursing homes, while few of the smaller counties do so. Only five of the 17 counties in the state with populations under 55,000 operate their own nursing homes. On the other hand, 16 of the 18 non-NYC counties with populations of more than 125,000 have county nursing facilities. Thirteen of the 15 counties with populations between 55,000 and 95,000 also maintain county nursing homes. Surprisingly, only two of the seven counties with mid-range

populations between 95,000 and 125,000 (including three along the eastern edge of Lake Ontario) operate county homes.

Distinct Mission of County Homes

The historic mission of most public nursing facilities has typically included providing care for higher proportions of indigent elderly residents and those with disabilities, as well as other persons considered "hard to place" for various reasons (such as crisis admissions and adult protective cases), than their proprietary or voluntary competitors. The costs of caring for such persons have often exceeded the level of reimbursement available to pay for the services. (See Chapters IV and V for data in support of these statements.)

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

Nonetheless, despite changing perceptions, most county homes do view themselves as retaining a sense of mission that is not typically shared by private/proprietary, or even many voluntary homes. That sense of mission typically involves one or more of the following:

- Caring for residents without regard for their ability to pay (i.e. insurance status or payment source);
- Accepting difficult-to-serve, and often costly-to-serve residents that other facilities may be reluctant, or refuse, to serve;

- Focusing primarily on providing services to county residents (though some make exceptions and offer services to others from surrounding regions).

County nursing homes are perceived as mission-driven, more so than competition- or profit-driven. They frequently provide a safety net and accept residents other facilities won't, while maintaining focus on quality of services.

Mission statements provided as part of the county home survey typically focused on themes related to the home's commitment to the community it serves, the provision of a safety net function (admitting residents without regard to the resulting facility case mix index or the person's ability to pay), the quality of care offered by the facility, and an emphasis on the value, needs and dignity of the individuals being served. Several counties emphasized the point that their facilities are proudly mission-driven, rather than competition- or profit-driven, and that their business model in effect emphasizes meeting needs that other providers may be unwilling to address—but that such an intentional focus does not mean that quality of services is in any way compromised.

Governance and Structure of County Homes

As noted above, the policymaking board of each county home is its county legislature or board of supervisors (with the exception of three counties which have created their homes, which they continue to support financially, as public benefit corporations).

Out of the 33 survey responses received from county facilities, 26 described themselves as operating as stand-alone nursing facilities, with five indicating they were affiliated with hospitals (NYAHSA and other data suggest that two additional county homes that did not complete the survey may also have affiliations with hospitals), and two being affiliated with other organizations within county government.

Of 31 county facilities answering the question, 26 reported that their financing arrangement is best described as an enterprise budget; five indicated their financing arrangement is through the county budget.

IV. Issues and Challenges Facing County Nursing Homes

This and the next chapter address challenges and issues facing county nursing homes, based primarily on historical and recent data comparing county homes with other types of facilities. (Chapter V focuses in more detail on the magnitude and implications of financial challenges and issues facing public facilities.)

Perceived Strengths and Limitations of County Homes

But prior to the discussion of such empirical data, the perceptions of county home administrators are presented here, focusing on how they perceive their respective strengths and limitations and challenges they face.

Perceived Strengths

In surveys and discussions, the following strengths were identified by significant numbers of administrators. They are presented in no particular order of priority:

County nursing homes are perceived as having a distinct mission and serving a population that other nursing homes are less likely to serve.

- The fact that county facilities provide access to care for difficult-to-place populations (e.g., adult protective cases, crisis admits, etc.) and are willing to operate as a "safety net," agreeing to serve those whom other facilities are unwilling to serve (this can also be viewed as a concern, since sufficient reimbursement is not always available to cover their costs);
- The distinctiveness of the county home mission;
- High quality of care and services;
- Responsiveness to local community, including provision of community leadership and partnership around various issues, including acting as emergency shelters at times of community crises;
- Quality of staffing, and relatively low turnover in many homes;

- County financial support and support for mission of homes;
- Economic impact as a significant employer (including paying a "living wage" and keeping local dollars in the community as opposed to being spent in private facilities, some of which are not headquartered locally);
- Good benefits, strong union support and professional working environment (helps with attracting and retaining good employees, though with a resulting downside of driving costs higher);
- The cost effectiveness of serving residents who might otherwise languish in costly hospital settings;
- Increasing diversity of services and specialized units/programs offered by some facilities;
- Facilities must be responsive to the public, and are under local control.

Perceived Limitations and Challenges

In surveys and discussions, the following limitations and challenges were frequently identified, and are presented in no particular order of priority:

County facilities face significant issues related to financial viability and the adequacy and stability of reimbursement mechanisms.

- Difficulties of serving some of the difficult-to-place residents, including insufficient reimbursement to cover all related costs;
- Future financial viability uncertain; inadequate state reimbursement system;
- Difficulties in recruiting skilled nursing staff;
- Rising costs and uncertainty of the future of various reimbursement sources;
- Outdated physical plant and general needs for refurbishment, modernization, updated equipment, and energy efficiencies;

- High proportion of residents with low clinical complexity but high staff burden due to behavioral problems (and often insufficient reimbursement to cover related costs);
- State regulations limiting the ability to manage, without fear of criticism and possible citations, high-maintenance residents requiring substantial amounts of staff monitoring;
- Public perception not always in line with the quality and nature of the homes' services (hasn't always caught up with changing realities);
- A lack of diversity in terms of the range of services offered;
- Insufficient focus on marketing to the public;
- Can't always be as flexible in management as needed due to county controls; nursing home management not always able to be part of labor negotiations or to affect decisions impacting on the home;
- Little flexibility in some cases to incorporate alternative services, because of reimbursement issues or state regulations (e.g., public facilities restricted in their ability to offer assisted living option);
- Legislators don't always understand the value and importance of what county homes do, especially when operating costs outstrip revenues consistently;
- Unionization helps drive up costs, though can also help with retention and staff stability.

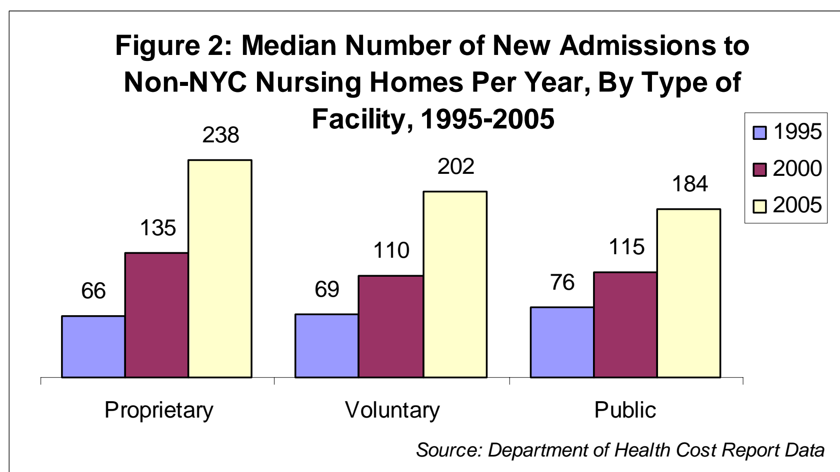
The data and discussions that follow provide more definitive documentation of many of the most critical issues and challenges facing county nursing homes.

More County Home Admissions, but Fewer than Competitors

New admissions to nursing homes have grown rapidly across all types of facilities, but especially among voluntary and proprietary homes, which have obtained more lucrative short-term residents.

Since the mid-1990s, the total numbers of admissions to nursing homes throughout the state have more than doubled. Increasingly, nursing homes have been providing short-stay care to people needing post-hospital, sub-acute care and rehabilitation services.[9]

As shown in Figure 2, new admissions have grown at rapid rates across all three types of nursing homes across the state. But the growth has been most pronounced among the proprietary and voluntary sectors. In 1995 the median county nursing home admitted more new residents than did the typical voluntary or proprietary home—not surprising, since the average county facility has about 50% more beds. However, by 2005, despite the differences in size, county homes had fallen far behind their competitors in the median numbers of new admits per year, in large part because *other types of facilities have cornered more of the market on the relatively lucrative short-term sub-acute and rehabilitation residents.*



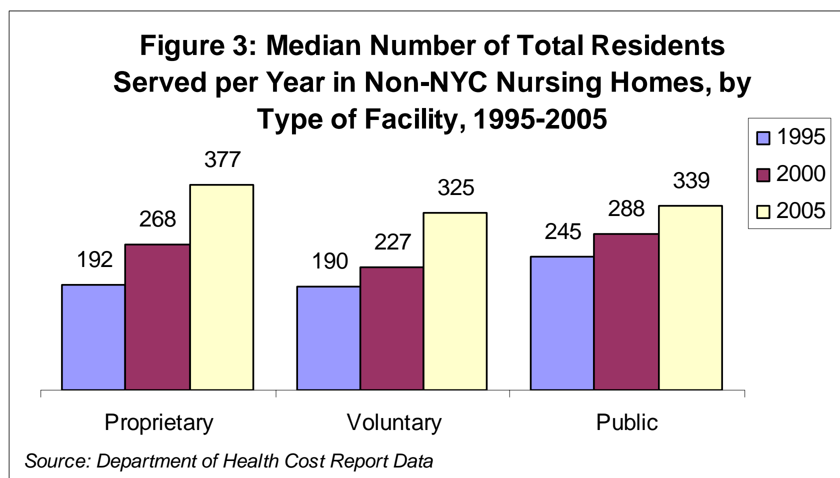
For example, in 2005, almost 58% of all discharges from voluntary homes, and 53% of those from proprietary homes, had been in their facility 30 days or less, compared with only 43% of those from county facilities. Conversely, about 16% of discharges from

[9] Commission on Health Care Facilities, *Planning for the Future*, op cit, p.21; Commission on Health Care Facilities, *A Plan to Stabilize and Strengthen New York's Health Care System*, op cit, p. 52.

The typical proprietary home now serves more nursing home residents per year than does the median county home, even though county homes are typically larger. Lengths of stay are typically shorter in both proprietary and voluntary facilities than in county homes, at higher reimbursement levels.

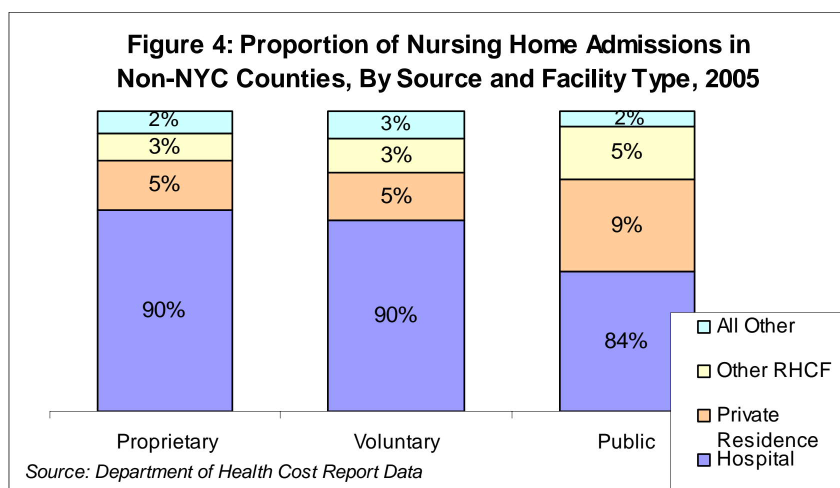
county facilities had been residents for three years or more—more than twice the rates of about 7% in both voluntary and proprietary homes. With a deliberate focus on more new admissions, for shorter periods of time, proprietary and voluntary homes "churn" through more residents in an average year now than they did in 1995. As shown in Figure 3, in 1995, the typical county home provided services to more than 50 additional residents during the year (both new admits and residents carrying over from the previous year) than did the median proprietary or voluntary home. But ten years later, the median proprietary home had almost doubled the total numbers of residents served during the year, and the typical voluntary home had increased its numbers served by 71%, while the typical county home had increased by 38%.

As a result, the median proprietary home now serves more residents per year than does the typical county home, and the typical voluntary home serves almost as many, even though both have fewer beds on average than does the median county home. County homes typically serve fewer new residents, and serve them longer, than is the case with the more rapid turnover of residents and shorter average length of stay (with typically higher reimbursement levels) in proprietary and voluntary homes.



Fewer Admissions from Hospitals to County Homes

Cost report data indicate that between 1995 and 2005, *the proportion of all NYS nursing home admissions from hospitals increased steadily from 78% to 89%*, while proportions from private residences declined from 12% to 5%, and proportions from other nursing homes declined from 6% to 3%. These trends were reflected consistently over those ten years in each type of nursing facility. However, as indicated in Figure 4, the pattern of admissions is slightly different among county facilities.



Although the proportion of admissions from hospitals has increased from 73% to 84% in county nursing homes since 1995, *county homes have consistently lagged behind the proportion of hospital admissions to proprietary and voluntary nursing homes by several percentage points*. Conversely, county facilities have consistently been several percentage points higher than other nursing homes in the proportions of admissions direct from private homes and from other RHCFs.

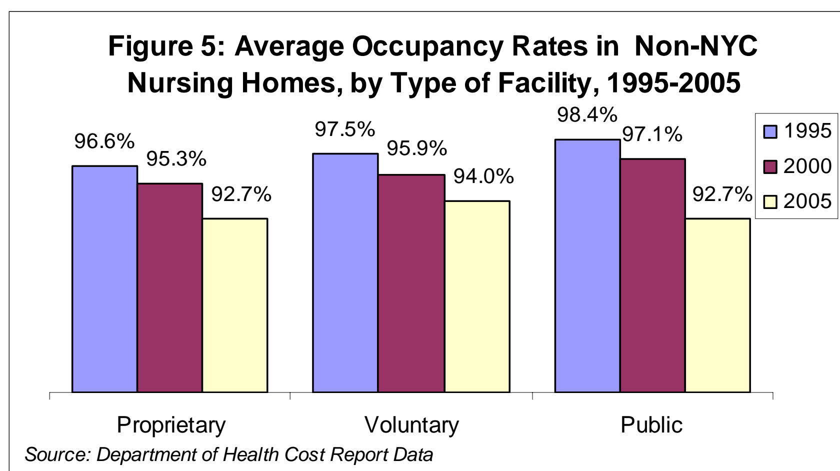
County homes admit smaller proportions of residents from hospitals than other types of homes, with resulting lower reimbursement levels. They also admit higher proportions of people that other nursing homes are unwilling to serve.

The significance of these patterns is twofold: (1) Admissions from hospitals are typically more lucrative because they are more likely to be qualified for higher RUGS categories (with their higher reimbursement rates) and because they typically have the 3-day hospital stay required by Medicare to qualify for nursing home reimbursement eligibility (with higher reimbursement rates than Medicaid rates, as discussed below). Higher proportions of

hospital admissions in voluntary homes are partly a function of the fact that almost a quarter of those facilities have a direct affiliation with a hospital—compared with about 18% of county homes. (2) Higher proportions of county home admissions from other RHCFs is believed to be at least in part a function of the county homes' "safety net" mission and willingness to accept residents whom voluntary and proprietary facilities are, for a variety of reasons, unwilling to continue to serve.

Declining Occupancy Rates

Nursing home occupancy rates have been steadily declining, from about 97% statewide in 1995 to about 93% in 2005. As indicated in Figure 5, average occupancy rates have declined across all three types of nursing facilities during that period.



In 1995 and 2000, county nursing homes consistently had average occupancy rates one to two percentage points higher than proprietary and voluntary homes. However, by 2005, county home average rates were at or below the averages for the other types of facilities. Moreover, county home survey data indicate that in each of the last three years (2004-2006), four or five of the 33 responding counties reported annual occupancy rates below 90%. These lower rates partly reflect the greater turnover among residents due to increases in number of short-term stays for sub-acute and rehabilitative care. But they also presumably reflect, at least in part, increases in use of lower levels of non-institutional

Nursing home occupancy rates have been declining statewide, with the biggest declines among county homes.

care, especially by younger subsets of the 65+ population, as noted earlier in the report.[10]

The declines in occupancy rates have obvious financial significance in terms of lost revenues. As noted in the Berger Commission report, a 97% occupancy rate has historically been the goal for nursing homes in terms of financial viability and efficiency. The report adds that a 95% rate is also of crucial importance because that rate is required to qualify for "bed-hold payments," which enable nursing homes to receive Medicaid compensation in order to reserve an empty bed in anticipation of a Medicaid resident expected to return from a hospitalization stay.[11]

Payment Sources Disadvantageous to County Homes

County homes serve disproportionately high numbers of Medicaid residents, with low reimbursement rates, and low proportions of Medicare and private pay residents, compared with other types of nursing facilities.

In order of value to nursing homes in terms of covering actual costs of services provided, Medicaid provides the lowest return. Various aspects of the Medicaid reimbursement formula impose restrictions that resulted in 2004 in a gap between allowable Medicaid costs and actual reimbursement of 11.2% (i.e., Medicaid covers less than 90% of actual costs of care). *This translates into a Medicaid shortfall well in excess of $20 per resident day.*[12] Medicare, on the other hand, pays close to or even slightly above actual costs of care, and private pay rates typically are set to exceed actual costs.

County nursing facilities are hit hardest by these payment realities because, in comparison with other types of facilities, they provide higher proportions of care to Medicaid residents and lower proportions to those paid for by Medicare and private pay.

