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## **Assisted Living Care: Extending the Promise to Low Income People**

### **Executive Summary**

The *Assisted Living Reform Act of 2004* established standards and licensure for assisted living in New York state. The legislation also allows residents to “age in place” in the Enhanced ALR model, and sets standards and licensure requirements for assisted living facilities serving specific population(s) with the Special Needs ALR. Although these new models create more opportunities to serve people in assisted living who might otherwise rely on nursing home care, these services remain largely out of reach to low-income elderly and disabled people. This proposal would address this affordability gap by developing a Medicaid funding stream to pay for assisted living health related services.

The overall objective of NYAHS’s proposal is to broaden access to assisted living for elderly and disabled New Yorkers of limited financial means by helping facilities meet current operating costs and encouraging development of more assisted living capacity. By giving facilities incentives to serve more Medicaid/SSI recipients, our proposal will forestall or prevent placements into the more expensive nursing home level of care. It will also leverage federal financial participation through Medicaid. This combination will lead to net savings for the state.

In 2005, state lawmakers increased SSI payments for qualified individuals living in adult care facilities and assisted living, an important step towards addressing the true costs of room, board and hospitality services in these facilities. This alone, however, does not resolve the financial challenge of providing assisted living to low-income people, since it does not offset the costs of providing health related services. This proposal would establish a daily Medicaid payment for personal care, medication supervision and administration, clinical assessments and health monitoring services, and enhanced Medicaid rates for special needs and enhanced care.

This proposal calls for state legislation to: (1) create a Medicaid-funded service package for basic, special needs and enhanced assisted living residents; (2) clarify that Medicaid—and not SSI—is responsible for paying for health related services in these settings; and (3) establish an annual cost of living adjustment (COLA) to the state SSI payment for residents of ACFs.

Making assisted living available to low-income people will further: (1) consumer choice and compliance with the Americans with Disabilities Act (ADA) and the U.S. Supreme Court’s landmark *Olmstead v. L.C.* decision; and (2) current reform efforts including the Commission on Health Care Facilities in the 21<sup>st</sup> Century, the nursing home “rightsizing” demonstration and the Nursing Home Transition and Diversion waiver.

NYAHS represents nearly 650 not-for-profit and public providers of continuing care services to over 500,000 elderly and disabled New Yorkers each year. If you have questions about this proposal, please contact Diane Darbyshire, NYAHS’s assisted living and community services policy analyst at (518) 449-2707, ext. 162 or [ddarbyshire@nyahsa.org](mailto:ddarbyshire@nyahsa.org); or Ken Harris, NYAHS senior housing policy analyst, at ext. 139 or [kharris@nyahsa.org](mailto:kharris@nyahsa.org).

## Introduction

Adult care facilities (ACFs) provide room and board, congregate meals, personal care, assistance with medication and activities to individuals with functional impairments associated with age and physical or mental disability. “Adult homes” and “enriched housing programs” are the two types of ACFs that serve elderly and disabled persons. Under the *Assisted Living Reform Act of 2004*, ACFs and other facilities that market themselves as assisted living providers, or that otherwise meet the definition of assisted living, must be licensed as both an assisted living residence (ALR) and an ACF. Those ACFs that are not otherwise required to be licensed as ALRs under the law may remain as ACFs. Both types of facilities are licensed and regulated by the NYS Department of Health (DOH).

NYAHSa is concerned about the availability of appropriate care alternatives for people who:

- generally require some assistance with activities of daily living (ADLs), and perhaps assistance with medication administration;
- may have a cognitive or psychiatric disability warranting 24-hour daily supervision;
- lack informal supports and caregivers (e.g., family members, friends, etc.);
- may experience issues of isolation, lack of transportation and other barriers to accessing community-based services; and/or
- are generally medically stable and not in need of care in a nursing home.

For people who fit this description, ACFs and ALRs can often be a viable and cost-effective residential care alternative. Unfortunately, inadequate funding of ACFs has, over time, led to a sharp decline in admissions of Supplemental Security Income (SSI) recipients, staffing problems, unnecessary nursing home placements and widespread ACF closures.

## Falling SSI Admissions

ACFs/ALRs are paid for services they provide mainly from SSI benefits and out-of-pocket payments from residents. The SSI category of assistance that applies to ACF/ALR residents is called SSI Congregate Care Level III.

Available census data from DOH for adult homes<sup>1</sup> show a precipitous decline in the number of SSI recipients served in adult homes between 1994 and 2004, despite an increase in the number of beds. Table 1 shows this alarming trend.

**Table 1. Decline in SSI Residents and Overall Occupancy in Adult Homes, 1994 – 2004**

|                           | 1994 <sup>2</sup> | 2004 <sup>3</sup> | Percentage Change |
|---------------------------|-------------------|-------------------|-------------------|
| <b>Facility Occupancy</b> |                   |                   |                   |
| Occupancy Percentage      | 84%               | 80%               | -5%               |
| <b>Source of Payment</b>  |                   |                   |                   |
| Private Pay               | 11,650            | 13,554            | +16%              |
| SSI                       | <b>15,114</b>     | <b>12,587</b>     | <b>-17%</b>       |

<sup>1</sup> Census figures are for adult homes only. The fiscal analysis of this proposal also includes the enriched housing program.

