An Overview of Medicaid Long-Term Care Programs in New York
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Established in 2005, the Medicaid Institute at United Hospital Fund provides information and analysis explaining the Medicaid program of New York State. The Medicaid Institute also develops and tests innovative ideas for improving Medicaid’s program administration and service delivery. While contributing to the national discussion, the Medicaid Institute aims primarily to help New York’s legislators, policymakers, health care providers, researchers, and other stakeholders make informed decisions to redesign, restructure, and rebuild the program.

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Medicaid Institute at United Hospital Fund

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An Overview of Medicaid Long-Term Care Programs in New York

PREPARED BY
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April 2009
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New York State’s Medicaid program plays a fundamental role in providing long-term care in both residential and community-based settings. An estimated 247,000 Medicaid beneficiaries each month receive long-term care services through 12 distinct programs. Because much of this population has multiple chronic illnesses that cause, contribute to, and interact with functional and cognitive disabilities, care for this group can be intensive and costly. In 2007, Medicaid spending for this population’s long-term care was roughly $12.3 billion, about one-quarter of all Medicaid spending in the state.

New York’s strategy for providing long-term care has come a long way since the 1970s, when nursing homes were the predominant care setting. The state’s Medicaid program now provides long-term care to frail seniors and adults with physical disabilities through 12 programs — 10 of which operate primarily in community-based settings. Newer service delivery models were designed to build on the strengths of previous efforts and to overcome their limitations. They were often created in response to the needs and preferences of specific groups, such as younger adults with physical disabilities, frail seniors, and people with traumatic brain injuries.

The current balance in long-term care settings — one-third of beneficiaries in nursing homes, compared to two-thirds in various community-based settings — is a direct result of the state’s 30-year commitment to provide access to non-institutional long-term care services. This shift would not have occurred without sustained leadership, a willingness to experiment with new approaches, a substantial investment in building provider capacity, a continued public policy commitment to providing access to high-quality care in the most integrated, home-like settings, and progressive eligibility rules that ensure community care remains a financially viable alternative to nursing home care.
Despite these significant achievements, New York’s Medicaid program now faces considerable challenges: heightened fiscal and demographic pressures, scarcity of affordable housing, and other external factors. Ideally, questions about how to finance long-term care would be resolved at the national level, as this challenge is shared by all states and localities. Unfortunately, a federal remedy is unlikely in the near term, so New York must continue to balance the need for long-term care against constrained resources. New York must also resolve programmatic difficulties particular to the state’s long-term care system, including:

- an array of programs that are not well connected to the rest of the health care system, or to each other;
- a resulting level of complexity that runs counter to key policy goals, such as informed choice, effective government oversight, provider efficiency, continuity of care, and cost-effectiveness;
- severe workforce shortages and high turnover rates in the direct care workforce;
- wide regional differences in program enrollment, service utilization, and availability of services; and
- a lack of timely, comprehensive, and consistent information that would inform policy discussions.

There are no quick solutions to these problems. New York has a large population of beneficiaries with extensive functional and cognitive impairments and behaviorally and medically complicated needs. Care for this population will require substantial resources regardless of the provider, program, or service setting. Already, the state faces tough questions about the sustainability of per-beneficiary spending levels. And there are good reasons to believe that over time more people will turn to Medicaid for assistance in meeting their long-term care needs: Medicare does not pay for long-term care; long-term care insurance remains unaffordable for most individuals; and for people with extensive long-term care needs, the cost of purchasing services in the amount needed rapidly becomes prohibitive.
New York needs a clear vision for the long-term care system of the future. Developing a comprehensive reform agenda will entail grappling with policy issues that affect the Medicaid long-term care system as a whole, and should include how to:

- provide timely information and guidance at points of entry and transition;
- simplify the long-term care system in ways that make it easier for beneficiaries and providers to understand and for government to regulate;
- promote more consistent implementation of policies, regulations, and service determinations;
- determine where additional capacity and capital improvements are warranted and the most efficient ways to finance them;
- routinely identify individuals who meet criteria for care management, and determine how best to provide and pay for it;
- integrate Medicare and Medicaid financing more fully while building on existing provider capacity;
- align payment to beneficiaries' level of need through risk-adjustment or other reimbursement strategies;
- develop a direct care workforce that is better trained, more equitably compensated, and more readily deployed across programs and settings, while also expanding support for family caregivers; and
- make quality monitoring a more dynamic, data-driven process.

While the need for reform is widely acknowledged, mapping out a reform agenda and implementing it will take some time. The complexity of the state’s long-term care system cannot be overstated, as a change in one program has ramifications for access, cost, and quality in others. Even modest changes can have profound consequences on the health and well-being of vulnerable beneficiaries. The strategy for reform must be systemic, not restricted to one program in isolation from the others.
About This Report

The purpose of this United Hospital Fund report is to inform these important policy decisions by providing an overview of how New York’s Medicaid long-term care system is currently organized. It provides a September 2007 snapshot of program enrollment, associated annual spending, and a summary of the rules that govern how each program operates. The data in the report will help policymakers better understand the challenges facing the long-term care system and identify key policy options for addressing them.

This report has five main chapters, which may be read together or as separate, stand-alone papers. Chapter 1, the system overview, provides data on the state’s long-term care programs, organization, and financing, and concludes with a discussion of critical issues for further research and discussion. This overview is followed by four chapters that present an in-depth look at four of the state’s largest long-term care programs: nursing homes, personal care, the Long-Term Home Health Care Program, and Medicaid managed long-term care.

Each chapter, including the system overview, is arranged into three sections:

**Program Snapshot**: Recent data on the program and the people served by it. Includes figures on enrollment, spending, demographics, and geography.

**Rules, Regulations, and Administrative Structure**: Descriptions of the programs’ organization, financing, legal basis, and regulation.

**Policy Implications**: Critical issues for future research and discussion.

At the end of the full report are technical notes on the data sources and methodology used in the analyses, and a glossary of terms and acronyms used throughout.

It is our hope that the data and analysis in this report will help guide efforts to improve the state’s long-term care system, on which so many New Yorkers depend.
Acknowledgments

This report would not have been possible without the generous and substantial input of the following individuals: David Gould, Fredda Vladeck, and Miles P. Finley of the United Hospital Fund; Carol Rodat of PHI; Thomas Dennison of Syracuse University; Rick Surpin of Independence Care System; Marie Brady of the New York City Human Resources Administration; Al Cardillo and Patrick Conole of the Home Care Association of New York State; Nick Asimakopoulos, Peter Gallagher, Mark Kissinger, and Carla Williams of the New York State Department of Health; and Darius Kirstein and Diane Darbyshire of New York Association of Homes and Services for the Aging.

The authors also gratefully acknowledge the input of many others who generously shared their time and expertise for this endeavor: Ann Berson of the NYC Chapter of the Alzheimer’s Association; Linda Gowdy, Kathleen Sherry, Mary Graziano, Mary Beth Fader, and Tim Casey of the New York State Department of Health; Barbara Draim and Arnold Ng of the Home Care Services Program of the New York City Human Resources Administration; Roberta Brill, Judy Duhl, and Kathryn Haslanger of the Visiting Nurse Service of New York; Valerie Bogart of the Evelyn Frank Legal Resources Program of Selfhelp Community Services; Sara Meyers of Enea, Scanlan & Sirignano, LLP; Sara Butterfield of IPRO; Joe Campanella of the Home Care Council of New York City; Joanne Cunningham and Andrew Koski of the Home Care Association of New York State; Paul Dieterich of Dieterich & Associates Consulting; Paula Freedman of Freedman Associates; Stuart Kaufer of Center for Independence of the Disabled, New York; Richard Mollot and Cynthia Rudder of the Long Term Care Community Coalition; Tracey Sokoloff of Isabella Geriatric Center; Paul Tenan of American PACE Exchange; Christine Fitzpatrick of Adult Day Health Care Association of New York; Karen Elder of the United Hospital Fund; Allen Rosen of YAI; and Paula Wilson.
Chapter 1
System Overview

An Overview of Medicaid Long-Term Care Programs in New York

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April 2009
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Introduction

This report provides an overview of New York State's 12 Medicaid long-term care programs that primarily enroll frail seniors and adults with disabilities. Monthly enrollment in these programs (247,000) accounts for roughly 6 percent of the state's 4.1 million Medicaid beneficiaries. Much of this population suffers from multiple chronic illnesses that cause, contribute to, and interact with functional and cognitive disabilities; care for this group can be intensive and costly. Spending for these long-term care programs was roughly $12.3 billion in federal fiscal year (FFY) 2007, more than a quarter of all Medicaid spending in the state.

The state's long-term care programs fall into two broad categories corresponding to the setting where most services are provided: residential; and home and community-based. Two-thirds of long-term care beneficiaries are enrolled in community-based programs.

New York Medicaid Long-Term Care Programs Primarily Serving Frail Seniors and Adults with Disabilities

<table>
<thead>
<tr>
<th>Residential Programs</th>
<th>Community-Based Programs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing Homes (NH)</td>
<td>Traditional Personal Care (PC)</td>
</tr>
<tr>
<td>Medicaid Assisted Living Program (ALP)</td>
<td>Consumer-Directed Personal Assistance Program (CDPAP)</td>
</tr>
<tr>
<td></td>
<td>Long-Term Home Health Care Program (LTHHCP)</td>
</tr>
<tr>
<td></td>
<td>Medicaid Managed Long-Term Care (MMLTC)</td>
</tr>
<tr>
<td></td>
<td>Program of All-Inclusive Care for the Elderly (PACE)</td>
</tr>
<tr>
<td></td>
<td>Certified Home Health Agency (CHHA) Services</td>
</tr>
<tr>
<td></td>
<td>Medical Adult Day Health Care (MADHC)</td>
</tr>
<tr>
<td></td>
<td>Traumatic Brain Injury (TBI) Waiver</td>
</tr>
<tr>
<td></td>
<td>Nursing Home Transition and Diversion Waiver (NHTDW)</td>
</tr>
<tr>
<td></td>
<td>Medicaid Advantage Plus</td>
</tr>
</tbody>
</table>

Long-Term Care Population: Health Status and Demographics

In New York's current long-term care system, it is difficult to compare key measures of beneficiary need — cognitive impairments, physical (functional) limitations, and chronic medical conditions — across care settings and among programs because this information is not easily accessible.
not collected in a common format. Each program uses a different assessment tool. The extent to which cognitive impairments, physical disabilities, and chronic illnesses (and often a combination of all three) impair an individual’s ability to perform activities of daily living and instrumental activities of daily living drives the need for long-term care. In community-based settings, the provision of care is influenced by other critical factors: the availability and capacity of family support; housing and living situations; and the availability of community services, such as transportation.

Although most long-term care program beneficiaries in both community-based and residential settings are 65 years of age or older, there is a sizeable population of younger beneficiaries too, who are more likely to be enrolled in community-based programs than in residential settings. For example, 83 percent of Medicaid nursing home residents are 65 or older, compared to only 59 percent of beneficiaries enrolled in community-based programs.\(^7\)

**Functional Limitations:** Long-term care beneficiaries have a wide range of needs. Some function well with minimal help, while others require around-the-clock care in a nursing home or at home. There is no common measure of functional impairment in the state’s long-term care programs. The most consistently available proxy is the need for nursing home level of care. [See discussion in the Eligibility section.]

Roughly two-thirds of the state’s Medicaid long-term care beneficiaries (157,000 individuals) have nursing home level of care needs. This estimate includes 79,000 nursing home residents; 51,000 in community-based programs limited to individuals with nursing home level of care needs; and an additional 27,000 in the traditional personal care program (Hokenstad et al. 2002).\(^8\)

---


\(^8\) Although the traditional personal care program does not require nursing home level of care for eligibility, previous UHF research estimated that 65 percent of PC beneficiaries in New York City require such a level of care. The number of PC beneficiaries in the rest of the state who require a nursing home level of care is unknown.
Cognitive Status: There is also no common measure of cognitive status in the state's long-term care programs. An imperfect compilation of available data suggests that roughly two-thirds of nursing home residents and one-half of beneficiaries in community-based programs have some degree of cognitive impairment.

Figure 1.1
Medicaid Long-Term Care Beneficiaries with Nursing Home Level of Care Needs

Note: NHLOC programs include ALP, LTHHCP, TBI, MMLTC, and PACE. Non-NHLOC programs include CDPAP, CHHA, and Medicaid ADHC.

Figure 1.2
Medicaid Long-Term Care Beneficiaries with Cognitive Impairment, by Program

Note: As previously noted, each program uses a different tool to assess cognitive impairment. We were unable to identify a valid source for extent of cognitive impairment in the LTHHCP.
Data Sources and Methods

There is no single reliable source of enrollment and spending data for New York’s Medicaid long-term care programs. In order to determine the number of beneficiaries enrolled in the programs and associated Medicaid spending, this analysis relies on data from several sources.

The enrollment data comes from the New York State Department of Health (SDOH) Management and Administrative Reporting Subsystem (MARS), a monthly summary of Medicaid program statistics, for September 2007. In a few programs, an accurate beneficiary count could not be ascertained from MARS; for these programs, enrollment data comes from provider census data. The spending data comes from the Centers for Medicare & Medicaid Services (CMS) Financial Management Reports (Form 64) and the MARS for Federal Fiscal Year 2007. In this study, the CMS 64 is used where possible to report spending by service or program because it reflects an audited record of actual Medicaid payments. Because the CMS 64 does not provide sufficiently disaggregated data by service or program, the MARS data is also used. To reconcile these data sets, the share of spending by service or program from the MARS is imputed into the service category totals from the CMS 64. The analysis excludes programs that primarily enroll individuals with developmental or intellectual disabilities and those that primarily enroll medically fragile children, such as the Care at Home waiver programs.

This study’s focus is long-term care as opposed to short-term post-acute care. However, two of the key providers of long-term care services — nursing homes and certified home health agencies — also provide a substantial amount of post-acute care. Available data sources do not distinguish between the two kinds of services. Because the distinction is significant for policy purposes, rough estimates of post-acute enrollment and spending are provided in the Technical Notes and in footnotes throughout this report. See Appendix II for more detail on methods and other data sources used.
Finally, for ease of discussion, this report employs a broad definition of “program.” In the current long-term care system, the distinction between covered services and the programs that provide them is hazy; the terms are often used interchangeably. Many individuals access long-term care services exclusively from a licensed service provider, such as a nursing home. Others receive them through designated “programs,” such as the Long-Term Home Health Care Program, which offer a constellation of services. In this report, "program" refers both to designated long-term care programs and to large groups of beneficiaries who access services exclusively from a licensed provider. For example, “personal care program beneficiaries” refers here to people receiving traditional personal care services and not enrolled in one of the designated long-term care programs.

Programs Highlighted in Report
This report focuses primarily on four of the largest Medicaid long-term care programs in New York: nursing homes, traditional personal care (also known as the Home Attendant program in New York City), the Long-Term Home Health Care Program (LTHHCP; also known as the Lombardi program or Nursing Home Without Walls), and Medicaid managed long-term care (MMLTC). Together, they account for 73 percent of long-term care program enrollment and 82 percent of associated long-term care spending.

This chapter presents an overview of New York’s Medicaid long-term care system, with particular focus on the four programs noted above. Chapters 2 – 5 of this report provide in-depth profiles of the programs.

System Snapshot: Recent Data on New York’s Long-Term Care Programs

Enrollment and Spending
In September 2007, there were approximately 247,000 individuals receiving Medicaid long-term care services in programs that primarily enroll frail seniors and adults with physical disabilities. Of these, approximately two-thirds (166,000) were receiving services in community-based settings; the remaining one-third (81,000) were receiving services in residential settings, almost entirely in nursing homes.

Medicaid spent roughly $12.3 billion on these programs in FFY 2007. Fifty-three percent of this spending ($6.6 billion) was for residential programs, almost entirely for nursing homes. The remaining 47 percent ($5.8 billion) was spent on community-based programs.
Figure 1.3
Enrollment and Spending in Medicaid Long-Term Care Programs, by Care Setting, 2007

![Bar chart showing enrollment and spending percentages]

* Community-based programs include traditional PC, CHHA, CDPAP, ADHC, TBI, LTHHCP, MMILTC, and PACE programs.

Table 1.1
Summary of Medicaid Long-Term Care Program Enrollment and Spending, by Program, 2007

<table>
<thead>
<tr>
<th>Medicaid LTC Programs</th>
<th>September 2007 Enrollment</th>
<th>FFY 2007 Spending</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of Beneficiaries[a]</td>
<td>Percentage of Total LTC</td>
</tr>
<tr>
<td>Nursing Homes</td>
<td>79,000</td>
<td>32%</td>
</tr>
<tr>
<td>Medicaid Assisted Living Program</td>
<td>2,000</td>
<td>1%</td>
</tr>
<tr>
<td><strong>Residential care</strong></td>
<td><strong>81,000</strong></td>
<td><strong>33%</strong></td>
</tr>
<tr>
<td>Traditional Personal Care</td>
<td>57,000</td>
<td>23%</td>
</tr>
<tr>
<td>Certified Home Health Agencies[b]</td>
<td>41,000</td>
<td>17%</td>
</tr>
<tr>
<td>Long-Term Home Health Care Program</td>
<td>24,000</td>
<td>10%</td>
</tr>
<tr>
<td>Medicaid Managed Long-Term Care</td>
<td>20,000</td>
<td>8%</td>
</tr>
<tr>
<td>Medical Adult Day Health Care</td>
<td>13,000</td>
<td>5%</td>
</tr>
<tr>
<td>Consumer-Directed Personal Care Program of All-Inclusive Care for the Elderly</td>
<td>7,000</td>
<td>3%</td>
</tr>
<tr>
<td>TBI Waiver</td>
<td>3,000</td>
<td>1%</td>
</tr>
<tr>
<td>Community-Based Care</td>
<td>166,000</td>
<td>67%</td>
</tr>
<tr>
<td><strong>Total LTC</strong></td>
<td><strong>247,000</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

Sources: Based on UHF analysis of September 2007 MARS, FFY 2007 CMS-64, 2007 LTHHCP census, and 2006 RHCF-4 cost report.
Notes: Enrollment is a snapshot from September 2007; spending is for FFY 2007. Categories may not sum to total due to rounding.
[a] Within a given month, a beneficiary may receive more than one of the long-term care services listed above; these beneficiaries have been included in enrollment figures for all such services. Therefore, enrollment totals and subtotals include some duplication in the number of LTC beneficiaries. According to UHF analysis of SDOH data, there is approximately 6 percent duplication across all long-term care programs; less than 1 percent duplication in residential programs; and almost 10 percent duplication in community programs. See Technical Notes for additional detail.
[b] Reported CHHA enrollment and spending figures for September 2007 include some short-term (typically post-acute) care recipients, defined here as beneficiaries who received home health care in September but not in each of the previous three months (June, July, or August 2007). According to an SDOH/OHIP analysis, 31 percent of Medicaid CHHA recipients were receiving such short-term home health care; this population accounted for approximately 16 percent of all reported CHHA spending in September 2007. An undetermined amount of short-term care is also included in nursing home enrollment and spending figures.
New York City vs. Rest of State: There are wide geographic differences in program enrollment and spending patterns between New York City and the rest of the state. Most enrollment in community-based programs is in New York City, while most nursing home enrollment is elsewhere in the state.

New York City also accounts for most long-term care spending. The proportion of spending in New York City compared to the rest of the state ranges from 53 percent of nursing home expenditures to 93 percent of Medicaid managed long-term care expenditures.

Figure 1.4
Share of Medicaid Long-Term Care Program Enrollment in New York City, September 2007

Figure 1.5
Share of Medicaid Long-Term Care Program Spending in New York City, FFY 2007

Figure 1.6
New York Counties, by Region


Direct Care Service Spending: Most spending in community-based programs is attributable to direct care services.\(^9\) We were not able to obtain comparable data for nursing homes, but a significant proportion of the spending is attributable to direct care in that setting as well.

Figure 1.7
Share of Medicaid Long-Term Care Spending on Direct Care Services, by Community-Based Program

![Bar chart showing percentage of Medicaid Long-Term Care spending on direct care services by program.]

Sources: UHF analysis of September 2007 MARS data; NYS Managed LTC Plan Performance, CY 2005 (from American PACE Exchange); and Hokenstad 1995.
Note: Payment rates for direct care services in the LTHHCP include A&amp;G (and care management) costs as well.

Program and Provider Capacity
As a matter of policy, the state does not restrict any of its long-term care programs geographically, and in practice most are available statewide. However, some program alternatives are not readily available everywhere in the state. For example, Medicaid managed long-term care is available primarily in New York City. Some rural counties (e.g., Chenango) have no LTHHCP provider or certified home health agency, and some (Schuyler, Madison) have extremely limited home care capacity.\(^10\)

There has been a net reduction in long-term care capacity in the nursing home sector in recent years. Several factors have contributed to this reduction. First, an increasing portion of the state’s nursing home beds are used to provide short-term care and post-acute

\(^9\) While the traditional personal care program provides only direct care services, approximately 11 percent of spending is for administrative costs, which includes quarterly nursing visits to supervise the direct care worker and review the plan of care.

\(^10\) Thomas Dennison, personal communication. See also: http://homecare.nyhealth.gov/.
rehabilitation (estimated at more than 13 percent in June 2008). Additionally, following the recommendations of the New York State Commission on Health Care Facilities in the 21st Century, the state has eliminated nearly 1,100 beds and plans to eliminate another 1,600 by 2011.

**Provider Caseload Size:** The size of individual providers within each program varies widely. For example, provider caseload size in the MMLTC program ranges from as few as 130 enrollees in some rural counties to as many as 5,900 in a single plan in New York City. In community-based programs, the average provider caseload in New York City is typically two to three times larger than that seen in the rest of the state.

<table>
<thead>
<tr>
<th>Medicaid LTC Program</th>
<th>Region</th>
<th>Number of Providers</th>
<th>Average Caseload Size</th>
<th>Range of Caseload Size</th>
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</thead>
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<tr>
<td>Nursing Homes</td>
<td>NYC</td>
<td>180</td>
<td>230</td>
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<td>Rest of State</td>
<td>469</td>
<td>150</td>
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<td>New York State</td>
<td>649</td>
<td>170</td>
<td>20 – 810</td>
</tr>
<tr>
<td>Traditional Personal Care</td>
<td>NYC</td>
<td>62</td>
<td>660</td>
<td>400 – 2,000</td>
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<td></td>
<td>New York State</td>
<td>215</td>
<td>270</td>
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<td>LTHHCP</td>
<td>NYC</td>
<td>29</td>
<td>350</td>
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<td></td>
<td>Both NYC and ROS</td>
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<td>700</td>
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<td>Rest of State</td>
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<td>13</td>
<td>1,410</td>
<td>130 – 5,900</td>
</tr>
</tbody>
</table>

Sources: Based on UHF analysis of SDOH Nursing Home Profile website, January 2008 Medicaid LTC reimbursement rate computation sheets for personal care (SDOH website), December 2008 NYC personal care vendor authorized caseload size (estimate from HRA), 2007 LTHHCP provider census, and September 2007 SDOH Monthly Medicaid Managed Care Enrollment Report.

Note: Average provider size for nursing homes was calculated for all residents in the home (beds in use), including non-Medicaid beneficiaries. Average caseload for personal care reflects authorized caseloads; we were unable to obtain actual enrollment by provider.

**Provider Payment**

More than half of Medicaid long-term care beneficiaries are enrolled in programs paid on a fee-for-service basis. The rest are enrolled in programs that are paid on a per-capita basis for each beneficiary enrolled.

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11 There were a total of 111,128 nursing home residents in June 2008. [Source: American Health Care Association, Health Services Research and Evaluation, analysis of CMS OSCAR Form 672.] Of these, 71 percent (79,031 residents) were Medicaid beneficiaries, 13 percent were Medicare beneficiaries, and 16 percent had other coverage or were paying privately.

Figure 1.8
Enrollment and Spending in All Medicaid Long-Term Care Programs, by Payment Type, 2007

Note: Daily rate = nursing homes, ALP, and ADHC. Monthly rate = MMLTC and PACE. Fee-for-Service = PC, CHHA, LTHHCP, ADHC, consumer-directed PC, and TBI.
Note: Percentages are rounded and may not sum to 100%.

Figure 1.9
Enrollment and Spending in Medicaid Community-Based Long-Term Care Programs, by Payment Type, 2007

Note: Daily Per-Person Rate = ADHC; Monthly Per-Person Rate = MMLTC and PACE; Fee-for-Service = PC, CHHA, consumer-directed PC, LTHHCP, and TBI.
Note: Percentages are rounded and may not sum to 100%.
Looking only at community-based programs, those that are paid on a per-capita basis (Medicaid managed long-term care, adult day health care, and PACE) account for only 22 percent of community-based program enrollment.

Direct Care Workforce

All of the state’s long-term care programs provide direct care, here defined as assistance with activities of daily living (ADLs) and instrumental activities of daily living (IADLs). There is no single source of information about the workforce specific to the Medicaid program or to the beneficiary population examined in this report. For all populations and public payers (both Medicaid and Medicare), there are an estimated 100,000 certified nursing aides, 131,000 home health aides, and 60,000 personal care aides (including home attendants) employed in New York State.\(^\text{13}-\text{14}\)

Job Titles and Training Requirements: New York’s Medicaid long-term care programs use a number of job titles to describe the workforce that provides direct care services: home attendant, personal care aide, home health aide, and certified nursing aide.\(^\text{15}\) Although there are modest differences in the range of tasks that direct care workers in these different titles can provide, and slightly different training requirements, the job responsibilities are essentially the same.\(^\text{16}\) For ease of discussion, the paraprofessionals performing these jobs are referred to collectively in this report as direct care workers.

<table>
<thead>
<tr>
<th>Medicaid LTC Program</th>
<th>Job Title</th>
<th>Hours of Training Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing Home</td>
<td>Certified Nursing Aide</td>
<td>100</td>
</tr>
<tr>
<td>Traditional Personal Care</td>
<td>Home Attendant</td>
<td>40</td>
</tr>
<tr>
<td></td>
<td>Personal Care Aide</td>
<td>40</td>
</tr>
<tr>
<td>LTHHCP</td>
<td>Personal Care Aide</td>
<td>40</td>
</tr>
<tr>
<td></td>
<td>Home Health Aide</td>
<td>75</td>
</tr>
<tr>
<td>MMLTC</td>
<td>Personal Care Aide</td>
<td>40</td>
</tr>
<tr>
<td></td>
<td>Home Health Aide</td>
<td>75</td>
</tr>
</tbody>
</table>

Source: PHI.
Note: These are minimum state requirements; many providers provide additional on-the-job training.