---

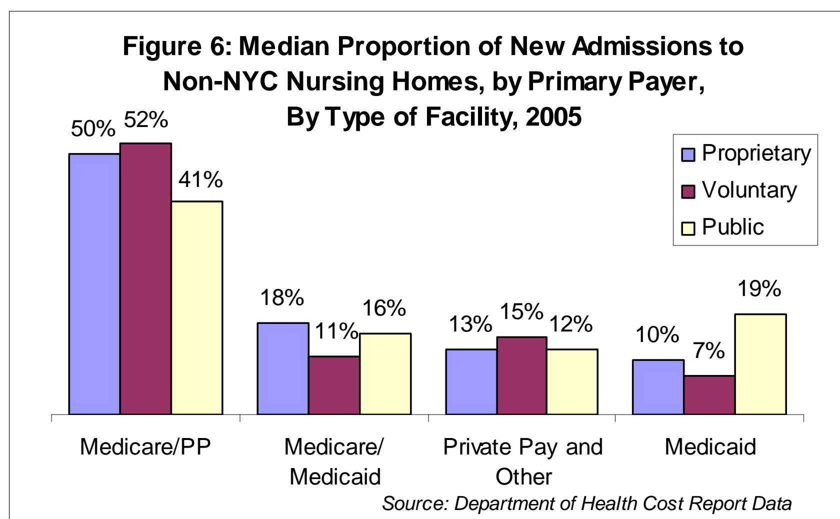
[10] See Commission on Health Care Facilities, *Planning for the Future*, op cit, p.20; CDC, National Center for Health Statistics, National Nursing Home Surveys.

[11] Commission on Health Care Facilities, *A Plan to Stabilize and Strengthen New York's Health Care System*, op cit, p. 51.

[12] NYAHSA, "Financial Distress and Closures: The Uncertain Fate of New York's Nursing Homes," NYAHSA Public Policy Series, February 2006, pp. 1, 14. This figure covers nursing homes in general; county home deficits are estimated to be much higher, though specific amounts were not available.

Primary Payer at Admission: Counties Often Lose Money from Day One

According to cost report data supplied by NYAHSA and summarized in Figure 6, *in the median county nursing home, almost twice the proportion of admissions as in proprietary homes and almost three times as many as in voluntary homes are Medicaid residents from day one—receiving daily Medicaid reimbursement of significantly more than $20 per day below the actual costs of serving that individual.*



If anything, these differences are on the conservative side. The proportions reflected in Figure 6 are generally thought to understate the Medicaid proportions and overstate the Medicare/ private pay proportions in typical county homes. *Data supplied for 2004-2006 in the county surveys suggest that the Medicaid proportions of new admissions in the median county facility may actually be closer to 25% or more, rather than 19%.* County home administrators in our regional discussions indicated that the cost report/NYAHSA data on private pay admits and the Medicare/private pay combination actually are misleading in that they include a substantial number of Medicaid-pending persons for whom the home actually receives no payment until Medicaid is approved.

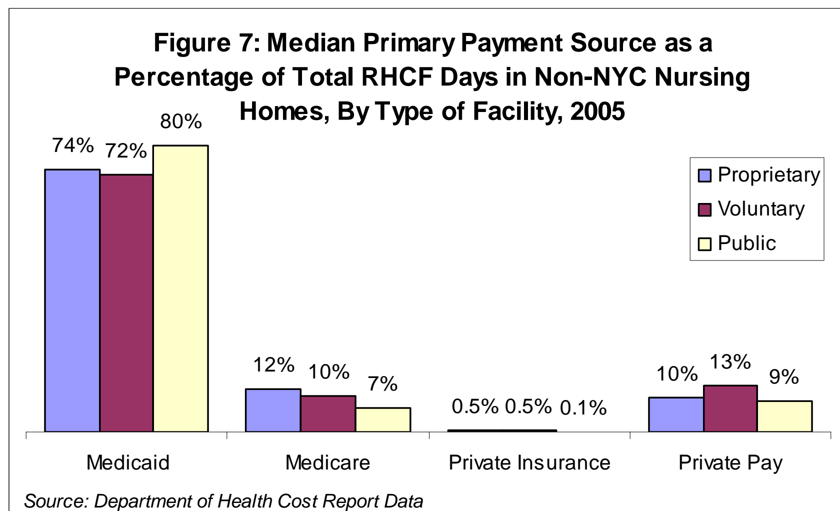
At least two to three times as many new admissions enter county homes on Medicaid from day one as is true in proprietary or voluntary homes, thus representing a loss of well over $20 per day for their entire stay in the facility.

Figure 6 suggests that proportions of county home admissions with a combination of Medicare and private pay reimbursement are about 10 percentage points lower in most county facilities than among their proprietary and voluntary counterparts. County homes also have slightly lower proportions of straight private pay residents at admission. Administrator comments, and survey data, suggest that the actual differences, when Medicaid-pending cases are factored in, are probably even more pronounced, to the detriment of the county homes.

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

Most Resident Days Paid for by Medicaid

Even most nursing home residents who are admitted as Medicare or private pay residents typically ultimately wind up on Medicaid at some point during their stay in the facility. In the typical nursing home, more than 70% of all non-NYC RHCF resident days during a typical year are paid for by Medicaid. As indicated in Figure 7, that is true regardless of type of facility.



Higher proportions of resident days are paid for by Medicaid in county homes than in other facilities, with fewer days covered by payment sources covering full costs of services.

However, primarily fueled by the disproportionate number of Medicaid days at admission in county homes, the proportion of *all* resident days paid by Medicaid is consistently several percentage points higher in the typical county home than in other types of facilities. Conversely, smaller proportions of resident days in county homes are paid for by Medicare and private pay. Even though the percentage gaps between types of facilities have narrowed somewhat between 1995 and 2005, and the current differences are measured in terms of a few percentage points, those relatively small differences—when applied to all resident days across a facility—add up to significantly fewer days in county facilities being reimbursed at anything resembling full costs.

Factors Contributing to Low Medicaid Reimbursement Rates

While Medicare and private pay residents are typically reimbursed per resident based on the approximate actual costs of the services provided, Medicaid reimbursement has historically been capped at levels below actual costs.

A recent NYAHSA report concluded that "many of the financial problems in New York's nursing homes are directly tied to the outdated system that bases reimbursement on 1983 costs increased by various adjustments that have failed to keep up with actual cost

increases."[13] Almost 60% of the county homes responding to the survey indicated that they are still being reimbursed based on the 1983 base year. Seven of those responding indicated that they have been able to convert to a post-2000 base year as a result of new construction or other upgrades made to their facilities, but *the majority of county homes remain locked into an outdated-base-year reimbursement formula that has been estimated by knowledgeable state associations to result in an average loss of $21.23 each resident day.*[14]

About 60% of all county nursing homes lose reimbursements because of an outdated reimbursement base year, and upper payment limits imposed strictly on county homes restrict millions of dollars in payments each year.

Twenty-one of 30 responding county homes indicated that they should have a different base year to more appropriately reflect changes that have affected their expense structure in the intervening years, and 13 have attempted to appeal their rates at various times, with varying levels of success. One county indicated that it was ludicrous that "appeals and auditing has become an important role in reimbursement."

Further reductions in Medicaid payments, as discussed in more detail in Chapter V, resulted from the imposition by the federal government in 2001 of an upper payment limit (UPL) applied specifically to county nursing homes. The UPL was imposed in response to actions taken by several states which had the effect of subverting and reallocating funds (intergovernmental transfers) away from their intended purpose of supplementing revenues for public health care facilities. *The UPL has reduced the amount of Medicaid and intergovernmental transfer funds that would otherwise have been available to county nursing homes by millions of dollars in each of the past several years.*

---

[13]NYAHSA, "Financial Distress and Closures ," op cit, p. 2.

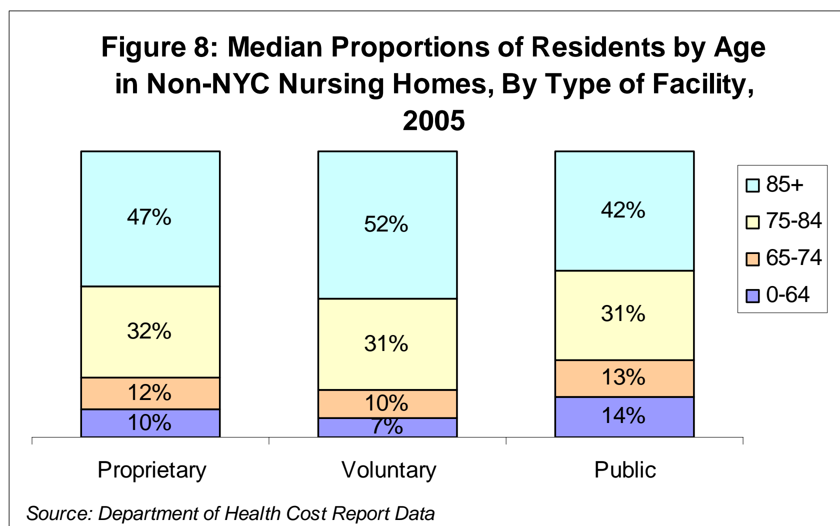
[14] Commission on Health Care Facilities, *A Plan to Stabilize and Strengthen New York's Health Care System*, op cit, Appendix 4, p. A4-6; Joint Association Task Force on Nursing Home Reimbursement (New York Association of Homes and Services for the Aging, NYS Health Facilities Association, Healthcare Association of New York State), February 2006. This represents all nursing homes; the loss for county homes is estimated to be much more per resident day.

Added County Home Costs Resulting from Resident Demographics

County nursing facilities appear to differ sufficiently from their voluntary and proprietary counterparts on a few demographic characteristics of residents that are likely to have staffing and reimbursement implications for the facilities. Specifically, NYAHSA data indicate differences between county and other types of nursing homes—related to age of residents and proportions of bariatric beds and behavioral beds—of sufficient magnitude that they appear likely to have an adverse impact on costs of operating the county homes. County survey data on the proportions of residents with low clinical complexity but high behavior-related needs suggest similar implications. Discharge and transfer data also suggest differences of note in the characteristics of residents of county homes.

Age Profile Lower in County Homes

As indicated in Figure 8, county homes typically have lower proportions of residents 85 and older, and significantly higher proportions of residents under the age of 65, than do their voluntary and proprietary counterparts. These patterns have held consistently in 1995, 2000 and 2005.



County homes are more likely to serve higher proportions of younger residents requiring more staff time to address behavioral issues. Staff costs are likely to exceed reimbursement levels for such residents.

The median county home in 2005 had twice the proportion of residents under 65 than did the typical voluntary home, and about a 40% higher proportion than the typical proprietary facility. County homes typically had higher proportions of residents between the ages of 55 and 64, as well as of even younger residents between the ages of 21 and 54. Those knowledgeable about nursing homes suggest that these differences are significant in that younger residents tend to have higher care needs, be more disruptive, and be more likely to have social problems and substance abuse problems, have sexual needs, and to stay for many years with relatively low RUGS scores. With higher proportions of such residents, there are likely to be higher demands on staff time in county homes, which in turn are less likely to be fully reimbursed for the costs of serving such residents.

More Bariatric and Behavioral Beds in County Homes

County facilities are somewhat more likely than other nursing homes to provide bariatric services (addressing issues related to obesity) and typically serve higher proportions of residents with behavioral needs, according to data from cost reports and the county home survey.

County nursing homes serve higher proportions of bariatric and behavioral residents, at higher costs and staff time, and less reimbursement, than do proprietary or voluntary homes.

Cost report data indicate that 7% of the beds in the median county home are devoted to bariatric care, compared with 5% and 6% in proprietary and voluntary homes respectively. The differences are greater in terms of beds specified by NYAHSA as behavioral beds. The median county home has a reported 13% of its beds serving those with behavioral needs, compared with 8% in proprietary and 9% in voluntary homes. Modeling done for the Joint Association Task Force on Nursing Home Reimbursement indicated that additional time, not now adequately reimbursed, is needed to adequately staff and care for behavioral and bariatric residents. *Thus at this point county facilities are disproportionately negatively affected by these staffing and reimbursement imbalances.* The Task Force's proposed

new reimbursement system includes enhanced reimbursement to address these populations in the future.[15]

County Homes: Many Residents with Low Clinical Complexity but High Behavioral Demands

The county home survey conducted as part of this study asked administrators to estimate what proportion of their residents have low clinical complexity but high behavioral needs/demands, and asked what impact if any such residents have on the fiscal viability of the home. Of the 25 who responded to this question, 72% said at least 20% of their residents fit that description, including just over half who indicated between a quarter and as many as half. Most of those fitting this description seemed to fall into three basic categories: those with Alzheimer's disease (and/or dementia) who require substantial monitoring and observation; younger residents requiring substantial observation and often 1:1 staff time; and "behaviorals," as discussed above. Additional staff time is typically required for such tasks as added supervision; additional social work; additional activities to keep residents occupied; and increased observation and monitoring to prevent wandering, smoking or other safety concerns, and aggressive behavior.

The majority of county homes indicate that a quarter or more of their residents have low clinical complexity but high behavioral demands, adding to demands on staff and costs, but with insufficient offsetting revenues.

Nearly all respondents to the question indicated in no uncertain terms that *serving substantial numbers of such residents has significant implications for staffing and added costs*, often citing the need for extensive 1:1 observation (some indicating that this can increase overtime costs). *Nearly all said that reimbursement is inadequate to cover the legitimate costs and staffing requirements associated with meeting the service needs of these subpopulations*, but they recognized that there was little to be done about this under the current reimbursement structure, and that these residents had legitimate service needs that must be met. Several county home administrators commented directly on the impact that these individuals have in driving down the facility's Case Mix Index, thereby equating to tens of thousands of dollars in lost revenues for the facility as a result. (See further discussion

[15] Staff email communication with NYAHSA, May 21 2007.

of CMI below.) A recent NYAHSA article echoed many of the concerns expressed by the administrators, recommending that enhanced reimbursement was needed for residents with Alzheimer's disease and other conditions whose care and behavioral needs are not adequately addressed by the current payment system.[16]

Transfers and Discharges

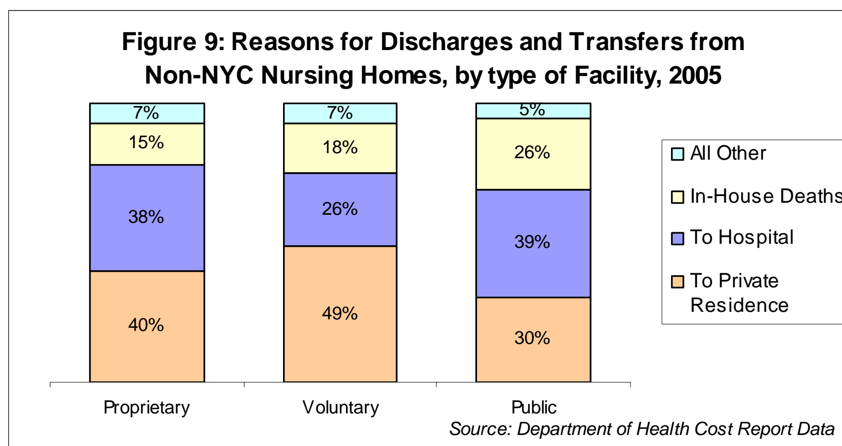
Patterns of destinations and reasons for discharges and transfers from nursing homes have changed significantly in recent years. In conjunction with the increased number of nursing home admissions, coupled with increasing proportions of short-term stays and rehabilitation services, the proportions of nursing home residents discharged to their homes has more than doubled in the past ten years. Cost report data indicate that 19% of all discharges from nursing homes across the state were to private residences in 1995, a proportion that more than doubled to 43% by 2005. Significant increases occurred across all three types of facilities.

The reverse trend has occurred in proportions of in-house deaths. With more "churning" being experienced in the resident population—with more admissions and discharges and people in and out of the facilities with short-term stays—the proportion of residents staying long enough to die as residents has declined dramatically over the same ten-year period. In 1995, 42% of all discharges from nursing homes were the result of in-house deaths. By 2005, that proportion had been reduced by almost 60%, to 17% of all discharges. As with discharges to private residences, this pattern of reductions has occurred in all three facility types.

[16] NYAHSA, "Financial Distress and Closures," op cit, p. 15.

County nursing homes are less likely than their counterparts to discharge residents to their private homes, and higher proportions of residents die while residents of county homes than of other types of nursing facilities.

Despite the consistent trends across types of facilities since 1995, distinctive differences remain in discharge patterns between county nursing homes and other types of homes. As indicated in Figure 9, despite the increases in recent years, county homes remain least likely to have residents discharged to private residences. The median county home sends three of every ten discharges back to their residence, compared to almost half of the discharges from the median voluntary nursing home and 40% of proprietary discharges. Conversely, although the rate is only about half of what it was in 1995, one of every four discharges from the median county home continue to be as a result of dying as a resident of the home, compared to 15% and 18%, respectively, among proprietary and voluntary homes.



Low Case Mix Index in County Homes

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

But this was not always so. The county home role has flipped over time. Under the cost-based reimbursement system in place in the 1980s, county homes typically served those with the highest case mix intensity because other types of homes could not afford

to be burdened with such high-cost cases. With the subsequent shift to a case-payment system, the incentives shifted. County homes historically have responded to those in the system whom no other providers wish to serve.

The reimbursement methodology which has now been in place for a number of years in NYS is based on Resource Utilization Groups (RUGs). There are currently 16 RUG categories.[17] Each person receives a RUG score as an indicator of patient acuity (degree of sickness/health). Persons with relatively high scores are reimbursed at higher rates. Those with low scores typically receive lower levels of reimbursement, even though many also have various behavioral, Alzheimer's disease or related circumstances that do not affect their score or reimbursement level, but which do require additional staff attention, as noted in the previous section. The scores summed across all residents of a nursing home become the basis for the institutional case mix index, with higher CMIs indicating higher composite patient sickness and typically higher reimbursement levels.

