



Essex County

Horace Nye Nursing Home Overview Report

Prepared for: Horace Nye Committee
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Introduction

The purpose of this report is to provide the Horace Nye Committee a sense of where we are as it relates to our current situation related to the operation of the Horace Nye home. My concern is that although I have not publicly mentioned all of the items that I have been considering the perception may be that I have not been preparing for the steps which may be necessary. Please be assured that is not the case, both Linda Wolf, myself, Chairman Douglas, Vice Chair Politi and Finance Chair Morency have been discussing how we are to address our needs as we move forward with any plans related to Horace Nye.

The purpose of this report is to examine the current status of the Horace Nye Nursing Home and how that plays into what we deliver as a budget to the taxpayers. I have always understood this is an emotional issue for the public. I also would hope that I would be able to dispel the idea that I personally do not want to have a county run nursing home.

It makes no difference to me if we choose to stay in the nursing home business or if we choose to go in another direction. The reality is the nursing home is not a mandated service and has costs that are increasing substantially each year. Ultimately if the decision is to remain in the Nursing home business, then it will necessitate we cover the cost. I have always maintained we can run a Nursing home, but we can't run a nursing home with a \$2.00 per thousand tax rate.

Part 1 - Public vs. Private

In order to understand where we are in terms of our nursing home it is necessary to review a number of factors which impact any nursing home operation. Nursing homes are defined based upon the following;

- ✓ County Nursing Homes or Public Homes.
- ✓ Proprietary Nursing Homes which are those run as Non-Profit.

- ✓ Voluntary facilities which are those run as private for profit businesses.

Much of the information related to the operation of Nursing Homes within New York has been taken from a report prepared by the Centers for Government Research¹ (www.cgr.org), in September of 2007. Essex County was a participating county within this report.

It is noted within this report that county nursing facilities provide just over 10% of all nursing home beds in the state, and 14% of all non-NYC beds. It is also noted that of these beds, *a much higher proportion of care for those considered hard to place and often with limited ability to pay for their services*, are covered by county facilities.

The report goes on to say, *county nursing homes consistently operate as a safety net, admitting residents that other facilities are reluctant or unwilling to admit- behavioral, bariatric patients, those with Alzheimer's disease, adult protective cases, crisis admissions, etc. - regardless of their ability to pay.*

The report includes the following examples which demonstrate to what extent county homes serve disproportionate numbers of “safety net, hard to place” residents;

- ✓ *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.*

¹County 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, www.cgr.org

- ✓ *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.*

Demographic Changes

The CGR Report points out the following; 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.

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 used², the numbers of people in *NYS 75 and older in 2025 may range from about 1.4 million to as many as 1.7 million—up from about 1.17 million currently.*

Even with these increased projections related to an aging population the report points out that older people today tend to be in better health, have fewer disabling conditions and less functional loss, and have different attitudes and preferences regarding their health care services. The feeling is much of the increased demand for nursing home beds in future years may be siphoned off into other, non-institutional care alternatives.

On the other hand, as the report points out, 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.³

The Commission on Health Care Facilities in the 21st Century (the “Berger Commission”)⁴ emphasized in its report “*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*

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

³Commission 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.

⁴Commission on Health Care Facilities, A Plan to Stabilize and Strengthen New York's Health Care System: Final Report, op cit, p. 1.

growing problem of afford ability.”

The Berger Commission made a number of recommendations to “rightsized and reconfigured” hospitals and Nursing Homes within the State. Included within these recommendations was to downsize Essex County’s home from 100 beds to 80 beds. These recommendations are predicated on the idea that Nursing homes should diversify their services to focus on lower levels of “non-institutional services.” The Berger Commission points out that 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.

In my view, the flaw contained within the concept that more private pay and third party insured payers will be in the system. In a rural County such as Essex the pool of elderly having such financial resources is significantly reduced. The median income levels in Essex County are so low as to suggest that our elderly simply may not be able to afford alternative care plans. Ultimately this may lead to an increased need for safety net patients which our county home may be the only alternative.

Financial Issues

The CGR Report points out that of the county homes outside NYC, an average of more than \$2.5 million per home per year is being paid for by the taxpayers. Those statistics were based upon only 28 of the homes reporting, and that if all of the homes reported, including the County homes within NYC then the number would be considerably higher.

