

FLHSA ANALYSIS TO SUPPORT ONTARIO COUNTY'S PROCESS FOR DECIDING WHETHER TO CONTINUE TO OPERATE THE ONTARIO COUNTY HEALTH FACILITY

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Executive Summary

At the request of Ontario County, Finger Lakes Health Systems Agency (FLHSA) has undertaken an analysis of the long term care needs of the Ontario County population. This includes reviewing the current operations of the Ontario County Health Facility (OCHF) and exploring options going forward available to Ontario County.

While the number of elderly in Ontario County is projected to rise during the time period from 2010 to 2035, this increase is accompanied by a trend of more care being delivered in the home setting rather than in nursing homes. This is driven largely by patient preference and is reflected in state wide projections calling for decreasing the numbers of nursing home beds. Projections of need are best viewed in aggregate for a multi-county planning area as patient demographics show significant numbers of people cross county borders for care. Although there is a projected need in Ontario County, there is also a projected excess of skilled nursing beds for the surrounding counties; where one in ten OCHF patients come from.

Cost analysis of the OCHF demonstrates consistent operational deficits that have been substantial in recent years. On the cost side this is driven by higher personnel expenses; on the revenue side income is compromised by lower patient Case Mix Intensity (define). Additionally, long term stays are not counterbalanced with short-stay rehabilitation patients. We cannot project that these operational deficits will be covered in the future with increased rates or intergovernmental transfer payments (IGT).

Without substantial changes in the operation of the OCHF, the county will be facing significant deficits in future years. There are potential opportunities to meet community needs with different care delivery models than are currently in place. We strongly encourage exploring collaborative approaches in the region that will create win- win solutions for the stakeholders serving the aging population.

Summary of Findings

From before the American Revolution, counties have a distinguished legacy of providing care for the indigent, widows, orphans, and the disabled. While the role has changed over the years, many counties continue to be "the provider of last resort." There is no legal requirement for counties to operate nursing homes, but the historical legacy continues to influence community expectation. Nevertheless, not all counties provide nursing home care, and because of special challenges counties face in operating facilities without running deficits, some counties in New York State have ceased their role as operators, and others are exploring options.

The 65 and older adult population of Ontario County is projected to increase significantly. Historically, those 85 and older have the greatest use rates for hospital and nursing home care. The 85 and older population will not increase significantly until 2020.

Since 1977, nursing home use by those 85 and older has shown a marked decline in the U.S. Symptomatic of peoples' preference to live and receive care in the community, nursing home occupancies in the U.S., NYS, and the FLHSA region have declined since 1990.

One way to assess gaps in long term care services is to monitor the number of people in hospitals awaiting discharge. In the Central Subarea, consisting of Ontario, Livingston, Seneca, Wayne and Yates Counties, there were on average 1 patient per day in each of the hospitals of the subarea awaiting discharge who had been placed on Alternate Care Status. Alternate Care levels in the subarea do not indicate a gap in needed long term care resources.

On May 11, 2011, FLHSA's Sage Commission completed a study of all of the resources needed to meet the needs of elders in the nine county region for the years 2020 and beyond. The study finds that Ontario is one of two counties in the region that has a need for additional nursing home capacity. However, some people elect to receive nursing home care outside of their county of residence. Our analysis of the migration patterns of people from the five county central finger lakes area shows that overall 90% of the care needs of people in Ontario County are met in the subarea.

Other counties in the subarea have excess beds. Looked at collectively, if Ontario County were to close its nursing home, the remaining nursing home capacity of the other facilities in the five counties would be sufficient to meet future need. There is one caveat. The Sage Report cites the need to develop additional Assisted Living and other housing capacity, as well as the needs to expand home care and adult day care capacity. If we are to "right size" nursing home capacity in this region, it is the recommendation of the Sage Commission that "right-sizing" occur in the context of developing the other needed long term care resources.

It is clear from the data that the Ontario County Health Facility serves a population that is somewhat distinct from both that of other nursing homes in the county as well as other facilities operated by counties in the Finger Lakes Region. Were the Ontario County to choose to discontinue its provision of nursing home care, alternatives to meet the needs of the population it serves would have to be sought. At this time, that population tends to be older women who in more instances than usual come from home or an adult care facility, are dependent on Medicaid, and have low acuity care needs. These residents are not the preferred admissions of other facilities because they are associated with lower rates of reimbursement, and adversely affect the overall facility case mix index on which reimbursement is based.

Despite having lower case-mix indexes, county operated facilities typically have higher nursing hours per staffed bed in comparison to facilities operated by voluntary or proprietary organizations. County facilities have the benefit of a much lower staff turnover rate, having contracts with significantly higher salaries and benefits; especially for aide level personnel. In order to remain financially viable and competitive, nursing home administrators need the flexibility to respond to changes in the case mix with adjustments to the staffing patterns.

IGT and direct county subsidies are not and have not been sufficient to offset increasing deficits of county operated facilities. While NYS Medicaid has been in the process of renegotiating facility rates for years, agreed-upon rate adjustments have not materialized. Some facilities continue to operate on a 1983 base year cost. A recent law suit was settled when NYS agreed to pay the facilities with retroactive rate adjustment payments by July 2011. While this may begin to address some of the historical losses, the State is currently in the process of developing a future approach to reimbursement based on statewide average costs. This means that Nursing Home Administrators continue to operating their business without knowing what revenue they can expect.

In the final analysis, Ontario County leaders must balance factors that will affect financial sustainability with ensuring the long term care needs of Ontario County residents are addressed. Consideration must also be given to the impacts on staff, residents of Ontario County and good will between county government and the other stakeholders (senior citizens, caregivers, health care providers etc.).

It is in this context that Ontario County considers its options for the future.

Options

Ontario County has many options to consider related to its current operation of the Ontario County Health Facility. The options will need to address two issues: the ability to meet the needs of Ontario County residents and financial sustainability.

In outline form we would see the options to be:

- 1. Ontario County continues to own the OCHF
 - a. Continue "as is";
 - b. Outsource some of the geriatric medical operations with a Management Contract, adding a geriatric assessment clinic and tele-health geriatric coverage for residents of OCHF in order to reduce unnecessary transfers to the emergency department and hospital;
 - c. Renovation or New Construction to add needed space needed and make the facility more competitive in the current market; (e.g. increase room size, add space for storage, staff offices, address code issues etc.).
- 2. Ontario County sells the OCHF
 - a. Sale of the facility to another organization;
 - b. Sale of the bed medallion.
- 3. Ontario County divests with closure of the OCHF
 - a. Planned closure in collaboration with other regional providers;
 - b. Closure meeting state requirements, but allowing market forces to shape the long term care landscape.

Each option has advantages and challenges. They also have different impacts on the services available to Ontario residents and the county finances. We cannot fully explore each option but can provide pivotal insights that would need in depth exploration once chosen paths are defined. Appendix 9 attached provides some of the factors in tabular form with a proposed scale that County Leaders might consider using in their assessment of feasibility, impact, barriers, and "other factors".

To review key aspects of each option:

- As Is scenario this would as detailed in the report likely result in increasing financial losses with inevitable decline in quality and increasing inability to keep the facility current and attractive to patients. It would also entail at least \$260,000 in capital costs for a sprinkler system to meet federal Life Safety code.
- Outsourcing this would entail contracting management of the medical care to a provider that could set up a comprehensive geriatric out-patient assessment clinic for the residents of the county, and provide tele-health consulting capability to augment services provided by the medical director. While this could potentially increase referrals to the facility, and reduce preventable trips to the emergency room for people in the community because of more comprehensive/stable care plans, and prevent preventable use of the emergency department and readmissions to the hospital for residents of OCHF, it does not address the issue of personnel costs inherent in current county ownership and therefore is not likely to be a long term solution to the financial issues, unless geriatric assessment clinic reimbursements are enhanced through a CMS transition grant or payment reform.

- Renovation or new construction This option would focus on correcting the patient mix currently driving some of the financial issues. It would make the facility more attractive to patients and allow service expansion to rehab and more lucrative lines of business. Inherently it would put the county in more direct competition with hospital and private long term care providers. It would also increase the total cost of the operation that would need to be offset with rebasing and added volume / services.
- Sale of the facility to another organization it is possible that another long term care provider would be interested in purchasing the current facility and continuing operations. If the county were to make acquisition contingent on serving patient who are hard to place there may well need to be subsidies as part of the deal. The fact that the building sits on the county campus, and the facility is unionized is likely to make it hard to market to local operators. Local operators in this region have a history of providing a better quality of care, than operators from outside the region.
- Sale of the bed medallion it is a more likely scenario that another long term care provider in the immediate region would be interested in obtaining the bed medallion and not assuming the actual facility for operation. This would allow expansion of their current operation and efficiencies not obtainable with on older plant. For both this and the preceding option a nursing home broker would be needed to determine value and the potential cost of ensuring provision for hard to place patients.
- Closure in collaboration with other regional providers As noted in Appendix 5, if need is evaluated more regionally, not just by county boundaries, there is enough capacity in the subarea to service the population without the capacity of the OCHF. This would be contingent on expanded capacity of home care, assisted living, housing and day care being available as an alternative for lower acuity patients who, without these options, would have a nursing home as their only option. By working in collaboration with other facilities in the subarea, patients who need nursing home care could be placed where excess capacity exists. Agreement of these providers to accept the hard to place patients whose needs could not be met at the alternative sites of care could fill Ontario County's need and still provide a net benefit to the other organizations through higher utilization.
- Closure meeting legal requirements It is possible to close operations of the OCHF meeting the legal requirements of the state, and then let market forces drive the availability of services in the county. The county would be required to find placement for all current residents, and then surrender the license for nursing home beds to NYS Department of Health. This scenario would, after closure, rely solely on the market to provide for the hard to place patients. It is potentially a problematic situation especially for the hospitals that are faced with placing these patients post acute care.

Chapter 1

Historical Context:

In the United States, counties have an historical legacy of caring for the poor, "the unwanted and hard to love" that can be traced back to the founding of the country. From the earliest days of the country's founding, poverty was a constant threat, and the plight of poor widows and orphans was a constant concern. Where possible there were attempts to have relatives and neighbors provide for them, and older boys were apprenticed out.

