NEW YORK STATE
HEALTH POLICY
RESEARCH CENTER

Medicaid and Long-Term Care: New York Compared to 18 Other States

February 2009

Prepared by
The New York Health Policy Research Center
A program of The Nelson A. Rockefeller Institute of Government

for
The New York State Department of Health

with funding from
The New York State Health Foundation

A Program of THE NELSON A. ROCKEFELLER INSTITUTE OF GOVERNMENT
phone: 518.443.5522 | *fax:* 518.443.5823 | www.rockinst.org/hprc | 411 State Street, Albany, NY 12203

About this Report

This report provides a comparative analysis of New York State versus 18 selected states on various items related to long-term care (LTC) such as state demographics for the elderly (defined as persons over age 65), poverty level, spending on long-term care, long-term care policies and services, and quality of nursing home care. The report is designed to demonstrate how New York State may differ from other states and inform hypotheses about why New York spends more Medicaid dollars on long-term care delivery relative to most other states. The report was written for the New York State Department of Health, with funding support from the New York State Health Foundation.

Acknowledgments

This report was prepared by the Rockefeller Institute's Health Policy Research Center (HPRC) under the direction of the New York State Department of Health (NYSDOH). Support for this work was provided by the New York State Health Foundation (NYSHealth). The mission of NYSHealth is to expand health insurance coverage, increase access to high-quality health care services, and improve public and community health. The views presented here are those of the authors and not necessarily those of the New York State Health Foundation or its directors, officers, or staff.

The primary author is HPRC Research Scientist Ajita P. De. Suggestions on data sources were provided by Senior Health Analyst Karen Ambros and her team from the New York State Department of Health's Office of Long Term Care. Some New York State-specific information was obtained from the Office of Health Insurance Programs and the New York State Office for Aging. Guidance on the analyses and report content was provided by HPRC Director Courtney Burke and Rockefeller Institute Co-Director Thomas Gais, with editing from HPRC's Barbara Stubblebine.

Content and Data Sources

For this analysis, a number of variables related to long-term care were identified from secondary sources such as the Kaiser Family Foundation, the Centers for Medicare and Medicaid Services (CMS), and the U.S. Census. A database of 63 variables for all 50 states with U.S. totals and averages (when applicable) was created. A purposeful sample of 19 states was selected for the comparison, with input from experts, including New York State Department of Health senior staff. Data regarding these 19 states were analyzed and are summarized in this report. This analysis is based on the most recently available information from secondary sources at the time the project commenced.

About the Rockefeller Institute and the Health Policy Research Center

The Nelson A. Rockefeller Institute of Government is the public policy research arm of the State University of New York. The New York State Health Policy Research Center (HPRC), a program of the Rockefeller Institute, provides relevant, nonpartisan research and analyses of state health policy issues for New York State and national policymakers. With funding support from the New York State Health Foundation and other foundations, HPRC uses its in-house staff of health policy experts, as well as national experts, to build on the Rockefeller Institute's strength in analyzing the role of state and local governments in financing, administering, and regulating state health care systems.

Table of Contents

I. Background

Medicaid, a public health insurance program funded jointly by the federal and state governments, but administered primarily by states, is the single largest funding source for long-term care (LTC). Medicaid pays for nearly half of all nursing home and community-based long-term care. New York State, like other states, spends a significant amount of its Medicaid program dollars on long-term care. State Medicaid long-term care spending includes payment toward services provided by nursing facilities, intermediate care facilities for the mentally retarded, mental health, home health, and personal care support services. Total Medicaid LTC spending in New York, including nursing homes, home care, and personal care, was about $19 billion in 2006, up from $13.7 billion in 2005.[1] Compared to other states, New York spends more than $5,500 (2.5 times the national average) on long-term care for every elderly New Yorker (aged 65 or over).

In requesting this report, the New York State Department of Health (NYSDOH) was interested in how New York compared with 18 other states on a range of long-term care factors. The comparative states were chosen to reflect diversity in geography but also because some have Medicaid long-term care policies similar to New York. The report shows that it is difficult to isolate any one particular cause of New York's higher than average Medicaid spending on long-term care, because the state differs on a range of factors. The factors compared in this report include demographic characteristics of persons needing long-term care, spending by type of long-term care service, LTC facility characteristics, Medicaid policy changes, and Medicaid estate recovery, among others. Detailed findings of the comparative analysis follow.

II. Findings

A. Spending

Among the 19 states selected for this comparison, New York and Maine had the highest rates of health spending in 2003 as a percent of gross state product (GSP), at 5.3 percent (see Table 1).[2] New York also spent more on its Medicaid program than any other state, both in terms of total dollars and per capita spending (see Table 2). A state's total Medicaid spending is made up primarily of expenditures for services provided under the program. This spending includes disproportionate share payments, which are payments to hospitals that treat high cost poor enrollees. It does not include administrative costs. In 2006, total Medicaid spending in New York was $44.7 billion, $10 billion more than the next highest spending state, California, for which total Medicaid spending was $34.2 billion for the same year (see Figure 1). In 2005, New York spent $7,733 per Medicaid enrollee (see Table 3), which was the highest among the sample states. In contrast, California had the lowest per enrollee Medicaid spending, at $2,701.

[1] Sources: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on data from Centers for Medicare and Medicaid Services-64 reports, July 2007. Available at www.statehealthfacts.org/profileind.jsp?ind=180&cat=4&rgn=34. Accessed 01/05/2009; Medicaid Watch '05. The Public Policy Institute of New York State, Inc. Issue #5, March 28, 2005.

[2] Gross State Product (GSP) is the dollar measure of the total product of all industries, goods and services, in a particular state and represents the economic output of that state for a particular year. The state health spending represents the money spent on all health related services in a state in a certain time period, usually one fiscal year. State health spending as a percentage of GSP provides insight into the state's health expenditures relative to other spending.

New York's total Medicaid spending on long-term care was highest among the 19 states in 2006 (see Figure 2). However, its long-term care spending as a percentage of total Medicaid spending was only third highest among the sample states, after Ohio and New Jersey (see Figure 3). New York spent the second highest amount ($21,223) on elderly Medicaid enrollees in 2006 (Table 3) and the second highest amount ($27,395) per medically needy enrollee in 2003 (see Figure 4). [3]

As shown in Table 4, home health and personal care services comprised 44.9 percent of New York's Medicaid LTC spending in 2006, while nursing facilities comprised 36.7 percent. Nursing facility spending as a percent of overall long-term care spending was lower in New York than in 13 other states. Vermont spent the highest percentage on nursing facilities, at 72.3 percent. New York was about average with regard to the percent of Medicaid dollars spent on intermediate care facilities for the mentally retarded (ICF-MR), on mental health facilities, and on home health and personal care services in 2006.

B. Demographics and Enrollment

i. Population

Although New York's elderly population (defined as persons age 65 years and older) is comparable to that of other states, it has a higher than average percentage (more than 2.0 percent) of people 85 years and older compared to the other states in the sample (see Table 5).[4] With the exception of Florida and Utah, there was little variation in the percentage of elderly among these states. When the states' populations of persons over 65 were compared, the range was from 8 percent in Utah to 16 percent in Florida. New York was nearer the national average, at 13 percent. States' populations of persons over 75 years varied from 3 percent in Utah to 8 percent in Pennsylvania and Florida. New York's percent of the population of persons over age 75 was 6 percent, which is equal to the average.

Figure 5 represents the 2010 projected percent of the population 65 years and older in the sample states. It also represents the interim projections of the change in total population of persons 65 and older from 2000 to 2030. New York State, at 14 percent, is near the U.S. average for 2010 projections. Florida's projection is the highest, at 18 percent, and Utah's is lowest, at 9 percent. Although New York's projection was higher than 11 of the other states in the sample for 2010, projections for 2030 show the percent change of persons 65 years and older for New York at 60 percent (one of the three lowest states among the 19 in the sample). In addition to Florida, nine other states in the group projected more than a 100 percent increase in their elderly population by 2030.

ii. Poverty

Perhaps more important for Medicaid spending is that a greater percentage (18 percent) of the elderly in New York are poor (see Figure 6). This is much higher than the 12 percent average for the sample states. Among sample states in 2005-2006, only Texas had similar poverty rates

[3] "Medically needy" enrollees are persons with heavy medical expenses. They are otherwise not qualified for Medicaid under other categories, as they may have excess income and do not normally meet Medicaid eligibility criteria, but because of their incurred medical expenses, they become eligible.

[4] Source: http://assets.aarp.org/rgcenter/health/d18763_2006_ats.pdf.

among the elderly. As Medicaid essentially is aimed at providing health care for the poor, the elderly poor could play a significant role in driving New York's Medicaid LTC spending in the near future.

iii. Medicaid Enrollment

In 2005, 26 percent of New York's total population was enrolled in Medicaid. Thirteen percent of these enrollees were age 65 and older. The percentage of the population enrolled in Medicaid in New York, 19 percent, is higher than average compared to the sample states. However, the state's percentage of elderly Medicaid enrollees, 13 percent, is lower compared to the sample states (see Figure 7). Pennsylvania had the highest percent of elderly Medicaid enrollees. California had the lowest percentage, at 9 percent, but the highest percentage of Medicaid enrollees as a percent of the state's total population, at 29 percent.

iv. Medically Needy Elderly

The medically needy component of the Medicaid program helps states provide care to persons who are otherwise not qualified for Medicaid under other categories. These individuals have incomes higher than the thresholds normally used to determine Medicaid eligibility. However, because of their incurred medical expenses, they become eligible. Eligibility criteria for the medically needy programs often are not extensive, and not every state provides coverage.

In 2003, the number of medically needy elderly enrollees was highest in New York (237,000) compared to the other 18 states.[5] California was second, with 195,300 medically needy enrolled. New York also spent more than any other state on the medically needy elderly — almost $6.4 billion in 2003. California spent the next highest total amount, at $2.6 billion. In contrast, Florida spent only $22.3 million, in part because of its lower eligibility levels and low medically needy enrollment. New York had the second highest spending per medically needy elderly enrollee ($27,395) in the same year (see Figure 4). Pennsylvania spent the most ($29,412) per enrollee. Medically needy elderly enrollees contribute to states' high Medicaid LTC spending, as this population typically requires more expensive care for a longer period of time.

C. Selected Benefits, Services, and Quality of Long-Term Care

Measures of quality in long-term care delivery under Medicaid can include the efficiency of the eligibility system, length of time to receive waiver services (if there is a waiting list), and presence of caregiver support programs. Similarly, quality may be measured by the types of nursing facilities available in a state, occupancy rates, nursing staff-resident ratios, inclusion of family and residents in the caregiving decision making process, and types and number of deficiencies in a nursing facility. This section outlines some of the factors that may contribute to the quality of long-term care delivery.

[5] Sources: www.statehealthfacts.org/comparemaptable.jsp?ind=209&cat=4; www.statehealthfacts.org/comparebar.jsp?ind=210&cat=4; www.statehealthfacts.org/comparebar.jsp?ind=213&cat=4

i. Single Entry Point for Long-Term Care and Supportive Services

Single entry points (SEPs) for long-term care and supportive services provide a "one-stop shop" for accessing long-term care services and follow-up monitoring. For instance, an SEP may provide information about how to apply for services, obtain referrals, access different services, and connect to advocacy and support groups. It also may provide a place where the elderly can be assessed and recommended for applicable services, including health screenings, preadmission screenings for nursing homes, functional and financial capacity evaluations, and long-term care planning and coordination.

SEPs make it easier for the elderly to receive timely care, can help maintain the care continuum, and may facilitate horizontal integration of LTC services across various departments and agencies within a state. For example, a single entry point program can help an individual access services from the department of health, department of aging, and/or the department of human and social services. Points of entry can facilitate coordination among the different agencies that deliver LTC services and they also can be a tool for vertical integration of the entire service system by linking different stages of services such as screening, assessment, and case management.