Voluntary and proprietary nursing homes typically attempt, to the extent possible, to minimize the number of low-acuity/sickness admissions, because of their low levels of reimbursement and their potential in many cases to need additional staff attention—thereby leaving higher proportions of such individuals to the county facilities, in turn lowering their composite case mix scores.

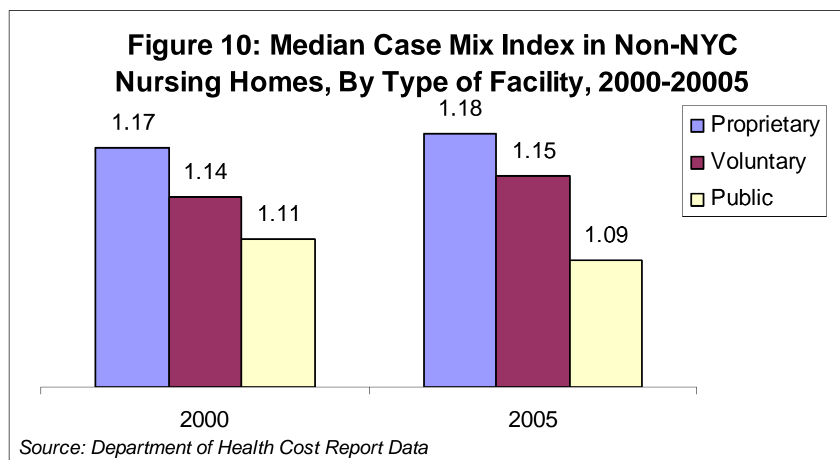
As indicated in Figure 10, *the CMI gap between county and other types of nursing homes was greater in 2005 than it had been in 2000*.[18]

---

[17] The Medicaid-based RUGs/CMI reimbursement system is in the process of transitioning to a system which will be more closely integrated with the Medicare reimbursement system. It is based on 53 categories, and is believed to represent a more accurate reflection of service needs and equitable reimbursement.

[18] Reliable comparison CMI data for just upstate counties were not available across facility types from NYAHSA for 1995.

There is an increasing gap between the median county home CMI and that of other facilities, with lower reimbursement and higher staff needs resulting.



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

County homes may have been able to increase their overall CMIs somewhat, compared to 1995, when the "average CMI" was reported in CGR's 1997 report as 1.03. The basis for computing that number was different than the source used in 2000 and 2005, so comparisons should be made with caution. But even if some increases did occur between 1995 and 2000, the median CMI declined again somewhat between 2000 and 2005. Furthermore, data provided in the survey by county homes for 2004, 2005 and 2006 suggest that over those three most recent years, the median CMIs were declining across the two full-house calculations in each of those years: from a median CMI of 1.10 in the initial 2004 full-

house calculation to as low as 1.06 in the first calculation in 2006.[19]

County homes would prefer a 1.15 CMI, but may be falling further from that ideal in recent years. The goal may be difficult to reach due to competition and the county homes' historic "safety net" mission.

With a few exceptions, county home administrators indicated that they would prefer to have a higher CMI than their historical levels. Most suggested ideal CMI levels .05 to .08 higher than their current levels. The median ideal county home CMI was 1.15, compared to the actual 2005 median of 1.09. But reaching such a level is acknowledged to be difficult. The 2004-2006 data suggest that the homes may actually be inadvertently retreating from that level, and a number of administrators noted the difficulty in attaining significantly higher CMI levels, given the competition in most counties from voluntary and proprietary facilities seeking the higher-acuity residents, and given the historic "safety net" mission of most county homes to accept the hard-to-place, lower-acuity, higher-behavioral-need applicants for admission.

Many administrators cited the possible expansion of rehabilitation services as a way of increasing the CMI level for their facility, and some have made strides in that direction. But others noted the difficulty of establishing a strong rehabilitation presence in such a highly-competitive market for such services. Several administrators also suggested that they may be able to improve their CMI in the future through better screening and better training of staff to more effectively use the scoring criteria to maximize the reimbursement potential. On the other hand, several administrators also acknowledged that they were serving substantial numbers of residents that ideally should not even be in a nursing home, but rather in an assisted living facility—but who were in the nursing home because of insufficient and/or unaffordable assisted living beds available in their counties.

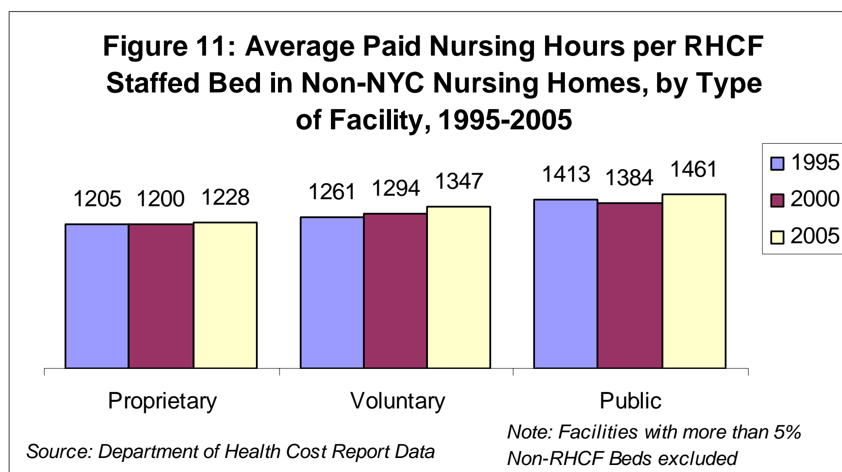
[19] Most of the individual county homes had CMIs ranging between 1.00 and 1.15. Each year only two or three facilities typically had CMIs below 1.00 or above 1.20.

Higher Staffing Levels in County Homes

County nursing facilities represent a significant economic force in their respective communities, with more than $600 million in cumulative annual expenditures across counties outside of NYC. In some smaller counties, the county homes are among the larger employers in the area. Our survey of county administrators indicates that the average county home employs about 320 staff, the vast majority full-time. Of the 30 homes supplying employment data, 14 employ between 100 and 200 staff, and 16 employ more than 200, including 12 with more than 300 and six with more than 500 employees.

County homes consistently maintain nursing staff levels between about 9% and 18% above those of their non-public sector competitors. Differences in staffing levels between types of facilities are smaller for non-nursing staff.

As shown in Figure 11, nursing staff levels have remained relatively stable since 1995 in each of the three types of homes, despite the increases in numbers of individuals served during that time (but with offsetting declines in occupancy rates over that period). County homes have consistently maintained higher nursing staff levels relative to other homes—averaging about 17% to 18% more staff time per staffed RHCF bed than employees in proprietary homes and about 9% to 10% more time than in voluntary facilities. Proponents of county facilities argue that these differentials imply a combination of two things: better quality direct care service within the typical county home, and a better profit margin among other types of facilities.



Nursing staff hours per bed consistently account for between 58% and 60% of total facility paid staff hours per bed, across all three

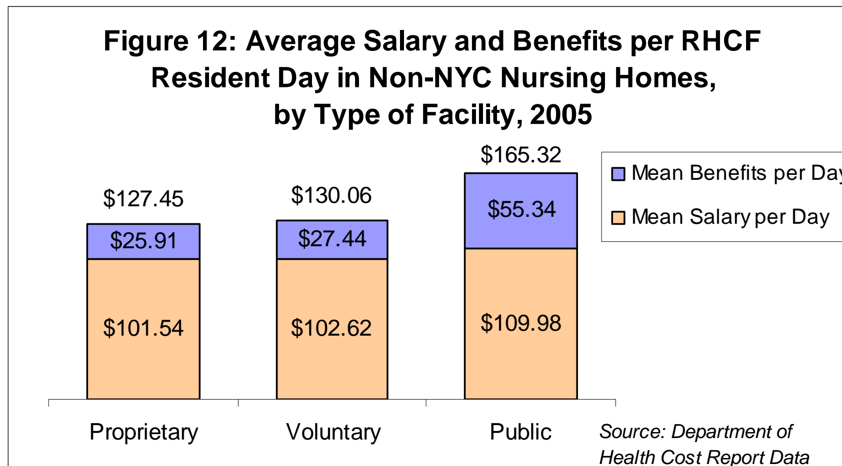
types of nursing homes. The difference between non-nursing staff hours in county homes versus other types of facilities is smaller than for nursing staff, implying that county homes pay for more nursing staff per bed than do other types of homes, but that staffing levels for other types of tasks are relatively comparable.

The level of turnover among direct care workers (e.g., RNs, LPNs, nurse aides) varies widely among county homes, based on data supplied in the survey of administrators. Only 18 homes responded to this question, and of those, the median reported annual turnover rate was 24%. Eight reported rates of 20% or less, including five of 15% or less (and three at 10% or less). At the other end of the spectrum, four facilities reported annual turnover rates between 45% and 50%. Several administrators complained about the difficulty of recruiting and retaining professional nursing staff at competitive salaries, though others bemoaned the fact that their facility's costs are driven up by high costs of benefits.

Rapidly Rising Staff Costs, Especially in Benefits, in County Homes

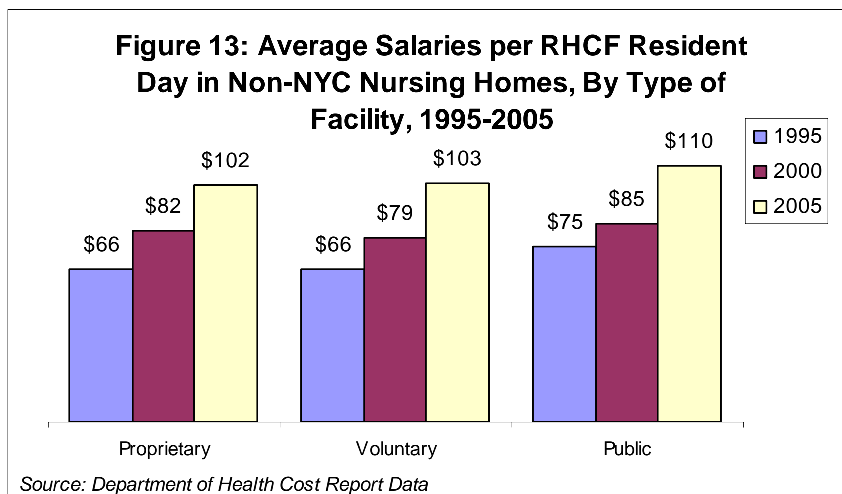
The average county payroll cost is $35 per day higher than in other homes, with most of the difference due to much higher benefits.

As shown in Figure 12, payroll costs of county homes significantly exceed those of their competitors. In 2005, the average cost of salaries plus benefits in a county home was more than $35 higher per RHCF resident day than the average in either proprietary or voluntary homes. Average salary plus benefits, unadjusted for inflation, increased 65% in county homes between 1995 and 2005, compared with increases over that time of 56% in proprietary homes and 58% in voluntary facilities. *Although average salaries are somewhat higher in county homes, the major contributor to the differential costs between types of facilities is the much higher benefits paid by public facilities.*



Salary Differential Actually Declining

As indicated in Figure 13, average salaries in county nursing homes have consistently exceeded those in other types of homes, but the differences have actually narrowed somewhat in the past ten years.



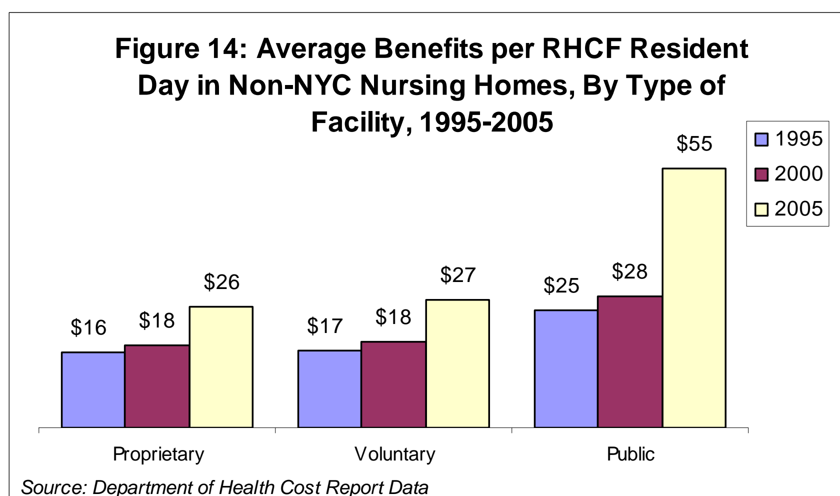
Average salaries have been consistently higher in county homes than in other types of facilities, but the differences have narrowed somewhat since 1995.

Between 1995 and 2005, the average salaries in voluntary and proprietary homes increased by about 55%, while the rate of increase in county homes was 46%. The average salary per resident day in county homes was about $9.50 higher in 1995 than in non-public homes. The difference shrank to about $5.50 or less in 2000, before increasing again in 2005 to about $8.50 between county and proprietary homes, and about $7.35 between county and voluntary facilities.

These figures reflect average salaries for all employees of the nursing homes, but the patterns of increases and order-of-magnitude differences between different types of facilities are virtually identical among the nurses, aides and administrators in the nursing cost centers making up the bulk of the staff in all nursing homes.[20]

Benefit Levels in County Homes Have Escalated Rapidly

While the differences in average salary levels between types of homes have narrowed, the differences in benefit levels have grown astronomically. Benefits have increased at faster rates than salaries across all types of homes, but Figure 14 indicates that the increases have been especially dramatic within county facilities.



Average benefits increased by substantial amounts between 1995 and 2005 in both proprietary and voluntary homes—by 62% and 66%, respectively. But those levels of increase were dwarfed by the average increase in benefits in county homes. Average benefits more than doubled (+121%) in just ten years, with most of that increase occurring in the five years since 2000 (+ 97%). In just

[20] The average salary and average benefit level for nursing cost center employees in county homes were consistently about 59% of the total facility average salary and benefit levels across all cost centers for all three years analyzed. The trends referenced above in comparison with other types of facilities were virtually identical for both total employees and nursing cost center employees.

Average benefits in county homes have more than doubled in ten years, mostly since 2000, and now represent about 50% of salary levels in county facilities. Escalating benefits are mostly attributable to mandated increased retirement costs passed on from the state to counties, and to increased health insurance costs; they account for most of the difference in personnel costs between county and non-public nursing homes.

those five years, the average county home's benefit level rose by more than $27 per RHCF resident day. *In 1995, the average county home paid benefits of about $9 per resident day higher than in the average proprietary facility; by 2005 that differential had more than tripled, to a difference of almost $29.50 per day.* In 1995 and 2000, the average benefit package in county homes represented about 32% or 33% of salaries, compared to about 25% in voluntary and proprietary homes. By 2005, the latter rates had moved to slightly more than 25%, but *county rates in 2005 had escalated to an average of fully 50% of salary levels.* As with salary levels, these overall patterns of increases across all nursing home employees were virtually identical among nursing cost center employees.

As noted below, much of this rapid increase in benefits was attributable to substantial increases in mandated pension/ retirement costs passed on to counties since 2000, and to increasing health insurance costs. Typically these were costs over which nursing home administrators had little or no control (see further discussion below).

Major Cost Differentials Among Nurse Aides

Within the nursing cost center, average salary and benefit costs over the years have been fairly consistent for RNs and to a lesser extent for LPNs across types of facilities, but the major differential costs have involved nurse aides.

For RNs, average salary and benefits per hour for county homes versus non-public facilities were within a dollar of each other in 1995 and 2000, and county average costs were actually a few cents lower in 2000. By 2005, county costs had risen to between $1.68 and $1.88 higher than voluntary and proprietary average costs, respectively. County average salary and benefit costs per hour were about 25 cents an hour lower for LPNs in 1995 than the average for proprietary homes, but in the intervening years, county average costs have risen more rapidly, so that by 2005, average costs in county homes were a little over $3 an hour higher than in voluntary homes.

Average salary and benefit costs for RNs and LPNs have been similar between different types of facilities until recent years, when county costs have increased at a faster pace. County homes have consistently paid more than other facilities for aides.

County facilities have consistently paid more per hour for aides than have other types of nursing homes, and the differences have increased over time. In 1995, when RN and LPN costs were comparable across facility types, counties were paying an average of $1.43 an hour more for aides than were proprietary homes, and by 2005 the average county rates had increased by 64%, compared to average increases of about 42% in both proprietary and voluntary homes. In 2005, county facilities were paying between $4.50 and $4.75 more per hour in salary and benefits for aides than were their non-public counterparts.

Growing Costs of Payments to Retirement System

As noted, one of the major components of the rapidly growing benefit costs to county nursing homes is the increasing amounts of dollars for payments into the state retirement system.

Across 29 county homes in the cost report data base that supplied information about retirement payments, the median home paid just under $600,000 in annual retirement payments in 2005—consistent with findings from our survey. The reported range in the more complete data base was from a low of about $286,000 to a high of about $2.9 million a year. The reported *median* value in 2005 was almost $200,000 higher than the *maximum* reported value in 1995, thereby providing a clear indication of the extent to which these payments have grown as an additional cost to county homes, as much of the burden was shifted from the state to counties. These payment levels are thought to exceed the pension expenditures of proprietary and voluntary nursing homes, although there were no comparison data available to confirm this.

More recently, there are indications that the level of retirement contributions may be decreasing and will represent a lower level of burden for the counties in future years.

Limited County Home Role in Labor Negotiations

County home administrators often have little opportunity to negotiate working conditions or benefit levels that directly affect their budget and operations.

