GATEWAY TO GLOBAL AGING DATA

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Gateway Policy Explorer: Long-Term Care Series

New York, USA

Long-Term Care In-Kind Benefit Plan Details

1992-2023

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Preface

This document is intended for researchers who want to understand the evolution of policy or the policy in place at a particular point in time. This document is not intended for financial advice or to aid in decision-making. The authors have made significant effort to identify and collect historical information pertaining to these policies, to accurately represent these policies, and to communicate how policies may interact to determine legal requirements, eligibility for benefits, and/or benefits levels. The policies presented in this document focus on rules applicable to most individuals aged 50 and older from 1992. Many systems include special policies or alternative eligibility rules for specific groups. We encourage all users to complete their own review of literature in this area depending on the research questions they have in mind.

If you have feedback or questions or identify an error, please contact policy@g2aging.org.

Background — *Gateway Policy Explorer: Long-Term Care Series*

The *Gateway Policy Explorer* (http://g2aging.org/policy-explorer) is part of the Gateway to Global Aging Data (http://g2aging.org) project. The *Long-Term Care Series* captures historical policy that affects the birth cohorts of respondents in the surveys covered by the Gateway. It was motivated by the rapid evolution of policies affecting older people across the world. As the Health and Retirement Study (HRS) began in 1992 and many of the international network of studies (HRS-INS) cover more than a decade, understanding the policies in place at the time of the survey has become more demanding for researchers.

Why are we tracking past policy? Individuals make choices based on current policies and the outcomes we see today may reflect responses to past policies. When interpreting the survey responses of individuals, an understanding of the policy environment under which those individuals operate is critical. The collection of contextual information in the *Gateway Policy Explorer* aims to support researchers who want to understand or use policy changes in their research and provide context for longitudinal or cross-country differences. Over the period 2023–2026 the *Gateway Policy Explorer* will be expanded to include information on retirement, long-term care, education, and other policies affecting the life cycle.

The key dimensions to the *Gateway Policy Explorer: Long-Term Care Series* are country and time. In the United States, policy is reported at the state level. We prioritize data collection for each country or state based on its first interview wave and are continuing to expand our data collection back in time to 1992, the earliest survey date in the HRS-INS.

A separate document, like this one, is developed for each country or state and each broad category of policies covered in the *Gateway Policy Explorer: Long-Term Care Series*.

New York, USA

In-Kind Benefits

Plan details 1992-2023 * †

Public long-term care (LTC) benefits in New York are primarily provided by Medicaid, a public health insurance program for low-income individuals. Enrollment in Medicaid is voluntary.

In New York, LTC services are primarily provided as in-kind benefits. LTC benefits vary by program, with separate programs for home-based care, semi-residential care, residential care, and some that cover a variety of care. Programs may vary in eligibility criteria.

Since 1992, New York's Medicaid LTC system has been subject to three major policy reforms: the approval of the 1997 Partnership Plan which established the Managed Long-Term Care program, the initiation of the Medicaid Redesign Team (MRT) in 2011 that required mandatory managed care enrollment, and the MRT II in 2020 that sought to control growing Medicaid expenses.

Key Dates

First law: 1965

Major changes since 1992: 1997, 2011, 2020

Contents

* If you have questions or suggestions, please contact policy@g2aging.org.

† Detailed information and definitions are provided in tables, formulas and a glossary at the end of this document. To facilitate switching back and forth, this document is designed with hyperlinks. Most PDF readers have shortcuts that permit a reader to return to the previous location after selecting a hyperlink. In Adobe Acrobat on a PC: "Alt" + "←"; In Adobe Acrobat on a MAC: "command" + "←"; In Preview on a MAC: "command" + "[".

Chapter 1: Policy enacted 1992-1996

Overview

Long-term care (LTC) benefits in New York are primarily provided by Medicaid, a public health insurance program for low-income individuals. Medicaid in New York is administered at the state level by the New York State Department of Health (NYSDOH), and enrollment is voluntary.

Eligibility for Medicaid is determined by eligibility tracks that may have different requirements, such as income and asset limits. LTC benefits in New York are mostly provided through state plan benefit programs (Personal Care Services Program - PCSP, Home Health Services, Nursing Facility Care), or through federally approved home-and community-based services (HCBS) LTC programs (Long-Term Home Health Care Program - LTHHCP).

Beneficiaries receiving state plan benefits must establish medical necessity for each service prescribed by a physician. PCSP and Home Health services provide home care for beneficiaries that have established medical necessity, while Nursing Facility Care only provides care in a nursing home. State plan benefits are not mutually exclusive, and a beneficiary may receive multiple benefits if eligible. Once a specific state plan benefit is determined to be medically necessary, the beneficiary may immediately receive care. People covered by the LTHHCP are able to receive a variety of LTC benefits in addition to services under the state plan if deemed medically eligible, such as social adult day care (SADC). Those applying for the LTHHCP are not immediately guaranteed care, as the program has a strict enrollment limit. If the program is at capacity, individuals are placed on a prioritized waiting list.

Benefit programs vary in dependence requirements. PCSP and Home Health require the individual to have a medical necessity for services, while Nursing Facility and LTHHCP beneficiaries must meet a nursing facility level of care (NFLOC) based on a comprehensive assessment before admission.

During this policy period, the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996 restricted most legal immigrants entering the United States after August 22, 1996 from receiving federally funded Medicaid (and some other public assistance) for at least five years after immigration.

Statutory basis

Federal Law for Medicaid: 42 U.S.C. 1396-1 to 1396w-5, Title XIX of the Social Security Act (SSA, 2023d)

New York Law for Medicaid

- N.Y. Comp. Codes R. & Regs. Tit. 10 - Department of Health (NYCCRR, 2023)
- N.Y. Comp. Codes R. & Regs. Tit. 18 - Department of Social Services (NYCCRR, 2023)

Financing

Source of financing

Funding for Medicaid is split between federal and state financing. The federal government matches state spending for individuals eligible for services, and the matching rate is determined by a formula based on a state's per capita income relative to other states, called the Federal Medical Assistance Percentage (FMAP). The federal share for New York Medicaid spending on beneficiaries in fiscal year 1992 was 50.0%. See Table 1 for historical FMAPs. The standard FMAP applies to most Medicaid spending (50.0% in 1992), though there are exceptions for certain administrative functions that may receive a higher federal matching rate.

Coverage

This section discusses the scope of risks covered and the requirements to be eligible for benefits when the need for care arises. Dependence requirements are discussed in the later section on *Benefit Eligibility*.

Risk covered definition

Medicaid LTC serves individuals with limited income and assets who need assistance with physical, functional, and cognitive impairments and/or other limitations of daily living that may prevent them from being fully independent. For example, many individuals pursue LTC for assistance with activities of daily living (ADLs), which are fundamental tasks like eating, dressing, and showering. If the beneficiary is eligible, Medicaid will also pay for 24-hour care in a nursing facility.

Eligible population

There exist several LTC benefits and programs under Medicaid, many of which have age or dependence-related eligibility requirements that must be met before service authorization or program enrollment. However, all benefits and programs first require eligibility for Medicaid. Here we detail eligibility for New York Medicaid, followed by additional requirements for specific benefits and programs under Medicaid.

Medicaid

States are federally required to provide Medicaid coverage to certain categorical populations, called the mandatory categorically needy. While there are many groups within this track (e.g., pregnant women, children), we only detail eligibility information for categories that are most likely to require LTC (e.g., aged or disabled individuals). Additionally, states may opt in to cover additional categorical populations, called the optional categorically needy. There is substantial variation in who is covered as optional categorically needy across states. Here we detail the eligibility criteria for the most relevant eligibility tracks and coverage groups in New York.

Eligibility for Medicaid in New York for people needing LTC services is primarily attained by satisfying at least one of 2 alternative eligibility tracks:

Eligibility Track 1: Mandatory Categorically Needy

- 1a. Supplemental Security Income (SSI) recipients
  - Income requirements: Monthly income may not exceed the maximum SSI benefit amount.[1] In 1992, the monthly federal benefit amount was $422 for an individual and $633 for a couple (SSA, 2023a). See Table 2 for historical monthly benefit amounts.
  - Asset requirements: Resources may not exceed $2,000 for an individual and $3,000 for a couple. This standard has remained the same since 1989.
    - Asset transfer: With some exceptions, applicants who dispose of resources or income for less than fair market value on or after the look back date will be subject to a period of ineligibility for LTC services (18 NYCRR S360-4.4, 1992).[2]
  - Citizenship/immigration requirements: The applicant must be a New York resident and a U.S. Citizen or non-citizen who meets additional eligibility requirements.[3] After 1996, the applicant must be a U.S. citizen or a qualified non-citizen, such as a lawfully admitted permanent resident, refugee admitted under Section 207 of the Immigration and Nationality Act (INA), or someone granted asylum under Section 208 of the INA —individuals who entered the United States on or after August 22, 1996, are ineligible for SSI and Medicaid for the first 5 years as a lawfully admitted permanent resident. See SSA (2023c) for additional information.
  - Other requirements
    - The individual must be at least age 65, blind, or disabled.[4]

Eligibility Track 3: Medically Needy

- 3a. Aged, blind, or disabled
  - Income requirements: In order to be eligible under the medically needy track, individuals must "spend down" their excess income to meet a specific standard. This functions similar to a deductible. The monthly spend down amount in 1992 was equal to 85% of the federal poverty level (FPL), or $509 for an individual and $742 for a household of two (CMS, 1992). Additional income disregards exist if a person is institutionalized and has a spouse residing in the community.[5]
  - Asset requirements: Resources may not exceed $3,050 for an individual and $4,450 for a household of two (OTDA, 1992a). Additional asset disregards exist if a person is institutionalized and has a spouse residing in the community.[6]
    - Asset transfer: Same as eligibility track 1a.
  - Citizenship/immigration requirements: Same citizenship requirements as eligibility track 1a.
  - Other requirements
    - The individual must be at least age 65, blind, or disabled.[4]

Other Eligibility Tracks

There exist alternative eligibility tracks targeted at other populations. Some of these tracks include:

- Medicaid Cancer Treatment Program: Breast, Cervical, Colorectal, and Prostate Cancer: Medicaid program for eligible persons who are found to be in need of treatment for breast, cervical, colorectal, or prostate cancer that provides full Medicaid coverage for a period as determined by the type of cancer or pre-cancerous condition being treated (NYSDOH, 2014).

Once eligibility for Medicaid has been determined, beneficiaries may have to meet additional eligibility criteria in order to become eligible for specific LTC health benefit programs under Medicaid. Additional program criteria (if applicable) is detailed below.

Personal Care Services Program (PCSP), Home Health Services, Nursing Facility Care
There are no additional conditions for coverage. Benefit qualification depends on minimum level of dependence.

Long-Term Home Health Care Program (LTHHCP)
Beyond meeting minimum level of dependence requirements, applicants must be at least age 65 or disabled. If the program has reached enrollment capacity, the applicant will be placed on a waiting list until a spot becomes available.

Other community-based programs
There exist several home and community-based services (HCBS) programs targeted at older adults that are omitted due to limited enrollment. Some of these programs include:

- Adult Day Health Care (ADHC)
- Private Duty Nursing
- Traumatic Brain Injury (TBI) Program —Began in 1995

Benefit

Home care benefit

PCSP
The PCSP provides personal care services, which include (18 NYCRR 505.23, 1992):

- Level 1: Assistance with IADLs, such as personal laundry, light housekeeping, shopping, meal preparation, and medication administration
- Level 2: Assistance with ADLs, such as eating, toileting, bathing, grooming, dressing, ambulation, and transferring

If the beneficiary is only receiving Level 1 services, care is limited to 12 hours per week.

Home Health Services
Home Health provides (18 NYCRR 505.23, 1992):

- Skilled nursing services: Intermittent or part-time nursing services, such as colostomy and ileostomy care, tracheotomy aspiration, Levin tube care, provided by a registered nurse or licensed practical nurse
- Home health aide services: Semi-skilled care, such as simple wound care, vital monitoring, and personal care

Nursing Facility Care
Nursing Facility Care does not provide home care during this policy period.

LTHHCP
The LTHHCP provides the following services in addition to those offered under the state plan, unless otherwise noted:

- Personal care services: Referred to as home and community support services under LTHHCP, personal care, oversight, and supervision beyond what is provided under the state plan
- Private duty nursing: Skilled nursing interventions on an individual and continuous basis (in contrast to intermittent) and respiratory care for participants who are ventilator dependent

Semi-residential care

PCSP, Home Health Services, Nursing Facility Care
These programs do not provide semi-residential care during this policy period.

LTHHCP
Semi-residential services may vary by provider, but can include:

- Social Adult Day Care (SADC): Centers that provide functionally impaired older adults with socialization, supervision and monitoring, personal care, and nutrition in a protective setting

Residential care

PCSP, Home Health Services, LTHHCP

These programs do not provide residential care during this policy period.

Nursing Facility Care

The state plan provides residential care in skilled nursing facilities (SNFs) and health-related facilities (HRFs) (NYCRR, 1990).[7] An SNF provides care to those requiring high levels of medical, social, and/or rehabilitation services. An HRF cares for residents that are more functionally independent than those residing in an SNF.

Other benefits

New York Medicaid provides additional benefits related to LTC:

- Durable medical equipment and supplies: Items that assist with an illness or injury, and may include walkers, wheelchairs, suction pumps, bandages, or similar aids —this is a required benefit under Home Health Services
- Non-emergency medical transportation: Medically necessary transportation for any recipient and personal care attendant or escort, if required, who have no other means of transportation available to any Medicaid-compensable service for the purpose of receiving treatment, medical evaluation, or therapy

LTHHCP

LTHHCP provides the following services in addition to those offered under the state plan, unless otherwise noted:

- Case Management: Services that assist the participant in developing, authorizing, and monitoring the plan of care
- Congregate and home-delivered meals: Delivers healthy meals to the beneficiary's home or in a group setting
- Personal emergency response systems (PERS): The installation and monitoring of electronic devices that allow enrollees at high risk of institutionalization to secure help in an emergency
- Respite: Services provided to participants unable to care for themselves that are furnished on a short-term basis because of the absence of or need of relief for those persons normally providing care for the participant
- Medical Social Services: Counseling service provided to the participant who is coping with altered abilities and skills, a revision of long-term expectations or changes in roles in relation to significant others
- Home maintenance
- Home improvement or adaptations: Physical adaptations to the home, which are necessary to assure the health, welfare and safety of the participant
- Moving assistance: Services intended to transport a participant's possessions and furnishings when they must be moved from an inadequate or unsafe housing situation to a viable environment that alleviates the risk of unwanted nursing home placement
- Transportation to and from semi-residential services

Provision of care

Medicaid benefits may be provided by non-profit organizations, home health agencies, hospitals, nursing facilities, and for-profit providers, all of which are licensed and overseen by the New York State Department of Health. Providers that accept Medicaid payment rates and meet licensing requirements may participate in Medicaid. Managed care plans will have limited provider networks.

Benefit eligibility

Qualifying period

Potential users may apply at any time.

Minimum level of dependence

The minimum level of dependence varies by LTC health benefit program. The details of the four largest programs are summarized below.

Personal Care Services Program (PCSP)

The beneficiary may receive personal care services if they are medically necessary (OTDA, 1992).

