

Changes in Nursing Home Care, 1996–2005: New York State

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Nursing homes in New York State aren't just providing long-term care anymore. Instead, they have come to play a more and more active role for people recuperating after a hospital stay. This movement toward short-term care is a response in part to financial pressures on hospitals to decrease length of stay and move patients out, and in part to decreased demand for long-term care beds, as other options have become more available for the elderly and disabled.

The author thanks Alene Hokenstad and Meghan Shineman, of the United Hospital Fund, for their invaluable help in preparing this report.

Not only has the number of short-term-stay patients with high levels of disability requiring rehabilitation increased dramatically, but longer-stay residents, too, have become more disabled, are more frequently cognitively impaired, and have more mental health diagnoses. The nursing home has come to play a bigger and bigger role in the care of individuals with mental health problems.

The purpose of this report is to paint a picture of the changes in patterns of nursing home care in New York State in recent years. Two primary sources of data were used to develop this profile. Cost reports filed with the New York State Department of Health by each nursing home for 1996 through 2005 were used as the foundation to describe the nursing home system. Data from the New York State Minimum Data Set (MDS) for 2000 through 2006 were used to profile the residents of nursing homes.¹

Data drawn from the Department of Health cost reports offer a perspective on the size of the nursing home resource: the number of homes, as well as the number of individuals served, how long they stayed, where they came from, and where they went. The cost reports also provide data on how care was financed and on the financial performance of nursing homes in the state.

¹ Automated transmission of MDS data did not begin until 1998. The data were not of high-enough quality and completeness for analytic purposes until 2000.

Ten Years in the Life of an “Average” New York Nursing Home: An Executive's Summary*

The last ten or so years have been tough for our “average” New York State nursing home. In 1996 we had a waiting list, and thought that with the graying of the population there would be unlimited demand. So we certified a few new beds, expanding from 175 to 183. But we were wrong. The elderly increasingly have other options, and our census remained at approximately 170, decreasing our occupancy rate from 96.9 to 93.2 percent.

We've been working a lot harder to keep the census up but it's not only more difficult to find elderly residents but also to attract younger people in need of short-term stays, usually to recuperate after a hospitalization, before returning to their own homes. Still, we have been able to more than double the number of admissions from local hospitals, from 136 to 323. To do that we had to develop therapy programs, increase registered nurse staffing to handle the paperwork that comes with more admissions, start admitting patients on the weekend, and hire a part-time intake coordinator to compete with other nursing homes for these short-term admissions.

Over these years the number of patients discharged after a stay of less than two months increased from 51 to 173, while the number of residents leaving after four years with us actually decreased. Discharge planning has become more and more time consuming; the total number of discharges doubled and the number of people going back home quadrupled.

More of our admissions are now covered by Medicare and private insurance. Medicare admissions more than doubled, from 70 in 1996 to 168 in 2005; private insurance admissions tripled. We used to count on the private-pay clients to subsidize Medicaid, but the number of private-pay days went down by 14 percent over the past ten years. Medicaid still accounts for almost 70 percent of our revenue.

Although the average age of our residents has not changed much (decreasing from a little over eighty to a little over seventy-nine), more younger residents are moving through our facility than ever before, and our elderly residents are older than those of ten years ago. It takes a lot more work to develop a reasonable plan for continued care in the community for those younger short-stay patients here for rehabilitation before returning home. They also demand amenities like cable TV, phone, and internet access. They want more choices at mealtime, and often prefer not to mingle with the older, often cognitively impaired, residents.

Our residents in general—both long- and short-term—have become harder and harder to care for. They have higher levels of functional disability, more diagnoses, more need for medications and various therapies. Nearly two-thirds of our long-stay residents are cognitively impaired, and half often display behavioral symptoms such as wandering and resisting care, or are verbally or physically abusive. The percentage with psychiatric diagnoses has also increased; now nearly half of our long-stay residents and over 30 percent of our short-stay patients are diagnosed with anxiety disorder, depression, bipolar disease, or schizophrenia.

Administrative and operating costs have climbed, as well. The industry-wide shortage of health care workers has driven wages up and, as we try to compete with hospitals for workers, costs have risen concomitantly. The workload in almost every department—nursing, therapies, activities, social work, medical records, and the business office—has increased to keep up with residents' demands, again increasing costs.

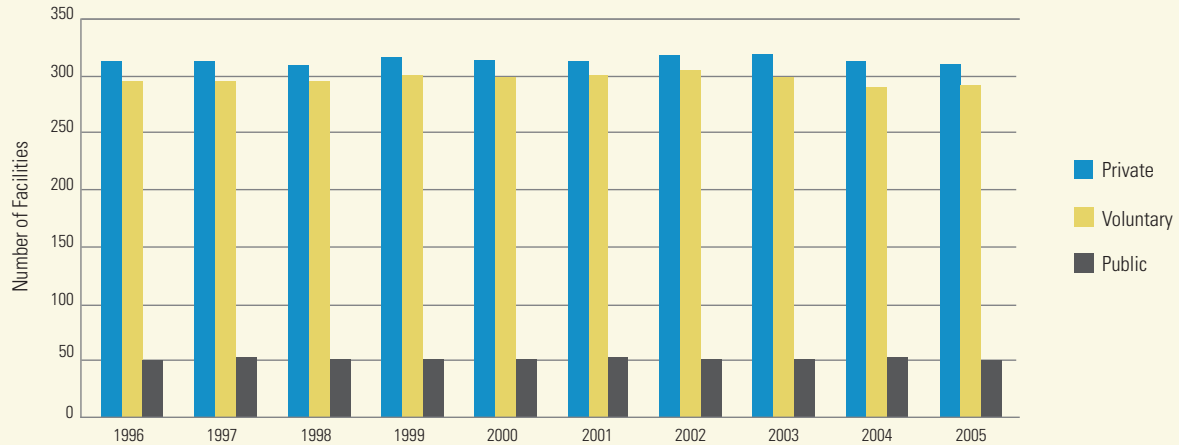
It's good to see people living longer in their own homes and using nursing homes to help them get better and return to their lives in the community. But it's difficult to meet the differing demands of our short-term patients and long-term residents at the same time.

**This look at the experience of a prototypical—but fictional—nursing home was prepared by Thomas Dennison.*

NURSING FACILITIES

The absolute number of nursing facilities and beds in New York State has changed very little in recent years, with just a slight decrease from 655 in 1996 to 649 in 2005. The total number of facilities, by sponsorship, remained fairly constant over the ten-year period (Figure 1).

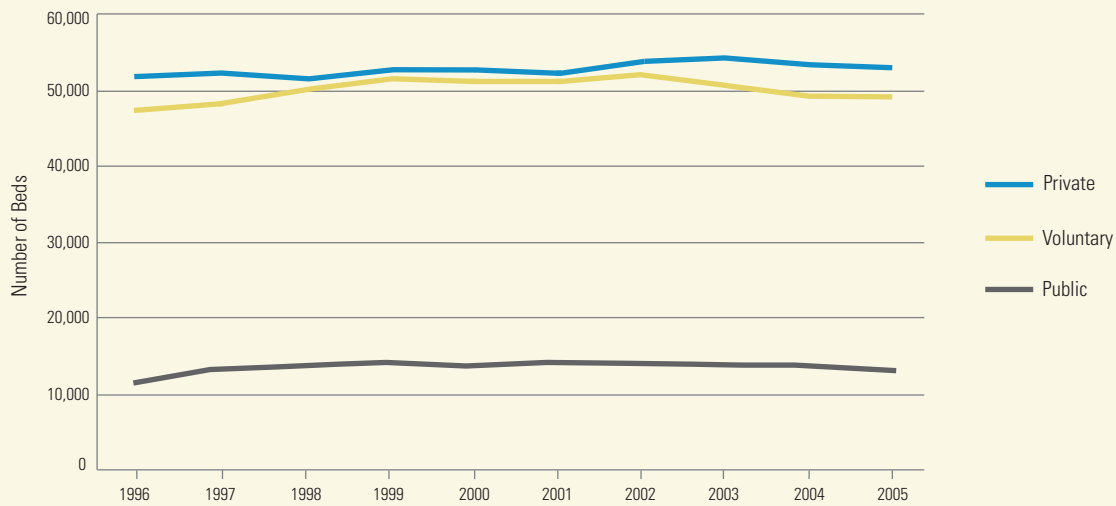
Figure 1
Nursing Homes by Sponsorship



Source: Cost reports for all nursing facilities, filed with the New York State Department of Health for 1996-2005.
Data obtained from Healthcare Association of New York State.