Increasing benefit levels in county nursing homes are virtually always tied to overall benefit levels of *all* county employees, as negotiated by county officials with various bargaining units. Although there is considerable variation across counties, many nursing home administrators report that they are rarely part of these overall negotiations—and rarely have opportunity to negotiate benefit levels, or other conditions affecting their home and its sometimes distinct circumstances, separately from agreements that are reached on behalf of all county employees. *Many of the administrators reflected frustrations that they are held accountable for the performance and financial well-being of their facilities, but have insufficient opportunity to negotiate working conditions or benefit levels apart from those created for all county employees.* (Chapter VI contains further discussion of this issue.)

Aging County Facilities

County nursing homes are often perceived, at least by their advocates, to be considerably older than most proprietary and voluntary nursing facilities. Data were not available for us to test that hypothesis directly. But in the absence of consistent data on the actual age of all nursing home buildings, a recent NYAHSA report calculated a proxy measure, an "average age of physical plant ratio," as an indicator of the accounting age of nursing home fixed assets, taking into consideration total accumulated depreciation on its physical assets such as land improvements, buildings, building improvements and non-movable equipment. The resulting calculations yielded the median average age of plant in 2004 for each type of facility. Public nursing homes had a significantly higher median accounting age than the other types of facilities: 16.6, compared to 12.6 for voluntary homes, and 9.9 for proprietary homes. In other words, *the median public facility accounting age of plant was 32% older than the median voluntary plant, and 68% older than the median proprietary plant.*[21]

---

[21] NYAHSA, "Financial Distress and Closures," op cit, p. 11.

The typical county nursing home is considerably older than proprietary or voluntary homes, but most county homes have recently invested in substantial new construction or renovation of existing structures.

Data obtained from the survey of county homes indicated that 71% of the core county facilities were built prior to 1980, including 29% before 1970 and 13% prior to 1960. On the other hand, almost 20% reported that they have moved into completely new facilities or added significant new facilities in the past ten years, including about 10% since 2000. Overall, 84% of the survey respondents indicated that they had undertaken major renovation projects of some type at their facility, and 60% of those had done so in the past ten years. About two-thirds of that 60% had constructed new buildings or significantly expanded existing ones.

Thus the data that are available suggest that the typical county home is indeed significantly older than are typical voluntary or proprietary homes, but that most county homes are investing financial resources in substantial upgrades of their physical plants. The most typical reported renovation efforts were: new facilities, new or updated units, renovation of non-residential areas, major equipment repairs or replacement, and co-generation.

Outstanding Capital Debt of County Homes

No comparative data were available on amounts of capital debt across different types of nursing home facilities. However, the survey of county homes asked what the amount of their outstanding capital debt was as of the spring of 2007. Of the 27 facilities which responded to the question, 23 (85%) reported at least some outstanding debt, a proportion consistent with the number of facilities reporting major renovation activities. The total reported outstanding debt among these 23 facilities was almost $272.5 million, an average of about $11.8 million per facility in debt, or about $10.1 million across all reporting facilities (including those reporting no debt). We have no way of knowing whether or not the non-responding counties had any outstanding debts.

At least 23 county homes have outstanding capital debt totaling more than $272 million. The median facility debt level is almost $2.8 million, with four homes with debt in excess of $25 million.

When the initial county nursing facility study was done in 1997, 38 facilities indicated the amount of their outstanding capital debt, and 27 (71%) indicated some amount of debt, with 11 reporting none. The total reported amount at that time was more than $220 million, an average of about $8.1 million per facility in debt, and about $5.8 million across all reporting facilities.

Figure 15 provides an indication of the numbers of county homes with varying reported debt levels in 2007, ranging from a low of $135,000 to more than $56 million, with a median value of about $2.8 million. Nine facilities reported outstanding debt in excess of $10 million, up from six county homes in 1995.

Figure 15: Number of Non-NYC County Nursing Homes with Outstanding Capital Debt, by Amount of Debt, 2007

No Oustanding Capital Debt	>$0 - $1Million	>$1 Million – $5 Million	> $5 Million - $10 Million	> $10 Million - $25 Million	> $25 Million
4	4	8	2	5	4

Source: Survey Responses

County Costs Allocated Against Nursing Homes

County nursing homes incur "charges" for services from other units of county government which are "allocated" as expenditures charged against the nursing home budget. In some cases these represent actual services provided, such as buildings and grounds maintenance, data processing and legal services—all of which any home (public, proprietary or voluntary) would need to provide directly or contract for. Often the chargeback allocations for such services are accurate reflections of actual services and costs. However, even some legitimate services rendered to the nursing home by other governmental units can be charged against the home's budget at amounts in excess of the actual market value of the services provided. County homes can also be charged for portions of the salaries of legislators and county executive or county manager where there is no equivalent in the private sector. Similarly, some of the costs of some services broadly provided by county government are in some counties allocated against the nursing home, whether the services are actually provided to the home or not. County home administrators typically have no say in the inclusion or actual amount of the allocated charges.

The typical county home has more than $325,000 of cost allocations charged against it by other units of county government, with allocations exceeding $8 million in two counties. These are not always legitimate costs against the nursing home, and typically are not redeemed by offsetting revenues.

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

As currently reflected in most nursing home budgets, it is not possible to determine which allocated costs represent real services and which are simply overall county administrative costs spread across multiple county units including the nursing home. But with that caveat noted, it is nonetheless instructive to realize that the allocated amounts tend to be fairly consistent from year to year (2004-2006) within each home and county. For example, in 2005, the 25 homes which provided data on allocations reported total allocation amounts of almost $27,700,000—an average of about $1.1 million per reporting facility (up from an average of $627,000 for each of 34 reporting homes in the 1997 survey). The average is pulled up significantly by six facilities with allocations amounts of more than $1 million, including two in excess of $8 million a year. Most amounts are much lower, with the median amount for 2005 of $329,515 a more accurate reflection of the amount levied against the typical county home budget (about half of the homes had amounts above and half below that figure).

The governmental services, some of whose costs are most commonly allocated against county nursing homes, are:

- human resources/personnel (about two-thirds of the reporting homes mentioned this item);
- information technology/management information services, county treasurer, county administration offices, purchasing and attorney services (each cited by about half the homes);

- auditor/auditing services and risk management/insurance services (each cited by about a third of the homes).

When asked how much of the cost allocations were recovered through reimbursements, almost none of the administrators knew or could readily provide an accurate number. Of those who did respond, most said one or more of the following: None of the allocations were recovered; or the amounts exceeded the administrative caps, so little if any of the costs would be reimbursed; or the allocations were simply subsidized by the county. Thus to the extent that any of these costs represent services not actually performed for the home's benefit (or exceeded the real value of such services), and to the extent that the allocated costs are not able to generate reimbursement, *allocated costs can have the effect of making the home's operating costs look higher than they actually are, without the offsetting benefit of claiming revenues against them.* This could have the unintended effect of inadvertently suggesting to the public and even legislators who must approve the home's budget that the home's costs are higher than they actually are.

The Impact of Competition on County Homes

As suggested in several contexts earlier in the report, most county homes operate in a very competitive environment. Of the 31 homes responding to the survey question about competition offered by other nursing homes, 22 (71%) reported that there was significant competition for admissions from other facilities. The other nine suggested either that there were few competitors nearby and/or that there was more than enough demand to fill available beds, or that because of the special mission of their facility to focus on the "hard-to-place" or the "safety net" population, they are able to attract those they target without much competition from other homes for those individuals.

Of those indicating that they are in competition with other homes, there was frequent reference to the desirability of being able to compete for, and ultimately attract, higher proportions of more-highly-reimbursable high-acuity residents and those with short-term sub-acute and/or rehabilitation service needs. Some were

optimistic about their ability to compete effectively in their market, though the majority indicated that other homes were at a competitive advantage due to such factors as having newer and more attractive facilities and the ability to be more selective about which residents they admit. Several survey respondents specifically referenced the difficulty of competing with homes that have built-in connections to hospitals because of the ready-made source of referrals, most of whom enter with revenue sources other than Medicaid.

Several counties noted the desirability of successfully competing for "rehab patients," but cited the difficulty in doing so without making significant investments in staff and facility to compete with existing homes that already have programs and staff—and reputations—in place.

Disproportionate Impact of Berger Commission Recommendations on County Homes

As noted earlier, the Berger Commission has made recommendations that would have a disproportionate impact on county nursing homes, relative to their share of the nursing home market. The Commission recommended a reduction of about 3,000 nursing home beds throughout the state, including about 1,750 in county facilities. These reductions would affect about 18% of all public nursing home beds outside of New York City. By contrast, the remaining roughly 1,250 recommended reductions would affect only about 2% of the combined non-NYC voluntary and proprietary beds.

Berger Commission proposed reductions would eliminate about 18% of all non-NYC county nursing home beds, compared with about 2% of non-NYC voluntary and proprietary beds.

We received completed surveys from eight of the nine affected county facilities (in seven of the eight affected counties). Of the seven counties, three (affecting four facilities) indicated that they believed the recommendations were appropriate, one said a combination of Yes and No, and three said they were not appropriate. Not surprisingly, those in agreement with the recommendations expect their counties to comply with at least most if not all of the recommendations, while the other three are in various stages of "considering their options" and meeting with various officials to consider alternatives.

Berger Commission recommendations for county homes have met with mixed reactions. Some support additional lower levels of care that could result in some settings, but others fear unintended negative consequences in unmet needs.

Even those who agreed with the recommendations and plan to act in support of them reported having some misgivings and concerns about the impact of the new directions. Only one administrator reported an unqualified "positive" impact of implementing the recommended changes. Other comments, even from supporters of the changes, forecast similar consequences, including: residents will be forced to go to other counties or even states for skilled nursing care, hospitals will be backed up with difficult-to-place patients, unmet needs for SNF services, and increased deficits, at least in the short run. On the other hand, some saw offsetting value in the addition of new levels of care that would result from implementing the recommendations.

V. Financial Challenges Facing County Nursing Facilities

The net impact of all of the issues and challenges facing county nursing homes, as outlined in Chapter IV, is that *the financial condition of almost every county home has worsened since 1995*.

To place the county homes in context, they are a part of what has become more than a $5 billion business in counties outside of New York City. With 84% of the non-NYC nursing homes included in the 2005 cost report database supplied by NYAHSA reporting revenues and expenditures, the known operating expenses totaled almost $5.3 billion. Projected to the full complement of 470 nursing homes in operation in 2005, it is not unreasonable to suggest that the total expenditures across non-NYC nursing homes probably exceeded $6 billion during that year.

The county facility share of the non-NYC nursing home business represented well over $600 million in 2005. Of the 32 county facilities with completed financial data in the cost report database for that year, expenditures totaled just under $595 million, representing about 11% of the $5.3 billion accounted for by the database. Had complete data been available, it is likely that county facilities as a whole would have totaled well over $700 million in expenditures in 2005, and perhaps more than $800 million.

County Homes Increasingly Lose Money on Operations

As county nursing home expenditures have increased over the years, revenues have not kept pace. As a result, *the median county home reported a net operating loss of about $2.6 million dollars in 2005—more than four times the reported loss in 1995* (unadjusted for inflation). As shown in Table 2, the median voluntary home has also lost money during those years, but much smaller amounts, and the typical proprietary home has consistently reported a profit, with revenues *exceeding* expenses.

Table 2: Median Operating "Surplus or Loss" (Operating Revenues Minus Operating Expenses) in Non-NYC Nursing Homes, by Type of Facility, 1995-2005

Type Facility	1995	2000	2005
Proprietary	$176,700	$185,972	$98,673
Voluntary	(-$20,488)	(-$50,076)	(-$298,465)
Public	(-$601,607)	(-$966,365)	(-$2,617,670)

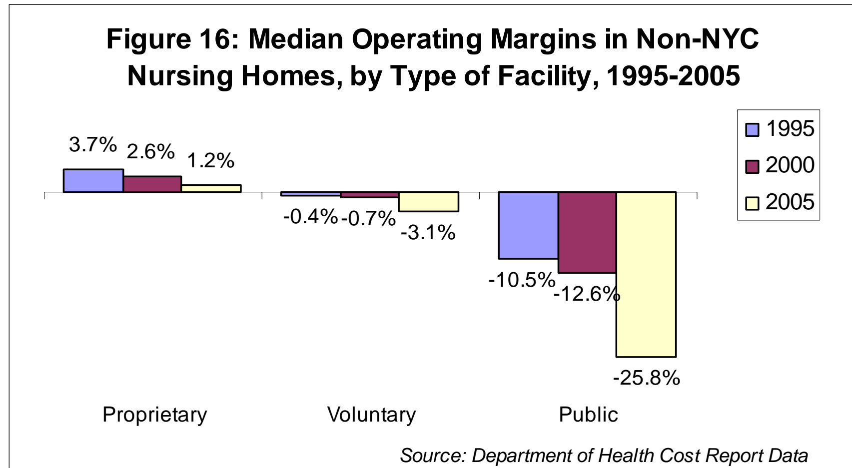
Source: Department of Health Cost Report Data

The median county home reported a net operating loss of about $2.6 million in 2005, compared to much smaller losses among voluntary homes and net profits among most proprietary facilities.

The operating revenues include primarily revenues generated by resident services, and do not include such additional non-operational revenues as intergovernmental transfers and local taxpayer subsidies (the implications of both of those non-operational revenue sources on the "bottom line" of the county homes are addressed later in the chapter). But the most fundamental measure of an organization's day-to-day financial health is its ability to take in enough revenues to cover or exceed its expenses in a given year, without the need for non-operating revenues which cannot necessarily be counted on from year to year. Thus the fact that the operating margin of county homes has continually deteriorated, compared both to historical trends and to other types of nursing home facilities, is troubling.

Operating margins of county homes have declined significantly since 2000, and more than half of all county facilities had operating losses of 20% or more of incoming operational revenues in 2005.

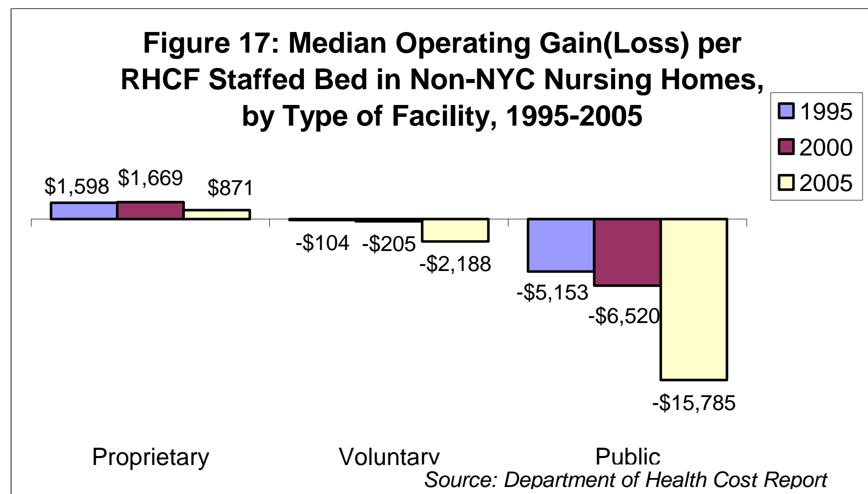
Perhaps a better indication of the relative financial health of each facility is the operating margin, the ratio of net operating gain or loss to operating revenues. As shown in Figure 16, the operating margin has been declining across all three types of facilities. But the slippage has been relatively modest among voluntary and proprietary homes. By contrast, the percentage amounts lost on operations in the median county home have gotten substantially worse, especially since 2000. The operating margin consistently exceeded 10% in previous years, but *in 2005, operational losses in the typical county home exceeded a quarter of the incoming operational revenues.* Worse, 56% of all county homes had operating margins of -20% or lower in 2005 (compared to 1.5% of proprietary homes and 5% of voluntaries with such poor operating margins).



Increasing Operating Losses per Bed

County homes in 2005 had a median operating loss of more than $15,000 per bed, a decline of more than $9,000 since 2000.

In order to account for differential sizes of nursing home facilities, we normalized the data in Table 2 by calculating the operating "surplus or loss" per RHCF staffed bed.[22] As shown in Figure 17, this provides a different way of emphasizing the dramatic explosion in the amount of operating losses in the typical county nursing home between 2000 and 2005, as the amount of loss per bed more than tripled between 1995 and 2005, with most of the decline (more than $9,000 per bed) occurring between 2000 and 2005.

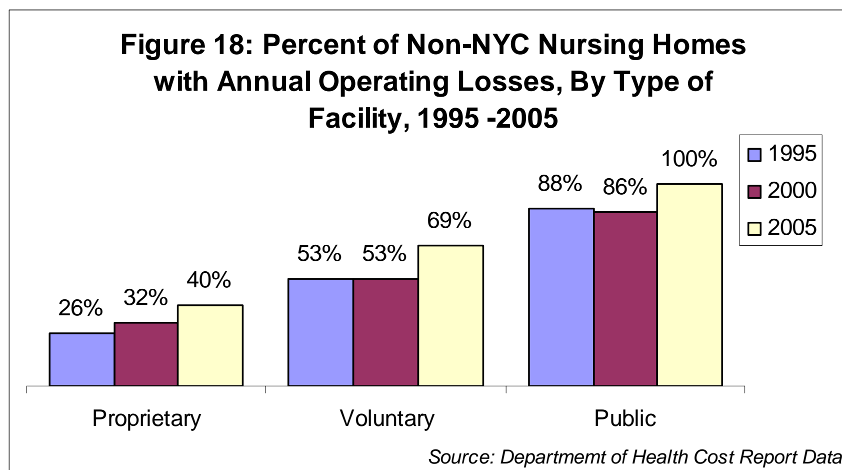


[22] Surpluses are reflected as operating profits for proprietary homes and operating surpluses or gains for voluntary and public/county facilities.

