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Key Challenges Facing County Nursing Homes

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

- Fewer lucrative transfer admissions from hospitals, including sub-acute care and rehabilitation patients;
- Disproportionate Medicaid admissions, for which county homes lose money from day one;
- Disproportionate total number of resident days paid for by Medicaid, compared to Medicare and private pay, both of which are more lucrative and pay more of the bills at voluntary and proprietary facilities;
- Demographic profile of residents with disproportionately high number of behavioral demands and need for staff attention, but with insufficient reimbursement to cover the staff costs;
- Low case mix index compared to other types of nursing homes;
- Rising costs related to Worker’s Compensation Claims due to injury of employees because of the failure of Nursing Home/County Management who understaff their nursing homes and who don’t use patient safe handling policies and systems;
- Increased maintenance costs due to aging facilities;
- Increasing operating losses per bed;
- Rapid decline in IGT payments designed to compensate for unique costs and mission of county homes.\(^1\)

Financing nursing home care

In order of value to nursing homes in terms of covering actual costs of services provided, Medicaid provides the lowest return. Various aspects of the Medicaid reimbursement formula impose restrictions that resulted in 2004 in a gap between allowable Medicaid costs and actual reimbursement of 11.2% (i.e., Medicaid covers less than 90% of actual costs of care). This translates into a Medicaid shortfall well in excess of $20 per resident day.\(^2\) Medicare, on the other hand, pays close to or even slightly above actual costs of care, and private pay rates typically are set to exceed actual costs. County nursing facilities are hit hardest by these payment realities because, in comparison with other types of nursing facilities, they provide

\(^1\) http://www.cgr.org/reports/07_R-1523_CountyNursingFacilitiesinNYS.pdf
\(^2\) NYAHSA, “Financial Distress and Closures: The Uncertain Fate of New York’s Nursing Homes,” NYAHSA Public Policy Series, February 2006, pp. 1, 14. This figure covers nursing homes in general; county home deficits are estimated to be much higher, though specific amounts were not available.
higher proportions of care to Medicaid residents and lower proportions to those paid for by Medicare and private pay.\(^3\)

**Uncertainty of State and Federal Funding**

The future of state and federal funding for long-term care in general, and nursing facilities in particular, is highly uncertain at best, and should probably most realistically be thought of as trending downward (although how much, and at what points in time, remain highly speculative, even among “experts” in the field). That reality of uncertainty is what makes the decision-making roles of policymakers so difficult around the issue of the future [nursing home] facilities.

Among the factors likely to affect funding of nursing homes over the next few years are the following:

**Changing Regulations Impact Costs and Revenues**

- A global spending cap limiting total growth of Medicaid expenditures to about 4%.
- The Medicaid reimbursement methodology, in general, disadvantages county nursing homes for a combination of reasons including: statewide limits on nursing home reimbursement in general; the state providing no trend factor increases over historic operating costs in establishing the Medicaid payment rates despite actual cost inflation; and a complex reimbursement formula which, for rate periods from 2009 through 2011 was based on 2002 reported costs for each facility.
- An additional 0.8% increase in the non-reimbursable cash receipts assessment in lieu of the 2% across-the-board cut in reimbursement rates to nursing homes and adult care facilities. This is expected to be in place at least through early 2013.
- Reduction of Medicare Part A rates by 11%, effective 10/1/11.
- Bed hold modification (effective 7/1/12), limiting the ability to bill for bed hold days for Medicaid recipients over age 21 to a combined 14 days annually for hospitalization and therapeutic leaves, and 10 days for other leaves of absence as yet undefined.
- Provisions for the financing of required nursing home sprinklers.

A recoupment (disallowance) by CMS (Centers for Medicare and Medicaid Services) of moneys that counties with nursing homes are being required to return to the federal government related to transactions occurring in federal fiscal years 2006-07, 2007-08 and 2008-09.

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\(^3\)http://www.cgr.org/reports/07_R-1523_CountyNursingFacilitiesinNYS.pdf
Intergovernmental Transfer (IGT) Program

It appears that the Intergovernmental Transfer (IGT) funds will continue to be available in the future. As of this year, payments have now been made to counties representing funds authorized through federal fiscal year 2010-11. The State budget has extended up to $300 million annually for county IGT payments for the 2011-12 and 2012-13 State fiscal years, although it is uncertain when those funds will actually be released to the counties. We also understand that an extension through March 2014 is pending at the federal level. Some expect the federal funding to continue at least until federal health care reforms begin to be fully implemented in 2014, with uncertainty after that.

