

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

**MEDICAID  
INSTITUTE**  
AT UNITED HOSPITAL FUND

Chapter 2  
**Nursing Homes**

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

April 2009

## Table of Contents

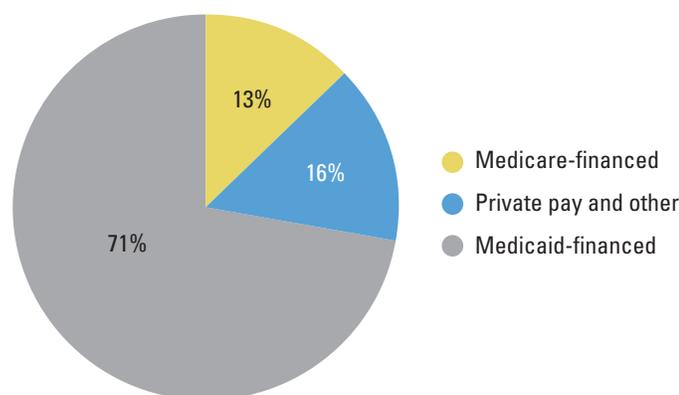
---

Program Snapshot		3
Enrollment and Spending		3
Program and Provider Capacity		5
Health Status and Demographics		7
Rules, Regulations, and Administrative Structure		7
Federal Coverage Requirements		7
Covered Services		7
Eligibility — Medical and Financial		7
Access		9
Provider Requirements		10
Payment		10
Quality Monitoring		11
Policy Implications		12
Information and Guidance at Points of Entry		12
Quality of Care		12
Transition and Diversion to Community-Based Care		13
Provider Capacity		14
Relationship to Other Programs		14
References		15
<hr/>		
Index of Figures		
Figure 2.1	Nursing Home Patients, by Primary Payer	3
Figure 2.2	Nursing Home Enrollment and Spending	4
Figure 2.3	Share of Enrollment and Spending in New York City, by Program	4
Figure 2.4	Share of Nursing Home Enrollment, Spending, and Beds in New York City	5
Figure 2.5	Nursing Home Residents with Cognitive Impairment	7
<hr/>		
Index of Tables		
Table 2.1	Regional Distribution of Nursing Home Capacity	6
Table 2.2	Nursing Home Payment Rates	10

## Program Snapshot

An estimated 111,000 New Yorkers were receiving nursing home care in June 2008.<sup>1</sup> 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.<sup>2</sup> 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.<sup>3</sup>

**Figure 2.1**  
**Percentage of Nursing Home Patients, by Primary Payer, June 2008**



Source: American Health Care Association, Health Services Research and Evaluation, analysis of June 2008 CMS OSCAR Form 672.

## 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.

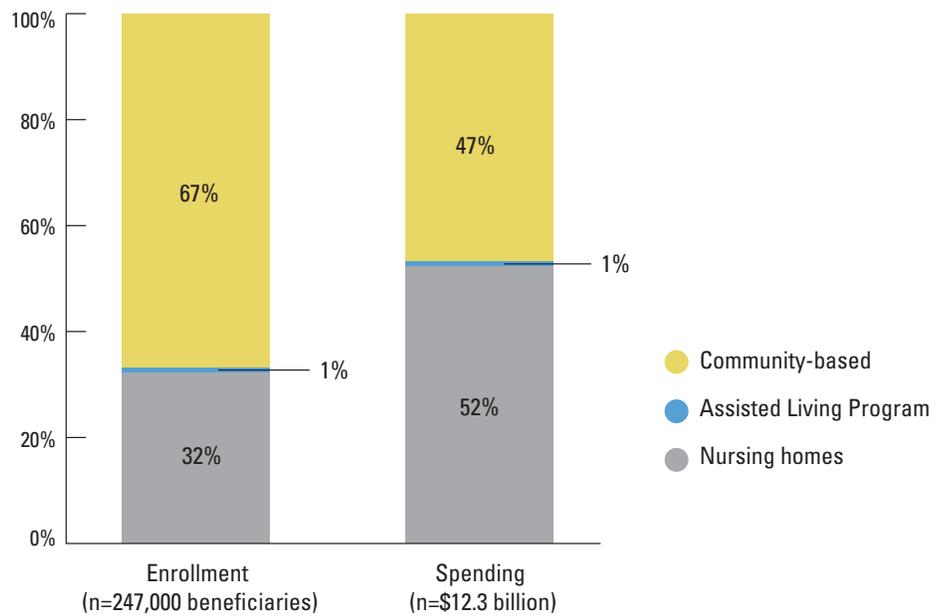
Medicaid spent roughly \$6.5 billion in FFY 2007 on nursing home care, accounting for 53 percent of Medicaid long-term care spending in programs primarily serving frail seniors and adults with disabilities in the state.