<sup>2</sup> New York State Department of Social Services, residential program summary, August 1994.

<sup>3</sup> DOH, *Adult Care Facilities Annual Census Report*, 2004.

As shown, the number of adult home SSI recipients fell by 17 percent from 1994 to 2004. Relative to total adult home capacity, the number of SSI recipients dropped from 47 percent to 39 percent, suggesting the occupancy decline is mostly explained by decreased SSI admission/retention. Census data from 2002 and 2004 shows the continuing trend of declining SSI occupancy in *both* adult homes and enriched housing.<sup>4</sup> In 2002, SSI recipients accounted for 47 percent of all ACF residents, and overall ACF occupancy was at 78 percent. In 2004, the percentage of SSI recipients fell further to 44 percent of all ACF residents, while overall occupancy was at 79 percent. The number of ACFs went from 527 to 513 in those two years alone. These numbers show that over time, ACFs are closing and the number of SSI recipients being served in ACFs is declining. Facilities indicate that the primary contributing factor to this decline is under-funding.

In New York, SSI is the only payment ACFs receive for providing room and board, personal care, medication supervision, transportation, recreation and other services to low-income residents. The cost of providing the mandated package of services averages **\$57 per resident day** according to data compiled in 2002.<sup>5</sup> In spite of recent state funding increases, ACFs will still lose approximately \$20 to \$25 per day for every SSI recipient they serve in 2006.

This disparity between the reimbursement rates and the actual cost of providing services for SSI residents also largely explains why the current average occupancy rate in adult homes is only 80 percent. Facilities are most often better off financially leaving beds open than filling them with SSI recipients. As shown in Table 1, overall occupancy fell by about 5 percent from 1994 to 2004.

### **SSI Increases: A Partial Solution**

The recent increase in the state portion of the SSI rate is a partial answer to this funding gap. Effective January 1, 2006, ACF residents were shifted from SSI Congregate Care Level II to Level III, and the state portion of Level III benefits is being increased in 2006 and 2007. In addition, the state typically passes through the federal COLA, increasing payments annually for inflation.

As previously noted, state law requires ALRs to be licensed as ACFs. Therefore, we presume that the SSI Level III benefits will be extended to SSI recipients residing in ALRs. This assumption will be reflected in our fiscal estimates later in this paper.

In 2006, the monthly Level III SSI benefit is \$1,128 downstate/\$1,113 upstate, which includes a \$150 recipient personal needs allowance (PNA). When the PNA is subtracted, this leaves a daily payment to the ACF/ALR of \$32.15 downstate, and \$31.66 upstate. On January 1, 2007, the state will increase its share of the benefit by the equivalent of about \$4.00 per day, thereby increasing the overall daily rates to approximately \$36.15 downstate and \$35.66 upstate (prior to any federal COLA). While these increases are helpful, they do not bridge the gap between the cost of care and the payment for SSI recipients living in ACFs or ALRs.

These increases will help to bring the SSI payment in line with room and board costs, but do not cover the cost of providing health related services. Even if operators' costs were to stay the same, ACFs/ALRs would still lose \$25 per day on average for each SSI resident they serve in 2006, annualizing to \$9,000 per SSI resident. In 2007, the losses would be \$21 per day or nearly \$8,000 per year, even if costs do not go up, which is highly unlikely. Clearly, continued operational losses of this magnitude will result in further facility closures and restrictions on serving SSI recipients.

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<sup>4</sup> DOH, *Adult Care Facilities Annual Census Report*, 2002 and 2004.

<sup>5</sup> Weighted average derived from data in *Report of the Adult Care Facility Workgroup*, October 2002, page 44.

## Limited Access for SSI Recipients

The 2002 ACF Workgroup report highlighted concerns of “limited access for low-income and SSI populations, including the mentally impaired, “despite an increase in the number of ACF beds throughout the state.”<sup>6</sup> This workgroup, comprised of various stakeholders and state agencies, issued a report to the governor and DOH in October 2002. The report evaluated the ACF model of care and made recommendations regarding various aspects of care delivery.

Of particular concern to NYAHSA is the workgroup’s finding that upstate facilities with a resident census of greater than 20 percent SSI “...appear to be suffering an annual loss.” The average upstate facility was serving 35 percent SSI recipients. The report also pointed out that the average size of facilities that closed in the last three years was 39 beds as compared to newer facilities, which average 63 beds. This too is particularly disturbing, since two thirds of not-for-profit facilities have a capacity of 40 beds or fewer.

In May 2004, NYAHSA reported that 49 ACFs had closed from 1995-99, representing a loss of 2,067 beds. Between 1999 and 2004, 80 more homes closed. NYAHSA’s report, *Closing Adult Care Facilities: Counting the Cost*, which profiled ten recently closed ACFs, showed that **39 percent of the displaced residents moved to nursing homes**. Since the May 2004 report, 45 more homes have closed, representing an additional **2,750** beds (see [Addendum A](#)).