\(^\text{13}\) PHI analysis of NYS Department of Labor statistics. Note that direct care worker employment in New York State is a rolling average of 2005 through 2007 and includes those working with: people with mental retardation or developmental disabilities, children, and people requiring short-term or post-acute care.

\(^\text{14}\) While the majority of home health aides, personal care aides, and home care aides are located in New York City, a much larger percentage of nursing aides and attendants are located elsewhere in the state.

\(^\text{15}\) Direct care services, also known as personal care services, are defined here as assistance with activities of daily living and instrumental activities of daily living.

\(^\text{16}\) The federal government requires 75 hours of certified nursing assistant (CNA) training. New York, like many other states, has additional requirements. As part of the required 100 hours, New York requires 30 hours of on-site clinical training in a nursing home facility.
Employment Arrangements and Worker Wages: Employment arrangements vary by region and program. Nursing homes directly employ most direct care workers as salaried staff. In New York City, traditional personal care program providers also directly employ direct care workers, while MMLTC and LTHHCP providers typically sub-contract with licensed home care service agencies (LHCSAs) for this service. In the rest of the state, it is more common for community-based program providers to employ their own workers, but a large proportion of direct care services are still provided through contractual arrangements with a LHCSA.

Workers in community settings are typically paid on an hourly basis. There is not a good source of statewide information about worker wages; however, in New York City, certified nursing aides and home attendants earn roughly $13 and $10 per hour, respectively. In contrast, home health aides earn roughly $7 to $8 per hour. The $2 to $3 per hour discrepancy between direct care worker wages in community-based settings is the result of the home attendant sector being unionized for more than 20 years with a master collective bargaining agreement administered by the Human Resources Administration, New York City’s department of social services. Furthermore, the city’s personal care program is governed by a living wage law that requires a $10 minimum wage for agencies with city contracts. Home health aides have unionized more recently, and the living wage law does not apply to them because they do not work directly under a city government contract.

Turnover Rates: In 2007, the national annual turnover rate for direct care workers (certified nursing assistants) was roughly 66 percent, compared to 47 percent for New York State (American Health Care Association 2008). Again, there is no reliable source of information about turnover rates by region. However, workforce analysts report lower turnover in nursing homes in New York City than in those in other parts of the state, where the experience is more similar to the national average. There is also no definitive source of information about turnover rates for direct care workers in community-based settings at the national, state, or local level. National and local estimates range from 40 to 50 percent (Seavey et al. 2006). Workforce analysts report much higher turnover rates in New York City’s home health aide workforce than in the city’s home attendant workforce, which averages about 10 to 15 percent annually. They report rates comparable to or worse than the national average in other parts of the state. Lower turnover in New York City’s personal care program and nursing homes is likely related to the previously mentioned labor-management agreements and living wage law mentioned above, and to more stability in obtaining full-time work. 

According to PHI (2008) the real median wage in 2006 for personal and home care aides in New York was $8.03 per hour.
Training: Most basic training programs are sponsored by long-term care providers. There are 385 provider-sponsored training programs approved by the Department of Health to provide the basic training course for personal care aides and home health aides, and an additional 162 nursing-home sponsored programs that provide basic training for certified nursing aides. In New York City, the unions that represent the majority of direct care workers sponsor the 1199 SEIU Training Employment Fund and the Consortium for Worker Education, which also provide the basic training course. The State Department of Education approves additional training programs, such as those offered by Boards of Cooperative Educational Services, community colleges, and proprietary training schools.

Organizational Sponsorship

Some programs can only be offered by specific types of organizational sponsors. For example, LTHHCP providers may only be sponsored by a nursing home, hospital, or a community-based certified home health care agency.

Figure 1.10
Enrollment and Spending in Medicaid Long-Term Care Programs, by Organizational Sponsor, 2007

Note: Percentages are rounded and may not sum to 100%.

Figures are as of April 2008 from SDOH, Home Health Aide Training Programs, All Programs: Open and Closed, posted to the Health Provider Network.

An additional 200 proprietary and other programs train certified nursing assistants as well. The department of health does not approve these programs; they are approved by the education department.
However, it is not uncommon for a single organization to sponsor more than one kind of long-term care program. In terms of both enrollment and total spending, the nursing home sector is the largest organizational sponsor of long-term care programs. They account for an estimated 42 percent of long-term care beneficiary enrollment and 59 percent of all Medicaid long-term care spending in programs primarily serving frail seniors and adults with disabilities.

**Rules, Regulations, and Administrative Structure**

A basic understanding of the rules that govern service delivery and the differences between the various long-term care programs provides an important context for understanding why the state’s long-term care system looks the way it does today, and how it might be improved. The state’s long-term care programs vary in terms of eligibility, covered services, enrollment procedures, payment methodology, and regulatory requirements.

**Federal Coverage Requirements**

As a condition of receiving federal matching funds for their Medicaid programs, all states are required to follow rules established by the federal government. Some of these rules apply to all states; others are proposed by individual states and approved (or rejected) by CMS. The results of these compulsory rules and negotiated agreements are the official operating rules for state Medicaid programs; they are commonly referred to as the State Medicaid Plan.

**Federal Coverage Requirements for New York State Medicaid Long-Term Care Programs**

<table>
<thead>
<tr>
<th>“Entitlement Programs”</th>
<th>1915(c) Waiver Programs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mandatory</td>
<td>Long-Term Home Health Care Program</td>
</tr>
<tr>
<td>Nursing Homes</td>
<td>Traumatic Brain Injury (TBI) Waiver</td>
</tr>
<tr>
<td>Certified Home Health Agency</td>
<td>Nursing Home Transition and Diversion Waiver</td>
</tr>
<tr>
<td>Optional</td>
<td></td>
</tr>
<tr>
<td>Traditional Personal Care</td>
<td></td>
</tr>
<tr>
<td>Consumer-Directed Personal Care</td>
<td></td>
</tr>
<tr>
<td>Medical Adult Day Health Care</td>
<td></td>
</tr>
<tr>
<td>Medicaid Assisted Living Program</td>
<td></td>
</tr>
</tbody>
</table>

| Managed Care Programs                                                                    |                                                             |
| Medicaid Managed Long-Term Care                                                         |                                                             |
| Program of All-Inclusive Care for the Elderly                                            |                                                             |
| Medicaid Advantage Plus                                                                  |                                                             |

20 Revenue from the federal government accounts for approximately half of all Medicaid spending in New York. For more information, see Birnbaum 2008.
The federal government requires states to provide some long-term care services (mandatory services) and gives them the option to cover others (optional services). These mandatory and optional state plan services, which must be made available to all individuals who meet statewide eligibility requirements, are sometimes referred to as “entitlements” because of their specific protections under federal law. In contrast, the federal government also allows states to provide long-term care to specific populations through 1915(c) waivers and managed care plans, but it gives them much more latitude to establish eligibility criteria.

**Mandatory and Optional State Plan Services:** Like all states, New York is required to provide nursing home care and home health care, also known as certified home health agency (CHHA) services. Like 33 other states, New York provides personal care as an optional state plan service, and does so in two ways: as traditional personal care (services provided by an agency) and as consumer-directed personal assistance (services provided by an individual hired and supervised directly by the beneficiary or their surrogate). The state has also opted to provide medical adult day health care services.

**1915(c) Waiver Programs:** New York, like all other states (except Arizona), has also chosen to provide long-term care through 1915(c) waiver programs. Section 1915(c) of the federal Social Security Act allows states to request a waiver of certain federal Medicaid requirements in order to establish community-based programs for specific target populations, such as frail seniors with nursing home level of care needs (defined below, in the Eligibility section). States have the authority to limit enrollment in these “waiver” programs by age, geographic region, or type of disability; there is no limit on the number of 1915(c) waiver programs a state can operate (Kitchener et al. 2005). New York has nine long-term care waiver programs that provide mandatory and optional state plan services (home health care and personal care) together with services not typically provided by Medicaid (called “waiver services”), such as home modification and meals on wheels. They also provide care management or service coordination. Only three of the nine programs primarily serve frail seniors and adults with physical disabilities: the Traumatic Brain Injury waiver program (TBI); the Nursing Home Transition and Diversion Waiver (NHTDW); and the Long-Term Home Health Care Program (LTHHCP), which is by far the largest. Federal approval to operate waiver programs must be reauthorized every five years.23
Managed Care: The federal government also allows states to provide long-term care services through managed care plans. New York provides long-term care services through three kinds of managed care arrangements — Medicaid managed long-term care (MMLTC), the Program of All-Inclusive Care for the Elderly (PACE), and Medicaid Advantage Plus. All three programs provide mandatory and optional state plan services (such as home health care, personal care, adult day health care, nursing home care, and preventive health care services such as dentistry and podiatry) and “waiver” services. They also provide care management services but have a broader scope of responsibility than waiver programs. They are responsible for managing the totality of beneficiaries’ health, mental health, and long-term care needs. The primary difference between the three programs is in how they are financed. MMLTC is financed exclusively by Medicaid, whereas PACE and Medicaid Advantage Plus are financed by both Medicaid and Medicare. As a result, PACE and Medicaid Advantage Plus provide (and pay for) Medicare covered services, such as primary and acute care. MMLTC is required to coordinate these services but does pay for them.

Geographic Availability and Choice: All 12 of the state’s long-term care programs are available statewide; New York does not restrict any of them to specific areas. In addition, enrollment in all programs is voluntary; New York does not mandate that beneficiaries access long-term care through any one particular program.

The Significance of Entitlement Programs
In contrast to some states that provide long-term care services exclusively through 1915(c) waiver programs (many of which have waiting lists), New York provides long-term care services primarily through its mandatory and optional state plan service “programs.” States are not permitted to maintain waiting lists for the services accessed through these programs.

Eighty percent of New York’s beneficiaries access long-term care through an “entitlement” program; associated spending accounts for 86 percent of Medicaid long-term care spending. Beneficiaries enrolled in waiver programs and managed long-term care plans account for 20 percent of all long-term care beneficiary enrollments; associated spending accounts for 14 percent of long-term care spending.

24 In terms of federal coverage requirements, PACE is technically a state plan optional service.
25 New York does require, however, that dually eligible beneficiaries (those who have both Medicaid and Medicare coverage) who are enrolled in a Medicare Advantage plan (Medicare HMO) receive Medicaid long-term care services through a Medicaid Advantage Plus plan sponsored by the same organization if it offers one.
Covered Services

Each of the state’s long-term care programs provides a distinct assortment of services. The services provided by the four programs described in this report are outlined below.

**Direct Care:** All of the state’s long-term care programs provide assistance with activities of daily living (ADLs), such as bathing and toileting, and instrumental activities of daily living (IADLs), such as meal preparation and housekeeping. However, each program uses different terminology to describe this type of care. For ease of discussion, these services are referred to as direct care in this report. See the Glossary for additional detail.

### Activities of Daily Living and Instrumental Activities of Daily Living (ADLs and IADLs)

**ADLs:**
- Feeding
- Toileting
- Bathing
- Transferring/Mobility
- Dressing/Grooming

**IADLs:**
- Household Chores
- Meal Preparation/Shopping
- Escort/Errands
Care Management: Three of the four programs (nursing homes, LTHHCP, and MMLTC) provide care management services, typically provided by nurses who are directly employed by the provider and sometimes by social workers. While the purpose of care management is to coordinate care, the scope of care management responsibilities is not well defined. As a result, it varies among the programs, as well as among providers within the same program.

Skilled Nursing and Therapies: Three of the four programs (nursing homes, LTHHCP, and MMLTC) provide skilled nursing services, physical therapy, speech therapy, and occupational therapy. However, because home health care (which includes skilled nursing and therapies) is a federally mandated service, traditional personal care program beneficiaries are not prohibited from accessing these services directly from a certified home health agency.

Waiver Services: Two of the four programs (LTHHCP and MMLTC) provide “waiver” services, such as home modification and meals on wheels. Waiver services are services that are not typically covered by Medicaid but are available to specific populations through 1915(c) “waiver” programs. The different programs (and individual providers within each program) provide slightly different sets of waiver services.

Nursing Home Care: Two of the four programs (nursing homes and MMLTC) provide nursing home care. Although current long-stay nursing home residents are not eligible to enroll in MMLTC, individuals who come to need this service after a period of enrollment are eligible to receive it and have it paid for by MMLTC; beneficiaries do not have to disenroll from MMLTC, and can continue to receive care coordination services from the MMLTC while receiving nursing home care. In contrast, beneficiaries in the LTHHCP or the traditional personal care program must disenroll from these programs in order to receive Medicaid long-stay nursing home care.

Preventive Care: Two of the four programs (nursing homes and MMLTC) are responsible for providing preventive care services, such as dentistry, optometry, and podiatry. However, because preventive care services are also Medicaid State Plan services, beneficiaries enrolled in the LTHHCP and traditional personal care programs are not prohibited from accessing them independently.

PACE and Medicaid Advantage Plus plans also provide care management services.

Care management is distinct from service coordination, a covered service in several of the smaller 1915(c) waiver programs (TBI, NHTDW). In these programs, service coordination is separated completely from the delivery of other services; one organization coordinates the plan of care, and one or more other organizations provide direct care and other specified services.
### Table 1.4
Covered Services, by Program

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Traditional PC</th>
<th>LTHHCP</th>
<th>MMLTC</th>
<th>Nursing Homes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Direct Care (home attendant, home health aide, personal care aide, or certified nursing aide)</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Care Management Services (provided by a nurse and/or social worker)</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Skilled Nursing and Therapies (physical therapy, occupational therapy, speech pathology)</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>“Waiver” Services (such as meals on wheels, home modifications, and respite care)</td>
<td>N/A</td>
<td>X</td>
<td>X</td>
<td>N/A</td>
</tr>
<tr>
<td>Nursing Home Care</td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Preventive Care (dentistry, optometry, podiatry, prostheses and orthotics, etc.)</td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

List of covered services according to CMS and New York State Department of Health websites:

**Eligibility — Medical and Financial**

Within federal guidelines, states have considerable latitude to establish eligibility rules for Medicaid long-term care services. In all states, beneficiaries must demonstrate both financial and medical need. Compared to other states, New York has fairly generous eligibility criteria.

**Medical (Functional) Eligibility Criteria**

For all long-term care programs (except certified home health agencies), applicants must demonstrate that they need help in order to perform direct care tasks. The need for assistance must result from a functional, cognitive, or medical impairment.

**Nursing Home Level of Care:** Eligibility for eight of the 12 long-term care programs is restricted to beneficiaries who require a level of care available in a nursing home. Each of the state’s long-term care programs uses a different assessment tool — and therefore slightly different criteria — to determine level of need. As a result, there is not a consistent definition of nursing home level of care across programs. The criteria always include an evaluation of functional capacity, cognitive status, health conditions, and clinical care needs.

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49 For more information on Medicaid long-term care program eligibility, see Bogart 2007.
50 The medical criterion for CHHA services is the need for “skilled care,” services typically provided by a specific type of professional — e.g., a nurse, physical therapist, or speech therapist. Also, eligibility to receive housekeeping services through the Personal Care program technically requires that an individual requires help with only IADLs, such as shopping, meal preparation, and housekeeping. Research suggests that most beneficiaries also need assistance with ADLs.
General Financial Eligibility Criteria

To be eligible for Medicaid long-term care, applicants must first meet general Medicaid eligibility rules. New York’s Medicaid state plan covers individuals with incomes up to the equivalent of approximately 80 percent of the federal poverty limit ($8,700 annually), and limits assets to $13,050 in savings. For long-term care, there is an additional limit on assets — beneficiaries cannot have home equity valued at more than $750,000.

<table>
<thead>
<tr>
<th>NH Level of Care Required</th>
<th>NH Level of Care Not Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing Homes</td>
<td>Traditional Personal Care</td>
</tr>
<tr>
<td>Long-Term Home Health Care Program</td>
<td>Consumer-Directed Personal Assistance Program</td>
</tr>
<tr>
<td>Medicaid Managed Long-Term Care</td>
<td>Certified Home Health Agency Services</td>
</tr>
<tr>
<td>Medicaid Assisted Living Program</td>
<td>Medical Adult Day Health Care</td>
</tr>
<tr>
<td>Program of All-Inclusive Care for the Elderly</td>
<td></td>
</tr>
<tr>
<td>Traumatic Brain Injury Waiver</td>
<td></td>
</tr>
<tr>
<td>Nursing Home Transition and Diversion Waiver</td>
<td></td>
</tr>
<tr>
<td>Medicaid Advantage Plus</td>
<td></td>
</tr>
</tbody>
</table>

Table 1.5

<table>
<thead>
<tr>
<th>Medicaid Eligibility: Income and Resource Levels, 2008</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Income Levels</strong></td>
</tr>
<tr>
<td>Monthly</td>
</tr>
<tr>
<td>Medicaid Eligibility Levels</td>
</tr>
<tr>
<td>Spousal Support and Resource Level</td>
</tr>
<tr>
<td><strong>Asset Levels</strong></td>
</tr>
<tr>
<td>$13,050</td>
</tr>
<tr>
<td>$74,820 – $104,400</td>
</tr>
</tbody>
</table>


Medically Needy Program: Higher-income applicants with high medical expenses may still qualify for Medicaid through the Medically Needy Program (commonly called the “spend-down” program). New York, like many other states, allows applicants with excess income attributable to medical expenses to “spend down” to the financial resource limit in order to qualify for Medicaid. In New York in 2008, “excess income” was the amount of monthly income above $725 attributable to medical expenses. For example, a man who routinely spends $25 a month on an over-the-counter medication would still qualify for Medicaid if his income was $750. Beneficiaries are required to document medical expenses above the income threshold in order to maintain eligibility.
The Medically Needy program plays an important role in access to long-term care. In 2003, one-quarter of all the state’s Medicaid enrollees qualified through the Medically Needy program. This trend was consistent for all Medicaid eligibility categories except the elderly; more than 70 percent of seniors who qualified for Medicaid did so through this program.31

**LTC-Specific Financial Eligibility Criteria**

Some financial eligibility criteria, such as the limit on the value of home equity, are unique to long-term care beneficiaries; other rules are unique to individual programs. For example, nursing homes have more stringent requirements than community-based programs, but they also have specific protections for beneficiaries’ spouses.

**Transfer of Assets:** Financial eligibility for nursing home care is subject to a retrospective review of assets (also called a look-back period) and is subject to financial penalties. For example, an applicant is subject to a penalty period if he or she has transferred assets (such as by making gifts to children or grandchildren) within the three years before applying for Medicaid. During the penalty period, he or she is ineligible to receive Medicaid-covered services. As a result of the federal Deficit Reduction Act of 2005, this federally mandated look-back period for nursing home care is being gradually extended from 36 to 60 months; expansion began in February 2009. New York does not require a financial look-back period for any other Medicaid long-term care program.

**Spousal Resource Protections:** Federal law also mandates income and asset thresholds for the spouses of nursing home residents ("community spouses") to ensure that they are not forced into poverty as a result of their wife or husband receiving long-term care; New York has traditionally granted the maximum spousal resource protections allowable under federal law ($31,320 in income and $104,400 in assets in 2008). New York currently provides comparable resource protections for spouses of beneficiaries enrolled in the Long-Term Home Health Care Program, as discussed in Chapter 4 of this report, but not for those enrolled in its two other 1915(c) waiver programs for these populations, TBI and NHTDW. There are no specific spousal resource protections for other long-term care programs.

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Spousal Refusal: New York also extends the spousal refusal provision, which is federally mandated for nursing home care, to its other long-term care programs. The provision protects the right of a Medicaid beneficiary’s spouse to remove his or her income or assets from the financial eligibility determination. (The state has the right to appeal when it believes the spouse has sufficient means to pay.) In programs that do not have specific spousal resource protections, the spousal refusal provision serves the same effective policy purpose — it helps ensure that spouses are not forced into poverty as a condition of their wife or husband receiving long-term care.

Table 1.6
Medicaid Financial Eligibility Rules Specific to Long-Term Care

<table>
<thead>
<tr>
<th>Medicaid LTC Program</th>
<th>Transfer of Asset Penalty</th>
<th>Spousal Resource Protections</th>
<th>Spousal Refusal</th>
<th>Home Equity Limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing Home</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Traditional PC</td>
<td></td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>LTHHCP</td>
<td></td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>MMLTC</td>
<td></td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>

Administration of Medicaid Determination

As it does for general Medicaid, county government is responsible for determining Medicaid financial eligibility for long-term care, on behalf of the State Department of Health (SDOH). Counties are required to make the initial determination of financial and medical eligibility within 45 days of application, and are then responsible for reauthorizing Medicaid eligibility every 12 months.14

Fair Hearings and Appeal Rights: Federal law requires that Medicaid eligibility be determined within 45 days, unless there is the need to establish disability status for the purposes of Supplemental Security Income (SSI) determination, in which case eligibility must be completed within 90 days. All Medicaid beneficiaries have the right to a fair hearing if they are deemed ineligible for services or receive fewer hours of service than they believe they need.

14 When retroactive coverage is appropriate, a case may be authorized for up to 15 months — 3 months retroactively and 12 months prospectively.
Access

Most beneficiaries access Medicaid long-term care services directly from a hospital following a crisis resulting from a sudden or dramatic health care event, such as a stroke or a fall. With the exception of the personal care program, beneficiaries typically enroll with the help of an individual program provider (a nursing home, LTHHCP provider, or MMLTC plan) who is then the service provider. Applicants to the personal care program, on the other hand, apply directly to their local department of social services office.

Information on Program and Providers: The SDOH website provides general information about Medicaid long-term care programs, services available, and how to access them. There is variation in how much additional information individual counties provide. The state is in the midst of implementing NY Connects, an initiative at the county level that will establish central points of information about long-term care services. As of January 2009, NY Connects programs were in operation in 47 of the state’s 62 counties.

Information about program-specific provider performance is available to the public on the federal CMS Home Health Compare and Nursing Home Compare websites and on the SDOH Home Health Profile (launched in March 2008) and Nursing Home Profile websites. There are concerns about the limitations of the publicly reported quality measures for the purpose of helping beneficiaries choose providers.

Provider Requirements

The State Department of Health is responsible for determining service capacity. The size of some programs is controlled through the certificate of need process. For example, new nursing homes and LTHHCP providers, as well as nursing home beds and LTHHCP slots, must be pre-approved by the State Hospital Review and Planning Council, which generally approves recommendations advanced by the SDOH. New providers and provider size in the personal care program are determined by the local department of social services (on behalf of SDOH). New MMLTC plans (and Medicaid Advantage Plus plans) must be approved by both the SDOH and the State Department of Insurance. There is no limit on the size of individual plans.

33 As of January 2009, NY Connects was not available in the following counties: Chenango, Columbia, Hamilton, Livingston, Madison, Oswego, Rensselaer, Seneca, Suffolk, Warren; and the five counties of New York City. See www.nyconnects.org.
34 Because the state requires LTHHCP providers to adhere to the Medicare conditions of participation, the federal government includes them in its national evaluation of CHHA performance. This inclusion may unintentionally misrepresent their performance on key measures of emergent care use and hospitalizations because the LTHHCP beneficiary population is more chronically disabled, and the duration of care is much longer, than that of the typical CHHA Medicare beneficiary.
Payment

Personal care and LTHHCP providers are paid for the number of hours or visits they provide (fee-for-service). Nursing homes receive a daily rate and MMLTC plans receive a monthly rate for each beneficiary they enroll. Nursing home rates are risk-adjusted to account for higher resource requirements for frailer residents; MMLTC rates are not risk-adjusted. The State Department of Health is responsible for fiscal monitoring. Providers are required

to submit cost reports detailing their expenditures at least once a year. Financial penalties or suspension of enrollment privileges may be assessed if spending on individual services or administrative and general (A&G) costs are exceeded. There is no publicly reported information about provider financial performance.

Quality Monitoring

The State Department of Health has oversight responsibility for the state’s 12 long-term care programs. Responsibility for the majority of programs has recently been consolidated within a newly created division, the Office of Long-Term Care, while responsibility for the MMLTC program remains located in a bureau within the Office of Health Insurance Programs. Both offices report directly to the Commissioner of Health.

The state’s primary vehicle for evaluating quality of care is the on-site performance review (survey process). SDOH regional offices are responsible for conducting performance reviews; the frequency of these reviews ranges from at least once every 12 months to once every 36 months for the various programs. The SDOH is also responsible for monitoring the performance of the local departments of social services, which in turn are responsible for monitoring the performance of personal care and LTHHCP providers. CMS, under the auspices of its regulatory responsibility for the Medicare program, evaluates quality outcomes in three of the state’s programs — nursing homes, LTHHCP providers, and certified home health agencies.

<table>
<thead>
<tr>
<th>Medicaid LTC Program</th>
<th>Payment Method</th>
<th>Risk-Adjusted</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing Home</td>
<td>Per person per day</td>
<td>Yes</td>
</tr>
<tr>
<td>Traditional PC</td>
<td>Fee-for-service</td>
<td>N/A</td>
</tr>
<tr>
<td>LTHHCP</td>
<td>Fee-for-service</td>
<td>N/A</td>
</tr>
<tr>
<td>MMLTC</td>
<td>Per person per month</td>
<td>No</td>
</tr>
</tbody>
</table>
Policy Implications

New York's Medicaid program plays a fundamental role in meeting the long-term care needs of the estimated 247,000 individuals enrolled in one of the state's 12 long-term care programs that primarily enroll frail seniors and adults with physical disabilities each month. The state's Medicaid program now faces heightened fiscal pressures and demographic realities. This section of the report highlights current and future challenges, and identifies nine critical issues for further research and discussion. These issues are further explored in the accompanying program portraits, which provide a more in-depth look at four of the largest long-term care programs: nursing homes, personal care, the Long-Term Home Health Care Program, and Medicaid managed long-term care.