By the end of the American Revolution, poorhouses were developing for people who lacked the capacity to help themselves. Public relief was regarded as a "minimal safety net for the deserving poor." These poorhouses were also seen as places to house criminals, abandoned children, widows, people with handicaps, and people who were mentally ill. While they were intended to be a humane way of caring for vulnerable people in the community, the manner in which these populations were housed under one-roof predictably became a cause for management problems, scandals and public investigations. Needless to say, all those who could did everything in their power to avoid going to the poor house.

By the early 19th century self-help societies began offering burial insurance, and groups like the Odd Fellows emerged and began caring for the orphans. By 1850's a host of commissions had formed to investigate poorhouses, and scathing reports were issued citing the inhumane conditions and lack of fiscal accountability.

Over time there emerged separate facilities to provide care for orphans, criminals and those judged to be "insane", those considered "mentally defective" and poor widows. Since there was always some overlap between those who had mental health challenges and those who were aging or physically disabled, it was not unusual from the mid-19th century through the mid-20th century for these people to be cared for at county poor farms.

These were typically farms which were bought by county government, to house the indigent and disabled. Those who resided there referred to as "inmates" and as many as possible were assigned jobs that consisted of growing the food, preparing the food, doing the laundry, maintaining the building, and caring for the other "inmates". Generally the county would hire a "superintendent" and he and his wife would assume responsibility for overseeing the operation of the facility. The approach was to care for the vulnerable in a manner that engaged those receiving care in the operation of the facility in order to make the organization as self-sufficient as possible. The counties would then pick up the deficit.

¹This historical overview is a synopsis of material taken from: <u>www.boisestate.edu/socwork/dhuff/us</u>

Thus in *History of Ontario* we find that:

"In 1825, the Board of supervisors purchased 100 acres for a farm for the county's poor. The county subsequently purchased additional land for a total of 200 acres. "The county farm and poor house are among the most noted institutions in the county and ones in which every resident feels just pride. No similar farm or property in the state is conducted on such a thorough and practical business principles. During the last five years the inmates and the farm have been entrusted to Mr. Wisner as keeper and his wife, and much of the fame which this farm has acquired is due to the keeper and his wife". From the earliest days, the people of Ontario County took pride in the manner in which they assumed responsibility for the care of the poor and indigent.

County records indicate that when the county home building was razed in 1926 it was "the end of an era". With the passage of Medicare and Medicaid in 1965, the state and federal government began to assume some of the cost for providing health care for the elderly, disabled and poor. With reimbursement came regulations. Thus in 1969, the County built a new facility to meet the federal and state standards so that they would be eligible to receive third party payment for long term care. By 1970 new state standards, and complicated regulations, were causing new troubles for the county. The county farm closed in 1966. In 1969 the state Department of Public Health (new agency, new emphasis) condemned the 1926 facility. The next year the Supervisors began the process of replacing it with a modern Health Related Facility which opened in 1976. "In October 1990 the skilled nursing and health related facility levels of care were eliminated in NYS as a result of the Federal Omnibus Reconciliation Act (OBRA). Hence all beds would be officially labeled residential health care facility beds. Former combined SNF/HRF facilities had the option of admitting patients in their former HRF units that were typical SNF type of patients (patients who required more skilled care). Some facilities increased staff throughout their facilities to be able to admit the higher care patients, others continued to kept the former HRF units as they had been by admitting lower case mix patients."⁵

Since all beds are considered skilled nursing today, that term will be used throughout this report.

For several reasons county operated nursing homes have sometimes been referred to as "provider of last resort". To older generations, county homes still carry the stigma of the "poorhouse" the place to be avoided at all costs. Today, hospital discharge planners and adult protective workers in counties often use these facilities for people that are hard to place elsewhere.

The historical legacy and mission of county homes has been to care for the poor, the indigent, and to be a safety net provider for those people who are difficult to find care for because other

² Lewis Cass Aldrich and George Stillwell Conover, ed. <u>History of Ontario County, New York</u>.

³ Preston E. Pierce, County Historian.

⁴ Health Related Facility referred to a level of care lower than provided in a skilled nursing facility to people who intermittently required skilled nursing supervision and treatment.

⁵ New York State Health Facilities Association. "Facility-Group Cost Comparison: User's Guide" (2007), p. 8.

providers elect not to serve them, usually due to their care needs, or low rates of reimbursement that is paid for their care.

Chapter 2

County's Legal Responsibility for Care of the Indigent

First, it should be stated that counties have no legal mandate to operate nursing homes, and not every county in NYS operates one. At the time of a CGR study in 1997 there were 44 county owned and operated facilities in 40 counties in NYS, and by the time CGR did a 2007 study 40 county facilities in 37 counties remained in operation.⁶ Since that time other counties are exploring options to operating county owned facilities.

Constitution:⁷

FLHSA staff are not attorneys, but there does not appear to be any affirmative requirement in law for counties to assume responsibility for the care of the poor. The responsibilities that do exist appear in Article XVII of the NYS Constitution created in 1938. Article XVII establishes an affirmative social right the individual may demand from the government.

Section 1 addresses Public Relief and Care

The aide, care and support of the needy are public concerns and shall be provided by the state and such of its subdivisions, an in such manner and by such means, as the legislature may from time to time determine. (193)

This requires the state to assume a major role in the field of social welfare. The court of appeals has interpreted this provision as a mandate of the constitution, imposing on the state an affirmative duty to aid the needy. The court has asserted that it's the judiciary's duty to see this duty is not shirked. (Tucker v Toia 1977). The legislature has great discretion in setting criteria for defining need and establishing programs to aid those in need (Kircher v Perales 1985).

Section 2 State board of social welfare- spells out the powers and duties for oversight, inspection of public, private institutions run by the state, counties, municipalities, and others that receive public funds. (It specifically excludes those operated by State Ed. Department, facilities for the blind, deaf, and mental hygiene.)

Section 7 deals with loans to hospitals and health care facilities regarding expenses for modernization.

If a State wants to extend Medicaid benefits to others, it is free to proceed at its own expense. New York has done so. It has provided non-federally subsidized Medicaid benefits to certain categories of individuals, including residents between the ages of 21 and 65 whose income and resources fall below a statutory "standard of need" and who are not otherwise entitled to

⁶ CGR. "County Nursing Facilities in New York State: Current Status, Challenges and Opportunities" (September 2007), p. 1.

⁷ Galia, Peter. NYS Constitution Reference Guide. Peter Galia. P. 262

federally subsidized Medicaid (see, Social Services Law § 366 [1]; 18 NYCRR 360-3.3 [b]). Thus, New York State's Medicaid system has two components: one that is federally subsidized and one that the State funds entirely on its own. ⁸

The State argues that the allocation scheme here does not contravene Tucker. It contends that the Constitution affords it discretion to set levels of benefits for the needy and, in the exercise of that discretion, it has provided plaintiffs full safety net assistance and emergency medical treatment. We agree that article XVII, § 1 affords the State wide discretion in defining who is needy and in setting benefit levels. Indeed, in Matter of Barie v Lavine (40 NY2d 565, 566), this Court upheld a regulation that required welfare recipients to participate in a work referral program and denied them benefits for 30 days if they failed to comply.

In this context, plaintiffs and amici argue that when such patients are treated in emergency settings, the hospitals are not permitted to release them without a discharge plan for necessary continuing health care services, citing Public Health Law § 2803 (1) (g). Because they cannot be readily discharged, many remain in hospital facilities. Those who are discharged experience a cycle of emergency, recovery, stabilization, deterioration and the onset of another emergency. All of this, plaintiffs and amici contend, could be avoided through ongoing medical treatment. ⁹

Because FLHSA lacks legal expertise, we respectfully refer the Ontario County Supervisors for further clarifications of these sections of the constitution and related court decisions to their legal counsel.

Note: The format of citations in the published opinions of the New York courts is the subject of a detailed manual of the New York State Law Reporting Bureau, the Official Reports Style Manual (2002), as amended by a 2004 supplement, http://www.courts.state.ny.us/reporter/Styman Menu.htm.

⁸ Aliessa v. Novello, 96 N.Y.2d 418, 754 N.E.2d 1085, 730 N.Y.S.2d 1 (2001

⁹ N.Y. Ct. App. R. Pract. § 500.5, http://www.courts.state.ny.us/ctapps/500rules.htm#500.5.

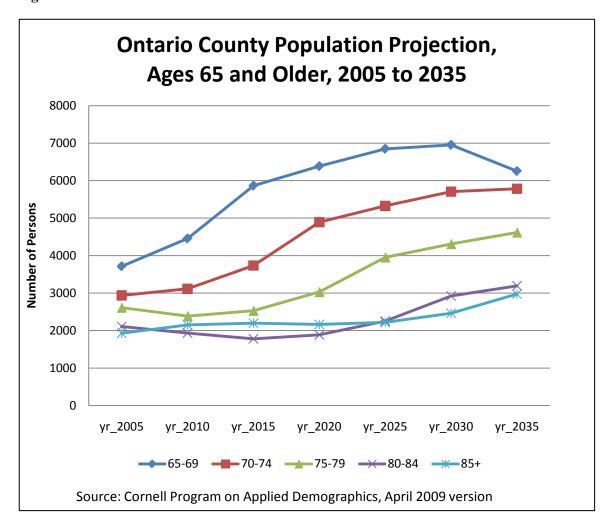
d) Where New York authorities are cited, New York Official Law Report citations must be included.

Chapter 3

Demographic Projections of Ontario County's Older Adult Population

From 2010 to 2030 there will be a steep increase in the population in their 70s which is a group that can be expected to use more home care and related community based services. Not until 2025 will the populations over 80, the primary users of residential skilled nursing care, begin to increase significantly. ¹⁰

Figure 1



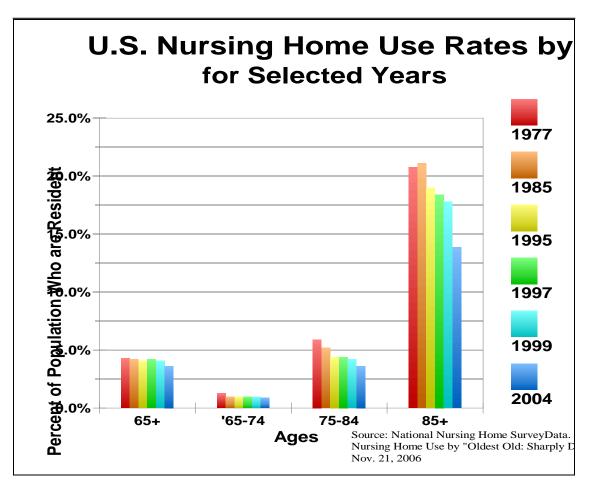
¹⁰ As the work on this contract was being concluded the Census Bureau began to release age specific data from the 2010 Census. Because all of 2010 Census data are not available, it is not possible to update the Sage Model at this time. Preliminary data indicate that the county has experienced a larger than projected increase in its 85 and older population. This has several implications. First, nursing home use rates for this older cohort have declined more than the rates used in the Sage Plan and this report. Second, the data suggest that the substance and direction of the findings of this report are correct. Finally Sage need projections that will be developed when needed U.S. 2010 Census data and future projections become available may vary slightly with those in the current plan. The core of the plan and strategic direction will not.