Between 1996 and 2005, the number of beds increased slightly from 114,331 to 118,781, with the distribution by sponsorship again remaining fairly constant (Figure 2). On average, 296 facilities operating 52,092 beds (44 percent of the total in 2005) were sponsored by voluntary providers, 313 facilities operating 53,772 beds (45 percent) were sponsored by private, proprietary operators, and 51 facilities operating 12,917 beds (11 percent) were sponsored by public agencies.

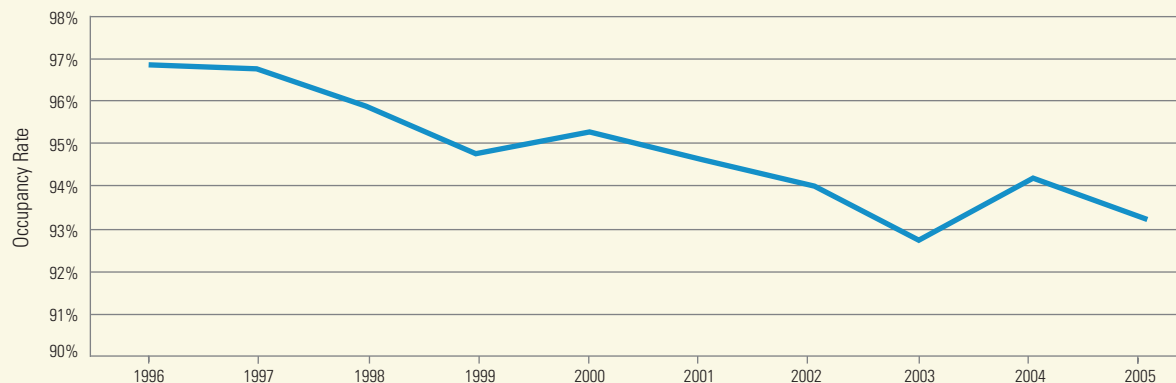
**Figure 2
Nursing Home Beds by Sponsorship**



Source: Cost reports for all nursing facilities, filed with the New York State Department of Health for 1996-2005. Data obtained from Healthcare Association of New York State.

The census in nursing homes grew more slowly than the increase in beds, from 110,943 in 1996 to 111,048 in 2005, resulting in a decline in the overall occupancy rate from 96.9 percent to 93.2 percent (Figure 3). Partly because occupancy rates dipped in some facilities, “bed hold days”² dropped by 13.5 percent, an estimated decrease from 776,000 in 1996 to 624,000 in 2005.

**Figure 3
Occupancy Rate by Year**



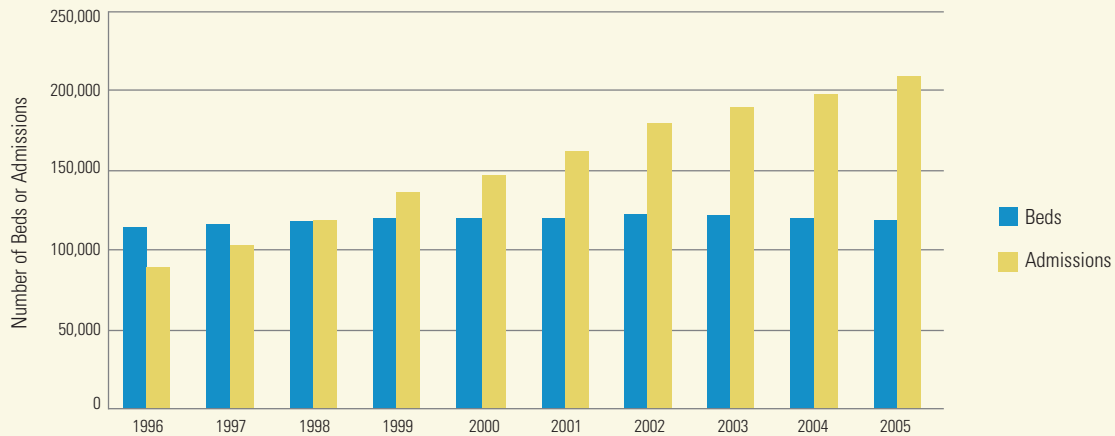
Source: Cost reports for all nursing facilities, filed with the New York State Department of Health for 1996-2005. Data obtained from Healthcare Association of New York State.

² Bed hold days are days of care paid for by Medicaid for hospitalized residents who are expected to return to a nursing facility with an average annual occupancy rate of 96 percent or more.

More Admissions, Shorter Stays

A decreasing portion of the care provided by New York's nursing homes is long-term residential care. While, as described above, the number of nursing home beds stayed fairly flat, the number of admissions more than doubled, increasing to 1.76 per bed in 2005 from 0.78 per bed in 1996 (Figure 4).³

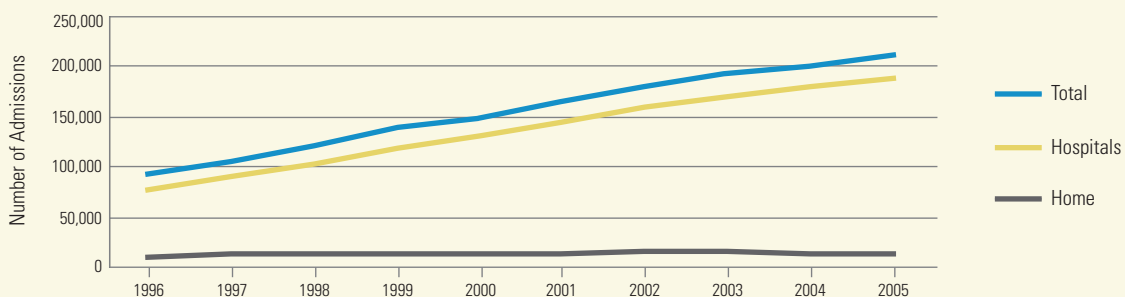
Figure 4
Nursing Home Beds and Admissions



Source: Cost reports for all nursing facilities, filed with the New York State Department of Health for 1996-2005. Data obtained from Healthcare Association of New York State.

That change was due largely to a substantial increase in admissions from hospitals, while admissions from home remained static (Figure 5).

Figure 5
Nursing Home Admissions, by Selected Source

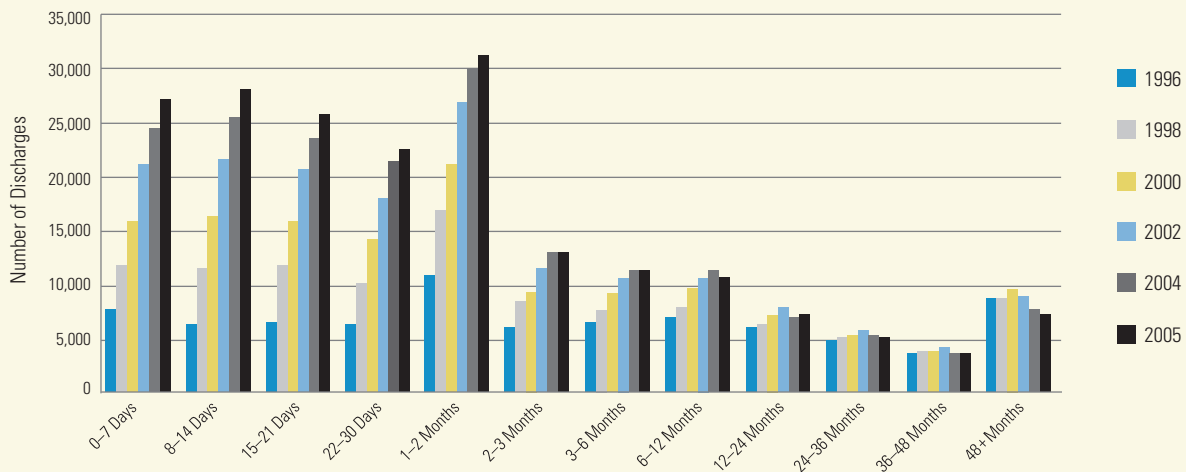


Source: Cost reports for all nursing facilities, filed with the New York State Department of Health for 1996-2005. Data obtained from Healthcare Association of New York State.