Critical Issues for System Redesign

- Information and Guidance at Points of Entry
- System Simplification
- Consistent Service Determinations
- Adequate Provider Capacity
- Effective Care Management
- Integration of Medicaid and Medicare Financing
- Payment Methodologies
- Direct Care Workforce: Paid and Family Care
- Regulation, Oversight, and Quality Improvement

In exploring these interrelated critical issues, it may be helpful to keep three general principles in mind:

- **Focus on people, not programs.** While it is essential to build on existing capacity, solutions should be appropriate to the needs of individuals and their caregivers. They should not merely preserve specific programs or individual providers.

- **Concentrate on systemic, not program-specific, reforms.** A change in one of the state's Medicaid-financed long-term care programs will affect access, cost, and quality in the rest. Thus, reform strategies should be systemic, not restricted to one program in isolation from the others.
• *Contemplate regional, not statewide, service delivery solutions.* Regional differences in
access to care and service utilization suggest the need for more uniform implementation of
policies and regulations. At the same time, solutions to questions about how to organize
and finance service delivery must be flexible in order to capitalize on existing capacity and
respond to varying regional circumstances.

**Critical Issues**

**Information and Guidance at Points of Entry**

Many people access long-term care services for the first time from a hospital or certified
home health agency at a moment of crisis, necessitating quick and often difficult decisions.
Some states have centralized access to Medicaid long-term care services through a single
organizational gateway (often called a “single point of entry”). This is not the case in New
York, where beneficiaries frequently seek services from an individual provider (e.g., a
nursing home or Medicaid managed long-term care plan) that then becomes their service
provider. These initial decisions can have a lasting impact, as the service provider selected
often continues to provide services over the long term. In the current system, there is wide
variation in how much information and support is currently provided by counties and other
common points of entry.

There is consensus that a reform agenda for New York State should include a strategy for
providing more timely information and guidance at points of entry and transition. However,
there is disagreement about how best to accomplish this: by consolidating access to all long-
term care services through one designated local entity (the single point of entry approach) or
by building capacity into pathways that already exist, such as hospitals and certified home
health agencies. Given regional differences that may favor one solution over the other, it is
conceivable that there might be different approaches in different parts of the state.
Regardless of the path (or paths) New York pursues, it will be important to clearly define expectations about what entry points into the long-term care system should be designed to accomplish and for whom. Responsibilities range from providing useful information (the goal of NY Connects) to actively helping beneficiaries plan for and secure services, which would involve more comprehensive needs assessments and options counseling. There are choices to be made about how to deliver and pay for these critical functions — for example, should they be provided individually or bundled? Should they be made available to all residents or only to Medicaid-eligible beneficiaries? Unsurprisingly, the thorniest issue is how a reorganized entry system would be financed, as any approach will require additional resources: for hiring and training qualified personnel, for ensuring that the available information stays current, and for implementing information technology for efficient data exchange.

**System Simplification**

New York’s Medicaid long-term care system is complex, serving a large population with diverse needs. Providing long-term care through 12 distinct programs supports the principle of choice by offering beneficiaries meaningful options. On the other hand, this array of programs adds complexity that runs counter to other policy goals — effective government oversight, provider efficiency, continuity of care, and cost-effectiveness. An important goal of system reform is to identify opportunities to simplify the long-term care system in ways that make it easier for beneficiaries and providers to understand and more manageable for government to regulate.

It is difficult to distinguish among the three community-based programs explored in this report — traditional personal care, the Long-Term Home Health Care Program, and Medicaid managed long-term care. They serve similar populations and most spending is attributable to direct care services. The LTHHCP and MMLTC provide care management and a broader array of services than the personal care program does, but the primary difference among the three programs is in how they are paid. The personal care program and LTHHCP providers are paid on a fee-for-service basis. In addition, the LTHHCP limits how much can be spent on each beneficiary to 75 percent of the average Medicaid nursing home rate in the same county. In practical terms, this means that beneficiaries in New York City who require more than 36 hours of direct care per week are not able to enroll in the LTHHCP. (As a point of reference, approximately 60 percent of New York City’s personal care program beneficiaries receive 36 or more hours of direct care per week.)

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35 There are some exceptions to this requirement. See Chapter 4.
MMLTC plans receive a monthly premium for each beneficiary they enroll; however, these premiums are not risk-adjusted. Therefore, plans may not have sufficient financial incentive or resources to enroll people with the most intensive direct care needs. As a result, some of these high-need individuals are enrolled in the personal care program. One of the most troubling aspects of the current long-term care system is the large number of beneficiaries in New York City who have nursing home level of care needs yet are enrolled in the personal care program. Many of these beneficiaries would likely benefit from care management and additional services that the MMLTC and the LTHHCP provide but that the personal care program does not.

A reform strategy must take a closer look at the population with nursing home level of care needs. Are they receiving the right care, in the right setting, at the right price? Given apparent overlap in target populations, it will be important to decide whether to maintain both LTHHCP and MMLTC programs as they are, consolidate them, or further differentiate between them by changing eligibility criteria, payment caps, or financing methodologies. Solutions must reflect regional differences. For instance, the LTHHCP plays a particularly significant role outside New York City. If the state opts to consolidate programs, it will likely need a different strategy for counties where the LTHHCP is the primary way for beneficiaries to receive community-based long-term care.

**Consistent Service Determinations**

Regional differences in enrollment, service utilization, and spending result, in part, from differences in the way local districts interpret state policies, such as health and safety regulations and level of need determinations. A stark example of such regional inconsistency may be seen in the personal care program: 24 percent of personal care program beneficiaries in New York City receive 12 to 24 hours of direct care per day, while this level of service is rarely found elsewhere in the state. In all likelihood, people outside New York City who require 24-hour care seven days a week, but do not have family members available to provide that much help, would receive care in nursing homes. A reform strategy should explore opportunities to achieve more consistent implementation of policies and regulations, including more specific guidelines about the roles and expectations of family caregivers.
The use of a different assessment tool in each program probably contributes to this variation. The Department of Health is in the process of developing a much-needed uniform assessment and data set. Such a tool is a fundamental building block for system reform. It has the potential to help meet a number of desirable policy objectives, including: a consistent definition of nursing home level of care; a standard basis for determining what resources are required to address a beneficiary’s needs; and a more robust evaluation of quality outcomes across programs and settings. Because several previous efforts to standardize an assessment tool have been unsuccessful, its accomplishment will depend on making this effort a high priority and garnering sufficient resources and stakeholder cooperation.

**Adequate Provider Capacity**

Regional differences in enrollment, service utilization, and spending also result from geographic variation in provider capacity. For example, in some rural counties there is no longer an LTHHCP provider or a certified home health agency, and in others access to direct care services is extremely limited. System redesign will require important decisions about where additional capacity and capital improvement projects are warranted, and how to finance them efficiently. These decisions would be informed by a needs methodology that can accurately project future needs and criteria to guide decisions about where the investments should be made.

In the current system, most providers have relatively small caseloads. Because they do not benefit from economies of scale, smaller organizations may struggle to remain financially viable, keep pace with technological advances, and provide clinical specialization. Smaller programs are also more vulnerable to the effects of the recent workforce shortages and rising transportation costs that have had a serious impact on access to services in some parts of the state. Better information would help assess where and to what extent smaller programs are needed to accommodate the needs of beneficiaries who live in rural or semi-rural areas, and where cost efficiencies could be achieved through provider consolidation without diminishing access to appropriate care.
Effective Care Management

Effective care management for people with multiple chronic health conditions helps prevent avoidable events, such as medication errors or urinary tract infections; promotes early treatment to slow functional and cognitive decline; and fosters more effective disease management, such as better glucose monitoring for diabetics. In order to address the full complement of beneficiaries’ needs, it will be important to implement strategies that more fully integrate long-term care with the delivery of medical, mental health, and social services. However, many factors make it difficult to provide care management that effectively balances cost and quality: a shortage of nurses and social workers with the required skills and experience; regulatory requirements whose documentation consumes a substantial amount of the time available to manage beneficiary care; differences in how providers interpret the scope of their care management responsibilities; and gaps in the availability of local services, such as transportation and in-home mental health care.

In the current system, care management is not consistently available where it is most needed. Some programs provide it; others do not. There is a need for more explicit criteria to guide decisions about who should receive care management and a routine process for identifying them, such as screening at points of entry and transition. A reform strategy also needs to determine if care management is mandatory for these individuals, or whether it should remain available only through designated programs (such as the LTHHCP and MMLTC). A reform agenda must also include a strategy for regularly monitoring and evaluating the effectiveness of care management, and for ensuring that professionals who perform this role have appropriate skills, training, and supervision.

More research would help determine which of the state’s program models are most successful at managing care for different populations, and how much they cost. Such research could inform both policy decisions about where additional capacity is needed, and beneficiary decisions about which program (or combination of services) is most appropriate.
Integration of Medicaid and Medicare Financing

Because most long-term care beneficiaries have multiple chronic medical conditions, they typically use a lot of medical services. For dually eligible beneficiaries (those with both Medicaid and Medicare coverage), acute care is paid for primarily by Medicare. Medicaid pays for long-term care services, but the substantial and more immediate savings that result from effective long-term care (e.g., avoiding costly hospitalizations) accrue primarily to Medicare, not Medicaid.

There is continuing interest at both the state and federal level in more fully integrating Medicare and Medicaid financing at the provider or plan level. The Program of All-Inclusive Care for the Elderly (PACE) is widely cited as a successful model of integrated financing and service delivery, but replicating the program (as currently configured) on a broad scale has been slow.\textsuperscript{36} In contrast, the state’s MMLTC plans have grown fairly rapidly, but MMLTC does not receive Medicare financing. To foster more service delivery integration and capture savings that accrue from effective long-term care, the State Department of Health now requires sponsors of new MMLTC plans to offer Medicare Special Needs Plans (SNPs);\textsuperscript{37} in addition, the Department of Health recently established a new program, Medicaid Advantage Plus.\textsuperscript{38}

Most MMLTC plans are currently sponsored by provider-based organizations. The new SNP requirement for future MMLTC sponsors and requirements for the new Medicaid Advantage Plus program both suggest the need for large organizational sponsors, such as insurance companies, that can assume the financial risks associated with providing both long-term and acute care. It may be difficult for provider-based organizations to meet these new requirements. Strategies to more fully integrate Medicare and Medicaid financing will need to consider how best to build on and incorporate the capacity and expertise of current long-term care providers.

\textsuperscript{36} PACE represents a very small share of long-term care enrollment and spending, with slightly more than 3,000 enrolled in September 2007. Providers receive prospective reimbursement from both Medicare and Medicaid and are responsible for all health care as well as long-term care services. The fiscal and regulatory requirements for PACE, such as the capital costs associated with building the required adult day health care system, restrict the number of community providers that can become plans (Hokenstad and Haslanger 2004).

\textsuperscript{37} A special needs plan (SNP) is a type of Medicare Advantage coordinated care plan that is designed specifically for beneficiaries with special needs, including institutional residents, dually eligible individuals, and people with severe or disabling chronic conditions. In 2008, there were 26 SNPs offered in New York; enrollment in the plans is optional. (Medicare Advantage is a more generic Medicare managed care plan available to all Medicare beneficiaries, regardless of their level of disability.) See Glossary.

\textsuperscript{38} Medicaid Advantage Plus is a managed care option for dually eligible individuals over the age of 18 with nursing home level of care needs. Beneficiaries must enroll in the same health plan for most of their Medicare and Medicaid benefits. Plans that participate in the program offer a uniform Medicare Advantage product and a supplemental Medicaid Advantage product, which also covers long-term care services. Enrollment in the plans is optional.
Payment Methodologies

The state’s nursing homes are paid a daily rate per person that is risk-adjusted to account for the additional resources associated with caring for individuals with more extensive needs. In community-based settings, the vast majority of beneficiaries are enrolled in programs that are paid on a fee-for-service basis. For these providers, revenue is directly related to units of service provided: more units mean more income. The remaining beneficiaries are enrolled in MMLTC and PACE plans, which receive per-capita payment; however, this payment is not risk-adjusted. In practical terms, unadjusted capitation means that plans may not have sufficient financial incentive or resources to enroll beneficiaries who are especially frail or have complex medical conditions. This situation has the potential to disrupt continuity of care if plans disenroll individuals whose care needs become too costly.

A reform agenda should consider a methodology for risk-adjusting Medicaid payment for MMLTC and PACE plans. More research is needed to address the many outstanding questions about how best to do this. For example, additional research is needed to determine the extent to which different payment methodologies achieve different results. Such analysis would help inform decisions about whether to risk-adjust payments in other programs that have traditionally been paid on a fee-for-service basis, such as the LTHHCP.

Regardless of how payment is structured, reform discussions should consider the extent to which underlying financial incentives affect current providers’ ability and capacity to change. For example, the LTHHCP is widely believed to subsidize the operation of nursing homes, and payment for direct care services in CHHAs and LTHHCP providers is widely believed to subsidize professional staff salaries and other mandates. Such cross-subsidization is not necessarily bad, but it does make it difficult to identify what Medicaid is paying for and at what price — and it may provide strong motivation for key parties to resist changing the way services are organized and financed.

Direct Care Workforce: Paid and Family Care

Direct care services account for a substantial share of service utilization and spending in all settings (PHI 2008). While technological innovations — such as telehealth monitoring of blood pressure — can make service delivery more efficient, they cannot replace the significant amount of direct care required by people with extensive physical and cognitive limitations. In the current system, workforce challenges — such as shortages and high
turnover — undermine access to quality care (Institute for the Future of Long Term Care Services 2007). Wage differentials limit the system’s flexibility to deploy a shrinking workforce where it is needed most. More information is required to determine if or how employment arrangements (such as subcontracting for direct care services) affects worker turnover, quality of care, and cost.

A strategy to develop a workforce that is better trained and more equitably compensated is essential. In formulating such a strategy, it will be important to examine cost-effective ways to provide worker training and continuing education, and to evaluate worker competency. For example, regional consolidation of training programs could be both efficient and a catalyst for better education. A workforce strategy should also include a socially responsible solution for achieving equity in direct care wages (comparable pay for similar work) across the long-term care sector. While reducing the current wage gap between home attendants and home health aides in New York City is an important step, it will not be easily accomplished in the current economic climate. Wage increases and rising health insurance costs are in direct competition for the scarce dollars available. Nonetheless, it is important to keep in mind the practical barrier that wage inequity presents to system reform. For example, in the current system, when a beneficiary moves voluntarily from personal care to MMLTC, a new direct care worker is assigned — otherwise the worker would have to accept lower wages and benefits when switching programs. Potential reform strategies, such as achieving administrative savings through program consolidations, may hinge on having flexibility to reassign workers where they are needed most.

The state’s workforce policy must also reflect the reality that there are two direct care workforces — paid workers and unpaid family caregivers — that increasingly work in tandem (Gibson and Houser 2007; Raphael and Cornwell 2008). Family members have no legal obligation to help but frequently do, and their contributions are significant. While family participation is not an explicit eligibility criterion for receiving long-term care, it is a common consideration that influences both eligibility determinations and service allocation decisions. In the current system, caregivers have no formal rights to information or services that would support their contributions (Levine et al. 2006). The effect of reform proposals on their participation and well-being should be carefully considered.
Finally, in light of workforce shortages, a reform agenda will need to determine the role consumer-directed care should play in a future service delivery system, including the extent to which beneficiaries may identify and hire their own workers. A reform strategy needs to consider whether to continue to provide the option through a single program (consumer-directed personal assistance program), or incorporate it more broadly into other programs. Although it is considerably smaller than the other programs highlighted in this report, the consumer-directed personal assistance program is growing rapidly — particularly outside New York City, as it is harder to recruit and retain direct care workers outside the city. Rising transportation costs may also be a factor in the growth of CDPAP in areas with limited or no public transportation.

Regulation, Oversight, and Quality Improvement

New York’s strategy for providing long-term care has come a long way since the 1970s, when nursing homes were the predominant care setting. Despite significant changes in the way services are delivered and financed, the performance survey process remains the primary mechanism for evaluating program quality, focusing on ensuring minimal standards, such as no harm (beneficiary safety) as compared to facilitating good care (quality outcomes). In addition, as the system has grown, new regulations have been layered upon the old ones, rather than replacing them. For example, many of the physical plant requirements for nursing home construction have become inconsistent with modern-day thinking about how physical spaces should be organized in order to create more home-like living environments.

A reform agenda should consider how to make quality monitoring a more dynamic, data-driven process. It must also achieve greater balance between regulations designed to ensure beneficiaries’ health and safety, and the freedom and flexibility required to provide high-quality care, such as creating more home-like nursing homes and other residential environments. Finally, since oversight responsibility for long-term care programs is divided between the Office of Long-Term Care and the Office of Health Insurance Programs within the State Department of Health, there must be a concerted effort to promote consistency in long-term care policy and regulation.
Conclusion

There is no escaping the reality that providing high-quality services to people who need extensive long-term care will require substantial resources — regardless of the provider, program, or setting. For example, the state will need substantial resources to care for nursing home beneficiaries, a population that on the whole is frailer and more medically complex than that served in community settings, and to update many of the facilities' aging infrastructures (Eljay 2008). At the same time, the state's community-based long-term care programs are also serving a population that has extensive needs; for example, roughly half of beneficiaries in community settings have some degree of cognitive impairment. Meeting the needs of a large population with cognitive impairment and other demanding conditions in the least restrictive setting (typically the home) may not be the most cost-efficient way to provide long-term care, especially if ensuring a beneficiary's health and safety requires 24-hour care. However, if providing individual in-home services is not financially sustainable, the state will need to pursue new alternatives that bridge the gap between current residential and community-based programs.

The next generation of long-term care policy will be crafted in challenging economic times. The pace of change will be influenced by external factors, such as workforce shortages, the scarcity of affordable housing, and widespread fraud and abuse investigations. While these barriers are significant, they are not insurmountable.

A reform agenda for long-term care in New York should include strategies to:

• Provide timely information and guidance at points of entry and transition
• Simplify the long-term care system in ways that make it easier for beneficiaries and providers to understand and for government to regulate
• Promote more consistent implementation of policies and regulations
• Determine where additional capacity and capital improvements are warranted and the most efficient ways to finance them
• Routinely identify individuals who meet criteria for care management and determine how best to provide and pay for it
• More fully integrate Medicare and Medicaid financing and decide how to build on and incorporate existing provider capacity into these efforts
• Align payment to beneficiaries' level of need, through risk-adjusted per capita payments or other reimbursement strategies

Part of the Federal-State Health Reform Partnership (F-SHARP) agreement that provides an additional $1.5 billion in Medicaid financing to the state over five years was an agreement to bolster fraud and abuse recoveries in general and in the long-term care sector specifically.
• Develop a better trained and more equitably compensated workforce that can be readily deployed where it is needed most, and sustain and support family caregiver involvement
• Make quality monitoring a more dynamic, data-driven process

Effective responses to the challenges inherent to developing these strategies would benefit from the input of all of the key stakeholders: policymakers, beneficiaries, family members, advocates, labor unions, service providers, private sector leaders, and others. New York’s progress will depend on many of the same factors that have contributed to its success thus far: cooperation and sustained leadership at all levels of government, a continued public policy commitment to providing high-quality care in the most integrated home-like settings, ongoing experimentation with new approaches, and progressive eligibility rules that ensure community care is a financially viable alternative to nursing home care.
References


Chapter 2
Nursing Homes

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and Roger Auerbach of Auerbach Consulting, Inc.

April 2009
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An estimated 111,000 New Yorkers were receiving nursing home care in June 2008. Not all of them were receiving long-term care services. For example, an estimated 13 percent had their care paid for by Medicare, which pays for short-term/post-acute skilled nursing and rehabilitation services up to 100 days after a related hospital stay. Another 16 percent had their care paid by other insurance or paid for it privately. The remaining 71 percent (79,000 individuals) were Medicaid nursing home residents — Medicaid beneficiaries receiving long-term care.

**Figure 2.1**

Percentage of Nursing Home Patients, by Primary Payer, June 2008


**Enrollment and Spending**

Medicaid nursing home residents account for an estimated one-third of Medicaid long-term care beneficiaries; the balance receive care in community-based settings.

Medicaid spent roughly $6.5 billion in FFY 2007 on nursing home care, accounting for 53 percent of Medicaid long-term care spending in programs primarily serving frail seniors and adults with disabilities in the state.

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1 This program portrait is a chapter of An Overview of Medicaid Long-Term Care Programs in New York by Alene Hokenstad and Meghan Shineman of the United Hospital Fund with Roger Auerbach of Auerbach Consulting, Inc. Please note: The spending and enrollment figures in this report are estimates for 10 programs primarily serving frail seniors and adults with disabilities, including nursing homes, Medicaid Assisted Living Program (ALP), traditional personal care (PC), certified home health care (CHHA), consumer-directed PC (CDPAP), adult day health care (ADHC), the Long-Term Home Health Care Program (LTHHCP), the Traumatic Brain Injury (TBI) waiver, Medicaid Managed long-term care (MMLTC), and the Program of All-Inclusive Care for the Elderly (PACE). They do not include programs that primarily serve people intellectual disabilities or medically fragile children, such as the Care at Home Program. See the Technical Notes of the full report for a discussion of data sources and research methods.

2 Medicare does not pay for long-term care services.

3 According to the American Health Care Association, Health Services Research and Evaluation, analysis of CMS OSCAR Form 672, there were a total of 111,128 nursing home residents in June 2008. Of these, three-fourths (71.1 percent) or 79,031 residents were Medicaid beneficiaries. The rest were Medicare beneficiaries (13.1 percent) or had other coverage or were paying privately (15.8 percent).
Figure 2.2
Percentage of Nursing Home Enrollment and Spending as a Share of All Medicaid LTC Programs, FFY 2007

Source: UHF analysis of FFY 2007 CMS-64 and Sept 2007 MARS. Percentages are rounded and may not sum to 100%.
Note: Community-based services include traditional PC, CHHA, CDPAP, ADHC, TBI, LTHHCP, MMLTC, and PACE programs.

Figure 2.3
Share of Enrollment and Spending in New York City, by Medicaid LTC Program, FFY 2007

New York City vs. Rest of the State: In contrast to regional distribution patterns for community-based long-term care programs, the majority of residential long-term care beneficiaries are in nursing homes outside of New York City. Forty-four percent of the nursing home enrollment (and 53 percent of spending) is in New York City, compared with 56 percent of enrollment (and 47 percent of spending) in the rest of the state.

Program and Provider Capacity

In 2006, there were 649 nursing homes and 119,000 total beds in New York.\(^4\) Thirty-eight percent of all nursing home beds are in New York City; 62 percent in the rest of the state.\(^5\)

The number of nursing homes and beds has changed very little in the last decade. However, the number of admissions has more than doubled — a result of nursing homes providing more short-term, post-acute rehabilitation services (Dennison 2008). In 2006, the Commission on Health Care Facilities in the 21st Century (also known as the Berger Commission) recommended the downsizing or closure of 3,000 nursing home beds, or 3 percent of the state’s supply. As a result, the state plans to close seven homes, eliminating 1,100 beds by the end of 2008. Another 1,600 nursing home beds are expected to be taken out of the system by 2011.\(^6\) These trends suggest that New York’s nursing homes, on the

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\(^4\) Beds also include those dedicated for Medicare-only and short-stay-only patients.

\(^5\) UHF analysis of SDOH Nursing Home Profiles

\(^6\) This final tally will be 300 beds short of the report’s recommendations.
whole, are providing less long-term residential care than they used to, and will likely be providing even less in the future.

Occupancy rates have also declined in the last decade, dropping from 97 percent in 1996 to 92 percent in 2007 – a rate still considerably higher than the national average of 85 percent. The average occupancy rate in 2006 ranged from 92 percent in the New Rochelle region to 95 percent in New York City. We do not know how the proportion of beds occupied by Medicaid long-term care residents (as opposed to short-stay patients) varies across the state.

<table>
<thead>
<tr>
<th>Region</th>
<th>Number of Homes</th>
<th>Number of Beds</th>
<th>Occupancy Rate, 2006</th>
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<tr>
<td>New York City</td>
<td>180</td>
<td>45,248</td>
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<tr>
<td>Rest of State</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Capital</td>
<td>71</td>
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<tr>
<td>New Rochelle</td>
<td>90</td>
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<td>92.1%</td>
</tr>
<tr>
<td>Western/Buffalo</td>
<td>79</td>
<td>11,228</td>
<td>94.5%</td>
</tr>
<tr>
<td>Western/Rochester</td>
<td>63</td>
<td>9,079</td>
<td>94.7%</td>
</tr>
<tr>
<td>New York State (Total)</td>
<td>649</td>
<td>119,040</td>
<td>94.2%</td>
</tr>
</tbody>
</table>


**Workforce:** In 2007, the national annual turnover rate for direct care workers (certified nursing assistants) was roughly 66 percent, compared to 47 percent for New York (American Health Care Association 2008). We do not have accurate turnover rates by region. However, workforce analysts report that the turnover rate is lower in New York City than in other parts of the state, where the experience is more similar to national averages. Lower turnover in New York City is likely related to labor-management agreements and the city’s Living Wage Law, which result in a higher and standardized wage.
Health Status and Demographics

Recent research documents that the Medicaid nursing home resident population in New York is sicker and frailer than it was five years ago (Eljay 2008). Nearly two-thirds (63 percent) are cognitively impaired, and one-half have psychiatric diagnoses. The “typical” resident has five or more chronic conditions, is obese, and takes ten or more medications (Dennison 2008).

Rules, Regulations, and Administrative Structure

Federal Coverage Requirements
Nursing home care is a federally mandated Medicaid state plan service.

Covered Services
Nursing homes are required to provide room and board; 24-hour nursing services; specialized rehabilitative services; medical social services; pharmaceutical services; dietary services; activities programs; routine dental care; and assistance with personal care.

Eligibility — Medical and Financial
Applicants must meet both medical and financial eligibility requirements. They cannot have a primary diagnosis of either severe and persistent mental illness or intellectual disability, such as mental retardation or a developmental disability.¹⁰

Medical Eligibility: The determination of medical eligibility is based primarily on the level of functional disability and extent of clinical conditions. Before a Medicaid beneficiary can enter a nursing home, New York mandates the use of two instruments to assess medical eligibility.