<sup>1</sup> 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 with 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.

<sup>2</sup> Medicare does not pay for long-term care services.

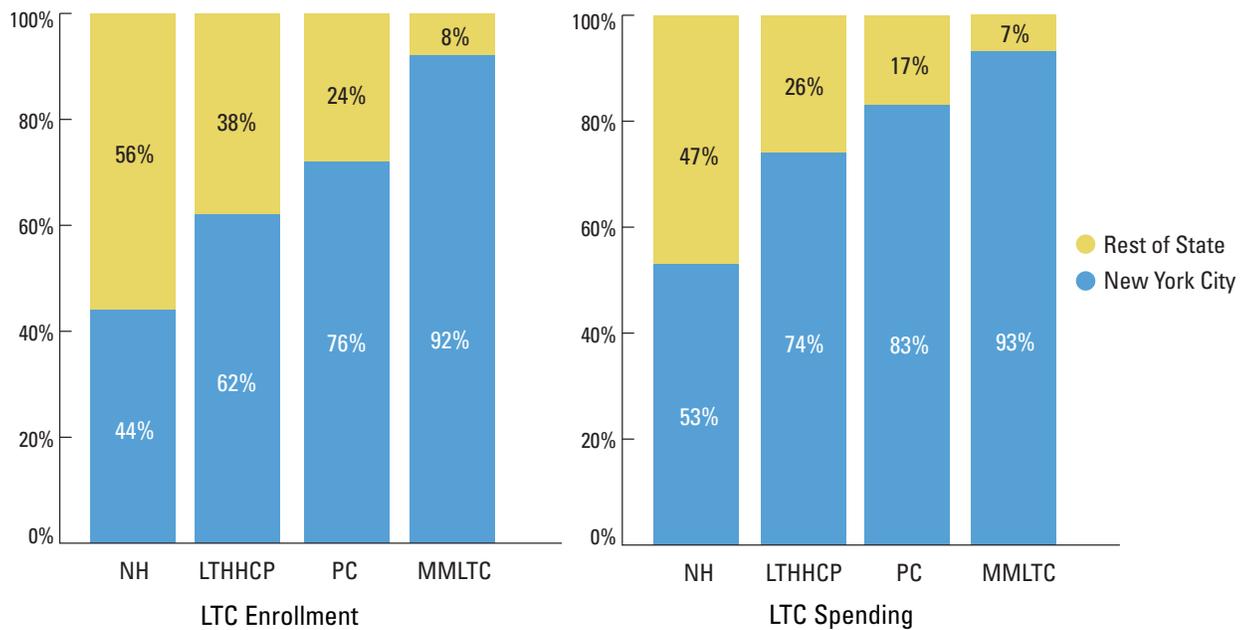
<sup>3</sup> According to the American Health Care Association, Health Services Research and Evaluation, analysis of CMS OSCAR Form 672, there were a total of 111,128 nursing home residents in June 2008. Of these, three-fourths (71.1 percent) or 79,031 residents were Medicaid beneficiaries. The rest 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**



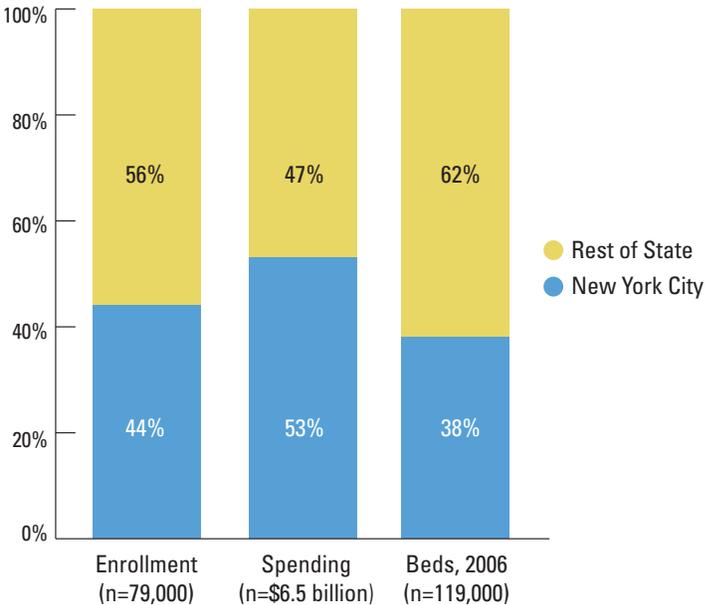
Source: For nursing homes, LTHHCP, and traditional personal care program: UHF analysis of Medicaid reference statistics, FFY 2005-2007 (SDOH, Office of Health Insurance Programs, June 2008). For MMLTC: UHF analysis of September 2007 SDOH managed care enrollment data and SDOH Medicaid Managed Care Operating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