## Lack of Access to Assisted Living Leads to Nursing Home Placements

Since 1986, New York has classified nursing home residents using a system called Resource Utilization Groups, Version 2 (RUG-II). RUG-II categorizes residents into one of 16 categories based on their functional status, medical conditions, and need for specialized treatments. RUG-II data can help identify individuals who may be able to live in ACFs or assisted living facilities.

RUG-II data from 2002 show that 26,895 people living in nursing homes fall into the lowest category, known as *Physical A*. An additional 5,162 people are classified in the next lowest category (*Physical B*). Some of these 32,057 people could have been served in ACFs or ALRs.

In its 1999 report *Assisted Living in New York: Preparing for the Future*, DOH analyzed the number of nursing home residents that could live in settings such as ACFs or assisted living. For this analysis, DOH used assessments that nursing homes complete for each resident. Four clinical screens “associated with significantly reduced risk of adverse outcomes in the near term” were applied to the MDS data. The results of this analysis are shown in Table 2.

**Table 2. DOH Nursing Home Resident Analysis, 1999**

| RUG-II Category      | Total Residents | Failed Screens      |                                  | Passed Screens      |                                  |
|----------------------|-----------------|---------------------|----------------------------------|---------------------|----------------------------------|
|                      |                 | Number of Residents | Percent of Residents in Category | Number of Residents | Percent of Residents in Category |
| Physical A           | 13,716          | 11,052              | 81%                              | 2,664               | <b>19%</b>                       |
| Physical B           | 4,275           | 3,741               | 87%                              | 534                 | <b>13%</b>                       |
| Physical C           | 26,828          | 24,426              | 91%                              | 2,402               | <b>9%</b>                        |
| Behavioral A         | 857             | 721                 | 84%                              | 136                 | <b>16%</b>                       |
| Clinically Complex A | 3,603           | 3,133               | 87%                              | 470                 | <b>13%</b>                       |
| All 16 Categories    | 116,579         | 110,373             | 95%                              | <b>6,206</b>        | <b>5%</b>                        |

<sup>6</sup> *Report of the Adult Care Facility Workgroup*, October 2002, page 46.

The DOH report concluded that, "...around 10 to 15 percent of the residents in the five lowest RUGs may have the potential for diversion to alternative settings were they available." Overall, the analysis showed that 6,206 residents, or five percent of the total population, could be served in alternative settings such as ACFs and ALRs.

Importantly, the above estimates were developed prior to the ALR legislation, which creates three levels of assisted living: a basic level nearly identical to ACF services, as well as enhanced and special needs categories. The enhanced and special needs assisted living models of care will allow ACFs to care for individuals with specialized needs and those that exceed the basic retention standards of an ACF. Given the capabilities of this new model of assisted living, the DOH estimates on nursing home diversions are likely quite low.

According to 2004 cost report data<sup>7</sup>, 38,213 people were admitted to nursing homes on a long-term basis (i.e., more than 60 days). Of the total nursing home admissions, 10,508 people were admitted from private homes or apartments in the community, and 1,300 were admitted from ACFs. Furthermore, 38 percent of the individuals admitted to nursing homes in 2004 were Medicaid-eligible. Based on current occupancy estimates, some number of these same individuals could be served in ALRs if there were proper reimbursed for them through SSI and Medicaid.

### **Assisted Living Law Fails to Address Needs of Low-income New Yorkers**

The *Assisted Living Reform Act* clarified the state's policy on assisted living. It requires providers that meet the assisted living definition to become licensed as both ACFs and ALRs. ALRs are required to meet greater standards than ACFs, including the use of resident assessments and individual service plans (ISPs). In addition, by obtaining special certificates that allow aging-in-place and programs for people with special needs such as dementia, the creation of the ALR creates more opportunities to serve people who might otherwise rely on nursing home care.

However, given the added requirements and inadequate SSI reimbursement, ALRs are unlikely to admit SSI recipients. The solution is to support existing ACF conversions to ALR, and create financial incentives for providers to admit low-income individuals into ALRs. The recent increase in SSI payments was a first step in this process. To further this important step, **NYAHSA proposes annual COLA increases to the state portion of SSI rates to keep up with increases in the costs of providing room and board and activities to residents.**

**In addition, for ACFs that are licensed as ALRs, NYAHSA proposes creating a Medicaid funding stream to pay for extra personal care needs, required clinical assessments, ISPs, medication supervision and administration, and health monitoring.** Medicaid would pay for these same services if they were delivered in other community settings, such as peoples' homes. Generally speaking, people who live in assisted living settings do so because they are unable to continue to live in their own homes, due to cognitive impairments, mental health issues or lack of informal supports. These individuals deserve to have access to the same Medicaid covered benefits afforded to those who can remain in their own homes.