³New York nursing homes appear to have experienced this increase somewhat later than those in the rest of the nation, but this pattern is consistent with and extends national trends, which showed an increase from 0.774 discharges per bed in 1985 to 1.34 in 1999. Decker FH. 2005. *Nursing Homes, 1977-1999: What Has Changed, What Has Not?* Hyattsville, MD: National Center for Health Statistics.

Each year over the past ten years, the number of patients discharged after short stays increased and the number of residents discharged after longer stays remained stable or decreased (Figure 6). The number of patients staying less than two months—typically individuals receiving rehabilitative services—more than tripled, from just over 39,000 in 1996 to over 135,000 in 2005.

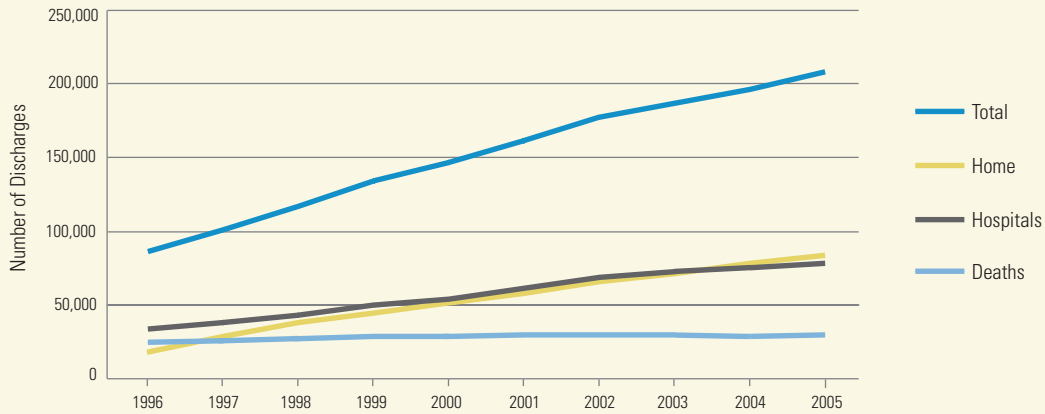
Figure 6
Nursing Home Discharges by Selected Length of Stay and Year



Source: Cost reports for all nursing facilities, filed with the New York State Department of Health for 1996-2005.
Data obtained from Healthcare Association of New York State.

Far more of those leaving nursing homes in 2005 were discharged to home or a hospital than in 1996 (Figure 7). The number discharged to their own homes increased by a factor of four, from 20,873 in 1996 to 85,306 in 2005; the number discharged to hospitals more than doubled, from 34,774 in 1996 to 79,376 in 2005. At the same time, the number who died in nursing facilities remained stable.

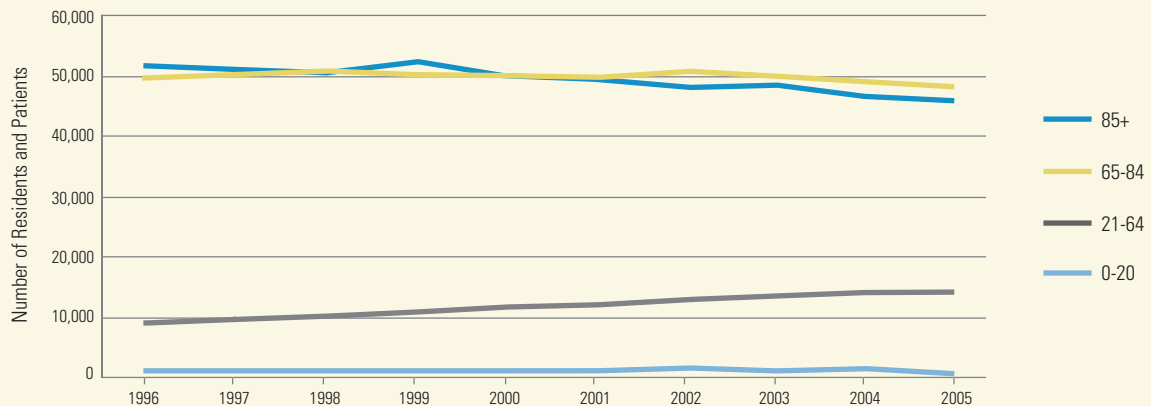
Figure 7
Nursing Home Discharges by Destination



Source: Cost reports for all nursing facilities, filed with the New York State Department of Health for 1996-2005. Data obtained from Healthcare Association of New York State.

While the average age of the nursing home population did not change significantly between 2000 and 2006 (decreasing only from 80.1 to 79.4),⁴ the age distribution of residents changed modestly over the period 1996 to 2005 (Figure 8). There is virtually no difference in age between long-stay residents and short-stay patients. The number of residents over age 65 declined from over 100,000 at the end of 1996 to 96,000 at the end of 2005, while the number of residents under 65 increased from 9,291 to 14,329 over the same period.

Figure 8
Nursing Home Residents, by Age Range, at End-of-Year

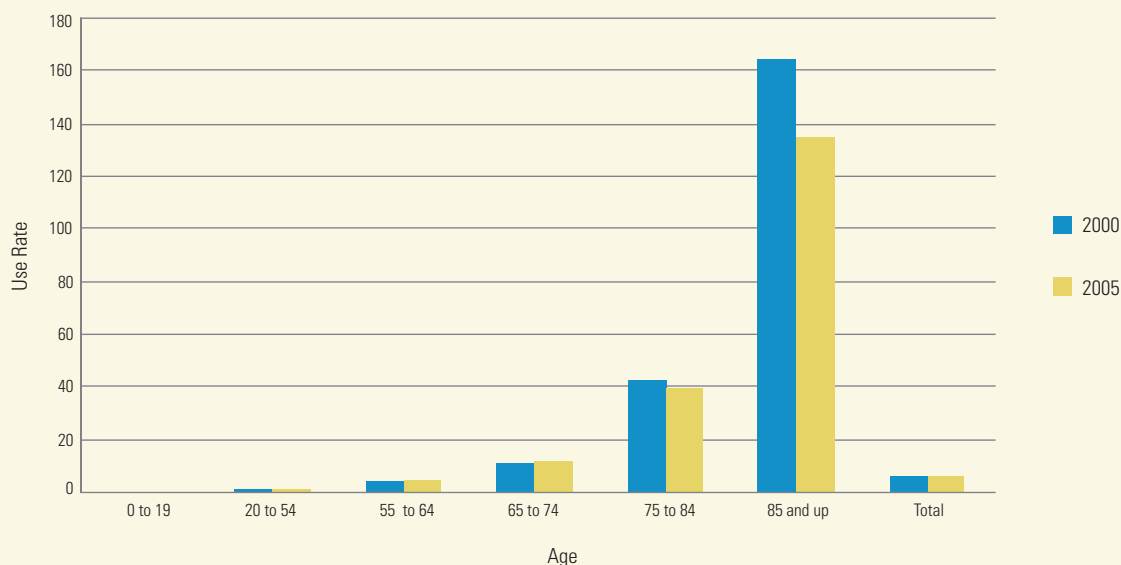


Source: Cost reports for all nursing facilities, filed with the New York State Department of Health for 1996-2005. Data obtained from Healthcare Association of New York State.