Home Health Services

The beneficiary must require skilled nursing services on a part-time or intermittent basis, be confined to the home, and services must be provided under a physician's plan of care (OTDA, 1992b).

Nursing Facility Care

The beneficiary must meet a nursing facility level of care (NFLOC) determined by the Long-Term Care Placement Medical Assessment Abstract (DMS-1). A DMS-1 score of 60 or greater indicates an individual is eligible for nursing facility care. An indicator score of 60-179 equates to a proxy calculation for a lower level of care in an HRF. A score greater than 180 indicates an SNF level of care (Medicaid.gov, 2013).

LTHHCP

The beneficiary must meet an NFLOC determined by the DMS-1 in order to be admitted to the program. A DMS-1 score of 60 or greater indicates an individual has met the level of care for admission (UHF, 2009).[8]

Duration of benefit

Reassessments of eligibility vary by LTC health benefit program. Below we detail reassessments for Medicaid, followed by reassessments for the four largest programs.

Medicaid

Federal law requires states to renew Medicaid eligibility at least every 12 months.

PCSP

Services must be reauthorized every 6 months (NYSDSS, 1980). However, there are some exceptions that allow for an authorization period of up to one year (18 NYCRR 505.14, 1991). The nurse assessment must be readministered every 6 months and/or when the beneficiary's needs may have changed (e.g., after a hospitalization). The social assessment must be readministered every 12 months (UHF, 2009).

Home Health Services

The beneficiary's physician must review the plan of care every 60 days (42 CFR 440.70, 1992; 42 CFR 440.70, 1997).

Nursing Facility Care

A review of medical necessity must be made every 30 days for the first 90 days that a patient is in a SNF or every 90 days thereafter, and at least every 6 months for patients in a HRF (18 NYCRR 505.9, 1991).

LTHHCP

Participants must be reassessed using the Long-Term Care Placement Medical Assessment Abstract (DMS-1) at least every 120 days (18 NYCRR 505.21, 1990).

Means testing

In-kind benefits are means-tested. Depending on the eligibility track used to qualify for Medicaid, the income and asset limits may differ.

Age requirement

There is no age requirement for Medicaid. Age would only impact the eligibility track used to qualify for Medicaid.

PCSP, Home Health Services, Nursing Facility Care

There is no age requirement.

LTHHCP

The individual must be at least age 65 or disabled.

Care needs assessment

Definition of dependence

Definitions of dependence vary by LTC health benefit program. The details of the four largest programs are summarized below.

PCSP

The local social services district may only consider authorizing personal care services when such services are medically necessary. Determination of medical necessity is the responsibility of the assessing nurse and is based upon his/her professional judgment in consultation with the physician and/or physician's order, the social assessment, and any other information deemed relevant in making that determination.

Next, before services may be authorized, the health and safety status of the applicant must be determined. Participants must be at least one of the following: self-directing, able to call for help, able to be left alone, or have available informal supports (OTDA, 1992b). Definitions of each of these criteria are detailed in Box 4.

Finally, participants must satisfy each of the following:

1. Have a stable medical condition, meaning there is no recent history of threatening changes in health status
2. Need some or total assistance with at least one paraprofessional health-related task (e.g., assistance with medicals or simple dressing changes), one ADL (e.g., bathing, eating, dressing, toileting, and transferring), or one IADL (e.g., transportation, shopping, laundry, or meal preparation)
3. Must not require skilled nursing or therapy (this would refer them to Home Health)

Home Health Services

A patient may receive home health services if their health and supportive needs can be met safely and adequately at home and their condition requires the services. In determining whether a prospective patient's health and supportive needs can be met safely at home, the patient must meet at least one of the criteria for PCSP listed above and defined in Box 4.

Additionally, home health is covered for beneficiaries whose conditions do not require continuous skilled nursing care, but do require skilled care on an intermittent basis in the home for the treatment of an injury, illness, or disability

Nursing Facility Care

Applicants must meet an NFLOC in order to be admitted to a nursing facility. An NFLOC is met if the applicant receives a DMS-1 score of 60 or greater. An indicator score of 60-179 equates to a proxy calculation for a lower level of care (HRF). A score greater than 180 indicates a SNF level of care (Medicaid.gov, 2013).

LTHHCP

Applicants for the LTHHCP must meet an NFLOC, meaning that they would require admission to a nursing facility if not for the existence of the LTHHCP. This is determined by the DMS-1, which follows the same level of care process as detailed above for nursing facility care. A score of 60 or higher indicates an NFLOC.

Evaluation of dependence

Evaluations of dependence vary by LTC health benefit program. The details of the four largest programs are summarized below.

PCSP

Individuals applying for the PCSP have four functional eligibility components: (1) physician's order, (2) nursing assessment, (3) social assessment, and (4) the Home Assessment Resource Review Instrument (HARRI) (NYSDSS, 1980; OTDA, 1992b).

All applicants must have a physician's order certifying the need for personal care services based on a medical examination. The order includes the patient's medical condition and regimens, including any medication, and the patient's need for the services (NYSDOH, 1992).

Next, individuals must have a nursing assessment completed by a registered nurse. The assessment must be conducted in the applicant's home and include an interpretation of the physician's orders, evaluation of the need for services, recommendations for all services required, including the type, frequency, and duration, and list of equipment needs.

Additionally, local social services districts are also required to have a current Long-Term Care Placement Medical Assessment Abstract (DMS-1), or an approved equivalent, available on each patient receiving personal care. If the individual does not have a current DMS-1, the nurse conducting the nurse assessment will complete the DMS-1 during the same appointment. The DMS-1 captures information about a patient's current health status (e.g., medical conditions, diagnoses, health services received), and assesses functional and mental status. Each answer converts to a specific point value. Upon completion, the sum of the point values directly corresponds to a specific level of care. See Box 1 for a description of the DMS-1.

Next, all applicants must have a completed social assessment. The social assessment considers both the expressed and identified needs of the client and the factors impacting their situation. This assessment primarily focuses on their motivation and desire for home care, and the patient's family. This is to provide an opportunity for input on the plan of care, and to gauge whether informal supports are available.

Finally, all applicants who are expected to receive services for over 60 days are required (as of June 1992) to have a completed HARRI assessment. The HARRI's goal is to evaluate the individual's health, social, and environmental needs to determine if home

care services are appropriate. The factors considered are the applicant's ability to perform ADLs, health and rehabilitation needs, the ability to direct care and summon assistance, and other health and safety factors (OTDA, 1992b).

Home Health Services

Individuals must have a written physician's order from the treating or attending physician that describes all of the following (42 CFR 430, 1992):

- Recipient's acute or chronic medical condition or diagnosis that causes a recipient to need home health care
- Documentation regarding the medical necessity for the service(s) to be provided at home
- Home health services needed
- Frequency and duration of the needed services
- Minimum skill level (nurse, home health aide) of staff who can provide the services

The physician's order may be sent directly to the Certified Home Health Agency (CHHA) that is administering the services. The CHHA may conduct their own assessment to establish the amount and scope of services required.

Nursing Facility Care

The DMS-1, described above under the PCSP, is the assessment tool used to determine whether institutional placement is appropriate for an individual. The point result automatically corresponds to a level of care. A score of 60 corresponds to a HRF, while a score of 180 or above indicates a SNF level of care. See Box 1 for a description of the DMS-1.

Nursing facilities are required by federal law to conduct a Preadmission Screening and Resident Review (PASRR) and periodic assessments using the Minimum Data Set (MDS). See Box 2 for more information on the PASRR, and Box 3 for the MDS.

LTHHCP

The DMS-1, described above under the PCSP, is the assessment tool used to determine eligibility for the LTHHCP. The point result automatically corresponds to a level of care. The applicant must meet a score of 60 or more for admission to the program but does not require a distinction between HRF and SNF levels of care. See Box 1 for a description of the DMS-1.

Evaluators

Evaluators vary by LTC health benefit program. The details of the four largest programs are summarized below.

PCSP

A licensed physician must order personal care services. A licensed professional nurse may administer the nurse assessment and DMS-1. The social assessment is completed by professional casework staff, who also have responsibility for case management (NYSDSS, 1980; NYSDOH, 1992). Finally, the HARRI may be completed by professional staff at the social services district, a nurse employed by a CHHA, a nurse employed by a LTHHCP provider, a nurse employed by the social service district or its designee, a nurse employed by a voluntary or proprietary agency under contract to the social services district, or a hospital discharge planner (OTDA, 1992b; UHF, 2009).

Home Health Services

A licensed physician must order home health services. The order may be sent directly to the CHHA administering the services. There, a registered professional nurse may conduct an assessment and establish a plan of care.

Nursing Facility Care

The DMS-1 must be completed by a registered nurse or physician.

LTHHCP

Applicants may apply through the local social services district or directly to an individual program provider. A nurse from the provider organization or the county will conduct the DMS-1 assessment. If conducted by a provider nurse, the provider will forward the completed assessment to the county. Upon completion, the county makes an in-home visit to confirm eligibility and computes and approves each individual's plan of care (UHF, 2009; Medicaid.gov, 2013).

Benefit limitations

Can you mix LTC benefits?

All New York Medicaid beneficiaries receive the state plan benefit package. Some beneficiaries, if eligible, may also enroll in a federally approved HCBS program. Individuals enrolled in managed care may receive state plan and additional benefits through capitated managed care plans. Beneficiaries may not duplicate services across programs.

Is there free choice between cash and benefits in-kind?

The LTC system does not offer a cash benefit.

Can you receive LTC benefits with other social security benefits?

It is possible to receive LTC benefits along with other welfare benefits, such as SSI and Supplemental Nutrition Assistance Program (SNAP).

User costs

User charges

Medicaid

As required by federal law, New York enforces Estate Recovery. The acceptance of Medicaid in New York creates a debt to the state agency in the total amount paid to or for the benefit of the recipient for medical assistance after the recipient reached 65 years of age or was permanently institutionalized. Upon the death of the recipient, the state agency may recover the debt by filing a statement of claim against the estate of the deceased Medicaid recipient. However, the debt will not be enforced if the recipient is survived by a spouse, child or children under 21 years of age, or a child or children who are blind or disabled (NYSOTDA, 1993; 18 NYCRR S 360-7.11, 1992). Beginning in 1993, the passage of the Omnibus Budget Reconciliation Act of 1993 expanded estate recoveries to Medicaid provided to individuals at least age 55 (NYSDOH, 2002).

PCSP, Home Health Services

There are no copayments for traditional home-and community-based LTC services.

Nursing Facility Care

Beneficiaries are expected to contribute all of their income to the cost of care in a nursing home, except for a monthly personal needs allowance (PNA). In 1992, the PNA was $50 per month. The exact contribution amount is called the Net Available Monthly Income (NAMI). See Box 5 for how the NAMI is calculated for institutionalized individuals, and Box 6 for institutionalized spouses.

LTHHCP

There are no copayments or similar charges imposed on program participants.

Taxation of benefits

In-kind benefits are not subject to taxation.

Chapter 2: Policy enacted 1997-2010

Policy change in 1997

In 1997, New York State received approval from the Centers for Medicare and Medicaid Services (CMS) for the Partnership Plan, the primary purpose of which was to enroll a majority of New York's Medicaid population into managed care and use a managed care delivery system to provide long-term care (LTC) to targeted groups (Medicaid.gov, 2022). The Managed Long-Term Care (MLTC) program was launched in 1998 under the Partnership Plan's existing authority to provide Medicaid managed care (Medicaid.gov, 2014). This was New York's first managed care program providing long term services and supports.

Following the implementation of MLTC, New York began transitioning existing state plan health benefit programs (e.g., Personal Care Services Program, Home Health Services) from a fee-for-service delivery system to managed care, meaning that most beneficiaries would now receive these services under a managed care health plan.

Other reforms during this period:

- (1997) The Long-Term Care Placement Medical Assessment Abstract (DMS-1) was replaced with the Patient Review Instrument (PRI) to determine eligibility for nursing facility admission. The DMS-1 remained as the assessment tool for the Long-Term Home Health Care Program (LTHHCP) (Medicaid.gov, 2013).
- (2006) The Deficit Reduction Act of 2005 introduced the home equity limit, which was implemented in 2006. The new law stated that individuals applying for Medicaid coverage of nursing facility services or community-based long-term care on or after January 1, 2006, are ineligible for coverage if the equity interest in the individual's home exceeds $750,000 (NYSDOH, 2011a).
- (2010) New York received approval of an amendment to the Partnership Plan to extend spousal impoverishment rules to spouses of individuals receiving home and community-based services (HCBS), including the LTHHCP and MLTC (Medicaid.gov, 2013).

Overview

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Eligibility for Medicaid is determined by eligibility tracks that may have different requirements, such as income and asset limits. LTC benefits in New York are mostly provided through state plan benefit programs (Personal Care Services Program - PCSP, Home Health Services, Nursing Facility Care), or through federally approved home-and community-based services (HCBS) LTC programs (Long-Term Home Health Care Program - LTHHCP, Managed Long-Term Care - MLTC).

Beneficiaries receiving state plan benefits must establish medical necessity for each service prescribed by a physician. PCSP and Home Health services provide home care for beneficiaries that have established medical necessity, while Nursing Facility Care only provides care in a nursing home. State plan benefits are not mutually exclusive, and a beneficiary may receive multiple benefits if eligible. Once a specific state plan benefit is determined to be medically necessary, the beneficiary may immediately receive care. People covered by the LTHHCP and MLTC are able to receive a variety of LTC benefits in addition to services under the state plan if deemed medically eligible, such as social adult day care (SADC). Those applying for the LTHHCP are not immediately guaranteed care, as the program has a strict enrollment limit. If the program is at capacity, individuals are placed on a prioritized waiting list.

Benefit programs vary in dependence requirements. PCSP and Home Health require the individual to have a medical necessity for services, while Nursing Facility, LTHHCP, and MLTC beneficiaries must meet a nursing facility level of care (NFLOC) based on a comprehensive assessment before admission.

Statutory basis

Federal Law for Medicaid: 42 U.S.C. 1396-1 to 1396w-5, Title XIX of the Social Security Act (SSA, 2023d)

New York Law for Medicaid

- N.Y. Comp. Codes R. & Regs. Tit. 10 - Department of Health (NYCCRR, 2023)
- N.Y. Comp. Codes R. & Regs. Tit. 18 - Department of Social Services (NYCCRR, 2023)

Financing

Source of financing

Funding for Medicaid is split between federal and state financing. The federal government matches state spending for individuals eligible for services, and the matching rate is determined by a formula based on a state's per capita income relative to other states, called the Federal Medical Assistance Percentage (FMAP). The federal share for New York Medicaid spending on beneficiaries in fiscal year 1997 was 50.0%. See Table 1 for historical FMAPs. The standard FMAP applies to most Medicaid spending (50.0% in 1997), though there are exceptions for certain administrative functions that may receive a higher federal matching rate.

Coverage

This section discusses the scope of risks covered and the requirements to be eligible for benefits when the need for care arises. Dependence requirements are discussed in the later section on *Benefit Eligibility*.

Risk covered definition

Medicaid LTC serves individuals with limited income and assets who need assistance with physical, functional, and cognitive impairments and/or other limitations of daily living that may prevent them from being fully independent. For example, many individuals pursue LTC for assistance with activities of daily living (ADLs), which are fundamental tasks like eating, dressing, and showering. If the beneficiary is eligible, Medicaid will also pay for 24-hour care in a nursing facility.