The prohibitive costs associated with running a county nursing home is clearly demonstrated based upon the CGR Report that showed *as of 2005*;

- ✓ *214 facilities are in Proprietary for profit hands,*
- ✓ *212 facilities are in Voluntary non-profit hands and*
- ✓ *only 44 are in Public hands. By 2007 the number in Public hands has dropped*

to 40.

- ✓ The burden is particularly striking for us, when you consider only *5 of the 17 counties with populations under 55,000, operate their own nursing home.*

The CGR Report points out a number of perceived limitations and challenges which they were able to determine based upon the survey and verbal discussion which included the following;

- ✓ 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 plants 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;
- ✓ Lack of flexibility in management 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.

Understanding Payment Sources and Admissions

In order to understand the problems associated with running a county owned nursing home it is necessary to understand the different types of admissions and how such admissions relate to the payment sources. Additionally, within those admissions it is important to understand from a financial standpoint what defines a desirable resident.

In no way am I trying to diminish the importance of any single individual's needs or their rights to care, but it is critical to understand why private and non-profit nursing homes can make money while public facilities continue to operate at a loss. Payment sources and the admissions process plays a part in contributing to a public homes operating losses but it is by no means the sole reason. I will cover those additional aspects of the operating losses later, but for this section a desirable resident is based in part on the following items;

- ✓ Private Pay Admissions - Ultimately these are the residents that all nursing homes want. For Essex County the Medicaid reimbursement rate is approximately \$148.00 per day. Our private pay rate is set at \$257.50. Our private pay rate is about mid range of other public homes. Clearly private pay represents the ultimate form of revenue to the facility that can not be recovered from Medicaid residents.

- ✓ Direct Admissions from a hospital - Medicare and/or Private Insurance Eligible. These residents represent a desirable admission based upon the favorable reimbursement rates under their Medicare coverage or their Private Insurance coverage. In order to be eligible for Medicare coverage the individual must meet the following;
 - They must have been hospitalized for at least 3 days.
 - They must enter the nursing home within 30 days of the hospitalization.
 - Only the first 20 days are 100% covered; then there is a daily deductible.
 - There's a 100-day maximum related to any one hospitalization and diagnosis.
 - They must be making regular progress as documented by medical professionals. If progress toward independence is no longer occurring, insurance coverage ends

It has been shown that these residents with the higher reimbursement rates for the first 100 days can be the difference between profit or loss if the resident should need to continue as a Medicaid resident, or the additional revenue from these types of residents works to offset those other residents who are Medicaid only.

- ✓ Medicaid Admissions - This is the least desirable class of resident from a purely financial standpoint. The CGR Report points out that, *in order of value to nursing homes in terms of covering actual costs of services provided, Medicaid provides the lowest monetary 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*⁵. 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.

The report goes on to say that these figures 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%.*

- ✓ Short term residents vs long term residents - The CGR report points out that private and non-profit homes have cornered 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 county facilities had been residents for three years or more—more than twice the rates of about 7% in both voluntary and proprietary homes.*

⁵NYAHSAs, “Financial Distress and Closures: The Uncertain Fate of New York’s Nursing Homes,” NYAHSAs 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.

The short term residents provide a home with the ability to replace them more often with revenue producing private pays or Medicare eligible residents. County homes typically serve fewer new residents, and serve them much longer. Additionally county homes serve the majority of Medicaid only residents which represent an operating loss from day one.

Understanding Case Mix and Resource Utilization Groups (RUGs)

As defined within the CGR report , the reimbursement methodology which has now been in place for a number of years in NYS is *based on Resource Utilization Groups (RUGs)*. 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.

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. The CMI gap between county and other types of nursing homes was greater in 2005 than it had been in 2000.*

With significantly lower county CMI scores, compared to those of other facilities, and apparently higher proportions of “behavioral” residents, county homes are typically disadvantaged in comparison with their counterparts in two significant ways:

- ✓ They receive generally lower levels of reimbursement, yet
- ✓ 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.

In general terms, county homes tend to get younger residents who are not as sick, therefore the reimbursement is lower, these younger residents stay longer thereby eliminating the bed from a possible private or Medicare paying resident. Additionally these residents tend to require higher staff time and attention, leading to higher costs.