⁴ Source: Minimum Data Set (MDS) data for all New York State nursing homes, 2000-2006. Analysis provided by New York Association of Homes and Services for the Aging (NYAHS/A)/EQUIP for Quality[®] under CMS Data Use Agreement (DUA) #08591 and NYS DUA #15407.

Over the past few years (2000 to 2005), a number of variables have made older people less reliant on nursing home care; these include the expansion of the assisted living industry, the availability of home care services,⁵ and decreased morbidity in the very old.^{6,7} While the number of persons over the age of 75 who reside in nursing homes, per 1,000 population, has decreased, the number of younger persons, particularly those between the ages of 54 and 65—whose use of nursing homes is frequently for sub-acute care and rehabilitation—has gone up (Figure 9). This trend parallels and extends the national experience between 1985 and 1995, reported in 1999,⁸ as well as more current data reported in 2007.⁹

Figure 9
Nursing Home Census per 1,000 Population, by Age Cohorts, 2000 and 2005



Source: Cost reports for all nursing facilities, filed with the New York State Department of Health for 1996-2005. Data obtained from Healthcare Association of New York State. Population data obtained through Cornell University's Institute for Social and Economic Research, New York State Statistical Information System.

TWO DISTINCT POPULATIONS

Cost report data suggest that the way residents use nursing home care has changed substantially, with many more individuals using such care for shorter periods of time, before returning to their own homes or to a hospital. These data suggest that nursing homes have two distinctly different populations: one group of individuals using nursing homes for

⁵Decker FH. 2005. *Nursing Homes, 1977-1999: What Has Changed, What Has Not?* Hyattsville, MD: National Center for Health Statistics.

⁶Bishop CE. July/August 1999. Where are the missing elders? The decline in nursing home use, 1985 and 1995. *Health Affairs* 18(4): 146-155.

⁷Kramarow E, J Lubitz, H Lentzner, Y Gorina. September/October 2007. Trends in the health of older Americans, 1970-2005. *Health Affairs* 26(5): 1417-1425.

⁸Bishop CE. July/August 1999. Where are the missing elders? The decline in nursing home use, 1985 and 1995. *Health Affairs* 18(4): 146-155.

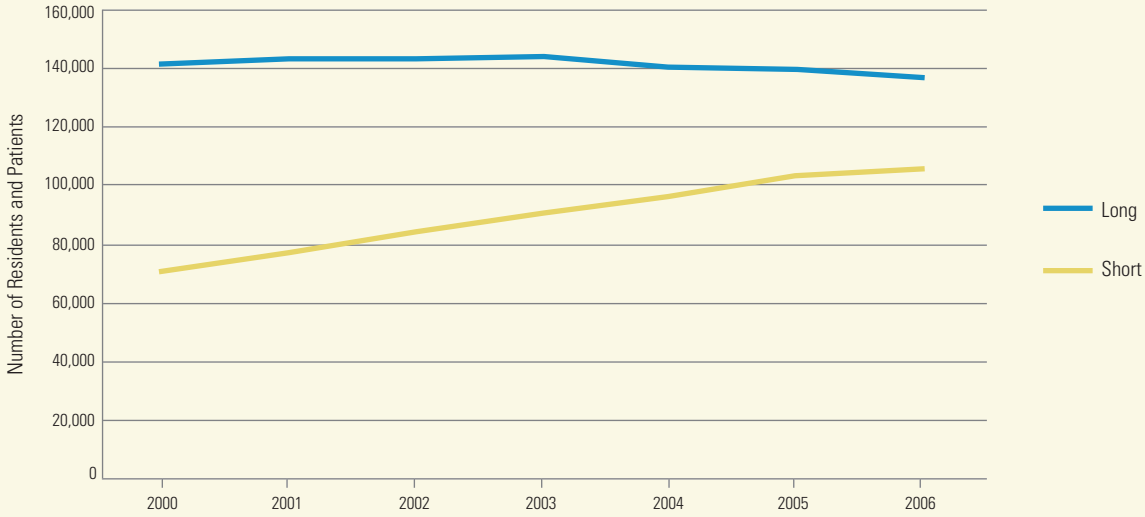
⁹El Nasser H. September 27, 2007. Fewer seniors live in nursing homes. *USA Today* 1A.

short-term rehabilitative or post-acute care, and another relying on them as a long-term placement. To describe the residents of nursing homes, therefore, and to understand the differences between the two groups, we've drawn additional data from the New York State Minimum Data Set (MDS) for the period 2000-2006, categorizing nursing home residents as either long- or short-term stays. Short-stay (post-acute) patients are defined as those with Medicare short-stay or other admissions projected, on assessment, to be less than ninety days. All others—including any resident who has been in the nursing home for ninety days or longer, and anyone whose stay, on assessment, is projected to be more than ninety days—are considered long-stay.

More Short-Stay Patients, Fewer Long-Stay Residents

The distribution of nursing home residents between short- and long-term stays shifted between 2000 and 2006. The number of long-stay residents served declined from 140,970 in 2000 to 135,932 in 2006, while that of short-stay patients rose from 67,777 in 2000 to 104,723 in 2006, a 50 percent increase (Figure 10). Overall, patient mix shifted considerably, with the proportion of long-term residents served in a given year dropping from 66 percent in 2000 to 56 percent in 2006.

Figure 10
Long-Stay Residents and Short-Stay Patients

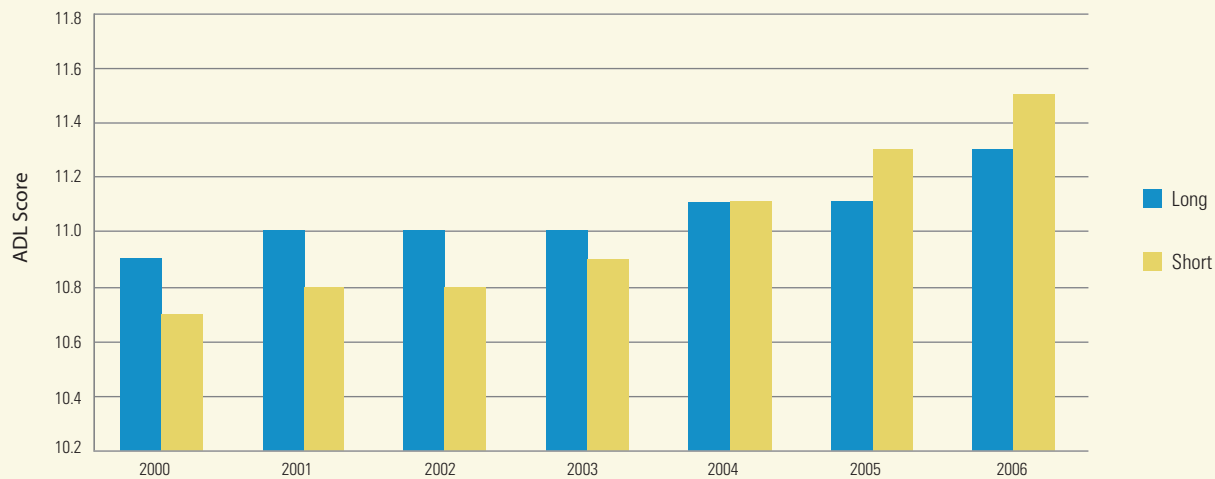


Source: Minimum Data Set (MDS) data for all New York State nursing homes, 2000-2006. Analysis provided by New York Association of Homes and Services for the Aging (NYAHSAs)/EQUIP for Quality® under CMS Data Use Agreement (DUA) #08591 and NYS DUA #15407.