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<sup>7</sup> Medicaid Residential Health Care Facility Cost Reports, 2004, obtained from New York State DOH.

## **NYAHSA Proposal: Part One**

### **Annual SSI Cost of Living Increases**

The costs of residential services—room, board, activities and meals—all increase with inflation. Because Medicaid does not reimburse for these services in ACFs, they must be met through SSI.

As previously noted, SSI recipients living in ACFs were recently targeted for a state SSI supplement increase which is occurring over a two-year period beginning this year. This immediate relief will move the SSI rate closer to actual room and board costs, and hopefully slow the rate of facility closings in the near-term. But it does not provide a long-term plan to meet the growing cost of providing residential services. **NYAHSA recommends that the state provide an annual COLA to its portion of the SSI Level III benefits, as the federal government provides each year on its share of the payment.** This would help assure that future payment levels keep pace with inflation.

## **NYAHSA Proposal: Part Two**

### **ALR Medicaid Health-related Service Package**

However, even if SSI payments meet the costs of providing residential services, they alone will not cover the true cost of ALR care, most notably the required array of health related services. Consequently, the SSI increase alone will not provide the necessary incentive for facilities to begin admitting SSI recipients.

In addition, the proposed SSI increases would not provide the funding level needed to address the added requirements that will be imposed on ALRs. More specifically, ALRs must provide resident assessments, ISPs, 24-hour supervision and monitoring. In some cases, ALRs will also provide enhanced care and/or specialty care, which carry added requirements beyond basic ALR. As a result, the new assisted living models increase the daily cost of providing care due to increased staffing levels and services, and building safety requirements.

Due to the higher cost structure and the patent inadequacy of the SSI rate, the ALR model will likely be accessible only to upper middle and middle class persons, with the enhanced and special needs ALR limited to those with significant financial means. **To ensure that low-income people also have access to ALR care, the health related services can and should be funded through the Medicaid program.**

NYAHSA recommends creating a Medicaid rate structure to reimburse ALRs for the increased personal care needs, medication management, resident assessments, ISPs and health care monitoring required of ALRs. We also propose special rates for ALRs with enhanced and/or special needs certificates.

A single, streamlined daily payment for the ALR package of services would have several advantages, including:

- administrative simplicity, which would free facility management and nursing staff to engage in more resident-centered care;
- creating a predictable and reliable funding stream for providers; and
- allowing the state and localities the ability to predict and manage spending, while reducing the financial risk inherent in cost-based fee-for-service models.

We propose that DOH work with NYAHSa and other stakeholders to develop three separate capitated daily rates for the three different levels of care—the “basic” ALR, enhanced ALR (EALR) and special needs ALR (SNALR). The basic rate may be foundation for services required in ALRs, whereas the EALR and SNALR rates would reflect the added costs of staffing, personal care and home care services required in those levels. In developing the rates, the costs of meeting the staffing requirements must fully account for resident assessments and developing/updating the ISPs. It is important to note that some of these details are still under discussion and regulations have not yet been promulgated.

NYAHSa recommends that the Assisted Living Program (ALP) rate setting methodology be used as a reference in determining how to arrive at a reasonable Medicaid rate for the ALR. Further, NYAHSa proposes that the Medicaid rate set for the ALR, EALR and SNALR, be capped at 50 percent of the local nursing home rate, as are the ALP rates. The rate must also reflect the true cost of the health related services that either must be provided by ALRs, EALRs and SNALRs under law/regulation or are otherwise consistent with standard health care practice.

Residents of enhanced ALRs, also known as “aging-in-place” programs, may need extensive health-related and skilled nursing services that can be provided directly by the ALR or coordinated by the ALR in conjunction with an outside home care agency. NYAHSa proposes a rate enhancement to the basic Medicaid ALR rate to cover the costs to meet staffing requirements and provide additional enhanced services.

Residents served in special needs ALRs require extra supervision and monitoring. Since these residents are not expected to be self-directing, they need *medication administration* rather than *medication assistance*. NYAHSa proposes a rate enhancement to the basic Medicaid ALR rate to cover the cost of additional nursing and other staff required to meet these needs.

The three rates must be realistic and fair, and based on true market costs. Otherwise, providers will not be properly encouraged to admit and retain SSI recipients, and the program will not have the intended affect of diverting or transitioning people from more costly nursing home care. For this reason, NYAHSa proposes a reporting mechanism by which providers would submit data on the cost of care to DOH. This data would help to determine whether the established ALR rates are reasonable and adequate to promote access to SSI recipients, and needed adjustments would then be made to the rates according to what is learned in that analysis. Further, regulations have not yet been promulgated, and some significant staffing issues have not yet been resolved. The resolution of such issues has the potential to impact the cost of providing care, and must be considered in arriving at a fair rate.

## **Resident Eligibility**

To assure that new state Medicaid spending for ALR services is appropriately targeted toward individuals who might otherwise need nursing home care, ALR residents would need to meet the following requirements:

- Medicaid eligibility for community-based services;
- eligibility for the basic ALR, EALR or SNALR model;
- demonstrated need for personal care and medication supervision; and
- lack of a practical alternative living arrangement in which to live safely in the community.