Eligible population

There exist several LTC benefits and programs under Medicaid, many of which have age or dependence-related eligibility requirements that must be met before service authorization or program enrollment. However, all benefits and programs first require eligibility for Medicaid. Here we detail eligibility for New York Medicaid, followed by additional requirements for specific benefits and programs under Medicaid.

Medicaid

States are federally required to provide Medicaid coverage to certain categorical populations, called the mandatory categorically needy. While there are many groups within this track (e.g., pregnant women, children), we only detail eligibility information for categories that are most likely to require LTC (e.g., aged or disabled individuals). Additionally, states may opt in to cover additional categorical populations, called the optional categorically needy. There is substantial variation in who is covered as optional categorically needy across states. Here we detail the eligibility criteria for the most relevant eligibility tracks and coverage groups in New York.

Eligibility for Medicaid in New York for people needing LTC services is primarily attained by satisfying at least one of 2 alternative eligibility tracks:

Eligibility Track 1: Mandatory Categorically Needy

- 1a. Supplemental Security Income (SSI) recipients
  - Income requirements: Monthly income may not exceed the maximum SSI benefit amount.[1] In 1997, the monthly federal benefit amount was $484 for an individual and $726 for a couple (SSA, 2023a). See Table 2 for historical monthly benefit amounts.
  - Asset requirements: Resources may not exceed $2,000 for an individual and $3,000 for a couple. This standard has remained the same since 1989.
    - Asset transfer: With some exceptions, applicants who dispose of resources or income for less than fair market value on or after the look back date will be subject to a period of ineligibility for LTC services (18 NYCRR S360-4.4, 1992).[2]
    - Home equity limit: Beginning in 2006, the equity interest in the individual's home may not exceed $750,000, or else they will be ineligible for LTC services (NYSDOH, 2011a).[9]
  - Citizenship/immigration requirements: The applicant must be a New York resident and a U.S. citizen or a qualified non-citizen, such as a lawfully admitted permanent resident, refugee admitted under Section 207 of the Immigration and Nationality Act (INA), or someone granted asylum under Section 208 of the INA —individuals who entered the United States on or after August 22, 1996, are ineligible for SSI and Medicaid for the first 5 years as a lawfully admitted permanent resident. See SSA (2023c) for additional information.
  - Other requirements
    - The individual must be at least age 65, blind, or disabled.[4]

Eligibility Track 3: Medically Needy

- 3a. Aged, blind, or disabled
  - Income requirements: In order to be eligible under the medically needy track, individuals must "spend down" their excess income to meet a specific standard. This functions similar to a deductible. The monthly spend down amount in 1997 was $575 for an individual and $834 for a household of two (NYSDOH, 1997). Additional income disregards exist if a person is institutionalized (or receiving HCBS, as of 2010) and has a spouse residing in the community.[10]
  - Asset requirements: Resources may not exceed $3,450 for an individual and $5,000 for a household of two (NYSDOH, 1997). Additional asset disregards exist if a person is institutionalized (or receiving HCBS, as of 2010) and has a spouse residing in the community.[11]
    - Asset transfer and Home Equity Limit: Same as eligibility track 1a.
  - Citizenship/immigration requirements: Same citizenship requirements as eligibility track 1a.
  - Other requirements
    - The individual must be at least age 65, blind, or disabled.[4]

Other Eligibility Tracks

There exist alternative eligibility tracks targeted at other populations. Some of these tracks include:

- Medicaid Cancer Treatment Program: Breast, Cervical, Colorectal, and Prostate Cancer: Medicaid program for eligible persons who are found to be in need of treatment for breast, cervical, colorectal, or prostate cancer that provides full Medicaid coverage for a period as determined by the type of cancer or pre-cancerous condition being treated (NYSDOH, 2014).

Once eligibility for Medicaid has been determined, beneficiaries may have to meet additional eligibility criteria in order to become eligible for specific LTC health benefit programs under Medicaid. Additional program criteria (if applicable) is detailed below.

Personal Care Services Program (PCSP), Home Health Services, Nursing Facility Care

There are no additional conditions for coverage. Benefit qualification depends on minimum level of dependence.

Long-Term Home Health Care Program (LTHHCP)

Beyond meeting minimum level of dependence requirements, applicants must be at least age 65 or disabled. If the program has reached enrollment capacity, the applicant will be placed on a waiting list until a spot becomes available.

Medicaid Managed Long-Term Care (MLTC)

Beyond meeting minimum level of dependence requirements, applicants must be at least age 21. Some plans may choose to only cover individuals over age 65.

Other community-based programs

There exist several home and community-based services (HCBS) programs targeted at older adults that are omitted due to limited enrollment. Some of these programs include:

- Adult Day Health Care (ADHC)
- Private Duty Nursing
- Assisted Living Program (ALP)
- Program of All-Inclusive Care for the Elderly (PACE)
- Traumatic Brain Injury (TBI) Waiver
- Nursing Home Transition and Diversion Waiver (NHTDW)
- Medicaid Advantage Plus (MAP)

Benefit

Home care benefit

PCSP

The PCSP provides personal care services, which include (18 NYCRR 505.23, 1992):

- Level 1: Assistance with IADLs, such as personal laundry, light housekeeping, shopping, meal preparation, and medication administration
- Level 2: Assistance with ADLs, such as eating, toileting, bathing, grooming, dressing, ambulation, and transferring

If the beneficiary is only receiving Level 1 services, care is limited to 12 hours per week.

Home Health Services

Home Health provides (18 NYCRR 505.23, 1992):

- Skilled nursing services: Intermittent or part-time nursing services, such as colostomy and ileostomy care, tracheotomy aspiration, Levin tube care, provided by a registered nurse or licensed practical nurse
- Home health aide services: Semi-skilled care, such as simple wound care, vital monitoring, and personal care

Nursing Facility Care

Nursing Facility Care does not provide home care during this policy period.

LTHHCP

The LTHHCP provides the following services in addition to those offered under the state plan, unless otherwise noted:

- Personal care services: Referred to as home and community support services under LTHHCP, personal care, oversight, and supervision beyond what is provided under the state plan
- Private duty nursing: Skilled nursing interventions on an individual and continuous basis (in contrast to intermittent) and respiratory care for participants who are ventilator dependent

MLTC

MLTC provides the following services in addition to those offered under the state plan, unless otherwise noted:[12]

- Personal care services (as described above under PCSP)
- Home health services (as described above under Home Health Services)
- Private duty nursing (as described above under the LTHHCP)

Semi-residential care

PCSP, Home Health Services, Nursing Facility Care

These programs do not provide semi-residential care during this policy period.

LTHHCP

Semi-residential services may vary by provider, but can include:

- Social Adult Day Care (SADC): Centers that provide functionally impaired older adults with socialization, supervision and monitoring, personal care, and nutrition in a protective setting

MLTC

MLTC provides:

- SADC (as described above under the LTHHCP)
- Adult Day Health Care (ADHC): Centers provide daytime supervision, personal care assistance, and sometimes meals to recipients in a group setting

Residential care

PCSP, Home Health Services, LTHHCP

These programs do not provide residential care during this policy period.

Nursing Facility Care

The state plan provides residential care in skilled nursing facilities (SNFs) and health-related facilities (HRFs) (NYCRR, 1990).[7] An SNF provides care to those requiring high levels of medical, social, and/or rehabilitation services. An HRF cares for residents that are more functionally independent than those residing in an SNF.

MLTC

Residential care is covered by MLTC plans (as described above under Nursing Facility Care) when appropriate (UHF, 2009).[13]

Other benefits

New York Medicaid provides additional benefits related to LTC:

- Durable medical equipment and supplies: Items that assist with an illness or injury, and may include walkers, wheelchairs, suction pumps, bandages, or similar aids —this is a required benefit under Home Health Services

- Non-emergency medical transportation: Medically necessary transportation for any recipient and personal care attendant or escort, if required, who have no other means of transportation available to any Medicaid-compensable service for the purpose of receiving treatment, medical evaluation, or therapy

LTHHCP

LTHHCP provides the following services in addition to those offered under the state plan, unless otherwise noted:

- Case Management: Services that assist the participant in developing, authorizing, and monitoring the plan of care
- Congregate and home-delivered meals: Delivers healthy meals to the beneficiary's home or in a group setting
- Transportation to and from semi-residential services
- Personal emergency response systems (PERS): The installation and monitoring of electronic devices that allow enrollees at high risk of institutionalization to secure help in an emergency
- Respite: Services provided to participants unable to care for themselves that are furnished on a short-term basis because of the absence of or need of relief for those persons normally providing care for the participant
- Medical Social Services: Counseling service provided to the participant who is coping with altered abilities and skills, a revision of long-term expectations or changes in roles in relation to significant others
- Home maintenance
- Home improvement or adaptations: Physical adaptations to the home, which are necessary to assure the health, welfare and safety of the participant
- Moving assistance: Services intended to transport a participant's possessions and furnishings when they must be moved from an inadequate or unsafe housing situation to a viable environment that alleviates the risk of unwanted nursing home placement

MLTC

MLTC provides the following services in addition to those offered under the state plan, unless otherwise noted:

- Case Management (as described above under the LTHHCP)
- PERS (as described above under the LTHHCP)
- Transportation to and from semi-residential services
- Medical Social Services (as described above under the LTHHCP)

Provision of care

Medicaid benefits may be provided by non-profit organizations, home health agencies, hospitals, nursing facilities, and for-profit providers, all of which are licensed and overseen by the New York State Department of Health. Providers that accept Medicaid payment rates and meet licensing requirements may participate in Medicaid. Managed care plans will have limited provider networks.

Benefit eligibility

Qualifying period

Potential users may apply at any time.

Minimum level of dependence

The minimum level of dependence varies by LTC health benefit program. The details of the five largest programs are summarized below.

Personal Care Services Program (PCSP)

The beneficiary may receive personal care services if they are medically necessary (OTDA, 1992).

Home Health Services

The beneficiary must require skilled nursing services on a part-time or intermittent basis, be confined to the home, and services must be provided under a physician's plan of care (OTDA, 1992b).

Nursing Facility Care

Before admission to a nursing facility, patients must be assessed using the Patient Review Instrument (PRI), a comprehensive assessment that assesses functional, cognitive, medical, and behavioral health characteristics in order to determine the level of care and the type of services required. Following the PRI, patients must also be administered the SCREEN, which explores

alternatives to nursing home care if appropriate. If the SCREEN indicates the patient could be suitable for care in the community, they will be referred to another program (UHF, 2009).

Unlike the Long-Term Care Placement Medical Assessment Abstract (DMS-1) used in previous years, the PRI does not use a point scoring system that corresponds directly to a level of care. Rather, the PRI may indicate that the patient falls into a particular categorical group that is nursing home eligible.

LTHHCP
The beneficiary must meet an NFLOC determined by the DMS-1 in order to be admitted to the program. A DMS-1 score of 60 or greater indicates an individual has met the level of care for admission (UHF, 2009).[8] Despite the PRI replacing the DMS-1 for nursing facility admission, the DMS-1 continued to be used to assess eligibility for the LTHHCP.

MLTC
The beneficiary must meet an NFLOC determined by the Semi-Annual Assessment of Members (SAAM). A SAAM score of 5 or greater indicates an individual has met the level of care for admission (UHF, 2009).

Duration of benefit

Reassessments of eligibility vary by LTC health benefit program. Below we detail reassessments for Medicaid, followed by reassessments for the five largest programs.

Medicaid
Federal law requires states to renew Medicaid eligibility at least every 12 months.

PCSP
Services must be reauthorized every 6 months (NYSDSS, 1980). However, there are some exceptions that allow for an authorization period of up to one year (18 NYCRR 505.14, 1991). The nurse assessment must be readministered every 6 months and/or when the beneficiary's needs may have changed (e.g., after a hospitalization). The social assessment must be readministered every 12 months (UHF, 2009).

Home Health Services
The beneficiary's physician must review the plan of care every 60 days (42 CFR 440.70, 1992; 42 CFR 440.70, 1997).

Nursing Facility Care
Mentions of reassessment protocol were omitted in department regulations beginning in 1997. Regulation now states that the Commissioner of Health or their designee will determine standards for reviews of medical necessity (18 NYCRR 505.9, 1998).

LTHHCP
Participants must be reassessed using the Long-Term Care Placement Medical Assessment Abstract (DMS-1) at least every 120 days (18 NYCRR 505.21, 1990). In 2010, an amendment extended the level of care assessment time frame from every 120 days to every 6 months (Medicaid.gov, 2013).

MLTC
Participants must be reassessed using the SAAM every 6 months (UHF, 2009).

Means testing

In-kind benefits are means-tested. Depending on the eligibility track used to qualify for Medicaid, the income and asset limits may differ.

Age requirement

There is no age requirement for Medicaid. Age would only impact the eligibility track used to qualify for Medicaid.

PCSP, Home Health Services, Nursing Facility Care
There is no age requirement.

LTHHCP
The individual must be at least age 65 or disabled.

MLTC

The individual must be at least age 18, but providers may choose to serve only certain populations. For example, some providers require a minimum age of 21 or 65 (NYSDOH, 2022b).

Care needs assessment

Definition of dependence

Definitions of dependence vary by LTC health benefit program. The details of the five largest programs are summarized below.

PCSP

The local social services district may only consider authorizing personal care services when such services are medically necessary. Determination of medical necessity is the responsibility of the assessing nurse and is based upon his/her professional judgment in consultation with the physician and/or physician's order, the social assessment, and any other information deemed relevant in making that determination.

Next, before services may be authorized, the health and safety status of the applicant must be determined. Participants must be at least one of the following: self-directing, able to call for help, able to be left alone, or have available informal supports (OTDA, 1992b). Definitions of each of these criteria are detailed in Box 4.

Finally, participants must satisfy each of the following:

1. Have a stable medical condition, meaning there is no recent history of threatening changes in health status
2. Need some or total assistance with at least one paraprofessional health-related task (e.g., assistance with medicals or simple dressing changes), one ADL (e.g., bathing, eating, dressing, toileting, and transferring), or one IADL (e.g., transportation, shopping, laundry, or meal preparation)
3. Must not require skilled nursing or therapy (this would refer them to Home Health)

Home Health Services

A patient may receive home health services if their health and supportive needs can be met safely and adequately at home and their condition requires the services. In determining whether a prospective patient's health and supportive needs can be met safely at home, the patient must meet at least one of the criteria for PCSP listed above and defined in Box 4.

Additionally, home health is covered for beneficiaries whose conditions do not require continuous skilled nursing care, but do require skilled care on an intermittent basis in the home for the treatment of an injury, illness, or disability

Nursing Facility Care

The Patient Review Instrument (PRI) determines dependency in two ways (NYSDOH, 2005):

1. Categories: Determined by medical conditions and treatments, need for rehabilitation, and mental health and behavior
    - Heavy rehabilitation
    - Special care
    - Clinically complex
    - Severe behavioral
    - Reduced physical functioning
2. Scoring: Defined by how much assistance or supervision is required with ADLs

Scoring criteria varies slightly for each ADL but in general, scores range from 1 (no supervision or assistance required) to 5 (needs highest amount of supervision/assistance). See Box 9 for full scoring criteria. Complete definitions for each category and scoring point conversions are located in Figure 1.