¹⁰ For extensive information on Medicaid long-term care program eligibility, see Bogart 2007.
eligibility: the Patient Review Instrument (PRI) and the Screen. The PRI, which is valid for 30 days, is necessary for Medicaid reimbursement in nursing facilities. Developed by the State Department of Health (SDOH), the PRI is a more comprehensive assessment than the Screen. It is used to assess functional, cognitive, medical, and behavioral health characteristics in order to determine the level of care and the type of services required. It must be administered by a nurse, generally one employed by the facility to which the beneficiary is seeking admission. If the PRI indicates that the individual can be cared for in his or her own home or in an adult home, an additional evaluation called a Screen is required. The Screen uses information gathered from the PRI and explores viable alternatives to nursing home placement. It can be completed by a social worker or other professional who has completed a required training course and is often administered in hospitals. The State Department of Health is planning to eliminate the PRI in 2009, and will use the Minimum Data Set (MDS) to assess medical eligibility instead. Unlike some community-based programs and many other states, New York does not have additional prior approval requirements for nursing home admission.

Financial Eligibility: County government (on behalf of SDOH) is responsible for determining financial eligibility. Nursing homes may assist applicants in obtaining necessary documentation. In addition to meeting the criteria that apply to general Medicaid eligibility determinations (income no greater than $8,700 annually and savings no greater than $13,050), applicants must meet criteria specific to nursing home care. For example, financial eligibility is subject to a retrospective review of finances. As a result of the Federal Deficit Reduction Act of 2005, this “look-back” period will be gradually extended from 36 to 60 months starting in February 2009. Federal law also mandates income and asset thresholds for the community-spouse of a NH resident for the purpose of ensuring that they are not forced into poverty as a condition of their spouse accessing nursing home services. New York has traditionally afforded spouses (and other legally responsible relatives) the maximum income and asset protections allowable under federal law: $2,610 per month ($31,320 annually) in income, and between $74,820 and $104,400 in assets in 2008.

The PRI includes assessment items in five general areas: Administrative Data (date of birth, etc.); Medical Conditions and Treatments (12 conditions, such as diabetes and urinary tract infections, and 13 medical treatments, such as wound care and transfusions); Activities of Daily Living (the degree to which the resident is independent in four areas: eating, mobility, toileting, and ability to transfer between positions); Selected Behaviors (frequency of verbally disruptive, physically aggressive, disruptive or socially inappropriate behavior, or hallucinations); Specialized Services (the frequency and level that the resident has received “specialized services, such as physical or occupational therapies, and physician visits; and the monthly average number of medications); and Diagnosis (the medical condition that requires the largest amount of nursing time).

In New York, the Screen is also used to comply with the federally required Pre-Admission Screening & Resident Review process, which is required upon admission and if a resident has a significant change in physical or mental condition.

Individuals whose income is higher than the rules allow may still qualify for Medicaid through the state’s Spend-Down (Medically Needy) program, which allows applicants with “excess income” (the amount above $730 per month) attributable to medical expenses to “spend down” to the financial resource limit in order to qualify for Medicaid (See Chapter 1).

In February 2009, the look-back period was 36 months; in March 2009, the look-back period expanded to 37 months. It will continue expanding thus until February 2011, when the look-back period will reach 60 months.
Access

Almost 90 percent of NH admissions (both short-term patients and long-term residents) come from hospitals (Dennison 2008). Often with the assistance of hospital staff, applicants apply directly to individual nursing homes. We do not know how many beneficiaries initially enter as rehab patients and remain in nursing homes on a longer-term basis.

Care Planning: Upon admission, an interdisciplinary team of licensed health care professionals employed by the facility (such as nurses, social workers, and therapists) conducts a comprehensive needs assessment (including nursing, psychosocial, nutritional, and behavioral issues). For care planning purposes, nursing homes are required to complete the Minimum Data Set (MDS).14 The federal government requires nursing homes that receive Medicare reimbursement to assess all of its residents with the MDS regardless of the payer source.15 The MDS is also administered quarterly and anytime there is a significant change in a resident’s functional status. Residents must have physician’s orders governing the scope of their medical treatment, including orders for medication.

Information for Consumers: Both federal and state websites provide basic information about the characteristics of nursing homes (facility locations, special services), performance on key quality indicators (such as successful treatment of pressure ulcers), and the results of an annual on-site survey of their performance.16

14 Currently nursing homes use the MDS 2.0; however, CMS plans to implement the new MDS 3.0 nationally, reportedly in October 2010. (Source: http://www.ascp.com/resources/index/mds.cfm)
15 The MDS basic assessment covers the following areas: customary routine, cognitive patterns (communication, hearing, and vision patterns); psychosocial well-being, physical functioning and structural problems; continence; disease diagnoses and health conditions; oral, dental, and nutritional status; skin condition; activity pursuit patterns; medications; special treatments and procedures; discharge potential; and vaccine immunization status.
Provider Requirements

New facilities, facility renovations, and the addition of new beds must be approved by the State Hospital Review and Planning Council. Unlike some other states, New York does not license nursing homes that only accept Medicaid; all facilities must participate in both the Medicare and Medicaid programs. While nursing facilities in New York cannot systematically discriminate against patients because of source of payment, they are not required to have an open admission policy.17

Payment

The state’s Medicaid program pays each nursing home a daily rate that is “risk-adjusted” (case-mix indexed) to account for the clinical complexity and extent of functional impairment of its resident population.18 Rates are also adjusted to account for capital costs and regional variation in spending. In 2007, facilities in New York City received the highest average daily rates. In June 2008, the federal Centers for Medicare & Medicaid Services (CMS) approved the state’s proposal to base nursing home rates on 2006 rates. These rebased rates are effective April 2009 and will be calculated using a Medicaid-only case mix.

Table 2.2
Medicaid Nursing Home Payment Rates, by Region, 2007

<table>
<thead>
<tr>
<th>Region</th>
<th>Range of Daily Rates</th>
<th>Average Daily Rate</th>
<th>Average Monthly Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>New York City</td>
<td>$158—338</td>
<td>$248</td>
<td>$7,535</td>
</tr>
<tr>
<td>Rest of State</td>
<td>$115—302</td>
<td>$188</td>
<td>$5,719</td>
</tr>
<tr>
<td>Capital</td>
<td>$119—224</td>
<td>$164</td>
<td>$4,978</td>
</tr>
<tr>
<td>Central</td>
<td>$119—234</td>
<td>$160</td>
<td>$4,853</td>
</tr>
<tr>
<td>Long Island</td>
<td>$170—302</td>
<td>$237</td>
<td>$7,218</td>
</tr>
<tr>
<td>New Rochelle</td>
<td>$148—280</td>
<td>$205</td>
<td>$6,248</td>
</tr>
<tr>
<td>Western/Buffalo</td>
<td>$115—268</td>
<td>$163</td>
<td>$4,960</td>
</tr>
<tr>
<td>Western/Rochester</td>
<td>$120—259</td>
<td>$173</td>
<td>$5,267</td>
</tr>
<tr>
<td>New York State (Average)</td>
<td>$115—338</td>
<td>$210</td>
<td>$6,400</td>
</tr>
</tbody>
</table>

Source: UHF analysis of 2007 Medicaid LTC reimbursement rate computation sheets for nursing homes.
Note: Estimated weighted averages based on estimated occupancy of facility. Rates for special units (i.e., AIDS, TBI, Neuro, and Vent) have been excluded.

17 New York State regulations require nursing homes to accept a “reasonable percentage” of Medicaid beneficiaries, defined as equal to 75 percent of annual enrollment rate in the respective planning area.
18 Reported rates do not include a $4 per day add-on for every resident with a primary diagnosis of cognitive impairment.
Bed Hold: Under certain circumstances, nursing homes are paid for “reserving” a bed for a beneficiary who is temporarily absent, such as in the case of a hospitalization. Before April 2009, payment for bed hold days was equal to the facility’s full daily “risk-adjusted” rate. This policy is intended to protect continuity of care by ensuring that beneficiaries can return to the same nursing home following an emergent care event. Bed hold payment, however, was only available to nursing homes with an occupancy rate of 95 percent or higher. It is limited to beneficiaries who have resided in the facility for at least 30 days, and is available for only 30 days, but can be used more than once in a year as appropriate.

Financial Reporting: Nursing homes are required to submit annual cost reports detailing their expenditures. Consequences for non-submission include fines and suspension of admitting privileges. There are no specific “rewards” for compliance. Public information about the financial performance of New York’s nursing homes is principally available through reports issued by provider associations (e.g., the Greater New York Hospital Association and the New York Association of Homes & Services for the Aging).

Quality Monitoring

The State Department of Health (on behalf of CMS) is accountable for monitoring nursing home performance; counties do not have a substantial role. CMS, under the auspices of its regulatory responsibility for the Medicare program, also evaluates quality outcomes (based on MDS and OSCAR data) in nursing homes. Measures of nursing home performance are publicly reported on the federal Nursing Home Compare and the state nursing home profile websites. Per federal law, nursing homes are subject to an annual on-site performance review (survey). Failure to meet survey standards can result in sanctions and civil monetary penalties. With the exception of a small pay-for-performance initiative in nursing homes, there are no specific financial rewards for good compliance or good clinical outcomes.

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19 Bed hold payment (or the reserved bed rate) is established for the facility by New York’s Commissioner of the Department of Health and approved by the Director of the Budget. A regulatory proposal to change the bed hold policy was accepted as part of the Enacted 2009-10 State Budget. It changes the bed hold payment to 75 percent of the facility’s full daily rate and increases the minimum occupancy rate to 97 percent.
20 Department of Health regulation (Title 10 NYCRR 415.3 – Resident’s Rights and Title 18 NYCRR 505.9 – Residential Health Care).
22 Federal law requires that performance surveys be conducted at least every 15 months, although the state average for all facilities must be equivalent to 12.9 months.
23 In 2004, New York passed a law creating a Nursing Home Quality of Care Improvement Fund, a segregated account for monies collected from federal civil money penalties and state fines. The state uses these funds, last reported at about $500,000, to finance nursing home improvement projects through individual grants.
24 In January 2008, SDOH posted draft regulations to establish a payment methodology for rate enhancements to nursing homes that demonstrate exceptional (or most-improved) performance in managing pressure ulcers.
New York’s nursing homes play a fundamental role in meeting the long-term care needs of an estimated 79,000 Medicaid nursing home residents each month. Much of this population suffers from multiple chronic illnesses that cause, contribute to, and interact with functional and cognitive disabilities; care for this group can be intensive and costly. In FFY 2007, Medicaid spending for nursing home care was roughly $6.5 billion. This section of the report explores some of the challenges facing the state’s nursing homes, and identifies critical issues for further research and discussion about how the delivery of long-term care services could be improved.

Information and Guidance at Points of Entry
Most people in nursing homes enter them for the first time at a moment of crisis, often following a hospitalization, which necessitates quick and often difficult decisions. With little time to evaluate alternatives, beneficiaries and their family members frequently select a facility based on a short list provided by a hospital discharge planner and with the beneficiary’s immediate needs for short-term (post-acute) care as a priority. Some individuals who enter a nursing home for short-term, post-acute care may end up receiving long-term care at the same facility. Selecting a nursing home is an important decision, particularly if that facility becomes the long-term service provider. In the current system, there is wide variation in how much information and support is provided to help beneficiaries and families make such decisions.

While there is consensus that a reform agenda for New York State should include a broad strategy for providing more timely information and guidance at points of entry and transition, there is disagreement about how best to accomplish this: by consolidating access to all long-term care services through one local entity, or by building more capacity into pathways that already exist. Reform strategies should explore which kinds of interventions, such as those in hospitals and nursing homes shortly after admission, are most likely to help beneficiaries (and family members) make informed care choices.

Quality of Care
The nursing home population overall is more frail and medically complex than the long-term care population in community settings (Eljay 2008). There is no escaping the reality that substantial resources are needed to care for this vulnerable population — a sizable group that will continue to require nursing home care for the foreseeable future.
Ensuring high quality care for this vulnerable population, at a time when New York faces significant fiscal challenges, is essential. Strategies to improve residents’ quality of life and end-of-life care merit particular attention. A reform agenda should include a strategy for achieving greater balance between regulations designed to ensure beneficiaries’ health and safety, and the freedom and flexibility required to implement changes that improve beneficiaries’ quality of life. For example, many of the physical plant requirements for nursing home construction have become inconsistent with modern-day thinking about how physical spaces should be organized in order to create more home-like living environments. There are successful strategies for improving quality of life, such as those that transform physical environments and that give beneficiaries and direct care workers more control over day-to-day decisions. Consideration should be given to how such “best practices” could be applied more broadly, and their costs and benefits should be assessed. Transitions at the end of life, most commonly nursing home-to-hospital transfers, are disruptive to beneficiaries and costly to both the Medicaid and Medicare programs. Better information and timelier decision-making about care plan goals and the role of palliative care could help prevent undesired medical interventions and transitions in the last months of life.

Transition and Diversion to Community-Based Care

The proportion of Medicaid nursing home residents whose long-term care needs could be met in community-based settings probably varies by region. Common barriers to effective transitions — such as lack of community-based provider capacity, workforce shortages, and the lack of affordable housing — are known to vary regionally. However, the only available rough estimate of those who could be transitioned (5 to 10 percent) is for the entire state (New York State Commission on Health Care Facilities 2006). More information is needed to quantify the potential target population at a county and regional level. A reform agenda should identify where there are opportunities to transfer beneficiaries from nursing homes to community settings; it should also include strategies for overcoming existing barriers. Because meeting the needs of individuals with cognitive impairments and other demanding conditions in the least restrictive settings (typically at home) is not necessarily the most cost-efficient way to provide long-term care, a reform agenda should also explore opportunities to bridge the gap between current residential and community-based programs.

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25 The Green House model is an example of how transformed physical environments and staff roles can be combined to improve quality of life. Green houses are self-contained dwellings for seven to ten residents requiring nursing home levels of care. They incorporate physical design changes such as private rooms and bathrooms, a residential-style kitchen, a communal dining area, and accessible outdoor space. Institutional elements — like medication carts, public address systems, and nurses’ stations — are avoided. The model also transforms the hierarchy of the institutional staff, giving wider responsibilities to certified nursing assistants who are supervised by an administrator, or “guide.” A visiting clinical team comprises all other professional staff members, such as nurses, doctors, physical therapists, and social workers (Kane et al. 2007).
Provider Capacity

New York’s current “rightsizing” initiatives for nursing homes are taking place at the tail end of a ten-year decrease in total long-term care bed capacity (New York State Commission on Health Care Facilities 2006). System redesign will require important decisions about where additional capacity and capital improvement projects are warranted, on a regional basis, and how to finance them efficiently. Addressing the needs of an aging nursing home infrastructure will require a major capital investment over the next five to ten years (New York Association of Homes and Services for the Aging 2001). Decisions about where to make these investments should be informed by a needs methodology that can accurately project future needs and guided by transparent criteria. The approval criteria and process for new building and upgrades should support quality goals, such as creating more home-like living environments.

Relationship to Other Programs

As stated in the introduction to this report, a change in one of the state's long-term care programs has ramifications on access, cost, and quality in all of the others. While this portrait focuses on traditional nursing home care, it is important to note that many nursing homes also sponsor community-based programs, such as medical adult day health care and the Long-Term Home Health Care Program. More information is needed to understand the configuration of these arrangements and how they affect access, cost, and quality of care.
References


Chapter 3

Personal Care

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and Roger Auerbach of Auerbach Consulting, Inc.

April 2009
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In September 2007, there were an estimated 57,000 New Yorkers enrolled in the “traditional” Medicaid personal care (PC) program (called the Home Attendant program in New York City) and an additional 7,000 enrolled in the consumer-directed personal care program. Other community-based Medicaid long-term care programs also provide personal care services, but the personal care program almost exclusively provides hours of personal care and is not typically responsible for other long-term care services, such as care management. This chapter focuses primarily on personal care in New York City, as most enrollment and spending is located there.

Enrollment and Spending

Traditional personal care program beneficiaries represent an estimated one-fourth (23 percent) of long-term care beneficiaries; consumer-directed personal care program beneficiaries account for an additional 3 percent of the total.

Figure 3.1
Percentage of PC Program Enrollment and Spending as a Share of All Medicaid Long-Term Care Programs, FFY 2007

Source: UHF analysis of FFY 2007 CMS-64 and Sept 2007 MARS.
Note:*Other community-based services = CHHA, ADHC, TBI, LTHHCP, MMLTC, and PACE programs.

1 This program portrait is a chapter of An Overview of Medicaid Long-Term Care Programs in New York by Alene Hakenstad and Meghan Shineman of the United Hospital Fund with Roger Auerbach of Auerbach Consulting, Inc. Please note: The spending and enrollment figures in this report are estimates for 10 programs primarily serving frail seniors and adults with disabilities, including nursing homes, Medicaid Assisted Living Program (ALP), traditional personal care, certified home health care, consumer-directed personal care, adult day health care, the Long-Term Home Health Care Program (LTHHCP), the traumatic brain injury waiver program, Medicaid Managed long-term care (MMLTC), and the Program of All-Inclusive Care for the Elderly (PACE). They do not include programs that primarily serve people intellectual disabilities or medically fragile children, such as the Care at Home Program. The personal care data presented here do not include enrollment and spending for beneficiaries who receive personal care services through other community-based long-term care programs, including LTHHCP, MMLTC, and PACE. It was not possible to identify and exclude enrollees in the TBI waiver program, an unknown percentage of whom receive services through the personal care program and are included in this profile’s analysis of enrollment and spending. See the Technical Notes of the full report for a discussion of data sources and research methods. For ease of discussion and consistency of terms, the consumer-directed personal assistance program is referred to here as the consumer-directed personal care program.
Medicaid spent an estimated $2.2 billion in FFY 2007 on the traditional personal care program and an additional $300 million on the consumer-directed personal care program—18 percent and 2 percent, respectively, of all Medicaid long-term care spending in programs primarily serving frail seniors and adults with disabilities.

**New York City vs. Rest of State:** An estimated three-fourths of all traditional personal care program beneficiaries and 29 percent of all consumer-directed personal care program beneficiaries reside in New York City. Beneficiaries in New York City account for an estimated 83 percent of traditional personal care expenditures.

**Figure 3.2**

*Share of Enrollment in the Traditional and Consumer-Directed Personal Care Programs in New York City, September 2007*

![Pie charts showing the distribution of traditional and consumer-directed personal care program beneficiaries between New York City (NYC) and the rest of the state (ROS).](image)


The regional distribution of enrollment and spending for the traditional personal care program is similar to the pattern for other community-based programs but different from that of nursing homes, which are used more outside New York City.
We do not have information on the spending or growth of the consumer-directed personal care program by region. We do know, however, that the program has grown fairly rapidly in the last five years, and that much of the growth has occurred outside New York City.

Figure 3.3
Share of Enrollment and Spending in New York City, by Medicaid LTC Program, FFY 2007

![Chart showing Share of Enrollment and Spending in New York City by Medicaid LTC Program, FFY 2007.](chart)

**Sources:** For nursing homes, LTHHCP, and personal care: UHF analysis of Medicaid reference statistics, FFY 2005-2007 (SDOH, Office of Health Insurance Programs, June 2008). For MMLTC: UHF analysis of September 2007 SDOH managed care enrollment data and SDOH Medicaid Managed Care Operating Report (MCOR) data, 12/31/07, provided by the MLTC/PACE Coalition.

Figure 3.4
Consumer-Directed Personal Care Program Enrollment, 2002 and 2007

![Chart showing Consumer-Directed Personal Care Program Enrollment, 2002 and 2007.](chart)

**Sources:** New York State MARS December 2002 and September 2007 data.
Program and Provider Capacity

There are 215 licensed home care services agencies that provide traditional personal care services in New York State, including 62 in New York City. In New York City, the local department of social services (the Human Resources Administration, or HRA) selects providers through requests for proposals. Agencies in New York City typically cover services for 400 to 2,000 beneficiaries, with an average of 680. Providers in the rest of the state serve an average of 100 beneficiaries. Licensed home care services agencies may also have contracts to provide Medicaid-financed direct care services for other long-term care programs and to provide Medicare-financed direct care services for certified home health care agencies. There are 27 fiscal intermediaries for the consumer-directed personal care program in the state, including two in New York City; fiscal intermediaries process payroll and benefits for the personal care assistants hired by consumer-directed personal care program beneficiaries.

Workforce: We do not have accurate information about turnover rates among direct care workers (home attendants and personal care aides). However, workforce analysts believe that the personal care program’s home attendant workforce in New York City is relatively stable; average turnover rates are about 10 percent (PHI 2008). This is very low compared to the average national turnover rates of 40 to 50 percent in the home care industry (Seavey et al. 2006). Workforce analysts attribute the stability of the home attendant workforce in New York City to fairly recent labor-management agreements.

Health Status and Demographics

In FFY 2007, 29 percent of all personal care beneficiaries were under 65 years. In New York City, an estimated 47 percent of personal care beneficiaries are 81 years and older, while 20 percent are under 65 years. Information about personal care beneficiaries’ health status is limited. One of the few available studies, conducted by the United Hospital Fund in 1995, found that half (52 percent) of personal care beneficiaries in New York City were cognitively impaired. Two-thirds (69 percent) had three or more chronic medical conditions. Three quarters (74 percent) were people of color (Hokenstad et al. 1997).

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1 Based on UHF analysis of January 2008 Medicaid long-term care reimbursement rate computation sheets for personal care (SDOH website) and December 2008 New York City personal care vendor authorized caseload size (estimate from HRA).
2 Average caseload for traditional personal care in NYC reflects authorized caseloads; we were unable to obtain actual enrollment by provider. Full range of provider size elsewhere in the state is not available.
4 According to the Home Care Council of New York City.
Health Status in Relationship to Nursing Home Beneficiaries: We do not have much information about how the needs of beneficiaries enrolled in one program compare to those of beneficiaries in another. While the previously mentioned study, based on 1995 data, found that the nursing home resident population on the whole was sicker and frailer, two-thirds of New York City’s personal care beneficiaries had comparable levels of need on key indicators, such as functional and cognitive status, as indicated by resource utilization group (RUG) scores.\(^6\)

\(^6\) Resource utilization groups (RUGs) are categories within a need-based classification system developed by the New York State Department of Health that is the basis for case-mix adjusting nursing home reimbursement rates. There are 16 RUGs, sorted into the following categories: rehabilitation (RA, RB), special care (SA, SB), clinically complex (CA, CB, CC, CD), severe behavior problems (BA, BB, BC), and reduced physical functioning (PA, PB, PC, PD, PE). Definition of need includes RUGs for clinically complex conditions, severe behavioral problems, or reduced physical functioning, as indicated by cognitive impairment or an ADL score of 5 or more on a 10-point scale.
The study also compared spending on direct care services in both settings. It found that, on average, Medicaid spending was less for the 72 percent of personal care program beneficiaries in the lowest RUG reimbursement groups and roughly equivalent for the 23 percent of beneficiaries in the next highest RUG reimbursement groups. Average Medicaid spending for personal care services for the 5 percent of personal care program beneficiaries in the highest RUG reimbursements groups was higher than nursing home spending (Hokenstad et al. 2002).

Figure 3.7
Medicaid Spending on Direct Care Services in New York City: Traditional Personal Care Program Compared to Nursing Homes, 1997

We do not know all of the ways in which New York City’s personal care population has changed since these data were collected. There is broad consensus that, like the nursing home population, the personal care program beneficiary population has grown sicker and frailer in the intervening years (Dennison 2008).

Rules, Regulations, and Administrative Structure

The personal care program provides a number of different levels and types of services. In this report, traditional personal care includes housekeeping, home attendant, and shared aide. While consumer-directed personal care is technically an option within the personal care program, we refer to it separately because of its policy significance. The principal difference is that in the traditional personal care program, the direct care worker is hired and supervised by a licensed home care services agency; in the consumer-directed program, the beneficiary (or a designated family member or guardian) hires and supervises the direct care worker.
Federal Coverage Requirements

The personal care program is an optional state plan service. The federal government gives states the option to cover some services in their Medicaid program. New York, like 33 other states, has opted to cover personal care services. Once a state opts to cover a service, it must make it available to all beneficiaries who meet medical and financial eligibility requirements.

Covered Services

The personal care program provides assistance with both activities of daily living (ADLs) and instrumental activities of daily living (IADLs). ADLs include basic personal care needs, and IADLs are activities associated with independent living; (see inset box). The assistance is generally provided in blocks of hours per day. Housekeeping is limited to help with IADLs. The state limits the number of hours of housekeeping services to 12 hours per week.

| Activities of Daily Living and Instrumental Activities of Daily Living (ADLs and IADLs) |
| ADLs: Feeding  Toileting  Bathing  Transferring/Mobility  Dressing/Grooming | IADLs: Household Chores  Meal Preparation/Shopping  Escort/Errands |

Service Utilization

Most beneficiaries in the traditional personal care program in New York City receive 20 or more hours of care per week. Almost a quarter of these beneficiaries receive 84 hours or more of personal care each week. (We do not know the breakdown of hours for beneficiaries in the personal care programs in the rest of the state.)

<table>
<thead>
<tr>
<th>Table 3.1  Traditional Personal Care Program Beneficiaries in New York City, by Service Hours per Week, December 2007</th>
</tr>
</thead>
<tbody>
<tr>
<td>0–19 hours</td>
</tr>
<tr>
<td>Beneficiaries</td>
</tr>
<tr>
<td>Percentage of Total Beneficiaries</td>
</tr>
</tbody>
</table>

Source: UHF analysis of data provided by the Home Care Council of New York City. Home attendant hours only.

Note: * Includes 27 clients who received between 85 and 167 hours of care; all the rest in this column received around-the-clock care (i.e., 168 hours per week).

Eligibility — Medical and Financial

Applicants must meet both medical and financial eligibility requirements. Unlike the restrictions on nursing home care that prohibit enrollment of individuals with a primary diagnosis of either a severe and persistent mental illness or intellectual disability, such as mental retardation or developmental disability, there are no excluded populations for personal care.  

Medical and Functional Eligibility: Medical eligibility is based on the level of functional disability. Unlike nursing home care and most community-based long-term care programs, personal care programs do not require applicants to demonstrate the need for nursing home level of care. Applicants must be capable of self-directing services, or have a designated representative to direct care on their behalf, and they must be able to remain safely in their home or community. Eligibility is determined primarily on the basis of a state-approved assessment (M27R in New York City), completed by a nurse for the local department of social services.  