In 2003, seven of the 19 states in this comparison had a single entry point system for the elderly and for adults with disabilities to access long-term care and supportive services; two states, Illinois and Massachusetts, offered this program only for the elderly.[6] Ten states, including New York, did not offer a single entry point for any population needing long-term care and supportive services.[7] New York introduced a single entry point program in 2004. As of mid-2008, 44 of New York's 57 upstate counties (excluding the five counties in the NYC region) had single entry point programs for long-term care and supportive services.

ii. Home and Community-Based Services (HCBS) Waiver Waiting List

Medicaid Home and Community-Based Services (HCBS) waiver programs provide additional benefits and services to people who meet special eligibility criteria and are willing to receive these services in their homes and communities. This helps avoid unnecessary institutionalization. Beneficiaries must meet financial, medical, and program criteria to access services under such waivers. Waiver programs usually have waiting lists, as applicants often outnumber the limited slots available. In 2004, four states (Florida, Louisiana, North Carolina, and Texas) had an HCBS waiting list of 6,000 or more; four states (California, Maine, New Jersey, and Vermont) had fewer than 6,000; and the rest, including New York, had no waiting list.[8]

Section 1915(c) of the Social Security Act, which authorized the Medicaid HCBS waiver program, has been in existence since the 1980s, and states have considerable discretion in designing their waiver programs to meet the needs of their target population. Medicaid long-term care programs usually are operated through a Section 1115 waiver, which gives the U.S. Secretary of

[6] Source: http://assets.aarp.org/rgcenter/health/d18763_2006_ats.pdf.
[7] Ibid.
[8] Ibid.

Health and Human Services broad authority to approve projects that will facilitate Medicaid program objectives.

iii. Caregiver Support Programs and Assessments

States can improve their long-term care safety through caregiver support programs, which provide supportive services to family caregivers. New York has a variety of these programs administered by county offices for the aging, the Alzheimer's Association, the American Red Cross, cooperative extensions, and community and faith-based organizations.

In 2003, the majority of the 19 sample states had at least some family caregiver support programs, including uniform assessment tools and training for staff who work with caregivers.[9] States use a variety of tools to assess caregiver support programs.[10] California's 11 resource centers use a common assessment tool that includes family caregivers in the care planning and service development process. Massachusetts is piloting a uniform assessment process with a new caregiver component. Minnesota includes caregiver assessment as part of the state's process for publicly funded long-term care services. Pennsylvania uses a uniform assessment process with a caregiver component for family members providing care for elderly relatives, while Washington includes a caregiver component for all HCBS programs for elderly and disabled adults based on an 18-item caregiver self-assessment questionnaire developed and tested by the American Medical Association.

In New York, while all programs must assess the elderly for community based long-term care services using an instrument that includes assessment of informal support availability, activities of daily living (ADL), instrumental activities of daily living (IADL), cognitive and physical health status, medication, nutrition, housing, and income status, the state does not require caregivers to be assessed for their needs and competence in a similar way.[11]

D. Facility Characteristics

Characteristics of certified nursing facilities (CNFs), such as the number of residents, percentage of elderly residents, occupancy rates, types of CNFs, percentage of Medicaid beds, types of payers, types and percent of deficiencies in the facilities, and per resident nurse hour rates are important for evaluating the quality of long-term care. Data on these factors indicate that states with a high number of nursing facility residents, a high percentage of elderly, and high nursing home spending tend to receive a larger percent of their funding from Medicaid.

As shown in Figure 8, compared to the other sample states, New York has the highest number of residents in nursing facilities, the highest occupancy rate, and the second highest percentage of Medicaid residents (i.e., residents with Medicaid as the primary payer source). [12] It also has the

[9] Sources: http://assets.aarp.org/rgcenter/health/d18763_2006_ats.pdf, NYSOFA staff.
[10] Source: www.caregiver.org/caregiver/jsp/content_node.jsp?nodeid=1717.
[11] Activities of Daily Living (ADL) include walking, getting in and out of a bed/chair, maintaining personal hygiene, and eating, drinking and taking medicine. Instrumental Activities of Daily Living (IADL) include preparing meals, doing household chores, driving, shopping, using the telephone, managing finances, etc.
[12] Note: Data are for 2006. Sources: www.statehealthfacts.org/comparemaptable.jsp?ind=408&cat=8; www.statehealthfacts.org/comparemaptable.jsp?ind=416&cat=8; www.statehealthfacts.org/comparebar.jsp?ind=410&cat=8.

highest number of special care beds. [13] The higher number of special care beds and the high percentage of residents with Medicaid as a primary payment source may help explain New York's high Medicaid spending. Unless acuity levels can be reduced and other sources of payment for care identified, future expenditures could be considerable.

New York State nursing homes were comparable to other states in average nurse hours per residents and total nurse staff hours (Figure 9). [14] New York's nursing homes scored relatively high on the measure of whether families were included in the decision making process regarding residents' care and treatment. [15] The state did not compare well on measures of nursing home deficiencies (see Table 6 and Table 7). [16]

i. Number of Certified Nursing Facilities and Residents

The number of certified nursing facilities (CNFs) and their residents help measure a state's overall supply and demand for long-term care. In turn, the balance between supply and demand may impact client access and the cost of care. For instance, a low resident to CNF ratio may indicate higher accessibility but less efficient use of resources, whereas a high occupancy rate may indicate efficient resource allocation, but potential overcrowding.

In 2006, California had 97,180 CNF residents, and had the highest total number of certified nursing facilities (1,189). By comparison, New York had fewer facilities, at 641, but had the highest total number of residents (110,139). Within these facilities, New York's occupancy rate was highest at 92.6 percent (Figure 8). New York also led in the total number of special care beds, with 10,285. The sample states were similar in the number of licensed nurse hours per resident, which ranged from 1.2 to 1.7, and the number of total nursing staff hours per residents, which ranged from 3.2 to 4.3 (Figure 9).

As shown in Figure 10, in 2005, Connecticut had the highest percentage of nursing home residents aged 65 and older, at 5.4 percent. Oregon had the lowest (1.6 percent). New York's percentage of residents age 65 and older in nursing homes during this period was 4.4 percent, which is higher than most of the states in the sample and also higher than the overall sample average of 3.6 percent. Having a greater number of elderly residents can lead to higher costs, as more care often is required later in life.

[13] Note: 2006 data. Source: www.statehealthfacts.org/comparemaptable.jsp?ind=415&cat=8.
[14] Note: Data are for 2006. The total hours of staffing per resident day are for all facilities including dually certified facilities (Title 18/19), for Medicare-only facilities (Title 18) and for Medicaid-only facilities (Title 19). Source: www.statehealthfacts.org/comparebar.jsp?ind=417&cat=8.
[15] Note: Data are for 2006. Source: www.statehealthfacts.org/comparebar.jsp?ind=422&cat=8.
[16] The deficiencies in nursing homes may be explained in part by the types of facilities (whether for profit, nonprofit, or government), by the case mix index, and potentially by surveyor differences. A 1998 study found that after controlling for other factors (like ADL index, Medicaid resident percentage, whether the facility was hospital based or Medicare only, whether it was part of chain, and location by state, etc.), investor ownership of nursing homes (for profit) was negatively correlated with quality of care. The same study also showed that for profit nursing homes reported lower staffing than their counterparts in the nonprofit and public sectors. The data in this report, commonly referred to as OSCAR, is a well-published standardized data source and surveyor differences are assumed to be minimal. As 50 percent of New York's nursing homes are for profit organizations, this relationship (i.e., ownership and quality of care) could be explored in more depth to determine if and how ownership relates to quality of care. See Harrington, C., S. Woolhandler, J. Mullan, et al., "Does Investor Ownership of Nursing Homes Compromise the Quality of Care?" *American Journal of Public Health*, 91 (9) Sept. 2001: 1452, available at www.ajph.org/cgi/content/abstract/91/9/1452, accessed 08/04/2008.

The case mix of residents by primary payment source may demonstrate the role of Medicaid in paying for the care of CNF residents. In 2006, it was found that all states relied more on Medicaid than other payment sources. However, among the 19 states, New York had the second largest percentage (72 percent) of CNF residents using Medicaid as the primary source of payment — second only to Louisiana, where 75 percent of residents used Medicaid as their primary payer.

ii. Family Groups in Nursing Facilities

A family group is an organized group of family members who meet regularly to discuss issues about residents' care, treatment, and quality of life. The presence of family groups in nursing facilities is an important indicator of the inclusiveness of the treatment decision process. In 2006, New York had the highest percentage (59.8 percent) of nursing facilities with family groups, and Vermont had the lowest percentage, at 22.5 percent, among the sample states.

iii. Deficiencies in Nursing Facilities

Deficiencies in certified nursing facilities can negatively impact the health and safety of residents. Thus, these can be one measure of the quality of care provided. Deficiencies can occur in several different areas of nursing home care, for example, housekeeping, food sanitation, accident prevention, pressure sores, infection control, etc.[17] Some deficiencies also can result in actual harm to the residents or cause immediate jeopardy to their conditions. Deficiencies indicate poor quality of care; hence, states with lower deficiency scores are considered to be providing better overall quality long-term care.

In 2006, New York's average number of deficiencies per certified nursing facility was 5.1, one of the lowest of the sample states (Table 6). Only New Jersey had fewer average deficiencies per facility. California, Connecticut, and Maine had almost twice the average number of deficiencies than New York during the same period. When the sample states were compared in 2006 on the percentage of CNFs receiving a deficiency for actual harm or jeopardy (the most serious kind of deficiency), New York was slightly higher than average, at 17.9 percent. Twelve other states in the sample had lower percentages in this category. This indicates that while New York's CNFs may have fewer overall deficiencies, those they do have tend to be serious.

The analysis also examined how CNFs in the sample states performed with regard to the top 10 deficiencies defined as the most frequently reported deficiencies in the U.S. [18] The top 10 deficiencies by this measure are: presence of accidents, absence of accident prevention, absence of comprehensive care plans, lack of incontinence/urinary care, lack of food sanitation, lack of good housekeeping, absence of infection control, presence of pressure sores, lack of professional standards, and inferior quality of care. Table 7 compares the sample states for 2006 by each of the 10 most frequent nursing home deficiency categories.

New York's CNFs performed better than average in seven of the 10 categories. Connecticut had the highest percentage of deficiencies in six of the 10 categories. Utah had the fewest

[17] "Nursing Facilities, Staffing, Residents and Facility Deficiencies, 2000-2006," September 2007. Department of Social & Behavioral Sciences, University of California, San Francisco; available at www.nccnhr.org/uploads/PartI-PagesfromHarringtonOSCARcomplete2006.pdf.
[18] Ibid.

deficiencies in four categories, two of which were 0 percent (no deficiency). New York's CNFs were more efficient in food sanitation, comprehensive care planning, providing incontinence/urinary care, and accident prevention than in providing overall quality care and housekeeping. New York performed poorly in maintaining professional standards, avoiding pressure sores, and preventing infections.

E. Medicaid Estate Recovery and Other Policy Changes

i. Estate Recovery

The federal government mandated estate recovery in the 1993 Omnibus Budget Reconciliation Act (OBRA).[19] OBRA '93 requires states to recover Medicaid spending from beneficiaries' estates upon their death.[20] Estates of persons receiving Medicaid services after age 55 and those permanently institutionalized (regardless of age) are affected under this regulation. A state is required to pursue recoveries from the probate estate, which, under state probate law, includes property that passes to heirs.

Alternatively, states may expand the definition of estate to allow recovery from property that bypasses probate, including property owned in joint tenancy with rights of survivorship, life estates, living trusts, annuity remainder payments, or life insurance payouts. States also may recover amounts spent by Medicaid for long-term care and related drug and hospital benefits, including any Medicaid payments for Medicare cost sharing related to these services. In addition, states may have other options to recover costs from Medicaid services paid on the individual's behalf.[21]

As shown in Table 8, states differ in Medicaid estate recovery collections and in the scope of policy options for recovery. New York's Medicaid estate recovery collection for 2005 was $34.4 million, which amounted to only 0.2 percent of its long-term care spending. California collected $56.3 million (0.7 percent) and Massachusetts collected $37.9 million, which at 1.2 percent, was the highest percentage recovered that year among the states included in this research.