Chapter 4

Trends in Nursing Home Use: Large Declines in the Use of Nursing Homes among the Oldest Old

In the last two decades, the way we support frail older adults in the United States changed significantly with a large shift away from nursing homes, particularly among the oldest old. This is consistent with the expressed desire of most older adults to continue to live in the community. This change in the preferences suggests continued decline in nursing home use as the baby boom generation begins to need long term care. Although the oldest old continue to use nursing homes more than younger age groups, over the last three decades the use rate among individuals age 85 and older declined by over one third – falling from 21.1 percent of individuals over the age of 85 living in nursing homes in 1985 to 13.9 percent in 2004 (See Figure 2). While the use rates are much lower in other age groups, the utilization trends in all groups are declining.

Figure 2

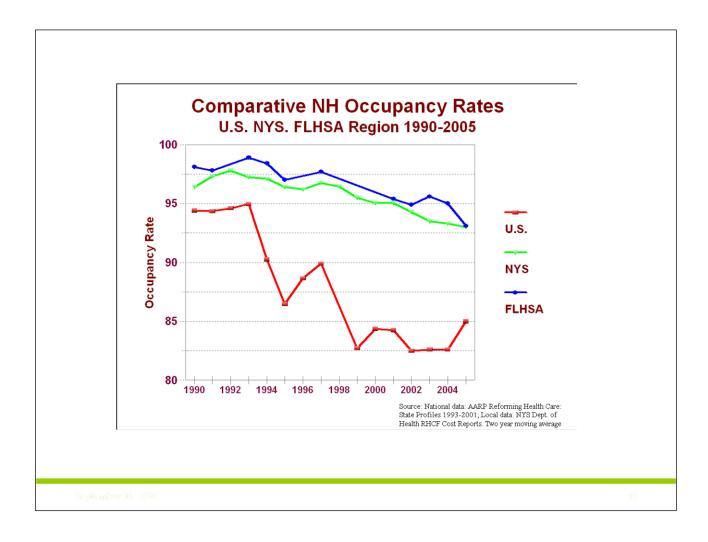


¹¹ Presented by: Lisa Alecxih. Vice President, The Lewin Group. "Nursing Home Use by "Oldest Old" Sharply Declines." The National Press Club. November 21, 2006. P. 1

Trends in Nursing Home Occupancy

Figure 3 shows nursing home occupancy rates over time in the U.S., NYS and the Finger Lakes Region. The data show that while nursing home occupancies have remained higher in this region than the state or the nation, occupancies have been declining. The data from the Finger Lakes Region for 2005 shows that average occupancy was approximately 93%, which was above the 2009 U.S. nursing home occupancy of 83.7%, but consistent with current NYS 2009 occupancy rate of 92.4%. ¹²

Figure 3

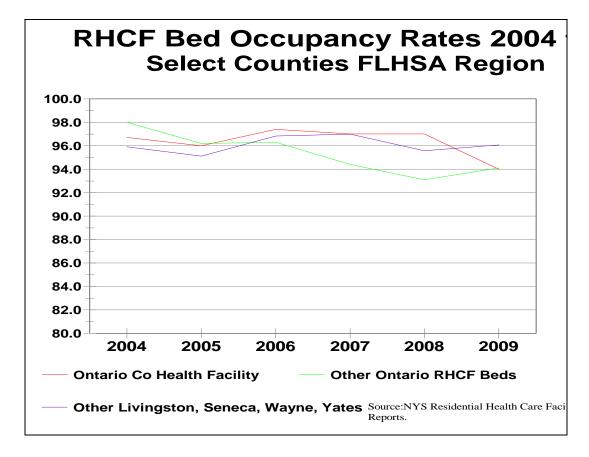


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 $^{^{12}\} http://www.statehealthfacts.org/comparemaptable.jsp?ind=416\&cat=8$

More recent utilization data from the Subarea show that as a group, facilities in Ontario County declined more between 2006-2009 than other counties in the subarea, but the Ontario County Health Facility did not follow that trend until 2008.

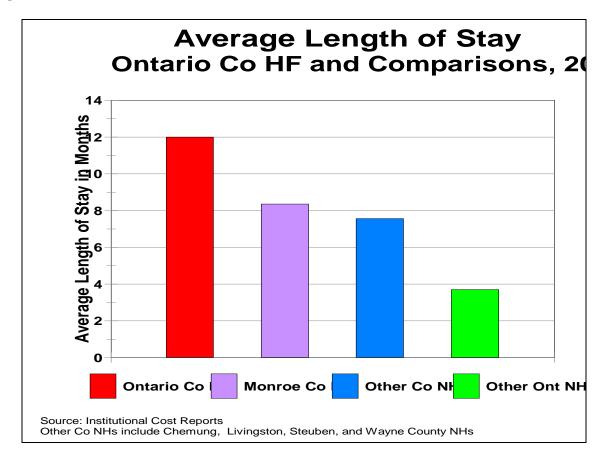
Figure 4



Length of Stay Comparisons

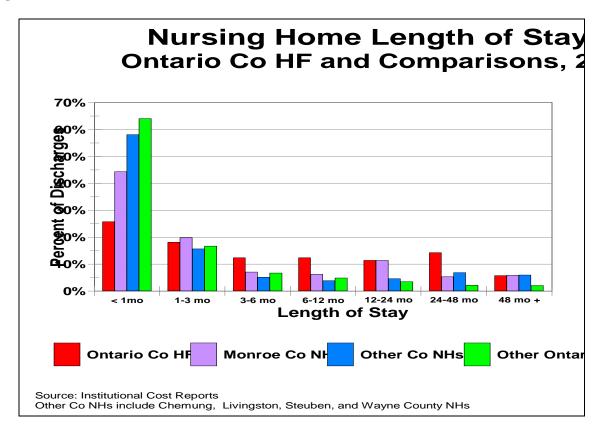
The Ontario County Health Facility (OCHF) has a significantly longer average length of stay (12 months) compared to other county operated homes (less than 8 months), and to the other nursing homes in Ontario County (less than 4 months).

Figure 5



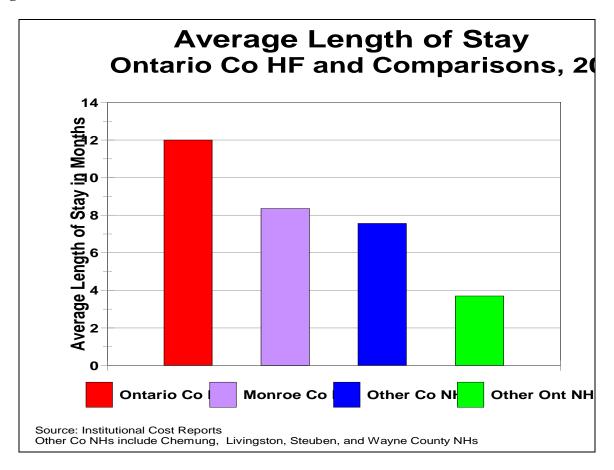
The longer average stay is due to OCHF having a smaller percentage of residents with stays of less than two months and a larger percentage of residents with stays for 6 months to 2 years. (See Figure 6)

Figure 6



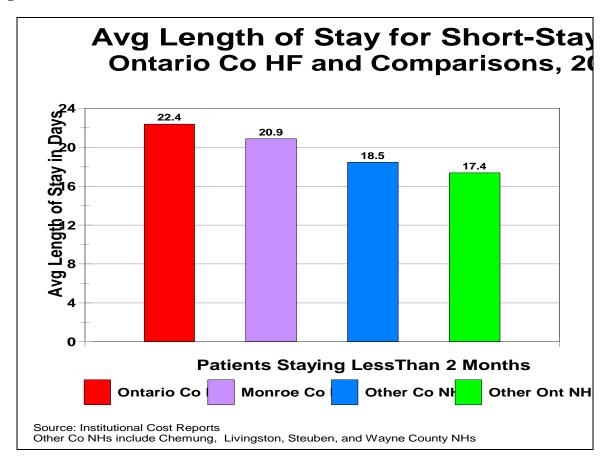
After eliminating the patients who stay less than 60 days – the post-acute rehab or short-term follow-up patients – the average length of stay in the Ontario County Health Facility is substantially shorter than that of other county operated nursing homes (19 months vs. 23 months), but also substantially longer than such patients in other nursing homes in Ontario County. (19 months in OCHF vs. 13.6 months in other Ontario facilities.)

Figure 7



Even among short-stay patients, the Ontario facility tends to have longer stays than their peer county operated homes or the other Ontario County facilities.

Figure 8



Chapter 5

Sage Plan: Skilled Nursing Need In Ontario and Central Subarea

In February 2009 the FLHSA Sage Commission was convened and charged by Finger Lakes Health Systems Agency with developing a strategic comprehensive, person centered plan for services for older adults in the nine county area for the years 2020 and beyond. This report was finalized in May 2011, and is available on the FLHSA web site (www.flhsa.org).

According to the Final Report of FLHSA's Sage Commission, Ontario County has the distinction of being one of only two counties in the FLHSA Region that has an unmet need for skilled nursing beds.