Unlike medical eligibility determinations in most other long-term care programs, the M27R does not yield a numerical score that corresponds to a level of need. Instead, it includes an algorithm (task-based assessment) that calculates the number of minutes of personal care assistance required per day. The local department of social services is responsible for administering the nursing assessment twice a year and whenever a beneficiary’s needs change (e.g., following a hospitalization). New York City’s HRA has a waiver that allows it to review the semiannual assessment, which is administered by the program provider’s nurse.

Financial Eligibility: On behalf of the State Department of Health (SDOH), county governments determine financial eligibility for personal care, using general Medicaid eligibility criteria (income no greater than $8,700 annually and savings no greater than $13,050) and the additional “home equity limit” that applies only to financial eligibility for long-term care (primary residence valued at no more than $750,000). County caseworkers may assist beneficiaries in gathering the documentation required to prove financial eligibility and with required annual recertifications. See Chapter 1.

---

8 For more information on Medicaid long-term care program eligibility, see Bogart 2007.
9 If the applicant is transitioning from certified home health care agency (CHHA) services in New York City, a CHHA nurse (in lieu of the local department of social service’s nurse) may complete the nursing assessment.
10 Individuals whose income is higher than the rules allow may still qualify through the spend-down (“Medically Needy”) program, which allows applicants with “excess income” (the amount above $725 per month in 2007) attributable to medical expenses to “spend down” to the financial resource limit in order to qualify for Medicaid.
Access

An estimated 90 percent of admissions to the personal care program in New York City come directly from the community — from physicians and from community-based social service providers. This includes an unknown number who have been disenrolled from other community-based long-term care programs, such as the Long-Term Home Health Care Program (LTHHCP) or Medicaid managed long-term care (MMLTC). The remaining 10 percent come primarily from certified home health agencies (CHHAs), a process commonly referred to as “conversion.”

A small number come directly from hospitals through the expedited hospital discharge program (commonly called the “Bridge” program). There is no reliable source of information about discharges from the program.

Figure 3.8
Percentage of Traditional Personal Care Program Referrals in New York City, by Source, 2007

Beneficiaries learn about personal care from their physicians, hospital discharge planners, community-based service program providers, or word of mouth (e.g., from other beneficiaries or family members). There is no publicly reported information about the quality of personal care programs to either promote application or help beneficiaries select a provider. An unknown percentage of applicants receive help navigating the application process from community-based aging and social services organizations.

Individuals apply to receive personal care through their local department of social services. A physician must first complete a medical form (the M11Q in New York City) attesting that the applicant requires help with ADLs or IADLs. (The same form must be resubmitted annually.) Unlike physician’s orders for CHHA services, the M11Q is a recommendation for

---

11 Personal communication, Marie Brady, HRA.
12 The Bridge program is a state program established to facilitate faster discharge of hospital patients receiving an “alternate level of care” after an acute medical event. It places individual discharged from the hospital into certified home health care agencies, provides faster processing of applications for personal care, and allows more hours of care than the personal care system usually does.
services, not a medical order; it attests that the applicant has a medical need for the services. After a telephone screening, a county nurse visits the applicant in his or her home and administers the previously mentioned assessment. A county caseworker then conducts a second in-home visit to administer another state-mandated screening called a social assessment (the M11S in New York City). The purpose of the social assessment is to review the home environment. The county is responsible for administering the social assessment annually.

In New York City, a medical review team is responsible for reviewing the three completed documents (M11Q, M11S, and M27R) and developing a service plan. The team comprises a nurse and social worker. All service plans recommending around-the-clock care or multiple shifts of personal care services must be approved by the local professional director, a physician. In the rest of the state, the county nurse and county caseworker who conduct the nursing and social assessments confer and develop the initial service plan.

Once the applicant has been approved for care and authorized to receive a stipulated amount of personal care, the case is assigned to a licensed home care services agency (commonly referred to as a service vendor), whose nurse may conduct another needs assessment (also usually the M27R in New York City). Unlike other community-based long-term care programs, such as MMLTC and the LTHHCP, the personal care program does not include care management services. Provider agencies are responsible for managing the service plan, but not for other care coordination. Provider nurses are required to make four home visits a year to supervise the direct care worker (home attendant or housekeeper); on two of those visits (semi-annually) they re-administer the nursing assessment. County caseworkers are responsible for resolving problems with the service plan and may assist beneficiaries in obtaining information needed to reconfirm medical and financial eligibility. Caseworkers in New York City have an average caseload of 190 beneficiaries. In the consumer-directed program, the beneficiary or a family member acts as his or her own care coordinator.

**Family Involvement:** There is no specific guidance about how the availability of family care should affect a beneficiary’s eligibility or the hours of service authorized. Anecdotal evidence suggests that the availability of family care is an “unofficial” consideration in determining eligibility and hours of service, and that such subjectivity may affect regional variation in access and utilization.

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13 There is more than one service vendor per zip code. Beneficiaries have the choice to switch vendors, and also to request a change in direct care worker assignment.

14 Data from Human Resources Administration.
An estimated 40 percent of traditional personal care program beneficiaries in New York City receive hands-on help with ADLs and IADLs from family members. An additional 20 percent receive other kinds of help from their families (Hokenstad et al. 1998). The extent of a personal care program beneficiary’s needs does not appear to change the likelihood of receiving help from families, nor does it seem to have a significant impact on the number of hours of help they provide.

Figure 3.9
Percentage of Traditional Personal Care Program Beneficiaries Receiving Family Help in New York City, 1995

Personal care program beneficiaries who have the most extensive needs — and who have family available to help — receive, on average, 72 hours of direct care per week: 23 hours of family care plus 49 hours of Medicaid-financed care (Hokenstad et al. 2002). Those without family help receive, on average, eight fewer hours of total care per week. For beneficiaries with extensive needs, family care appears to supplement — and possibly substitute for — paid help (Hokenstad et al. 1998).

15 “Extensive needs” is a grouping that represents the 40 percent of personal care beneficiaries with an ADL score of 5 or more based on a 10-point scale: 4 or more and a clinically complex condition; or 3 or more and a severe behavioral problem. Data for the beneficiaries who scored in the two lowest RUGs (PA and PB) are not included.
Figure 3.10
Median Weekly Hours of Direct Care Services and Family Help for Beneficiaries with Extensive Needs in New York City, 1995

Payment
The Medicaid program pays agency providers directly for each hour of service provided. The administrative component of the rate in New York City is approximately 9 to 11 percent. Average provider rates are $16 per hour in New York City and $21 per hour in the rest of the state. Differences in payment rates may be attributable to economies of scale that allow for efficiency in overhead expenditures, including training costs.

Table 3.2
Average Hourly Medicaid Provider Payment Rates for Traditional Personal Care, by Region, 2007

<table>
<thead>
<tr>
<th>Region</th>
<th>Average Hourly Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>New York City</td>
<td>$16</td>
</tr>
<tr>
<td>Rest of State</td>
<td></td>
</tr>
<tr>
<td>Capital</td>
<td>$21</td>
</tr>
<tr>
<td>Central</td>
<td>$21</td>
</tr>
<tr>
<td>Long Island</td>
<td>$21</td>
</tr>
<tr>
<td>New Rochelle</td>
<td>$22</td>
</tr>
<tr>
<td>Western/Buffalo</td>
<td>$20</td>
</tr>
<tr>
<td>Western/Rochester</td>
<td>$21</td>
</tr>
<tr>
<td>New York State (Average)</td>
<td>$20</td>
</tr>
</tbody>
</table>

Note: Estimated weighted averages based on total patient hours of service, 2006.
In New York City, HRA actively monitors providers’ finances, reviewing all provider expenditures at the line-item level. HRA conducts programmatic and financial audits three times a year, and arranges an annual independent audit of its personal care contracts.

**Quality Monitoring**

County governments monitor the quality of personal care programs on behalf of the state Department of Health. In New York City, HRA tracks and rates 34 service performance measures. Numerical scores are shared with individual providers as part of their “Vendor Stat” report, but are not publicly available. Poor performance results in the development of a corrective action plan. Lack of progress in making corrections may result in suspension of admission privileges (i.e., no additional client referrals). There are no specific rewards for achieving good clinical outcomes.

**Policy Implications**

New York’s traditional and consumer-directed personal care programs play a fundamental role in meeting the long-term care needs of approximately 64,000 people each month. Much of this population suffers from multiple chronic illnesses that cause, contribute to, and interact with functional and cognitive disabilities; care for this group can be intensive and costly. In FFY 2007, Medicaid spending on this population’s long-term care services was roughly $2.5 billion. Although other long-term care service delivery models have emerged and grown over time, the traditional personal care program remains the flagship of New York City’s community-based long-term care system. It provides a safety net for beneficiaries unable to enroll in other programs for a variety of reasons, such as resource intensity. This section of the report discusses current and future challenges of the personal care program, and identifies critical issues for further research and discussions about how the state might improve the delivery of Medicaid long-term care services in New York State.

**Coordinated Care**

The large number of traditional personal care program beneficiaries with nursing home level of care needs, an estimated two-thirds of personal care beneficiaries in New York City, is troubling. The personal care program provides neither care management nor coordinated access to the broader array of services available through program alternatives, such as the Long-Term Home Health Care Program or Medicaid managed long-term care. A reform strategy for New York State should consider explicit criteria about who should receive care management, a routine process for identifying such beneficiaries, and guidance on whether care management should be mandatory for them. It should determine whether care
management should remain available only through designated programs or be provided as a discrete service through the Medicaid state plan. Finally, since many long-term care beneficiaries have multiple chronic conditions, it will be important to more fully integrate long-term care with the delivery of medical, mental health, and social services.

**Barriers to Accessing Program Alternatives**

There are many reasons why beneficiaries might enroll in personal care instead of other programs. They may simply be unaware of the alternatives, which are not routinely discussed as part of the enrollment process, or they may be able to access personal care services faster than other programs. Beneficiaries may be counseled not to enroll in other programs (such as 1915(c) waiver programs or managed long-term care plans) that do not provide as much legal protection as the personal care program does. [See Chapter 1.] Finally, beneficiaries may not be able to enroll in alternatives because of the way some programs are financed and regulated. For example, the hard cap on individual spending in the LTHHCP means that individuals in New York City who require more than 36 hours of direct care services are frequently unable to enroll. (As a point of reference, an estimated 60 percent of personal care program beneficiaries in New York City receive 36 or more hours of direct care services per week.) Similarly, because payment rates for MMLTC plans are not risk-adjusted, they may have strong financial incentives or insufficient resources to enroll beneficiaries with the most extensive needs.

There is consensus that a reform agenda for New York should include a strategy for providing beneficiaries more timely information and guidance about their choice of program and provider at points of entry and transition. However, there is disagreement about how best to accomplish this: by consolidating access to all long-term care services through one designated local entity, or by building capacity into pathways that already exist, such as hospitals and CHHAs. New York City’s HRA is also a common pathway into community-based long-term care, so its role in providing timely information should be carefully considered.

**Consistent Service Determinations**

In New York City, 24 percent of personal care program beneficiaries receive 12 to 24 hours of direct care per day, a level of service rarely found elsewhere in the state. In all likelihood, people outside New York City who require around-the-clock care, but do not have family members available to provide it, receive care in nursing homes. Differences in the way local districts interpret state policies (such as health and safety regulations and level of need
determinations) contribute to these stark regional differences, which are likely exacerbated by workforce shortages in some parts of the state. A reform strategy should explore opportunities to achieve more consistent implementation of policies and regulations, including more specific guidelines about the roles and expectations of family caregivers.

The use of a different assessment tool in each of the state’s long-term care programs may be another factor in the variation among programs. The Department of Health is in the process of developing a much-needed uniform assessment and data set. Such a tool is a fundamental building block for system reform. It has the potential to help meet a number of desirable policy objectives, including providing a standardized basis for determining what resources are required to address a beneficiary’s needs, and supporting a more robust evaluation of quality outcomes across programs and settings. Because several previous efforts to standardize an assessment tool have been unsuccessful, its accomplishment will depend on making this effort a high priority and garnering sufficient resources and stakeholder cooperation.

Family Care
Although family members of frail elderly Medicaid beneficiaries have no legal obligation to provide personal care, their contributions appear to provide a substantial supplement to service hours provided by traditional Medicaid personal care. Family participation is not an explicit eligibility criterion for receiving long-term care, but it is often a common consideration that influences both eligibility determinations and service allocation decisions. In some localities, beneficiaries with extensive needs who do not have family care available may be denied eligibility for personal care on the grounds that they do not meet health and safety requirements. In the current system, caregivers have no formal rights to information or services to support them in their caregiver role (Levine et al. 2006). The effect of reform proposals on their participation and well-being should be carefully considered. A reform agenda should more clearly define the role that availability of family care should play in determining program eligibility and hours of service. It should also explore policies and program strategies that would help support and sustain family caregivers’ contributions.

Direct Care Workforce
As in other programs, direct care services account for a substantial share of long-term care service utilization and spending in the personal care program. In formulating a reform strategy for long-term care in New York, it will be important to examine cost-effective ways to provide worker training and evaluate worker competency. For instance, regional
consolidation of training programs for direct care workers in all of the state’s long-term care programs could save costs and also be a catalyst for better education. Separately, a successful training curriculum must prepare workers to manage the situations they encounter effectively. For example, more than one-half of personal care beneficiaries have some degree of cognitive impairment, so training should provide a strong foundation in how to address the specific needs of this population.

The Role of Consumer-Directed Care
Outside of New York City, where the recruitment and retention of direct care workers has been more difficult, the small consumer-directed personal care program has grown fairly rapidly in the last five years. This growth is likely related to the severe workforce shortages in some parts of the state. A reform agenda should determine the role that consumer-directed care should play in a future service delivery system, including the extent to which beneficiaries may identify and hire their own workers. Future plans must also decide whether to continue to provide the option through a single program (consumer-directed personal care), or to incorporate it more broadly into other programs.

Administrative Payments
Data limitations make it difficult to compare the cost-efficiency of the various program alternatives. A commonly cited financial advantage of providing direct care through the personal care program is that it has the lowest administrative overhead of any of the state’s long-term care programs (an estimated 9 to 11 percent). However, this low administrative payment may limit organizational growth and make it difficult to keep pace with advances in evidence-based practices, improve quality, and provide clinical specialization. More research is needed to evaluate the cost-effectiveness of various service delivery alternatives and the relationship between payment arrangements and quality outcomes.

We do not have complete information on program enrollment growth by region. The available information about regional distribution is from HRA.
References


Chapter 4

Long-Term Home Health Care Program

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Program Snapshot

In December 2007, approximately 24,000 New Yorkers were enrolled in the state’s Long-Term Home Health Care Program (LTHHCP). The program, also known as the Lombardi program or the Nursing Home without Walls program, was established in 1978 as one of the nation’s first comprehensive community-based service programs for beneficiaries who require nursing home level of care. It is one of the largest waiver programs for aged and disabled Medicaid beneficiaries in the nation.

Enrollment and Spending

LTHHCP beneficiaries account for an estimated 10 percent of the state’s Medicaid long-term care beneficiaries.

Figure 4.1
Percentage of LTHHCP Enrollment and Spending as a Share of All Medicaid LTC Programs, 2007

Medicaid spent an estimated $700 million in FFY 2007 on the LTHHCP, approximately 6 percent of all Medicaid long-term care spending in programs primarily serving frail seniors and adults with disabilities in the state.

1 This program portrait is a chapter of An Overview of Medicaid Long-Term Care Programs in New York by Alene Hokenstad and Meghan Shineman of the United Hospital Fund with Roger Auerbach of Auerbach Consulting, Inc. Please note: The spending and enrollment figures in this report are estimates for 10 programs primarily serving frail seniors and adults with disabilities, including nursing homes, the Medicaid Assisted Living Program, traditional personal care, certified home health agencies, consumer-directed personal care, adult day health care, the Long-Term Home Health Care Program, the traumatic brain injury waiver program, Medicaid managed Long-term care, and the Program of All-Inclusive Care for the Elderly (PACE). They do not include programs that primarily serve people intellectual disabilities or medically fragile children, such as the Care at Home Program. See the Technical Notes of the full report for a discussion of data sources and research methods.

2 Every state except Arizona has at least one 1915(c) waiver program for aged or disabled Medicaid beneficiaries. Programs in five states (Illinois, Ohio, Oregon, Texas, and Washington) have more participants in a single waiver program than New York’s LTHHCP.
New York City vs. Rest of State: The LTHHCP has larger percentages of program enrollment and spending in New York City than nursing homes do: 62 percent of its enrollment and 74 percent of its expenditures are in New York City. The regional distribution of LTHHCP enrollment and spending is consistent with enrollment and spending patterns in other community-based programs. New York City programs tend to be larger than those in the rest of the state; because budget caps are based on regional nursing home rates, which are higher in the city than in other parts of the state, the amount of the individual budget cap is higher, which results in higher per-beneficiary spending.

Figure 4.2
Share of Enrollment and Spending in New York City, by Medicaid LTC Program, FFY 2007

Program and Provider Capacity
There are 109 LTHHCP providers in the state. One-third (34 percent) of LTHHCP beneficiaries are enrolled in a program sponsored by a nursing home; one-fourth (26 percent) in a program sponsored by a hospital; and 40 percent in a program sponsored by a community-based (free-standing) certified home health care agency (CHHA). Because the state requires all providers to follow the Medicare conditions of participation for CMS surveillance purposes, all LTHHCP providers are technically treated as CHHAs.

Approved Slots: Unlike most other community-based long-term care programs, LTHHCP providers are approved to provide services to a specified number of beneficiaries at any given point in time, sometimes referred to as “approved slots.” Applications for new providers and most new “slots” must be approved by the State Hospital Review and Planning Council, which generally approves the recommendations advanced by the Department of Health. To be eligible for new slots, the providers in the county must have an aggregate LTHHCP “occupancy rate” of greater than 85 percent for more than one year.\(^4\)

Program Size and Occupancy Rates: Both provider size and occupancy rates (the difference between approved slots and actual enrollment) vary widely by region. On average, LTHHCP providers in NYC have 402 enrollees and an occupancy rate of 87 percent; in the rest of the state, they average 101 enrollees and have an occupancy rate of 60 percent. (Lower occupancy may be related to staffing shortages and the way in which local departments of social services interpret state policies, which affect access to the program.) The Department of Health does not maintain a program-wide waiting list. However, individual providers in some counties maintain their own waiting lists.\(^5\)

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\(^4\) Under these circumstances, the State Department of Health has the authority to increase capacity for an individual provider by up to 50 slots, as long as the additional program slots do not double the size of the program. This policy only applies to programs that already have more than 50 approved slots.

\(^5\) Although all regions have more approved slots than enrollees, some of the individual providers have more beneficiaries enrolled than the number of approved slots. The practice of provider-maintained waiting lists is unusual; waiting lists in other states are generally maintained by state or local governments.
Table 4.1
Regional Distribution of LTHHCP Capacity, 2007

<table>
<thead>
<tr>
<th>Region</th>
<th>Number of Providers</th>
<th>Census</th>
<th>Average Enrollees per Program</th>
<th>Approved Slots</th>
<th>Occupancy Rates</th>
</tr>
</thead>
<tbody>
<tr>
<td>New York City</td>
<td>40</td>
<td>16,067</td>
<td>402</td>
<td>18,407</td>
<td>87.3%</td>
</tr>
<tr>
<td>Rest of State</td>
<td>80</td>
<td>8,062</td>
<td>101</td>
<td>13,337</td>
<td>60.4%</td>
</tr>
<tr>
<td>Capital</td>
<td>11</td>
<td>1,244</td>
<td>113</td>
<td>1,880</td>
<td>66.2%</td>
</tr>
<tr>
<td>Central</td>
<td>13</td>
<td>801</td>
<td>62</td>
<td>1,813</td>
<td>44.2%</td>
</tr>
<tr>
<td>Long Island</td>
<td>19</td>
<td>1,477</td>
<td>78</td>
<td>2,345</td>
<td>63.0%</td>
</tr>
<tr>
<td>New Rochelle</td>
<td>22</td>
<td>2,509</td>
<td>114</td>
<td>3,735</td>
<td>67.2%</td>
</tr>
<tr>
<td>Western/Buffalo</td>
<td>10</td>
<td>950</td>
<td>95</td>
<td>1,812</td>
<td>52.4%</td>
</tr>
<tr>
<td>Western/Rochester</td>
<td>8</td>
<td>1,081</td>
<td>135</td>
<td>1,752</td>
<td>61.7%</td>
</tr>
<tr>
<td>New York State (Total)</td>
<td>109</td>
<td>24,129</td>
<td>221</td>
<td>31,744</td>
<td>76.0%</td>
</tr>
</tbody>
</table>

Source: United Hospital Fund analysis of 2007 LTHHCP census as reported by the New York State Department of Health, Bureau of Licensure and Certification.

Note: Subtotals may not match totals because some LTHHCP sponsors have programs in more than one region.

Workforce: LTHHCP providers typically employ nurses directly, but subcontract with licensed home care service agencies for services from home health aides and personal care aides. There is no independent, reliable source of data about turnover rates among such workers at the national, state, or local level.6

Health Status and Demographics
In accordance with eligibility rules, LTHHCP enrollees must require a nursing home level of care. Although enrollment is open to individuals of all ages with physical disabilities, the majority (69 percent) of beneficiaries are frail elderly.7,8 We were unable to obtain more specific information about the health status of LTHHCP beneficiaries.

Rules, Regulations, and Administrative Structure

Federal Coverage Requirements
The Long-Term Home Health Care Program is a state program enhanced by a Medicaid 1915(c) home and community-based services waiver. Section 1915(c) of the Social Security Act allows states to request a waiver of certain federal Medicaid requirements in order to provide a wider range of services to beneficiaries who would otherwise be in an institution,
including services not generally covered by Medicaid (such as medical social work and home modifications). In addition, Medicaid generally requires that states provide services to all beneficiaries who meet eligibility requirements. Waiver programs allow states to limit services to specific populations or geographic areas.

The LTHHCP is limited to individuals who require a nursing home level of care; it is not limited to a specific geographic area. Federal approval requires that the program be cost-neutral — i.e., that it not cost more than nursing home care for the same population would cost.

**Federal Waiver Assurances:** Federal approval to operate waiver programs must be reauthorized every five years; the LTHHCP waiver is in the process of being reauthorized. The federal re-approval process requires states to demonstrate their capacity to perform six specific functions or “assurances” (see inset box).

<table>
<thead>
<tr>
<th>Federal Waiver Renewal Assurances</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. To ensure that level of care determinations are consistent with care provided in institutional settings (e.g., nursing homes and hospitals);</td>
</tr>
<tr>
<td>2. To actively monitor the adequacy of each beneficiary’s plan of care;</td>
</tr>
<tr>
<td>3. To ensure that waiver services are provided by qualified providers;</td>
</tr>
<tr>
<td>4. To proactively identify and respond to beneficiary abuse, neglect, and exploitation;</td>
</tr>
<tr>
<td>5. To ensure that oversight is properly exercised over all services and functions provided by the program; and</td>
</tr>
<tr>
<td>6. To provide adequate financial oversight, including program cost-neutrality in relationship to institutional care.</td>
</tr>
</tbody>
</table>

Source: Centers for Medicare & Medicaid Services, Interim Procedural Guidance.

**Covered Services**

LTHHCP providers are responsible for care management and for providing (as required by beneficiary need) specified state plan services: nursing; personal care; home health aide services; physical, occupational, and speech therapies; and medical equipment and supplies. They are also required to provide, as appropriate, the following waiver services: medical social services, audiology, respiratory therapy, and nutritional counseling. Additional waiver services may include a personal emergency response system, home maintenance, home improvement or adaptation, moving assistance, home-delivered and congregate meals, social day care, non-medical transportation, and respite care.

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9 Initial 1915(c) home and community-based service waivers are approved for a three-year period. The LTHHCP was due for reauthorization in 2008, but the Department of Health has been granted an extension.

10 The term “personal care” encompasses three different levels of care: housekeeping services, personal care aide services (commonly referred to as home attendant services in other programs), and homemaking services. [See Glossary.]
LTHHCP providers are required to provide at least one of the following services directly and in its entirety: nursing, physical therapy, speech language pathology, occupational therapy, medical social services, or home health aide services. Other covered services may be provided either directly or through a subcontractor.

Table 4.2
Long-Term Home Health Care Program: Covered Services

<table>
<thead>
<tr>
<th>State Plan Services</th>
<th>Required Waiver Services</th>
<th>Optional Waiver Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing</td>
<td>Medical social services</td>
<td>Personal emergency response system</td>
</tr>
<tr>
<td>Physical therapy</td>
<td>Respiratory therapy</td>
<td>Home maintenance</td>
</tr>
<tr>
<td>Occupational therapy</td>
<td>Nutritional counseling</td>
<td>Respite care</td>
</tr>
<tr>
<td>Speech pathology</td>
<td>Audiology</td>
<td>Home improvement or adaptation</td>
</tr>
<tr>
<td>Home health care</td>
<td></td>
<td>Moving assistance</td>
</tr>
<tr>
<td>Personal care</td>
<td></td>
<td>Social day care</td>
</tr>
<tr>
<td>Homemaking</td>
<td></td>
<td>Non-medical transportation</td>
</tr>
<tr>
<td>Housekeeping</td>
<td></td>
<td>Congregate meals</td>
</tr>
<tr>
<td>Medical supplies and equipment</td>
<td></td>
<td>Home-delivered meals</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Telehealth*</td>
</tr>
</tbody>
</table>

Note: *Currently outside of waiver. Some programs provide telehealth services as part of a state demonstration project.

Service Utilization

As is the case in other long-term care programs, the majority of service use in the LTHHCP is attributable to direct care services—hands-on help with activities of daily living and instrumental activities of daily living. Nearly all LTHHCP beneficiaries receive direct care services (either personal care or home health aide services), and more than three-quarters of program spending (78 percent) is for direct care. [See Figure 4.4.]

Figure 4.4  
Percentage of LTHHCP Medicaid Spending, by Type of Service, FFY 2007

Total FFY 2007 LTHHCP Spending = $700 million

Source: UHF analysis of FFY 2007 CMS-64 and September 2007 MARS data.
Direct spending for waiver services accounts for a very small percentage of total program spending; some services (e.g., respite care) are used infrequently and others (e.g., home modification) are one-time expenditures.