Nationally, eight states implemented policies in 2005 that followed the minimum federal law requirements. Twenty-nine states, including New York, used a mix of policy options. Nine states made maximum use of federal policy options for estate recovery during this period. California and Illinois were among these maximum use states. Although the states using maximum level s of federal regulations did well in estate recovery, no obvious correlation emerged from this analysis. As New York presently does not make use of the expansive federal estate recovery policies, there may be opportunity for tightening the laws to increase collections.

ii. The Deficit Reduction Act (2005)

The Deficit Reduction Act (DRA) of 2005 included provisions targeted at decreasing Medicaid long-term care spending, such as lengthening the time a state can "look back" to count asset

[19] The mandate was imposed by Section 13612 of P.L. 103-66 (OBRA 93), which amended Section 1917 of the Social Security Act, accessible at: www.ssa.gov/OP_Home/ssact/title19/1917.htm. Detailed federal guidance to states is in the State Medicaid Manual, Chapter 3, Section 3810, at: www.cms.hhs.gov/Manuals/PBM/list.asp?listpage=2.
[20] www.cms.hhs.gov/MedicaidEligibility/08_Estate_Recovery.asp.
[21] Ibid.

transfers from three years to five years and changing the time when a "penalty period" may start. While a look back period allows the state to review an applicant's financial records for evidence of asset transfer for a period of time prior to the application date, a penalty period is a period during which an applicant is ineligible for Medicaid long-term cares services because of an asset transfer. States have started incorporating these changes in their Medicaid policies. To further comply with DRA 2005, states have expanded Programs of All-Inclusive Care for the Elderly (PACE), added more services to the HCBS waiver, enhanced institutional services, and promoted changes in the delivery of care. Louisiana and Michigan are trying to change their nursing facility reimbursement policies to promote quality improvements. Louisiana now allows nursing facilities to convert double rooms to private rooms without a reimbursement penalty, and Michigan allows reimbursement for facility innovative design programs (Table 9).[22]

Look Back Period: One of the changes DRA 2005 (Section 6011) put forth was to increase the look back period. Among the sample states, most, including New York, had already made policy changes regarding look back and penalty periods by end of 2007 to comply with the new requirement. Five states (California, Florida, Louisiana, North Carolina, and Ohio) had not made any such changes by October 2007, and two states (Connecticut and Vermont) did not need to make changes, as their legislature already complied with the DRA requirement. Information for the rest of the sample states was not available for analysis.

Penalty Period: Section 6011(b) of DRA 2005 changed when a penalty period began. Previously, it began either in the month the asset was transferred or the following month, depending on the state. Now it begins from the date of application. DRA Section 6016 also made changes to how transfers could be determined. For instance, it allows states to count smaller amounts of transfers and impose a single penalty period for multiple assets transfers.

More than half of the sample states had planned to make necessary changes to their policies by summer 2007. Only two states, California and Virginia, had not made any changes by that time period. Four states — New Jersey, New York, Texas, and Vermont — did not need to make changes because their legislation already complied, and Florida was waiting for legislative approval. Information for the rest of the sample states was not available.[23]

Purchase of Promissory Note and Life Estates: DRA Section 6016 indicates that funds used to purchase a promissory note, loan, or mortgage should be included among assets, except under certain conditions. Purchase of a life estate interest in another individual's home, unless the purchaser resides in the home for at least one year after the date of purchase, is counted as an asset.[24] More than half of the sample states, including New York, had planned to make necessary changes in their policies by fall 2007.[25] Only two states, California and Washington, had not made any changes by that time period. Two states, Louisiana and New Jersey, did not

[22] *As Tough Times Wane, States Act to Improve Medicaid Coverage and Quality: Results from a 50-State Medicaid Budget Survey, State Fiscal Years 2007 and 2008*, Appendix A-1a. Kaiser Commission on Medicaid and the Uninsured, October 2007. Available at: www.kff.org/medicaid/upload/7699.pdf.
[23] SSL Section 366(5)(d)(4) [for transfers made after 8/10/93 and before 2/08/06]; SSL Section 366(5)(e)(5)[for transfers made on or after 2/08/06].
[24] Source: http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=109_cong_bills&docid=f:s1932enr.txt.pdf; www.okhca.org/about/pdflib/mac/5-17-07_DRA_Summary.pdf.
[25] SSL Section 366(5) (e)(3)(iii).

need to make changes because their legislation already complied, and Florida was waiting for legislative approval. Information for the rest of the sample states was not available. By fall 2007, most of the sample states, including New York, also had made changes regarding the purchase of life estates.[26] Among the sample states, only California had not made the changes by 2007, and Florida was waiting for legislative approval.

Home Equity: DRA Section 6014 renders those who have an equity interest in their homes greater than $500,000 ineligible for obtaining Medicaid for their nursing facilities or other LTC services. It allows states to set the home equity limit higher than $500,000, but not more than $750,000. Most of the sample states have set their home equity limits below $500,000. Five states: California, Connecticut, Maine, New Jersey, and New York, planned to set their limits at $750,000. Information was not available for the rest of the sample states (see Table 10). [27]

iii. Long-Term Care Partnership Program

Long-term care partnership programs allow states to promote the purchase of long-term care insurance by individuals. The promotion offers access to Medicaid beyond the terms of LTC insurance contracts if additional coverage is needed, while protecting some amount of assets and income. The original partnership demonstration model began in 1992, and New York, along with California, Connecticut, and Indiana (which is not a sample state), is one of the original partnership program states (see Table 11). Michigan, Ohio, Texas, and Virginia became Long-Term Care Partnership Expansion grantees of the Robert Wood Johnson Foundation Center for Health Care Strategies (RWJF/CHCS) initiative after DRA 2005 lifted the technical barriers imposed by Congress on such programs. [28] Florida was the only state among the sample planning for a long-term care partnership program and has an approved amendment to move the program forward as of 2007.

III. Summary and Conclusion

The findings suggest that although New York spends more on health care, and specifically on long-term care, not all of the spending differences are due to demographics. Demographic differences that may contribute to spending variations include a higher rate of persons over 85, a higher poverty rate among the elderly, and greater acuity of patients in nursing facilities. Other factors that may contribute to higher Medicaid long-term care spending in New York are the greater number of medically needy elderly, a greater percentage of persons in nursing homes that rely on Medicaid as their primary source of funding, and the availability of a broader range of Medicaid long-term care services.

In addition to its higher than average spending, New York stands out because it has been generally more aggressive at implementing new policies and initiatives that expand Medicaid funded long-term care services such as HCBS waivers, PACE, and managed long-term care. The state also was one of four original “partnership plan” demonstration states. More recently, New York has taken steps to

[26] SSL Section 366(5) (e)(3)(ii).
[27] SSL Section 366(2)(a)(1)(ii). When NYS amended its statute to conform to DRA, it opted to set the home equity limit for all regions of the state at the maximum allowed of $750,000.
[28] Sources: www.chcs.org/usr_doc/Long-Term_Care_Partnership_Expansion.pdf; www.chcs.org/usr_doc/Long-Term_Care_Partnership_Expansion.pdf.

implement a single point of entry to facilitate access to long-term care and supportive services. Establishing this system may help improve efficiency by eliminating overlapping services and by promoting efficient screening, monitoring, and case management of long-term care service beneficiaries. The state also has taken several steps to reduce asset transfers to ensure that Medicaid LTC spending is better targeted to low-income populations. By fall 2007, it had conformed to all of the long-term care policy changes outlined in DRA 2005.

Unfortunately, New York's broad range of services and higher spending have not produced a higher quality of care. The state is about average or slightly above average on measures of quality. The comparisons in this report show that New York has room to improve quality and lower costs. As the state seeks ways to reduce spending and improve quality, one consolation is that New York's elderly population is projected to grow more slowly relative to other states over the next two decades.

IV. Potential Areas for Further Research

The findings suggest that further research may better inform future long-term care policy decisions. Potential research areas include:

1. Trends in poverty rates among the elderly in New York to assess potential demands on the Medicaid program.
2. How DRA 2005 is affecting Medicaid long-term care spending.
3. The impact of existing programs, like the Long-Term Care Partnership Program, on the purchase and utilization of private long-term care insurance in New York.
4. The estate recovery practices of other states, so New York could parlay successful policies and practices to its own program.
5. How streamlined administration of long-term care, such as the use of uniform assessments and single points of entry, influence long-term care costs.
6. How long-term care policies and spending interact with quality, so quality improvement also can be used as a tool to contain Medicaid long-term care costs.
7. What other strategies might allow New York to rely less on Medicaid to fund long-term care?

APPENDIX

Table 1: Health Spending, FY 2003

State	State Health Spending ($ millions)	State Health Spending as a % of GSP
United States	$357,765	3.3%
New York	**$44,564**	**5.3%**
Maine	$2,134	5.3%
Pennsylvania	$18,873	4.3%
Louisiana	$6,347	4.3%
Vermont	$847	4.1%
North Carolina	$10,581	3.4%
Ohio	$13,336	3.3%
New Jersey	$12,742	3.3%
Washington	$7,759	3.2%
Michigan	$11,558	3.2%
Oregon	$3,842	3.2%
Connecticut	$5,254	3.1%
Texas	$25,315	3.1%
Florida	$15,397	2.8%
California	$38,574	2.7%
Massachusetts	$7,743	2.6%
Illinois	$13,295	2.6%
Utah	$1,528	2.0%
Virginia	$5,423	1.8%

Sources: www.statehealthfacts.org/comparemaptable.jsp?ind=283&cat=5; www.statehealthfacts.org/comparemaptable.jsp?ind=284&cat=5.

Gross State Product (GSP) is the dollar measure of the total product of all industries, goods and services, in a particular state and represents the economic output of that state for a particular year. The state health spending represents the money spent on all health related services in a state in a certain time period, usually one fiscal year. State health spending as a percentage of GSP provides insight into the state's health expenditures relative to other spending. New York spent a larger proportion of its GSP on health care compared to all other sample states.