Table 1

	Sage Commission Skilled Nursing Bed Need Estimates									
County	2010 County Bed Capacity	2015 Sage Bed Need	Need/Surplus 2015	2025 Sage Bed Need	Need/Surplus 2025					
Ontario	623	720	97	719	96					
Livingston	354	310	-44	313	-41					
Seneca	280	199	-81	158	-122					
Wayne	559	505	-54	480	-79					
Yates	196	193	-3	185	-11					
Monroe	5,473	5,067	-406	4,060	-1,413					
Chemung	736	560	-176	395	-341					
Schuyler	120	137	17	145	25					
Steuben	699	677	-22	631	-68					
Region	9,040	8,368	-672	7,086	-1,954					
2020 Vision fo	or Aging Services	s, May 2011								

While nursing home need estimates are done at the county level, a certain percentage of people migrate outside of their own county for care. In some cases this is to be closer to a relative, in other cases it is to receive specialty care (e.g. ventilator needs, dialysis needs, severe behavioral needs, preferring to reside in a faith based facility.)

The data in Table 2 indicate that at the end of 2009, two-thirds of Ontario County residents receiving skilled nursing care were in nursing homes in Ontario County. The other third (226 people) received care outside of the county. Further analysis shows that nearly 90% of the county residents received their care within the subarea (Ontario, Seneca, Wayne, Yates, Livingston), and all but 1.6% of Ontario residents were receiving care in the 9-county FLHSA region.

Table 2: Where Ontario County Residents Received Care by Payer, December 2009

	Medicaid	Medicare	Private	Total	%
Ontario facilities	314	34	95	443	66.2%
Seneca facilities	47	5	12	64	
Wayne facilities	27	4	14	45	
Yates facilities	23	2	13	38	
Livingston facilities	6	1	4	11	
Total Central Subarea	417	46	138	601	89.8%
Monroe facilities	30	3	23	56	
Steuben facilities	1	0	0	1	
Total FLHSA Region	448	49	161	658	98.4%
Other NYS facilities	6	1	4	11	1.6%
Total Ontario Residents					
in NYS facilities	454	50	165	659	100.0%
Source: Residential Health Care	Facilities Cost	Reports			

In order to assess whether this pattern of out-of-county use was unique or persisted over time, FLHSA staff looked back to data from 1989 which was used to assess patient migration for the 1993 Plan for Skilled Nursing Home Beds. Those data are shown in Table 3. The data are quite consistent for the percentage of people cared for in Ontario County. Over the recent 20 year period, significantly more people are cared for within the FLHSA Region.

Table 3: Pattern of Where Ontario County Residents Received Care, 1989

Location	%
Ontario facilities	63.5%
Seneca facilities	8.7%
Wayne facilities	1.7%
Yates facilities	.7%
Livingston facilities	1.6%
Total Central Subarea	76.4%
Monroe facilities	6.9%
Steuben facilities	0.3%
Total FLHSA Region	83.6%
Other NYS facilities	15.6%

Source: RHCFs Cost Reports, 1989

Use of Ontario County Skilled Nursing Beds By County of Residence and Payer

Table 4 shows that 75% of all beds in Ontario County were used by Ontario County residents. A total of 145 people (24.7%) of those in care, were from outside the county. Ninety percent of the nursing home beds in Ontario County were used by people from the Finger Lakes Central Subarea at the end of 2009. Overall 94% of the bed days were used by people from the 9 county Finger Lakes Region, with the other (4%) coming from other counties in NYS and (2%) from out of state.

Table 4: Use of Ontario County Nursing Home Beds by County of Residence, December 2009

	Medicaid	Medicare	Private	Total	Cum.%
Ontario	314	34	95	443	75.3%
Wayne	20	3	8	31	
Seneca	20	5	2	27	
Yates	10	3	4	17	
Livingston	8	0	2	10	
Total Central Subarea	372	45	111	528	89.8%
Monroe	14	0	5	19	
Steuben	2	1	2	5	
Total FLHSA Region	388	46	118	552	93.9%
Other NYS	15	6	1	22	3.7%
Other States	9	0	5	14	2.4%
Total Patients in Beds	412	52	124	588	100.0%
Total Beds				623	
Source: Residential Health Care Faciliti	es Cost Reports, 2	2009		·	

From Tables 2 and 4 we see that the net migration of people coming into and out of Ontario County for nursing home care was a net out-migration of 81 people leaving Ontario to receive care, generally in other counties of the sub-area. Table 3 shows that there is a history of Ontario County people going out of county, but remaining in the region, and generally the subarea to receive skilled nursing facility services.

Table 5 shows the origins of the residents of OCHF. The Table shows that 25% of those in OCHF were not from Ontario County in December of 2009.

Table 5: Patient Origin of Ontario County Nursing Home Residents, December 2009

Ontario County Health Facility Residents by County of Origin and Payer										
County of Origin	Medicaid	Medicare	Private	Total	% Dist					
Ontario	56		14	70	76.1%					
Yates	5			5						
Wayne	2		1	3						
Livingston	2		1	3						
Total Central Subarea	65	0	16	81	88.0%					
Monroe	2			2						
FLHSA Region	67	0	16	83	90.2%					
Other NYS	3	5	1	9	9.8%					
Total OCHF Residents	70	5	17	92	100.0%					
Source: Residential Health (Care Facility C	ost Report, 200	19							

Nursing Home Bed Need in the Subarea

Since approximately twenty percent of the existing need for SNF beds of Ontario County residents is met by facilities in other counties in the subarea, it is appropriate to look at net unmet need for skilled nursing beds in the subarea. Table 6 shows that overall the subarea is expected to have an excess of 85 beds in 2015 and an excess of 150 beds in 2025.

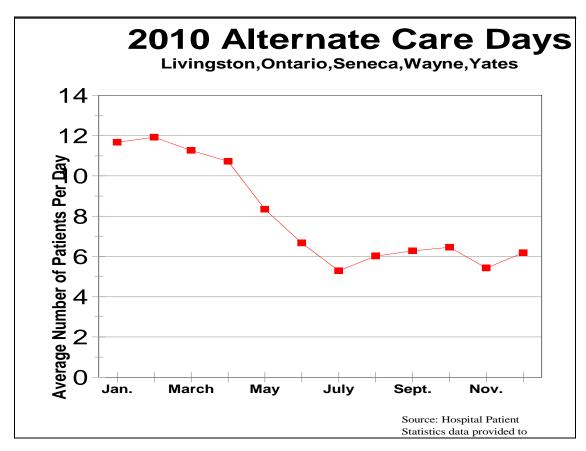
Table 6: Net Subarea Need/Surplus for Skilled Nursing Beds 2015 and 2025

	Need/Surplus 2015	Need/Surplus 2025
Ontario	97	96
Wayne	-54	- 79
Seneca	-81	-122
Yates	- 3	- 4
Livingston	-44	- 41
NetNeed/Surplus	-85	-150

Alternate Care Patients as an Indicator of Unmet Need

People who remain in hospitals beyond the time they are medically ready for discharge are put on alternate care status. The number of people on alternate care on any given day may be an indicator of unmet need for post-hospital services. Figure 9 provides data on the average number of people reported on alternate care status by Ontario County hospitals in 2010. Last year alternate care dropped from 12 persons reported per day to 6. Considering there are six hospitals in the subarea, this represents 1 person per day per hospital during the second half of 2010. While it is never in an individual patient's interest to remain in a hospital beyond medical necessity, from a community perspective, the reported alternate care days are not an indication of unmet need for long term care services.

Figure 9



Other Long Term Care Resources Needed in Ontario County

FLHSA's Sage Plan shows the following needs for alternative long term care services in Ontario County (*See* Table 7).

Table 7: Future Ontario County Long Term Care Needs

	2007	2010	2015	2020	2025	Chg '07-25					
Assisted Living Units	1		_		1	•					
Market Rate	226	241	249	250	262	36 units					
Affordable Funded	85	96	103	105	118	33 units					
Independent Housing Units											
Market Rate	944	981	1,015	1,052	1,149	205					
Affordable Funded	655	655	655	655	655	0					
Affordable Unfunded		325	358	395	491	491					
Adult Day Health Care						•					
Existing Slots	55	55	55	55	55						
Additional Need	5	8	19	31	44	39					
Home and Community Bas	sed Services	S									
Medicare Skilled Home Care Visits	22,000	23,.000	25,000	27,000	29,000	7,000					
County Funded Home Health Aides Visits	89,000	97,000	119,000	143,000	168,000	79,000					
County Funded Other Services EISEP, Transportation,PCA	81,000	86,000	98,000	113,000	133,000	52,000					
Source: Sage Plan Propose	ed Scenario	Ontario Cor	unty, May 20	011							

Two of the key items shown in Table 7 are the need for 20 additional units of Assisted Living housing that would be accessible to Medicaid and low income people by 2020, as well as the need to add 31 adult day health care program slots, and substantially increase home health aide services. The need for Assisted Living for Medicaid and low income is consistent with the case mix findings of the Ontario County Health Facility, as well as statements made by management staff of the facility that some of the population would be appropriate for Assisted Living were it available.

Conclusions on Need

Ontario County has a need for 96 nursing home beds. However, Ontario County residents have shown an historical pattern of using Ontario County facilities for approximately 65% of their care and using nursing home in other counties of the region, especially the Central Subarea, for most of their remaining care needs. Given this pattern, it is appropriate to look at the need for

skilled nursing beds in the context of the need for Central Subarea. The data show that there are excess capacity of skilled nursing home beds. Were Ontario County to elect to cease operating the OCHF and plan with stakeholders in the five counties, it would be possible to address projected need with the remaining bed capacity, and development of alternative housing and community based services needed.

From a subarea perspective Alternate Care data do not show indication of immediate unmet need for long term care services.

Chapter 6

Profile of the Population Served in Ontario County Homes

The data in Table 8 show that Ontario County Nursing Home had a higher percentage of people over the age of 90 than other facilities in the county and its percentage of people under 65 was lower than all facilities except Elm Manor. OCHF and MM Ewing Facility had nearly 80% women in their census, while the other facilities had seventy-five percent women.