Although most beneficiaries receive care management, its utilization and cost cannot be ascertained from available data. Unlike in most other programs, care management is not paid for discretely.

**Eligibility — Medical and Financial**

Applicants must meet both medical and financial eligibility requirements.11

**Medical Eligibility**

Medical eligibility is determined primarily by the level of functional disability. Eligibility is limited to beneficiaries who require nursing home level of care as measured by the Long-Term Care Placement Form (DMS-1). Eligibility also requires that the applicant can be safely and appropriately maintained in a home and community-based setting as indicated by the Home Assessment Abstract (HAA, or DSS 3139), and a physician’s order.12 Physician orders are required every 60 days, and program providers must conduct a comprehensive needs assessment (including the HAA) at least every 120 days.

**Individual Budget Cap:** The cost of care is an explicit consideration in determining medical eligibility for the LTHHCP. CMS requires that waiver program expenditures be cost-neutral in relation to institutional care. (The individual budget cap is the main way the state meets this requirement.) With some exceptions, New York statute requires that the annual service plan expenditures for each individual not exceed 75 percent of the average Medicaid payment rate for nursing home care in the same county (as indicated by the Summary of Service Requirements).13 In practice, this means that applicants who require more than a maximum number of hours — more than 36 hours per week in New York City, roughly — of Medicaid-reimbursed direct care services (home health aide or personal care aide services) are not typically enrolled. It also means that beneficiaries may have to disenroll and seek services elsewhere if their needs increase above the threshold.

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11 For more information on Medicaid long-term care program eligibility, see Bogart 2007.
12 The definition and interpretation of “Health and Safety” requirements has varied over time. New York requires LTHHCP providers to adhere to the Medicare conditions of participation, which require that “patients are accepted for treatment on the basis of a reasonable expectation that the patient’s medical, nursing, and social needs can be met adequately by the agency in the patient’s place of residence.” The state has additional regulations and directives, such as the requirement that beneficiaries be “self-directing” or have an informal caregiver (family member or friend) willing to direct care on their behalf. Variations in how the state, local departments of social services, and individual providers interpret and apply health and safety regulations likely affects access to the program and may explain some of the regional variation in enrollment patterns.
13 The individual beneficiary budget is calculated on a monthly basis, but expenditures may be “annualized” to account for projected fluctuations in spending, such as a one-time expense for home modification. There are two spending cap categories tied to a now defunct distinction in nursing home level of care needs: health-related facility level of care (HRF) and skilled nursing facility level of care (SNF). A score of 80 to 179 on the DMS-1 denotes HRF and a score of 180 or more denotes SNF. Through a demonstration program, exceptions can be authorized for up to 100 percent of the average SNF/HRF budget cap for people with “special needs.” The demonstration period was recently extended to March 31, 2012.
Table 4.3
Long-Term Home Health Care Program: Individual Monthly Budget Caps, by Region, 2007

<table>
<thead>
<tr>
<th>Region</th>
<th>Average Monthly Nursing Home Payment Rates</th>
<th>Average Monthly LTHHCP Individual Budget Cap</th>
</tr>
</thead>
<tbody>
<tr>
<td>Capital</td>
<td>$4,978</td>
<td>$3,610</td>
</tr>
<tr>
<td>Central</td>
<td>$4,853</td>
<td>$3,560</td>
</tr>
<tr>
<td>Long Island</td>
<td>$7,218</td>
<td>$4,952</td>
</tr>
<tr>
<td>New Rochelle</td>
<td>$6,248</td>
<td>$4,221</td>
</tr>
<tr>
<td>Western/Buffalo</td>
<td>$4,960</td>
<td>$3,250</td>
</tr>
<tr>
<td>Western/Rochester</td>
<td>$5,267</td>
<td>$3,738</td>
</tr>
<tr>
<td>New York City</td>
<td>$7,535</td>
<td>$5,438</td>
</tr>
</tbody>
</table>

Sources: Average monthly nursing home payment rates based on UHF analysis of 2007 average regional daily reimbursement rates from SDOH website. Average LTHHCP individual budget cap based on UHF analysis of 2007 maximum allowable monthly expenditure cap per patient under the LTHHCP by level of care, by county.

Exceptions to the Cap: For certain conditions and needs (e.g., Alzheimer’s disease, decubitus ulcer, tube feeding), local departments of social services can increase an individual’s budget cap to 100 percent of the cost of nursing home care in the same county. The state limits such exceptions to 25 percent of a county’s total enrollees (15 percent in New York City); further exceptions are subject to Department of Health approval on an individual basis. We do not know how frequently exceptions are authorized. In addition, there is no individual cap requirement for the estimated 2,000 LTHHCP beneficiaries enrolled through the AIDS Home Care program.

Family Care: The availability of family help is not an official eligibility criterion for any of the state’s long-term care programs; however, it is often a consideration, and because of the individual budget cap requirement, it has particular relevance for the LTHHCP. For example, having a family caregiver available to supplement hours of care is likely to determine whether beneficiaries with extensive personal care needs can enroll in the program. We were not able to find a reliable measure of the extent that family care plays in the LTHHCP.
Financial Eligibility
County governments determine financial eligibility for the LTHHCP, using general Medicaid eligibility criteria (income no greater than $8,700 annually and personal savings no greater than $13,050) and the additional “home equity limit” criterion that applies only to financial eligibility for long-term care (primary residence valued at no more than $750,000).14

New York currently extends the same set of financial protections to spouses of LTHHCP beneficiaries that it extends to spouses of nursing home residents. These spousal impoverishment protections allow spouses to retain $2,610 per month ($31,320 annually) in income, and between $74,820 and $104,400 in assets.15

Access
More than one-third (35 percent) of program admissions come from hospitals, residential care facilities, and other institutions; 11 percent come from CHHAs; and more than half (54 percent) from the community (physicians, self-referral, provider outreach, and other community-based programs).16 We were not able to obtain good information about the relationship between program sponsorship and source of program referrals. As a result, we do not know what percentage of program admissions are “in-network” referrals from organizational sponsors (nursing homes, hospitals, and free-standing CHHAs).

Beneficiary Needs Determination Process: As with other long-term care programs, LTHHCP applicants generally apply directly to an individual program provider (as opposed to applying...
Some waiver services, such as home improvement and adaptation, are subject to an additional level of review and approval by the local department of social services. The provider then sends a nurse to the applicant’s home to conduct an initial eligibility determination. At this visit, the nurse assesses the applicant’s care needs, which includes administering the DMS-1 and the HAA. These forms are the basis for the Summary of Service Requirements, with which the local department of social services computes and approves each individual’s budget.

The provider forwards all three documents (sometimes referred to as the 120-day package) to the local department of social services, which makes an in-home visit to confirm eligibility. This visit (sometimes called a “joint visit”) is required in the statute and regulations for the program. The local department of social services reviews each plan of care at least every 120 days.\(^7\)

**Alternate Entry:** There is also an expedited enrollment process (“alternate entry”) that allows providers, under specific circumstances, to provide services for up to 30 days prior to the joint visit. The provider is at risk for associated spending if the beneficiary is found to be ineligible. In practice, the local department of social services determines the extent to which beneficiaries can access the program this way. In some regions, including New York City, it is rarely used.

**Regional Differences in LDSS Policies:** There are other regional differences in policies of local department of social services that contribute to wide variation in access to the programs. For example, there are reported variations in how local departments interpret health and safety regulations, how they score assessments, and how they calculate budgets.

**OASIS:** To meet the Medicare conditions of participation, LTHHCP providers are required to complete the Outcome and Assessment Information Data Set (OASIS), a federally mandated assessment tool that must be re-administered every 60 days.

**Discharge Patterns:** We do not know very much about discharge patterns. The available data come from annual statistics submitted by program providers; because the information

\(^7\) Some waiver services, such as home improvement and adaptation, are subject to an additional level of review and approval by the local department of social services.
is reported inconsistently, the data are not complete. It is unclear how many beneficiaries are discharged from the LTHHCP into other programs when their needs exceed the individual budget cap.

**Provider Requirements**

The state’s policy of requiring LTHHCP sponsors to meet the Medicare conditions of participation is unique; most states with similar programs for frail seniors do not have this requirement. The goals of this policy are to promote continuity of care and access to Medicare services and to claim Medicare revenue for LTHHCP beneficiaries who have both Medicaid and Medicare coverage (dually eligible). For example, because LTHHCP providers can bill Medicare directly, they are well positioned to expedite discharge from a hospital in order to transition dually eligible beneficiaries into the program.

Adhering to the Medicare conditions of participation, however, entails regulatory requirements that far exceed those of most other programs. For example, providers are required to supervise home health aides with an in-home visit every two weeks (versus once every three months in the personal care program); complete the OASIS clinical data set every 60 days (a similar assessment is due every 180 days in the personal care and Medicaid managed long-term care programs); and meet additional federal reporting requirements.

**Payment**

The state’s Medicaid program pays providers on a fee-for-service basis for each hour or visit. Rates are set prospectively, based on reported costs for the two years prior to the rate year, trended forward. LTHHCP sponsors are required to allocate administrative and general costs to each direct cost center. The state department of health establishes a cost guideline for each category of service. If the provider fails to provide a justification to maintain the rate at the actual amount, the provider is paid at the cost guideline level. The Department of Health also holds each LTHHCP provider to a ceiling on administrative and general expenses (the final A&G allocation cap in 2007 was 25.48 percent). These expenses include recordkeeping, technology, corporate compliance, quality assurance, and training, as well as some care management costs (e.g., cost of initial needs assessments).

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18 Per Medicare accounting rules, program sponsors are required to allocate administrative and general costs across all cost centers.
Table 4.4
Average Medicaid Provider Payment Rates for LTHHCP Services, by Region, 2007

<table>
<thead>
<tr>
<th>Region</th>
<th>Nursing (per visit)</th>
<th>Therapy (per visit) (PT, SP, OT)</th>
<th>Home Health Aide (per hour)</th>
<th>Personal Care (per hour)</th>
</tr>
</thead>
<tbody>
<tr>
<td>New York City</td>
<td>$131</td>
<td>$91</td>
<td>$19</td>
<td>$19</td>
</tr>
<tr>
<td>Rest of State</td>
<td>$118</td>
<td>$83</td>
<td>$26</td>
<td>$24</td>
</tr>
<tr>
<td>Capital</td>
<td>$104</td>
<td>$78</td>
<td>$34</td>
<td>$32</td>
</tr>
<tr>
<td>Central</td>
<td>$100</td>
<td>$71</td>
<td>$31</td>
<td>$28</td>
</tr>
<tr>
<td>Long Island</td>
<td>$127</td>
<td>$85</td>
<td>$18</td>
<td>$19</td>
</tr>
<tr>
<td>New Rochelle</td>
<td>$130</td>
<td>$84</td>
<td>$24</td>
<td>$22</td>
</tr>
<tr>
<td>Western/Buffalo</td>
<td>$109</td>
<td>$81</td>
<td>$29</td>
<td>$26</td>
</tr>
<tr>
<td>Western/Rochester</td>
<td>$109</td>
<td>$95</td>
<td>$28</td>
<td>$23</td>
</tr>
<tr>
<td>New York State (Average)</td>
<td>$127</td>
<td>$88</td>
<td>$21</td>
<td>$21</td>
</tr>
</tbody>
</table>

Source: United Hospital Fund analysis of 2007 Medicaid LTC reimbursement rate computation sheets for the LTHHCP.

Note: Differences in payment rates for different kinds of direct care workers (home health aides and personal care aides) do not necessarily reflect differences in the actual compensation that workers receive, which tends to be fairly similar. Estimated weighted averages based on estimated occupancy of program. These figures include administrative and general costs. Figures for personal care exclude housekeeping and homemakers.

Medicare Revenue: Medicare pays for post-acute home care services on an episodic basis (60-day episodes). Medicare revenue accounts for a small share (5 percent) of provider revenue statewide, ranging significantly by region, from 2 percent in New York City to 21 percent in the Finger Lakes region. This wide variation in payment source could suggest that some providers are better at maximizing Medicare revenue, but it more likely reflects differences in practice patterns and beneficiary populations. For example, a higher proportion of Medicare revenue could result from more appropriate opportunities to bill Medicare for post-acute services—such as more initial referrals from hospitals for dually-eligible individuals with post-acute care needs who are eligible for the Medicare home health benefit—or it could result from higher enrollment of medically fragile individuals who have more hospitalizations and therefore more Medicare-billable post-acute episodes. We do not have information about length of stay or hospitalization rates by level of need, factors that would shed greater light on the extent of different practice patterns.
Table 4.5
Percentage of LTHHCP Revenue, by Payment Source, by Region, 2004

<table>
<thead>
<tr>
<th>Region</th>
<th>Census, 2007</th>
<th>Payment Source (Percent of Total Revenue)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Medicare</td>
</tr>
<tr>
<td>New York City</td>
<td>16,067</td>
<td>2.4%</td>
</tr>
<tr>
<td>Rest of State</td>
<td>8,062</td>
<td>11.8%</td>
</tr>
<tr>
<td>Capital</td>
<td>1,244</td>
<td>10.6%</td>
</tr>
<tr>
<td>Central</td>
<td>801</td>
<td>12.2%</td>
</tr>
<tr>
<td>Long Island</td>
<td>1,477</td>
<td>8.9%</td>
</tr>
<tr>
<td>New Rochelle</td>
<td>2,509</td>
<td>6.5%</td>
</tr>
<tr>
<td>Western/Buffalo</td>
<td>950</td>
<td>16.7%</td>
</tr>
<tr>
<td>Western/Rochester</td>
<td>1,081</td>
<td>20.9%</td>
</tr>
<tr>
<td>New York State (Total)</td>
<td>24,129</td>
<td>5.0%</td>
</tr>
</tbody>
</table>

Source: Home Care Association of New York State’s analysis of cost reports/ regional source of payment data obtained from the Department of Health, Division of Home & Community Based Care.

Note: “Other” may include private pay and revenue from subcontracting relationships with other long-term care programs, such as Medicaid managed long-term care plans.

Quality Monitoring

As noted above, the local department of social services reviews and approves care plans every 120 days, on behalf of the state department of health, who is accountable for performance. An on-site performance review by state surveyors is required no less than once every three years. There are no financial rewards for good performance.

Because the state requires all providers to follow the Medicare conditions of participation for CMS compliance purposes, all LTHHCP providers are technically treated as CHHAs and are subject to federal performance evaluation. The federal government evaluates CHHA performance on 42 outcome-based quality measures drawn from the OASIS, a set of demographic and clinical information submitted to CMS and the state Department of Health every 60 days. A subset of these measures is published on CMS’s Home Health Compare website and the state’s Home Health Profile website, launched in March 2008. There are concerns that the information reported for individual LTHHCP providers misrepresents their performance on key indicators, such as hospitalization rates and emergency room utilization, because the comparison group is primarily Medicare CHHA patients—a less chronically impaired population than the Medicaid long-term care beneficiaries typically enrolled in the LTHHCP.
Policy Implications

The Long-Term Home Health Care Program plays a fundamental role in meeting the long-term care needs of 24,000 New Yorkers each month. Most of this population has multiple chronic illnesses that cause, contribute to, and interact with functional and cognitive disabilities. Care for this group can be intensive and costly; associated Medicaid spending was roughly $700 million in FFY 2007. This section of the report explores some of the challenges facing the LTHHCP and identifies critical issues for further research and discussion about how to improve the delivery of long-term care in New York.

The Individual Budget Cap

The LTHHCP is the state’s only long-term care program with a hard cap on individual spending per beneficiary. Although the federal government requires that 1915(c) waiver programs be cost-neutral, the state has considerable latitude to determine how cost neutrality is achieved. For other 1915(c) waiver programs, such as the Traumatic Brain Injury and the Nursing Home Transition and Diversion waiver programs, New York has opted to achieve the required cost neutrality in the aggregate — i.e., at a program level rather than at an individual level.

The individual budget cap presents a potential barrier to access and continuity of care. Beneficiaries whose needs exceed the maximum allowable cost cannot enroll in the program, and beneficiaries whose needs increase over time may have to disenroll in order to receive more care, either in a nursing home or through other community-based programs. While the effect of this state policy on access to long-term care has not been fully determined, there is some evidence to suggest that it may be significant. For example, more than 60 percent of traditional personal care program beneficiaries in New York City receive more than 36 hours per week of direct care; Medicaid spending associated with this many hours of service would typically exceed the budget cap and would effectively prevent the beneficiary from enrolling in the LTHHCP.

A long-term care reform agenda for New York should include a recommendation about whether to maintain the individual budget cap or to pursue other strategies, such as requiring cost neutrality at the program or individual provider level. This policy decision has greater financial implications than it did for other waiver programs because the

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19 The personal care program does not have a hard cap on spending, but beneficiaries receiving housekeeping services are limited to a maximum of 12 hours per week.
20 United Hospital Fund analysis of data from the Brookdale Center for Healthy Aging & Longevity, Hunter College/CUNY.
LTHHCP operates on a much larger scale. It is also important to keep in mind that introducing this type of change is more logistically complicated. The LTHHCP does not have the same structural checks and balances on service utilization that exists in other programs. For example, in the LTHHCP, the state contracts with the same entity for care management and the provision of services; in the other waiver programs, the state contracts with different entities for services coordination and for service provision. This is not to suggest that the organizational structure is bad — more information is needed to determine the effect of different structural relationships on access, cost, and quality — but rather that an alternative to the individual budget cap is not as easily achieved. Given the way the program is structured, it is likely that alternatives to the budget cap depend on having more capacity to tie payment levels to a more standardized measure of need, similar to the case-mix index used to adjust nursing home payment levels.

**System Simplification**

Since the LTHHCP was established in 1978, the state has introduced several other programs that are also limited to beneficiaries with nursing home level of care needs, including Medicaid managed long-term care (MMLTC). At the same time, a large number of beneficiaries with nursing home level of care access services through the traditional personal care program in New York City (Hokenstad et al. 2002). The three programs are similar in that most spending is attributable to direct care services. Yet they also have important differences. For example, both MMLTC and the LTHHCP provide care management — a service not provided in the personal care program. In addition, while there are modest differences in the services provided by MMLTC and the LTHHCP, the primary difference is in how the programs are paid. LTHHCP providers (like providers in other waiver programs) are paid on a fee-for-service basis; MMLTC plans receive a monthly premium for each beneficiary they enroll.

Given the apparent overlap in target populations, it is important to decide whether to maintain the three program options as they are, consolidate them, or further differentiate between them by changing eligibility criteria, payment caps, or financing methodologies. If the state opts for consolidation, it will be important to consider how to incorporate existing provider capacity. For example, the new requirement that MMLTC plans also become special needs plans (SNPs) under Medicare effectively excludes many current LTHHCP providers from transitioning into that role. In addition, differences in direct care worker wages present a practical barrier to voluntarily transferring beneficiaries from the personal care program into either the LTHHCP or MMLTC. And any solution should reflect regional
There is disagreement about whether or not federal law gives states the authority to extend nursing home spousal impoverishment protections to 1915(c) home and community-based waiver programs for beneficiaries who qualify through the Medically Needy/Spend-Down Program. [See Chapter 1 for a discussion of the Medically Needy Program.]

Based on an internal analysis conducted by the New York State Department of Health in 2007.

In lieu of program consolidation, a long-term care reform agenda should include strategies to address the following issues in the LTHHCP.

**Variation in Local Department of Social Service Policy**

Variation in the way local departments of social services interpret and implement state policies is widely cited (but poorly documented) as a significant barrier to access. There appears to be a need for more uniformity across the state with respect to consistent interpretation of health and safety regulations, level of need determinations, budget calculations, and access to the LTHHCP through the alternate entry process.

**Spousal Impoverishment Protections**

Until recently, New York had a long-standing policy of extending spousal impoverishment protections for nursing home residents to beneficiaries in 1915(c) home and community-based waiver programs (Hartocollis 2009). However, in response to CMS objections, the state eliminated spousal impoverishment protections for the Traumatic Brain Injury waiver program and agreed to forgo them for the new Nursing Home Transition and Diversion waiver program. As part of the 2009-10 Enacted State Budget, the state has agreed to remove them for the LTHHCP as well. For all three programs, the legislative language that eliminates the protections includes a provision that automatically restores them in the event that CMS withdraws its objections. The current status of the protections in the LTHHCP is unclear. CMS has granted the state an extension of the current waiver until July 14, 2009.

The Department of Health estimates that eliminating financial protections in the LTHHCP could affect as many as 4,000 married couples — more people than are enrolled in the NHTD and TBI waiver programs combined. Because these beneficiaries have nursing home level of care needs, those who lose eligibility for the LTHHCP are likely to access long-term care services through other, potentially more expensive, programs. The impact would be more acutely felt outside New York City — particularly in counties with fewer

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21 There is disagreement about whether or not federal law gives states the authority to extend nursing home spousal impoverishment protections to 1915(c) home and community-based waiver programs for beneficiaries who qualify through the Medically Needy/Spend-Down Program. [See Chapter 1 for a discussion of the Medically Needy Program.]

22 Based on an internal analysis conducted by the New York State Department of Health in 2007.
community-based program alternatives and therefore a greater probability that such beneficiaries would be placed in nursing homes. In order to promote the right care in the right setting at the right time, a long-term care reform agenda for New York State should include strategies that help to ensure that community-based care remains a financially viable alternative to nursing home care.

Program Size
The typical LTHHCP provider has between 100 and 400 enrollees. Small scale operations may make it harder for smaller organizations to remain financially viable, keep pace with technological advancements, improve quality, and provide clinical specialization. Smaller programs are also more vulnerable to the effects of the recent workforce shortages and rising transportation costs. Better information will help assess where and to what extent smaller programs are needed in order to accommodate the needs of beneficiaries who live in rural or semi-rural areas, and where cost-efficiencies could be achieved through provider consolidation without diminishing access to appropriate care. To maintain small programs, New York will need a sound strategy for ensuring that providers have the capacity to keep pace with evidence-based practice.

Lack of Transparency in Reporting Care Management Costs
Care management was conceived as a central element of the LTHHCP — one that distinguishes it from the personal care program. Unlike other community-based programs that provide care management, LTHHCP providers do not receive discrete payment for this service. Instead, its cost is incorporated into the payment rate for nursing or medical social services, and is included in the calculation of the administrative and general (A&G) costs. As a result, it is very difficult to determine how much and what type of care management (nursing or medical social services) beneficiaries are receiving, and how much Medicaid is paying for this service. A reform agenda should establish whether or not to reimburse or report care management as a distinct service.

Medicare Conditions of Participation
Most states that operate programs like the LTHHCP for frail seniors and adults with disabilities do not require program sponsors to meet the Medicare conditions of participation. The historical goals of New York’s policy have been to promote continuity of care for dually eligible beneficiaries, who have both Medicaid and Medicare coverage, and to access Medicare services and revenue. Adhering to Medicare’s conditions of participation, however, necessitates costly regulatory requirements that far exceed those of most other long-term care programs. A long-term care reform agenda for New York should assess the clinical
relevance of these requirements, and determine the extent to which cost savings could be achieved either by eliminating the conditions of participation requirement or obtaining regulatory relief for CMS — for instance, scaling back nursing supervision requirements for medically stable enrollees. In light of the ongoing nursing shortage, a reform agenda should determine whether the opportunity to maximize Medicare outweighs the burden of additional regulatory requirements, or if other strategies for accessing Medicare revenue — such as the SNP requirement for new MMLTC plans — should be pursued instead. In addition, the conditions of participation requirements are a central feature of the state’s quality assurance strategy for the LTHHCP. If these requirements were eliminated, alternative quality assurance strategies for the LTHHCP would likely be required.

**Financial Incentives**

LTHHCP providers are paid on a fee-for-service basis, and payment for A&G expenses is then applied as a proportion of each hour or unit of service provided. To the extent that A&G is a source of revenue for the program sponsor, there is a strong financial incentive to maximize the hours or units of service. Additional research could determine the extent to which different payment methodologies achieve different results. More generally, it is important to decide whether to explore different ways of financing the LTHHCP, including whether providers should receive a monthly payment and be allowed to pool funds in order to care for all enrollees — and if so, whether payment rates should account for wide variations in beneficiary needs.

Providers are also required to follow Medicare accounting rules, which require providers to allocate A&G costs across all cost centers. In practice, this means that A&G revenues can be allocated to cost centers that have no direct application to the operation of the LTHHCP. It is widely believed that some LTHHCP sponsors subsidize the operation of other health care programs and services — such as nursing homes or hospitals — using A&G revenue generated by the LTHHCP. Such cross-subsidization is not necessarily bad, but it does make it difficult to identify what Medicaid is paying for and at what price, and it may provide strong motivation for key parties to resist changing the way services are organized and financed. Regardless of how payment is structured, reform discussions should consider the extent to which underlying financial incentives affect current providers’ ability and capacity to change.

**Standardized Needs Measurement**

In the current long-term care system, many concerns about quality cannot be fully addressed because of insufficient information. Each long-term care program in the state uses a different assessment tool to measure beneficiaries’ level of need. Therefore it is unclear
whether there are differences in health status or quality outcomes in the LTHHCP compared to other long-term care programs. More research would help determine which of the state’s program models are most successful at managing care, for which populations, and at what cost to Medicaid.

The Department of Health is in the process of developing a much-needed uniform assessment and data set. Such a tool, which would standardize the definition of nursing home level of care across programs and settings, is a fundamental building block for system reform. It has the potential to help meet a number of desirable policy objectives: a more standardized basis for determining what resources are required to address a beneficiary’s needs, regardless of geographic location, and supporting a more robust evaluation of quality outcomes across programs and settings. However, because several previous efforts to standardize an assessment tool have been unsuccessful, its accomplishment will depend on making this effort a high policy priority and garnering sufficient resources and stakeholder cooperation.

There is broad consensus that the DMS-1, the form that New York uses to determine eligibility for the LTHHCP, is not the optimal tool for this job. It was originally developed for the purpose of determining nursing home eligibility and has two major limitations when applied in community settings: it does not fully measure functional limitations that result from cognitive impairments, and it does not assess all instrumental activities of daily life, such as the capacity to prepare meals. To address these limitations, the state has long allowed physicians to override the score for otherwise eligible applicants. CMS originally objected to this policy during the recent waiver renewal process, but subsequently agreed to allow its continued use with the understanding that it would be eliminated when the state completed development and implementation of the new assessment tool.