Clearly, any assumptions should be made cautiously; but as of now, there is no indication that IGT will cease to exist at any particular time, although the level of IGT funding remains uncertain. And even if IGT continues for the foreseeable future, it is important to note, as made clear by previous delays in payment dates, that payments are generally not received in the same year in which the funds are announced. Rather, there can be, and typically is, a significant lag time before funds are received at the county level. Also, it is important to remember that the IGT payments must be matched by County contributions from the General Fund in the year in which any payments are made.

New Statewide Pricing Methodology

After much uncertainty, a statewide Medicaid pricing and reimbursement strategy has been approved by New York State, pending federal CMS approval, and is to be implemented retroactively effective January 1, 2012. This will replace the rebasing payment methodology currently in place. However, as with so many changes in the reimbursement structure over time, when it will be formally approved at the federal level, and when funds will actually begin to flow under the new plan, is uncertain. The new pricing methodology is based on a statewide base reimbursement structure adjusted for such things as regional wage differentials, case-mix of residents and the size of the facility.

The plan is scheduled to be phased in over a six-year period, with full implementation scheduled in 2017. Initial calculations based on the new plan's formulas suggest that counties may experience an increase in revenues, compared to the previous Medicaid reimbursement structure in each of the next several years.

Managed Care

One of the major unknowns, and greatest perceived threats, concerning the future of all nursing homes, but especially county-owned facilities, is the pending expansion of managed long-term care. As an alternative to the current fee-for-service reimbursement model, managed care would be designed to negotiate set prices for a range of services, and nursing home providers fear that the reimbursement levels will fall short of current levels, even as their costs continue to rise. But nothing is yet certain as to the future of these approaches across the state.
As one leading authority at a statewide agency observed: “Who knows when or how, or even if, nursing homes will be included in this process, and what the financial impact will be?”

Early mandatory expansion is being tested initially in the New York City area, involving dual-eligible (Medicaid and Medicare) individuals 21 and older who need community-based long-term care services for 120 days or more. Nursing homes are specifically excluded at this point. Phase-in of this model is expected to be expanded to other regions of the state between 2013 and mid-2014, but there are signs that this timeline is already being pushed back. Successful implementation partly depends on having sufficient managed care companies engaged in a region, and having a network of service providers sufficient to respond to the needs.

Assuming that the community-based managed long-term-care model is successfully implemented, it will presumably be expanded to nursing homes and other institutional levels of care, but when and how, and with what impact, remains very much unknown. Although some anticipate that significant expansion of managed care will become a reality for nursing homes within a short period of time (perhaps two to three years), other knowledgeable stakeholders expect little movement, at least in the western part of the state, before 2016 or 2017.

And while the general expectation is that significant expansion of the managed care model will lead to major reductions in revenues for nursing homes, others are not so sure, and expect little or no net reduction in revenues, depending on market conditions and what levels of quality care are provided and how facilities perform on quality measures yet to be determined. Skills in negotiating rates and conditions with insurance companies may become critical in the process if nursing homes are to survive and thrive in the future.

Uncertainties notwithstanding, there seems to be little real doubt that managed care is on the horizon, and eventually will become a key player in how nursing homes are funded and conduct their business. The question is how soon, and with what impact.

It seems likely that facilities in upstate NY have some time—perhaps as much as four to five years—before managed care makes major inroads into nursing homes in Western NY. This period provides a window of opportunity to consider options and make decisions that will best position counties and their nursing facilities to meet the challenges of this likely new era—by making decisions to sell their facilities before the changes occur, or to begin to position themselves (individually and perhaps in partnerships with others) to be able to function in more cost effective ways that can help them survive if reimbursement levels do indeed decline under the likely new system.

**Conclusions of Non-County Revenue Sources**

Uncertainties include such things as the future implications of the affordable care act, the future of Intergovernmental Transfer (IGT) funds to county nursing homes, new statewide Medicaid funding approaches, and the timing of likely expansion of managed care. Certainly any county that is pondering its options,
including consideration of staying in the public nursing home business, should be realistic in its assumptions about the availability and levels of future non-County revenue sources, and how well it would be able to function if those levels decline significantly in future years.4

**InterGovernmental Transfer (IGT) Funds**

The IGT program is a federal initiative which has been in existence at some level for almost 20 years. The federal government through CMS (Centers for Medicare and Medicaid Services) works in partnership with New York State to determine the amounts of available funds, and to distribute them through a complicated matching process to county nursing homes across the state. The program is designed to support public facilities and help offset some of the added costs of running a public nursing home.