Return to II.A. **Spending**

Table 2: Comparison of Total and Per Capita Health Spending, FY 2004

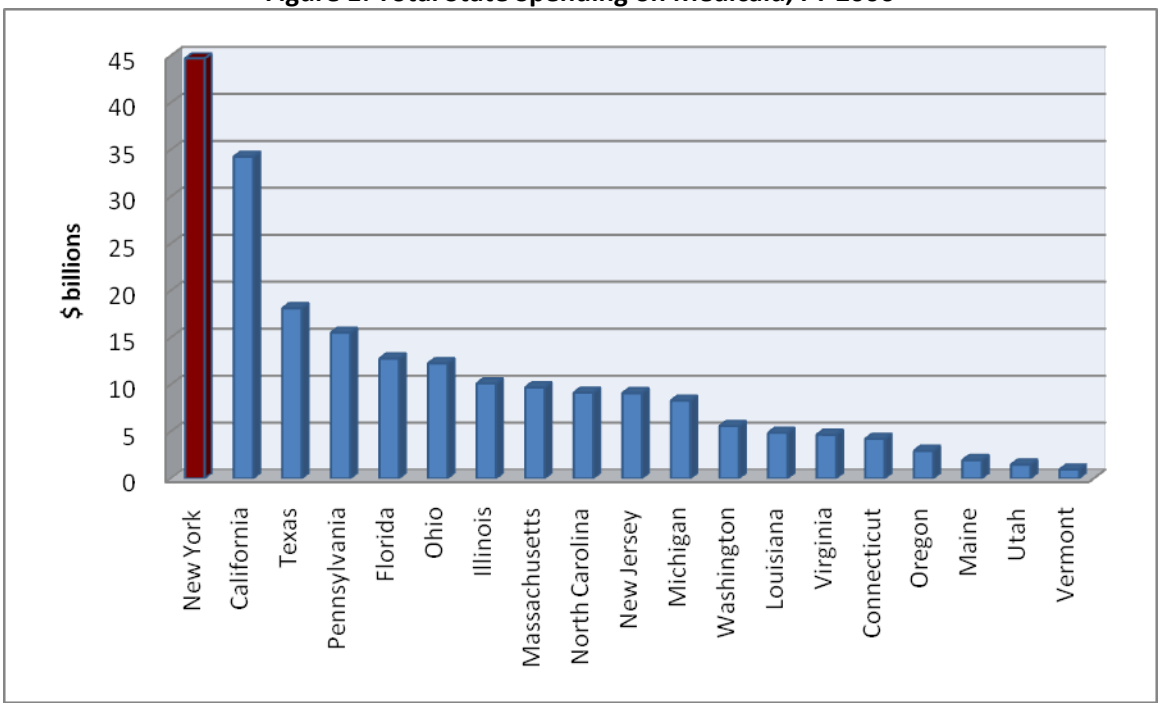
State	Total Health Spending by State ($ millions)	Rank (Total Spending)	Per Capita Health Spending by State ($ millions)
United States	**$1,551,255**		**$5,283**
Massachusetts	$43,009	11	$6,683
Maine	$8,59	18	$6,540
New York	**$126,076**	**2**	**$6,535**
Connecticut	$22,167	15	$6,344
Vermont	$3,768	19	$6,069
Pennsylvania	$73,441	5	$5,933
New Jersey	$50,384	9	$5,807
Ohio	$65,622	7	$5,725
Florida	$95,223	4	$5,483
Illinois	$67,292	6	$5,293
North Carolina	$44,281	10	$5,191
Washington	$31,600	13	$5,092
Michigan	$51,048	8	$5,058
Louisiana	$22,658	14	$5,040
Oregon	$17,516	16	$4,880
Virginia	$36,032	12	$4,822
California	$166,236	1	$4,638
Texas	$103,600	3	$4,601
Utah	$9,618	17	$3,972

Source: www.statehealthfacts.org/comparemaptable.jsp?ind=27&cat=1.

Per capita health spending of states provides a standardized measure to compare different states' health care expenditures. New York had the second highest total health spending and the third highest spending per capita health on health care in 2004 among the group of states selected for this research.

Return to II.A. **Spending**

Figure 1: Total State Spending on Medicaid, FY 2006

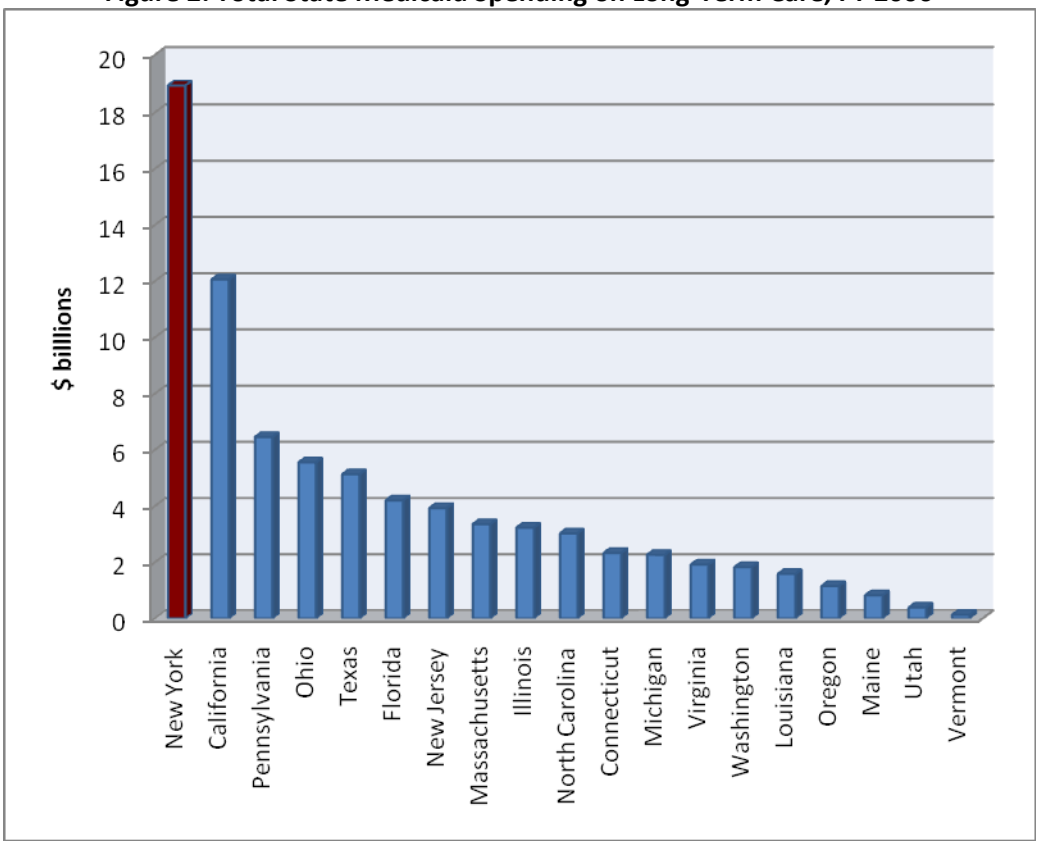


Source: www.statehealthfacts.org/comparemaptable.jsp?ind=177&cat=4.

The total Medicaid spending of a state represents the combined state and federal expenditure on Medicaid benefit payments. This also includes disproportionate share payments but does not include administrative costs or accounting adjustments, which might vary from state to state. Disproportionate share payments are the payments made to specific hospitals treating high cost poor enrollees.

Return to II.A. **Spending**

Figure 2: Total State Medicaid Spending on Long-Term Care, FY 2006

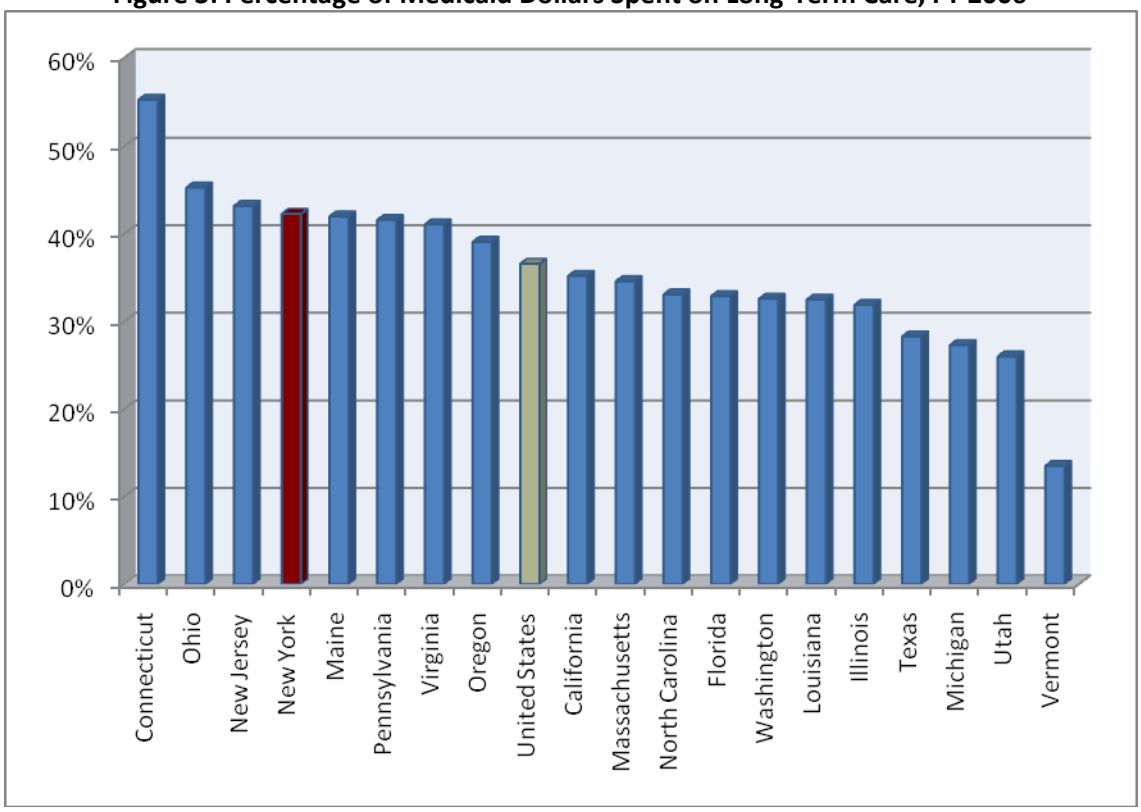


Calculated from data available at: www.statehealthfacts.org/comparetable.jsp?ind=178&cat=4, and www.statehealthfacts.org/comparemaptable.jsp?ind=177&cat=4.

State Medicaid spending on long-term care includes payment toward services provided by nursing facilities, intermediate care facilities for the mentally retarded, mental health, home health services, and personal care support services. The total Medicaid spending of a state includes both state and federal expenditures on Medicaid services. This also includes disproportionate share payments, but does not include administrative costs or accounting adjustments, which may vary by state. Disproportionate share payments are those made to specific hospitals treating high cost poor enrollees. New York had the highest total Medicaid LTC spending for 2006 among the sample states.

Return to II.A. **Spending**

Figure 3: Percentage of Medicaid Dollars Spent on Long-Term Care, FY 2006



Source: www.statehealthfacts.org/comparetable.jsp?ind=178&cat=4.

State Medicaid dollars are spent on various long-term care services such as services provided by nursing facilities, intermediate care facilities for the mentally retarded, mental health, home health services, and personal care support services. Among the 19 states selected for this research New York spent the fourth highest percentage of its total Medicaid funds on long-term care.