Nearly All County Homes Losing Money on Operations

Nearly all county homes in 2005 reported operating losses of more than $1 million.

Perhaps the most revealing statistic describing the declining financial conditions of county nursing facilities is the increasing number of individual homes losing money on operations. As shown in Figure 18, all three types of facilities have shown increases in recent years in the proportions of homes with annual operating losses, but the picture is especially challenging among public nursing homes. In 2005, NYAHSA data indicate that 100% of the county homes in their database reported operating losses. (Our survey data indicated that one county home with missing data in the NYAHSA database did report an operating surplus in 2005. If we combine the two databases, 97% of county homes reported operating losses in 2005.) Perhaps even more telling is the fact that nearly all the operating losses in county facilities (94% of all homes) exceeded $1 million (voluntary and proprietary comparable proportions were 20.5% and 7%, respectively). Moreover, almost 30% of the county facilities had operating losses exceeding $5 million in 2005.



Possible Sign of Improvement in 2006?

It should be noted that there was an encouraging sign in the 2006 financial data in the survey of county nursing homes. Although one should not put too much stock in comparisons from one year to the next (they may indicate only a one-year "blip" rather than suggesting an emerging trend), there may be reason for restrained optimism in a comparison of operating "surplus and loss" statements for county facilities in 2005 and 2006. Of the 23

county facilities reporting operating revenues and expenses for those two years in our survey, 16 (almost 70%) reported improvements from 2005 to 2006.

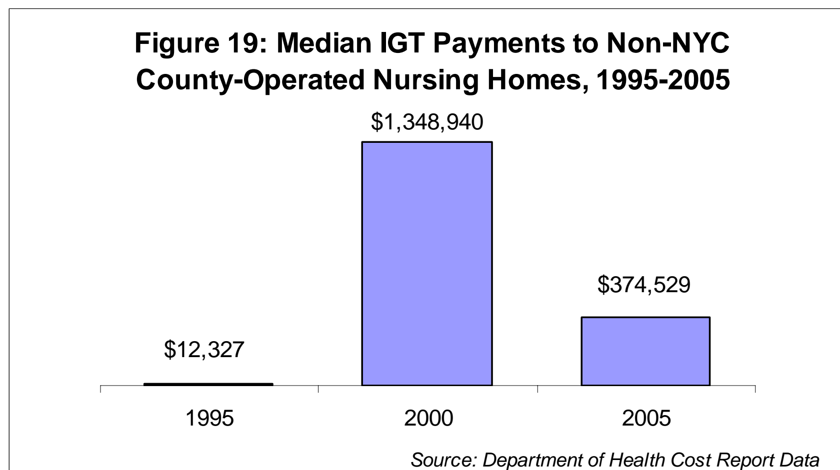
In only one of those cases did the improvement reflect a movement from a loss in 2005 to a net gain in 2006, but in many other cases, the degree of improvement (i.e., the reduction in amount of operating loss) was significant. In seven of the 16 cases in which there was an improvement from year to year, the amount of the improvement represented a reduction in operating losses of $1 million or more, including five counties reporting reductions in operating losses of $2.5 million or more from one year to the next. In 2006, five of the 23 reporting counties indicated operating losses of $5 million or more—down from nine such counties one year earlier. Possible reasons for these apparent improvements in financial conditions were not available, and there is no guarantee that these data represent anything other than a one-time aberration. But this could in part reflect the early indication of a possible reduction in the retirement contribution burden on the counties. *It would be worth having CNFNY continue to track such data across county homes in the future to see if this one-year finding may be the beginning of a trend and, if so, to explore the reasons behind any ongoing improvements in the financial operations of those county facilities.*

Ebb and Flow of IGT Payments

Intergovernmental transfers (IGTs) have been used since the mid-1990s as a source of increased Medicaid reimbursement for publicly-operated nursing homes in New York and other states, to help offset low reimbursement rates and the high proportions of "safety net" residents served by most county homes. Proprietary and voluntary homes are not eligible to receive the IGTs.

Under the federal IGT program, local government tax funds generate federal matching payments, which are in turn shared by state and county governments. The amount of the IGT payments available to counties and county homes is determined by the state on an annual basis. This source of funds grew significantly during the late 1990s through the early part of this decade, before beginning a marked decline based on restrictions imposed by the

federal government in response to abuses by several states which diverted IGT payments from their intended health care uses. This ebb and flow of IGT payments is reflected in Figure 19.



Rapid Growth, Rapid Decline in IGT Payments

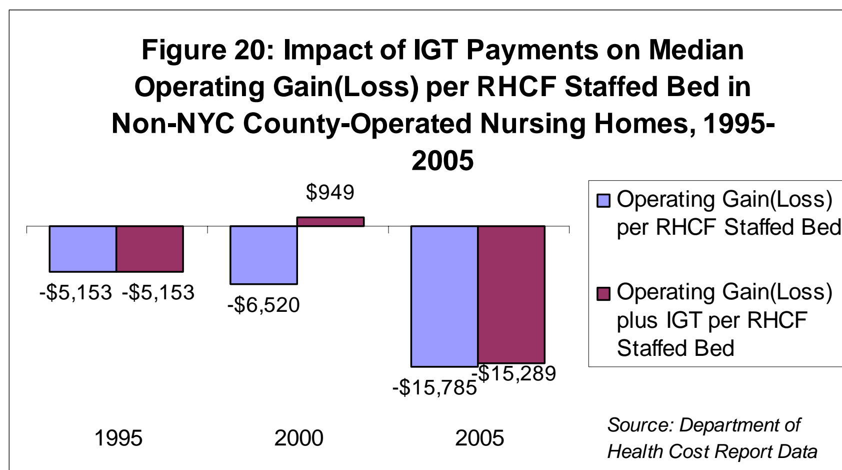
In the first year of the program, county homes received modest amounts of IGT payments, totaling only about $175,000 in reported amounts (other payments may have been made to counties, but not properly recorded in that year). As documented in the original 1997 CNFNY/CGR study, by the 1997-98 state fiscal year, the total allocation had grown to more than $63 million, including New York City facilities. By 2000, around the peak of the IGT allocations, *all* county facilities were receiving payments, ranging from about $90,000 to multi-millions of dollars. The *median* payment (half the homes above and half below) had reached more than $1.3 million, with the *average* payment per facility, pushed higher by many larger amounts, reaching $4.8 million, with well over $100 million allocated to county homes. Fifty-seven percent of the facilities received IGT payments that year of $1 million or more, including five homes in excess of $5 million. By 2005, the average IGT payment had shrunk to about 10% of the 2000 level, and the median payment was down to less than $375,000—with total IGT allocations of only about $11.3 million (possibly slightly higher if some non-reporting homes received IGT payments). Only 9% of the county homes received a payment in 2005 in excess of $1 million.

In 2000, all county homes received IGT payment, including 57% with payments in excess of $1 million, including five homes exceeding $5 million. By 2005, only 9% of the payments exceeded $1 million.

Financial "Savior" of Homes, Followed by Rapidly Declining Impact

IGT payments created surpluses out of operating losses for many county facilities in 2000, but the much smaller IGT amounts in 2005 had little impact on the bottom line of county homes.

The practical impact of IGT payments is demonstrated clearly in Figure 20. At its peak, IGT payments were virtually the savior of county nursing facilities, making the difference in many cases between an operating loss and a bottom line "surplus," with the IGT factored in (exclusive of any county subsidies). In 2000, IGT payments by themselves made the difference between a median facility operating shortfall/loss of about (-$6,500) per RHCF bed and a median "surplus" with IGT included of about +$950 per bed. For about 45% of the facilities, the IGT payment pushed the home from a loss to a surplus situation. By contrast, by 2005, the reduced number and amounts of IGT payments barely made a dent in the bottom line for most facilities, as the median facility operating loss, even with IGT factored in, remained well over $15,000 per bed. In only an average of three county homes a year between 2004 and 2006 (11% of reported cases per year) did the addition of IGT payments push a county facility from an operating loss into a surplus situation.



The IGT of the Future?

The significant impact of the then-new IGT initiative was emphasized in the initial 1997 CGR report for CNFNY, but it came with a warning that was well understood at the time: "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….The question is to what extent this revenue source will continue, and if so at what levels, in subsequent years."[23]

There is a clear need for stable IGT-like funding for county homes to be able to plan with some level of assurance of available resources, and for counties to anticipate their subsidy demands.

The caution was clearly appropriate, and the scaling back, if not outright elimination of this revenue resource, has huge implications for county nursing homes and for county taxpayers, as discussed in the next section. The absence in the future of the IGT, and/or the inability to replace it with some similar revenue resource of significant magnitude, would likely have dire consequences for many current county homes. *County homes, with their distinct mission, need to be able to plan with some degree of assurance that stable financial resources will be available to continue to underwrite their mission and core services—so that their sponsoring counties can also plan their budgets around reasonable expectations as to what will be required from local taxpayers to make the homes continuing viable entities.*

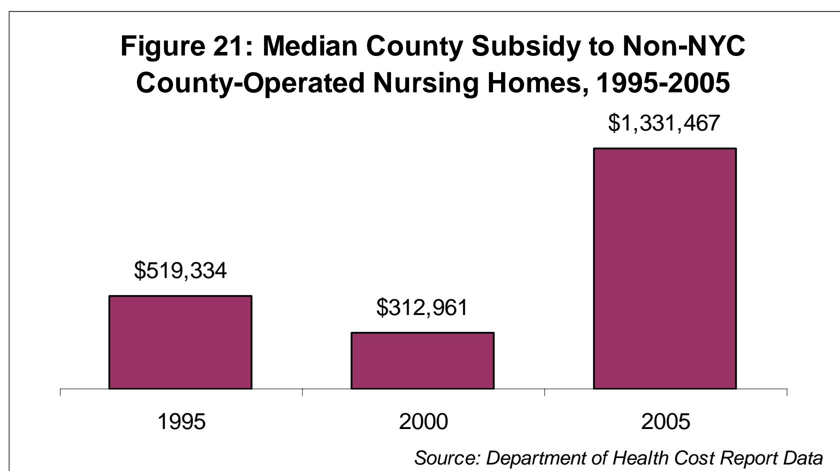
As this report is written, state legislation has been passed which, if fully implemented over the next four years, will go a long way toward helping provide some much-needed financial stability for public homes. In gradually increasing increments, by 2009-10, $100 million of funding will be available to all county nursing homes to meet their special needs and to offset the loss of IGT payments. Such funding should provide consistent stable sources of revenues that address the special circumstances of county facilities—and should at the same time hold the facilities accountable for responsible stewardship of their resources. This funding is essential if most counties are to be willing to continue to provide their own ongoing financial support for the special mission made possible by their nursing homes. It is anticipated that by full implementation in 2009-10, this new source of funds will ensure that most county homes should no longer need to be subsidized with county taxpayer dollars.

[23] CGR, op cit, pp. 26-27.

Increasing County Taxpayer Support of County Homes

In the meantime, as county homes have increasingly suffered operating losses, the degree to which their county governments have needed to provide taxpayer subsidies to offset some or all of the losses has depended to a great extent on the availability of IGT payments. As shown in Figure 21, the median county subsidy was about half a million dollars in 1995, when there were few IGT payments available, and declined to about $300,000 in 2000, when IGT payments peaked. In reality, it seems likely that the 2000 median subsidy was probably actually considerably lower than that, as a number of county homes had missing subsidy values in the 2000 cost report database, and officials suggest that probably many of those blanks reflected the absence of county subsidies for that year. In any event, with the dramatic increases in operating losses and the substantial declines in IGT payments, the median county subsidy value had increased substantially, to more than $1.3 million, by 2005. *Among 28 reporting counties, more than $70 million in subsidies were provided by counties for their nursing homes in 2005—a $27 million increase in just one year.* The $70 million is a conservative total, as additional subsidies were provided by other counties which were not included among the reporting counties.

County subsidies have needed to increase dramatically to offset the significant loss of IGT payments since 2000.



Because of the incomplete database on county subsidies, we cannot be certain for each year what proportion of counties provided direct taxpayer subsidies to their homes, but the data that are available suggest that almost all counties are now providing

subsidies—typically of substantial amounts—to their public nursing homes. The original 1997 study indicated that between two-thirds and three-quarters of the county homes required county support in the years between 1994 and 1996. *Our current survey data indicated that in 2006, only one county (of 24 completing the question) was not subsidizing its nursing facility.*

By 2006, only one known county was not subsidizing its county nursing home. Almost 2/3 were providing more than a million dollars in annual subsidies, including 17% above $5 million a year.

Furthermore, of those counties providing subsidies, in 1995 and 2000 about 25% were subsidizing their homes at the level of $1 million or more each year, including about 10% with subsidies of more than $5 million a year. By 2005, at least 19 counties (63% of the 30 completing the survey question) reported subsidies of $1 million or more, including 17% at or well above the $5 million level. Of the 24 facilities that provided subsidy information for 2006, 18—75%—reported subsidies of $1 million or more.

And yet, even after the often-substantial subsidies had been added to help offset the operating losses, those were rarely enough to move the bottom line of most county homes into a surplus for the year. The high operating losses, coupled with dwindling IGT payments, created a combination that was too large for even the substantial subsidies provided by taxpayers of many counties to overcome. *Over the past three years, even with subsidies applied, an average of more than 60% of the county nursing homes each year still reported a bottom line deficit.*

Not only have county subsidies increased, but fund balances have declined significantly in the past two years.

These subsidies do not include unknown numbers of facilities that draw additional funds from their respective enterprise fund balances. It is likely that most if not all of these remaining deficits were offset by withdrawals from the fund balances that most county homes maintain. In just one year from 2004 to 2005, in 25 homes for which fund balance information was reported, the average balance went from about $1.1 million to a minus $59,000, and the average balance shrank to a minus $1.4 million in 2006 (though this figure should be treated with caution, as it only included 17 of the original 25 homes). The more reliable figure is that *in just two years, 60% of the fund balances were lower in 2006 than they were in 2004.*

Importance and Likely Maximum Value of County Subsidies

In the current environment, county administrators believe that county taxpayer support is essential to their future. Of the 33 completed survey responses, 30 (91%) indicated that they would not be able to operate without a continuing subsidy from the county, unless major changes occur in the current reimbursement and/or cost structures. Two indicated that they currently operate without subsidies or have in the past. For ongoing subsidies to be avoided, various combinations of the following would need to occur, in the judgment of the nursing home administrators: increases in reimbursement rates, different payer proportions, changes in the case mix and/or mixes of services, changes in union contracts and wage packages, and reductions in benefit levels.

When asked their opinion of the maximum subsidy their county government is likely to provide on an annual basis for the continued operation of the county home, about 30% were uncertain. But of those who ventured an opinion, most were fairly optimistic, yet seemingly realistic about the amounts their counties would be willing to provide. Some suggested maximum subsidy amounts that their counties are already exceeding, while others suggested their counties will be likely to provide higher levels of subsidies in the future than are currently being provided.

Although about a third of the county homes currently receive subsidies of a million dollars or less, about 90% of those who forecast their county's future ongoing subsidy amount suggested maximum amounts of $1 million or more. About two-thirds anticipated amounts between $1 million and $5 million a year, more than the current actual proportion of about half the counties with subsidies in that range. About one-fifth of the administrators thought their counties would provide subsidies of more than $5 million, slightly more than the proportion of about 16% of counties currently providing subsidies in that range.

VI. Opportunities to Strengthen County Nursing Homes

Despite the many challenges facing county nursing facilities, as enumerated in the previous chapters, a number of opportunities are available for county homes to strengthen their internal operations, to expand the range of long-term care options available in the future, and to consider alternative approaches to operating the nursing facility. All aside from actions already taken and those still needed at the state and federal levels, this chapter focuses on actions which counties and their nursing homes can act on themselves. Indeed, the types of opportunities discussed in this chapter have already been undertaken successfully by some counties and may offer promise for other counties to consider in the future.

Strong County Support for County Nursing Home Mission

The opportunities begin with and are predicated on strong support provided by most counties and their elected officials for their county nursing homes. That support is provided in tangible ways by the financial subsidies discussed in the previous chapter. Beyond that, most nursing home administrators perceive that their county officials believe in the distinctive mission and focus of their home, and that the home is an essential part of the mission of county government.

More than two-thirds of those completing the survey (23 of 33) said that without qualification their county government officials see the home as "essential to the mission of local government," with another saying it is "not essential, but important as a meaningful part of county services." Only four homes (approximately one of every eight) said definitively "no" in response, typically because of the increasing tax burden. Another five expressed mixed levels of support for the mission within their counties, ranging from strong support among some elected county officials to "varying opinions" and reduced support among some as the deficit grows.

There is strong general support for most county homes among elected officials, though somewhat tempered in some cases by declining financial conditions.

Asked more specifically about whether county government is "supportive of the home and its services," regardless of their understanding of whether or not the home is essential to the government's mission, two-thirds answered "very supportive," just under a third said "somewhat supportive," one said "in the middle," and one said "somewhat unsupportive." Similar proportions view the county government as "understanding of the home's operations and concerns" and very cooperative in its relationship with the nursing home, with only one characterizing the relationship as "very adversarial." Most administrators expected continuing county support for the home, though most also indicated that at some tipping point of county subsidy level, the question of future support may be reassessed by county officials.

Opportunities to Outsource Services

All but four of the county homes that completed the survey indicated that they are currently outsourcing some services (i.e., services are provided by individuals or organizations who are not county governmental employees). The most frequently-mentioned outsourced services, in order, were: rehab therapists (almost 40% of the homes); pharmacy, food service/dietary, and dentist (each almost a third of the homes); clinical services and mental health/ social work (each about a fourth of the homes).