The CGR report points out that 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.

Part 2 - Horace Nye Operational Review

Up to this point within the report I have concentrated on the problems associated with doing business as a public nursing home facility versus private or non-profit home. It seems clear given the current issues associated with public nursing homes that *even if our home was operating at its ultimate efficiency it would still require we support its cost via the tax levy.*

This begs the question of how close are we to operating our facility at its maximum productivity. Inherent within such discussion are several external factors, including our rural area,, the age and condition of our building and infrastructure , and most importantly the “mission of the home” which is to admit residents of Essex County without regard for their ability to pay.

Within the context of said mission, it is interesting to note that private nursing homes often run below capacity. In other words they have empty beds, *it seems from the perspective of a private nursing home that it would be preferable to leave a bed empty than to fill it with a Medicaid only patient and lose money from day one.* Our home does not take that approach, the need of the resident is considered without regard for profit or loss.

However, having said this it is still relevant that we recognize our operational efficiencies and deficiencies in comparison to other public nursing homes, who share the same mission. In 2004, Essex County contracted with Rotenberg & Co., Certified Public Accounts to conduct a complete review of the status of the Horace Nye operations. They compared our operations with the following facilities;

- ✓ Orleans County with 137 Beds
- ✓ Delaware County with 199 Beds
- ✓ Genesee County with 160 Beds
- ✓ Ontario County with 98 Beds
- ✓ Livingston County at Geneseo with 124 Beds
- ✓ Livingston County at Mt. Morris with 142 Beds

The Rotenberg Report

I preface this section with the clarification that the Rotenberg report was intended as a management document to be used to access our operations and to maximize our potential revenues and to mitigate our expenses. It represented a snap shot of the operation based upon the 2003/2004 time frame. *Ultimately, it was a report card on our fiscal health and unfortunately we received a failing grade.* That failure was based upon a comparison to public homes of similar size and characteristics, it was not a comparison based on private or non-profit homes.

I do want to make it clear that this was not an indictment of quality of care, but rather is a critique of financial status. A recommendation that I will be making to the Board, as it relates to the Rotenberg Report, is to consider their further engagement as a means of updating prior recommendations. In other words, have our operations gotten better or worse since the 2004 report.

Fiscal Services

At the time of the study the fiscal overview consisted of a comptroller and three clerical full time equivalent (FTE) or a total of four FTE's. It was determined that Horace Nye had one more FTE than the average of the other public homes used as comparisons. Currently our Fiscal Services budget includes four FTE's, which represented in 2009, a total labor cost of \$142,586.00.

The 2004 report noted that the business office functions *were "cumbersome, inefficient and labor-intensive"*. The report noted that too many manual systems were being performed and that automation was underutilized. It was further noted that it is "taking 6 to 10 months to obtain Medicaid approval for new admissions (a process which usually takes 1 to 3 months)" thereby generating a greater loss of resident contributions.

We currently have in place a computer billing system which replaced the prior manual systems of 2004, but how that implementation has been reflected in the Medicaid process should be fully explored.

Administrative

Under the Administrative section, it was noted that intra-county expenses make up the largest category of expenses, representing those costs other departments charge back to the home for services. Examples include payroll, purchasing, building maintenance etc.

The reason these are charged back is to accurately reflect what it costs to run the home, and to maximize federal and state reimbursements. The report suggested that these charges may be too high to justify the return under the existing Medicaid reimbursement system.

In 2004, \$311,036.00 in cost allocations were charged back to the home. In 2005, the allocations were reduced to \$257,281.00, but in 2009, the costs rose to \$286,766.00. Based upon these numbers it would appear that some progress has been made here.

Laundry and Linen

The facility had 5.5 FTE's in the department in 2003, which was significantly higher than the comparison facilities which averaged 2.25 FTE's. The facility currently has 3.36 FTE's which represented in 2009 a total labor cost of \$81,097.00. This represents approximately one FTE more than the average of the other facilities in the 2004 report. *It is important to note that our facility contracts out its linen service as it did in 2004, with only the residents personal laundry processed in-house.*

Housekeeping

In 2004, the report noted that the FTE's were significantly higher than the comparison facilities, and went on to express that there is *"nothing apparently unique about this facility to account for the high number of housekeeping personnel"*. The FTE's in the 2004 were listed as 11.60, and the report recommended a reduction of 2 FTE's. As of 2009, the housekeeping stands at 9.7 FTE's and the recommendation to reduce the staff by 2 has been accomplished.