In addition to the above criteria, resident eligibility for Medicaid-reimbursed special needs and enhanced care would be based on the resident needs assessment and the resulting ISP.

### **SSI and Medicaid as Payors for ACF and ALR Services**

As previously noted, ACFs are paid for services they provide mainly through SSI benefits and private payments from residents. Since all ALRs must also be licensed ACFs, we presume that SSI payment rules will apply to assisted living as well. Without needed reforms, SSI will be the only public financial support in place for ALR services to indigent and low-income individuals.

Although state regulations indicate that ACFs should be staffed to provide 3.75 hours of personal care per week to each resident, they do not directly address how this personal care is to be paid for or how additional hours of care should be provided. This lack of clarity often leads county Medicaid gatekeepers to deny approval for “additional” Medicaid-covered services for ACF residents. In fact, many counties operate under the assumption that SSI covers all services needed by ACF residents, despite the fact that these individuals are much more frail and in need of personal care today than when SSI first began funding ACF care in 1974.

Since the ACF standards are the foundation of the ALR model, and public funding of ALR care has not been addressed, we predict the same payment problems will be associated with ALRs.

Policymakers and the public should be concerned about this ambiguity in the current payment structure for SSI and personal care. In effect, concern over inappropriate “billing” of two public funding sources (i.e., SSI and Medicaid) for the same services deprives SSI recipients living in ACFs, and presumably ALRs, of their rightful benefits under the law, the same benefits that individuals can receive in their own homes.

**Medicaid (not SSI) should cover all personal care, medication management by a nurse, resident assessments and health monitoring for ALR residents otherwise covered by Medicaid when delivered by home care agencies.**

ALRs are responsible for directly providing or arranging for personal and home care needs for their residents. These services would be funded through capitated rates (i.e., daily set amounts) created for ALRs, SNALRs and EALRs. The SSI payment would continue to cover residential services. Precedence for this clarification of SSI reimbursed services is evidenced in the ALP payment structure as well as residences overseen by the Office of Mental Retardation and Developmental Disabilities.

This approach is consistent with the growing trend that considers a congregate residential setting such as an ALR as a person’s home. In contrast, ALR residents who need to access Medicaid-funded health related services would face barriers that would not exist if they lived in an apartment

or their own house. These roadblocks result from the ambiguous SSI and Medicaid coverage rules and payment standards that NYAHSA's proposal would address.

## **Fiscal Analysis of Proposal**

### **The proposal would produce two cost-efficient outcomes:**

- *Medicaid savings from preventing or postponing the need for more costly levels of care.* NYAHSA estimates that increased admissions of SSI-qualified individuals to ALRs would lead to reduced Medicaid expenditures for people who would otherwise live in nursing homes. Similarly, facilities may be able to defer premature placements of such individuals in more costly levels of care. SSI recipients are categorically eligible for Medicaid.
- *Increased federal financial participation for services provided in ALRs.* State funds invested in Medicaid-covered services are "matched" by the federal government. This is a more cost-effective approach to assuring access to ALRs than relying on "unmatched" state subsidies, and would limit needed increases in the state's SSI supplement to only that which is needed to cover residential services.

Determining the financial impact of this proposal on the state requires a number of assumptions since there is no way to know how the provider marketplace will respond to either the new assisted living law or the financial incentives recommended in this proposal. The following are some conservative estimates regarding potential state savings resulting from this proposal.

According to this proposal, the highest Medicaid rate for a resident of an ALR, EALR or SNALR would be 50 percent of the nursing home rate. This maximum rate would likely apply to those residents with the highest level of care needs, in either or both the EALR or SNALR category. Under Medicaid, the state is responsible for funding approximately 40 percent of the cost of continuing care services (the "state share"), whereas county governments finance about 10 percent (the "local share"). The federal government finances the remaining 50 percent.

To estimate potential savings to the state, it necessary to look at the Medicaid rates paid for nursing home residents that could be cared for in assisted living. To calculate the daily state cost of the *nursing home rate for "light care" residents*, we adjusted the median nursing home rate<sup>8</sup> to reflect the difference in payment between the typical nursing home resident and those residents who might otherwise be appropriate for ALR care, resulting in a daily rate of \$146.43.<sup>9</sup> The state share is \$58.57 per day.

Fifty percent of the average nursing home Medicaid rate for "light care" residents is \$73.22, which is the approximate ALP rate for the five lowest RUG categories averaged together. The state portion of this average ALP daily rate is \$29.29. This average ALP rate is used as a reference because, like ALP rates, the proposed ALR rate would be capped at 50 percent of the nursing home rate. These numbers are thus used to develop estimates of the fiscal impact of this proposal.