About a third of the homes were not able to estimate how many, if any, county government positions have been eliminated as a result of outsourcing. Of those who did respond to the question, half said that outsourcing had not directly saved or eliminated any positions. Of the other half, seven facilities estimated that between one and five positions had been eliminated as a result of outsourcing, and three said six or more, including as many as 10, 28 and "approximately 100."

Most were not able to estimate how much money, if any, has been saved as a result of outsourcing. However, four facilities estimated savings in the $75,000 to $100,000 range per year, and three estimated amounts ranging from "over $100,000" to about $750,000 to $3 million a year. Others were less certain of specific

Outsourcing selected services appears to have saved money in several county homes, though many are not sure of the amounts of savings, if any.

amounts, but indicated that they had been able to hire staff on a contractual basis that they would not have been able to afford at county wage scales, and that those contractual services had made it possible to significantly increase billable units and thereby increase revenues in ways not possible except for outsourcing the service.

Most of the homes indicated that they were currently outsourcing the services they felt most appropriate, and that there were no other services they would like to contract out. Of those that were interested in outsourcing additional services, the most frequently mentioned (by three or four homes each) were: housekeeping, dietary services, and maintenance and grounds.

Opportunities to Streamline Purchasing

About three-fourths of the county facilities indicated that they are part of one or more purchasing consortia. Just over half of those are part of either two or three different consortia. Most were not able to estimate the value of any savings resulting from participation in a purchasing consortium. Two indicated that the annual savings were "minimal" or less than $500, but seven noted annual amounts in the $50,000 to $75,000 range, and five indicated that savings amounted to $100,000 or more per year, with an average annual savings of about $250,000.

Of those county homes not now part of a purchasing consortium, half are open to the idea and see possible financial benefits from doing so. The other half suggested that they had either considered and decided not to join a consortium, or had been advised not to by the purchasing department of their county government.

Opportunities to Expand Marketing

Only about half of the county homes have any budget allocation for marketing their facility, and a third of the homes see no benefit to increasing marketing efforts in the future.

Of those with funds allocated for marketing, about half provided no indication of the amount. Of those that did indicate the amount, four simply described it as "small or nominal," and another four mentioned amounts of about $2,500 to $4,000 per year. Only two homes mentioned amounts of more than $10,000

($25,000 and $50,000). Most marketing efforts involve distribution of brochures, use of newspaper/print advertisements, presentations or presence at events, and open houses. A few mentioned the use of a web site, and about 10% said they made occasional use of TV and radio.

Those homes that have chosen to place little emphasis on marketing, including the third of the homes that indicated that they saw little or no benefit to doing more marketing in the future, focused primarily on the fact that they already have a full census, that they are well-known in the community, and that they attract residents by word of mouth without needing to advertise as reasons in support of not being more aggressive in marketing the facility. Several administrators indicated that people in their communities are aware of the quality of their services and that in small communities their reputation is sufficient to attract people without the need to spend money to promote the facility. In a few cases, administrators noted that county officials have discouraged the home from advertising, because of the belief that this could have a negative impact on competitors, and particularly proprietary homes which pay taxes.

Some county homes emphasize marketing efforts, though typically with small budgets, while others resist advertising for various reasons.

On the other hand, two-thirds of the administrators said there would be significant benefits to the facility and the larger community if they were able to provide more information about the services they provide. Some talked about promoting new services such as dementia and rehab initiatives, and about competing more effectively for higher-paying residents in the future, while others noted the need in a competitive environment to simply remind the community of the relevance and mission of the county home, "so it doesn't get taken for granted, viewed as irrelevant, viewed just as a place of last resort, or worst of all, just be forgotten about." Several mentioned the value of making more effective routine use of the print, TV and radio media, and others noted that "we aren't even listed with other nursing homes in the yellow pages, which should be done to remind people of the county home option when they are considering nursing homes for

themselves or a loved one." Other administrators mentioned that they have not been as effective as they need to be in cultivating ongoing relationships with hospital discharge planners.

Opportunities to Strengthen Management Accountability

A number of county nursing home administrators expressed frustration at being held accountable for the service quality and administrative and financial performance of their facility, but without always being given the administrative control or flexibility to make necessary decisions affecting all aspects of performance. As noted earlier, this is particularly true with regard to involvement in contract negotiations.

About a third of the administrators reported that they have little or no involvement in negotiations affecting terms of contracts impacting their organizations. *Only about 15% described their role as being heavily involved in the negotiation process.* Even many of those reporting involvement indicated that their role was limited to providing recommendations or other types of input, but without necessarily being present as part of the negotiation process.

Many nursing home administrators reported having limited involvement in contract negotiations, and most seek more involvement and/or having separate contracts reflecting the distinct needs of the nursing homes.

About two-thirds of the administrators say they think they should be more involved, in particular because of various issues pertaining to nursing homes that should be addressed in ways that are separate and distinct from more general county employee issues. About a quarter of the administrators indicated the desirability of having the nursing home have its own contract, rather than being a part of a broader county bargaining process. Particular concerns were expressed by some administrators about needing to be able to negotiate salaries and especially benefits more in line with other health care providers, rather than with other governmental units. The 24/7 operations of the nursing home were also cited by some as being sufficiently unique to justify separate provisions and possibly a separate contract.

The general consensus of administrators was that they could do a better job of operating and managing their facilities and services—for example, by better controlling overtime and other costs, managing scheduling and coverage of shifts, and hiring and

maintaining staff—if they had more direct control over these issues over which they currently perceive themselves as having little control—often because of items negotiated in general county contract provisions which do not reflect circumstances unique to nursing homes.

One other management-related issue raised by the survey had to do with managed care contracts. There was considerable reported variation among contracts concerning their use and perceived value. About half the counties covered in the survey reported currently using one or more managed care contract, and about half of those which do not have actively considered contracting with a managed care organization. At least two or three of those ultimately decided against entering into such an arrangement. Proponents of managed care contracts typically cited the advantages of increased sources of admissions, typically at reasonable reimbursement levels, and reimbursement levels higher than what Medicaid would pay. Those nursing homes that resisted using managed care, or limited its use, typically expressed concerns about reimbursement levels below those paid by Medicare and/or below the home's actual costs, and the administrative burdens, inefficiencies and documentation occasioned by the managed care oversight process.

Other Perceived Opportunities

When asked about other "major opportunities" for their facility, administrators provided a variety of responses. Several mentioned that the foundation for any opportunities for change in the future is provided by the strong relationship with the county government, and the enduring commitment to the core mission of the county nursing home.

Beyond that, the types of specific opportunities mentioned most frequently were various opportunities (mentioned by nine separate homes) to expand the variety of services offered by the facility, with most frequent references made to enhancing rehabilitation initiatives, sub-acute care programs, and Alzheimer's/dementia programs. Others mentioned the need for and desirability of having the homes provide leadership in expanding their county's

availability of alternative levels of care such as assisted living and adult day care programs. In addition, five homes noted opportunities to build new facilities and/or expand or renovate existing ones.

VII. Alternatives for Consideration: Possible Strategies for the Future

As part of the survey of county nursing homes, respondents were asked to indicate the extent to which they have considered or acted upon one or more of 34 separate strategies or alternatives in recent years. For continuity and comparison, the alternatives were the same ones asked about in the original 1997 CGR/CNFNY study. (See the list of alternatives and choices to be checked for each in question 24 of the survey, presented in Appendix A. For detailed descriptions of each option, along with its potential advantages and limitations if implemented by a county nursing home, see the original 1997 report.)

The alternatives were grouped into three broad categories that fall roughly in order along a continuum of possible options a county could implement regarding the future provision of nursing home care. This "degree of change" continuum ranges at one end from the "least change" options of continuing to provide traditional nursing home care under current arrangements, but with some internal reforms or new initiatives, to a "mid-range" set of options that would maintain county operations of the homes but with various service expansions and modifications, to more "extreme change" options which would significantly limit or even fully eliminate direct county responsibility for future operation of nursing facilities. These categories can be summarized as follows:

- continuing county nursing home operations with reforms/new initiatives;
- expanding the range of long-term care options offered;
- limiting the county's role in nursing home care.

County nursing facilities may be viewed as approaching a crossroads, given the various challenges and external environmental factors facing them, as described in previous

chapters. All have significant resources, historic mission and support to draw on, and most county governments seem to value their role and want their partnership with the homes to continue. At the same time, *as financial challenges increase, county homes are increasingly being forced to recognize the possibility that their future, individually and collectively, is at stake.* In that context, it is important for county homes—and ultimately their governing county governments and the state—to consider options available to them, and to plan strategically for their future. Consideration of the alternatives outlined here provides one way of beginning to engage in a strategic process of considering which options make most sense for individual county homes.

County nursing homes are at or approaching a crossroads, all with significant resources and support, but also faced with major challenges. Most will need to make choices for the future along a continuum of options ranging from internal changes to limiting the county's responsibilities for nursing care provision.

The options that make most sense will vary from home to home and county to county, given circumstances unique to each. In addition, the viability of—and potential need for—various options will be determined to a great extent by funding and policy decisions made at the state and federal levels. But as those federal and state decisions are being made, counties can begin to determine for themselves which of various options would be logical and reasonable to consider under their distinct circumstances, and which should be discarded as untenable for various reasons. Indeed most county homes have begun to undergo such a process of consideration of options, at least informally, while others have done so more formally and have even made specific decisions to adopt or reject certain options. Those informal and formal thought processes and decisions are summarized in Figure 22.

Options Chosen and Not Considered by Counties To Date

Given counties may choose to adopt one or more of the possible alternatives, in varying combinations. The options are many, with no clear definitive right or wrong approaches for any given county. Several different solutions may be workable in any given community, yet no one solution or combination is likely to be best across the board for all counties. The point is for every county and nursing home to examine its own circumstances and decide for itself what option(s) make most sense given its unique

combination of mission, history, competition, demographics, demand and financial reality.

Figure 22: Options and Strategies for Possible Implementation by Non-NYC County Nursing Homes: Status of Decisions and Consideration of Options by 28 Facilities as of Spring 2007.

	Not Considered	Considered and Rejected	Considered and Implemented	Currently Being Considered
Continuing County Nursing Home Operations with Reforms				
More aggressive marketing	12	0	9	5
Management efficiencies and contracting arrangements	9	2	11	4
Efficiencies through labor reforms	15	1	7	4
Separate bargaining unit for county home	14	5	3	4
Implementing the “Eden Alternative”	19	5	3	0
Renovation or new construction	6	5	10	6
Merging the home with another county department	24	1	2	0
Revisiting County cost allocations	18	0	4	3
Expanding the Range of Long-Term Care Options Offered				
Non-regulated services (e.g., home delivered meals, transportation)	21	1	4	1
Social Model Adult Day Care	19	4	1	3
Medical Model Adult Day Care	10	6	6	5
Respite Care Social Model	22	0	3	2
Respite Care Medical Model	17	3	3	4
Enriched Housing Social Model	25	0	0	2
Adult Care Facility Social Model	18	3	3	3
Early to Mid-Stage Dementia Social Model	22	1	0	4
Assisted Living Program (New York State Defined)	18	3	0	5
Assisted Living Program (as defined by other states)	22	3	0	2
Certified Home Health Agency	22	2	0	1
Licensed Home Care Service Agency	25	0	0	2
Managed Care and Integrated Systems of Care	25	0	0	1
Continuing Care Retirement Community	25	1	0	1
Subacute Care and Special Care Units	15	1	5	5
Specialized Care of Geriatric Prisoners	25	1	0	0
Limiting the County’s Role in Nursing Home Care				
Management contracts to operate nursing home	21	3	2	1
Sale of licensed beds	17	6	2	2
Establishment of public benefit corporation	16	8	1	1
Becoming part of a state authority	24	1	0	1
Conversion to free-standing not-for-profit/voluntary corporation	19	5	0	3
Conversion to existing voluntary corporation	22	3	0	2
Employee buy-out	26	0	0	0
Sale of County home to proprietary corporation	12	10	1	3
Partnership with organization outside of County government	20	5	0	1
Cessation of County nursing home with no transfer of facility	18	4	0	2
Other	4	0	1	0

Note: Figures are the number of survey respondents checking each option, out of a total of 28 who answered the question

Source: Survey responses

As indicated in Figure 22, out of the 34 options considered, only five have to date been considered, implemented or rejected by as many as half of the 28 county homes responding to the question. All the others have not yet been considered by more than half of

the county homes. Three of the five are in the "least change" group of options—renovation or new construction, management efficiencies and contracting arrangements, and more aggressive marketing. The other two—medical model adult day care and sale of the home to a proprietary corporation—have been among the most frequently considered and rejected options. By contrast, the options least often considered to date have typically been some of the more drastic options to limit the county's role in the operations of the home. In between are the expansion of long-term-care options, with some of those receiving substantial consideration to date and others very little. Out of all 34 options, all have received at least some consideration by at least one county, with one exception—the employee buy-out option.

Even options frequently rejected or not even considered by many counties have been implemented by one or more other counties.

Figures 23 and 24 highlight the options most commonly not considered, or considered and rejected by county homes in recent years. It is instructive to note, especially in Figures 22 and 24, that *most of those options that have been rejected, or not even considered, by large numbers of counties have also been implemented by one or more other counties.* Thus counties can and should learn from each other's experiences, but they should not be slaves to what others have or have not done. One size does not fit all, and regardless of what has or has not worked in one county, circumstances in another county may be so different that an option not appropriate in one place may be a perfect fit in another.

Figure 23: Options Most Commonly Not Considered or Considered and Rejected by Non-NYC County Nursing Homes as of Spring 2007

Option	Count
Continuing Care Retirement Community	26
Specialized Care of Geriatric Prisoners	26
Employee Buy-out	26
Partnership with organization outside of County government	25
Assisted Living Program (as defined by other states)	25
Conversion to existing voluntary corporation	25
Becoming part of a state authority	25
Merging the home with another county department	25
Managed Care and Integrated Systems of Care	25
Enriched Housing Social Model	25
Licensed Home Care Service Agency	25

Source: Survey Responses

Figure 24: Options Most Commonly Rejected by Non-NYC County Nursing Homes as of Spring 2007

	Not Considered	Rejected	Implemented	Being Considered
Sale of County home to proprietary corporation	12	10	1	3
Establishment of public benefit corporation	16	8	1	1
Medical Model Adult Day Care	10	6	6	5
Sale of licensed beds	17	6	2	2

Source: Survey Responses

Even though a number of options have been implemented by several county homes, many other counties have not even considered their potential value for their facilities.

Conversely, Figure 25 highlights those options that been most frequently implemented in recent years and that are currently under consideration by county homes. Although, again, what one county has done successfully does not necessarily imply successful implementation somewhere else, *what is most striking in the data presented in Figure 25 is the large number of counties that have not even considered options that have been implemented in five or more counties throughout the state.*

Figure 25: Options Most Commonly Implemented or Currently Under Consideration by Non-NYC County Nursing Homes as of Spring 2007

	Considered and Implemented	Currently Under Consideration	Not Considered	Rejected
Management efficiencies and contracting arrangements	11	4	9	2
Renovation or new construction	10	6	6	5
More aggressive marketing	9	5	12	0
Efficiencies through labor reforms	7	4	15	1
Medical Model Adult Day Care	6	5	10	6
Sub-acute Care and Special Care Units	5	5	15	1

Source: Survey Reponses

Continuing County Nursing Home Operations with Reforms

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

As such, it is not surprising that several of these options, as shown clearly in Figure 22, are among the most frequently implemented alternatives available to county homes. The three most commonly implemented options—creating management efficiencies and outsourcing/contractual arrangements, renovation or new construction, and more aggressive marketing—have all been discussed earlier in the report. Each of these has been implemented or is currently under consideration by half or more of the county homes which responded to this survey question. Nonetheless, substantial numbers of other county homes have not considered the possibility of implementing change related to these options.

Internal changes to existing operations have been implemented more frequently than other changes requiring more fundamental shifts in the nature of county homes, but many homes have not considered the possibility of making even such internal changes.

Several homes and their governing counties have implemented various reforms via discussions with labor unions, and a few have created distinct separate bargaining units for their homes, separate from bargaining units representing broader sets of county government employees. Several administrators in the survey and in our group discussions mentioned the need for more effective working relations with unions representing county home employees, and for the creation of separate home-focused bargaining units. Yet despite implementation of change by several counties on these fronts, and despite the concerns routinely expressed about the effects of these issues on the ability to effectively manage the county homes, far more homes reported *not* having considered possible changes in these areas than had implemented changes or had such changes under current consideration.

A handful of county homes have implemented the "Eden Alternative," designed to create a more home-like, less institutional nursing home environment; have combined operations with other county governmental units; and have worked out ways with their counties to provide more rational approaches to allocating county costs against the nursing home (and presenting the information to decision-makers). However, the number of county homes that have implemented or considered such options represents only a

small fraction of the numbers of homes that have not considered these options.

Expanding the Range of Long-Term Care Options Offered by the County

Given efforts to control long-term care costs, the need to maintain high bed occupancy rates in nursing homes, and the desires of more older people and people with disabilities to remain in their homes and other community-based, less-institutional settings for as long as possible, more and more emphasis is being placed on offering lower levels of long-term care. The second group of options along the "degree of change" continuum involves the possibility of having nursing homes add various long-term care options to their core nursing home services.

The assumption underlying this set of options is that the county nursing homes would stay in business, but would consider the possibility of adding, themselves or in partnership with others, one or more alternative levels of services to enhance their core nursing home services. Most options would require approval by a state agency and ongoing state regulation, as do the core nursing home services. Most would have the potential to generate revenue for a home, while at the same time creating potential for recruiting future nursing home residents.