Patients and Residents are Sicker and More Disabled

As measured by limitations in activities of daily living (ADL),¹⁰ there has been a slow but gradual increase in level of disability among both short- and long-term nursing home populations (Figure 11). This extends the national trend of increased disability reported between 1987 and 1996.¹¹

Figure 11
Mean Level of Disability, by Length of Stay



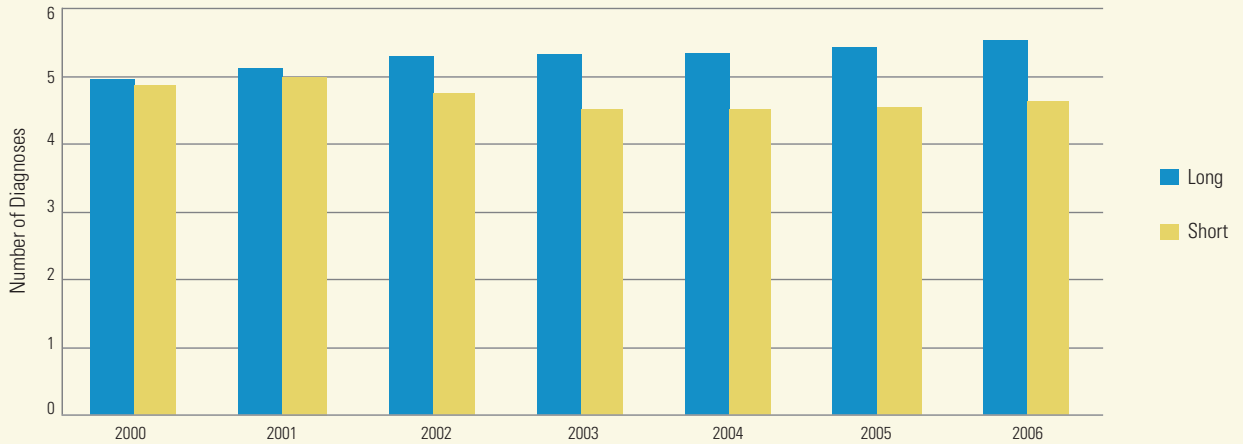
Source: MDS data for all New York State nursing homes, 2000-2006. Analysis provided by NYAHS/A/EQUIP for Quality® under CMS DUA #08591 and NYS DUA #15407.

Although they now have lower levels of disability than short-stay patients, long-stay residents have, on average, a greater number of diagnoses (Figure 12). They are more likely to be diagnosed with neurological diseases and less likely to be diagnosed with pulmonary disease, cancer, or renal failure. A review of selected diagnoses suggests that both groups are equally likely to be diagnosed with heart/circulatory disease and musculoskeletal diseases.

¹⁰ ADL composite scores are based on how much assistance is needed with transferring from one position to another, toileting, bed mobility (to another position), and eating; higher scores indicate greater disability.

¹¹ Rhoades JA and NA Krauss. May 1999. *Chartbook #3: Nursing Home Trends, 1987 and 1996*. Rockville, MD: Agency for Healthcare Research and Quality. Available online at http://www.meps.ahrq.gov/data_files/publications/cb3/cb3.shtml.

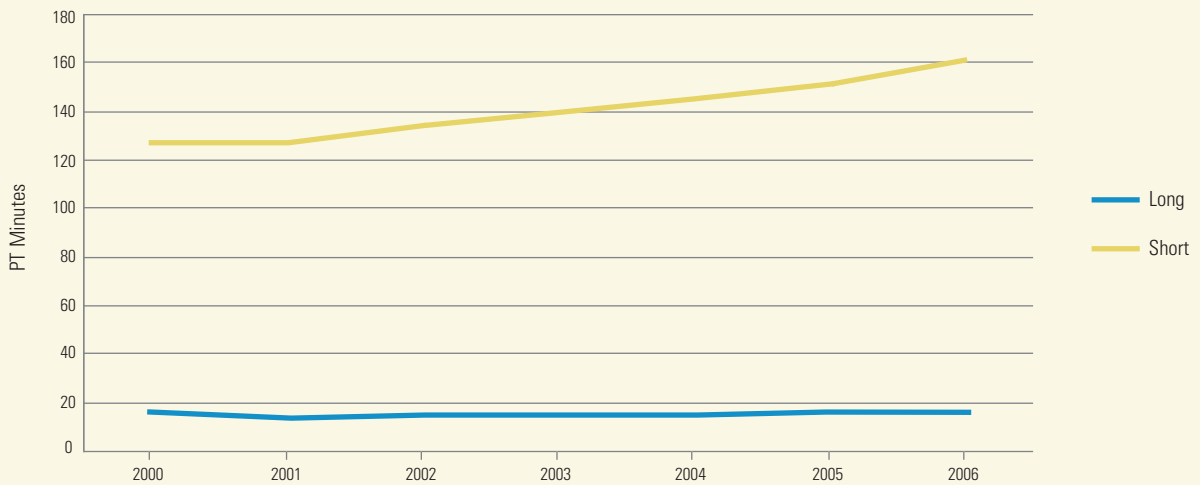
Figure 12
Mean Number of Diagnoses, by Length of Stay



Source: MDS data for all New York State nursing homes, 2000-2006. Analysis provided by NYAHS/A/EQUIP for Quality® under CMS DUA #08591 and NYS DUA #15407.

There is a marked difference between the long-stay and short-stay populations with regard to use of therapy services, as could be expected. A far greater proportion of short-stay patients receive therapy: over 75 percent receive physical therapy and 67 percent receive occupational therapy, compared with 10 percent and 7 percent, respectively, of long-term residents. The number of therapy minutes per patient receiving physical therapy in a seven-day period is also substantially higher for the short-term group, increasing by 21 percent from 2000 to 2006 (Figure 13).

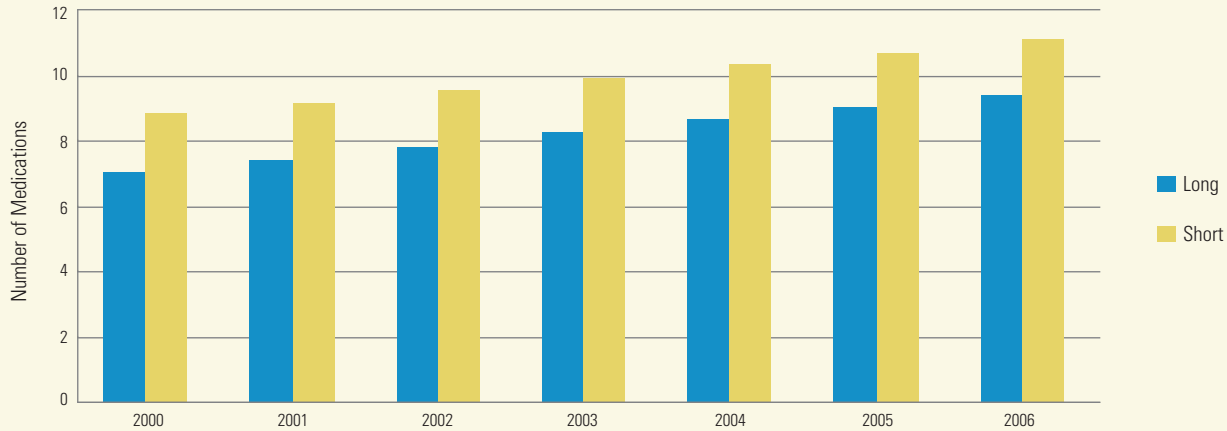
Figure 13
Mean Physical Therapy Minutes in Last Seven Days Before Assessment, by Length of Stay



Source: MDS data for all New York State nursing homes, 2000-2006. Analysis provided by NYAHS/A/EQUIP for Quality® under CMS DUA #08591 and NYS DUA #15407.

Medication use in both populations has increased since 2000, although short-term patients receive, on average, more medications (including both over-the-counter and prescription) than long-term residents (Figure 14).