Return to II.A. **Spending**

Table 3: Per Enrollee Medicaid Spending by Specific Category, 2005

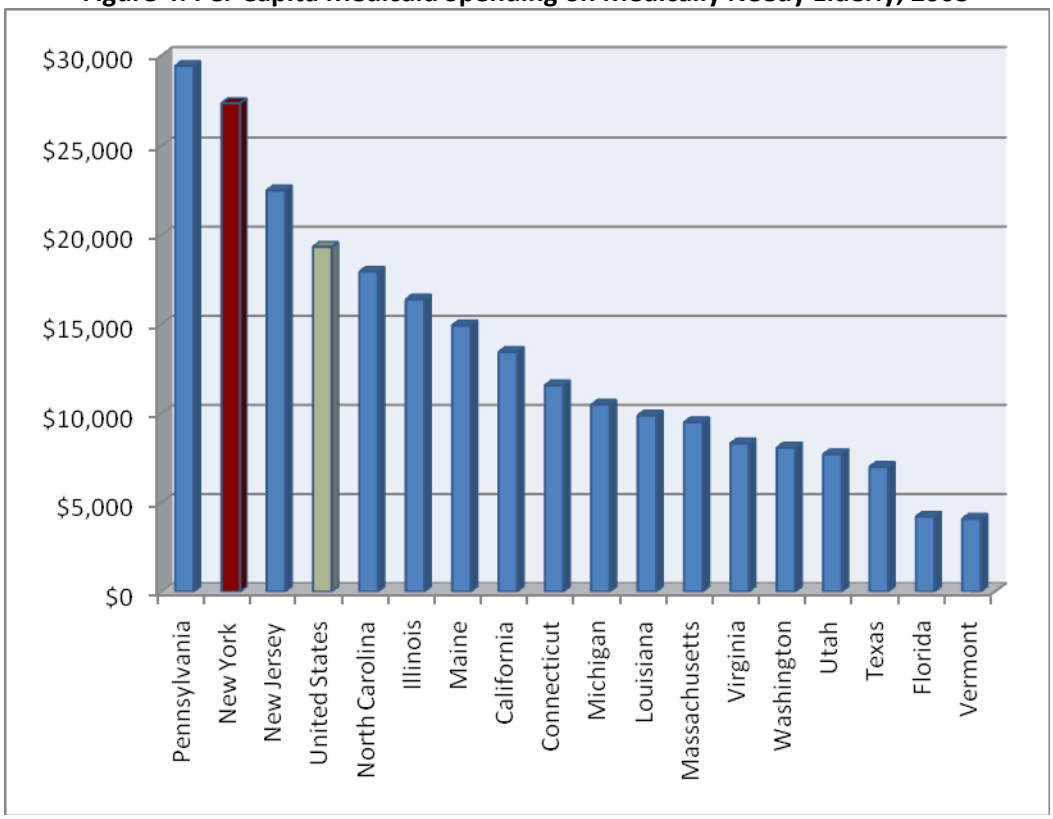
State	For "All Medicaid" Category		State	For "Medicaid Elderly" Category
United States	**$4,662**		**United States**	**$11,839**
New York	**$7,733**		Connecticut	$21,522
Maine	$7,691		**New York**	**$21,223**
Connecticut	$7,212		Ohio	$20,730
New Jersey	$7,022		New Jersey	$17,806
Massachusetts	$6,837		Pennsylvania	$16,634
Pennsylvania	$5,932		Massachusetts	$16,083
Ohio	$5,764		Maine	$12,631
North Carolina	$5,372		North Carolina	$11,973
Vermont	$5,315		Utah	$11,777
Utah	$4,914		Michigan	$11,188
Virginia	$4,644		Oregon	$10,863
Washington	$4,439		Washington	$10,501
Oregon	$4,403		Virginia	$10,410
Illinois	$4,393		Vermont	$10,216
Florida	$4,389		Florida	$9,212
Michigan	$4,348		Louisiana	$8,772
Louisiana	$3,823		California	$8,750
Texas	$3,598		Texas	$8,362
California	$2,701		Illinois	$5,939

Calculated from sources: www.statehealthfacts.org/comparetable.jsp?ind=177&cat=4; www.statehealthfacts.org/comparemaptable.jsp?ind=198&cat=4;www.statehealthfacts.org/comparemaptable.jsp?ind=199&cat=4; www.statehealthfacts.org/comparebar.jsp?ind=200&cat=4.

Per enrollee Medicaid spending is derived by dividing total Medicaid spending (both federal and state) in a state by the total number of enrollees in all Medicaid eligibility categories for a given fiscal year. The calculation does not include disproportionate share hospital payments, i.e., payments made to specific hospitals treating high cost poor enrollees. Enrollees are presumably unduplicated individuals who participate in Medicaid program. The duration of participation may vary per person even within a single fiscal year. New York had the largest per enrollee Medicaid spending in calendar year 2005. The category-specific per enrollee Medicaid spending is calculated by dividing the total Medicaid benefit payments along with the disproportionate share hospital payment by the number of enrollees within a specific Medicaid category (category 'aged,' defined as 65 years and older, in this case) for a particular fiscal year. New York had the second highest expenditures in this category.

Return to II.A. **Spending**

Figure 4: Per Capita Medicaid Spending on Medically Needy Elderly, 2003



Source: www.statehealthfacts.org/comparebar.jsp?ind=213&cat=4.

The medically needy component of the Medicaid program helps states provide care to persons who are otherwise not qualified for Medicaid under other categories. These individuals have excess income and do not normally meet the Medicaid eligibility criteria, but because of their incurred medical expenses, they become eligible. Eligibility criteria for the medically needy programs often are not extensive, and not every state provides coverage for the medically needy. A high percentage of medically needy can increase a state's Medicaid LTC expenditures more quickly because they tend to be more expensive than other enrollees.

Return to II.A. **Spending**
Return to II.B.iv. Demographics and Enrollment – **Medically Needy Elderly**

Table 4: Percentage of Medicaid Spending by Long-Term Care Categories, 2006

State	Intermediary Care Facility for the Mentally Retarded	State	Mental Health Facilities	State	Nursing Facilities	State	Home Health & Personal Care
United States	**11.7%**	**United States**	**3.7%**	**United States**	**43.7%**	**United States**	**40.9%**
Louisiana	27.0%	Virginia	20.1%	Vermont	72.3%	Oregon	73.2%
Illinois	22.3%	California	9.6%	Michigan	64.1%	Washington	60.8%
Texas	16.8%	Ohio	7.2%	Pennsylvania	59.8%	Maine	55.3%
Ohio	16.7%	Maine	5.8%	Florida	57.1%	California	51.7%
New Jersey	16.4%	New Jersey	3.8%	Connecticut	52.7%	Texas	46.9%
New York	**15.9%**	Utah	3.4%	Massachusetts	49.6%	North Carolina	46.4%
Utah	15.9%	Louisiana	3.3%	Ohio	47.9%	**New York**	**44.9%**
North Carolina	14.9%	**New York**	**2.5%**	New Jersey	46.4%	Massachusetts	44.0%
Virginia	13.3%	Oregon	2.5%	Illinois	45.6%	Utah	42.9%
Connecticut	12.4%	Illinois	2.4%	Louisiana	40.4%	Florida	35.3%
Maine	8.8%	Pennsylvania	1.9%	Utah	37.8%	Michigan	34.7%
Pennsylvania	8.8%	North Carolina	1.8%	North Carolina	36.9%	Connecticut	33.7%
Florida	7.5%	Washington	1.6%	Virginia	36.8%	New Jersey	33.5%
California	7.1%	Massachusetts	1.5%	**New York**	**36.7%**	Illinois	29.8%
Washington	6.9%	Connecticut	1.2%	Texas	35.8%	Virginia	29.8%
Massachusetts	4.9%	Michigan	0.8%	California	31.6%	Pennsylvania	29.5%
Michigan	0.4%	Texas	0.5%	Washington	30.7%	Louisiana	29.4%
Oregon	0.0%	Florida	0.2%	Maine	30.1%	Ohio	28.2%
Vermont	0.0%	Vermont	0.0%	Oregon	24.4%	Vermont	27.7%

Source: www.statehealthfacts.org/comparetable.jsp?ind=180&cat=4.

Return to II.A. **Spending**

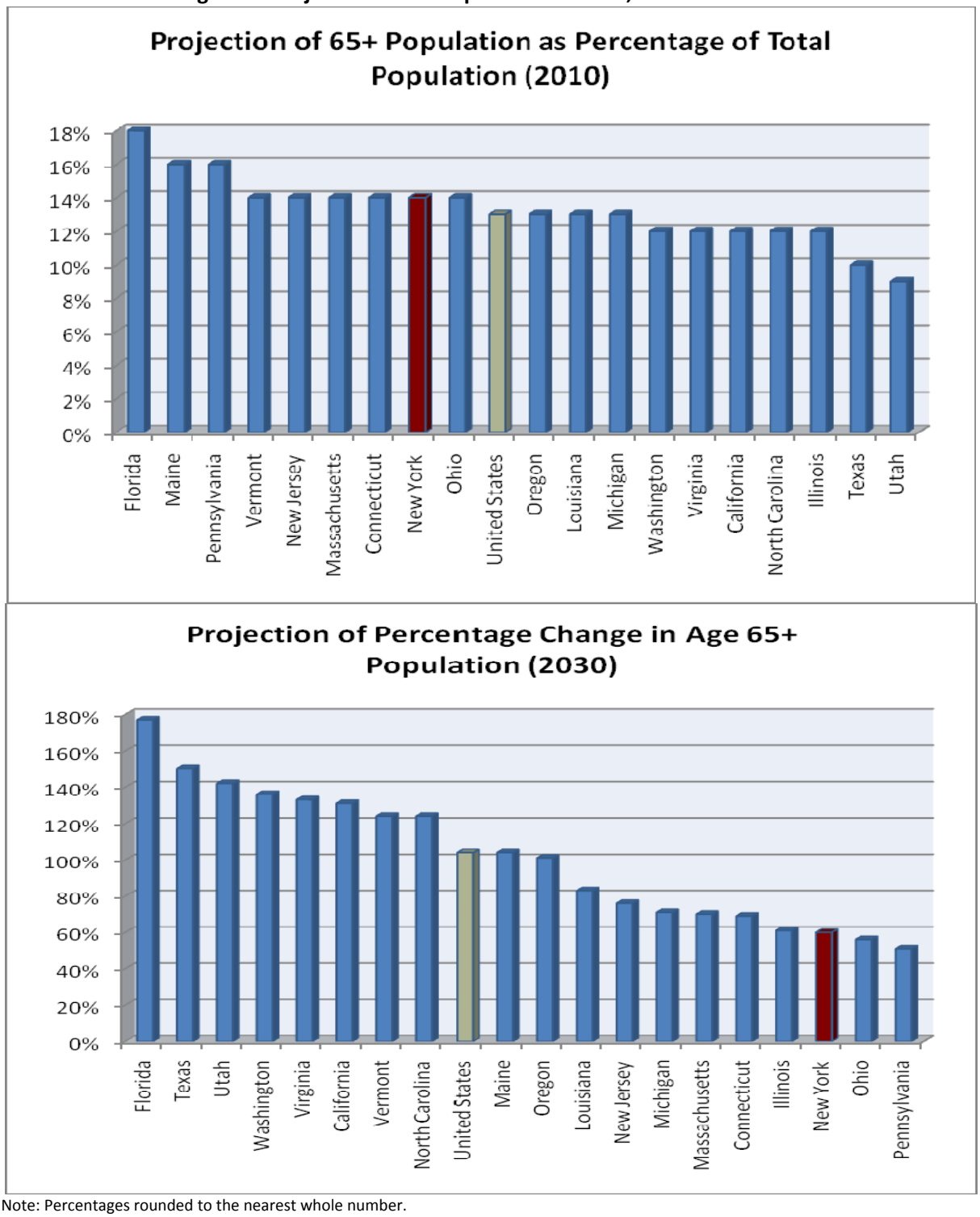
Table 5: Total Resident Population and Percentage of Elderly Population, 2005-2006

State	Population (Residents)	Population Distribution by Age	
		Age 65+	Age 75+
United States	**296,056,836**	**12%**	**6%**
Florida	17,922,259	16%	8%
Pennsylvania	12,301,907	14%	8%
Maine	1,313,338	14%	7%
Massachusetts	6,328,346	13%	7%
Connecticut	3,467,153	13%	6%
Illinois	12,602,623	12%	6%
Michigan	9,969,056	12%	6%
New Jersey	8,683,143	13%	6%
New York	**19,022,430**	**13%**	**6%**
Ohio	11,306,003	12%	6%
Oregon	3,667,471	13%	6%
Vermont	620,079	12%	6%
Washington	6,236,919	11%	6%
California	35,973,138	11%	5%
Louisiana	4,142,504	14%	5%
North Carolina	8,663,828	12%	5%
Texas	22,968,248	11%	5%
Virginia	7,410,393	11%	5%
Utah	2,524,825	8%	3%

Note: The table is ranked ordered by population 75+.
Sources: www.statehealthfacts.org/comparemaptable.jsp?ind=1&cat=1; www.statehealthfacts.org/comparebar.jsp?ind=2&cat=1.