Table 8

	Profile of	Ontario Cou	nty Nursing	Home Popul	ations		
	Ontario County HF	Ontario Geneva South	Ontario Geneva North	Ontario Clifton Springs	Ontario MM Ewing	Ontario Elm Manor	Total Ontario Facilities
	RHCF	RHCF	RHCF	Total	RHCF	RHCF	
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Distribution by Sex							
Males	20.7%	33.7%	28.9%	26.4%	20.1%	25.0%	25.0%
Females	79.3%	66.3%	71.1%	73.6%	79.9%	75.0%	75.0%
Distribution by Age							
Under 65	2.2%	18.9%	9.%	4.7%	8.9%	0.0%	8.2%
65-74	4.3%	6.3%	7.9%	10.4%	3.9%	7.5%	6.3%
75-79	16.3%	10.5%	10.5%	9.4%	10.6%	12.5%	11.4%
Subtotal Under 80	22.8%	35.8%	27.6%	24.5%	23.5%	20.0%	25.9%
80-84	12.0%	20.0%	18.4%	17.9%	20.7%	22.5%	18.5%
85-89	28.3%	25.3%	23.7%	23.6%	24.0%	40.0%	25.9%
90 & older	37.0%	18.9%	30.3%	34.0%	31.8%	17.5%	29.8%
Median Age from grouped data	87.7	83.6	85.8	85.5	86.2	85.9	86.1
Source: Residential Health C	are Facilities (Cost Reports,	2009		•	•	

When the Ontario County Nursing Home population is compared to that of other county operated skilled nursing facilities (see Table 9) the data show that Steuben serves a greater percentage of those over 90 than Ontario, and Ontario County serves a lower percentage of people under the age of 65 than other county operated facilities.

While county operated facilities have traditionally served a higher percentage of younger people than facilities operated by other providers, several factors may be changing this phenomenon. First, the Olmsted Court case ruled that people have the right to be cared for in the least

restrictive and most integrated setting. Second, there are increasing options for younger people with disabilities to receive care and support in the community. Third, as a result of hip and knee replacement surgeries, increasing numbers of middle aged and young elders are using nursing home rehabilitation services for short stays after their surgeries.

Table 9

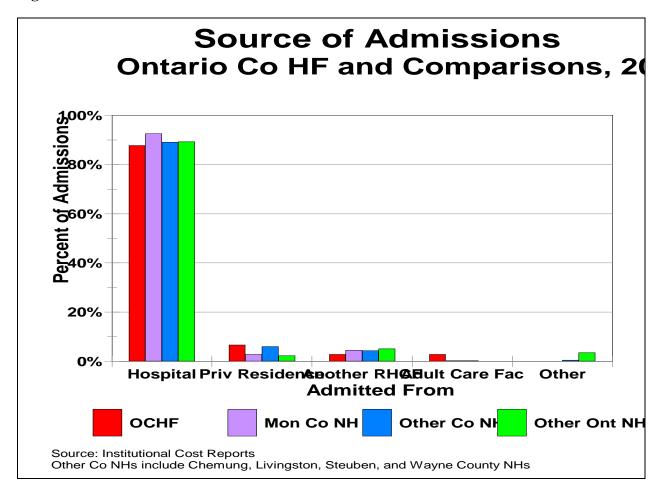
Profile of County Operated Nursing Home Populations									
	Chemung	Livingston	Monroe	Steuben	Wayne	Ontario			
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%			
Distribution by Sex									
Males	24.2%	26.3%	41.2%	17.6%	33.9%	20.7%			
Females	75.8%	73.7%	58.8%	82.4%	66.1%	79.3%			
Distribution by Age									
Under 65	3.7%	8.0%	33.7%	3.9%	12.0%	2.2%			
65-74	8.9%	11.5%	177%	4.9%	8.2%	4.3%			
75-79	11.6%	15.6%	11.0%	7.8%	9.3%	16.3%			
Subtotal Under 80	24.2%	35.1%	62.4%	16.7%	29.5%	22.8%			
80-84	22.1%	21.4%	12.1%	18.6%	14.2%	12.0%			
85-89	23.7%	25.6%	13.4%	22.5%	24.0%	28.3%			
90 & older	30.0%	17.9%	12.1%	42.2%	32.2%	37.0%			
Median Age from grouped data	85.8	83.5	75.0	88.3	86.3	87.7			
Source: Residential Healt	h Care Facilitie	es Cost Report	s, 2009						

Comparison of Admission and Discharge Data

Source of Patients

The Ontario County Health Facility gets a somewhat smaller portion of its admissions from hospitals than do other nursing homes, and a slightly higher portion from private residences. This may be reflective of the fact that most of the other nursing homes in Ontario are hospital-affiliated, resulting in fewer hospital referrals to OCHF. Likewise, most of the hospital-affiliated facilities do not take admissions from the community, producing a role for the County Home to admit community patients that others don't select. Ontario County Health Facility is the only facility in the county that accepted patients from Adult Care Facilities in 2009. (see Figure 10)

Figure 10

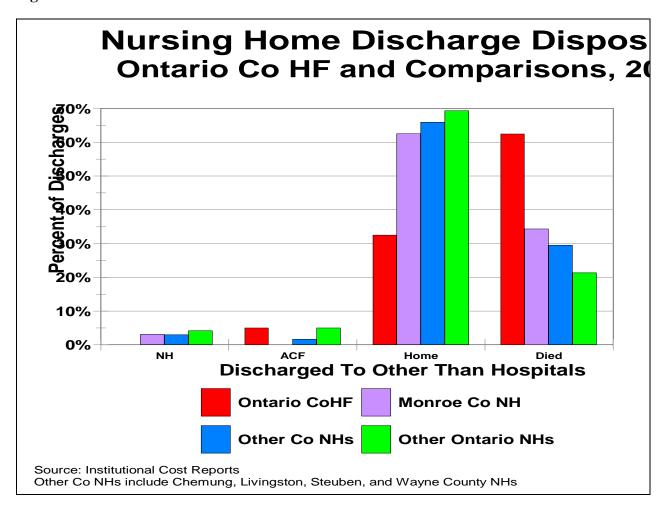


Disposition of Patients

Ontario County Health Facility's rate of discharge to the hospital was more than double that of other nursing homes in the county. According to nursing home leadership, this is the result of hospital-based facilities having more immediate access to physicians who can stabilize a patient and monitor patients more readily in adjoining facilities, and OCHF not have registered nurses on duty 24/7 which limits the possibility of keeping a patient who requires round-the-clock RN supervision or treatment.

OCHF's rate of discharge to home was substantially lower than all of the other facilities considered. This is a reflection of OCHF's lower admission rates for patients requiring post-acute rehabilitation.

Figure 11



Case Mix

The mix of patients with varying types of care needs vary from one facility to another and within a facility over time. This phenomenon is referred to as the case mix. The case mix is calculated based on the percentage of people in five resource utilization group categories, and five resource acuity levels.

Tables 10 and 11 illustrate the change in the case mix of Ontario County Health Facility over time. The data show that from 1986 to 2009 there has been an increase in the percentage of people receiving rehabilitation services and care that is slightly more clinically complex. There has also been a slight shift in the acuity of patients from level A to level B. Nevertheless, the Ontario County Health Facility serves a preponderance of Reduced Physical Function patients, providing care to relatively small numbers of Special, Complex, Behavioral, and Rehabilitation patients. The facility's current overall case mix index is 1.06 which is low. In fact, 27% of patients are in classifications NY State recognizes as low acuity (blue in the table). Patients in

these categories are generally considered to need assisted living level care where that is available. (An individual's unique needs may make SNF placement necessary.)

Table 10

		RUGS A	RUGS Acuity Level								
		A Lowest	В	С	D	E Highest	Total	% Dist			
RUGS Category		Number o	f Patient	S							
Special Care	(S)	2	1				3	3%			
Rehabilitation	(R)	0	0				0	0%			
Clinically Complex	(C)	2	3	1	0		6	6%			
Severe Behavioral	(B)	2	3	1			6	6%			
Reduced Physical	(P)	41	2	28	10	1	82	85%			
Function											
Total		47	9	30	10	1	97	100%			
% Distribution		48%	9%	31%	10%	1%					

Table 11

		RUGS Acuity Level						
		A Lowest	В	С	D	E Highest	Total	% Dist
RUGS Category		Number of Patients						
Special Care	(S)	0	1				1	1%
Rehabilitation	(R)	2	10				12	13%
Clinically Complex	(C)	1	12	2	0	0	15	16%
Severe Behavioral	(B)	0	0	0			0	0%
Reduced Physical Function	(P)	21	4	31	10	2	68	71%
Total		24	27	33	10	2	96	100%
% Distribution		25%	28%	34%	10%	2%		
Low acuity Cases (Index≤0.83)	=							

In interviews with the Administrative staff of the facility, the director of nursing explained that the facility's determinations regarding the types of patients they are able to admit is based on the

patient's needs and the facility's ability to meet those needs. Since the facility lacks RNs on all shifts, this limits the facility's ability to admit patients with clinically complex care needs.

The data in Figure 12 compares the case mix change in all facilities outside of NYC from 2000 to 2005. The data show that the for-profit nursing homes have had the highest case mix, and it has increased over time. The not-for-profit (voluntary) facilities have had case mixes in the mid range that have increased slightly. The public facilities, such as Ontario County, have as a group had the lowest acuity scores, and the case mix index has declined. A survey of county nursing home administrators found that:

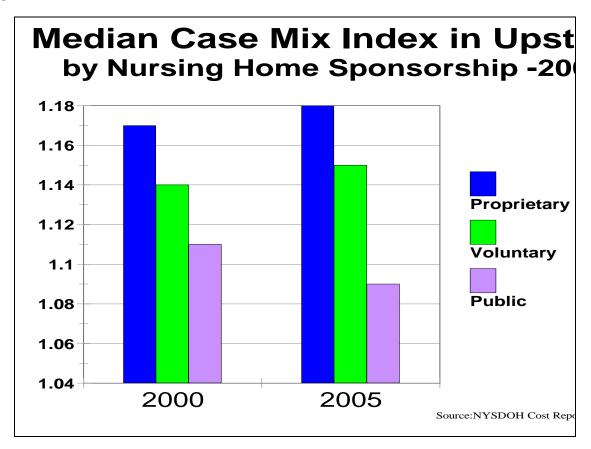
"with few exceptions, county home administrators indicated they would be prefer to higher CMI's than their historical levels. The median ideal county home CMI was 1.15 ompared to the actual 2005 median of 1.09. ... A number of administrators noted the difficulty in attaining significantly higher CMI levels, given the competition in most counties from voluntary (including hospital based facilities) 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, in this case lower acuity, higher behavioral need applicants for admission." ¹³

The Ontario County Health Facility's case-mix was 1.06 in 2009 and 1.02 in the prior reporting period, making it significantly lower than both the actual and preferred case mix index of other upstate county operated facilities.