Information from the PRI is then used in the SCREEN, an additional form that determines the specific level of care needed. For example, if the Screener marks the question "All ADL scores are 1 or 2" as "YES" using information from the PRI, the applicant will be referred to a CHHA to perform an assessment for Home Health Services. This scenario would direct the applicant away from residential care. After filling out the SCREEN, the assessor makes a final determination of whether the patient is recommended for residential care, or if they should be referred to community care options.

LTHHCP

Applicants for the LTHHCP must meet a nursing facility level of care (NFLOC), meaning that they would require admission to a nursing facility if not for the existence of the LTHHCP. This is determined by the DMS-1. A score of 60 or higher indicates an NFLOC.

MLTC

Applicants for MLTC must meet an NFLOC, meaning that they would require admission to a nursing facility if not for the existence of MLTC. This is determined through the SAAM form. A score of 5 or higher indicates an NFLOC.

Evaluation of dependence

Evaluations of dependence vary by LTC health benefit program. The details of the five largest programs are summarized below.

PCSP

Individuals applying for the PCSP have four functional eligibility components: (1) physician's order, (2) nursing assessment, (3) social assessment, and (4) the Home Assessment Resource Review Instrument (HARRI) (NYSDSS, 1980; OTDA, 1992b).

All applicants must have a physician's order certifying the need for personal care services based on a medical examination. The order includes the patient's medical condition and regimens, including any medication, and the patient's need for the services (NYSDOH, 1992).[14]

Next, individuals must have a nursing assessment completed by a registered nurse. The assessment must be conducted in the applicant's home and include an interpretation of the physician's orders, evaluation of the need for services, recommendations for all services required, including the type, frequency, and duration, and list of equipment needs.

Additionally, local social services districts are also required to have a current Long-Term Care Placement Medical Assessment Abstract (DMS-1), or an approved equivalent, available on each patient receiving personal care. If the individual does not have a current DMS-1, the nurse conducting the nurse assessment will complete the DMS-1 during the same appointment. The DMS-1 captures information about a patient's current health status (e.g., medical conditions, diagnoses, health services received), and assesses functional and mental status. Each answer converts to a specific point value. Upon completion, the sum of the point values directly corresponds to a specific level of care. See Box 1 for a description of the DMS-1.

Next, all applicants must have a completed social assessment. The social assessment considers both the expressed and identified needs of the client and the factors impacting their situation. This assessment primarily focuses on their motivation and desire for home care, and the patient's family. This is to provide an opportunity for input on the plan of care, and to gauge whether informal supports are available.

Finally, all applicants who are expected to receive services for over 60 days are required (as of June 1992) to have a completed HARRI assessment. The HARRI's goal is to evaluate the individual's health, social, and environmental needs to determine if home care services are appropriate. The factors considered are the applicant's ability to perform ADLs, health and rehabilitation needs, the ability to direct care and summon assistance, and other health and safety factors (OTDA, 1992b).

Home Health Services

Individuals must have a written physician's order from the treating or attending physician that describes all of the following (42 CFR 430, 1992):

- Recipient's acute or chronic medical condition or diagnosis that causes a recipient to need home health care
- Documentation regarding the medical necessity for the service(s) to be provided at home
- Home health services needed
- Frequency and duration of the needed services
- Minimum skill level (nurse, home health aide) of staff who can provide the services

The physician's order may be sent directly to the Certified Home Health Agency (CHHA) that is administering the services. The CHHA may conduct their own assessment to establish the amount and scope of services required.

Nursing Facility Care

The Patient Review Instrument (PRI) is the assessment tool used to determine whether placement in an institution is appropriate. The PRI evaluates physical, medical, and cognitive characteristics of the patient, and documents selected services they may receive. The SCREEN is the supplemental form that determines the specific level of care needed using information from the completed PRI. The final determination of whether to recommend the patient for institutionalization or to pursue community-based care takes place at the end of the SCREEN. See Box 7 for a description of the PRI and SCREEN.

Nursing facilities are required by federal law to conduct a Preadmission Screening and Resident Review (PASRR) and periodic assessments using the Minimum Data Set (MDS). See Box 2 for more information on the PASRR, and Box 3 for the MDS.

LTHHCP

The DMS-1, described above under the PCSP, is the assessment tool used to determine eligibility for the LTHHCP. The point result automatically corresponds to a level of care. The applicant must meet a score of 60 or more for admission to the program but does not require a distinction between HRF and SNF levels of care. See Box 1 for a description of the DMS-1.

MLTC

The SAAM is the assessment tool used to determine eligibility for MLTC. The point result, called the SAAM index, corresponds to a level of care. It is calculated using only the answers from the incontinence, cognitive functioning, and ADL sections, for a total of 13 questions. The applicant must meet a score of 5 or more for admission to the program. See Box 8 for a description of the SAAM. To view the full assessment, see NYSDOH (2005b).

Evaluators

Evaluators vary by LTC health benefit program. The details of the five largest programs are summarized below.

PCSP

A licensed physician must order personal care services. A licensed professional nurse may administer the nurse assessment and DMS-1. The social assessment is completed by professional casework staff, who also have responsibility for case management (NYSDSS, 1980; NYSDOH, 1992). Finally, the HARRI may be completed by professional staff at the social services district, a nurse employed by a CHHA, a nurse employed by a LTHHCP provider, a nurse employed by the social service district or its designee, a nurse employed by a voluntary or proprietary agency under contract to the social services district, or a hospital discharge planner (OTDA, 1992b; UHF, 2009).

Home Health Services

A licensed physician must order home health services. The order may be sent directly to the CHHA administering the services. There, a registered professional nurse may conduct an assessment and establish a plan of care.

Nursing Facility Care

The PRI must be completed by a registered nurse. The SCREEN may be completed by a county caseworker or another professional that has completed the required training.

LTHHCP

Applicants may apply through the local social services district or directly to an individual program provider. A nurse from the provider organization or the county will conduct the DMS-1 assessment. If conducted by a provider nurse, the provider will forward the completed assessment to the county. Upon completion, the county makes an in-home visit to confirm eligibility and computes and approves each individual's plan of care (UHF, 2009; Medicaid.gov, 2013).

MLTC

The SAAM must be completed by a health plan nurse (UHF, 2009).

Benefit limitations

Can you mix LTC benefits?

All New York Medicaid beneficiaries receive the state plan benefit package. Some beneficiaries, if eligible, may also enroll in a federally approved HCBS program. Individuals enrolled in managed care may receive state plan and additional benefits through capitated managed care plans. Beneficiaries may not duplicate services across programs.

Is there free choice between cash and benefits in-kind?

The LTC system does not offer a cash benefit.

Can you receive LTC benefits with other social security benefits?

It is possible to receive LTC benefits along with other welfare benefits, such as SSI and Supplemental Nutrition Assistance Program (SNAP).

User costs

User charges

Medicaid

As required by federal law, New York enforces Estate Recovery. The acceptance of Medicaid in New York creates a debt to the state agency in the total amount paid to or for the benefit of the recipient for medical assistance after the recipient reached 55 years of age or was permanently institutionalized. Upon the death of the recipient, the state agency may recover the debt by filing a statement of claim against the estate of the deceased Medicaid recipient. However, the debt will not be enforced if the recipient is survived by a spouse, child or children under 21 years of age, or a child or children who are blind or disabled (NYSOTDA, 1993; NYSDOH, 2002).

PCSP, Home Health Services, MLTC

There are no copayments for traditional home-and community-based LTC services.

Nursing Facility Care

Beneficiaries are expected to contribute all of their income to the cost of care in a nursing home, except for a monthly personal needs allowance (PNA). In 1997, the PNA was $50 per month. The exact contribution amount is called the Net Available Monthly Income (NAMI). See Box 5 for how the NAMI is calculated for institutionalized individuals, and Box 6 for institutionalized spouses.

LTHHCP

There are no copayments or similar charges imposed on program participants.

Taxation of benefits

In-kind benefits are not subject to taxation.

Chapter 3: Policy enacted 2011-2019

Policy change in 2011

In 2011, New York established the Medicaid Redesign Team (MRT), a group of key Medicaid stakeholders tasked to provide proposals that would improve the New York Medicaid program. Beginning in 2011, New York began receiving approval from the Center for Medicare and Medicaid Services (CMS) for amendments to the Partnership Plan, which was renamed the New York MRT upon renewal in 2016 (Medicaid.gov, 2018). Detailed below are the significant policy changes recommended by the MRT, along with their year of implementation.

Since 2011, New York added several home-and community-based long-term care (LTC) services to Mainstream Managed Care (MMC), the dominant managed care plan for Medicaid recipients not also eligible for Medicare, to assist those that need the services but are ineligible for Managed Long-Term Care (MLTC). Prior to 2011, the only similar services that were covered by MMC plans were short-term. With this, the provision of these services became the responsibility of managed care organizations rather than the Local Department of Social Services (LDSS), and the vast majority of home-and community-based LTC services transitioned to managed care (NYSDOH, 2017). These services include (UHF, 2014):

- (2011) Personal Care Services
- (2012) Consumer-Directed Personal Assistance Services (CDPAS) —added to both MMC and MLTC
- (2013) Adult Day Health Care (ADHC)
- (2014) Nursing facility care

In 2012, adults eligible for both Medicaid and Medicare (known as dual eligible) in need of or receiving home-and community-based LTC services for 120 days or more, including Long-Term Home Health Care Program (LTHHCP) participants, became required to enroll in MLTC plans. This was phased-in over several years. The LTHHCP's approval expired in 2016 and was not renewed. Non-dual eligible (Medicaid only) adults in need of or receiving these services were required to enroll in an MMC plan.

In 2013, New York implemented the Uniform Assessment System (UAS-NY) as the statewide assessment tool for authorization of certain LTC services. This replaced any service, program, or plan-specific assessment tools that were being used to determine eligibility and level of care. See Table 4 for all assessment tools that were replaced. This did not affect Nursing Facility Care, which continued to use the Patient Review Instrument (PRI).

In 2014, New York introduced the Conflict-Free Evaluation and Enrollment Center (CFEEC), which administered all UAS-NY assessments for MLTC (UHF, 2017).

In 2015, mandatory managed care enrollment extended to the nursing home population. See Box 10 for the mandatory enrollment policies implemented for different populations (Leading Age NY, 2014).

Other reforms during this period:

- (2011) The home equity limit was increased to $758,000 pursuant to state law, Section 366 of Social Services Law (NYSDOH, 2011a). The limit would increase year to year from 2011 onward in an amount determined by the federal Department of Health and Human Services, based on the percentage increase in the consumer price index.
- (2012) Personal Care Level 1 Services and CDPAS were limited to 8 hours per week for recipients only receiving Level 1 Services. This was a reduction in hours, as it previously was limited to 12 hours per week (NYSDOH, 2012a).
- (2014) New York implemented Medicaid expansion under the Affordable Care Act (ACA), which expanded Medicaid coverage to most adults under age 65. New York had previously covered this group up to 100% of the Federal Poverty Level (FPL), but did not provide LTC. Following the ACA, the income level rose to 138% of the FPL, and the population was transitioned to the newly covered adult group, referred to here as Eligibility Track 2c, under the ACA (NYSDOH, 2013e).
- (2016) New York implemented the Community First Choice Option (CFCO) under the ACA. This allowed states to provide certain home-and community-based LTC services to Medicaid beneficiaries who meet a nursing facility level of care (NFLOC). See Box 11 for additional details.

Overview

Long-term care (LTC) benefits in New York are primarily provided by Medicaid, a public health insurance program for low-income individuals. Medicaid in New York is administered at the state level by the New York State Department of Health (NYSDOH), and enrollment is voluntary.

Eligibility for Medicaid is determined by eligibility tracks that may have different requirements, such as income and asset limits. LTC benefits in New York are mostly provided through state plan benefit programs (Nursing Facility Care), federally approved home-and community-based services (HCBS) LTC programs (Long-Term Home Health Care Program - LTHHCP, Managed Long-Term Care - MLTC), or through comprehensive plans providing both acute care and LTC (Mainstream Managed Care - MMC).

Beneficiaries receiving state plan benefits must establish medical necessity for each service prescribed by a physician. Similarly, MMC enrollees must establish medical necessity for each service requested from their health plan. State plan benefits are not mutually exclusive, and a beneficiary may receive multiple benefits if eligible. Once a specific state plan benefit is determined to be medically necessary, the beneficiary may immediately receive care. Nursing Facility Care only provides care in a nursing home, while people covered by the LTHHCP, MLTC, or MMC are able to receive a variety of LTC benefits in addition to services under the state plan if deemed medically eligible, such as social adult day care (SADC). Those applying for the LTHHCP are not immediately guaranteed care, as the program has a strict enrollment limit. If the program is at capacity, individuals are placed on a prioritized waiting list.

Benefit programs vary in dependence requirements. Each requested service under MMC requires the individual to have a medical necessity for services, while Nursing Facility, LTHHCP, and MLTC beneficiaries must meet a nursing facility level of care (NFLOC) based on a comprehensive assessment before admission.

It is important to note that while many state plan health benefit programs still existed (Personal Care Services Program - PCSP, Home Health Services), the statewide transition to managed care dramatically reduced enrollment in the traditional, fee-for-service state plan programs, and most of the population began receiving these services through capitated managed care plans (e.g., MLTC and MMC). For this reason, these programs will not be detailed in this policy period (chapter). For information on their eligibility criteria, please see previous policy periods (chapters).

Statutory basis

Federal Law for Medicaid: 42 U.S.C. 1396-1 to 1396w-5, Title XIX of the Social Security Act (SSA, 2023d)

New York Law for Medicaid

- N.Y. Comp. Codes R. & Regs. Tit. 10 - Department of Health (NYCCRR, 2023)
- N.Y. Comp. Codes R. & Regs. Tit. 18 - Department of Social Services (NYCCRR, 2023)

Financing

Source of financing

Funding for Medicaid is split between federal and state financing. The federal government matches state spending for individuals eligible for services, and the matching rate is determined by a formula based on a state's per capita income relative to other states, called the Federal Medical Assistance Percentage (FMAP). The federal share for New York Medicaid spending on beneficiaries in fiscal year 2011 was 50.0%. See Table 1 for historical FMAPs. The standard FMAP applies to most Medicaid spending (50.0% in 2011), though there are exceptions for certain administrative functions and populations that may receive a higher federal matching rate. [15,][16]

Coverage

This section discusses the scope of risks covered and the requirements to be eligible for benefits when the need for care arises. Dependence requirements are discussed in the later section on *Benefit Eligibility*.

Risk covered definition

Medicaid LTC serves individuals with limited income and assets who need assistance with physical, functional, and cognitive impairments and/or other limitations of daily living that may prevent them from being fully independent. For example, many individuals pursue LTC for assistance with activities of daily living (ADLs), which are fundamental tasks like eating, dressing, and showering. If the beneficiary is eligible, Medicaid will also pay for 24-hour care in a nursing facility.

Eligible population

There exist several LTC benefits and programs under Medicaid, many of which have age or dependence-related eligibility requirements that must be met before service authorization or program enrollment. However, all benefits and programs first require eligibility for Medicaid. Here we detail eligibility for New York Medicaid, followed by additional requirements for specific benefits and programs under Medicaid.