IGT legislation must be re-enacted whenever existing legislation expires and, therefore, its continuance is never guaranteed, thus making fiscal planning for public nursing homes even more uncertain.

But notwithstanding the perception of the uncertain nature of IGT and when the payments will be forthcoming, it is important to note that IGT money has been available at varying levels since the mid-1990s as a means of supporting public nursing homes to offset low reimbursement rates, high public benefit costs, and the high proportions of low income or “safety net” residents typically perceived to be served by these homes. Private providers (for-profit or not-for-profit) are not eligible for IGT funds.5

**How IGT Works: Double Return for County Match**

IGT funding is in reality a re-distribution of surplus Federal money resulting from the difference between the Federal Upper Payment Limit (UPL) and State Medicaid rates for specific medical services, such as state Medicaid nursing home rates. The basic methodology is that the state Medicaid rate for a particular service cannot be below the average Medicare rate for the same service since both Medicaid and Medicare are federal mandated programs covering the same types of service.

Under the federal IGT program, local government tax funds generate federal matching payments. The amount of IGT payments available to county homes is determined by the State on an annual basis (although the actual cash payments have typically been made on a one- to two-year lag basis).

In order to receive IGT funds, a county has to “front” its 50% matching share of the funds through its General Fund in the years in which the IGT funds are paid.

The nursing home then receives the total funding amount, i.e., the county share and the federal match. Thus all of the funds accrue directly to the Nursing Home Enterprise Fund, as intended by the federal legislation. The concern from the perspective of county policymakers and taxpayers is that none of these matching

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4 [http://www.cgr.org/reports/12_R-1674_FutureOptionsCattaraugusNursingHomes.pdf](http://www.cgr.org/reports/12_R-1674_FutureOptionsCattaraugusNursingHomes.pdf)
5 [http://www.cgr.org/reports/12_R-1674_FutureOptionsCattaraugusNursingHomes.pdf](http://www.cgr.org/reports/12_R-1674_FutureOptionsCattaraugusNursingHomes.pdf)
funds are ultimately returned to a county’s General Fund—due to the underlying legislation which requires the IGT funds to be paid solely to the nursing home. In short, in order to access these IGT funds, a county and its taxpayers must make a conscious decision to provide the matching contribution to support the public nursing home. From a return on investment perspective, a county is able to double its investment on behalf of the nursing home.

As a result of the federal stimulus package, the county matching share was reduced for about two years to 38% and is in the process of returning to the original 50% county share.

While IGT payments have been erratic, this federal funding source, available only to public nursing homes, has become essential to keeping many of these public nursing homes financially viable.6

Is IGT a County Subsidy?

Whether IGT is viewed as an investment and a standard revenue stream for public nursing homes to operate or is seen as a required subsidy from taxpayers is certainly legitimately debated.

An IGT match portion of the County contribution to its nursing home can reasonably be viewed as an investment yielding a doubled return directly to the nursing homes, and therefore has value different from a subsidy that is limited to filling a gap between expenses and other available revenues.

However, from a County taxpayer and Legislator perspective, these investments nonetheless do represent direct “hits” against the County’s General Fund and available tax resources in any year in which they are required.7

Other Counties’ Use of IGT Match

As far as we know, counties throughout New York have maximized the full IGT payments they were eligible for, by agreeing to provide a match for the full value of the available allocation. But we do not know that for certain. Center for Governmental Research, Inc. (CGR) is currently leading a statewide study of county nursing homes and the impact of decisions previously made by counties to sell or close their county homes. As part of that study, we will be determining what decisions counties currently, and in recent years, have made concerning what portion of their available IGT allocations they have agreed to match. Unfortunately, the results of such analyses will not be known for several months and thus cannot be included in this report. We do know from early returns on that study that several counties have reported substantial IGT match amounts, suggesting that their counties have allocated sufficient matching funds to access the maximum IGT payment available in a given year.