Figure 14
Average Number of Medications in the Last Seven Days Before Assessment, by Length of Stay

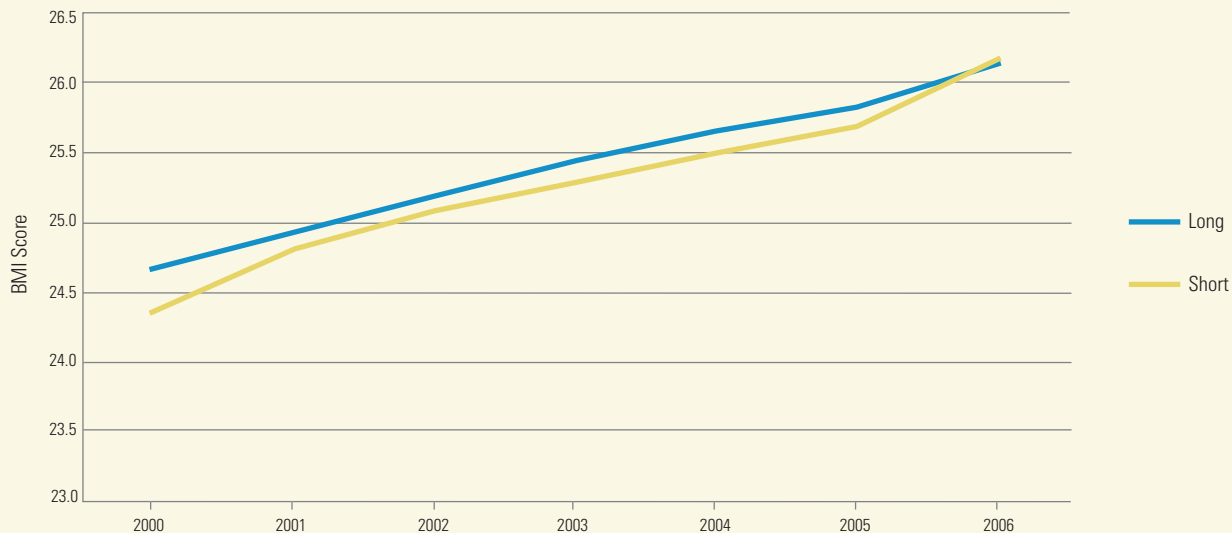


Source: MDS data for all New York State nursing homes, 2000-2006. Analysis provided by NYAHS/A/EQUIP for Quality® under CMS DUA #08591 and NYS DUA #15407.

Increased Prevalence of Diabetes and Obesity Between 2000 and 2006, the prevalence of diabetes in both the short- and long-term populations increased from 22.7 percent to 29.9 percent. Over the same time period, body mass index in both populations increased from a mean of approximately 24.5 to over 26, moving from the category of normal weight (18.5-24.9) to overweight (25-29.9) (Figure 15). Obesity and its attendant disorders contribute to the increase in disability observed in these data, particularly in the younger population.¹²

¹² Lakdawalla DN, J Bhattacharya, and DP Goldman. January/February 2004. Are the young becoming more disabled? *Health Affairs* 23(1): 168-176.

Figure 15
Mean Body Mass Index, All Nursing Home Residents

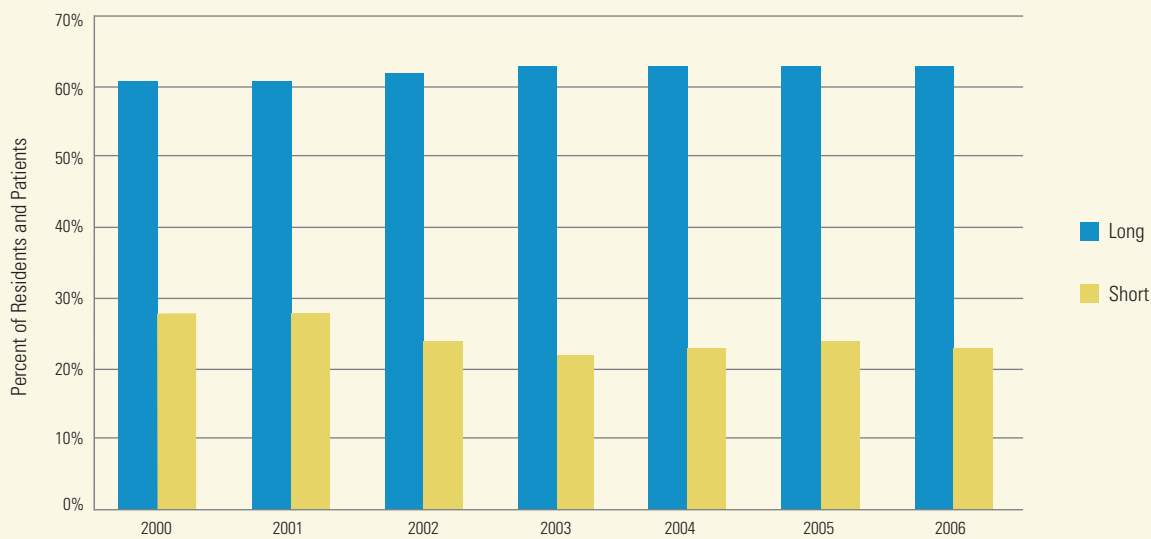


Source: MDS data for all New York State nursing homes, 2000-2006. Analysis provided by NYAHS/A/EQUIP for Quality® under CMS DUA #08591 and NYS DUA #15407.

Cognitive, Behavioral, and Mental Health Issues Are Common

Roughly one-half of the nursing home population is cognitively impaired, consistent with national findings,¹³ but such impairment is more prevalent among long-stay residents. Nearly two-thirds of long-term residents have cognitive impairments, compared with less than a quarter of short-term patients (Figure 16).

Figure 16
Percentage of Residents with Cognitive Impairments, by Length of Stay

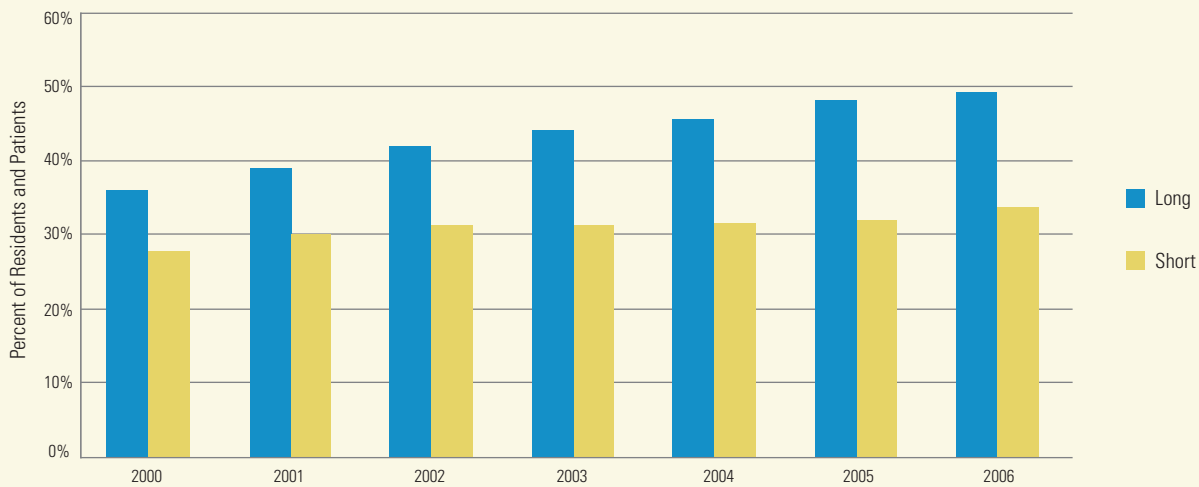


Source: MDS data for all New York State nursing homes, 2000-2006. Analysis provided by NYAHS/A/EQUIP for Quality® under CMS DUA #08591 and NYS DUA #15407.

¹³ Sahyoun NR, LA Pratt, H Lentzner, KN Robinson. 2001. The changing profile of nursing home residents: 1985-1997. *Aging Trends* 4. Hyattsville, MD: National Center for Health Statistics.