Food Service

In 2004, the Food Service operation was a combination of in-house and outside contracted services. It was noted that the total cost per day was significantly higher than any of the

comparison facilities. It was pointed out that Horace Nye FTE's were higher than Ontario County with 98 beds which did not contract out any of its services. Additionally, the total cost per day was approximately *twice as high* as comparative facilities *that contracted out all services*.

In 2004, the kitchen supplied meals to Elizabethtown Hospital and the County Jail. The feeling at the time was the reimbursement received from these sources, did not cover the actual per meal cost. In 2004 the home had 19.49 FTE's which was 7.96 FTE's higher than the average of the comparison facilities.

In 2009, we had 18.08 FTE's within the dietary department. What is particularly troubling is that this only represents a drop of a little over one FTE, from 2004 to 2010. *When you consider that we no longer provide meals for the County Jail or Elizabethtown Hospital, it seems evident that the staffing still far exceeds the recommended parameters.*

The 18.08 FTE's within Dietary represents a total labor cost of \$528,980.00. If you have 100 residents at 3 meals a day times 365 days a year, then this represents 109,500 annual meals. The hourly wage cost alone, not counting any benefit costs represents *\$4.83 per serving excluding any food costs*.

When you add in the estimated benefit costs of 53%, as well as a 15% cost of overhead and the actual food costs of \$348,000.00 per year, *the total cost per meal jumps to \$11.51 per serving*. As a frame of reference, the cost we pay ACAP for our home delivered meals thru the "meals on wheels" program is \$5.05 per meal. This cost also represents labor, overhead and the actual cost of the food.

Nursing Services

The Rotenberg report addressed the nursing services portion of the home and compared such services to the other public nursing home identified. As reviewed earlier in this report, the Case Mix Index (CMI) is an important component of determining appropriate nursing levels.

In its simplest terms a CMI is a number assigned to a nursing home by the Department of Health, based upon the data compiled and submitted by the home on the various categories within the Resource Utilization Guide (RUGs) as it relates to each resident's care within the home.

At the time of the Rotenberg report the RUGs classification in place provided for a range of 0.55 to 1.79 within the CMI. A higher number within the range represents a higher level of care a resident will need. *Of importance here is that a higher CMI results in greater reimbursements to the homes. Additionally, it is assumed that a higher CMI results in higher staffing ratios given that the residents require more direct nursing care. Conversely, a lower CMI should represent lower staffing ratios.*

The latest CMI numbers I could find that compared our operation with other facilities, were contained within a report titled "Staffing Levels in New York Nursing Homes", which was presented by former Attorney General, Eliot Spitzer⁶ in January of 2006. The staffing charts provided details of the comparison counties used within the Rotenberg report, and were based upon CMI numbers taken from 2004.

The charts within the Spitzer report are based *upon hours per resident day (hprd)* which allows comparison regardless of the number of total residents within a facility. Hours per resident day is based upon the average number of hours of daily care that staff members provide to each resident of the home. This measure is calculated by adding up the total number of hours worked by the nursing staff and dividing it by the number of resident-days during the reporting period.

The charts are based upon the following categories;

- ✓ Total Nursing Staff Hours - which is the sum of licensed nursing care plus nurse aide care.

⁶Staffing Levels in New York Nursing Homes: Important Information for Making Choices., http://www.ag.ny.gov/media_center/2006/jan/final.pdf

- ✓ Total Direct Care - this includes hands on care by all nursing caregivers (RNs, LPNs, and CNAs).
- ✓ RN Direct Care - this includes hands-on care by RN and excludes hours reported for Nurses with Administrative Duties.
- ✓ LIC direct Care - means licensed nursing care. This would include the hands on care by RN s and LPNs and excludes administrative hours.
- ✓ CNA Care - includes the hours reported for Certified Nurse Aides.
- ✓ CMI number