Medicaid

States are federally required to provide Medicaid coverage to certain categorical populations, called the mandatory categorically needy. While there are many groups within this track (e.g., pregnant women, children), we only detail eligibility information for categories that are most likely to require LTC (e.g., aged or disabled individuals). Additionally, states may opt in to cover additional categorical populations, called the optional categorically needy. There is substantial variation in who is covered as optional categorically needy across states. Here we detail the eligibility criteria for the most relevant eligibility tracks and coverage groups in New York.

Eligibility for Medicaid in New York for people needing LTC services is primarily attained by satisfying at least one of 3 alternative eligibility tracks:

Eligibility Track 1: Mandatory Categorically Needy

- 1a. Supplemental Security Income (SSI) recipients
  - Income requirements: Monthly income may not exceed the maximum SSI benefit amount.[1] In 2011, the monthly federal benefit amount was $674 for an individual and $1,011 for a couple (NYSDOH, 2013a). See Table 2 for historical monthly benefit amounts.
  - Asset requirements: Resources may not exceed $2,000 for an individual and $3,000 for a couple (NYSDOH, 2013a). This standard has remained the same since 1989.
    - Asset transfer: With some exceptions, applicants who dispose of resources or income for less than fair market value on or after the look back date will be subject to a period of ineligibility for LTC services.[17]
    - Home equity limit: The equity interest in the individual's home may not exceed $758,000, or else they will be ineligible for LTC services. This figure increases annually with inflation.[9]
  - Citizenship/immigration requirements: The applicant must be a New York resident and a U.S. citizen or a qualified non-citizen, such as a lawfully admitted permanent resident, refugee admitted under Section 207 of the Immigration and Nationality Act (INA), or someone granted asylum under Section 208 of the INA —individuals who entered the United States on or after August 22, 1996, are ineligible for SSI and Medicaid for the first 5 years as a lawfully admitted permanent resident. See SSA (2023c) for additional information.
  - Other requirements
    - The applicant must be at least age 65, blind, or disabled.[4]

Eligibility Track 2: Optional Categorically Needy

- 2c. Affordable Care Act (ACA) expansion adults
  - Income requirements: Monthly income may not exceed 138% of the Federal Poverty Level (FPL). In 2014 (when the ACA was officially implemented), this was $973 for an individual and $1,311 for a household of two (NYSDOH, 2013a). See Table 2 for historical income limits.
  - Asset requirements: There is no asset test for this population.
  - Citizenship/immigration requirements: Same citizenship requirements as eligibility track 1a.
  - Other requirements
    - Applicants must be ages 19-64, ineligible for Medicare, ineligible for other Medicaid eligibility tracks, and not pregnant at the time of application.

Eligibility Track 3: Medically Needy

- 3a. Aged, blind, or disabled
  - Income requirements: In order to be eligible under the medically needy track, individuals must "spend down" their excess income to meet a specific standard. This functions similar to a deductible. The monthly spend down amount in 2011 is $767 for an individual and $1,117 for a household of two (NYSDOH, 2013a).[18] Additional income disregards exist if a person is institutionalized or receiving HCBS and has a spouse residing in the community.[19]
  - Asset requirements: Resources may not exceed $13,800 for an individual and $20,100 for a household of two (NYSDOH, 2013a).[18] Additional asset disregards exist if a person is institutionalized or receiving HCBS and has a spouse residing in the community.[20]

        - Asset transfer and Home Equity Limit: Same as eligibility track 1a.
    - Citizenship/immigration requirements: Same citizenship requirements as eligibility track 1a.
    - Other requirements
        - The applicant must be at least age 65, blind, or disabled.[4]

Other Eligibility Tracks

There exist alternative eligibility tracks targeted at other populations. Some of these tracks include:

- Medicaid Cancer Treatment Program: Breast, Cervical, Colorectal, and Prostate Cancer: Medicaid program for eligible persons who are found to be in need of treatment for breast, cervical, colorectal, or prostate cancer that provides full Medicaid coverage for a period as determined by the type of cancer or pre-cancerous condition being treated (NYSDOH, 2014).

Once eligibility for Medicaid has been determined, beneficiaries may have to meet additional eligibility criteria in order to become eligible for specific LTC health benefit programs under Medicaid. Additional program criteria (if applicable) is detailed below.

Nursing Facility Care

There are no additional conditions for coverage. Benefit qualification depends on minimum level of dependence.

Long-Term Home Health Care Program (LTHHCP)

Beyond meeting minimum level of dependence requirements, applicants must be at least age 65, or disabled. If the program has reached enrollment capacity, the applicant will be placed on a waiting list until a spot becomes available.

Medicaid Managed Long-Term Care (MLTC)

Beyond meeting minimum level of dependence requirements, applicants must be at least age 21. Some plans may choose to only cover individuals over age 65. As of 2012 policy changes, MLTC enrollment is mandatory for individuals that are eligible for both Medicare and Medicaid (known as dually eligible) and require community-based LTC services for more than 120 days (NYSDOH, 2011).

Mainstream Managed Care (MMC)

There are no additional conditions for coverage. However, enrollment is mandatory for most Medicaid beneficiaries unless they are exempt, excluded, or qualify for MLTC. See Box 10 for full list of exempt and exclusion criteria.

Other community-based programs

There exist several home and community-based services (HCBS) programs targeted at older adults that are omitted due to limited enrollment. Some of these programs include:

- Adult Day Health Care (ADHC)
- Private Duty Nursing
- Assisted Living Program (ALP)
- Home Health Services
- Personal Care Services Program (PCSP)
- Program of All-Inclusive Care for the Elderly (PACE)
- Traumatic Brain Injury (TBI) Waiver
- Nursing Home Transition and Diversion Waiver (NHTDW)
- Medicaid Advantage Plus (MAP)

Benefit

Home care benefit

Nursing Facility Care

Nursing Facility Care does not provide home care during this policy period.

LTHHCP (until 2015)

The LTHHCP provides the following services in addition to those offered under the state plan, unless otherwise noted:

- Personal care services

  - Level 1: Assistance with IADLs, such as personal laundry, light housekeeping, shopping, meal preparation, and medication administration, as well as oversight and supervision from an aide —if the beneficiary is only receiving Level 1 services, care is limited to 8 hours per week
  - Level 2: Assistance with ADLs, such as eating, toileting, bathing, grooming, dressing, ambulation, and transferring
- Private duty nursing: Skilled nursing interventions on an individual and continuous basis (in contrast to intermittent) and respiratory care for participants who are ventilator dependent

MLTC, MMC

MLTC and MMC provide the following services in addition to those offered under the state plan, unless otherwise noted (NYSDOH, 2019d; NYSDOH, 2019b):

- Personal care services (as described above under the LTHHCP)
- Home health services
  - Skilled nursing services: Intermittent or part-time nursing services, such as colostomy and ileostomy care, tracheotomy aspiration, Levin tube care, provided by a registered nurse or licensed practical nurse
  - Home health aide services: Semi-skilled care, such as simple wound care, vital monitoring, and personal care
- Private duty nursing (as described above under the LTHHCP)
- Consumer-Directed Personal Assistant Services (CDPAS): Option for home care that allows the beneficiary to hire and manage the aide of their choice (added in 2012)

Semi-residential care

Nursing Facility Care

Nursing Facility Care does not provide semi-residential care during this policy period.

LTHHCP (until 2015)

Semi-residential services may vary by agency, but can include:

- Social Adult Day Care (SADC): Program that provides functionally impaired older adults with socialization, supervision and monitoring, personal care, and nutrition in a protective setting

MLTC

MLTC provides:

- SADC (as described above under the LTHHCP)
- Adult Day Health Care (ADHC): Centers provide daytime supervision, personal care assistance, and sometimes meals to recipients in a group setting

MMC

In 2013, ADHC (as described above under MLTC) was added to MMC covered benefits.

Residential care

Nursing Facility Care

The state plan provides residential care in skilled nursing facilities (SNFs) and health-related facilities (HRFs) (NYCRR, 1990).[7] An SNF provides care to those requiring high levels of medical, social, and/or rehabilitation services. An HRF cares for residents that are more functionally independent than those residing in an SNF.

LTHHCP (until 2015)

The LTHHCP does not provide residential care during this policy period.

MLTC

Residential care is covered by MLTC plans (as described above under Nursing Facility Care). In 2015, individuals eligible for both Medicare and Medicaid (known as dually eligible) that are classified as long-term nursing home stays (stay of 3+ months) began to mandatorily transition into MLTC (UHF, 2017).

MMC

In 2014, residential care became covered by MMC plans (as described above under Nursing Facility Care). In 2015, individuals ineligible for Medicare (known as non-dual eligible) that are classified as long-term nursing home stays (stay of 3+ months) began to mandatorily transition into MMC (UHF, 2017).

Other benefits

New York Medicaid provides additional benefits related to LTC:

- Durable medical equipment and supplies: Items that assist with an illness or injury, and may include walkers, wheelchairs, suction pumps, bandages, or similar aids —this is a required benefit under Home Health Services
- Non-emergency medical transportation: Medically necessary transportation for any recipient and personal care attendant or escort, if required, who have no other means of transportation available to any Medicaid-compensable service for the purpose of receiving treatment, medical evaluation, or therapy

LTHHCP (until 2015)

LTHHCP provides the following services in addition to those offered under the state plan, unless otherwise noted:

- Case Management: Services that assist the participant in developing, authorizing, and monitoring the plan of care
- Congregate and home-delivered meals: Delivers healthy meals to the beneficiary's home or in a group setting
- Transportation to and from semi-residential services
- Personal emergency response systems (PERS): The installation and monitoring of electronic devices that allow enrollees at high risk of institutionalization to secure help in an emergency
- Respite: Services provided to participants unable to care for themselves that are furnished on a short-term basis because of the absence of or need of relief for those persons normally providing care for the participant
- Medical Social Services: Counseling service provided to the participant who is coping with altered abilities and skills, a revision of long-term expectations or changes in roles in relation to significant others
- Home maintenance
- Home improvement or adaptations: Physical adaptations to the home, which are necessary to assure the health, welfare and safety of the participant
- Moving assistance: Services intended to transport a participant's possessions and furnishings when they must be moved from an inadequate or unsafe housing situation to a viable environment that alleviates the risk of unwanted nursing home placement

MLTC

MLTC provides the following services in addition to those offered under the state plan, unless otherwise noted (NYSDOH, 2019d):

- Case Management (as described above under the LTHHCP)
- PERS (as described above under the LTHHCP)
- Transportation to and from semi-residential services
- Medical Social Services (as described above under the LTHHCP)
- Respite care (as described above under LTHHCP)
- Home improvement or adaptations (as described above under LTHHCP)
- Home-delivered meals: Delivers healthy meals to the beneficiary's home

MMC

MMC provides the following services in addition to those offered under the state plan, unless otherwise noted (NYSDOH, 2013):

- Case Management (as described above under the LTHHCP)
- PERS (as described above under the LTHHCP)
- Medical Social Services: Only for enrollees who previously received this benefit through the LTHHCP and transitioned to MMC
- Respite care (as described above under the LTHHCP)
- Home-delivered meals: Only for enrollees who previously received this benefit through the LTHHCP and transitioned to MMC

Provision of care

Medicaid benefits may be provided by non-profit organizations, home health agencies, hospitals, nursing facilities, and for-profit providers, all of which are licensed and overseen by the New York State Department of Health. Providers that accept Medicaid payment rates and meet licensing requirements may participate in Medicaid. Managed care plans will have limited provider networks.

Benefit eligibility

Qualifying period

Potential users may apply at any time.

Minimum level of dependence

The minimum level of dependence varies by LTC health benefit program. The details of the four largest programs are summarized below.

Nursing Facility Care

Before admission to a nursing facility, patients must be assessed using the Patient Review Instrument (PRI), a comprehensive assessment that assesses functional, cognitive, medical, and behavioral health characteristics in order to determine the level of care and the type of services required. Following the PRI, patients must also be administered the SCREEN, which explores alternatives to nursing home care if appropriate. If the SCREEN indicates the patient could be suitable for care in the community, they will be referred to another program (UHF, 2009).

LTHHCP

The beneficiary must meet an NFLOC determined by the DMS-1 in order to be admitted to the program. A DMS-1 score of 60 or greater indicates an individual has met the level of care for admission (UHF, 2009).[8] Despite the PRI replacing the DMS-1 for nursing facility admission, the DMS-1 continued to be used to assess eligibility for the LTHHCP.

MLTC

The beneficiary must meet an NFLOC determined by the Semi-Annual Assessment of Members (SAAM). A SAAM score of 5 or greater indicates an individual has met the level of care for admission (UHF, 2009). In 2012, the minimum level of dependence became only the need for community-based LTC services for more than 120 days (NYSDOH, 2013). This was still determined by the SAAM, and later the UAS-NY after its implementation in 2013.

MMC

There is no minimum level of dependence to be enrolled in MMC. However, plans may organize for an assessment and/or require a physician's order to determine whether particular services are medically necessary before approval and authorization.

Duration of benefit

Reassessments of eligibility vary by LTC health benefit program. Below we detail reassessments for Medicaid, followed by reassessments for the four largest programs.

Medicaid

Federal law requires states to renew Medicaid eligibility at least every 12 months.

Nursing Facility Care

Mentions of reassessment protocol were omitted in department regulations beginning in 1997. Regulation now states that the Commissioner of Health or their designee will determine standards for reviews of medical necessity (18 NYCRR 505.9, 1998).

LTHHCP

Participants must be reassessed using the Long-Term Care Placement Medical Assessment Abstract (DMS-1) at least every 6 months (Medicaid.gov, 2013).

MLTC

Participants must be reassessed using the SAAM (in 2013, the UAS-NY) every 6 months.

MMC

Reauthorization and reassessment timelines for most services vary by provider and health plan. Authorizations for personal care services and ADHC must be reauthorized every 6 months (NYSDOH, 2011b; NYSDOH, 2013d).

Means testing

In-kind benefits are means-tested. Depending on the eligibility track used to qualify for Medicaid, the income and asset limits may differ.

Age requirement

There is no age requirement for Medicaid. Age would only impact the eligibility track used to qualify for Medicaid.

Nursing Facility Care, MMC

There is no age requirement. However, age may affect whether an individual is required to enroll in MMC.

LTHHCP

The individual must be at least age 65 or disabled (Medicaid.gov, 2013).

MLTC

The individual must be at least age 18, but providers may choose to serve only certain populations. For example, some providers require a minimum age of 21 or 65 (NYSDOH, 2022b). Additionally, age may affect whether an individual is required to enroll in MLTC.

Care needs assessment

Definition of dependence

Definitions of dependence vary by LTC health benefit program. The details of the four largest programs are summarized below.

Nursing Facility Care

The Patient Review Instrument (PRI) determines dependency in two ways (NYSDOH, 2005):

1. Categories: Determined by medical conditions and treatments, need for rehabilitation, and mental health and behavior
    - Heavy rehabilitation
    - Special care
    - Clinically complex
    - Severe behavioral
    - Reduced physical functioning
2. Scoring: Defined by how much assistance or supervision is required with ADLs

Scoring criteria varies slightly for each ADL but in general, scores range from 1 (no supervision or assistance required) to 5 (needs highest amount of supervision/assistance). See Box 9 for full scoring criteria. Complete definitions for each category and scoring point conversions are located in Figure 1.

Information from the PRI is then used in the SCREEN, an additional form that determines the specific level of care needed. For example, if the Screener marks the question "All ADL scores are 1 or 2" as "YES" using information from the PRI, the applicant will be referred to a CHHA to perform an assessment for Home Health Services. This scenario would direct the applicant away from residential care. After filling out the SCREEN, the assessor makes a final determination of whether the patient is recommended for residential care, or if they should be referred to community care options.