Other than specialized care and sub-acute units, and medical model adult day care, most lower-level long-term care alternatives have received relatively little consideration by most county nursing homes. However, most of the options are beginning to be considered by a few counties each.

In some cases, a county may wish to decertify some of its RHCF beds, especially if the nursing home has been experiencing a pattern of low occupancy rates in recent years, and converting those into lower-levels-of-care beds. Or, alternatively, a county may choose, as several have, to maintain its existing number of RHCF beds and create additional county-owned beds or program "slots" at a lower level of care (perhaps adding an on-site unit adjacent to the core nursing home facility), or to create a partnership with one or more other providers to integrate services.

To date, as shown in Figure 22, the most frequently-implemented of these lower-level options are the medical model adult day care program, sub-acute care and special care units, various non-regulated services, social and medical respite care models, and the adult care facility (ACF) social model. Various other lower-level

long-term care alternatives have received very little attention (and rare implementation) by most homes, although most of those options are under some level of consideration by a few homes. But except in the case of the medical model adult day care alternative, far more counties report having given all the other long-term care options no consideration (or considered and rejected them) than either have implemented the options or are currently considering them.

Limiting the County's Role in Nursing Home Care

This final set of options along the "degree of change" continuum would involve by far the greatest amount of change in governance or oversight responsibility for county nursing homes. Counties opting for options in this category would severely limit, if not fully eliminate in some cases, any direct responsibility for the operation of the current county nursing facilities. In most cases, the county would get out of the nursing home business entirely, while in others it would continue to play some reduced role. But in each of the options (with the possible exception of the sale of licensed beds, depending on the number sold), the county government's day-to-day responsibility for managing and operating the county nursing home would be at least significantly reduced, if not eliminated.

Few counties with existing nursing homes have actively considered closing or selling their homes, though more may do so as financial shortfalls increase.

County decisions to embrace any of these options should only occur after careful consideration of all factors, including the impact the choices would have on the county's historical mission and the population of people traditionally served by the county homes. 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. *With years of history, tradition and mission to factor into the decision-making process, it is not surprising that few counties have made choices to disengage from their homes*, as suggested by Figure 22.

On the other hand, it is important to note that not reflected in the survey findings in Figure 22, which are based on a survey of *existing* county homes, is the fact that between the 1997 study and

2005, there was a reduction from 44 non-NYC county homes to 40, including just since 2005 the sale of two county homes to proprietary facilities and the consolidation of two other homes into one.

However, beyond those recent decisions, few of the current county facilities report having actively considered more than a handful of the limited-county-role options shown in Figure 22. Three counties (including two which did not complete this portion of the survey) have created public benefit corporations for their nursing homes, thereby creating an arms-length distance from county government, but still receiving taxpayer subsidies from their counties. Two counties report having entered into management contracts to oversee nursing home operations under the county's overall policy-making and budget oversight, and two have sold some of their licensed beds to another organization for its use (unknown numbers of those sold beds could in the process have been converted to lower-level uses).

Most of the options in this category have been formally considered and rejected by several counties—most notably ten counties which have rejected the sale of their homes to a proprietary corporation, and eight which have rejected the creation of a public benefit corporation. At the time of the survey, few counties had any of these limited-role options under active consideration, although as noted below, possible growing future financial shortfalls could lead to more counties placing some of these options under scrutiny.

The Future: What is Likely to Happen to County Homes?

When asked about expectations for the future of county nursing homes, administrators expressed opinions ranging from relatively sanguine to concerned and alarmed. On the one hand, many feel that there are virtually no circumstances under which their counties would opt out of the nursing home business, given their long-standing commitment to the mission and core values of the home as an integral part of county government. Others say realistically their county may have no alternative but to pursue one or more options for ending the county's role as operator and

partial funder of the nursing home, unless financial circumstances improve. *Both optimists and pessimists about the future of public facilities share an overwhelming concern about what would happen to residents of the current facilities* and, to a lesser but still substantial extent, staff of the homes, if they were to cease to exist as public entities.

Importance of Stable, Viable State Funds

More specifically, worries about the future viability of the county homes begin with the state (and related federal legislation and rules changes). Uncertainties about the future of the IGT payments (or proposed successors to those payments which could potentially cover most if not all of the previous amounts paid to county homes through the IGT mechanism) dominate the concerns.

Recently-enacted state legislation promises significant response to these concerns about the future.. As noted earlier, legislation has initiated gradually-increasing amounts of state payments to county nursing homes, culminating in $100 million in payments scheduled in 2009-10. The major goal of county nursing home advocates at this point is to ensure that the gains achieved over the past few months—specifically the public facility grant payments, a new nursing home rate methodology, and an updated base year (2002)—are preserved and fully implemented. Each of these initiatives will go a long way towards stabilizing the financial situation of county nursing homes and significantly reducing the need for local government subsidies. With these measures still only in their phase-in periods, however, state Medicaid cuts have already been implemented that significantly offset some of the benefits, and additional Medicaid cuts are possible.

County nursing home funding must be based on sound public policy-making that remains consistent from year to year. Advocates of county facilities and their special mission fear that county homes will continue to be subjected to short-sighted government budget decisions. R*emoving the year-to-year uncertainty of state funding support and ensuring a more stable, viable payment methodology that counties can count on for budget planning purposes would go a long way toward easing counties' financial concerns about the future of public nursing homes.*

Circumstances Under Which County Homes May Consider Closing

Asked if there are circumstances under which counties "should get out of the nursing home business," responses were mixed. Fourteen of 31 respondents (45%) said under no circumstances, while the other 17 said yes, that realistically financial conditions could become so untenable from their county's perspective that they would be forced to consider strategies to close, or at least significantly downsize, the home. The "tipping point" would vary across counties in terms of the threshold amount of subsidies or number of years of substantial subsidies that would tip the scales in favor of limiting or ending the county's role in the provision of nursing home care, but it is clear to at least 17 of the current administrators that such a point could be reached in their respective counties.

On the other hand, a significant number of that 17 temper their assessments with the further important caveat that the financial circumstances would need to be balanced against the long-standing mission and commitment to the county home as a safety net offering services to many who might not otherwise be served if the home were to cease to exist. Given fears that many of those current residents (and similar people in the future) may not be assimilated by the remaining non-public nursing homes in their areas (see below), several administrators indicated that this concern may temper and perhaps negate, at least in the short run, any financially-driven demands to close the facility.

Stability of reimbursements and amount and years of county subsidies, combined with the county's commitment to mission and safety net role of county nursing homes, will shape decisions about future of county facilities.

In short, all things being equal, there appear to be relatively few if any remaining counties with public nursing homes where there is a strong desire to close or sell the county home. The key questions that may ultimately determine whether a line is crossed to open consideration of closing the county home are: (1) whether sufficient changes can be ensured in the reimbursement system to close the financial gaps in the operations of the facility, and (2) whether, if divestiture becomes an option being seriously considered by a county, sufficient assurances can be obtained that would adequately protect the interests of residents (and to a lesser extent) staff of the home.

At the current time, about 70% of the county home administrators indicated that they are not feeling any "active encouragement" to consider alternatives for the future of their home. Half of the counties where there is such encouragement are focused on the consideration of developing alternative levels of long-term care, such as assisted living (currently prevented for Medicaid residents in public facilities by federal legislation) and adult day care. Another four or five counties, however, have raised for consideration the issue of selling and/or privatizing or otherwise closing the county home.

Regardless of the current level of encouragement to actively consider other options for the county home's future, the reality is that *a number of administrators believe that they have a relatively limited period of time within which to stabilize the financial circumstances of their facilities, thereby limiting the need for extensive ongoing county subsidies.* Although more than 60% of the administrators believe there is a zero or very low probability that the county home "would go out of business in the next 3 to 5 years," just under 40% described the probability as some combination of "good," "high," or "50% or higher" that the home may either be closed within that period, merged with another public facility in the area, or significantly downsized.

Despite strong support for the mission of county nursing homes, 40% of the home administrators think it is quite possible that their homes may be closed within the next 3-5 years, without greater financial stability.

Likely Consequences of Closing County Homes

As suggested above, the overriding concern administrators have about the future, beyond their basic concern about keeping the home open and viable if at all possible, is what will be the consequences if their home is to ultimately close. *Almost 90% of the administrators expressed explicit concerns that current residents would be unable to find adequate nursing home care elsewhere if their county home were to close or be sold.* Most expressed the concern that there would not be sufficient beds in the rest of the nursing home system locally to absorb the residents who would be displaced. Even if the home were to remain open but under new ownership, many administrators expressed the fear that the "hard to place" residents— covered by the county home's mission of providing a safety net for those whom other facilities would not serve—would

not be absorbed by new owners. Others were concerned about long hospitalizations and hospital backups resulting without the county home's willingness to admit patients other homes will be reluctant to admit.

County home administrators estimate that substantial numbers of current residents would be in jeopardy of loss of needed care if the home were to close, given the county's safety net role.

Although there is no way of independently verifying the information, administrators provided estimates of the numbers or proportions of their current residents "who would not be served by other nursing homes" if the county facility were to close. The median response was between 75 and 100 current residents per facility, representing about 20% to 25% of all current residents (two facilities estimated as many as 90% of their residents would not be served by other area homes). Most of those who would not be likely to be served by other facilities fell into the categories of low-scoring individuals (contributing to a low institutional CMI and lower reimbursement levels for most), people with significant behavioral problems, and people with other specific characteristics and diagnoses (including Alzheimers disease, dementia, young residents, those on Medicaid, severe HIV/AIDS residents).

Not only is there concern about loss of service for existing residents of county homes, but there may be even greater concern about who will provide the safety net function in the future for people seeking nursing home admission.

Administrators were concerned not just about what would happen to existing residents of facilities, but also about people in the future with similar characteristics. In fact, many were more worried about future populations than about current residents. Their expressed rationale was that it may be possible to enter into agreements with other facilities as part of any arrangements to close the county home which will accommodate as best as possible the needs of many and perhaps most of the current residents. *But as time goes on and new applicants for admission appear, the concern is that the county will lose any leverage to ensure that the safety net provisions in place while the county home is open will be respected by other nursing homes in the future, thereby potentially leaving many people needing nursing home care who may be unable to access it within their respective counties in the future.*

In addition to concerns about the residents, many administrators expressed concerns about the impact of potential home closings on the local economy, with the potential of several hundred employees losing their jobs in some closings. Administrators assumed that some of those would be able to find

other jobs within county government or within other nursing homes, but that others would lose their jobs, and that fewer jobs systemwide would be available in the future. Again, administrators expressed the hope and, in most cases, the expectation that part of the negotiations related to the closing of county homes would involve making provisions as much as possible for finding post-closing employment and/or re-training for the displaced workers, and for maintaining benefit levels to the extent possible. The assumption of most administrators is that such provisions would be provided to the extent possible, but that there would be limitations as to how far they could go toward guaranteeing future options for current employees of the closing homes.

County home closings could result in substantial loss of jobs and negatively impact on the local economy.

In addition to the loss of jobs and the concerns about the future of current residents of county homes, administrators were asked what else would be lost if county homes were to be closed. The factors noted most often, which could be thought of as reasons to keep county homes in business, included:

- accountability to the public;
- access to care for difficult-to-place populations;
- the provision of a safety net function to ensure that people can receive care regardless of their circumstances;
- employment opportunities and the impact on the local economy;
- quality of care; and
- a clear mission-driven business model that focuses on meeting needs of people, consistent with the best values of government.

Several administrators added that those positive factors would be further enhanced with two additional future developments: a more viable reimbursement mechanism in place to help ensure financial stability of county homes, and more effective use of

lower levels of long-term care to best meet the needs for less institutional care at the most reasonable costs in the future.

VIII. Conclusions and Recommendations

County nursing homes have provided valuable services to residents throughout New York for many years. County homes have many significant strengths and attributes, and have provided needed long-term care services to many county residents who in all likelihood would not have been served by other proprietary or voluntary homes. County nursing facilities have also been an important contributor to the local economy in many counties. However, county homes throughout the state are nonetheless increasingly vulnerable.

A statement to that effect was made in the concluding chapter of CGR's 1997 report, *What Should Be Done with County Nursing Facilities in New York State?* That statement is just as true ten years later. If anything, the status of many county homes may be even more vulnerable or precarious today than was the case then. Their future, individually and collectively, is jeopardized by increasing operating losses, reimbursement levels that fail to cover operating costs, declining intergovernmental transfer payments, and the need for increasing county subsidies.

County nursing homes consistently admit residents that other facilities are reluctant or unwilling to admit—behaviorals, bariatric patients, those with Alzheimer's disease, adult protective cases, crisis admissions, etc.—regardless of their ability to pay. Many of those they serve receive reimbursement levels far below the actual costs of the services provided and the staff attention needed. The value of the county homes is typically recognized and appreciated, but the state and federal funding to cover their unique contributions has been dwindling, leaving it to counties to increasingly subsidize their homes, often at millions of local taxpayer dollars per year.

County nursing facilities may be viewed as approaching a crossroads, given the various challenges and external environmental factors all are facing. All have significant strengths,

resources, historic mission and support to draw on, and most county governments seem to value their role and want their partnership with the homes to continue. Nonetheless, as financial challenges increase, few if any county homes can afford to continue to conduct business in the future as they have in the past. It is important for county homes—and ultimately their oversight county governments and the state—to consider options available to them, and to plan strategically for their future.

A number of options along a continuum of change have been outlined in this report, and several of these have already been implemented by one or more counties across the state. There is no one set of solutions that will universally work for every county. Conversely, variations of several combinations of options could work for a number of counties, especially if county homes find ways to more effectively share with each other their experiences and rationales for making certain types of decisions. The reality is that each county on a case-by-case basis must assess its unique set of strengths and circumstances and consider which option or combination of options will best address its particular reality and act accordingly.

This report does not attempt to suggest what individual counties or types of counties should attempt to do. But it is hoped that the information provided in this report, the options discussed in the previous chapter, the mission and guiding principles that have shaped for years the nature and culture of county homes throughout the state, and the general recommendations that follow, will provide guidance for counties as they make decisions affecting the future of their county nursing homes.

The viability of—and potential need for—implementation of various options at the county level will be determined to a great extent by funding and policy decisions made at the state and federal levels. Some of these decisions have begun to be made, based on collaborative efforts between state officials and nursing home advocates. Thus we begin with a series of overall recommendations directed at state and federal officials, followed

by recommendations geared more to county elected officials and policymakers and to county nursing home administrators.

Recommendations with State and Federal Implications

A series of recommendations are made for state (and to some extent federal) consideration that would help shape state policies and funding methodologies, while at the same time directly impacting on individual county nursing homes.

- ***New York State should undertake a comprehensive review of the future role of county-owned and –operated nursing homes.*** This recommendation was made by the Berger Commission, and is endorsed here. This report could serve as the first phase of such a review, providing much of the context needed for a more comprehensive study that would address in more detail funding issues, systemic changes needed to address the unique role of county homes as providers of care for those less likely to be cared for by other types of nursing homes, and the types of policies needed to guide decision-making about county homes and the residents they serve. Such a study should also focus on broader long-term care issues, the relationship between nursing home care and other types of long-term care, and policies and incentives needed to develop transitions that may be needed to shift some nursing home beds to beds and slots allocated to lower levels of care.

- ***The current state legislation—expanding state payments to county nursing homes to $100 million by 2009-10, implementing a new rate methodology, and changing the base year—should be fully implemented to make the system more rational and recognize the special circumstances of facilities with a mission to operate as a safety net and serve "hard to place" persons.*** Various changes have been set in motion in recent months to restructure the current reimbursement formulas and to recognize the distinct circumstances faced by many public facilities, but implementation of these recommendations has either not occurred, or is in the early stages of implementation. Legislation and regulations that address these issues comprehensively need to be fully implemented. They need to

address such concerns as reforming the overall Medicaid payment methodology; using the reimbursement system to create incentives to encourage desired outcomes; aligning compensation to equitably pay for services for those with dementia, bariatric and behavioral problems that have traditionally been under-compensated; establishing the new cost base year and a system for updating the base year on a regular and logical basis; ensuring full implementation of the grant system to replace IGT payments to address special needs of public facilities; removing the upper payment limit and its negative implications for county homes; and ensuring that patient needs are more effectively measured and tied to reimbursement schedules.

- ***The state should sponsor a study of the impact of what happens when county nursing homes close or sell their facility to another nursing home.*** The experiences of counties which have recently divested themselves of their public nursing homes should be analyzed to determine the implications of their decisions and what implications their experiences may have for other counties. (Consideration might also be given to the possibility of including in the study counties which have converted their nursing homes to Public Benefit Corporations.) Such a study should examine such issues as financial implications for the counties involved, what happened to residents and staff of the former county homes, implications for hospitals in the affected areas, what has happened since county home closings to subsequently-emerging "hard to place" persons who would formerly have been served by the county homes, any differential patterns of admissions from hospitals, out-of-county placements, etc. The findings from such a study could be very helpful in providing guidance to other counties that may at some point be considering the possibility of closing or downsizing their county homes.

- ***The state may wish to consider offering financial incentives for counties to establish new lower-level long-term care services not now provided in county nursing homes.*** The specifics of such an approach and how it might

fit with larger state policies could be assessed as part of the comprehensive state study recommended above. The intent would be to consider a form of financial incentive that may make it easier for counties to consider converting nursing home beds, or adding new beds, to meet increasing demands for lower levels of care. For example, if a county wishes to decertify some of its nursing home beds and convert them to a lower level and less expensive form of care—and in the process reduce the state's level of Medicaid expenditures, for example—it may make sense for the state to share some of its savings as a financial incentive for the county to undertake the necessary conversion expenses and/or to help subsidize any loss of revenues the county might experience as a result of the transition.