To what extent such matching decisions will be made in future years may be shaped in some counties by New York State tax cap considerations.8

6 http://www.cgr.org/reports/12_R-1674_FutureOptionsCattaraugusNursingHomes.pdf
7 http://www.cgr.org/reports/12_R-1674_FutureOptionsCattaraugusNursingHomes.pdf
Future of IGT

The future of IGT is uncertain and cannot be definitively assumed at this point. On the other hand, that has been the case now for almost two decades and the program has consistently been renewed.

Nearly all of the stakeholders we have talked to at local and state levels who track such matters and are knowledgeable about intergovernmental and political decision-making processes advise us that the IGT program appears likely to continue at least into 2014. Beyond that, there is some uncertainty until the implications of the health care reform act becomes more clear between now and 2014. But most “experts,” even with those unknowns, seem reasonably optimistic that the program will continue in some form even beyond that. No definitive judgment of probabilities is possible at this point; therefore, each county will simply have to determine how much of a risk it is willing to take concerning the likely future of the IGT payments as it assesses its options for the future of its nursing facilities.9

Personal funds

Individuals entering a nursing home as private pay residents use a combination of their own resources to pay their expenses. Many residents eventually "spend down" their resources and meet the requirements for Medicaid to pay for care. Some nursing homes require payment upon admission. If a resident pays for nursing home care with personal funds and depletes their resources, they may then qualify for Medicaid.

Medicaid Overview

Enacted in 1965 through amendments to the Social Security Act, Medicaid is a health and long-term care coverage program that is jointly financed by states and the federal government. Each state establishes and administers its own Medicaid program and determines the type, amount, duration, and scope of services covered within broad federal guidelines. States must cover certain mandatory benefits and may choose to provide other optional benefits.

Federal law also requires states to cover certain mandatory eligibility groups, including qualified parents, children, and pregnant women with low income, as well as older adults and people with disabilities with low income. States have the flexibility to cover other optional eligibility groups and set eligibility criteria within the federal standards. The Affordable Care Act of 2010 creates a new national Medicaid minimum eligibility level that covers most Americans with household income up to 133 percent of the federal poverty level. This new eligibility requirement is effective January 1, 2014, but states may choose to expand coverage before this date.

8 http://www.cgr.org/reports/12_R-1674_FutureOptionsCattaraugusNursingHomes.pdf
9 http://www.cgr.org/reports/12_R-1674_FutureOptionsCattaraugusNursingHomes.pdf
The Children’s Health Insurance Program (CHIP) was created in 1997 through an amendment to the Social Security Act to provide health care coverage to low-income children not already eligible for Medicaid. Like Medicaid, CHIP is jointly financed by states and the federal government. States have the option of using CHIP funds to expand their existing Medicaid program, create a separate stand-alone CHIP, or do a combination of both.\(^\text{10}\)

**Medicaid Enrollments and Payments**

Medicaid and CHIP are jointly funded by the federal government and states. The following data show the number of enrollees in the New York Medicaid program, as well as the total program cost by federal and state shares.

<table>
<thead>
<tr>
<th>Year</th>
<th>Population *</th>
<th>Enrollment Count</th>
<th>Total Medicaid Paid</th>
<th>Federal Share Paid</th>
<th>States Share Paid</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>unavailable</td>
<td>unavailable</td>
<td>unavailable</td>
<td>unavailable</td>
<td>unavailable</td>
</tr>
<tr>
<td>2009</td>
<td>19,541,453</td>
<td>5,208,143</td>
<td>$47,678,723,205.00</td>
<td>$28,270,895,547.00 (59.29%)</td>
<td>$19,407,827,658.00 (40.71%)</td>
</tr>
<tr>
<td>2008</td>
<td>19,467,789</td>
<td>4,937,275</td>
<td>$46,263,483,642.00</td>
<td>$23,202,779,176.00 (50.15%)</td>
<td>$23,060,704,466.00 (49.85%)</td>
</tr>
<tr>
<td>2007</td>
<td>19,422,777</td>
<td>4,955,487</td>
<td>$43,564,119,806.00</td>
<td>$21,833,195,390.00 (50.12%)</td>
<td>$21,730,924,416.00 (49.88%)</td>
</tr>
<tr>
<td>2006</td>
<td>19,356,564</td>
<td>5,117,764</td>
<td>$43,553,526,510.00</td>
<td>$21,834,004,009.00 (50.13%)</td>
<td>$21,719,522,501.00 (49.87%)</td>
</tr>
</tbody>
</table>