Given that we are proposing that SSI pay for ALR residential services, we must also factor in the state contribution to the SSI payment to fully capture the state's cost. The state share for individuals in SSI Level III is \$525 per month downstate and \$510 for the rest of the state. For the

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<sup>8</sup> We used the 2005 median Medicaid rate for geriatric care (i.e., excluding specialty care rates, which are considerably higher). Inflated to 2006 dollars, this rate is \$175.96 per day, and reflects the care needs of average nursing home residents.

<sup>9</sup> For this purpose, we used the case-mix indices for the five RUG-II categories identified in Table 2.

purpose of this analysis, we will use an average of the two figures and presume that the average monthly state contribution for each SSI recipient is \$517.50, or \$17.01 per day.

As above, the state share of the average ALR rate is \$29.29 which, when added to the daily SSI state contribution of \$17.01, results in an average total state cost of \$46.30 per day. The state share of the average nursing home rate for similar residents is \$58.57; therefore, the state would save a *minimum* of \$12.27 a day for every Medicaid eligible individual residing in an ALR who otherwise would have been in a nursing home. This is a conservative estimate, however, as this is based on the highest possible Medicaid rate for all three levels of the ALR. This proposal caps the Medicaid rate at 50 percent of the nursing home rate; individuals with more basic needs and thus a lower daily Medicaid rate would show a higher daily savings to the state. The cost-effectiveness of this proposal relies on keeping low-income residents in ALRs (and ACFs that could convert to ALRs) that would otherwise close without further funding reforms, as well as transitions and diversions of individuals from nursing home placement to ALRs.

#### *Retention of Residents in ALRs*

To illustrate the potential state share cost of this proposal, we used 2004 census data from DOH, which identify 11,373 SSI recipients living in ACFs and 10,821 individuals with mental illness residing in ACFs. If we presume that all 10,821 of the mentally ill residents are SSI recipients, this leaves an estimated 552 SSI recipients residing in ACFs who are frail elderly and would be appropriate for ALR services. Again, this is a conservative estimate.

Based on NYAHSA's 2004 report, 39 percent of residents in ACFs that closed were transferred to nursing homes. Applying this percentage to the 552 frail elderly still living in ACFs, we can estimate that approximately 215 of these residents would go to nursing homes if the facilities they live in close or are no longer able to serve SSI recipients. Again, SSI recipients are categorically eligible for Medicaid covered services. If we multiply that number of frail elderly that could be retained in an ALR (i.e., 215) by the maximum state share of the Medicaid ALR rate (\$29.29) and 365 days, **the result is an estimated annual state cost for ALR services of \$2.3 million<sup>10</sup>.**

To compare this cost to the annual cost of nursing home care for the same individuals, the state share of nursing home Medicaid payments of \$4.6 million a year (i.e., \$58.57 x 215 x 365) would be reduced by \$1.3 million (i.e., \$17.01 x 215 x 365) to reflect the state share of the Level III SSI payment that would occur in the ALR. The net annual state cost of having these individuals in a nursing home level of care is thus \$3.3 million. **Put simply, the state would save approximately \$1 million per year to retain these individuals in the ALR level of care.**

#### *Transition and Diversion of Residents from Nursing Homes to ALRs*

In Table 2, we showed 1999 DOH estimates that over 6,000 nursing home residents could be cared for in assisted living. While there may be disagreement on this number, the potential for transition is there. In addition, DOH's recent Nursing Home Transition and Diversion waiver<sup>11</sup> application to the federal government estimates that 1,000 individuals would be enrolled in the first year alone.

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<sup>10</sup> The state contribution for the SSI rate is not a new cost and is therefore not factored in; these individuals are assumed to already be receiving SSI Congregate Care Level III benefits.

<sup>11</sup> DOH has submitted a waiver application to the Centers for Medicaid and Medicare to create a Nursing Home Transition and Diversion waiver. The waiver would provide an array of services to Medicaid eligible individuals aged 18 or over and in need of a nursing home level of care to enable them to be diverted from or transitioned out of nursing homes in the state.

When considering the implications of these figures, along with potential outcomes from nursing home “rightsizing,”<sup>12</sup> we conservatively estimate that our proposal could result in 500 transitions of Medicaid eligible individuals from nursing homes to ALRs. We also estimate that approximately 500 SSI recipients living in the community could be diverted from nursing home to ALR placement under our proposal.

To determine the state cost of transitioning individuals from nursing homes to ALRs, we must multiply the total estimated transitions (500) by the estimated state share of Medicaid and SSI payments (i.e., \$46.30 per day) and annualize it. The maximum annual state cost for this group of individuals to reside in ALRs would be approximately \$8.4 million. If these individuals were to remain in nursing homes, the annual state cost would be \$10.7 million (\$58.57 x 500 x 365 days). **The state would thus save \$2.3 million annually if 500 SSI/Medicaid recipients were transitioned from nursing homes to ALRs.**

In considering the impact of diverting SSI recipients living in the community from nursing home to ALR placement, we must look at a variety of factors. The state share contribution of SSI payments for those individuals living in the community is \$87 per month for someone living alone, and \$23 per month for someone living with others. To calculate an average state cost for these individuals, we will average the two for an average payment of \$55 per month, or \$1.81 per day. If we subtract this amount from the average daily state cost of the proposed ALR package, \$46.30, we arrive at a net daily state cost of \$44.49 per person. Thus, the maximum annual state cost under our proposal for 500 SSI recipients entering ALRs from the community would be \$8.4 million (\$44.49 x 500 x 365 days). This estimate does not factor in the Medicaid covered community services that many of these individuals are likely receiving (which could duplicate what an ALR would provide), and thus is a conservative estimate of actual new Medicaid cost.