	Total Nurse Staffing Hours	Total Direct Care	RN Direct Care	LIC Direct Care	CNA Care	CMI
Horace Nye	4.33	4.03	0.40	1.31	2.72	1.05
Orleans	3.26	2.92	0.00	1.09	1.83	1.03
Delaware	4.00	3.87	0.27	1.32	2.55	1.05
Genesee	3.89	3.63	0.56	1.19	2.43	1.31
Ontario	3.10	2.73	0.19	0.90	1.83	1.11
Livingston/Genesee	4.19	3.84	0.15	1.23	2.61	1.17
Livingston/Mt. Morris	4.13	3.84	0.26	1.28	2.55	1.12

The numbers contained within the table above indicates that Horace Nye *averages higher staffing hours per resident than every other public nursing facility used in the comparison study* by Rotenberg. Again, we are not measuring the quality of care, but rather the financial impacts such additional staffing has on the financial status of the facility.

The results indicate that our CMI of 1.05 is one of the lowest with only Orleans County lower at 1.03. Our cumulative average across the five categories is 2.56 hours. Orleans is 1.82 hours,

Delaware is 2.40 hours, Genesee is 2.34, Ontario is 1.75, Livingston at Genesee is 2.40 and Livingston at Mt. Morris is 2.41.

Keeping in mind that a lower CMI means “residents with less medical care needed” these numbers reflect that *we spend more staff time than any other of the public facilities* (compared in the study) *on residents who generally should require less.*

This conclusion is supported in the Rotenberg report which indicated there *were serious issues within the staffing patterns of Horace Nye.* Rotenberg used information from the facility as it related to the direct care nurse staffing patterns for a 24 hour period. They computed staffing hours needed based upon the case mix index of 1.046 which was in place at the time. They arrived at a total of 298.22 hours of direct nursing care required for the 100 residents on a daily basis.

Of those predicted hours, 43.32 should have been RN time, 51.93 should have been LPN time and 202.97 should have been CNA time. Taking the 298.22 total nursing care hours needed divided by 8 hours per person equals 37 nursing care hours needed in a 24 hour period, or 4 RN’s, 11 LPN’s and 22 CNA’s.

At the time the facility master staffing pattern included 49 direct care staff in a 24 hour period, 3 RN’s, 12 LPN’s and 34 CNA’s. *Based upon this, the facility had 15 more direct care staff members working a 24 hour shift then recommended by Rotenberg.*

In comparison to other like facilities, Horace Nye had 89.51 actual FTE’s compared to the average of 69.01 for the comparative facilities. *This represents 20.5 FTE’s higher for Horace Nye than the average of the other facilities.*

It is important to note, the actual FTE’s are hours paid as opposed to hours worked. What drives the higher hours paid is the higher percentages of absences and vacations which are supplemented with per diems or shift hold-overs working overtime. Our generous benefit package clearly contributes to this problem, however this comparison report was based upon

“other public homes” so those facilities were dealing with the same issues.

It is clear that we are significantly overstaffed based upon a comparison of similar public homes.

Two important questions need to be addressed;

- ✓ Have our FTE’s decreased since 2004?

- ✓ Have our CMI numbers improved since 2004?

Understanding our FTE’s

As noted earlier, Full Time Equivalent (FTEs) represents hours paid and do not necessarily reflect the actual number of employees that may be on the roster. *The FTE formula is used because it accurately reflects the paid labor time an employer has in its operations.*

It was also pointed out that our FTEs are driven in large part by the nature of a 24 hour operation, combined with the amount of vacation, sick, and personal time we provide the employees. In a 24 hour operation, if an employee calls in sick, we pay the sick time but also pay another employee to take that shift. This is true of all of those benefit hours and often results in overtime for those taking over the abandoned shift,

Another factor to higher FTE’s is the amount of time employees spend on Workers Comp claims. The Horace Nye home is our single largest expense category under our self insured Workers Comp coverage. The nature of the work lends itself to injuries due to the lifting and moving of patients. *Unfortunately our costs here also exceed the other comparable nursing homes within the public sector.*

As per the Rotenberg Report, Horace Nye had 144.95 FTEs at the end of 2003.. The average of the other six public facilities was 107.31 FTEs. ***Horace Nye had 37.64 FTEs more than the average FTEs for the other six public facilities.***