**Medicaid New York Managed Care Statistics**

<table>
<thead>
<tr>
<th>Medicaid Enrollment*</th>
<th>Managed Care Enrollment*</th>
<th>Percent in Managed Care*</th>
</tr>
</thead>
<tbody>
<tr>
<td>5,208,143</td>
<td>3,628,756</td>
<td>69.67%</td>
</tr>
</tbody>
</table>

\(^{10}\) [http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-State/new-york.html](http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-State/new-york.html)
Rebasing Article
In New York’s reimbursement methodology for nursing homes, the Medicaid rate is comprised of four components: (1) direct; (2) indirect; (3) non-comparable; and (4) capital. The first three components collectively make up the “operating portion” of the rate. The operating portion of each facility’s rate is calculated using a base year that is fixed in time, whereas the capital component of the rate is re-based each year to reflect capital costs that apply to the rate year. To compensate for the fixed base year, the operating portion of the rate is adjusted each year by a trend (i.e. inflationary) factor. The trend factor is intended to be a proxy for inflationary increases in operating costs.

Medicare Program - General Information

Medicare is another source of nursing home revenue. Medicare is a health insurance program for:

- people age 65 or older,
- people under age 65 with certain disabilities, and
- people of all ages with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant).

Medicare has:

Part A Hospital Insurance
Most people don’t pay a premium for Part A because they or a spouse already paid for it through their payroll taxes while working. Medicare Part A (Hospital Insurance) helps cover inpatient care in hospitals, including critical access hospitals, and skilled nursing facilities (not custodial or long-term care). It also helps cover hospice care and some home health care. Beneficiaries must meet certain conditions to get these benefits.

Part B Medical Insurance
Most people pay a monthly premium for Part B. Medicare Part B (Medical Insurance) helps cover doctors' services and outpatient care. It also covers some other medical services that Part A doesn't cover, such as some of the services of physical and occupational therapists, and some home health care. Part B helps pay for these covered services and supplies when they are medically necessary.

Prescription Drug Coverage
Most people will pay a monthly premium for this coverage. Starting January 1, 2006, new Medicare prescription drug coverage will be available to everyone with Medicare. Everyone with Medicare can get this coverage that may help lower
prescription drug costs and help protect against higher costs in the future. Medicare Prescription Drug Coverage is insurance. Private companies provide the coverage. Beneficiaries choose the drug plan and pay a monthly premium. Like other insurance, if a beneficiary decides not to enroll in a drug plan when they are first eligible, they may pay a penalty if they choose to join later.\(^\text{11}\)

**Medigap insurance**
Many companies sell Medicare supplemental insurance — a private insurance, not a public benefit. Often called "Medigap" or "MedSup," this insurance is designed to fill in the "gaps" in Medicare coverage. It is standardized and regulated by federal laws and state rules.

In 1992, federal law and state rules began limiting insurance companies to 10 standardized packages of Medigap benefits. The Centers for Medicaid and Medicare Services has a Medigap Compare feature on their website. If you bought a Medigap policy prior to 1992, you may choose to keep your existing policy. You do not have to switch to one of the 10 standardized plans. Evaluate policies on benefits that help fill gaps in coverage of deductibles, medical bills above the approved Medicare amount, and medical expenses not covered by Medicare.

Before you buy a Medigap policy, consider these other options. If you are part of an employee group plan, a member of a Medicare HMO, or on Medicaid, you don't need Medicare Supplement Insurance.

Contact the Centers for Medicare & Medicaid Services for information about Medicare and about Medigap insurance.

**Long-term care insurance**
Long-term care insurance is sold by private insurance companies to cover costs of care in a nursing home, your home, or adult day care. It helps protect assets against the potentially catastrophic cost of extended long-term care.

State and Federal governments pay about 70% of nursing home costs and for about 85% of all residents the government pays part of or all of their costs. Because the government pays such a large portion, nursing homes structure their care delivery system around the government payment system.

**The New York State Partnership for Long-Term Care**
The New York State Partnership for Long-Term Care is a unique program combining long-term care insurance and Medicaid Extended Coverage. Its purpose is to help New Yorkers financially prepare for the possibility of needing nursing home

care, home care or assisted living services someday. The program allows New Yorkers to protect some or all of their assets (resources), depending on the insurance plan purchased, if their long-term care needs extend beyond the period covered by their private insurance policy.