Among both short- and long-term populations, the percent with psychiatric diagnoses (including anxiety disorder, depression, bipolar disease, and schizophrenia) has increased over the past six years, consistent with increases found nationally between 1985 and 1995 (Figure 17).¹⁴

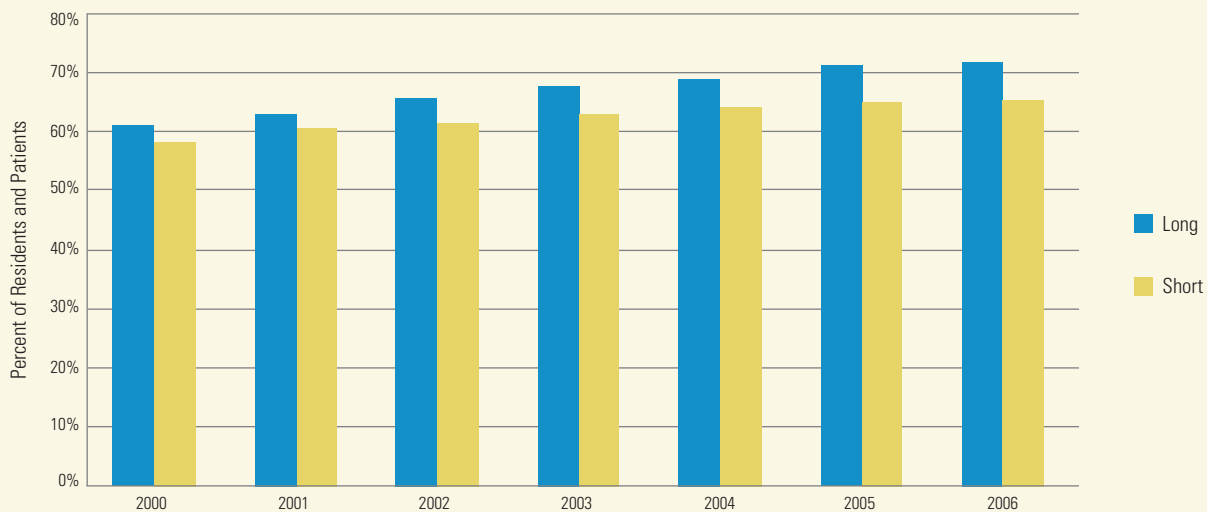
Figure 17
Percentage of Residents with Psychiatric Diagnoses, by Length of Stay



Source: MDS data for all New York State nursing homes, 2000-2006. Analysis provided by NYAHS/A/EQUIP for Quality[®] under CMS DUA #08591 and NYS DUA #15407.

Psychotropic medications (antidepressants, antipsychotics, and/or hypnotics) are frequently prescribed for both long- and short-stay populations (Figure 18).

Figure 18
Percentage of Residents Taking Psychotropic Medications, by Length of Stay

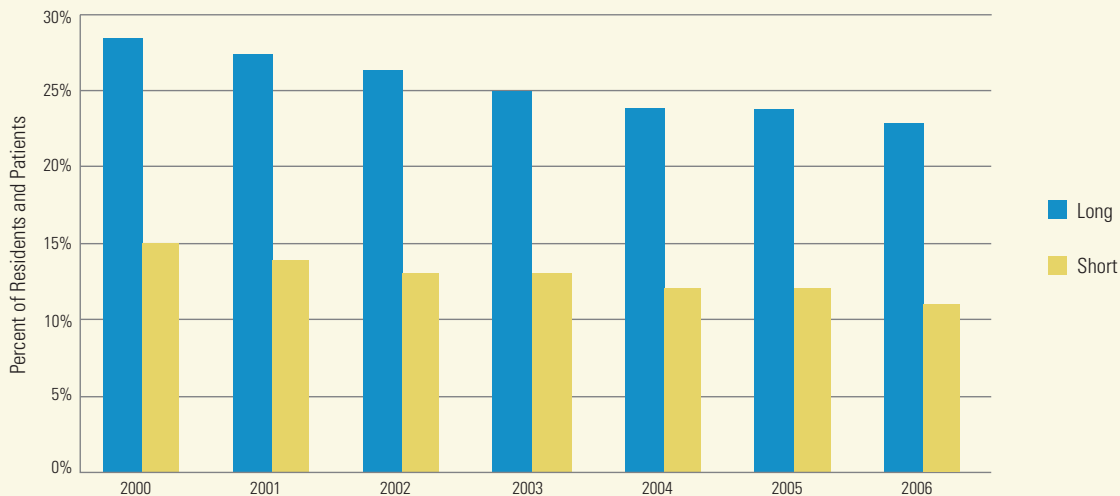


Source: MDS data for all New York State nursing homes, 2000-2006. Analysis provided by NYAHS/A/EQUIP for Quality[®] under CMS DUA #08591 and NYS DUA #15407.

¹⁴ Mechanic D and D McAlpine. March 2000. Use of nursing homes in the care of persons with severe mental illness: 1985-1995. *Psychiatric Services* 51(3): 354-358.

While long-stay residents are twice as likely as short-stay patients to display behavioral symptoms (wandering, physical abusiveness, verbal abusiveness, social inappropriateness, or resisting care), the proportion of all residents displaying these behaviors has declined, perhaps as a result of the use of psychotropic medications (Figure 19).

Figure 19
Percentage of Residents Displaying Behavioral Symptoms, by Length of Stay



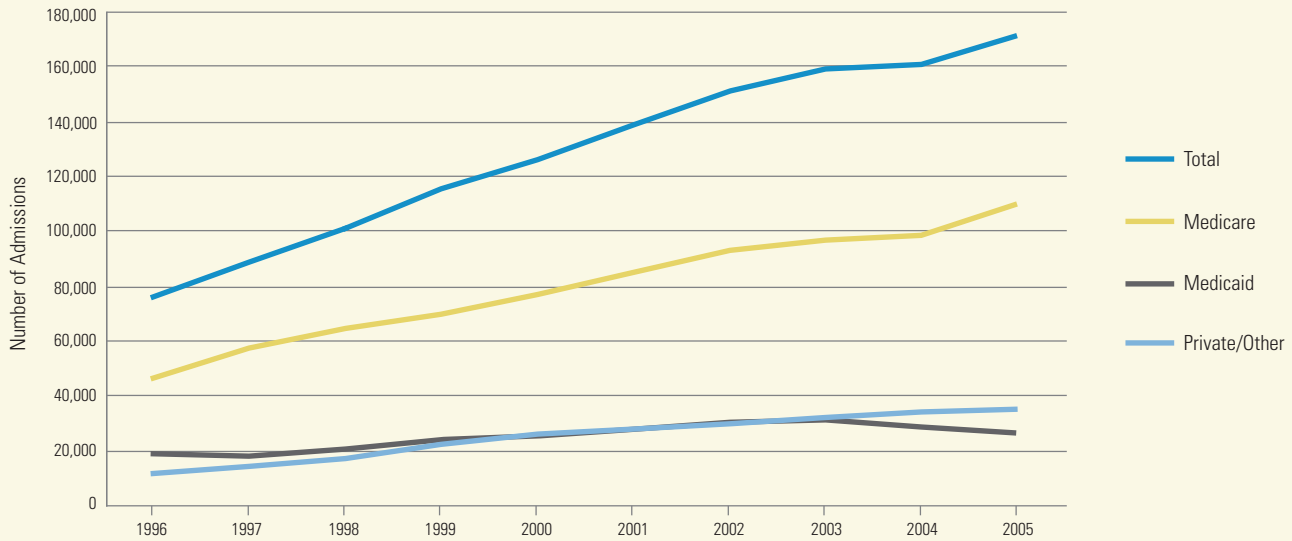
Source: MDS data for all New York State nursing homes, 2000-2006. Analysis provided by NYAHS/A/EQUIP for Quality® under CMS DUA #08591 and NYS DUA #15407.

SHIFTING SOURCES OF PAYMENT

New York's nursing homes have seen major changes in the way care is paid for. While nursing home reimbursement is undergoing major change, and the financial status of many homes is stressed, we focus here on how the changing mix of patients has driven changes in payer mix.

The source of payment for new patients admitted to nursing homes has shifted dramatically since 1996. Medicare admissions more than doubled, from 45,841 to 108,977; the number of individuals covered by other sources, including private insurance, tripled from 10,628 to 34,404. New Medicaid admissions have declined since 2003, but not in total since 1996 (Figure 20).