As of the end of 2009, our FTEs represented 133.77 or a decline of 11.18 FTEs. At first glance

it would appear we have been doing a better job over the last six years. However, these number still represent *26.46 FTEs over the average of the other public facilities in 2004.*

It is troubling that our FTEs in 2003, included *Certified Nursing Assistant trainees* which were part of the 144.95 number. During that period and as a matter of policy, the nursing home ran 8 week paid trainee courses on a regular bases throughout the year. *Many of these trainees position would not extend beyond the 8 weeks because they would either not pass the course or they would become per diem as a standby position.*

The end result of having these trainee positions was that it increased the paid hours, resulting in a higher FTE number. We looked back to see how many CNA trainees positions were on the payroll in 2004, and it was 13 FTEs. In 2009, we were no longer allowed by the Department of Health to run these CNA trainee class.

The FTEs in 2009 of 133.77 did not include any temporary paid trainee time. The net result is that our staffing in 2004 included paid trainee time but such trainee time is not within the 2009 numbers, *which means our reduction in actual staffing is not nearly as high as it may appear.*

Understanding CMI

The reason I have concentrated so much on the Case Mix Index (CMI) is because I believe this to be an important indicator of how our home is operating on a number of levels. In terms of the finances, the higher the CMI the higher your reimbursements and clearly this is important.

However, that is not to say a lower CMI necessarily means the home is operating poorly. Typically a public nursing home will have a lower CMI since public homes typically accept younger patients who score lower pursuant to the Resource Utilization Guide (RUGs), simply because they are not as sick.

What is important to understanding is that the CMI formula utilizing RUGs is comprised of categories. *Inherent within these categories is some subjectivity as to what category a resident may be classified in during a particular billing period.* In other words are we making the best

use of those billing categories as they relate to the care that the resident receives? Comparing CMI numbers over a period of time can provide management with a tool to assure that we are making the best use of the reimbursement system.

That is not to say that we are doing a poor job of classifying our residents, but rather there seems to be some confusion as to our management's interpretation of CMI. The CMI is an important factor in determining our overall efficiency from a reimbursement standpoint.

It is difficult to compare our current CMI to the 2004 CMI since the RUGs system has been modified in recent years. The current system has increased the categories and the weighted value of each of those categories has increased. In other words the range of the CMI value changed. At the time of the Rotenberg report the RUGs classification in place provided for a range of .55 to 1.79. The range under the new RUGs classification is 0.49 to 2.54.

Our CMI as reported in the Rotenberg report was 1.05. Linda Wolf and I were able to calculate the current CMI at 0.840, which would indicate we have residents needing less care, therefore should require less staffing.

The previous range in 2004 was .55 to 1.79, therefore *the CMI of 1.05 at the time represented 58.66% of the scale in 2004*. The new range in 2010 is 0.49 to 2.54, therefore the CMI of 0.840 *represents 33.09% of the scale*. Given those numbers our CMI, as a percentage of the weighted scale, has declined significantly from 2004 to 2010, which ultimately means a lower reimbursement rate from Medicaid and higher cost to our budget.

Comparing Cost per Day

The Rotenberg report provided a cost per resident day for the public nursing homes included within the survey. The costs were derived from the 12/31/2003 cost report document. Reviewing all of the costs an average was determined on a per day per resident basis, for both expenses and revenues.

The average costs for the other six public facilities within the survey was \$206.56 per resident

day. *Horace Nye had an average cost of \$245.23 per resident day, or \$38.67 more than the average of the other facilities.* In terms of revenue, the other six public facilities had an average income of \$174.20 per resident day. *Horace Nye had an average income of \$157.46 or \$16.73 per resident day less than the average of the other facilities.* Within this group of public facilities, *Horace Nye had a negative \$87.77 per resident day while the average of the other facilities was only \$32.36 in the negative.*

Using our 2009 costs reports, Linda Wolf and I calculated what those numbers would look like today. Unfortunately, they have gotten significantly worse. Our revenues, with the IGT funding included, is now at \$191.67 per resident day. *Our costs have jumped to \$322.26 per resident day, leaving a negative \$130.59 per resident day.*

What that means in terms of our overall impact is that we are now *losing \$42.82 per resident day more in 2009 than we did in 2004.* We don't have information related to how the other facilities within the study are doing now, but it seems we have fallen even further behind.