LTHHCP

Applicants for the LTHHCP must meet a nursing facility level of care (NFLOC), meaning that they would require admission to a nursing facility if not for the existence of the LTHHCP. This is determined by the DMS-1. A score of 60 or higher indicates an NFLOC.

MLTC

Applicants for MLTC must meet an NFLOC, meaning that they would require admission to a nursing facility if not for the existence of MLTC. This is determined through the SAAM form. A score of 5 or higher indicates an NFLOC. Following the implementation of the UAS-NY in 2013, an assessment demonstrating the need for a community-based LTC service for 120 days or more indicates the applicant has met the required level of dependence.

There are 7 degrees of dependence that determine the beneficiary's level of functioning with their ADLs and IADLs (NYSDOH, 2019):

1. Independent: No help, setup, or supervision
2. Supervision: Oversight/cueing
3. Limited Assistance: Help on some occasions
4. Extensive Assistance: Help through task, but performs 50% or more of task on own
5. Maximal Assistance: Help throughout task, but performs less than 50% of task on own
6. Total Dependence: Full performance by others during entire period

An applicant's ability to perform ADLs and IADLs informs the plan of care. For example, an applicant demonstrating the need for extensive assistance with several ADLs will therefore demonstrate a need for personal care services.

MMC

There is no standard definition of dependence required to enroll in MMC. However, many LTC services require authorization from the health plan. Authorization is often provided following a physician's order that certifies the need for services. New York Social Services Law defines medically necessary as "necessary to prevent, diagnose, correct, or cure conditions in the person that cause acute suffering, endanger life, result in illness or infirmity, interfere with such person's capacity for normal activity, or threaten some significant handicap and which are furnished an eligible person in accordance with state law" (NY Soc Serv L 365-A (2022).

For some services, such as personal care, plans must conduct DMS-1 assessments (and the UAS-NY after implementation) to determine the amount and scope of services required. Depending on the outcome of the functional assessment criteria, the applicant would be approved for a certain amount of personal care hours. Sixteen hours of care or more are separated into two levels (NYSDOH, 2011b):

- Continuous services: The provision of uninterrupted care, by more than one person, for more than 16 hours per day for a patient who requires total assistance with toileting, walking, transferring or feeding at times that cannot be predicted
- Live-in 24-hour services: The provision of care by one person for a patient who requires some or total assistance with one or more personal care functions during the day and night and whose need for assistance during the night is infrequent or can be predicted —the member´s home must have adequate sleeping accommodations for the personal care services worker

Evaluation of dependence

Evaluations of dependence vary by LTC health benefit program. The details of the four largest programs are summarized below.

Nursing Facility Care

The Patient Review Instrument (PRI) is the assessment tool used to determine whether placement in an institution is appropriate. The PRI evaluates physical, medical, and cognitive characteristics of the patient, and documents selected services they may receive. The SCREEN is the supplemental form that determines the specific level of care needed using information from the completed PRI. The final determination of whether to recommend the patient for institutionalization or to pursue community-based care takes place at the end of the SCREEN. See Box 7 for a description of the PRI and SCREEN.

Nursing facilities are required by federal law to conduct a Preadmission Screening and Resident Review (PASRR) and periodic assessments using the Minimum Data Set (MDS). See Box 2 for more information on the PASRR, and Box 3 for the MDS.

LTHHCP

The Long-Term Care Placement Medical Assessment Abstract (DMS-1) is the assessment tool used to determine eligibility for the LTHHCP. The DMS-1 captures information about a patient's current health status (e.g., medical conditions, diagnoses, health services received), and assesses functional and mental status. Each answer converts to a specific point value. Upon completion, the sum of the point values directly corresponds to a specific level of care. See Box 1 for a description of the DMS-1. The applicant must meet a score of 60 or more for admission to the program but does not require a distinction between HRF and SNF levels of care.

MLTC

The Semi Annual Assessment of Members (SAAM) is the assessment tool used to determine eligibility for MLTC. See the previous policy period (Chapter 2: 1997-2010) for detailed assessment information.

After the implementation of the UAS-NY in 2013, plans used the Community Health Assessment (CHA), found within the UAS-NY, to determine MLTC eligibility. The CHA evaluates the patient's cognition, communication and vision, mood and behavior, functional status, continence, and nutritional status. See Box 12 for additional details on the CHA. As of 2014, the CFEEC conducts all UAS-NY assessments for MLTC.

MMC

In order to obtain LTC services through MMC, enrollees must be authorized to receive each service from their health plan. Enrollees seeking service authorization must have an order from a physician showing medical necessity for the specific service. There is no standard form for this order (NYSDOH, 2013c).

Secondly, plans are responsible for organizing required DMS-1 assessments, as well as the UAS-NY once implemented, with the contracted provider of the service. A licensed professional from the service provider conducts this assessment and alerts the plan

of the outcome, including expected hours of care needed (NYSDOH, 2013d; NYSDOH, 2021b).

Evaluators

Evaluators vary by LTC health benefit program. The details of the four largest programs are summarized below.

Nursing Facility Care

The PRI must be completed by a registered nurse. The SCREEN may be completed by a county caseworker or another professional that has completed the required training.

LTHHCP

Applicants may apply through the local social services district or directly to an individual program provider. A nurse from the provider organization or the county will conduct the DMS-1 assessment. If conducted by a provider nurse, the provider will forward the completed assessment to the county. Upon completion, the county makes an in-home visit to confirm eligibility and computes and approves each individual's plan of care (UHF, 2009; Medicaid.gov, 2013).

MLTC

The SAAM must be completed by a health plan nurse (UHF, 2009). After 2013, UAS-NY assessments were conducted by a registered nurse that is trained in the UAS-NY assessment process. As of 2014, a registered nurse from the CFEEC conducts all eligibility assessments.

MMC

Criteria vary by provider and benefit. For example, ADHC recipients have assessments conducted at their respective center. Following the implementation of the UAS-NY in 2013, assessments were conducted by a registered nurse that is trained in the UAS-NY assessment process for most services.

Benefit limitations

Can you mix LTC benefits?

All New York Medicaid beneficiaries receive the state plan benefit package. Some beneficiaries, if eligible, may also enroll in a federally approved HCBS program. Individuals enrolled in managed care may receive state plan and additional benefits through capitated managed care plans. Beneficiaries may not duplicate services across programs.

Is there free choice between cash and benefits in-kind?

The LTC system does not offer a cash benefit.

Can you receive LTC benefits with other social security benefits?

It is possible to receive LTC benefits along with other welfare benefits, such as SSI and Supplemental Nutrition Assistance Program (SNAP).

User costs

User charges

Medicaid

As required by federal law, New York enforces Estate Recovery. The acceptance of Medicaid in New York creates a debt to the state agency in the total amount paid to or for the benefit of the recipient for medical assistance after the recipient reached 55 years of age or was permanently institutionalized. Upon the death of the recipient, the state agency may recover the debt by filing a statement of claim against the estate of the deceased Medicaid recipient. However, the debt will not be enforced if the recipient is survived by a spouse, child or children under 21 years of age, or a child or children who are blind or disabled (NYSOTDA, 1993; NYSDOH, 2002).

Nursing Facility Care

Beneficiaries are expected to contribute all of their income to the cost of care in a nursing home, except for a monthly personal needs allowance (PNA). In 2011, the PNA was $50 per month. The exact contribution amount is called the Net Available Monthly Income (NAMI). See Box 5 for how the NAMI is calculated for institutionalized individuals, and Box 6 for institutionalized spouses.

LTHHCP

There are no copayments or similar charges imposed on program participants.

MLTC, MMC

Individuals requiring nursing facility coverage must apply the same institutional charges as detailed above for nursing facility care, and the NAMI will be calculated and contributed to the cost of care through the managed care plan.

Taxation of benefits

In-kind benefits are not subject to taxation.

Chapter 4: Policy enacted 2020-2023

Policy change in 2020
In 2020, New York initiated the Medicaid Redesign Team (MRT) II, tasked with the same goal as the earlier MRT (2011). At this time, long-term care (LTC) services were the fastest growing Medicaid expense, prompting the MRT II to set up an advisory group focused only on LTC (NYSDOH, 2020c).

Many proposals from the MRT II made eligibility more restrictive (NYSDOH, 2020b). However, most of these proposals have yet to be implemented due to the COVID-19 pandemic. As of December 2022, the only major proposal from the MRT II that has been implemented is the establishment of the New York Independent Assessor (NYIA). The NYIA conducts all initial assessments for individuals who have expressed an interest in enrolling in a Managed Long-Term Care (MLTC) plan or who are seeking personal care services, regardless of the provider (NYSDOH, 2022c). The NYIA eligibility process replaced the role of the Conflict Free Evaluation and Enrollment Center (CFEEC) for MLTC eligibility, and changed the reassessment policy to require annual reassessments rather than every 6 months.

The eligibility determination from the NYIA is detailed in the *Evaluation of Dependence* section for this policy period. The most significant changes from previous policy are the addition of a physician's order requirement for MLTC, and the Independent Practitioner Panel, a secondary review for all cases deemed "high needs" (NYSDOH, 2022c).

Other reforms during this period:

- (2020) New York State began involuntary disenrollments from MLTC plans if an individual was determined to require a long-term nursing home stay (stay of 3+ months) (NYSDOH, 2019b). This policy was a reversal of the mandatory enrollment of the same population into managed care in 2015. Disenrolled beneficiaries would be transitioned to state plan, fee-for-service (FFS) Medicaid.
- (2023) New York raised the income spend down amount for individuals eligible under eligibility track 3a (aged, blind, and disabled) to 138% of the federal poverty level (FPL). Asset limits were also increased to $28,134 for an individual and $37,908 for a couple (NYSDOH, 2023).

Overview

Long-term care (LTC) benefits in New York are primarily provided by Medicaid, a public health insurance program for low-income individuals. Medicaid in New York is administered at the state level by the New York State Department of Health (NYSDOH), and enrollment is voluntary.

Eligibility for Medicaid is determined by eligibility tracks that may have different requirements, such as income and asset limits. LTC benefits in New York are mostly provided through state plan benefit programs (Nursing Facility Care), federally approved home-and community-based services (HCBS) LTC programs (Managed Long-Term Care - MLTC), or through comprehensive plans providing both acute care and LTC (Mainstream Managed Care - MMC).

Beneficiaries receiving state plan benefits must establish medical necessity for each service prescribed by a physician. Similarly, MMC enrollees must establish medical necessity for each service requested from their health plan. State plan benefits are not mutually exclusive, and a beneficiary may receive multiple benefits if eligible. Once a specific state plan benefit is determined to be medically necessary, the beneficiary may immediately receive care. Nursing Facility Care only provides care in a nursing home, while people covered by MLTC or MMC are able to receive a variety of LTC benefits in addition to services under the state plan if deemed medically eligible, such as social adult day care (SADC).

Benefit programs vary in dependence requirements. Each requested service under MMC requires the individual to have a medical necessity for services, while Nursing Facility and MLTC beneficiaries must meet a nursing facility level of care (NFLOC) based on a comprehensive assessment before admission.

It is important to note that while many state plan health benefit programs still existed (Personal Care Services Program - PCSP, Home Health Services), the statewide transition to managed care dramatically reduced enrollment in the traditional, fee-for-service state plan programs, and most of the population began receiving these services through capitated managed care plans (e.g., MLTC and MMC). For this reason, these programs will not be detailed in this policy period (chapter). For information on their eligibility criteria, please see previous policy periods (chapters).

Statutory basis

Federal Law for Medicaid: 42 U.S.C. 1396-1 to 1396w-5, Title XIX of the Social Security Act (SSA, 2023d)

New York Law for Medicaid

- N.Y. Comp. Codes R. & Regs. Tit. 10 - Department of Health (NYCCRR, 2023)
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Coverage

This section discusses the scope of risks covered and the requirements to be eligible for benefits when the need for care arises. Dependence requirements are discussed in the later section on *Benefit Eligibility*.

Risk covered definition

Medicaid LTC serves individuals with limited income and assets who need assistance with physical, functional, and cognitive impairments and/or other limitations of daily living that may prevent them from being fully independent. For example, many individuals pursue LTC for assistance with activities of daily living (ADLs), which are fundamental tasks like eating, dressing, and showering. If the beneficiary is eligible, Medicaid will also pay for 24-hour care in a nursing facility.

Eligible population

There exist several LTC benefits and programs under Medicaid, many of which have age or dependence-related eligibility requirements that must be met before service authorization or program enrollment. However, all benefits and programs first require eligibility for Medicaid. Here we detail eligibility for New York Medicaid, followed by additional requirements for specific benefits and programs under Medicaid.

Medicaid

States are federally required to provide Medicaid coverage to certain categorical populations, called the mandatory categorically needy. While there are many groups within this track (e.g., pregnant women, children), we only detail eligibility information for categories that are most likely to require LTC (e.g., aged or disabled individuals). Additionally, states may opt in to cover additional categorical populations, called the optional categorically needy. There is substantial variation in who is covered as optional categorically needy across states. Here we detail the eligibility criteria for the most relevant eligibility tracks and coverage groups in New York.

Eligibility for Medicaid in New York for people needing LTC services is primarily attained by satisfying at least one of 3 alternative eligibility tracks:

Eligibility Track 1: Mandatory Categorically Needy

- 1a. Supplemental Security Income (SSI) recipients
  - Income requirements: Monthly income may not exceed the maximum SSI benefit amount.[1] In 2020, the monthly federal benefit amount was $783 for an individual and $1,175 for a couple (SSA, 2020). See Table 2 for historical monthly benefit amounts.
  - Asset requirements (NYSDOH, 2019a): Resources may not exceed $2,000 for an individual and $3,000 for a couple (NYSDOH, 2013a). This standard has remained the same since 1989.
    * Asset transfer: With some exceptions, applicants who dispose of resources or income for less than fair market value on or after the look back date will be subject to a period of ineligibility for LTC services.[17]
    * Home equity limit: The equity interest in the individual's home may not exceed $893,000, or else they will be ineligible for LTC services. This figure increases annually with inflation.[9]

  - Citizenship/immigration requirements: The applicant must be a New York resident and a U.S. citizen or a qualified non-citizen, such as a lawfully admitted permanent resident, refugee admitted under Section 207 of the Immigration and Nationality Act (INA), or someone granted asylum under Section 208 of the INA —individuals who entered the United States on or after August 22, 1996, are ineligible for SSI and Medicaid for the first 5 years as a lawfully admitted permanent resident. See SSA (2023c) for additional information.
  - Other requirements
    * The applicant must be at least age 65, blind, or disabled.[4]

Eligibility Track 2: Optional Categorically Needy

- 2c. Affordable Care Act (ACA) expansion adults
  - Income requirements: Monthly income may not exceed 138% of the Federal Poverty Level (FPL). In 2020, this was $1,468 for an individual and $1,983 for a household of two (NYSDOH, 2020a). See Table 2 for historical income limits.
  - Asset requirements: There is no asset test for this population.
  - Citizenship/immigration requirements: Same citizenship requirements as eligibility track 1a.
  - Other requirements
    * Applicants must be ages 19-64, ineligible for Medicare, ineligible for other Medicaid eligibility tracks, and not pregnant at the time of application.