Return to II.B.i. Demographics and Enrollment – **Population**

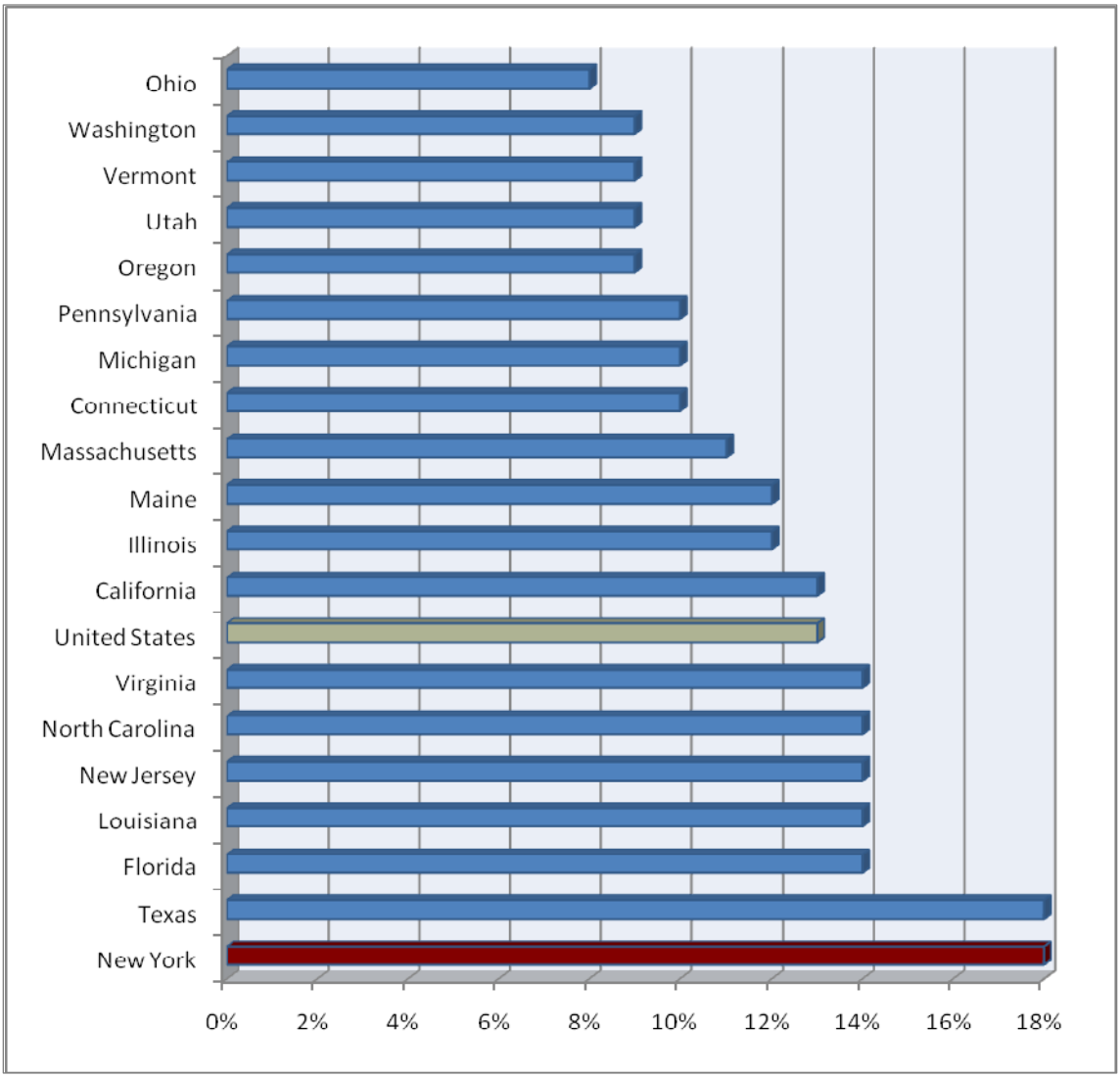
Figure 5: Projection of 65+Population Growth, FY 2010 and 2030



Note: Percentages rounded to the nearest whole number.
Source: From Table 1 and Table 3, U.S. Census projections: www.census.gov/population/www/projections/projectionsagesex.html.

Return to II.B.i. Demographics and Enrollment – **Population**

Figure 6: Poverty Rate among the Elderly, FY 2005-2006

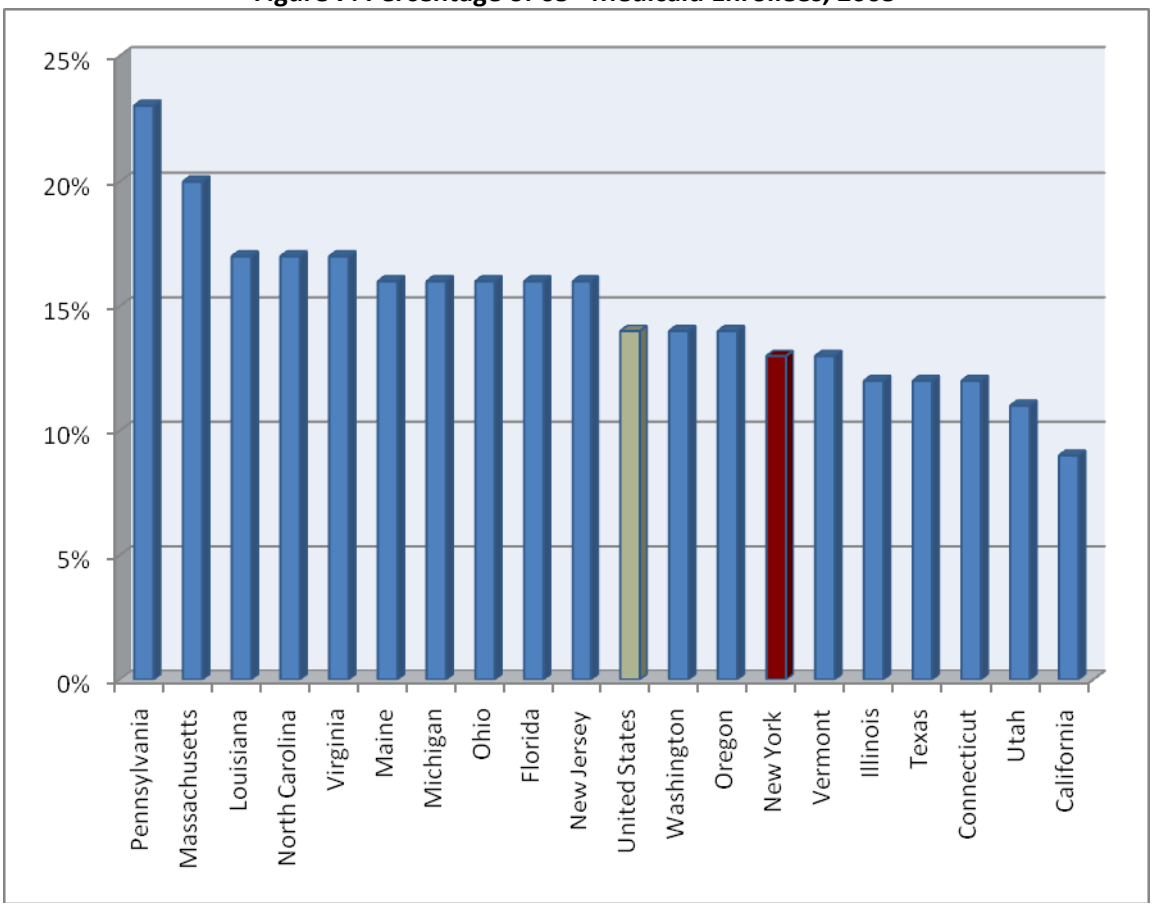


Note: Percentages are rounded to the nearest whole number.
Sources: www.census.gov/population/www/projections/projectionsagesex.html; www.statehealthfacts.org/comparebar.jsp?ind=10&cat=1.

In this report poverty rate represents the proportion of population/subpopulation living in poverty during a given time period. Persons in poverty are defined as those with incomes less than 100 percent of the Federal Poverty Level (FPL) and living in health insurance units. The FPL is measured according to the guidelines of the U.S. Census Bureau's poverty threshold, which was $19,971 in 2005 and $20,641 in 2006 for a family of four in 48 contiguous states and Washington D.C. The U.S. Department of Health and Human Services produces simplified versions of federal poverty thresholds to be used while determining financial eligibility of several government programs. The health insurance units are related to individuals who are eligible as a group for family coverage in a health plan as opposed to household units where a group of individuals occupies the same dwelling.

Return to II.B.ii. Demographics and Enrollment – **Poverty**

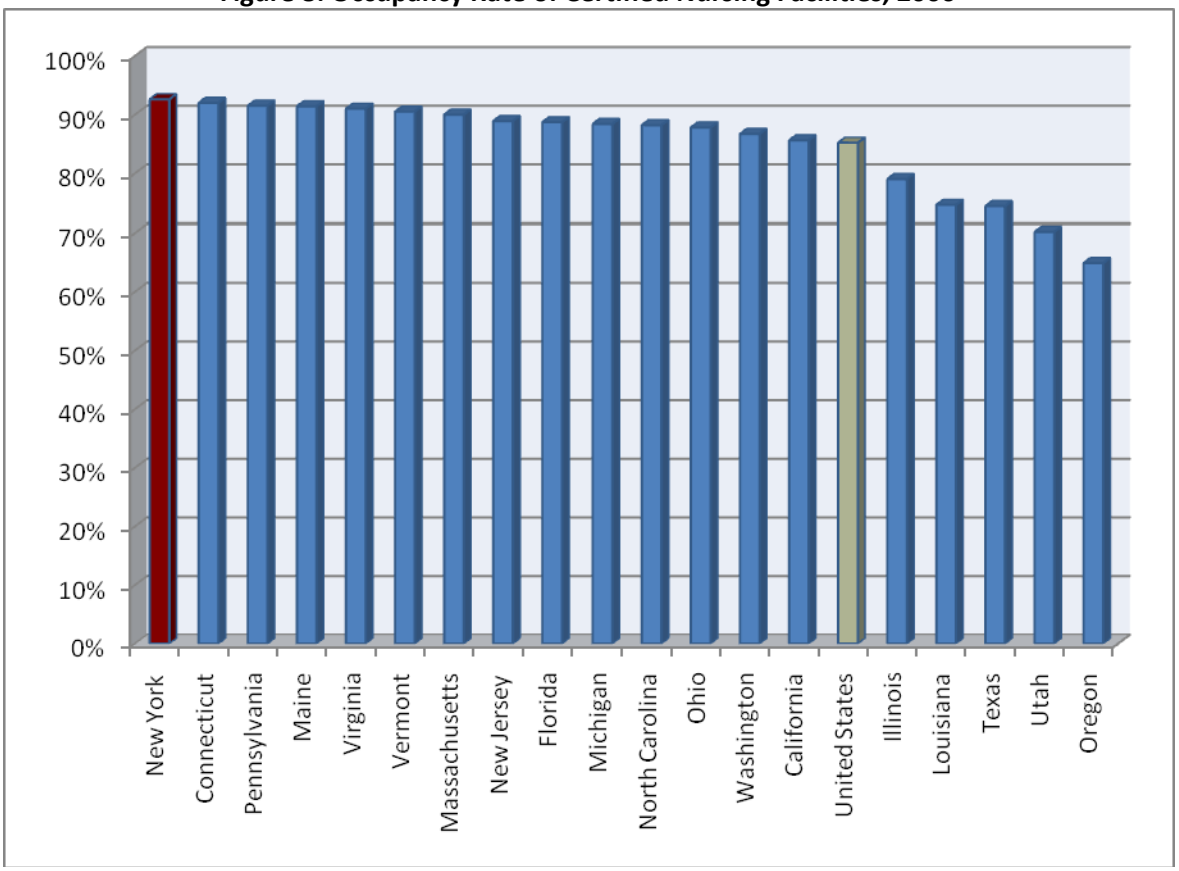
Figure 7: Percentage of 65+ Medicaid Enrollees, 2005



Sources: www.statehealthfacts.org/comparemaptable.jsp?ind=198&cat=4; www.statehealthfacts.org/comparemaptable.jsp?ind=199&cat=4; www.statehealthfacts.org/comparebar.jsp?ind=200&cat=4.