If these same 500 individuals went into nursing homes, the added state cost would be \$10.4 million (i.e., \$58.57 x 500 x 365 days minus SSI Level 1 payments of \$1.81 x 500 x 365 days). **The estimated annual state savings for these nursing home diversions, thus, is \$2 million (\$10.4 million minus \$8.4 million).** This estimate is conservative, since it doesn’t account for the cost of Medicaid covered services these individuals were receiving when living in the community.

### *Summary of Fiscal Estimates*

Table 3 compares the state share cost for retention, transition and diversion of individuals. It summarizes the estimated annual savings that the state would realize based on the cost differences and assumptions explained above.

**Table 3. Estimated Annual State Share Savings From ALR Retention and Nursing Home Transitions and Diversions**

| <b>Factor</b>                           | <b>Retention in ALR Models</b> | <b>Transitions from Nursing Homes to ALRs</b> | <b>Diversions from Nursing Homes to ALRs</b> | <b>Totals</b>  |
|---|--------------------------------|---|--|----------------|
| Number of SSI/MA recipients             | 215                            | 500   | 500  | 1,215          |
| Annual state cost for nursing home care | \$3.3 million                  | \$10.7 million                                | \$10.4 million                               | \$24.4 million |

<sup>12</sup> State legislation enacted in 2005 authorizes a demonstration program allowing nursing homes to voluntarily reduce up to 2,500 beds statewide. Conversion to assisted living is among the options available to participating nursing homes.

|                                    |                    |                      |                      |                      |
|------------------------------------|--------------------|----------------------|----------------------|----------------------|
| Annual state cost for ALR services | \$2.3 million      | \$8.4 million        | \$8.4 million        | \$19.1 million       |
| <b>Net Savings to State</b>        | <b>\$1 million</b> | <b>\$2.3 million</b> | <b>\$2.0 million</b> | <b>\$5.3 million</b> |

As the chart highlights, our proposal results in savings for each group, resulting in an **estimated total savings to the state of \$5.3 million per year**. As noted above, there are many factors that lead us to believe this is a conservative estimate of savings to the state.

### Factors Critical to Success of this Proposal

The proposal rests on critical success factors, which we believe exist:

1. *There is enough “room” in ACFs for the diverted individuals.* There must be a sufficient number of vacant and certified ACF/ALR beds to accommodate the diversions to ACFs/ALRs instead of nursing homes. DOH census data from 2004 show an average occupancy rate for all adult homes and enriched housing programs of 80 percent. This means that approximately 6,000 ACF beds are empty on any day throughout the state.
2. *As initiatives and funding in the state for home and community-based care grow, concern about the “woodwork effect” is diminished.* At present, the state is clearly focusing its efforts on “rightsizing” nursing homes and building community-based services as a care alternative and a way to promote independence and self-determination. Programs such as the Long Term Home Health Care Program (LTHHCP), the Program Of All-Inclusive Care for the Elderly (PACE), and adult day health care are examples of existing programs that have successfully maintained individuals in the community who might otherwise need nursing home placement. The Nursing Home Transition and Diversion Waiver, currently under development, is another plan to meet the same end. The ALR can actually work in tandem with this waiver, allowing an individual in receipt of waived services to live in the ALR. In addition, the long term care point-of-entry initiative, also in development, is intended to give consumers more information about service options, and assistance in navigating the system.

These new programs and funding streams, along with existing services, will help those individuals who have a viable support system and adequate housing to remain in the community. Based on years of working with consumers, NYAHSAs and its members believe that individuals who *can* stay home *will*. In spite of these additional resources, funding and support, it is unlikely that individuals will move into an ALR simply because the funding is there. It can be expected that consumers who choose to live in an ALR do so because it is necessary to meet their needs.

Furthermore, the Commission on Health Care Facilities in the 21<sup>st</sup> Century has conducted an analysis of services on a county level, throughout the state<sup>13</sup>. The Commission has identified that there is an undersupply of home and community-based services and intermediate care (i.e. assisted living, ACF) in most regions of the state to accommodate the individuals they believe could be transitioned out of nursing homes. Without needed reforms, the problem identified by the Commission is compounded by the fact that many Medicaid eligible individuals who could be transitioned out of nursing homes will not have

<sup>13</sup> Analysis of the Commission on Health Care Facilities in the 21<sup>st</sup> Century, *Long Term Care Re-Structuring Opportunities by County and Region*.

a viable discharge option they can access or afford. Our proposal creates a viable option to support the aims of the Commission.