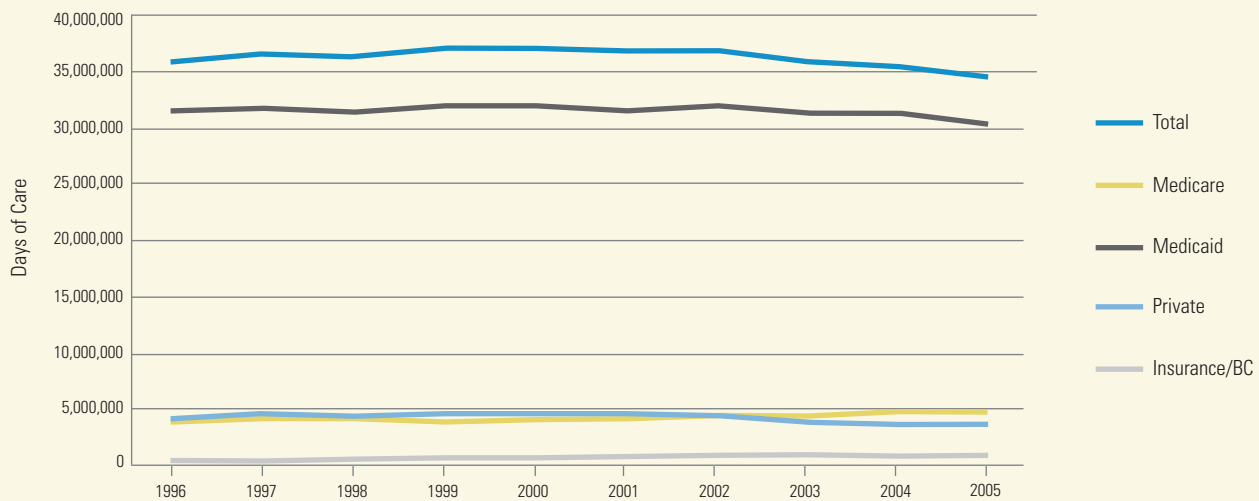
Figure 20
Nursing Home Admissions, by Primary Source of Payment



Source: Cost reports for all nursing facilities, filed with the New York State Department of Health for 1996-2005. Data obtained from Healthcare Association of New York State.

There were shifts in days of care, by payer, as well. Medicaid paid for slightly fewer days in 2005 than in 1996, while days of care paid for by Medicare and insurance increased. The number of days paid for privately also decreased (Figure 21).

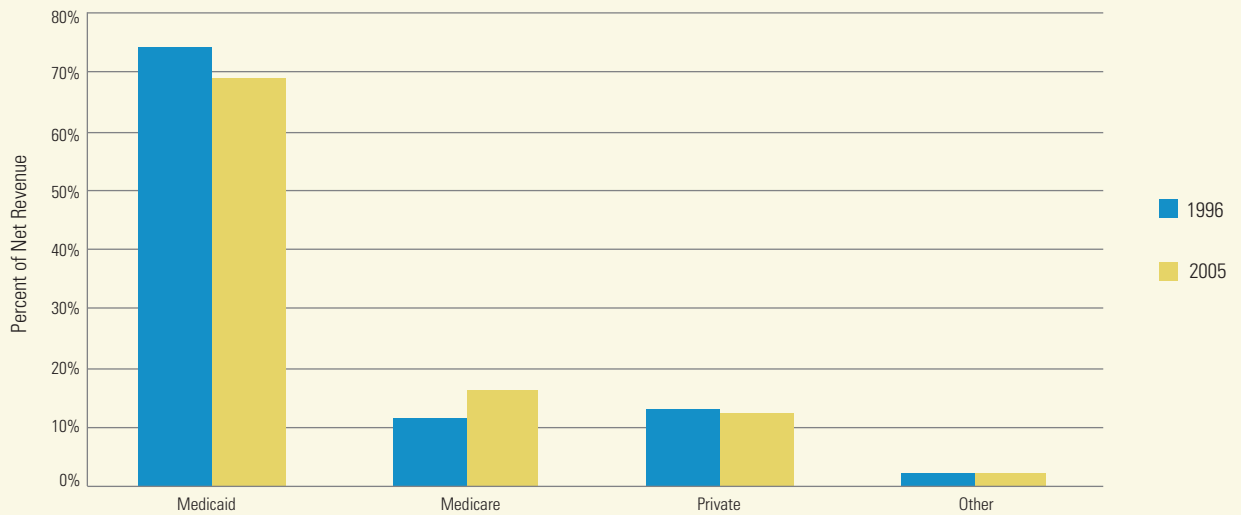
Figure 21
Days of Care, by Payer



Source: Cost reports for all nursing facilities, filed with the New York State Department of Health for 1996-2005. Data obtained from Healthcare Association of New York State.

Medicaid remains the dominant payer, but now provides a smaller portion of operating revenues (which totaled over \$10 billion in 2005), dropping from 74 percent in 1996 to 69 percent in 2005. At the same time, Medicare payments increased from 11.5 percent to 16 percent of total revenues, and payments from other sources (largely private insurers) increased from 1.5 percent to 2.4 percent (Figure 22). Private-pay revenue dropped slightly, from 13 percent to 12.4 percent.

Figure 22
Percentage of Net Patient Revenue, by Payer, 1996 and 2005



Source: Cost reports for all nursing facilities, filed with the New York State Department of Health for 1996-2005.
Data obtained from Healthcare Association of New York State.

SUMMARY AND CONCLUSIONS

Cost report data suggest that nursing homes in New York State have become a more active part of medical care delivery over the last ten years. More people (and younger people) than ever before now use nursing homes for short-term post-acute or rehabilitative stays before returning home or going back into the acute care system for continuing care.

While the majority of the residents of nursing facilities at any point in time are long-stay, chronically disabled people, the elderly overall now rely less on nursing home care. The absolute number of long-stay residents admitted to nursing homes in a given year has decreased, and the rate of nursing home usage among the very old has declined. This is due to a number of variables, including the expansion of the assisted living industry, the availability of home care services, and, possibly, decreased morbidity in the very old.

The patients served by nursing homes have changed in other ways, as well, over the past several years. Today's short-stay patients and long-term residents are more functionally disabled, have more medical and psychiatric diagnoses, and take more medications. Diabetes has become more prevalent among nursing home residents, and the average body mass index of residents has climbed into the officially "overweight" category, contributing, perhaps, to the higher levels of disability observed in that population.

Cognitive, behavioral, and mental health issues are common, particularly among the long-stay population. At least half of long-stay residents are cognitively impaired, have other psychiatric diagnoses, and/or display symptoms such as wandering, resisting care, or physically or verbally abusive behavior. Mental health issues have become pervasive in nursing homes, and psychotropic drugs are frequently prescribed.

Many of these findings—the shift from long-term to short-term rehabilitative and sub-acute care, increased numbers of admissions and turnover of beds, higher levels of disability, and prevalence of mental health issues, to name a few—have been reported in other, earlier national studies. This report validates many of these findings. Indeed, the same trends continue in New York and do not, at this time, show signs of slowing down.

RELATED PUBLICATIONS

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The first comprehensive analysis of the elements needed for universal health insurance in New York State, this special report presents the costs and benefits of several model strategies for covering the State’s uninsured and creating a more stable, affordable system for all.

2006

The Costs and Policy Implications of Covering Dual Enrollees of Medicaid and Medicare

This examination of the coverage of “duals” focuses on spending associated with acute and long-term care, and on ramifications of possible changes to Medicare coverage.

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Medicaid Coverage for Adults in New York 2001-2003

The expansion of Medicaid coverage among non-elderly, non-disabled adults, and the impact of that expansion on costs, have important implications for the debate about coverage and spending.

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New York’s SSI Medicaid Beneficiaries: The Move to Managed Care

Mandating enrollment in managed care plans for Supplemental Security Income Medicaid beneficiaries has implications not only for how enrollees receive health care services but also for New York’s Medicaid program itself.

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