Return to II.B.iii. Demographics and Enrollment – **Medicaid Enrollment**

Figure 8: Occupancy Rate of Certified Nursing Facilities, 2006

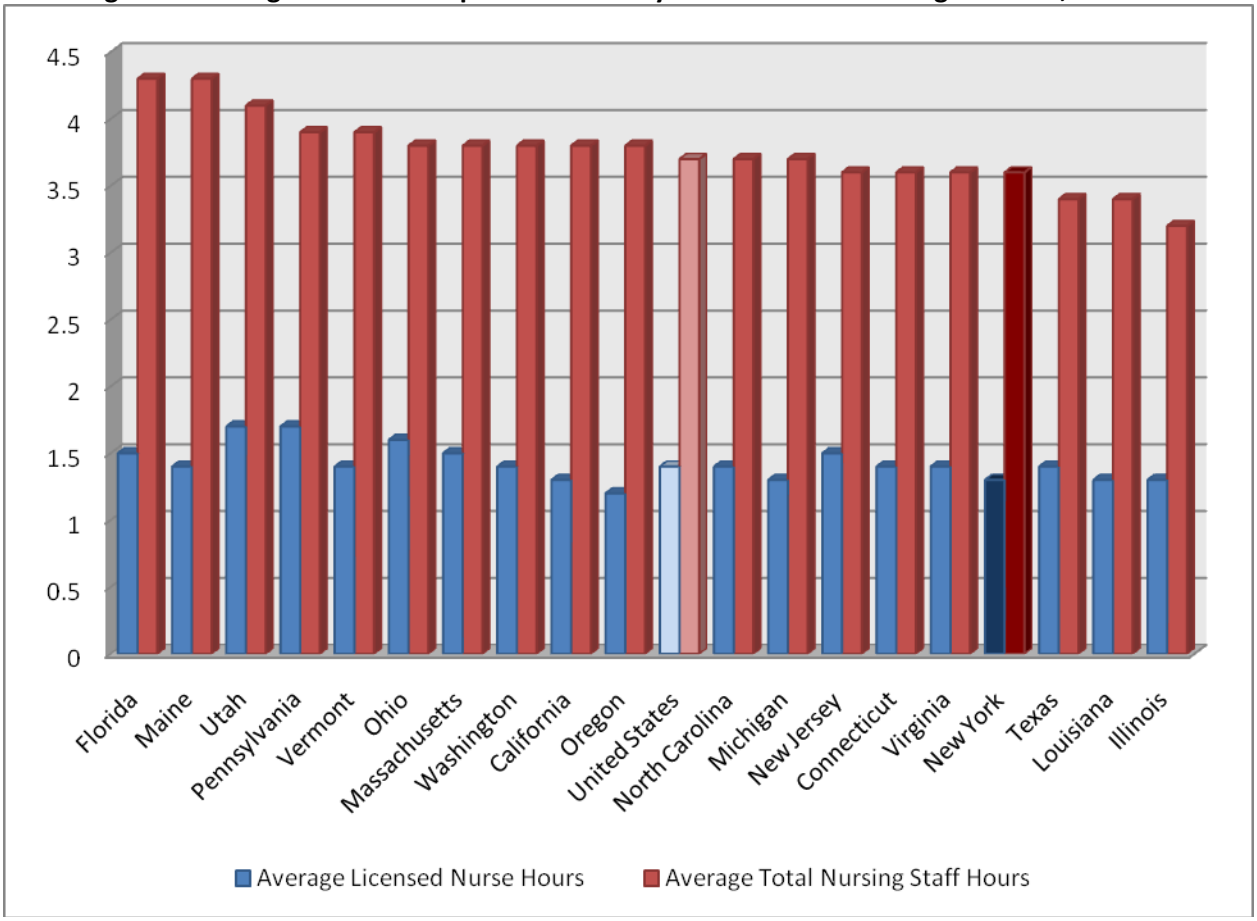


Note: Data are for calendar year 2006.
Sources: www.statehealthfacts.org/comparemaptable.jsp?ind=416&cat=8; www.statehealthfacts.org/comparemaptable.jsp?ind=415&cat=8.

The occupancy rate of centrified nursing facilities is defined as the percentage of total beds occupied by residents at any point in time during a given time period (one fiscal year in this case). For example: An occupancy rate of 95 percent means that 95 out of 100 beds are occupied at any given point of time throughout the year under consideration.

Return to II.D. **Facility Characteristics**
Return to II.D.i. Facility Characteristics – **Number of Certified Nursing Facilities and Residents**

Figure 9: Average Nurse Hours per Resident Day in All Certified Nursing Facilities, FY 2006

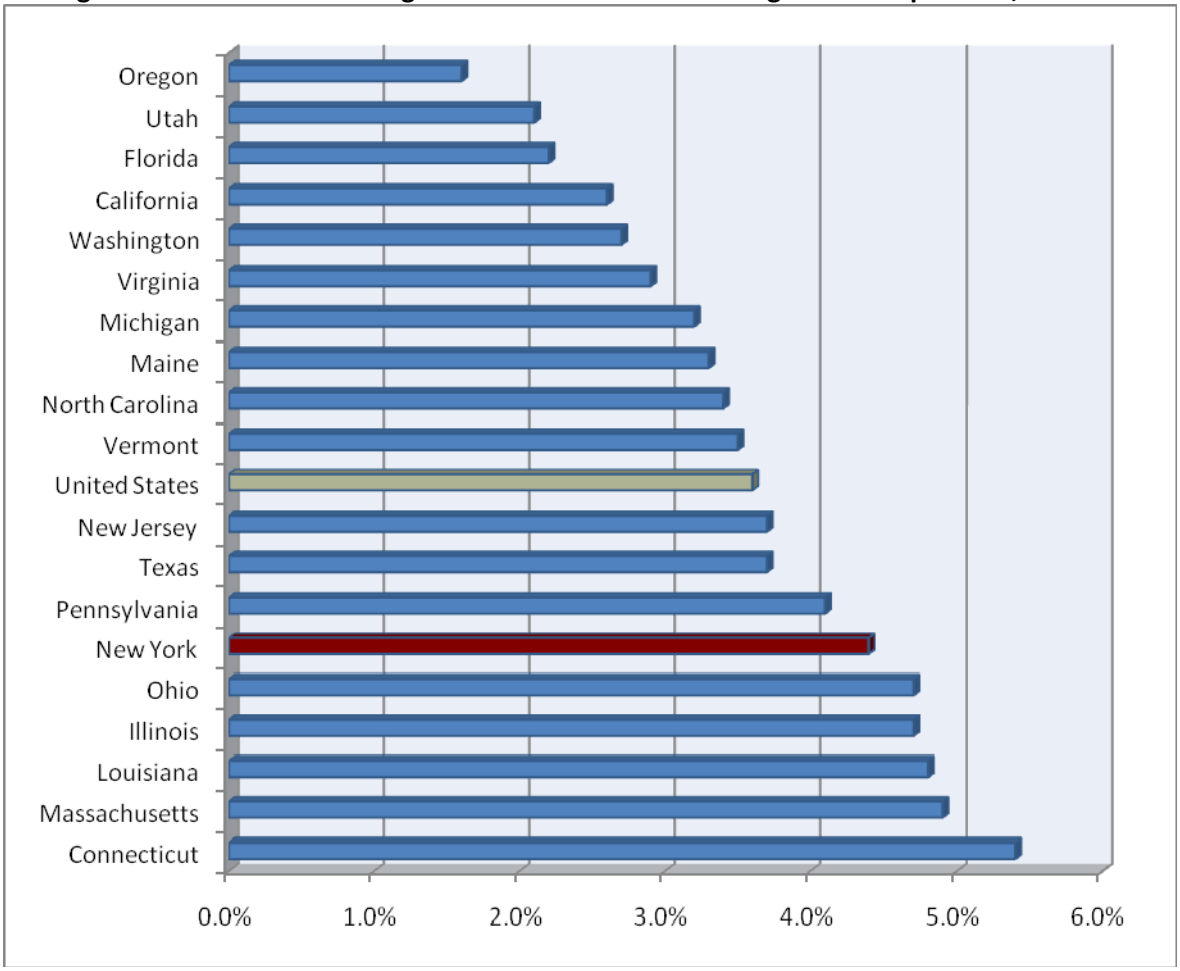


Note: Data are for calendar year 2006. The total hours of staffing per resident day are for all facilities including dually certified facilities (Title 18/19), for Medicare-only facilities (Title 18) and for Medicaid-only facilities (Title 19).
Source: www.statehealthfacts.org/comparebar.jsp?ind=417&cat=8.

Nursing staff hours per resident day is important for providing quality care in certified nursing facilities. Licensed nurse hours, in this case, include hours of services provided by registered nurses, licensed practical nurses, and licensed vocational nurses. Total nursing staff hours include licensed nurse hours and also work hours of other nursing staff like aides, orderlies, and nursing assistants.

Return to II.D. **Facility Characteristics**
Return to II.D.i. Facility Characteristics – **Number of Certified Nursing Facilities and Residents**

Figure 10: Number of Nursing Home Residents as Percentage of 65+Population, FY 2006



Note: "These data include the number of nursing facility residents in certified nursing facilities that were surveyed in each state during calendar year 2006. Not all facilities are surveyed by state agencies during each calendar year. These data exclude residents in uncertified beds. Please note that while these rates are a measure of a state's share of the 65+ population in nursing homes, the total number of nursing facility residents used in these calculations also includes residents who may be under 65 years of age and in need of nursing facility care." State Health Facts; the Henry J. Kaiser Family Foundation. For full details about the data and data collection, please see C. Harrington, H. Carrillo, C. Crawford, and C. LaCava. "Nursing, Facilities, Staffing, Residents, and Facility Deficiencies; 2000 through 2006," Department of Social and Behavioral Sciences, University of California, San Francisco, accessed January 2008. Available at www.pascenter.org. Source: www.statehealthfacts.org/compare.jsp.

Return to II.D.i. Facility Characteristics – **Number of Certified Nursing Facilities and Residents**

Table 6: Nursing Home Deficiency Indicators, 2006

State	Average Number of Deficiencies per CNF	State	% of CNFs Receiving a Deficiency for Actual Harm or Jeopardy	State	% of CNFs with No Deficiencies
United States	7.5	**United States**	18.1%	**United States**	7.7%
California	11.6	Connecticut	43.9%	Oregon	24.1%
Connecticut	10.4	Michigan	28.2%	Massachusetts	16.4%
Maine	9.5	Washington	25.7%	Ohio	13.3%
Florida	9.2	Illinois	23.3%	Illinois	12.4%
Michigan	8.3	Oregon	20.3%	Virginia	11.9%
Louisiana	7.8	Massachusetts	19.7%	New Jersey	10.9%
Texas	7.4	**New York**	**17.9%**	Texas	8.3%
Vermont	7.4	Texas	16.3%	**New York**	**8.1%**
Washington	6.9	Virginia	14.9%	North Carolina	7.4%
Virginia	6.7	California	14.6%	Louisiana	7.3%
Massachusetts	6	Utah	14.4%	Washington	7.2%
North Carolina	5.9	Ohio	14.1%	Utah	6.7%
Pennsylvania	5.8	Pennsylvania	14.0%	Pennsylvania	6.4%
Utah	5.4	New Jersey	13.4%	Michigan	4.9%
Illinois	5.3	North Carolina	12.9%	Florida	2.7%
Ohio	5.3	Louisiana	12.8%	Vermont	2.5%
Oregon	5.1	Vermont	12.5%	Connecticut	2.1%
New York	**5.1**	Maine	10.0%	California	1.8%
New Jersey	4.6	Florida	6.7%	Maine	1.8%

Sources: www.statehealthfacts.org/comparemaptable.jsp?ind=418&cat=8; www.statehealthfacts.org/comparemaptable.jsp?ind=419&cat=8.