One tool under consideration for replacing the DMS-1 is the Semi-Annual Assessment of Members (SAAM), a chronic care version of the OASIS tool already in use in the MMLTC and PACE programs.23 If the state adopted the SAAM for both the LTHHCP and the personal care program, it would then have both a standard measure of need and the ability to compare health status for two-thirds of all Medicaid long-term care beneficiaries receiving community-based services.

23 The State Department of Health conducted an evaluation to determine the correlation in eligibility determinations using the SAAM in lieu of the DMS-1 in the MMLTC and PACE programs. They eventually decided, based on the outcomes of the evaluation, that the SAAM was an appropriate substitute.
References


An Overview of Medicaid Long-Term Care Programs in New York

Chapter 5

Medicaid Managed Long-Term Care

PREPARED BY
Alene Hokenstad and Meghan Shineman of the United Hospital Fund
and Roger Auerbach of Auerbach Consulting, Inc.

April 2009
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Program Snapshot

In September 2007, there were approximately 20,000 New Yorkers with nursing home level of care needs enrolled in the state’s Medicaid managed long-term care (MMLTC) program.¹ The program, sometimes referred to as the “Medicaid-only” managed long-term care program to distinguish it from the Program of All-Inclusive Care for the Elderly (PACE), was established in 1997 under the state’s existing authority to provide Medicaid managed care.²

Enrollment and Spending

MMLTC program beneficiaries (enrollees) account for an estimated 8 percent of all Medicaid long-term care beneficiaries.

Medicaid spent roughly $700 million on the MMLTC program in FFY 2007, approximately 6 percent of all Medicaid long-term care spending in programs primarily serving frail seniors and adults with disabilities in the state.

Figure 5.1
Percentage of MMLTC Enrollment and Spending as a Share of All Medicaid Long-Term Care Programs, 2007

1 This program portrait is a chapter in An Overview of Medicaid Long-Term Care Programs in New York by Alene Hokenstad and Meghan Shineman of the United Hospital Fund with Roger Auerbach of Auerbach Consulting, Inc. PLEASE NOTE: The spending and enrollment figures in this report are estimates for 10 programs primarily serving frail seniors and adults with disabilities, including nursing homes, Medicaid Assisted Living Program (ALP), traditional personal care (PC), certified home health care (CHHA), consumer-directed PC (CDPAP), adult day health care (ADHC), the Long-Term Home Health Care Program (LTHHCP), the Traumatic Brain Injury (TBI) waiver program, Medicaid managed long-term care (MMLTC), and the Program of All-Inclusive Care for the Elderly (PACE). They do not include programs that primarily serve people intellectual disabilities (OMRDD) or medically fragile children, such as the Care at Home Program. See Technical Notes for a discussion of data sources and research methods.

2 The state’s Managed Long-term Care Integration and Finance Act (Chapter 659 of the Laws of 1997) consolidates all managed long-term care demonstrations and plans (including Medicaid managed long-term care and PACE) under one legislative authority.
New York City vs. Rest of State: The vast majority of the state’s MMLTC enrollment (92 percent) and spending (93 percent) is in New York City. This regional distribution of spending and enrollment is consistent with the pattern seen in other community-based programs, though the concentration in New York City is more pronounced. It differs from the enrollment pattern for New York’s nursing homes, in which a larger proportion of enrollment is outside of New York City.

Figure 5.2
Share of Enrollment and Spending in New York City, by Medicaid LTC Program, FFY 2007

Program and Provider Capacity
There are 13 MMLTC plans in New York (September 2007). Seven of the plans operate exclusively in New York City; one operates primarily in the city but has a small number of enrollees in an adjacent county; and five operate exclusively outside of the city. Only three counties outside of the New York City metropolitan area have an MMLTC plan.\(^3\)\(^4\)

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\(^3\) Metropolitan area includes New York City, Long Island (Nassau and Suffolk counties), and New Rochelle regions (Westchester, Orange, and Rockland counties).

\(^4\) MMLTC is available in at least 13 counties (Erie, Herkimer, Nassau, Oneida, Orange, Rockland, Suffolk, Westchester, and the five counties in New York City). Plans may expand into additional counties.
Figure 5.3
Share of MMLTC Plans and Enrollment in New York City, September 2007

Source: September 2007 Medicaid managed care statistics, SDOH.
Note: Percentages are rounded and may not sum to 100%.

Program Size: There is no limit on the number of beneficiaries that an individual MMLTC plan can enroll. The seven plans with enrollment primarily in New York City are significantly larger than the five plans that operate exclusively outside the city (average enrollment of 2,340 and 310, respectively). This pattern is consistent with the Long-Term Home Health Care Program (LTHHCP), which has smaller programs outside of New York City. Within the City, however, average program enrollment in MMLTC plans is much larger than in LTHHCP providers.

Table 5.1
Average Caseload Size of MMLTC Plans and LTHHCP Providers

<table>
<thead>
<tr>
<th></th>
<th>MMLTC Plans</th>
<th>LTHHCP Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>New York City</td>
<td>2,340 (7 plans)</td>
<td>350 (29 providers)</td>
</tr>
<tr>
<td>Both NYC and ROS</td>
<td>420 (1 plan)</td>
<td>700 (11 providers)</td>
</tr>
<tr>
<td>Rest of State</td>
<td>310 (5 plans)</td>
<td>100 (69 providers)</td>
</tr>
</tbody>
</table>

Sources: Sept 2007 Medicaid managed care statistics (SDOH) and 2007 LTHHCP census.

The state’s Managed Long-term Care Integration and Financing Act of 1997 authorized up to 37 managed long-term care plans (including MMLTC and PACE plans) for up to 25,000 frail seniors and adults with physical disabilities.
**Program Growth:** For the last five years, statewide program enrollment has grown by approximately 20 percent per year (New York State Department of Health 2006). However, plans in New York City have grown more rapidly than those in other parts of the state. For example, between September 2003 and September 2007, enrollment in New York City increased by 135 percent, compared to an increase of only 60 percent in the rest of the state.

**Workforce:** MMLTC plans typically employ nurses and social workers directly. In New York City, plans subcontract with licensed home care service agencies for direct care services (home health aides and personal care aides), but in the rest of the state it is more common for plans to employ their own workers. There is no independent, reliable source of data about turnover rates at the national, state, or local level.

**Health Status and Demographics**

The figures in this section of the report include enrollees from both the MMLTC and PACE programs. Enrollment in both programs is limited to individuals with nursing home level of care needs. The vast majority of enrollees receive services in community-based settings. However, a small percentage (an average of 7 percent statewide) are nursing home residents.

The majority of enrollees are frail seniors. Eleven percent are adults (under the age of 65) with physical disabilities; most of these are enrolled in a single plan in New York City. Seventy-six percent of enrollees are female, 62 percent are people of color, and 43 percent speak a primary language other than English.

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6 National and local estimates of the turnover rates for direct care workers in the home care industry range from 40 to 50 percent (Seavey et al. 2006). PHI reports that in New York City, the turnover rate of the MMLTC program is higher than that of the personal care program, which is estimated to be 11 to 15 percent annually. It reports that in the rest of the state, the turnover rate is comparable to or worse than the national average (Carol Rodat, PHI, personal communication, September 25, 2008). The contrast to New York City is likely related to labor-management agreements which are standardized and approximately $2 to $3 more per hour than the wages paid by the licensed home care services programs with whom the MMLTC plans contract.

7 Figures in this section of the report come from the New York State Department of Health Managed Long-Term Care Final Report (2006), which cites December 31, 2005 data. PACE accounted for 16 percent of total MLTC enrollment in December 2005.
According to the Semi-Annual Assessment of Members (SAAM), transferring is the “ability to move from bed to chair, on and off toilet or commode, into and out of tub or shower, and ability to turn and position self in bed if member is bedfast.” See Eligibility section for a description of the SAAM.

### Table 5.2
**Frequency of Chronic Medical Conditions Among Managed Long-Term Care Enrollees, December 2005**

<table>
<thead>
<tr>
<th>Medical Condition</th>
<th>Percent of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hypertension</td>
<td>82%</td>
</tr>
<tr>
<td>Cardiac, Heart Problems</td>
<td>52%</td>
</tr>
<tr>
<td>Visual Impairments</td>
<td>44%</td>
</tr>
<tr>
<td>Osteoarthritis</td>
<td>42%</td>
</tr>
<tr>
<td>Diabetes</td>
<td>40%</td>
</tr>
<tr>
<td>Stroke/CVA</td>
<td>23%</td>
</tr>
</tbody>
</table>

Source: New York State Department of Health (28 March 2006). New York State Managed Long-Term Care: Final Report to the Governor and Legislature.

Note: Health status statistics include both MMLTC and PACE enrollees.

Enrollees generally have a number of chronic medical conditions. Out of every 10 enrollees, eight have hypertension; five have cardiac problems; four have visual impairment; four have osteoarthritis; four have diabetes; and two have suffered a stroke. Most enrollees have a combination of these conditions.

Most beneficiaries require help with dressing (89 percent), bathing (93 percent), transferring (72 percent), walking (95 percent), and eating (78 percent). Nearly one-half (46 percent) require some assistance with toileting. Roughly one-half of enrollees have some degree of cognitive impairment.

### Table 5.3
**Percentage of Managed Long-Term Care Enrollees Requiring Help with Activities of Daily Living, December 2005**

<table>
<thead>
<tr>
<th>ADL</th>
<th>None</th>
<th>Some</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dressing</td>
<td>11%</td>
<td>69%</td>
<td>20%</td>
</tr>
<tr>
<td>Bathing</td>
<td>7%</td>
<td>50%</td>
<td>43%</td>
</tr>
<tr>
<td>Toileting</td>
<td>54%</td>
<td>26%</td>
<td>20%</td>
</tr>
<tr>
<td>Transferring</td>
<td>28%</td>
<td>60%</td>
<td>12%</td>
</tr>
<tr>
<td>Walking</td>
<td>5%</td>
<td>94%</td>
<td>1% (bedfast)</td>
</tr>
<tr>
<td>Eating</td>
<td>22%</td>
<td>77%</td>
<td>1% (tube feeding)</td>
</tr>
</tbody>
</table>

Source: New York State Department of Health (28 March 2006). NYS Managed Long-Term Care: Final Report to the Governor and Legislature.

Note: Functional status statistics include both MMLTC and PACE enrollees.
Figure 5.4
Managed Long-Term Care Enrollees with Cognitive Impairment, December 2005

Note: Health status statistics include both MMLTC and PACE enrollees.

Rules, Regulations, and Administrative Structure

Federal Coverage Requirements
Title 19, Section 1932 of the Social Security Act allows states to establish voluntary managed care plans as an alternative to fee-for-service Medicaid. MMLTC plans operate under the state’s authority to regulate managed care plans (Article 44 of the New York Public Health Law).

Covered Services
MMLTC plans are responsible for care management and for several specified services: nursing; personal care and home health aide services; physical, occupational, and speech therapies; and medical equipment and supplies. Plans may also provide services not typically covered by Medicaid, such as medical social services and social day care. Unlike the state’s Long-Term Home Health Care Program, MMLTC plans are required to provide nursing home care, when appropriate and for as long as necessary, as well as dentistry, optometry, and podiatry — services that beneficiaries who have both Medicare and Medicaid coverage (dually eligible) cannot typically access through the federal Medicare program.9

9 Residents of nursing homes are not eligible to enroll in MMLTC plans, although enrollees who come to need nursing home care may remain enrolled in MMLTC.
Table 5.4
Medicaid Managed Long-Term Care Program: Covered Services

<table>
<thead>
<tr>
<th>Covered Services</th>
<th>Services Coordinated But Not Covered</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care management</td>
<td>Physician services</td>
</tr>
<tr>
<td>Nursing</td>
<td>Inpatient/outpatient hospital services</td>
</tr>
<tr>
<td>Home health</td>
<td>Rural health clinic services</td>
</tr>
<tr>
<td>Personal care</td>
<td>Pharmacy</td>
</tr>
<tr>
<td>Homemaking</td>
<td>Laboratory</td>
</tr>
<tr>
<td>Housekeeping</td>
<td>Radiology and radiation services</td>
</tr>
<tr>
<td>Physical therapy</td>
<td>Chronic renal dialysis</td>
</tr>
<tr>
<td>Occupational therapy</td>
<td>Mental health and mental retardation / developmental disability services</td>
</tr>
<tr>
<td>Speech pathology</td>
<td>Alcohol and substance abuse services</td>
</tr>
<tr>
<td>Respiratory therapy</td>
<td>Family planning services</td>
</tr>
<tr>
<td>Audiology</td>
<td>Emergency transportation</td>
</tr>
<tr>
<td>Medical supplies &amp; equipment</td>
<td>Other services listed in the state’s Medicaid plan</td>
</tr>
<tr>
<td>Medical day care</td>
<td></td>
</tr>
<tr>
<td>Social day care</td>
<td></td>
</tr>
<tr>
<td>Nutritional counseling</td>
<td></td>
</tr>
<tr>
<td>Personal emergency response system and other social/environmental supports</td>
<td></td>
</tr>
<tr>
<td>Non-emergency transportation</td>
<td></td>
</tr>
<tr>
<td>Nursing home care *</td>
<td></td>
</tr>
<tr>
<td>Dentistry*</td>
<td></td>
</tr>
<tr>
<td>Optometry*</td>
<td></td>
</tr>
<tr>
<td>Podiatry*</td>
<td></td>
</tr>
<tr>
<td>Assisted living (optional) *</td>
<td></td>
</tr>
</tbody>
</table>

Note: * Services covered by MMLTC plans but not by the Long-Term Home Health Care Program.

Scope of Care Management Responsibility: MMLTC plans are responsible for managing all the care needs of beneficiaries, regardless of the care setting. If an enrollee is hospitalized or requires nursing home care, the plan remains responsible for managing his or her care and associated costs. Care management caseloads vary in size from plan to plan. Care managers, usually nurses (sometimes social workers), typically have responsibility for managing the care of 25 to 30 beneficiaries (Hokenstad and Haslanger 2004).

Service Utilization
Consistent with service utilization patterns in most long-term care programs that primarily enroll frail seniors and adults with physical disabilities, most service use is attributable to direct care services — hands-on help with activities of daily living and instrumental activities of daily living.
Nearly all enrollees receive direct care services (either personal care or home health aide services). In 2005, New York City plans spent 61 percent of their Medicaid revenue on direct care services.

**Figure 5.5**
Percentage of MMLTC Spending in New York City, by Type of Service, 2005

![Pie chart showing 39% for Personal care and home health aides, 61% for Other services.]


**Eligibility — Medical and Financial**

**Medical Eligibility:** Applicants must be 18 years or older. There are no excluded adult populations. Unlike nursing homes, MMLTC plans can admit enrollees with a primary diagnosis of either a severe and persistent mental illness or an intellectual disability (such as mental retardation or a developmental disability), provided that they meet all other eligibility requirements.¹⁰

Eligibility is limited to individuals who require nursing home level of care as measured by the Semi-Annual Assessment of Members (SAAM).¹¹ Eligibility also requires that the applicant can be safely and appropriately maintained in a home and community-based setting, as indicated by the SAAM and a physician’s order. Plans must conduct a comprehensive needs assessment, including the SAAM, at least every 180 days.¹²

The local department of social services is responsible for approving medical eligibility determinations before plan enrollment. New York City’s department of social services (HRA) does not make an independent home visit to confirm eligibility and service plans, as it does for the LTHHCP; instead, it reviews the paperwork (SAAM and plan of care).

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¹⁰ For more information about eligibility, see Bogart 2007.
¹¹ The SAAM is a chronic care version of the Outcome and Assessment Information Set (OASIS), a tool that is a federally mandated assessment used to determine level of care and reimbursement, and to measure outcomes of care in organizations that are required to comply with Medicare regulations (CHHAs and LTHHCP providers). Applicants must require a nursing home level of care, scoring five or more on the SAAM.
¹² Unlike LTHHCP providers, MMLTC plans are not required by the state to adhere to the Medicare conditions of participation.
Individuals whose income is higher than the rules allow may qualify for Medicaid through the Spend-Down (Medically Needy) program, which allows applicants with “excess income” (the amount above $725 per month) attributable to medical expenses to “spend down” to the financial resource limit. [See Chapter 1 and Glossary.]

Total December 2005 enrollment was 11,976 beneficiaries in MMLTC (84 percent) and 2,338 beneficiaries in PACE (16 percent).

More than 90 percent of involuntary disenrollments are initiated by the plan because the enrollee no longer met enrollment criteria for one of the following reasons: the enrollee moved out of the service area, left the service area for more than 60 days, was hospitalized for more than 45 days, failed to pay their Medicaid spend-down surplus, or exhibited such abusive or disruptive behavior that it was “no longer possible for the plans to provide effective and quality services.” Voluntary disenrollments may include issues such as moving outside of the service area, enrollment in another Medicaid joining program, or dissatisfaction with the quality or quantity of services.
Provider Requirements

All program sponsors approved before 2007 were provider-based organizations with expertise in providing home care services rather than insurance companies. However, because they are managed care plans providing Medicaid services, MMLTC plans operate under both the state’s insurance regulatory authority and the federal authority to provide managed care alternatives to traditional fee-for-service Medicaid. New plans must be approved by the New York State Insurance Department and the State Department of Health. New York requires plans to have fiscal reserves equal to 5 percent of net premium income. Plans approved as MMLTC providers after 2006 must be sponsored by organizations that are also designated as Special Needs Plans (SNPs) under Medicare. A SNP is a type of Medicare managed care plan (Medicare Advantage) that is designed specifically for beneficiaries with special needs, including institutional residents, dually eligible individuals, and people with severe or disabling chronic conditions. The purpose of this requirement is to locate the responsibility for managing beneficiaries’ medical and long-term care needs within a single organization.

Payment

The state’s Medicaid program pays each plan a negotiated monthly premium for each enrolled beneficiary. There are different payment amounts for enrollees aged 18–64 years and those 65 and older; in addition there are different payment amounts for those who have Medicare coverage (dually eligible) and those who do not. Unlike nursing home payment, these premiums are not risk-adjusted (case-mix indexed) to account for different levels of functional, cognitive, and clinical need. Before 2006, the state negotiated the monthly premiums for each plan independently based on the prior year’s expenditures; an extremely labor-intensive process. The state changed the process: premiums are individually negotiated every other year, and in the intervening years all plans receive a trend factor adjustment (2 percent in 2007) applied to the prior year’s rates. There is no specific payment adjustment for additional costs associated with enrollees who have extensive needs, such as those who reside in nursing homes or who require a high level of personal care or costly equipment (Kronick and Llanos 2008).
In 2007, the statewide average monthly Medicaid premium for an MMLTC plan was about $3,600 per member. However, the premiums varied greatly between New York City and the rest of the state, as well as among plans within the same region. The premium for enrollees who do not have Medicare coverage (Medicaid only) is higher than that for those who are dually eligible. Some of the variation among plans in the same region is likely related to the proportion of enrollees with Medicare coverage compared to those without.

Table 5.5
Average Monthly Medicaid Payment Rates for MMLTC Plans, 2007

<table>
<thead>
<tr>
<th>Region</th>
<th>Average Per Member Per Month Premiums</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>New York State</td>
<td>$3,600</td>
<td>$2,000 - $5,000</td>
</tr>
<tr>
<td>New York City</td>
<td>$3,600</td>
<td>$3,000 - $5,000</td>
</tr>
<tr>
<td>Rest of state</td>
<td>$3,000</td>
<td>$2,000 - $4,000</td>
</tr>
</tbody>
</table>

Source: UHF analysis of SDOH Medicaid Managed Care Operating Report data, December 2007, provided by the MLTC/PACE Coalition.

Quality Monitoring

The State Department of Health is accountable for plan performance. Although the state recently restructured and co-located responsibility for most of the long-term care programs (including nursing homes, the LTHHCP, and personal care) within a single division (the Office of Long-Term Care), oversight of the MMLTC and PACE remains the responsibility of the managed care division. Plans are subject to an annual on-site performance review and are required to submit SAAM data and disenrollment statistics semiannually. Failure to meet survey standards can result in sanctions, including suspension of enrollment privileges. There are no specific rewards for good performance. The state does not publicly report outcomes for the MMLTC plans, as it does for LTHHCP providers and nursing homes.

Each plan is required to have an internal quality assurance and performance improvement program and to conduct at least one major quality improvement project per year. Plans are also required to conduct at least one enrollee satisfaction survey each year.
The Medicaid managed long-term care program plays a fundamental role in meeting the long-term care needs of more than 20,000 New Yorkers each month. Most of this population suffers from multiple chronic illnesses that cause, contribute to, and interact with functional and cognitive disabilities. Care for this group can be intensive and costly. In FFY 2007, Medicaid spending for the MMLTC program was roughly $700 million. This section of the report explores some of the challenges facing the program, and identifies critical issues for further research and discussion about how the delivery of long-term care services could be improved.

System Simplification
In the current long-term care system, it is difficult to distinguish among programs that enroll similar populations. For example, MMLTC and the LTHHCP enroll similar populations (both are limited to individuals who have nursing home level of care needs), and although MMLTC provides a slightly broader array of services than the LTHHCP does, most spending in both programs goes toward direct care services. The primary difference between the programs is how they are paid. MMLTC plans are paid a monthly premium for each beneficiary, and they are responsible for meeting beneficiaries’ long-term care needs for as long as necessary, including providing nursing home care when appropriate. Meanwhile, LTHHCP providers are paid on a fee-for-service basis, but there is a limit on how much can be spent on each beneficiary. If a beneficiary’s needs exceed the budget threshold, they may have to disenroll and seek services elsewhere (such as a nursing home, certified home health agency, or through the personal care program).

Given the apparent overlap in target populations, it is important to decide whether to maintain both MMLTC and the LTHHCP as they are, consolidate them, or further differentiate between them by changing eligibility criteria, payment caps, or financing methodologies. Solutions must address regional differences in capacity. MMLTC is primarily a New York City program, and the LTHHCP plays a particularly significant role outside of the city; in some counties it is the primary way for beneficiaries to receive community-based care.

[20] The per-beneficiary spending cap in the LTHHCP is equivalent to 75 percent of the average Medicaid nursing home rate in the same county. There are some exceptions to this requirement. [See Chapter 4 for an in-depth look at the Long-Term Home Health Care Program.]
Effective Care Management

Because most long-term care beneficiaries have multiple chronic medical conditions, they typically require a lot of medical services and acute care. Effective care management for people with chronic medical conditions can accomplish many tasks: preventing avoidable events, such as medication errors or urinary tract infections; promoting early treatment to slow functional and cognitive decline; and fostering more effective disease management, such as better glucose monitoring for diabetics. In order to address the full complement of beneficiaries’ needs, it will be important to implement strategies that more fully integrate long-term care with the delivery of medical, mental health, and social services.

However, many factors make it difficult to provide care management that effectively balances cost and quality: a shortage of nurses and social workers with the required skills and experience; regulatory requirements whose documentation consumes a substantial amount of the time available to manage beneficiary care; differences in how providers interpret the scope of their care management responsibilities; and gaps in the availability of local services, such as transportation and in-home mental health care. A long-term care reform agenda for New York State should include clear guidelines about expectations for care management services; a strategy for ensuring that the professionals who perform this important role have appropriate skills, training, and supervision; and a strategy for regularly monitoring and evaluating the effectiveness of care management services. Careful consideration should be given to reform solutions that would narrow gaps in the availability of local services.

Integration of Medicare and Medicaid Financing

For dually eligible beneficiaries (those with both Medicaid and Medicare coverage), effective long-term care can save money for both the Medicaid and Medicare programs. For example, a serious fall can permanently impair an individual’s ability to walk. Preventing that fall could avert the cost of additional hours of personal care or placement in a nursing home, paid for by Medicaid. The more substantial and immediate savings, however, would accrue to Medicare, by obviating the need for emergency room visits, hospitalizations, and rehabilitation services.
There is continuing interest at both the state and federal level to more fully integrate Medicare and Medicaid financing at the provider or plan level. The Program of All-Inclusive Care for the Elderly (PACE) is widely cited as a successful model of integrated financing and service delivery, but it has been slow to replicate the program (as currently configured) on a broad scale. Therefore, the state has pursued other strategies. For example, since 2006, the state department of health has required sponsors of new MMLTC plans to also offer Medicare special needs plans (SNPs). In addition, the state has recently established a new long-term care program, Medicaid Advantage Plus, which is another managed care option for dually eligible individuals over the age of 18 with nursing home level of care needs. The purpose of the SNP requirement and the new Medicaid Advantage Plus program are similar — to integrate service delivery and to allow the Medicaid program to capture savings that often accrue to Medicare as a result of Medicaid-financed interventions. To capture these Medicare “savings,” it is likely that the Medicaid premiums for these integrated plans will be lower than rates for current MMLTC plans.

There are practical implications related to these changes. For example, the new SNP requirement suggests the need for large organizational sponsors, such as insurance companies, that can assume the financial risks associated with capitated financing and meet the financial reserve requirements. While it does not prohibit organizations with extensive home care experience from applying to sponsor an MMLTC plan, it does make qualification more difficult. MMLTC sponsors are typically organizations with expertise in providing home care services, and therefore have strong connections to other community-based organizations serving frail seniors and adults with physical disabilities. Having strong community relationships is one of the factors that the state department of health has identified as critical to successful program growth (New York State Department of Health 2006). The SNP policy may be difficult for these provider-based organizations to meet. For similar reasons, the requirements for the new Medicaid Advantage Plus program may also be difficult for these provider-based organizations to meet.

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21 PACE represents a very small share of long-term care enrollment and spending in New York, with slightly more than 3,000 enrolled in December 2007. Providers receive prospective reimbursement from both Medicare and Medicaid and are responsible for all health care as well as long-term care services. The fiscal and regulatory requirements for PACE, such as the capital costs associated with building the required adult day health care system, restrict the number of community providers that can become plans (Hokenstad and Haslanger 2004).

22 See description of SNPs in section on provider requirements. There were 26 SNPs offered in New York in 2008, with total enrollment of 64,940 as of March 2007 (Kaiser State Health Facts). Enrollment in these plans is optional.