**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.<sup>4</sup> Thirty-eight percent of all nursing home beds are in New York City; 62 percent in the rest of the state.<sup>5</sup> The number of nursing homes and beds has changed very little in the last decade. However,

**Figure 2.4**  
**Share of Medicaid Nursing Home Enrollment and Spending, and All Payer Beds in New York City**



Source: UHF analysis of Medicaid reference statistics, FFY 2005-2007 (SDOH, Office of Health Insurance Programs, June 2008) and SDOH Nursing Home Profiles.

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.<sup>6</sup> These trends suggest that New York’s nursing homes, on the

<sup>4</sup> Beds also include those dedicated for Medicare-only and short-stay-only patients.

<sup>5</sup> UHF analysis of SDOH Nursing Home Profiles

<sup>6</sup> 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.<sup>7</sup> 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.<sup>8</sup>

**Table 2.1  
Regional Distribution of Nursing Home Capacity**

Region	Number of Homes	Number of Beds	Occupancy Rate, 2006
New York City	180	45,248	95.0%
Rest of State	469	73,792	93.7%
Capital	71	9,904	94.0%
Central New York	89	13,092	93.2%
Long Island	77	16,178	94.1%
New Rochelle	90	14,311	92.1%
Western/Buffalo	79	11,228	94.5%
Western/Rochester	63	9,079	94.7%
New York State (Total)	649	119,040	94.2%

Source: United Hospital Fund analysis of SDOH Nursing Home Profile website: <http://nursinghomes.nyhealth.gov/>.

**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.

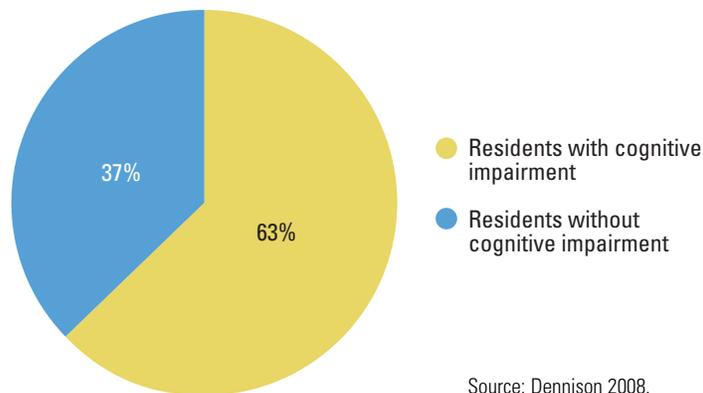
<sup>7</sup> Dennison 2008 and Kaiser State Health Facts, 2007 Nursing Home Occupancy Rates ([www.statehealthfacts.org](http://www.statehealthfacts.org))

<sup>8</sup> Occupancy rates reflected in this portrait include all beds, regardless of payer source.

## 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).

**Figure 2.5**  
**Medicaid Nursing Home Residents with Cognitive Impairment, 2006**



Source: 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.<sup>9</sup>

**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

<sup>9</sup> 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.<sup>10</sup> 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.<sup>11</sup> 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.<sup>12</sup> 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.<sup>13</sup> 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.

<sup>10</sup> 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).

<sup>11</sup> 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.

<sup>12</sup> 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].

<sup>13</sup> 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).<sup>14</sup> The federal government requires nursing homes that receive Medicare reimbursement to assess all of its residents with the MDS regardless of the payer source.<sup>15</sup> 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.<sup>16</sup>

<sup>14</sup> 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>)

<sup>15</sup> 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.

<sup>16</sup> More information about individual nursing homes is available at the federal Nursing Home Compare website: <http://www.medicare.gov/NHCompare/> and the SDOH Nursing Home Profile website: <http://nursinghomes.nyhealth.gov/>.