Eligibility Track 3: Medically Needy

- 3a. Aged, blind, or disabled
  - Income requirements: In order to be eligible under the medically needy track, individuals must "spend down" their excess income to meet a specific standard. This functions similar to a deductible. The monthly spend down amount in 2020 is $875 for an individual and $1,284 for a household of two (NYSDOH, 2019a).[18] Additional income disregards exist if a person is institutionalized or receiving HCBS and has a spouse residing in the community.[21] From 2023, the limit increased to 138% of the FPL, or $1,563 for an individual and $2,106 for a couple (NYDOH, 2023).
  - Asset requirements: Resources may not exceed $15,750 for an individual and $23,100 for a household of two (NYSDOH, 2019a).[18] Additional asset disregards exist if a person is institutionalized or receiving HCBS and has a spouse residing in the community.[22] From 2023, the asset limit increased to $28,133 for an individual and $37,902 for a household of two (NYDOH, 2023).
    * Asset transfer and Home Equity Limit: Same as eligibility track 1a.
  - Citizenship/immigration requirements: Same citizenship requirements as eligibility track 1a.
  - Other requirements
    * The applicant must be at least age 65, blind, or disabled.[4]

Other Eligibility Tracks

There exist alternative eligibility tracks targeted at other populations. Some of these tracks include:

- Medicaid Cancer Treatment Program: Breast, Cervical, Colorectal, and Prostate Cancer: Medicaid program for eligible persons who are found to be in need of treatment for breast, cervical, colorectal, or prostate cancer that provides full Medicaid coverage for a period as determined by the type of cancer or pre-cancerous condition being treated (NYSDOH, 2014).

Once eligibility for Medicaid has been determined, beneficiaries may have to meet additional eligibility criteria in order to become eligible for specific LTC health benefit programs under Medicaid. Additional program criteria (if applicable) is detailed below.

Nursing Facility Care

There are no additional conditions for coverage. Benefit qualification depends on minimum level of dependence.

Medicaid Managed Long-Term Care (MLTC)

Beyond meeting minimum level of dependence requirements, applicants must be at least age 21. Some plans may choose to only cover individuals over age 65. MLTC enrollment is mandatory for individuals that are over age 21, eligible for both Medicare and Medicaid (known as dually eligible), and require community-based LTC services for more than 120 days (NYSDOH, 2019c). Enrollment is voluntary for individuals that are over age 18 and meet dependence requirements. See Box 13 for or a list of populations that are exempt or excluded from mandatory enrollment.

Mainstream Managed Care (MMC)

There are no additional conditions for coverage. However, enrollment is mandatory for most Medicaid beneficiaries unless they are exempt, excluded, or qualify for MLTC. See Box 14 for full list of exempt and exclusion criteria.

Other community-based programs

There exist several home and community-based services (HCBS) programs targeted at older adults that are omitted due to limited enrollment. Some of these programs include:

- Adult Day Health Care (ADHC)
- Private Duty Nursing
- Assisted Living Program (ALP)
- Home Health Services
- Personal Care Services Program (PCSP)
- Program of All-Inclusive Care for the Elderly (PACE)
- Traumatic Brain Injury (TBI) Waiver
- Nursing Home Transition and Diversion Waiver (NHTDW)
- Medicaid Advantage Plus (MAP)
- Expanded In-Home Services for the Elderly (EISEP)
- New York Long-Term Care Partnership

Benefit

Home care benefit

Nursing Facility Care

Nursing Facility Care does not provide home care during this policy period.

MLTC, MMC

MLTC and MMC provide the following services in addition to those offered under the state plan, unless otherwise noted (NYSDOH, 2019d; NYSDOH, 2019b):

- Personal care services
  - Level 1: Assistance with IADLs, such as personal laundry, light housekeeping, shopping, meal preparation, and medication administration —if the beneficiary is only receiving Level 1 services, care is limited to 8 hours per week
  - Level 2: Assistance with ADLs, such as eating, toileting, bathing, grooming, dressing, ambulation, and transferring
- Home health services
  - Skilled nursing services: Intermittent or part-time nursing services, such as colostomy and ileostomy care, tracheotomy aspiration, Levin tube care, provided by a registered nurse or licensed practical nurse
  - Home health aide services: Semi-skilled care, such as simple wound care, vital monitoring, and personal care
- Private duty nursing: Skilled nursing interventions on an individual and continuous basis (in contrast to intermittent) and respiratory care for participants who are ventilator dependent
- Consumer-Directed Personal Assistance Services (CDPAS): Option for home care that allows the beneficiary to hire and manage the aide of their choice

Semi-residential care

Nursing Facility Care

Nursing Facility Care does not provide semi-residential care during this policy period.

MLTC

Semi-residential services provided include:

- Social Adult Day Care (SADC): Program that provides functionally impaired older adults with socialization, supervision and monitoring, personal care, and nutrition in a protective setting
- Adult Day Health Care (ADHC): Centers provide daytime supervision, personal care assistance, and sometimes meals to recipients in a group setting

MMC

MMC plans may include ADHC (as described above under MLTC).

Residential care

Nursing Facility Care

The state plan provides residential care in skilled nursing facilities (SNFs) and health-related facilities (HRFs) (NYCRR, 1990).[7] An SNF provides care to those requiring high levels of medical, social, and/or rehabilitation services. An HRF cares for residents that are more functionally independent than those residing in an SNF.

MLTC

Residential care is covered by MLTC plans (as described above under Nursing Facility Care) if the stay does not exceed 3 months. If the beneficiary resides in a nursing facility for more than 3 months, they will be considered a long-term stay. Long-term stays are involuntarily disenrolled from their MLTC plan and transitioned into traditional FFS Nursing Facility Care (detailed above) (NYSDOH, 2019b).[23]

MMC

Residential care is covered by MMC plans (as described above under Nursing Facility Care) unless the individual is under 21 and/or their stay exceeds 3 months.

Other benefits

New York Medicaid provides additional benefits related to LTC:

- Durable medical equipment and supplies: Items that assist with an illness or injury, and may include walkers, wheelchairs, suction pumps, bandages, or similar aids —this is a required benefit under Home Health Services
- Non-emergency medical transportation: Medically necessary transportation for any recipient and personal care attendant or escort, if required, who have no other means of transportation available to any Medicaid-compensable service for the purpose of receiving treatment, medical evaluation, or therapy

MLTC

MLTC provides the following services in addition to those offered under the state plan, unless otherwise noted (NYSDOH, 2019d):

- Case Management: Services that assist the participant in developing, authorizing, and monitoring the plan of care
- Personal Emergency Response System (PERS): Electronic communication equipment in the home of an individual which signals a monitoring agency for help when activated, or after a period of time if a timer mechanism has not been reset
- Transportation to and from semi-residential services[24]
- Medical Social Services: Counseling service provided to the participant who is coping with altered abilities and skills, a revision of long-term expectations or changes in roles in relation to significant others
- Respite care: Scheduled short-term nursing care in which an enrollee who is normally cared for in the community resides in a residential facility for purposes of providing breaks for caregiver(s)
- Home improvement or adaptations: Physical adaptations to the home, which are necessary to assure the health, welfare and safety of the participant (known as Home Modifications)
- Home-delivered meals: Delivers healthy meals to the beneficiary's home

MMC

MMC provides the following services in addition to those offered under the state plan, unless otherwise noted (NYSDOH, 2013):

- Case Management (as described above under LTHHCP)
- PERS (as described above under LTHHCP)
- Medical Social Services: Only for enrollees who previously received this benefit through the LTHHCP and transitioned to MMC
- Respite care (as described above under LTHHCP)
- Home-delivered meals: Only for enrollees who previously received this benefit through the LTHHCP and transitioned to MMC

Provision of care

Medicaid benefits may be provided by non-profit organizations, home health agencies, hospitals, nursing facilities, and for-profit providers, all of which are licensed and overseen by the New York State Department of Health. Providers that accept Medicaid payment rates and meet licensing requirements may participate in Medicaid. Managed care plans will have limited provider networks.

Benefit eligibility

Qualifying period

Potential users may apply at any time.

Minimum level of dependence

The minimum level of dependence varies by LTC health benefit program. The details of the three largest programs are summarized below.

Nursing Facility Care

Before admission to a nursing facility, patients must be assessed using the Patient Review Instrument (PRI), a comprehensive assessment that assesses functional, cognitive, medical, and behavioral health characteristics in order to determine the level of care and the type of services required. Following the PRI, patients must also be administered the SCREEN, which explores alternatives to nursing home care if appropriate. If the SCREEN indicates the patient could be suitable for care in the community, they will be referred to another program (UHF, 2009).

MLTC

Applicants must require at least one community-based LTC service (i.e., personal care services or CDPAS) for more than 120 days. However, while personal care Level 1 services and SADC are provided by MLTC plans, requiring either of them alone is not enough to qualify.

MMC

There is no minimum level of dependence to be enrolled in MMC. However, plans may organize for an assessment and/or require a physician's order to determine whether particular services are medically necessary before approval and authorization.

Duration of benefit

Reassessments of eligibility vary by LTC health benefit program. Below we detail reassessments for Medicaid, followed by reassessments for the three largest programs.

Medicaid

Federal law requires states to renew Medicaid eligibility at least every 12 months.

Nursing Facility Care

Patients must be reassessed using the Patient Review Instrument (PRI) every 12 months (HCRAPools, 2022).

MLTC, MMC

Participants must be reassessed by the New York Independence Assessor (NYIA) every 12 months (NYSDOH, 2022d).

Means testing

In-kind benefits are means-tested. Depending on the eligibility track used to qualify for Medicaid, the income and asset limits may differ.

Age requirement

There is no age requirement for Medicaid. Age would only impact the eligibility track used to qualify for Medicaid.

Nursing Facility Care, MMC

There is no age requirement. However, age may affect whether an individual is required to enroll in MMC.

MLTC

Applicants must be at least age 18, but providers may choose to serve only certain populations. For example, some providers require a minimum age of 21 or 65 (NYSDOH, 2022b). Additionally, age may affect whether an individual is required to enroll in MLTC.

Care needs assessment

Definition of dependence

Definitions of dependence vary by LTC health benefit program. The details of the three largest programs are summarized below.

Nursing Facility Care

The Patient Review Instrument (PRI) determines dependency in two ways (NYSDOH, 2005):

1. Categories: Determined by medical conditions and treatments, need for rehabilitation, and mental health and behavior
    - Heavy rehabilitation
    - Special care
    - Clinically complex
    - Severe behavioral
    - Reduced physical functioning
2. Scoring: Defined by how much assistance or supervision is required with ADLs

Scoring criteria varies slightly for each ADL but in general, scores range from 1 (no supervision or assistance required) to 5 (needs highest amount of supervision/assistance). See Box 9 for full scoring criteria. Complete definitions for each category and scoring point conversions are located in Figure 1.

Information from the PRI is then used in the SCREEN, an additional form that determines the specific level of care needed. For example, if the Screener marks the question "All ADL scores are 1 or 2" as "YES" using information from the PRI, the applicant will be referred to a CHHA to perform an assessment for Home Health Services. This scenario would direct the applicant away from residential care. After filling out the SCREEN, the assessor makes a final determination of whether the patient is recommended for residential care, or if they should be referred to community care options.

MLTC

Applicants must demonstrate the need for plan services for at least 120 days. This is determined through the UAS-NY assessment that evaluates the functional ability of each applicant. There are 7 degrees of dependence that determine the beneficiary's level of functioning with their ADLs and IADLs (NYSDOH, 2019):

1. Independent: No help, setup, or supervision
2. Supervision: Oversight/cueing
3. Limited Assistance: Help on some occasions
4. Extensive Assistance: Help through task, but performs 50% or more of task on own
5. Maximal Assistance: Help throughout task, but performs less than 50% of task on own
6. Total Dependence: Full performance by others during entire period

An applicant's ability to perform ADLs and IADLs informs the plan of care. For example, an applicant demonstrating the need for extensive assistance with several ADLs will therefore demonstrate a need for personal care services.

MMC

There is no standard definition of dependence required to enroll in MMC. However, many LTC services require authorization from the health plan. Authorization is often provided following a physician's order that certifies the need for services. New York Social Services Law defines medically necessary as "necessary to prevent, diagnose, correct, or cure conditions in the person that cause acute suffering, endanger life, result in illness or infirmity, interfere with such person's capacity for normal activity, or threaten some significant handicap and which are furnished an eligible person in accordance with state law" (NY Soc Serv L 365-A (2022).

For some services, such as personal care, plans must conduct UAS-NY assessments to determine the amount and scope of services required. Depending on the outcome of the functional assessment criteria, the applicant would be approved for a certain amount of personal care hours. Sixteen hours of care or more are separated into two levels (NYSDOH, 2011b):

- Continuous services: The provision of uninterrupted care, by more than one person, for more than 16 hours per day for a patient who requires total assistance with toileting, walking, transferring or feeding at times that cannot be predicted
- Live-in 24-hour services: The provision of care by one person for a patient who requires some or total assistance with one or more personal care functions during the day and night and whose need for assistance during the night is infrequent or can be predicted —the member´s home must have adequate sleeping accommodations for the personal care services worker

As of 2022, particular services such as personal care services and CDPAS require an eligibility determination through the NYIA using the UAS-NY, detailed above under MLTC (NYSDOH, 2022d)

Evaluation of dependence

Evaluations of dependence vary by LTC health benefit program. The details of the three largest programs are summarized below.

Nursing Facility Care

The Patient Review Instrument (PRI) is the assessment tool used to determine whether placement in an institution is appropriate. The PRI evaluates physical, medical, and cognitive characteristics of the patient, and documents selected services they may receive. The SCREEN is the supplemental form that determines the specific level of care needed using information from the completed PRI. The final determination of whether to recommend the patient for institutionalization or to pursue community-based care takes place at the end of the SCREEN. See Box 7 for a description of the PRI and SCREEN.

Nursing facilities are required by federal law to conduct a Preadmission Screening and Resident Review (PASRR) and periodic assessments using the Minimum Data Set (MDS). See Box 2 for more information on the PASRR, and Box 3 for the MDS.

MLTC

As of May 2022, the NYIA assesses individuals for MLTC plan eligibility. See the previous policy period (Chapter 3: 2011-2019) for information on the evaluation process under the CFEEC. The NYIA process includes (NYSDOH, 2022) —

1. Community Health Assessment (CHA): Initial assessment conducted by an NYIA nurse that evaluates patient's cognition, communication and vision, mood and behavior, functional status, continence, and nutritional status. See Box 12 for additional details on the CHA.
2. Practitioner Order (PO): Independent, licensed clinician conducts a clinical exam after reviewing the completed CHA and determines if personal care services and/or CDPAS are recommended. See Box 15 for additional details on the clinical exam.
3. Plan of Care (POC): Health plan reviews the NYIA CHA and the PO, and if indicated by the NYIA, authorizes services and/or plan eligibility. A POC is developed that details all community-based LTC services that may address the patient's demonstrated needs to maintain their health and safety in the community. In the POC, the health plan will also record the level, amount, frequency, and duration of services that they authorize. If the plan intends to authorize more than 12 hours of services per day on average for a new recipient of personal care and/or CDPAS, the health plan must refer the case back to the NYIA for an additional review, detailed below.
4. High Needs Review/Independent Review Panel (IRP): Panel of at least two clinicians that review the most recent NYIA CHA and PO as well as the POC to determine whether the proposed POC is adequate and reasonable to ensure the patient's health and safety in the home.