Understanding IGT Funding

Explaining the Inter Governmental Transfer (IGT) Funds process is complex and beyond the scope of this report. I am presenting a summary only because the potential impact of losing this funding is so significant to the operation of the Horace Nye.

The information presented herein has been taken from the Kaiser Commission on Medicaid and the Uninsured⁷, a report completed in April of 2004. Inter Governmental Transfer (IGT) funds are really based upon the inter action between Medicaid funding on the Federal, State and Local level.

In New York State, the Federal Government covers 50% of the cost of medicaid claims; the State has the responsibility for the other 50% but passes ½ of this total back to the County or 25%. We

⁷<http://www.kff.org/medicaid/upload/Current-Issues-in-Medicaid-Financing-An-Overview-of-IGTs-UPLs-and-DSH.pdf>

often refer to IGT as the funding source yet technically it is not. IGT is a term which is defined as a transfer of public funds between governmental entities.

Ultimately, the program calculates amounts the state can pay providers (ie, nursing homes) under medicaid for covered services. The amounts or limits are based upon federal regulations and are the estimated amounts paid for medicaid services under *medicare payment principles* for each class of providers. Under this process, an individual facility could be paid more by Medicaid than what Medicare would have paid *provided* some facilities in the same class were paid *sufficiently less to offset the overpayment*.

In simplified language, New York State pays private facilities less for medicaid services , which constitutes a savings within the same class of providers. The savings derived from paying the private facilities less is shared statewide with the public facilities.

For Essex County, the IGT funding in the 2009 budget represented \$1.2 million as additional revenue to us. The problem with this funding source is based upon the knowledge that the Federal Government has decided to phase out this process of allowing private facilities to be paid less for medicaid services, thereby generating revenue for public facilities. The process was due to end but has been temporarily extended. At this point we are uncertain of the ending date, *however its ultimate termination is inevitable.*

In terms of the impact, our 2010 Horace Nye budget had to be supplemented from the general fund by \$1.8 million, which included the IGT funding source. *If we did not have the IGT funds available to us, we would have had to supplement the Horace Nye budget in the amount of \$3 million which represents over 23% of our total tax levy.*

Base Year Adjustment

The Rotenberg Report reviewed the medicaid base year rate to determine if a rebase would be helpful, and to what degree it would have on our financial status. The medicaid reimbursement rate structure is a blended cost based/prospective rate system. The rate is comprised of four separate components; direct, indirect, non-comparable and capital costs. The direct, indirect and

non-comparable portions of the costs are combined to comprise the operating component of the rate. The operating component of the rate is computed utilizing the base period costs (1983 for Horace Nye) trended forward to the current rate period.

The main problem with the 1983 base period is that costs for many items have far outstripped the trend factor. Our prescription drugs, liability insurance and health insurance are increasing at a much higher rate than the consumer price index, causing significant shortfalls in the reimbursement system.

Nursing homes are allowed to receive a rebased rate (based on current costs) if they meet certain criteria as follows;

- ✓ The facility experiences a complete change in ownership (i.e. sale of the facility). The new owner would receive a rebased rate.
- ✓ The nursing home constructs a replacement facility (all beds are replaced).
- ✓ The nursing home completes a substantial renovation project that results in significant changes to operations. This criterion is subjective and the state would need to determine whether the facility's renovation is substantial enough to qualify.

Rotenberg calculated the impact of rebasing based upon Horace Nye's 2003 Medicaid cost report. It was determined that such rebasing would provide approximately \$220,000 per year in additional revenue.

If the county was going to invest millions of dollars in building a new facility, and the rebasing process only resulted in an additional \$220,000 then clearly that would not be cost effective. That is not to say we should never consider building a new facility, but rather ***rebasing alone is not a valid reason for building a new facility.***

It is important to understand why rebasing is not effective for Horace Nye. The direct and indirect cost components of the rebasing formula is subject to ceilings based upon statewide averages. Rotenberg determined that *Horace Nye's direct costs were over the statewide ceiling by approximately \$2,300,000 while its indirect costs were over ceiling by approximately \$920,000.* Rotenberg stated, *“the sheer magnitude of the amount in excess of ceiling of \$3,220,000 is an indication that the facility's cost structure is exceptionally high compared with state averages”.*

Going back to the importance of the CMI, Rotenberg pointed out that the ceilings are influenced by case mix, so an increase in the case mix of the facility will result in an increase in the ceiling amount. *Given that our CMI has decreased since the 2004 report, it is likely that the projected savings of \$220,000 has probably disappeared as well.*

Our current Budget Projections

Currently our budget adopted for 2010 included \$10,317,056 for Horace Nye as total operating funds. Our total revenues including all sources represents \$8,581,405, which means we had to put \$1,888,156.00 on the levy to support the operation of the home.