Deficiencies in certified nursing facilities can negatively impact the health and safety of residents. Deficiencies may occur in different areas of nursing home care, e.g., housekeeping, food sanitation, accident prevention, pressure sores, infection control, etc., and are associated with poor resident/patient outcomes.[29] Some deficiencies also can result in actual harm to the residents or cause immediate jeopardy to their conditions.

Return to II.D. **Facility Characteristics**
Return to II.D.iii. Facilities Characteristics– **Deficiencies in Nursing Facilities**

[29] "Nursing Facilities, Staffing, Residents and Facility Deficiencies, 2000-2006,"Department of Social & Behavioral Sciences, University of California, San Francisco.

Table 7: Percentage of Certified Nursing Facilities with Ten Most Frequent Deficiencies, 2006

State	Food Sanitation	State	Quality of Care	State	Professional Standards	State	Presence of Accidents	State	Housekeeping
US	**38%**	**US**	**30%**	**US**	**29%**	**US**	**24%**	**US**	**24%**
CA	53%	CT	55%	ME	64%	CT	38%	FL	33%
FL	53%	VA	53%	CT	62%	LA	38%	TX	30%
NC	50%	PA	52%	FL	47%	ME	33%	MI	29%
UT	47%	OR	50%	VT	45%	IL	31%	WA	28%
WA	44%	CA	40%	NC	38%	MI	30%	CA	27%
MI	41%	MI	37%	**NY**	**36%**	CA	29%	ME	27%
LA	34%	ME	34%	IL	35%	OH	22%	UT	24%
ME	34%	OH	28%	MI	32%	PA	22%	LA	21%
TX	34%	WA	26%	VA	31%	**NY**	**20%**	OH	21%
PA	32%	**NY**	**23%**	CA	30%	FL	18%	**NY**	**18%**
CT	29%	UT	23%	WA	30%	TX	18%	IL	17%
VT	28%	NJ	22%	NJ	27%	VT	18%	NC	16%
VA	28%	TX	22%	OH	25%	NJ	17%	VT	15%
OH	26%	FL	19%	MA	24%	NC	16%	CT	14%
NY	**23%**	NC	19%	UT	20%	WA	16%	PA	10%
IL	22%	MA	18%	LA	16%	UT	12%	NJ	9%
NJ	22%	VT	18%	PA	9%	MA	10%	VA	7%
OR	14%	IL	17%	OR	8%	VA	9%	MA	6%
MA	13%	LA	15%	TX	7%	OR	7%	OR	3%

The 10 most frequently cited deficiencies in the U.S. are identified by the Online Survey Certification and Reporting (OSCAR) [30] data as: presence of accidents, absence of accident prevention, absence of comprehensive care plans, lack of incontinence/urinary care, lack of food sanitation, lack of good housekeeping, absence of infection control, presence of pressure sores, lack of professional standards, and inferior quality of care. Pressure sores are areas of damaged skin and tissue that develop due to pressure, usually from a bed or wheelchair cutting off circulation to vulnerable parts of the body. Typically, people living with paralysis, bedridden individuals, persons using wheelchairs or someone who is unable to change positions without help can develop pressure sores. Nursing home residents are more at risk of pressure sores due to their acuity of illness and long period of institutionalization.

Return to II.D. **Facility Characteristics**
Return to II.D. Facilities Characteristics– **Deficiencies in Nursing Facilities**

[30] Ibid.

Table 7: Percentage of Certified Nursing Facilities with Ten Most Frequent Deficiencies, 2006 (cont.)

State	Absence of Accident Prevention	State	Pressure Sores	State	Comprehensive Care Plans	State	Incontinence / Urinary Care	State	Infection Control
US	**24%**	**US**	**20%**	**US**	**21%**	**US**	**20%**	**US**	**20%**
CT	54%	CT	38%	CT	57%	ME	44%	VT	68%
MI	36%	ME	32%	ME	53%	CA	26%	LA	36%
OH	31%	MI	23%	CA	38%	WA	24%	CA	30%
NJ	26%	VT	22%	FL	24%	VT	22%	PA	27%
CA	24%	IL	21%	TX	24%	CT	20%	**NY**	**23%**
MA	24%	WA	21%	PA	21%	FL	19%	TX	21%
PA	24%	**NY**	**20%**	LA	20%	IL	15%	MI	20%
WA	24%	OH	20%	MA	20%	OR	15%	CT	19%
IL	23%	CA	19%	UT	19%	PA	12%	FL	19%
VA	23%	VA	19%	VA	19%	MA	11%	ME	19%
NC	19%	OR	18%	VT	18%	NJ	11%	OH	15%
OR	19%	NJ	16%	WA	16%	VA	11%	WA	13%
NY	**18%**	TX	16%	NJ	15%	MI	10%	VA	12%
VT	18%	LA	14%	OH	15%	NC	10%	MA	8%
LA	16%	PA	14%	IL	12%	OH	10%	IL	7%
FL	11%	FL	10%	MI	11%	TX	9%	NJ	6%
TX	11%	MA	10%	OR	9%	**NY**	**8%**	NC	4%
ME	6%	NC	8%	**NY**	**5%**	LA	7%	OR	2%
UT	3%	UT	2%	NC	5%	UT	0%	UT	0%

Source: C. Harrington, H. Carrillo, C. Crawford, and C. LaCava, Table 35, "Nursing, Facilities, Staffing, Residents, and Facility Deficiencies, 1999 Through 2006," Department of Social and Behavioral Sciences, University of California, San Francisco; accessed May 2008 at www.pascenter.org. Based on the Online Survey, Certification, and Reporting System (OSCAR); Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services.

Return to II.D. **Facility Characteristics**
Return to II.D. Facilities Characteristics– **Deficiencies in Nursing Facilities**

Table 8: Relationship Between Estate Recovery Policies and Amount Recovered as a Percentage of LTC Spending, 2005

Types of Estate Recovery Policies	State	Total Amount Recovered	Amount Recovered as % of LTC Spending
States Making Maximum Use of Federal Policy Options	California	$56,290,075	0.7%
	Illinois	$9,669,790	0.7%
States with a Mix of More and Less Expansive Policy Options	Massachusetts	$37,919,215	1.2%
	Florida	$17,235,856	0.5%
	Connecticut	$7,297,972	0.4%
	New Jersey	$10,237,331	0.3%
	Ohio	$14,841,666	0.3%
	Maine	$986,420	0.2%
	New York	**$34,351,987**	**0.2%**
	Oregon	$1,161,185	0.1%
	Utah	$471,655	0.1%
	Virginia	$793,892	0.1%
	Louisiana	$169,437	0.0%
	Washington	$282,893	0.0%
State Implementing Minimum Required by Federal Law	Pennsylvania	$35,097,958	0.6%
	North Carolina	$7,417,825	0.3%
	Vermont	$872,387	0.3%

Notes: Information for Michigan and Texas was not available for this analysis; Percentages are rounded to the nearest whole number. Sources: http://assets.aarp.org/rgcenter/il/2007_07_medicaid.pdf; http://aspe.hhs.gov/daltcp/reports/estreccol.htm.[31]

Medicaid Estate Recovery refers to recouping the entirety or a portion of Medicaid funds used to provide care for beneficiaries from their estates after their death. The Omnibus Budget Reconciliation Act (OBRA) of 1993 enabled states to recover public funds used to pay for services for certain Medicaid beneficiaries. OBRA defines what qualifies as a recoverable estate. It also requires that states attempt to recover expenditures on Medicaid long term care services, specifically home and community based services and services provided in a nursing facility, intermediate care facility for the mentally retarded, and other medical institutions. An estate recovery process can only commence after the death of the Medicaid beneficiary. States' Medicaid estate recovery is typically a very small percentage of the total spent on long-term care services[32]]

Return to II.E.i. Medicaid Estate Recovery and Other Policy Changes – **Estate Recovery**

[31] Department of Health & Human Services; Office of Assistant Secretary for Policy & Evaluation ,"Medicaid Estate Recovery Collections," Medicaid Eligibility for Long-Term Care Benefits Policy Brief #6; September 2005.
[32] www.cms.hhs.gov/MedicaidEligibility/08_Estate_Recovery.asp, http://aspe.hhs.gov/daltcp/reports/estaterec.htm.

Table 9: Medicaid Policy Changes in Accordance with DRA 2005, as of 2007

Type of Policy Change	States That Have Made Changes as of Fall 2007	States That Have Not Made Changes as of Fall 2007	States That Do Not Need to Make Changes Because Legislation Complies	States Waiting for Approval of Legislation/Rule
State Changes to Apply Months of Ineligibility for Individuals Applying for Medical Assistance for LTC Costs	Maine Massachusetts Michigan New Jersey **New York** Oregon Texas Utah Virginia Washington	California Florida Louisiana North Carolina	Connecticut Vermont	
State Changes to Accumulate Multiple Transfers in More Than One Month and Impose a Single Period of Ineligibility into One Period	Connecticut Louisiana Maine Massachusetts Michigan North Carolina Ohio Oregon Utah Washington	Ohio Virginia	New Jersey **New York** Texas Vermont	Florida
State Changes Regarding the Purchase of Promissory Notes, Loans, and Mortgages	Connecticut Maine Massachusetts Michigan **New York** North Carolina Ohio Oregon Texas Utah Vermont Virginia	California Washington	Louisiana New Jersey	Florida
State Changes Regarding the Purchase of Life Estates	Connecticut Louisiana Maine Massachusetts Michigan New Jersey **New York** North Carolina Ohio Oregon Texas Utah Vermont Virginia	California	Washington	Florida

Note: Information for Illinois and Pennsylvania was not available for this analysis.
Source: NYSDOH staff; www.statehealthfacts.org/comparetable.jsp?ind=190&cat=4; www.nasmd.org/resources/docs/LongTermCareRpt1007.pdf.

The Deficit Reduction Act (DRA) of 2005 included provisions targeted at decreasing Medicaid long-term care spending, such as lengthening the time during which a state can "look back" to count asset transfers.

Return to II.E.ii. Medicaid Estate Recovery and Other Policy Changes – **The Deficit Reduction Act (2005)**

Table 10: Changes in Home Equity Limits in Accordance with DRA 2005, as of 2007

State Home Equity Limits	
States Not Planning to Set Limit Above $500,000	**States Planning to Set Limit at $750,000**
Florida	California
Louisiana	Connecticut
Massachusetts	Maine
Michigan	New Jersey
North Carolina	**New York**
Ohio	
Oregon	
Texas	
Utah	
Vermont	
Virginia	
Washington	

Note: Information for Illinois and Pennsylvania was not available for this analysis.
Source: www.nasmd.org/resources/docs/LongTermCareRpt1007.pdf, NYSDOH staff.

DRA 2005 Section 6014 renders those who have an equity interest in their homes greater than $500,000 ineligible for Medicaid-funded LTC services. States have the option to raise the home equity limit to $750,000. Only five states in the sample of states have a limit of $750,000.

Return to II.E.ii. Medicaid Estate Recovery and Other Policy Changes – **The Deficit Reduction Act (2005)**

Table 11: Status of Long-Term Care Partnership Programs, as of 2007

State Long-Term Care Partnership Program Progress			
Original LTC Partnership State	**LTC Partnership Expansion Grantee**	**Planned and Approved State Plan Amendment**	**No LTC Partnership Program**
California	Michigan	Florida	Illinois
Connecticut	Ohio	Virginia	Louisiana
New York	Texas		Maine
	Virginia		Massachusetts
			New Jersey
			North Carolina
			Oregon
			Pennsylvania
			Vermont
			Washington

Source: www.nasmd.org/resources/docs/LongTermCareRpt1007.pdf.

Long-term care partnership programs allow states to promote the purchase of long-term care insurance by individuals. The programs offer access to Medicaid once LTC insurance contracts are expired or if additional coverage is needed, while protecting some amount of an individual's assets and income. The original LTC partnership demonstration model began in 1992.

Return to II.E.iii. Medicaid Estate Recovery and Other Policy Changes – **Long-Term Care Partnership Program**