## 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.<sup>17</sup>

## 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.<sup>18</sup> 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**

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

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.

<sup>17</sup> 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.

<sup>18</sup> 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.<sup>19</sup> 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.<sup>20, 21</sup>

**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).<sup>22</sup> Failure to meet survey standards can result in sanctions and civil monetary penalties.<sup>23</sup> 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.<sup>24</sup>

<sup>19</sup> 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.

<sup>20</sup> Department of Health regulation (Title 10 NYCRR 415.3 – Resident’s Rights and Title 18 NYCRR 505.9 – Residential Health Care).

<sup>21</sup> New York State Department of Health, Dear Administrator Letter 05-13: [http://www.health.state.ny.us/professionals/nursing\\_home\\_administrator/docs/dal\\_05-13\\_medical\\_bed\\_hold.pdf](http://www.health.state.ny.us/professionals/nursing_home_administrator/docs/dal_05-13_medical_bed_hold.pdf).

<sup>22</sup> 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.

<sup>23</sup> 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.

<sup>24</sup> 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.

## Policy Implications

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.<sup>25</sup> 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.

<sup>25</sup> 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

- American Health Care Association. July 2008. *Report of Findings — 2007 AHCA Nursing Survey, Nursing Staff Vacancy and Turnover in Nursing Facilities*. Washington, D.C.: American Health Care Association. Available at [http://www.ahcancal.org/research\\_data/staffing/Documents/Vacancy\\_Turnover\\_Survey2007.pdf](http://www.ahcancal.org/research_data/staffing/Documents/Vacancy_Turnover_Survey2007.pdf). Accessed January 6, 2009.
- Bogart VJ. October 2003, revised June 2007. *Financial Eligibility for Medicaid and the Medicaid Spend-Down Program in New York*. New York, NY: Evelyn Frank Legal Resources Program, Self-Help Community Services. Available at <http://onlinerresources.wnyc.net/healthcare/docs/spendownOUTLINE.pdf>. Accessed January 6, 2009.
- Dennison T. January 2008. *Changes in Nursing Home Care: 1996 to 2005: New York State*. New York: United Hospital Fund. Available at [http://www.uhfnyc.org/pubs-stories3220/pubs-stories\\_show.htm?doc\\_id=670516](http://www.uhfnyc.org/pubs-stories3220/pubs-stories_show.htm?doc_id=670516). Accessed January 6, 2009.
- Eljay, LLC. October 2008. *A Report on Shortfalls in Medicaid Funding for Nursing Home Care*. Washington, D.C.: American Health Care Association. Available at [http://www.ahcancal.org/research\\_data/funding/Documents/2008%20Medicaid%20Shortfall%20Report.pdf](http://www.ahcancal.org/research_data/funding/Documents/2008%20Medicaid%20Shortfall%20Report.pdf). Accessed January 6, 2009.
- Greater New York Hospital Association (GNYHA). 2007. *GNYHA Health Care Statistics 2007*. New York: Greater New York Hospital Association.
- Institute for the Future of Long-Term Care Services. January 2007. *The Long-Term Care Workforce: Can the Crisis be Fixed?* Washington, D.C.: American Association of Homes & Services for the Aging and the Institute for the Future of Aging Services. Available at [http://www.aahsa.org/uploadedFiles/IFAS/Publications\\_amp\\_Products/LTCCCommissionReport2007.pdf](http://www.aahsa.org/uploadedFiles/IFAS/Publications_amp_Products/LTCCCommissionReport2007.pdf). Accessed January 6, 2009.
- Kane RA, TY Lum, LJ Cutler, HB Degenholtz, and T-C Yu. June 2007. Resident outcomes in small-house nursing homes: a longitudinal evaluation of the initial Green House program. *Journal of American Geriatrics Society*. 55(6): 832-839. Available at [http://www.commonwealthfund.org/publications/publications\\_show.htm?doc\\_id=516105](http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=516105). Accessed January 6, 2009.
- New York Association of Homes & Services for the Aging (NYAHSAs). March 2005. *Situation Critical: New York's Nursing Homes Face Growing Threat*. Albany: NYAHSAs Public Policy Series. Available at [http://www.nyahsa.org/nyahsa\\_org/special\\_reports/documents/16503501.pdf](http://www.nyahsa.org/nyahsa_org/special_reports/documents/16503501.pdf). Accessed January 6, 2009.