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¹³ CGR. County Nursing Home Facilities in NYS, op.cit. p. 37.

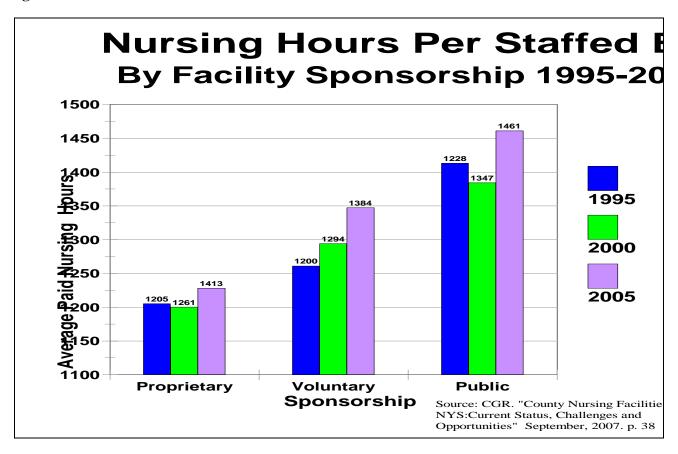
Figure 12



Higher Staffing Levels

Even though public facilities on average have a patient population with lower care needs than proprietary or voluntary homes, county operated nursing homes have consistently had higher average nursing hours per staffed nursing home bed than proprietary or voluntary facilities. (See Figure 13) County homes averaged 17-18% more nursing staff time per bed than employees in for profit homes and 9% to 10% more staff per bed than not-for-profit homes. (Nursing staff time for this purpose includes the time of aides, licensed practical nurses and registered nurses.)

Figure 13



Comparison of the Utilization of the Ontario County Health Facility with Other Skilled Nursing Homes in Ontario County and with Other County Homes in the Region

Table 12 compares the most recent data for county operated nursing homes in the FLHSA Region. The data suggest that new and renovated facilities generally operated at 97-98% versus 94-95% for those which are older facilities. Two other observations from these data are the Ontario County Health Facility, unlike a number of the other facilities, has no days paid by the Veteran's administration, and its percentage of Medicaid days are on the low end of the percentage of Medicaid days at all of the county operated facilities in this region, while its percentage of private pay and insurance day are higher than the others.

¹⁴ Steuben did not move into the new facility until 2009, so Chemung, Ontario and Steuben are considered older facilities for this purpose

Table 12: Comparison of County Operated Facilities Utilization and Payer Mix in the Finger Lakes Region 2009

	Chemung Co Facility	Livingston Co Facility	Monroe Co Facility	Steuben Co Facility	Wayne Co Facility	Ontario Co HF
Certified Medicare Bed Capacity	200	266	566	105	190	98
Medicaid Days	88.7%	80.4%	88.1%	76.5%	77.9%	76.4%
Medicare Days	5.6%	9.5%	6.1%	12.15	5.6%	8.7%
Blue Cross Days	0.4%	.3%	.1%	.4%	.2%	
Other Private Insurance Days		.4%	1.4%		.4%	
Private Pay Patient Days	4.6%	9.2%	3.5%	10.9%	12.8%	14.8%
Veterans Administration Days	1.1%	.0%	.8%		.7%	
Total Patient Days	69,140	95,693	201,274	36,061	67,868	33,622
Percent Reserved Bed Days Included above	5%	1%	1%	2%	1%	<1%
Possible Patient Days (Beds * 365)	73,000	97,090	206,590	38,325	69,350	35,770
Occupancy Rate (Pt Days/Bed Days)	94.7%	98.6%	97.4%	94.1%	97.9%	94.0%
Source: Residential Health Care Facilities Cost Reports						

Table 13 compares Ontario County Nursing Home to the other facilities in Ontario County. These data indicate that Geneva South which does the most rehabilitation has the lowest occupancy rate. This is due to in part to higher rates of turnover for rehabilitation beds, and may also reflect a facility's preference to use a certain percentage of beds for patients needing rehabilitation to increase the case mix index. (Nevertheless, even nursing homes that do rehabilitation usually try to achieve 95% occupancy rates vs. 97% without rehabilitation.) Since case mix was introduced in NYS in 1986, the higher a facility's case mix, the higher its reimbursement from Medicaid. The data also suggest that two of the six facilities in the county appear to be limiting their Medicaid days. Decisions of operators to focus on rehabilitation or limit Medicaid admissions have direct bearing on potential barriers to local options that might be available for patients traditionally cared for by Ontario County Health Facility.

Table 13: Comparison of Skilled Nursing Facilities Utilization and Payer Mix in Ontario County

	Ontario Co HF	Ontario Geneva South	Ontario Geneva North	Ontario Clifton Springs	Ontario MM Ewing	Ontario Elm Manor
	RHCF	RHCF	RHCF	RHCF	RHCF	RHCF
Certified Medicare Bed Capacity	98	103	80	100	188	46
Medicaid Days	76.4%	60.6%	80.0%	56.1%	73.9%	70.5%
Medicare Days	8.7%	24.2%	2.6%	12.7%	8.1%	19.0%
Blue Cross Days		1.4%		0.4%		.1%
Other Private Insurance Days		.3%	0.1%	0.7%	1.1%	
Private Pay Patient Days	14.8%	10.7%	14.8%	30.1%	17.0%	5.1%
Veterans Administration Days			0.2%			
Other Days		2.9%	2.2%			5.3%
Total Days	33,622	32,671	28,110	34,803	66,338	15,690
Percent Reserved Bed Days Included above	0.4%	0.2%	0.3%	0.4%	0.4%	0.4%
Possible Patient Days (Beds * 365)	35,770	37,595	29,200	36,500	68,620	167,90
Occupancy Rate (Pt Days/Bed Days)	94.0%	86.9%	96.3%	95.4%	96.7%	93.4%
Source: Residential Health Care Facilities Cost Reports						

Summary of How Ontario County Health Facility Is Used Compared to Peers

In relation to other Ontario County Nursing Homes the Ontario County Health Facility generally serves:

- A higher percentage of the oldest elderly;
- The lowest percentage of people under the age of 75; which is consistent with its not doing as much post-acute rehabilitation;
- A higher percentage of women, which is consistent with the relative age of the population and providing less post-acute rehabilitation;
- The highest percentage of admissions from adult care facilities and one of the higher percentages of admissions from home;

The facility also has:

 The highest percentage of people discharged to hospitals; double the rate of other facilities, which reflects the facilities not being hospital based, and its lack of RN coverage 24 hours a day, seven days a week;

- The lowest rate of discharges to home, which is consistent with providing less short term rehabilitation services; and admitting patients from home situations which were no longer adequate to meet the patients' needs.
- Relatively low turnover rates and longer lengths of stay due to the emphasis on long term care not short term rehabilitation.
- One of the highest percentages of Medicaid paid days among Ontario County facilities.

Compared to other county operated facilities Ontario County Health facility has:

- one of the lowest percentage of Medicaid paid days;
- no paid veterans days; and
- an occupancy rate comparable to other older facilities that have not been modernized or replaced.

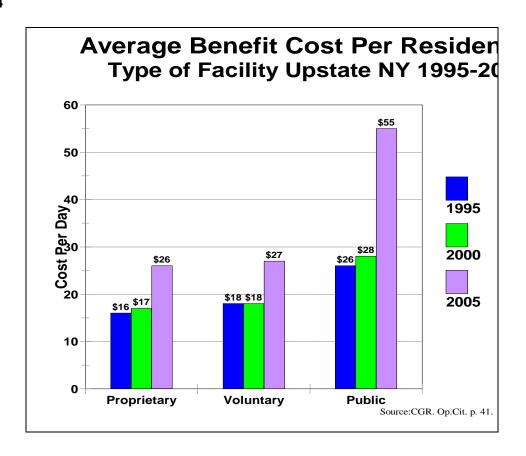
Chapter 7

Finances

Salary and Benefits Drive Operating Costs

"In 2005 the average cost of salaries plus benefits in county operated nursing homes was more than \$25 higher per 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. The major contributor to the differential costs between types of facilities is the much higher benefits paid by public facilities." Most of the rapid increase that occurred after 2000 was due to substantial increases in mandated pension/retirement costs passed on to counties, and to increases in the cost of health insurance. While the cost of health insurance would be comparable for facilities in a given geographic area, facilities that operate without union contracts would have greater latitude to alter the benefit package than organizations with contracts.

Figure 14



¹⁵ CGR. Op.Cit. p. 41.

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Case Mix and Payer Mix Drive Revenue

As with most nursing homes, the majority of patient days (76% at the Ontario County Health Facility) are paid by Medicaid. A larger portion of OCHF patients are Medicaid dependent from admission than other facilities. (20% of new admissions versus 6% at other county operated nursing homes (excluding Monroe) and 8% at other skilled facilities in Ontario County.) ¹⁶

It appears the Ontario Health Facility admits a larger portion of Medicaid residents and a lower portion of private pay residents than the other nursing homes in the county or peer facilities in other counties.

Trends in Net Surplus/Deficit Over Time

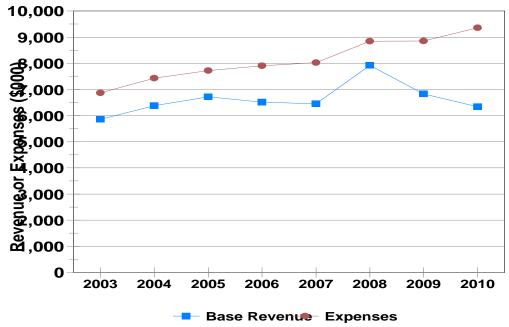
- Costs of Operations have increased by approximately 36% in the past 8 years, or about 4.5% per year compounded. As seen later, in Figures 19 and 20, a disproportionate share of that growth has been in personnel costs.
- On the other hand, patient revenue has been essentially static, with the exception of CY 2008, increasing only 9% during that period.
- Figure 3 showed that patient days have declined from levels in the mid-decade, although 2010 was higher than 2009;
- Revenue per patient day has increased by 18%, despite an increase in the proportion covered by Medicaid (see Figure 4) and Figure 15 below.
- Operating Revenue has been less than Operating Cost throughout the decade, and the deficits are increasing

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¹⁶ In what appears to FLHSA to be a coding idiosyncrasy at the Ontario facility, nearly 70% of patients are recorded as Medicare/Private pay on admission, a rate one-third larger than other Ontario County nursing homes. In contrast, only 7.5% of patients are recorded as Private Pay only, only one-fifth as much as other Ontario facilities. Conversations with management suggest that Ontario County records all people who are Medicare eligible as having a secondary private payer if there is no payer established.