Our total tax levy, which is the amount we needed to raise by the property tax stands at \$13,275,436 in 2010. *The \$1.88 million needed for support of the Horace Nye nursing home represents 14.22% of total tax levy. Without the \$1.2 million of IGT funding, that percentage jumps to 23.26%.*

Conclusions

As has been noted a number of times within this document, this report is not an evaluation of the quality of care. Nor is this report intended to somehow diminish the importance of providing quality care for our elderly population. It is a detailed and careful review of the finances associated in operating a nursing home within the public sector, and specifically the operation of the Horace Nye nursing home.

It is important to understand nursing homes within the public sector were originally set up as enterprise funds. The basic definition of an enterprise fund is that it is supposed to be self supporting with revenues equaling expenditures. As noted in the first part of this report, that is currently an unrealistic expectation within the public sector.

As this report demonstrates our nursing home is performing well below the level of most comparable public nursing homes. Ultimately, the easy answer for myself as the County Manager and for this Board of Supervisors is to simply ignore the problems and lay everything off to “we owe it to our elderly”.

We have an obligation to provide care to those residents, and it is an obligation that we all take seriously. Demanding accountability for the operation of the home does not mean we lack concern for the residents and their families.

Ultimately this Board will have to decide in what direction we will proceed. However, it is not prudent to move in any direction without first knowing where you stand now which is the purpose of this report. It is also critical to consider all available options in order to make informed decisions that represent the best interest of the constituents we are asked represent.

Recommendations

Requests for Proposals (RFP)

Although the idea of private firm operating this facility may not be popular, it is necessary to consider it. The Board needs to determine if there is any interest from the private sector and how such interest could benefit Essex County. An RFP has been prepared and will need authorization from the Board to proceed.

Operational Changes

Clearly this report and the Rotenberg report has demonstrated that we have serious operational problems which need to be addressed. As I noted earlier in the report, I would recommend that Rotenberg come back in to provide the Board with additional review and recommendations.

Such recommendations must be implemented by Board resolution in order for it to be effective. However, I would not pursue this until such time that it was determined the RFP process produced no workable alternatives.

New Construction

If no practical or acceptable alternatives are found within the RFP process and it is determined that we are staying in the nursing home business, than a determination of building a new nursing home must be made. It is not practical or advisable to continue operating long term given the condition of the current building.

Centralize Billing

It is evident to me that the process of medicaid billing and reimbursements is not correctly understood by the fiscal office now. If we remain as a public nursing home, a reorganizing must take place with a Medicaid/Medicare Compliance Officer created, who would have direct supervision of staff assigned to do the billings. This position could be expanded to include Public Health and Mental Health as needed.

Right Sizing

Based upon the Rotenberg report and this report, we are overstaffed in a number of areas within the operation. The per meal cost within the kitchen is unacceptable, and it may be appropriate to contract out all of the kitchen duties. Some of the other areas are overstaffed as well. If a new review is completed by Rotenberg, then the recommendations need to be followed. Rotenberg made a number of recommendations in the 2004 report and most do not seem to have been implemented.

Benefit Levels

If we are staying in the nursing home business a new level of benefits must be established for the employees working within the facility. The labor costs are driving much of the cost overruns. It may be necessary to have a different contract for Nursing home employees similar to what many public homes have already done.

Resident Recruitment

The home needs to be more active in recruiting residents to the home. It is important that a certain level of Private Pay or Medicare patients be part of the admissions. Understanding that we have many medicaid only residents to consider, it still is important that a certain amount of our beds need to be filled with residents who help to reduce the per day per resident losses that are occurring.

It has been shown that these residents with the higher reimbursement rates for the first 100 days can be the difference between profit or loss if the resident should need to continue as a Medicaid resident.