- ***As part of a review of long-term care policies, the state should lobby the federal government to remove its restrictions against public nursing homes offering assisted living programs.*** A number of county nursing homes have raised the issue of providing an assisted living option, indicating that it would be a more appropriate level of care for some of their residents. But at this time, federal regulations restrict counties from investing in this alternative level of care for Medicaid residents. The rationale behind these restrictions should be reviewed, and changes in the regulations should be considered. One approach might be to consider providing such care through Medicaid Waivers. At least one or two counties appear to be attempting to get around the restrictions and establish an assisted living program, and the state should work with them to help ensure that these initiatives are given every opportunity to be successful, and perhaps become models for other counties.

- ***The state should work with County Nursing Facilities of New York, other appropriate associations, and county officials to assess the strengths, limitations and related implications of the proposed Community Benefit Corporation (CBC)***. This concept is designed to enable counties to continue to provide their safety net role while being able to access special state or federal funding, without

being subject to such limitations as imposition of upper payment limits, restrictions on the implementation of assisted living and other levels of community-based care, the need for county taxpayer subsidies, etc. On the other hand, any homes under CBC sponsorship would no longer be under the direct control of county governments, which could have a variety of implications that need to be carefully thought through. The concept has merit, but is in need of considerable assessment and review of its possible implications before being formally endorsed or implemented by any counties. The concept would ultimately need federal approval to go forward, followed by state legislation before a county could implement such an authority.

Recommendations with County Implications

A series of recommendations are made for consideration by county nursing homes and their county governments.

- ***Counties and their nursing homes should actively explore the various options outlined in the "degree of change" continuum discussed in Chapter VII.*** Variations of most of the 34 options outlined along the continuum have typically been implemented by one or more county nursing homes. Successful implementation of one approach in one county does not imply that the same approach will work under separate circumstances in another, but it may at least suggest the potential for productive changes that should be considered in other settings. The fact that most of the options outlined in the continuum have not even been considered by most county homes suggests that there may be significant untapped opportunities waiting to be explored to the benefit of various county homes. As part of any possible consideration of closing or selling a county nursing home, counties should carefully consider the full impact on existing residents, future hard-to-serve people who would currently be covered by county home safety net provisions.

- ***Counties should place more focus on opportunities to expand the provision of lower levels of long-term care by expanding the numbers of non-institutional beds and program slots.*** In some cases, this may mean that a county

may wish to create one or more new units adjacent to the existing nursing home facility, or it may mean creating free-standing unit(s), or counties may choose to decertify underused nursing home beds and convert them to other types of service provision. Expansion of lower levels of care may have value in its own right in addressing unmet needs in a county, and it may also help create links to individuals and families that may establish a marketing/ recruiting base for subsequent admission to the nursing home when that level of care is needed. The Berger Commission suggests that "In the majority of counties, the existing supply of such alternative services meets less than half of the total calculated need," adding that the shortage of non-institutional slots is greatest in upstate and rural counties.[24]

- ***County homes should more aggressively market their services and the quality of their care.*** County homes throughout the state have very different approaches to marketing, and different perceptions of its value. Some counties are at least implicitly encouraged to downplay marketing because of the potential negative impact on taxpaying private nursing homes. Nonetheless, especially if county homes begin to more aggressively expand services and levels of care, marketing and expanded communications with the public may become especially important, especially to the extent that homes consciously attempt to attract more Medicare and private pay residents to supplement the Medicaid/safety net core of the clientele of most county homes. Not only is it potentially important to be attempting to reach more of the senior population directly, but attention should also be given to more effectively reaching the generation of children of older people who are often key components of the decision-making process of deciding where and when to place parents in nursing home settings.

- ***Particular efforts should be made to market to, and cultivate relationships with, discharge planners in local***

[24] Commission on Health Care Facilities, *A Plan to Stabilize and Strengthen New York's Health Care System*, op cit, p. 54.

hospitals. The more referrals county homes can obtain from hospitals, the greater the likelihood of obtaining residents who will, at least in the short-run, bring relatively high levels of reimbursement. Developing targeted marketing and relationship-building efforts to people responsible for discharge planning should be helpful to the long-term financial well-being of the county facilities. Targeted efforts also make sense with physicians, social workers, senior centers and other service providers working with concentrations of older citizens.

- ***Counties should consider establishing separate bargaining units involving nursing home employees and/or including nursing home administrators more directly and substantively in labor negotiations.*** This happens now in some counties, but in most, the special 24/7 and related circumstances associated with managing a nursing home do not get adequately factored into the broader county contract negotiation process, and often decisions are made (or not made) as a result that have direct implications for the cost effectiveness and performance of, and overall ability to manage, the county home. If county home administrators are to be held accountable for the performance of their homes, counties should consider ways to give them more management flexibility, with fewer limitations on what they are and are not allowed to do by terms of a contract which they may have had little say in shaping. At the same time, making conscious efforts to strengthen working relationships between nursing home management and labor representatives would also be likely to prove beneficial in most counties.

- ***Counties should more effectively develop means of sharing their experiences and decision-making processes concerning various options they have considered, rejected or implemented. More extensive sharing of what has worked, what hasn't, and why could be helpful as counties explore various options in their efforts to improve their performance and operating margins in the future.*** To some extent this happens now through conferences, the County Nursing Facilities of New York,

NYAHSA and other professional associations. But discussions with administrators suggest that sharing of experiences in detail, and helping think through the pros and cons of various options, does not happen as consistently and systematically as it might. It is suggested that CNFNY and its leadership consider ways it could help facilitate such sharing of information—in both formal and informal, written and unwritten ways—to expand the knowledge and experience base of administrators and county elected officials throughout the state. Special efforts may be important in the future to present concepts, experiences, and impacts of various types of decisions to elected officials who may be considering the implications of various choices about the future of nursing homes in their counties.

APPENDIX A: SURVEY QUESTIONS

MISSION

1a. How would you describe the mission of your facility? (Please feel free to attach your mission statement.)

1b. How do you feel your facility is perceived by the community in which you are located? Please explain.

1c. How do the mission of your home and the population you serve compare with others in your area?

1d. Does your facility have a role in the community above and beyond that of a nursing facility? Please provide examples.

POPULATION SERVED AND SERVICES OFFERED

2a. How many beds are in your facility?

2b. Please indicate your facility's average occupancy rate for the last three years.

Year	Average Occupancy Rate
2004	
2005	
2006	

2c. Please indicate the proportion of resident days for each primary payer type for the last three years.

	Percentage of Resident Days by Primary Payer			
Year	Medicaid	Medicare	Private Pay	Other Payer
2004				
2005				
2006				

2d. Please indicate the proportion of admissions for each primary payer type.

	Percentage of Admissions by Primary Payer			
Year	Medicaid	Medicare	Private Pay	Other Payer
2004				
2005				
2006				

3. How would you characterize the population you serve in terms of:

Demographic characteristics?

Primary diagnoses?

Other significant characteristics?

4a. What specialty services does your facility offer?

Young Adults	
Ventilator	
Rehabilitation	
Traumatic Brain Injury	
Dialysis	
Alzheimer's	
Other (Please specify):	

4b. Do the services you offer differ significantly from those offered by other facilities in your county? If so, in what way?

4c. Are there services that are unique to your facility? If so, which ones?

4d. Does your facility offer any services that draw patients from specific populations or outside your County? If so, please describe the services and the clients they draw.

4e. Have you considered adding any unique services? If so, which ones, and what benefit do you see in adding them?

TYPE OF FACILITY

5a. What year was your facility founded?

5b. What year did you move into your current location?

5c. Have there been any major renovation projects undertaken at your facility? If so, when? Please describe the renovation and its effects on the facility.

6a. Which of the following arrangements best describes your facility?

Stand-alone nursing facility	
Affiliated with a hospital	
Affiliated with another organization Please describe:	
Other arrangement Please describe:	

6b. Has this arrangement changed within the past ten years? In what way?

6c. What do you consider the pros and cons of your current arrangement?

6d. Which of the following best describes your financing arrangement?

Enterprise budget	

County budget	
Other arrangement Please describe:	

CASE MIX INDEX

7a. What was your full house case mix index at the points indicated in the table?

Year	First Full House CMI	Second Full House CMI
2004		
2005		
2006		

7b. Is there a case mix index that you would consider optimal for your facility, and if so, what is that case mix index?

7c. What steps do you take to maximize your ability to achieve the optimal case mix index?

7d. Is there anything that prevents you from achieving your optimal case mix index? If so, please explain.

7e. What is your best estimate of the proportion of your residents who have low clinical complexity but high behavioral demands? What effect, if any, does this have on your facility and its fiscal health?

7f. At what level was your case mix index frozen in December 2006?

FACILITY STAFFING

8a. How many staff are employed in your home?

Full-Time	Part-Time	Casual	Total FTEs

8b. Is the level of employee benefits you provide consistent with other County employees?

8c. What is the estimated overall annual rate of staff turnover among your facility's direct care workers (e.g. RNs, LPNs, nurse aides, allied health professionals)?

8d. Do you consider your staff to be receptive to change?

8e. What is your involvement with contract negotiations?

8f. Do you think your role should be different? If so, in what way?

8g. Have you attempted to negotiate or obtain any exceptions to the County contract for your employees through memoranda of understanding or other negotiations?

8h. Are there any particular contract provisions you would like to change? Please explain which ones and why they should be changed.

9. Are there any other staffing concerns that affect your facility that have not been addressed in the previous questions? Please explain.

OUTSOURCING

10a. Which functions or services at your facility, if any, are outsourced, i.e., provided by individuals or organizations who are not County employees?

10b. How much money has outsourcing by your facility saved the County annually?

10c. How many County government positions have been eliminated as a result of outsourcing?

10d. Are there any other services you would like to outsource? If so, which ones, and what would you see as the benefit of doing so?

PURCHASING

11a. Do you belong to a purchasing consortium? (If not, please skip to question 11d).

11b. Which purchasing consortium do you belong to?

11c. What is the estimated annual dollar value of any savings you have realized by participating in a purchasing consortium?

11d. If you do not belong to a purchasing consortium, why not? Would you see any benefits to joining such a consortium?

MARKETING

12a. Is there a budget allocation for marketing for your facility? Please describe.

12b. Please describe any marketing efforts undertaken for your facility.

12c. Do you think it would be beneficial to do more marketing? Please explain what types of marketing would be beneficial and in what ways they would be beneficial.

FINANCIAL INFORMATION

13. Please complete the following table concerning the financial status of your facility for the last three years. Please use actual figures wherever possible.

Year	Total Annual Operating Expenses	Annual Payroll	Fringe Benefits for Current Employees	Retiree Benefits
2004				
2005				
2006				
Year	County Cost Allocations (excluding retiree benefits)	Total Annual Operating Revenue (excluding County subsidy)	Revenue from Grants or Contributions	Total Annual Patient Revenue
2004				
2005				
2006				
Year	IGT	Annual Operating Profit or Loss (excluding County subsidy)	County Subsidy	Fund Balance
2004				
2005				
2006				

14a. Please identify the major components of the County costs allocated against your budget for the most recent year available. If you are able to, please assign an amount for each component.

Item	Amount

14b. How much of your County cost allocation was recovered through reimbursements?

14c. How have IGT dollars been allocated in your County (e.g. nursing home, general fund, etc.)?

14d. What is your outstanding capital debt?

14e. What do you expect will be the impact on your finances, mission and/or services of changes in IGT, the upper payment limit, or proposed Medicaid reforms?

15a. Could you operate without a County subsidy?

15b. What changes, if any, would need to occur for you to be able to operate without a County subsidy?

REIMBURSEMENT RATES

16a. What is your base year for Medicaid and Medicare reimbursement?

16b. Have you attempted to appeal your rates? If so, what is the amount of outstanding appeals?

16c. Do you feel your facility should have a different base year? If so, why?

16d. Are there any challenges related to reimbursement that affect your facility's ability to serve its target population?

RELATIONSHIP WITH COUNTY GOVERNMENT

17a. To what extent is the County government involved in your facility's management concerns?

Very Involved	Somewhat Involved	Not Involved at All

17b. How would you characterize your relations with the County government?

Very Cooperative	Somewhat Cooperative	Neither Cooperative Nor Uncooperative	Somewhat Adversarial	Very Adversarial

17c. Does the County government see the nursing home as essential to the mission of local government?

17d. Does the County government understand your operations and concerns?

17e. Is the County government supportive of the County home and the services you provide?

Very Supportive	Somewhat Supportive	Neither Supportive nor Unsupportive	Somewhat Unsupportive	Very Unsupportive

17f. Under what circumstances will the County continue to support the home?

17g. Are any officials actively encouraging you to consider alternatives for the future of the home? If so, which alternatives are being encouraged or suggested?

17h. In your opinion, what is the maximum subsidy the County will provide on an annual basis for the continued operation of the County home?

OTHER NURSING FACILITIES

18a. What impact do other nearby nursing homes have on your operations, case mix, and profitability?

18b. How does your competition affect options you might consider for the future of the County home?

FUTURE OF THE COUNTY NURSING HOME

19a. What are the major challenges facing your facility?

19b. Have these challenges changed significantly in the last ten years? How?

20a. What are the major opportunities for your facility?

20b. Have these opportunities changed significantly in the last ten years? How?

21a. Did the Berger Commission Report make specific recommendations concerning your facility? (If you answer no, please skip to Question 22.)

21b. What were the recommendations of the Berger Commission for your facility?

21c. Did you feel that the recommendations were appropriate? If not, why not?

21d. What plans does your County have to act on the Berger Commission's recommendations?

21e. What do you expect will be the impact for your County of implementing the Commission's recommendations?

22a. What concerns would you have if the County home were to go out of business?

22b. Are there circumstances under which the County should get out of the nursing home business?

22c. If the County were to get out of the business, are there reasonable alternatives available to your clientele elsewhere?

22d. Are there residents who would not be served by other nursing homes? About how many? How would you characterize those residents who could not be served?

22e. If the County home were to go out of business, what should your County government do to protect the interests of your clientele?

22f. If the County home were to go out of business, what should your County government do to protect the interests of your staff?

22g. What do you feel is the probability that the County nursing home would go out of business in the next 3 to 5 years?

23a. Do you have any managed care contracts?

23b. Have you considered contracting with a managed care organization?

23c. Please describe the actual or potential contracts, the services covered and any advantages or disadvantages of the contracts.

24. In the following table, please indicate which of these alternatives your County has considered or attempted in recent years. You may use the space below the table to provide any additional information about these alternatives, including any benefits or concerns related to specific alternatives.

Limiting the County's Role in Nursing Home Care	**Not Considered**	**Considered and Implemented**	**Considered and Rejected**	**Currently Being Considered**
Management contracts to operate nursing home				
Sale of licensed beds				
Establishment of public benefit corporation				
Becoming part of a state authority				
Conversion to free-standing not-for-profit/voluntary corporation				
Conversion to existing voluntary corporation				
Employee buy-out				
Sale of County home to proprietary corporation				
Partnership with organization outside of County government				
Cessation of County nursing home with no transfer of facility				
Continuing County Nursing Home Operations with Reforms				
More aggressive marketing				
Management efficiencies and contracting arrangements				
Efficiencies through labor reforms				
Separate bargaining unit for county home				
Implementing the "Eden Alternative"				
Renovation or new construction				
Merging the home with another county department				
Revisiting County cost allocations				
Expanding the Range of Long-Term Care Options Offered				
Non-regulated services (e.g., home delivered meals, transportation)				
Social Model Adult Day Care				
Medical Model Adult Day Care				
Respite Care Social Model				
Respite Care Medical Model				
Enriched Housing Social Model				

Adult Care Facility Social Model				
Early to Mid-Stage Dementia Social Model				
Assisted Living Program (New York State Defined)				
Assisted Living Program (as defined by other states)				
Certified Home Health Agency				
Licensed Home Care Service Agency				
Managed Care and Integrated Systems of Care				
Continuing Care Retirement Community				
Subacute Care and Special Care Units				
Specialized Care of Geriatric Prisoners				
Other (Please specify):				

25a. Are there any alternatives not listed above that your facility has considered or undertaken in recent years? Please describe.

25b. Are there any alternatives you expect to consider or implement in the next 3 to 5 years? Please describe.

26. Are there any other issues you would like to raise with us? Feel free to do so here, in an attachment, or by telephone or email using the contact information below.

APPENDIX B: LIST OF COUNTY NURSING FACILITIES AND SURVEY RESPONDENTS

Counties Outside of New York City with County-Operated Nursing Homes	County Participated in Survey
Albany (Two Facilities)	Yes - Responses received for both facilities
Broome	Yes
Cattaraugus (Two Facilities)	Yes - Responses received for both facilities
Cayuga	Yes
Chatauqua	No
Chemung	Yes
Clinton	Yes
Columbia	Yes
Erie (Two Facilities)	No
Essex	Yes
Franklin	Yes
Fulton	Yes
Genesee	Yes
Lewis	Yes
Livingston	No
Monroe	Yes
Nassau	Yes
Niagara	Yes
Onondaga	Yes
Ontario	Yes
Orange	Yes
Orleans	Yes
Otsego	Yes
Rensselaer	Yes
Rockland	Yes
Saratoga	Yes
Schenectady	Yes
Steuben	No
Suffolk	Yes
Sullivan	Yes
Ulster	Yes
Warren	Yes
Washington	Yes
Wayne	Yes
Westchester	No
Wyoming	Yes