Figure 15

Finance Results From Oper Ontario Co Health Facility, 2003

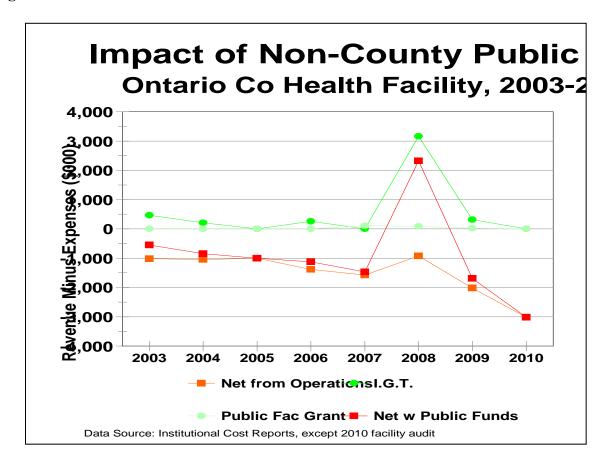


Data Source: Institutional Cost Reports, except 2010 from facility audit.

- Offsetting the operating deficit are two streams of funds: non-County public funds, and
 County funds. The non-County funds include Intergovernmental Transfers, or I.G.T.
 payments. As noted below, this funding stream is sometimes available and sometimes it is
 not. Although meant to recognize the exceptional expenses of public facilities, 2008 was
 the only year in which provided sufficient funds to convert the deficit to a surplus.
- While about 45% of public nursing homes in NYS reported a bottom line surplus with IGT in 2000, by 2005, only 3 county homes in NY experienced a surplus rather than a deficit with IGT factored in and by 2010 all showed county operated facilities reported a loss. ¹⁷
- A second non-county funding stream, again meant to recognize the unique experience of county nursing homes, is Public Facility grant program of the state. Although meant to provide a relatively steady subsidy to county NH operation, the Public Facility grant provided \$756,000 in 2008 and \$391,000 in 2009, but was zero in 2010.
- Even factoring in the non-County funds, the OCHF has seen a deficit in every year this decade except 2008. The deficit has generally increased over time as illustrated in Figure 16 below.

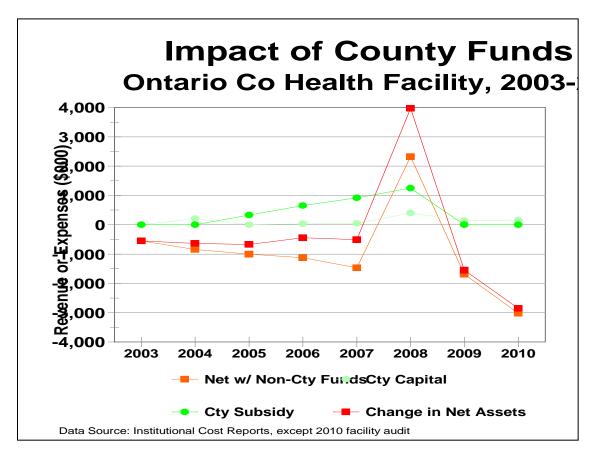
¹⁷ Personal conversation of Lynn Varricchio's with the Administrator of Monroe Community Hospital May 2011.

Figure 16



• The other funding source available to the facility is funding from Ontario County. Some of that funding comes in the form of infusions for capital projects. The other county funding, though, is outright subsidy to shore up the facility bottom line. The graph below shows that, even though the County has been subsidizing the facility with increasing amounts, the facility has experienced a decrease in its Net Assets in each year this decade but 2008. Even with the \$4 million infusion to the bottom line in 2008, net assets have declined by \$2.7 million since 2003, from \$4.2 million to \$1.5 million

Figure 17



Financial Structural Issues

Low CMI/Low Reimbursement

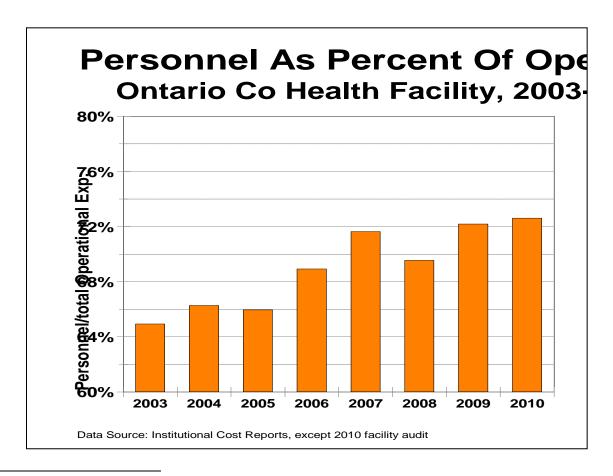
• As noted in prior sections of this report, the OCHF has a case mix index (CMI), nominally measuring the complexity of care needed by the facility residents, which is lower than many other county nursing homes, and substantially lower than other nursing homes in Ontario County. Because one of the variables in the Medicaid reimbursement formula is the case mix index, a low case mix index results in the reimbursement rate being low. While some nursing homes can have satisfactory financial results with low complexity

cases, if they staff accordingly, such staffing patterns are not usually observed in county homes. As previously shown in Figure 13, county operated facilities have higher nursing staff to bed ratios than proprietary and voluntary homes. Moreover, they have less flexibility in adjusting staffing because county operated facilities are usually locked into county contracts. Moreover, based on data from the advocacy group County Nursing Facilities of New York, cited by the Center for Governmental Research 18, county homes with low CMI nonetheless tend to care for patients with many clinical/(behavioral) problems not adequately captured in the case mix system because of the type of monitoring and redirecting required, which results in concentrated staffing, without a corresponding reimbursement factor in the case mix index.

High and Rising Personnel Costs

 Personnel costs are by far the largest operating expense nursing homes. As seen in Figure 18, at OCHF those costs are rising faster than other cost components, resulting in an increasing portion of cost due to payroll and benefits.

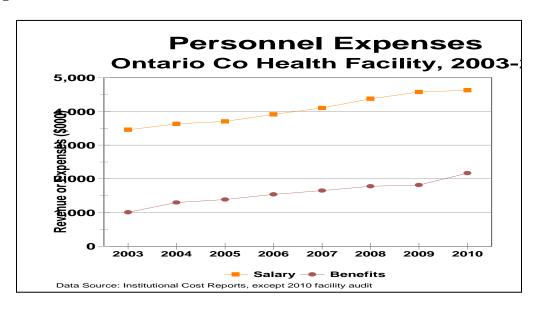
Figure 18



¹⁸ Center for Governmental Research, "County Nursing Facilities in New York State, Current Status, Challenges and Opportunities," September 2007, Rochester, NY.

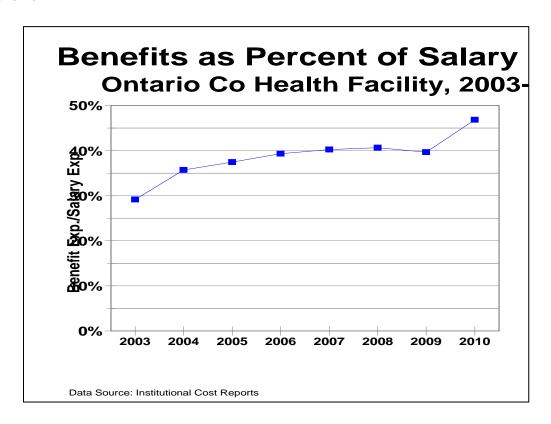
Breaking these costs down further, data show that both payroll and benefit costs are increasing.

Figure 19



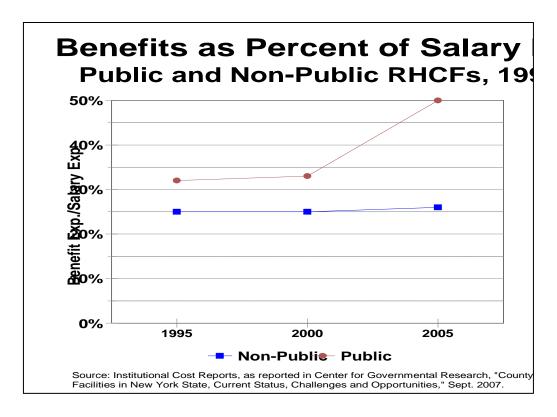
But the benefit to payroll ratio is increasing rapidly because of the 2000 decision that pensions must be fully funded and health insurance costs are increasing.

Figure 20



Benefits to payroll equal a bit over 25% in 2005 among proprietary and voluntary nursing homes in NY. Benefits have always been higher than that among public facilities, but jumped in the first half of this decade to a full 50% of payroll. As noted previously, since 2000 organizations have had to fully fund pensions, and health insurance premiums have risen. An additional driver of the high benefit costs is the disability policy which pays for six months at full pay according to the Administrator for the Ontario County Health Facility ¹⁹. Thus, while OCHF is not alone in having high benefit costs, such costs are a major structural element contributing to the ongoing deficits of the facility.

Figure 21



IGT Prospects

• Intergovernmental Transfers (IGT) have been in use since the 1990s and are meant to help offset the relatively higher costs of operating a county nursing home (they are not available to proprietary or voluntary homes). Late in the 1990s, the IGT mechanism was sharply curtailed in response to abuses in some states which diverted the IGT funds for use in non-health projects. It still exists, with restrictions, but does not provide the level of funding of prior times.

¹⁹ The actual cost of disability benefit in days of service lost to the facility has been requested by not received to date.