### **Legislative Recommendation**

NYAHSa urges lawmakers to empower ALRs to accept and retain more SSI recipients who would otherwise be served in more expensive care settings. This proposal would require legislative authorization to: (1) provide an annual COLA increase in the state SSI supplement for Congregate Care Level III benefits to keep up with growing residential services costs; (2) create a Medicaid-funded service package for eligible ALR residents, including residents in special needs and enhanced assisted living; and (3) clarify that Medicaid—and not SSI—is responsible for paying for health related services provided in ALRs.

NYAHSa is available to address any questions or concerns on this proposal. Please contact Diane Darbyshire at [ddarbyshire@nyahsa.org](mailto:ddarbyshire@nyahsa.org) or 518-449-2707, ext. 162. for this purpose

## Addendum A—List of ACFs Closed/Closing From May 2004 to November 2005<sup>14</sup>

| Facility  | Location        | County      | # of Beds |
|---|-----------------|-------------|-----------|
| Adirondack Manor                                      | Mannsville      | Jefferson   | 19        |
| Andrew Freedman                                       | Bronx           | Bronx       | 100       |
| Arbor Manor Retirement Home                           | Horseheads      | Chemung     | 22        |
| Atlantic  | Long Beach      | Nassau      | 200       |
| Bayport   | Bayport         | Suffolk     | 26        |
| Bay Shore Adult Home                                  | Bayshore        | Suffolk     | 42        |
| Bethany Methodist                                     | Brooklyn        | Kings       | 30        |
| Blakemore West  | Elmira          | Chemung     | 15        |
| Braley Home for Adults                                | Altmar          | Oswego      | 13        |
| Brighton Home For Adults (in the process of closing ) | Long Beach      | Nassau      | 130       |
| DePaul Home for Adults Parkside (Converted to SRO)    | East Rochester  | Monroe      | 169       |
| Eagle's Nest  | Niagara Falls   | Niagara     | 14        |
| Faith Adult Home                                      | Ossining        | Westchester | 14        |
| Family Lodge Adult Home                               | West Sayville   | Suffolk     | 64        |
| Family Promise  | Angola          | Erie        | 40        |
| Garden View Manor                                     | Otego           | Otego       | 30        |
| Golden Villa  | Lake Ronkonkoma | Suffolk     | 29        |
| Henry Perkins Home                                    | Riverhead       | Suffolk     | 120       |
| Holiday Manor   | Lindenhurst     | Suffolk     | 20        |
| Holy Family Home                                      | Williamsville   | Erie        | 85        |
| House of Hope   | Wyandach        | Suffolk     | 14        |
| Hylan Manor   | Staten Island   | Richmond    | 62        |
| Inver Adult Home                                      | Lindenhurst     | Suffolk     | 38        |
| Johnson Home at Seneca Falls                          | Seneca Falls    | Seneca      | 23        |
| King David  | Long Beach      | Nassau      | 227       |
| Little Flower   | Babylon         | Suffolk     | 69        |
| Long Beach Atlantic Home for Adults                   | Long Beach      | Nassau      | 200       |
| Lyons Restorium Home for Adults                       | Lyons           | Wayne       | 17        |
| Maplecrest Manor                                      | Hornell         | Steuben     | 24        |
| Millcrest Rest Home                                   | Yaphank         | Suffolk     | 16        |
| Mill View Adult Home                                  | Waterford       | Saratoga    | 40        |
| Montauk Manor   | Lindenhurst     | Suffolk     | 30        |
| Mercy Gardens   | Islip           | Suffolk     | 26        |
| Park Lake Rest  | Lake Ronkonkoma | Suffolk     | 46        |
| The Pearl   | Albany          | Albany      | 88        |
| Pillars   | Rochester       | Monroe      | 34        |
| Rutger House  | Utica           | Oneida      | 23        |

<sup>14</sup> Listing courtesy of the Empire Association of Adult Homes and Assisted Living Facilities, and NYS Department of Health.

| <b>Facility</b>                                       | <b>Location</b> | <b>County</b>          | <b># of Beds</b> |
|---|-----------------|------------------------|------------------|
| Savoy Boro Park                                       | Brooklyn        | Kings                  | 105              |
| South Country Adult Home                              | East Patchogue  | Suffolk                | 172              |
| St. Cabrini Adult Care Home                           | West Park       | Ulster                 | 71               |
| St. Joseph's Villa                                    | Catskill        | Greene                 | 60               |
| Sterling Glen of Forest Hills (in process of closing) | Forest Hills    | Queens                 | 90               |
| Valehaven Mannsville                                  | Mannsville      | Jefferson              | 19               |
| Valley View Manor                                     | Olean           | Cattaraugus            | 16               |
| Virginia Del Torro                                    | Manhattan       | New York               | 50               |
| Westchester Jewish EHP #1                             | White Plains    | Westchester            | 8                |
|   |                 | <b>Total # of Beds</b> | <b>2,750</b>     |

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