If you buy New York State Partnership for Long-Term Care insurance from participating insurers, use the benefits according to the conditions of the program, and you are a New York State resident, you can apply for New York State Medicaid Extended Coverage which may assist in paying for your ongoing care. Unlike regular Medicaid, Medicaid Extended Coverage allows you to protect some or all of your assets, depending on whether you select a Dollar for Dollar Asset Protection plan or a Total Asset Protection plan. However, your income is countable in determining your eligibility for Medicaid Extended Coverage.

The Partnership was created to help New Yorkers finance long-term care without impoverishing themselves or signing over their life savings, with the accompanying loss of dignity. In the long run, the program will help reduce New York's Medicaid long-term care expenditure - over $9 billion in 2003. The Partnership offers New Yorkers and New York State a better alternative.\(^\text{12}\)

\(^{12}\) http://www.nyspltc.org/
Grants:

There are several grants available to nursing homes meeting established criteria.

Private Grants

Nursing homes provide a much-needed resource for the community and the elderly. To improve the quality of life services, nursing homes can use grants from foundations.


Federal Grants

Affordable Care Act Initiative To Reduce Avoidable Hospitalizations Among Nursing Facility Residents (93.621)


Affordable Care Act (aca) Nursing And Home Health Aides Training Program (93.503)

Links to Useful Resources:

**Centers for Medicare and Medicaid Services:**
http://www.cms.gov/

**Estimated Average Nursing Home Rates:**
http://www.health.ny.gov/facilities/nursing/estimated_average_rates.htm

**Intergovernmental Transfers:**

**Impact of State Budget on Counties:**

**Medicaid website:**
http://www.medicaid.gov/

**State Health Facts and Statistics:**
http://www.statehealthfacts.org/comparemaptable.jsp?ind=428&cat=8

**State Hospital Review and Planning Council:**

**Nursing Homes in NYS:**
http://www.cgr.org/reports/07_R-1523_CountyNursingFacilitiesinNYS.pdf
Additional Resources:


Health care reform has dominated public discourse over the past several years, and the recent passage of the Affordable Care Act, rather than quell the rhetoric, has sparked even more debate. Donald A. Barr reviews the current structure of the American health care system, describing the historical and political contexts in which it developed and the core policy issues that continue to confront us today.

This comprehensive analysis introduces the various organizations and institutions that make the U.S. health care system work—or fail to work, as the case may be. A principal message of the book is the seeming paradox of the quality of health care in this country—on the one hand it is the best medical care system in the world, on the other it is one of the worst among developed countries because of how it is organized.

Barr introduces readers to broad cultural issues surrounding health care policy, such as access, affordability, and quality. He discusses specific elements of U.S. health care, including insurance, especially Medicare and Medicaid, the shift to for-profit managed care, the pharmaceutical industry, issues of long-term care, the plight of the uninsured, medical errors, and nursing shortages. The latest edition of this widely adopted text updates the description and discussion of key sectors of America’s health care system in light of the Affordable Care Act.

2. *Introduction to U.S. Health Policy: The Organization, Financing, and Delivery of Health Care in America* (October 11, 2011) by Donald A. Barr

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3. Essentials of Health Care Organization Finance: A Primer for Board Members by Dennis D. Pointer and Dennis M. Stillman (Sep 22, 2004)

Accounting for $1.4 trillion in expenditures (13.7 percent of gross domestic product), health care is one of the nation's largest and fastest growing industries. This concise, expertly written primer on health care organization finance is a nuts and bolts guide to what has become every hospital's most sensitive topic. Health care organization board members must possess basic financial competence to govern effectively. This book will help them acquire, easily and painlessly, the basic financial literacy essential for discharging their roles and fulfilling their fiduciary duties.


Health and medical professionals rely on Getzen for its engaging introduction to the economic analysis of medical markets. It is updated with the latest information in the field including a detailed look at health care reform and the emergence of Barack Obama's plan. The developing health care system in China is covered to provide a more global perspective. Investment cases along with a look at the ROI of specialty medical education are also presented. And new C-B and CEA case studies help health and medical professionals see how to effectively apply the principles and concepts.