- As a county/federal program, the IGT mechanism has been relatively unscathed in the Medicaid Redesign process. Yet, the program requires a 50% county match, which often is difficult given constrained county finances.
- Per the NYS Association of Counties²⁰, the Federal government has pre-approved a substantial IGT level that will help improve county nursing home facility finances. The delay in implementing the "rebasing" reimbursement methodology (see below) prohibits the IGT program from moving forward because no official rate has been established. With the settlement of the nursing home industry suit against the state over the rebasing program (see below), the state is mandated to initiate new rates by July 1, 2011 and repay adjusted rates retroactively.
- Thus, it is likely that Intergovernmental Transfers will return as a part of the funding mechanism for county homes. However, it is unlikely they will again be of a magnitude that will return county homes to profitability.

Other Factors Expected to Affect Future Reimbursement

• Next Steps:

- o The NYS Department of Health has circulated draft Medicaid reimbursement rates by facility. For the Ontario County Health Facility, Medicaid rates would rise from approximately \$155 today to an adjusted rate \$169 when the rebasing methodology goes into effect.
- o The rebasing methodology was agreed to nearly two years ago, but has not yet been implemented. The nursing home industry took the state to court, asserting that the existing reimbursement method (based on 1983 costs, trended forward) did not provide adequate reimbursement, contrary to federal law. In April 2011, a settlement was reached on that suit, under which NYS will implement the rebased rates by July 1, 2011, including retroactive amounts.
- o Bonadio & Co, in its audit of the CY 2010 financials of the county home, estimates the new rates would provide approximately \$375,000 in additional revenue for 2010 and \$433,000 in 2009. Thus, while a substantial improvement, the new rates would not erase the annual operating deficit the home has experienced in the last decade.
- Regional Rates While the rebasing methodology is being put in place, the state had also proposed a system of region-wide rates; that proposal would likely have been detrimental to the county homes, which typically have higher costs than the average. That proposal has now been withdrawn, however, in favor of a proposal for statewide rates.

²⁰ NYS Association of Counties, 2011 Legislative Conference Resolution #02, accessed on May 10, 2011 at http://www.nysac.org/legislative-action/2011-Leg-Conf-Mediciad-reso2.php.

• <u>Statewide Rates</u> – A new reimbursement methodology now being circulated would provide for rates based on statewide averages. Individuals privy to this proposal indicate it would include a facility-specific wage equalization factor. This proposal would likely be favorable to upstate facilities, in that New York City nursing homes tend to have higher costs. It would also be favorable to county-operated homes, which tend to have higher labor costs. Unfortunately, there are few specifics available at this time.

Chapter 8

Unique Aspects and Challenges of County Operated Facilities

To some extent county homes have been unfairly stigmatized by their historical association with the poor house. In this nine county area, there are six county operated nursing homes. Three are new facilities opened since 2005. One Monroe Community Hospital is associated with the University of Rochester Medical Center and is one of the premier geriatric teaching nursing homes in the United States.

County operated facilities are by definition accountable to a board of supervisors or a county legislature, with the exception of a few in NYS that are operated by public benefit corporations.²¹ As such they may require procedures for bidding contracts, and barriers like county hiring freezes that make them less nimble than facilities with other types of ownership.

Typically the strengths of county operated facilities are:

- They admit hard to place people in need of care; (people without final payer determined, people from home who may not have resources to go to an assisted living program; people with care needs, characteristics or behaviors that other facilities elect not to admit.),
- They have low staff turnover;
- They provide higher wages and benefits particularly for para-professional staff (aides, dietary, housekeeping, maintenance);
- Staff enjoy the protection and benefits of a union;
- Facilities are responsive to the needs of the residents because there is an accountability to elected officials;
- The jobs provided at a county operated facility remain in the county, and the reimbursement paid for the care provided largely stays in the county for the services and goods purchased;
- Facilities have financial support from the counties, and inter-governmental transfer payments.

Challenges that are unique to county operated facilities:

- In this region, county facilities all have unions, while the majority of other nursing home employees are not represented by unions;
- While government employee unions are to be credited for obtaining wages and benefits more consistent with the needs of supporting a family, there are benefit costs associated with union operated facilities. As previously shown in Figure 18, the benefits cost to

²¹ CGR. County Facilities in NYS: Current Status, Challenges and Opportunities. September, 2007. P. 17.

- salary ratio for public to facilities rose to 50% by 2005 compared to non-public nursing homes whose ratio held steady at about 25%.
- Because of the manner in which counties manage union contract negotiations, the facility administrators may have no role in the terms of the contract, even though the administrator is responsible for trying to balance the facility's budget;
- Because county operated facilities have historically admitted the "hard to serve", the mix
 of patients referred to county facilities results in an adverse selection process that
 disadvantages the case mix and therefore the reimbursement that counties receive for the
 patients they care for. In other words, for structural reasons the cost of providing care is
 greater than the reimbursement received for the care.
- Because county facilities are accountable to an elected body there can be differences of opinion whether county facilities should: 1) compete for patients that can be served by the "private sector;" 2) advertise; 3) hire as the administrator sees fit; 4) make capital improvements.

Specific challenges Ontario County experiences which weakens its ability to "compete" in the market with other facilities:

- The civil service contract provides 6 month disability coverage at full pay, with the result that management of the OCHF reported that 24 employees making use of this benefit on 36 occasions cost the county \$191,799 and 1438days of service lost over the last 3 years. Lack of bench strength:
 - o The facility has no assistant administrator, no assistant director of nursing, and one physician.
 - While the physician comes to the facility once a week and knows the patients well according to the Director of Nursing, his availability is limited;
 - O Should something happening to the director of nursing there are not sufficient RNs to readily fill the position and meet the RN staffing needs for the facility.
 - o RN coverage on evening and night shifts limits the ability of the facility to admit people who require 24/7 skilled nursing supervision/treatments.

• Limited Use of Technology

- The director of nurses does not have care tracker software that can allow her to electronically receive report on patient status changes when she is out of the building;
- o There is no use of electronic medical records to facilitate transfer of patients from hospitals, home care, or a physician's office;
- o There is no electronic health monitoring to allow the physician to make an assessment of the patient from his office, rather than sending patients to the hospital.
- o The facility is just beginning to bring internet technology to the facility, and it is unclear when it will be accessible to residents. At least 50% of seniors currently

use computers and this is expected to increase as "boomers" begin to need nursing home care.

• Lack of Advertising

- O Signage for the facility is inadequate. One needs to know where the facility is to find it:
- o There is no road that leads directly to the nursing home;
- o There is no marketing of the facility;
- o Many people in the county are unaware the facility exists according to administrative staff interviewed;
- There are minimal ads run for personnel, most referrals come from current staff; (An ad for an RN that was run produced 1 response.)
- o Employees at hospital-based facilities are aware of other opportunities for health care employment within the hospital system;

Appendix 1

Admissions and Discharges To Nursing Homes in the FLHSA Region

Comparison of Sources of Admission and Discharges Across County Operated Nursing Homes in Finger Lakes Region

	Chemung Co NH	Livingston Co NH	Monroe Co NH	Steuben Co NH	Wayne Co NH	Ontario Co HF	
	RHCF	RHCF	RHCF	RHCF	RHCF	RHCF	
Census Dec 31 Last Report Period (Including Bed Reservations)	190	266	554	93	187	91	
Source of Admissions							
from Hospital	85.9%	89.9%	92.5%	90.5%	88.4%	87.7%	
from Private Residence	5.4%	6.1%	2.8%	5.9%	6.3%	6.6%	
from Another RHCF	8.7%	2.8%	4.5%	3.0%	4.9%	2.8%	
from Adult Care Facility	0.0%	0.0%	0.2%	0.6%	0.4%	2.8%	
Other	0.0%	1.2%	0.0%	0.0%	0.0%	0.0%	
Total Admissions & Transfers	149	426	493	169	285	106	
Total Patients Under Care During Reporting Period	339	692	1,047	262	472	197	
Discharges to							
to Hospital	0.0%	24.7%	29.8%	30.0%	27.7%	61.9%	
to Private Residence	22.1%	54.2%	43.9%	47.5%	50.2%	12.4%	
to Another RHCF	3.4%	0.9%	2.2%	6.9%	0.7%	0.0%	
to Adult Care Facility	0.0%	2.8%	0.0%	0.0%	0.0%	1.9%	
Deaths (In-house)	37.6%	17.4%	24.1%	15.6%	21.5%	23.8%	
Total Discharges & Transfers	149	430	510	160	289	105	
Census Midnight of Dec 31, (Including Bed Reservations)	190	262	537	102	183	92	
Turnover Ratio (patients cared for during year / bed)	1.7	2.6	1.8	2.5	2.5	2.0	
Source: Residential Health Care Facilities Cost Reports							

Comparison of Admission and Discharge Data to Other Skilled Facilities in Ontario County

	Ontario Co HF	Ontario Geneva South	Ontario Geneva North	Ontario Clifton Springs	Ontario MM Ewing	Ontario Elm Manor		
	RHCF	RHCF	RHCF	RHCF	RHCF	RHCF		
Census Dec 31 Last Reporting Period (Including Bed Reservations)	91	87	71	98	175	40		
Source of Admissions								
from Hospital	87.7%	97.0%	77.4%	16.7%	72.1%	99.6%		
from Private Residence	6.6%	2.6%	6.5%	83.3%	13.2%	0.0%		
from Another RHCF	2.8%	0.5%	16.1%	0.0%	14.7%	0.4%		
from Adult Care Facility	2.8%	0.0%	0.0%	0.0%	0.0%	0.0%		
Other	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%		
Total Admissions and Transfers	106	428	62	255	335	74		
Total Patients Under Care During Reporting Period	197	515	133	353	510	114		
Discharges to								
to Hospital	61.9%	27.6%	29.8%	0.0%	27.0%	19.6%		
to Private Residence	12.4%	55.0%	21.1%	83.3%	27.0%	60.8%		
to Another RHCF	0.0%	4.3%	7.0%	16.7%	7.9%	1.6%		
to Adult Care Facility	1.9%	5.5%	5.3%	0.0%	4.8%	0.4%		
Deaths (In-house)	23.8%	7.6%	36.8%	0.0%	33.3%	17.6%		
Total Discharges and Transfers	105	420	57	255	331	74		
Census Midnight of Dec 31, 2009 (Including Bed Reservations)	92	95	76	98	179	40		
Turnover Ratio(pts cared for during year/bed)	2.0	5.0	1.7	3.5	2.7	2.5		
Source: Residential Health Care Facility Cost Reports, 2009								

Appendix 2

State Regulations Related to Closure