23 In the Medicaid Advantage Plus program, beneficiaries must enroll in the same health plan for most of their Medicare and Medicaid benefits. Plans that participate in the program offer a uniform Medicare Advantage product and a supplemental Medicaid Advantage product, which also covers long-term care services. Enrollment in the plans is optional.
Strategies to more fully integrate Medicare and Medicaid financing will need to consider how best to build on and incorporate the capacity and expertise of current long-term care providers. They may also need to consider how best to foster viable partnerships between the insurance companies that operate SNPs and provider organizations with long-term care expertise.

**Risk-Adjusted Payment**

From a budgetary perspective, prospective payment approaches have the advantage of more predictability; the state can more effectively project how much it will be spending. MMLTC payment is adjusted by age, but unlike nursing home payments, monthly premiums are not risk-adjusted (case-mix indexed) to account for different levels of functional, cognitive, and clinical need. In practical terms, this means that plans may not have sufficient financial incentives or resources to enroll beneficiaries who are especially frail or have complex medical conditions. Ideally, financial incentives should award plans more resources for enrolling beneficiaries with more complicated needs. A reform agenda should consider a methodology for risk-adjusting Medicaid payment to MMLTC (as well as payments to PACE and Medicaid Advantage Plus plans). More research is needed to address outstanding questions about how best to do this.

**Barriers to Access**

Many of the personal care program beneficiaries in New York City have needs comparable to those of MMLTC enrollees and would likely benefit from the care management and expanded array of services that MMLTC provides but that the personal care program does not (Hokenstad et al. 2002). In part because of the way they are paid, some plans may not have sufficient financial incentives or resources to enroll people with the most extensive direct care needs. As a result, some of these high-need individuals become enrolled in the personal care program.

A growing body of evidence from similar programs in other states and countries suggests that programs similar to MMLTC are effective in delaying nursing home placements and reducing the number of unnecessary hospitalizations (Saucier and Fox-Grage 2005; Kane and Homyak 2003; Kane et al. 2003; Chatterji et al. 1998; APS Healthcare 2003; Aydede 2003). A reform strategy must take a closer look at the population with nursing home level of care needs in all long-term care programs. Are they receiving the right care, in the right setting, at the right price? More research is needed to determine which of the state’s program models are most successful at managing care, for which populations, and at what cost to Medicaid.
Direct Care Worker Wages

It is also important to keep in mind the practical barrier that wage differences present to system reform. Beneficiaries value their relationships with direct care workers. The likelihood of beneficiaries voluntarily switching from one program (such as personal care) to another (such as MMLTC) would be increased if direct care workers were able to remain with them. However, as a result of successful collective bargaining agreements, personal care program workers (home attendants) in New York City earn approximately $2 to $3 more per hour than the personal care aides and home health aides who typically provide direct care services in MMLTC and the LTHHCP. Understandably, direct care workers would be reluctant to transfer with beneficiaries if it meant that they would have to accept lower wages and benefits. A workforce strategy should include a socially responsible solution for achieving equity in direct care wages (comparable pay for comparable work) across the long-term care sector. Potential reform strategies, such as achieving administrative savings through program consolidations, may hinge on having flexibility to reassign workers where there are needed most.

Program Oversight

Within the department of health, responsibility for the MMLTC program and the other long-term care programs are not located in the same office. Oversight responsibility for long-term care programs is divided between the Office of Health Insurance Programs (for managed long-term care) and the Office of Long-Term Care. There will need to be a concerted effort to promote consistency in long-term care policy and regulation.
References


Appendix I. Glossary of Key Terms and Acronyms

A&G: Administrative and general (expenses).

ADHC: Adult day health care. An optional state Medicaid plan service that provides nursing; transportation; physical, occupational, and speech therapies; medical social services; rehabilitation and socialization; and referrals for outpatient health care and dental services. Also referred to as medical adult day health care.

ADL: Activity of daily living. Basic ADLs include feeding/eating, bathing, dressing/grooming, using the toilet, and transferring/mobility (e.g., getting into or out of bed). See also IADL.

ALP: Assisted living program. A Medicaid-reimbursable long-term care program that combines residential and home care services. Providers must be dually certified as an adult home or enriched housing program (for the housing component) and as a home care services agency, a certified home health agency, or a long-term home health care program (for the service component).

Capitated reimbursement. A fixed amount that is paid to a provider for each beneficiary enrolled (“per capita”).

CDPAP: Consumer-directed personal assistance program. Also referred to as consumer-directed personal care. Includes services provided by someone hired and supervised directly by the beneficiary or a surrogate. See also personal care and direct care.

CHHA: Certified home health agency. Provides skilled nursing care; home health aide services; physical, occupational, and speech therapies; and medical social work services. CHHAs provide both post-acute/rehabilitation and long-term care services.

CON: Certificate of need. All health facilities in New York must apply to the State Department of Health for this certificate before embarking on any construction, purchasing major medical equipment, changing ownership, or adding services.¹


CNA: Certified nursing assistant.

Direct care. Assistance with activities of daily living and instrumental activities of daily living. In this report, “direct care workers” refers to paid workers providing assistance with personal care, including certified nursing aides, home health aides, personal care aides, and home attendants.

FFS: Fee-for-service. Payment for the number of hours, visits, or services provided.

FFY: Federal fiscal year. Runs from October 1 to September 30.

HCBS: Home and community-based services. This report frequently uses the term “community-based care” to refer to these services.

HRA: Human Resources Administration. In this report, refers to New York City’s local department of social services.

¹http://www.health.state.ny.us/nysdoh/cons/index.htm
IADL: Instrumental activity of daily living. IADLs are activities associated with independent living, including shopping, meal preparation, money management, and other household chores and errands. See also ADL.

LDSS: Local department of social services.

LHCSA: Licensed home care service agency.

LTC: Long-term care.

LTHHCP: Long-Term Home Health Care Program. Also known as the Lombardi program or the Nursing Home Without Walls program, New York’s LTHHCP is a Medicaid 1915(c) home and community-based waiver program. It provides care management, skilled nursing services, direct care, and a variety of waiver program services to Medicaid beneficiaries. See waiver programs.

MARS: Management and Administrative Reporting Subsystem. A monthly summary of program statistics from the New York State Department of Health, Office of Medicaid Management. The September 2007 MARS is the primary source of data analyzed in this report.

MDS: Minimum Data Set. An assessment tool used in all nursing homes receiving Medicare reimbursement, administered quarterly and after any significant change in a resident’s functional status. It covers the following areas: customary routine; cognitive patterns (communication, hearing, and vision); psychosocial well-being; physical functioning and structural problems; continence; disease diagnoses and health conditions; oral, dental, and nutritional status; skin condition; activity pursuit patterns; medications; special treatments and procedures; discharge potential; and vaccine immunization status.

Medicaid Advantage Plus. Managed care option for dually eligible individuals over the age of 18 with nursing home level of care needs. Beneficiaries must enroll in the same health plan for most of their Medicare and Medicaid benefits. Plans that participate in the program offer a uniform Medicare Advantage product and a supplemental Medicaid Advantage product that also covers long-term care services. Enrollment in the plans is optional.

Medically Needy program. Under this program, people with substantial health care costs but income above Medicaid’s financial criteria may “spend down” to Medicaid eligibility levels by paying for medical care. New York has such a program; the programs are defined but not required by CMS.

Medicare Advantage. A generic Medicare managed care plan available to all Medicare beneficiaries regardless of their level of disability.

MMLTC: Medicaid managed long-term care. New York’s MMLTC plans provide skilled nursing services, direct care, preventive health care services (such as dentistry, optometry, and podiatry), and nursing home care as appropriate.

MSIS: Medicaid Statistical Information System.

NHLOC: Nursing home level of care. A standard of eligibility for care in a nursing facility, based on one’s care needs and functional, cognitive, and medical status.


NY Connects. A joint initiative of the New York State Department of Health and Office for the Aging that attempts to establish central points of information about long-term care services at the county level. See www.nyconnects.org.
**OASIS: Outcome and Assessment Information Data Set.** A federally mandated assessment tool, used by certified home health agencies and long-term home health care programs, that collects Medicare beneficiaries’ demographic and clinical information. CMS requires it to be administered every 60 days and at discharge.

**PACE: Program of All-Inclusive Care for the Elderly.** Similar to MMLTC, this managed care program is a capitated benefit authorized by the federal Balanced Budget Act of 1997. It offers a comprehensive service delivery system, including both acute and long-term care services. Unlike MMLTC, which is financed only by Medicaid, PACE is financed by both Medicare and Medicaid.²

**PC: Personal care.** Assistance with activities of daily living and instrumental activities of daily living. In traditional personal care, these services are provided by an agency; in consumer-directed personal care, they are provided by someone hired and supervised directly by the beneficiary or a surrogate. See direct care.

**ROS: Rest of state.** In this report, some tables and figures present data from New York City (NYC) and “rest of state” (ROS).

**RUG: Resource utilization group.** Part of a need-based classification system developed by the New York State Department of Health to determine a daily reimbursement rate for nursing homes, based on a patient’s severity of illness and type of care needed (case-mix adjusting). There are 16 RUGs: rehabilitation (RA, RB), special care (SA, SB), clinically complex (CA, CB, CC, CD), severe behavior problems (BA, BB, BC), and reduced physical functioning (PA, PB, PC, PD, PE).

**SAAM: Semi-Annual Assessment of Members.** A chronic care version of the OASIS, this assessment tool is used in MMLTC and PACE plans.

**SDOH: New York State Department of Health.**

**SNF: Skilled nursing facility.** A nursing home. Provides post-acute care, rehabilitation services, and long-term care services. Nursing home services include room and board; 24-hour nursing services; specialized rehabilitative services, such as physical, speech, and occupational therapy; medical social services; pharmaceutical services; dietary services; activities programs; routine dental care; and personal care.

**SNP: Special needs plan.** A Medicare Advantage coordinated care plan focused on individuals with special needs, such as dual eligibles and individuals with severe or disabling chronic conditions.³

**Spend-down.** See Medically Needy program.

**SSI: Supplemental Security Income.** A federal income supplement program, funded by general tax revenues (not Social Security taxes). SSI helps aged, blind, and disabled people who have little or no income meet basic needs of food, clothing, and shelter.⁴

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**TBI: Traumatic brain injury.** In this report, refers to New York’s 1915(c) home and community-based waiver program for the long-term care of Medicaid beneficiaries with a traumatic brain injury. It provides access to 11 waiver services, many of which are not available to long-term care beneficiaries enrolled in other programs, including structured day programs and community integration counseling. It also facilitates access to other community-based services and a state-financed housing subsidy program. See waiver programs.

**UHF: United Hospital Fund.**

**Waiver programs.** The Social Security Act allows states to waive certain federal Medicaid requirements in order to establish programs for specific populations or purposes. These “waiver programs” are intended to give states flexibility in addressing their populations’ particular needs with the resources available. There are several types of waiver programs, described below. They are referred to by the section of the Social Security Act that defines them.

- **Section 1115, Research & Demonstration Projects.** Projects that test policy innovations likely to further the objectives of the Medicaid program.

- **Section 1915(b), Managed Care/Freedom of Choice Waivers.** Waivers that allow states to implement managed care delivery systems, or otherwise limit individuals’ choice of provider under Medicaid.

- **Section 1915(c), Home and Community-Based Services Waivers.** Waivers that allow long-term care services to be delivered in community-based settings. States have the authority to develop waiver programs for specific target populations (such as frail seniors or people with physical disabilities) who would otherwise be in an institution, and to limit enrollment by age, region, or type of disability. There is no limit on the number of 1915(c) waiver programs a state can operate. Federal approval requires that such programs be cost-neutral — i.e., that they not cost more than nursing home care for the same population would cost. These programs provide a wider range of services than those generally covered by Medicaid — including, for instance, medical social work and home modifications. In New York, 1915(c) waiver programs primarily serving frail seniors and adults with disabilities are the LTHHCP, the TBI waiver, and the NHTDW program.

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1 http://www.health.state.ny.us/health_care/medicaid/program/longterm/tbi.htm
2 http://www.cms.hhs.gov/MedicaidStWaivProgDemoPSI/
Basic information about New York’s Medicaid long-term care programs is hard to come by. There are 12 long-term care programs in the state, and there is no single source of consistently gathered, formatted, and reported data. Therefore, the information presented in this report was obtained from several sources. The study had three main components: an analysis of enrollment and spending data; expert interviews; and an analysis of program statistics. Sources and methods for all three are described below.

**Enrollment and Spending Analysis**

The enrollment data came from the September 2007 Management and Administrative Reporting Subsystem (MARS), a monthly summary report of Medicaid program statistics (Form MR-O-50) from the New York State Department of Health (SDOH). In a few programs, an accurate beneficiary count could not be ascertained directly from MARS; enrollment data for these programs came from provider census documents, cost reports, and the SDOH website.

The spending data came from the Centers for Medicare & Medicaid Services (CMS) financial management reports (CMS 64) and the MARS (Form MR-O-72) for federal fiscal year 2007. In this study, the CMS 64 was used to report spending by service or program whenever possible because it reflects an audited record of actual Medicaid payments. Because the CMS 64 does not provide sufficiently disaggregated data by service or program, MARS data were also used. To reconcile these data sets, the share of spending by service or program from the MARS was imputed into the service category totals from the CMS 64.

Please note that the enrollment and spending data presented in this report may differ from information in other published reports on Medicaid for several reasons. First, enrollment data is for a single point in time (September 2007) rather than an entire year; annual enrollment figures include a count of all beneficiaries who receive services at any point during the year. “Point-in-time” figures control for most of the movement of beneficiaries among programs within a year, such as when beneficiaries transition from a certified home health agency to a personal care program. Second, spending data is presented by program and not by individual service. For example, spending on personal care and certified home health care for people enrolled in the Long-Term Home Health Care Program (LTHHCP) has been reallocated to LTHHC for this report. Third, enrollment and spending data do not include programs that primarily enroll individuals with developmental or intellectual disabilities or medically fragile children, such as the Care at Home waiver program.

This report focuses on long-term care, not short-term care. However, two key providers of long-term care services — nursing homes and certified home health agencies — also provide a substantial amount of short-term, typically post-acute, skilled nursing and rehabilitation services, also financed by Medicaid. Most available data sources — including both MARS and CMS 64 — do not distinguish between long-term and short-term care. Although the amount of post-acute enrollment, and spending in CHHAs has not been removed, an estimate is provided in Table 1-1 and its accompanying footnotes. There is also an undetermined amount of short-term enrollment and spending in the nursing home figures.
Specific Adjustments

A number of technical adjustments were made in order to overcome the limitations of the available data. The adjustments are listed below, by program and data source.

Certified Home Health Agencies (CHHA)
Post-acute care is included in CHHA enrollment and spending numbers in this report. However, an estimated one-third of reported enrollment is believed to be attributable to CHHA beneficiaries receiving short-term, typically post-acute, care. This estimate was based on an SDOH/Office of Health Insurance Programs (OHIP) Audit, Fiscal and Program Planning (AFPP) DataMart analysis of Medicaid enrollees who received at least one long-term care service in September 2007, which identified that 31 percent of Medicaid CHHA recipients were receiving short-term home health care. Short-term care is defined here as those beneficiaries who received home health care in September but not in each of the previous three months (June, July, and August 2007). This population accounted for approximately 16 percent of all CHHA spending in September 2007. This estimate is also supported by an internal analysis of enrollment and length of stay in New York City’s largest CHHA, from which it was determined that roughly two-thirds of Medicaid CHHA recipients in December 2006 were receiving home health care on a long-term basis (more than 90 days) as compared to short-term (less than 90 days).

Medical Adult Day Health Care (ADHC)
The ADHC program is not reported discretely in either the MARS or the CMS 64. Therefore, enrollment and spending for ADHC came from an analysis of the 2006 Residential Health Care Facility cost report (RHCF-4) produced by the New York Association of Homes & Services for the Aging (NYAHSA). The shares of enrollment and spending attributable to ADHC from the NYAHSA analysis were reassigned from MARS and CMS 64 reported nursing home data and reported separately for the ADHC program. Although 2007 RHCF cost reports have not been released yet, interviews with key stakeholders indicate that there has not been a significant growth in ADHC enrollment over the past few years. In addition, transportation is no longer part of the rate for most ADHC programs, although it was included in 2006; therefore, the reported Medicaid spending for ADHC programs may slightly overstate associated program spending.

Long-Term Home Health Care Program (LTHHCP)
While MARS reports the number of beneficiaries receiving individual LTHHCP services, it does not provide an exact count of enrollment because each beneficiary receives a different combination of services. (The closest proxy is direct care services, which in aggregate are close to the figures reported in the 2007 census.) Therefore, LTHHCP enrollment data came from the December 31, 2007 LTHHCP census from the SDOH Bureau of Licensure and Certification. The CMS 64 reports LTHHCP spending on waiver services only, but does not identify spending on other program services (e.g., personal care or home health care). Thus, associated LTHHCP spending in these categories was reassigned from MARS and CMS 64 reported PC and CHHA data to reported figures for the LTHHCP.

Medicaid Managed Long-Term Care (MMLTC) and Program of All-Inclusive Care for the Elderly (PACE)
MARS does not distinguish between PACE and MMLTC; both are reported within a single category entitled “Managed LTC.” The SDOH Medicaid Managed Care statistics report (available on the SDOH website) lists the percentage distribution of PACE and MMLTC enrollment, which was applied to MARS for enrollment. While PACE spending is separately listed in the CMS 64, MMLTC spending is not. Therefore, the amount of spending for PACE reported in the CMS 64 was subtracted from the MARS “Managed LTC” spending figures. The remainder in this report is reported as MMLTC spending.

A small number of PACE and MMLTC care beneficiaries (roughly 7 percent) receive care in nursing homes. No adjustment was made to nursing home enrollment; therefore it is likely that PACE and MMLTC beneficiaries receiving care in nursing homes are double-counted in the enrollment analysis. The same is not true for spending figures. All spending for these program enrollees is included in reported spending totals for the MMLTC and PACE programs.
Expert Interviews

A series of structured interviews was conducted with experts in the long-term care sector: government officials, program administrators, policy experts, and staff at long-term care providers and provider associations. The following experts were interviewed: Marie Brady of the New York City Human Resources Administration; Al Cardillo and Patrick Conole of the Home Care Association of New York State; Thomas Dennison of Syracuse University; Christine Fitzpatrick of the Adult Day Health Care Association of New York; Darius Kirstein of New York Association of Homes and Services for the Aging; Carol Rodat of PHI; Rick Surpin of Independence Care System; and Paul Tenan of American PACE Exchange.

After the structured interviews, the following experts provided additional technical consultation: Nick Asimakopoulos, Tim Casey, Mary Beth Fader, Peter Gallagher, Linda Gowdy, Mary Graziano, Mark Kissinger, Kathleen Sherry, and Carla Williams of the New York State Department of Health; Ann Berson of the NYC Chapter of the Alzheimer’s Association; Valerie Bogart of the Evelyn Frank Legal Resources Program of Selfhelp Community Services; Roberta Brill, Judy Duhl, and Kathryn Haslanger of the Visiting Nurse Service of New York; Sara Butterfield of IPRO; Joe Campanella of the Home Care Council of New York City; Joanne Cunningham and Andrew Koski of the Home Care Association of New York State; Diane Darbyshire of New York Association of Homes and Services for the Aging; Paul Dieterich of Dieterich & Associates Consulting; Barbara Draimin and Arnold Ng of the Home Care Services Program of the New York City Human Resources Administration; Paula Freedman of Freedman Associates; Stuart Kaufer of Center for Independence of the Disabled, New York; Sara Meyers of Enea, Scanlan & Sirignano, LLP; Richard Mollot of the Long Term Care Community Coalition; Allen Rosen of YAI; and Tracey Sokoloff of Isabella Geriatric Center.

Program Statistics

Other program-specific information — such as provider capacity and sponsorship, beneficiary health status and demographics, workforce statistics, and reimbursement rates — came from a variety of sources, including facility cost reports, program censuses, provider reimbursement rates set by SDOH, reports to the legislature, state regulations, and both published and unpublished research.

Specific Adjustments

A number of technical adjustments were made in order to overcome the limitations of the available data. The adjustments are listed below, by program and data source.

Provider Capacity

There is no single source of information about provider size. Thus, data was drawn from several sources.

Nursing Homes: The number of long-stay Medicaid residents living in nursing homes and beneficiaries receiving traditional personal care services through agencies was not available by individual nursing home facility or personal care vendor. In order to determine the average and range of beds in use for nursing homes, the number of beds was multiplied by the facility’s 2006 occupancy rate, both listed on the SDOH Nursing Home Profile website. (Please note that the number of beds includes non-Medicaid beneficiaries.)

Personal Care: The average caseload size of personal care vendors was determined by dividing regional personal care enrollment by the number of personal care vendors serving that region; the number of total vendor agencies was used rather than number of vendor contracts. HRA provided a list of authorized caseload by individual vendor for New York City; however, authorized caseload differs from actual enrollment. We were not able to obtain information on the range of provider caseload size was not available for the rest of the state. Reported figures exclude consumer-directed care providers and enrollment.
LTHHCP and MMLTC. Enrollment data for each LTHHCP provider and MMLTC plan were available through 2007 LTHHCP census and the September 2007 SDOH Medicaid managed care statistics report (available on the SDOH website), respectively.

Organizational Sponsorship
Reported figures for “nursing home-sponsored” include all enrollment and spending for nursing homes and the Medical Adult Day Health Care program. They include the portion of spending and enrollment for LTHHCP providers sponsored by nursing homes (as distinct from those sponsored by hospitals, CHHAs, or other organizations). MMLTC and PACE plans sponsored by nursing homes were also included in the count. The counts for “Other” include all the remaining LTHHCP providers and MMLTC and PACE plans, as well as the remaining programs: ALP, personal care (both consumer-directed and traditional), CHHA, and TBI waiver. Where the organizational sponsor was unknown, the program was classified as “Other.”

Provider Reimbursement
Provider reimbursement rates for 2007 were listed on Medicaid long-term care reimbursement rate computation sheets (SDOH website) for nursing homes, personal care, and the LTHHCP. In order to determine average rates by region, reimbursement rates were weighted based on estimated enrollment or occupancy of program. For example, individual LTHHCP provider reimbursement rates were multiplied by their 2007 census, which were then accumulated into regions and divided by the region’s total census. Average premiums for MMLTC plans were inputted from the SDOH Medicaid Managed Care Operating Report (MCOR) data (December 31, 2007), which were obtained from the MLTC/PACE Coalition.

Study Limitations

1. Enrollment and spending data is not an exact accounting. The intent of this analysis was to illustrate the proportional relationships in enrollment and spending among the existing programs that primarily enroll frail seniors and adults with disabilities; it was never the intent to provide an exact accounting. Therefore, it is important to keep in mind that figures in this report are estimates based on a compilation of available data.

2. This study does not explore other health care use. This analysis focuses solely on long-term care service utilization. It does not explore spending or utilization data for acute and preventive medical services or mental health services, even though many Medicaid long-term care beneficiaries often use these services.

3. It is not possible to calculate per-capita spending for individual programs from the figures provided in this report. As previously mentioned, the enrollment figures represent monthly enrollment only, while the spending figures represent annual expenditures. Because of increased enrollment or beneficiary turnover, programs and services may have a larger number of beneficiaries over the course of a year than they have enrolled during a single month. Therefore, dividing total expenditures by enrollment will not yield an accurate per capita cost.

4. A small number of beneficiaries who are not frail seniors or adults with disabilities are included in the enrollment counts. While the programs highlighted in this report primarily enroll frail seniors and adults with disabilities, they also enroll other beneficiary populations. For example, although children enrolled in the Care at Home waiver program were excluded, a small number of medically fragile children are included in reported enrollment and spending for some of the programs. Roughly 5 percent of beneficiaries in CHHAs and 4 percent of beneficiaries in the LTHHCP are medically fragile children. In addition, reported enrollment and spending for the CHHA and personal care programs may include beneficiaries with intellectual and developmental disabilities.
5. **There is some duplication in enrollment.** In order to provide an unduplicated count of beneficiaries, this study presents point-in-time enrollment data. However, this approach does not completely eliminate double-counting, because within a given month an individual may receive LTC services from more than one provider or program. (For example, in addition to receiving care management and waiver services through the TBI program, an unknown number of the beneficiaries enrolled in the program also access care directly through the personal care, CHHA, and ADHC programs.) With that in mind, it is likely that a small number of beneficiaries have been included in enrollment figures for more than one program. Therefore, enrollment totals and subtotals include some duplication in the number of long-term care beneficiaries because these individuals would be counted more than once. According to a UHF analysis of NYSDOH/OHIP data, there is approximately 6 percent duplication across all long-term care programs; less than 1 percent duplication in residential programs; and almost 10 percent duplication in community programs. Of greatest significance is the amount of duplication among the traditional personal care program, CHHAs, and ADHC. (Of those beneficiaries receiving traditional personal care services, 9 percent also received CHHA services and 6 percent received ADHC services in the same month. Of those beneficiaries receiving CHHA services, 16 percent also received personal care and 3 percent received ADHC services in the same month. Of those beneficiaries receiving ADHC services, 33 percent also received personal care and 10 percent received CHHA services in the same month.) While this affects the double-counting of enrollment data, spending data is not affected.

6. **There is some overcounting in spending figures.** The TBI program is relatively small, so double-counting a subset of this population is not likely to affect the accuracy of the proportional distribution of program enrollment. Associated spending, on the other hand, may be affected more by this duplication. Many TBI beneficiaries have extensive direct care needs that are met outside of the waiver program (e.g., through traditional personal care or CHHA programs). With the data sources available, it was not possible to determine how much of the reported spending for certain Medicaid community-based services was attributable to beneficiaries in the TBI waiver program. In this report, associated spending for these individuals’ direct care services is reported as part of personal care program and CHHA spending.

The enrollment and spending figures reported for nursing homes and CHHAs also include a substantial amount of short-term care, as noted above and in the footnotes accompanying Table 1-1. However, some of the short-term beneficiaries using CHHA services may also be double-counted in other Medicaid community-based services. Therefore, some spending on these short-term beneficiaries may not be fully captured in the in the spending figures reported for community-based programs (e.g., traditional personal care).