Once the CHA and PO are completed by the NYIA, the MLTC plan shall not conduct its own CHA but use the NYIA CHA and PO to inform its POC development.

MMC

In order to obtain LTC services through MMC, enrollees must be authorized to receive each service from their health plan. Enrollees seeking service authorization must have an order from a physician showing medical necessity for the specific service. There is no standard form for this order (NYSDOH, 2013c).

Secondly, plans are responsible for organizing required UAS-NY assessments with the contracted provider of the service. A licensed professional from the service provider conducts this assessment and alerts the plan of the outcome, including expected hours of care needed. After these steps are completed, the plan approves the care plan and authorizes the services (NYSDOH, 2013d; NYSDOH, 2021b).

As of May 2022, the evaluations to determine eligibility and need for personal care services and CDPAS are managed by the NYIA. If already enrolled in MMC, the enrollee's health plan will refer them to the NYIA to schedule assessments. Interested new enrollees will have to call the NYIA to schedule their assessments. The process for MMC service authorization is the same as detailed above under MLTC.

Evaluators

Evaluators vary by LTC health benefit program. The details of the three largest programs are summarized below.

Nursing Facility Care

The PRI must be completed by a registered nurse. The SCREEN may be completed by a county caseworker or another professional that has completed the required training.

MLTC

Prior to the implementation of the NYIA, a registered nurse from the CFEEC conducted all eligibility assessments. As of 2022, the initial, Independent Assessment (IA) is carried out by a New York Medicaid Choice (NYMC) nurse using the Uniform Assessment System's (UAS) Community Health Assessment (CHA). The subsequent Clinical Assessment (CA) is carried out by NYMC physician, physician's assistant, or nurse practitioner (NYSDOH, 2022d). An MLTC plan may (but is not required to) conduct a separate assessment for new enrollees to determine informal caregiver availability and night-time needs.

MMC

The IA is carried out by an NYMC nurse using the UAS-NY CHA. The subsequent CA is carried out by a NYMC physician, physician's assistant, or nurse practitioner (NYSDOH, 2022d).

Benefit limitations

Can you mix LTC benefits?

All New York Medicaid beneficiaries receive the state plan benefit package. Some beneficiaries, if eligible, may also enroll in a federally approved HCBS program. Individuals enrolled in managed care may receive state plan and additional benefits through capitated managed care plans. Beneficiaries may not duplicate services across programs.

Is there free choice between cash and benefits in-kind?

The LTC system does not offer a cash benefit.

Can you receive LTC benefits with other social security benefits?

It is possible to receive LTC benefits along with other welfare benefits, such as SSI and Supplemental Nutrition Assistance Program (SNAP).

User costs

User charges

Medicaid

As required by federal law, New York enforces Estate Recovery. The acceptance of Medicaid in New York creates a debt to the state agency in the total amount paid to or for the benefit of the recipient for medical assistance after the recipient reached 55 years of age or was permanently institutionalized. Upon the death of the recipient, the state agency may recover the debt by filing a statement of claim against the estate of the deceased Medicaid recipient. However, the debt will not be enforced if the recipient is survived by a spouse, child or children under 21 years of age, or a child or children who are blind or disabled (NYSOTDA, 1993; NYSDOH, 2002).

Nursing Facility Care

Beneficiaries are expected to contribute all of their income to the cost of care in a nursing home, except for a monthly personal needs allowance (PNA). In 2020, the PNA was $50 per month. The exact contribution amount is called the Net Available Monthly Income (NAMI). See Box 5 for how the NAMI is calculated for institutionalized individuals, and Box 6 for institutionalized spouses.

MLTC, MMC

Individuals requiring nursing facility coverage must apply the same institutional charges as detailed above for nursing facility care, and the NAMI will be calculated and contributed to the cost of care through the managed care plan.

Taxation of benefits

In-kind benefits are not subject to taxation.

Tables and Formulas

Table 1: New York Federal Medical Assistance Percentage (FMAP) for Medicaid

Fiscal Year	FMAP
1992	50.00%
1993	50.00
1994	50.00
1995	50.00
1996	50.00
1997	50.00
1998	50.00
1999	50.00
2000	50.00
2001	50.00
2002	50.00
2003	51.48
2004	52.21
2005	50.00
2006	50.00
2007	50.00
2008	50.00
2009	59.84
2010	61.59
2011	56.81
2012	50.00
2013	50.00
2014	50.00
2015	50.00
2016	50.00
2017	50.00
2018	50.00
2019	50.00
2020	54.65
2021	56.20
2022	56.20
2023[1]	54.98

Source: U.S. DHHS (2022)

Notes: FMAPs displayed here apply to the federal fiscal year indicated unless otherwise noted, which runs from October 1 through September 30. For example, FY 2022 refers to the period from October 1, 2021 through September 30, 2022. FY 2020, FY 2021, FY 2022, and FY 2023 FMAPs reflect higher federal matching funding (6.2 percent increase in FMAP rates for all states) made available through the Families First Coronavirus Response Act for the duration of the public health emergency period (H.R. 6201). [1] The enhanced FMAP decreased from 6.2 to 5 percentage points from April to June 2023, 2.5 percentage points from June to September 2023, and 1.5 percentage points from October to December 2023.

Table 2: Historical New York Medicaid Income Limits

Year	SSI (Individual)	SSI (Couple)	SSP (Individual)	SSP (Couple)	Total SSI & SSP (Individual)	Total SSI & SSP (Couple)	138% FPL (Individual)	138% FPL (Couple)
1992	$422.00	$633.00	$86.00	$102.50	$508.00	$735.50		
1993	434.00	652.00	86.00	102.50	520.00	754.50		
1994	446.00	669.00	86.00	102.50	532.00	771.50		
1995	458.00	687.00	86.00	102.50	544.00	789.50		
1996	470.00	705.00	86.00	102.50	556.00	807.50		
1997	484.00	726.00	86.00	102.50	570.00	828.50		
1998	494.00	741.00	86.00	102.50	580.00	843.50		
1999	500.00	751.00	87.00	104.00	587.00	855.00		
2000	513.00	769.00	87.00	104.00	599.00	873.00		
2001	531.00	796.00	87.00	104.00	618.00	900.00		
2002	545.00	817.00	87.00	104.00	632.00	921.00		
2003	552.00	829.00	87.00	104.00	639.00	933.00		
2004	564.00	846.00	87.00	104.00	651.00	950.00		
2005	579.00	869.00	87.00	104.00	666.00	973.00		
2006	603.00	904.00	87.00	104.00	690.00	1,008.00		
2007	623.00	934.00	87.00	104.00	710.00	1,038.00		
2008	637.00	956.00	87.00	104.00	724.00	1,060.00		
2009	674.00	1,011.00	87.00	104.00	761.00	1,115.00		
2010	674.00	1,011.00	87.00	104.00	761.00	1,115.00		
2011	674.00	1,011.00	87.00	104.00	761.00	1,115.00		
2012	698.00	1,048.00	87.00	104.00	785.00	1,152.00		
2013	710.00	1,066.00	87.00	104.00	797.00	1,170.00		
2014	721.00	1,082.00	87.00	104.00	808.00	1,186.00	1,343.00	1,809.00
2015	733.00	1,100.00	87.00	104.00	820.00	1,204.00	1,354.00	1,832.00
2016	733.00	1,100.00	87.00	104.00	820.00	1,204.00	1,367.00	1,843.00
2017	735.00	1,103.00	87.00	104.00	822.00	1,207.00	1,387.00	1,868.00
2018	750.00	1,125.00	87.00	104.00	837.00	1,229.00	1,397.00	1,893.00
2019	771.00	1,157.00	87.00	104.00	858.00	1,261.00	1,437.00	1,945.00
2020	783.00	1,175.00	87.00	104.00	870.00	1,279.00	1,468.00	1,983.00
2021	794.00	1,191.00	87.00	104.00	881.00	1,295.00	1,482.00	2,004.00
2022	841.00	1,261.00	87.00	104.00	928.00	1,365.00	1,564.00	2,106.00
2023	914.00	1,371.00	87.00	104.00	1,001.00	1,475.00	1,677.00	2,268.00

Source: SSA (2023b); Social Services Law - SOS § 209 (2023)

Notes: Supplemental Security Income (SSI) federal benefit rates, State Supplementary Payments (SSP), and federal poverty levels (FPL) for the Affordable Care Act (ACA) expansion population for individuals and couples are monthly. Income limits at 138% of the FPL begin in 2014, corresponding to the implementation of the new eligibility track under the ACA. Income limits for individuals and couples are monthly. SSPs in New York are provided to all SSI recipients, including children, except those living in publicly operated residences having more than 16 residents, in publicly operated emergency shelters, or in medical facilities where Medicaid pays less than 50 percent of the cost of care. This table provides the SSP amounts for eligible individuals and couples living independently, but there are additional payment amounts for other groups that vary by living arrangement and geographic location.

Box 1: Long-Term Care Placement Form (DMS-1)

The DMS-1 contains 6 assessment sections:

1. Diagnosis occasioning current use of services (e.g., diagnoses, surgeries, allergies)
2. Significant medications and/or injections
3. Nursing care and therapy (e.g., parenteral meds, inhalation treatment, suctioning), incontinence (e.g., urine and stool), special diets
4. Functional status (e.g., walking, transferring, wheeling, eating/feeding)
5. Mental status (e.g., alert, impaired judgement, hallucinates)
6. Impairments (e.g., vision, hearing, speech)

Following the assessment sections, the DMS-1 asks a series of questions about care recommendations (e.g., "Should the patient be cared for under home care?"), where the assessor may recommend institutional care. The point result automatically corresponds to a residential level of care. If the total point score is below 60, then the applicant is suitable for home care (as opposed to residential care).

Source: AJPH (1980); NYSDOH (2012b)
Notes: Sources detailing the point conversion charts, including naming each DMS-1 section, were found for the years 1980 and 2012. Both sources from these years listed the same section names and point values. From this, we can reasonably infer the DMS-1 remained the same throughout the period 1980 to 2012.

Box 2: Preadmission Screening and Resident Review (PASRR)

Nursing facilities are required by federal law to conduct a Preadmission Screening and Resident Review (PASRR). The purpose of PASRR is to prevent individuals with mental illness, intellectual disability, developmental disability, or a related condition from inappropriate admission to a nursing facility. The process consists of a Level I screen, Level II evaluation (depending on the outcome of the Level 1 screening), and a final determination. All applicants of Medicaid certified nursing facilities receive a Level I screen to identify possible conditions. These screens generally consist of forms completed by hospital discharge planners, community health nurses, or others as defined by the state. Individuals who do or may have a mental condition as described above are referred for a Level II PASRR evaluation. New York's Patient Review Instrument (PRI) and SCREEN satisfy the Level I PASRR requirement.

PASRRs were required on an annual basis until 1996, when the annual requirement was removed. Some states continue to conduct PASRRs on an annual basis.

Source: 42 CFR 483.100-138

Box 3: Minimum Data Set (MDS)

Nursing facilities are required by federal law to periodically assess each resident. The Minimum Data Set (MDS) is the uniform instrument used nationally to assess resident condition. The MDS collects resident data for a variety of purposes, such as to inform care plans or assess a resident's ongoing need for nursing home care. Assessments are performed every 3 months or more often depending on the resident's health condition.

The first MDS was implemented nationally in 1991. There have been two new versions of the MDS since then —one in 1995 (MDS 2.0), and another in 2010 (MDS 3.0). However, all versions generally assess the following domains: functional and cognitive status, behavioral symptoms, diagnoses and medications, geriatric syndromes, and psychosocial functioning.

Source: UCSF (2023)

Box 4: Definitions of Dependence for the Personal Care Services Program and Home Health Services

Applicants must meet at least one of the following criteria:

1. Self-directing: Capable of making choices about their clinical care and ADLs, and understands the impact of the choice and assumes responsibility for the results of the choice —they may alternatively have informal supports to provide advice and/or direction on their behalf
2. Able to call for help: Physically, mentally and cognitively capable of initiating effective communication to individuals outside their immediate presence and who can provide timely assistance
3. Can be left alone: Based on their physical, mental and cognitive capability does not require continuous presence of another individual to meet their minimal ongoing health and safety requirements
4. Has available informal supports: Friends, relatives or associates of the patient, whether compensated or not, unaffiliated with the agency, who are able to provide needed care, support and other services during the periods agency staff are not present

Source: OTDA (1992b)

Box 5: Net Available Monthly Income (NAMI) Calculations: Institutionalized Individuals

To determine the individual's eligibility for Medicaid and the amount of his/her income to be applied to the cost of care, deductions are made in the following order:

1. Subtract the appropriate Personal Needs Allowance (PNA) from his/her available income.
2. Deduct an amount to cover any third-party health insurance premium.
3. The needs of any children under 21 years of age for whom the applicant is legally responsible, in his/her former family household are then considered. The applicant's income is used to bring such children's income up to the appropriate Medically Needy Income level or Medicaid Standard, whichever is higher.
4. Deduct any expenses incurred for medical care, services or supplies and/or remedial care, not paid by Medicaid or a third party.

Any remaining income is applied to the cost of care on a monthly basis.

Source: NYSDOH (2008)

Box 6: Net Available Monthly Income (NAMI) Calculations: Institutionalized Spouses

To determine the individual's eligibility for Medicaid and the amount of his/her income to be applied to the cost of care, deductions are made in the following order:

1. Subtract the appropriate Personal Needs Allowance (PNA) from his/her available income.
2. When the community spouse's otherwise available monthly income is less than the minimum monthly maintenance needs allowance (MMMNA), deduct the amount required to bring the community spouse's otherwise available monthly income up to the MMMNA.
3. When the applicant has a dependent family member(s), deduct a family member allowance for each family member. The family member allowance is deducted for each dependent whether or not the income is actually made available to the family member. The family member allowance is first deducted from any excess income of the community spouse. If the community spouse's income is insufficient to cover a family member allowance, then the remainder is deducted from the income of the institutionalized individual.
4. Deduct any expenses incurred for medical care, services or supplies and/or remedial care, not paid by Medicaid or a third party.

Any remaining available income of the institutionalized spouse and any amount actually contributed from the community spouse is applied to the cost of care on a monthly basis.

Source: NYSDOH (2010a)

Table 3: Household Size Determination for Medically Needy Aged, Blind, and Disabled Population

	Household size for income	Household size for resources
Lives alone or with spouse who receives SSI	ONE	ONE
Lives with children but no spouse	ONE	ONE
Lives with aged, blind, or disabled spouse who is not on SSI and no children	TWO	TWO
Lives with spouse who is not aged, blind, or disabled AND there are no children under age 18	ONE if spouse's income is less than the allocation amount ($409 in 2020). Spouse's income is not counted. TWO if spouse's income is more than $409 (2020). Spouse's income is counted	TWO
Lives with spouse who is not aged, blind, or disabled AND there are children under age 18	ONE is spouse's income is less than $409 (2020) for each child under 18. Spouse's income is not counted. TWO if spouse's income is equal to or more than $409 (2020) for each child under 18. Spouse's income is counted in amount exceeding allocation amount for kids.	TWO

Source: NYSDOH, 2022a; NYSDOH (2019a)
Notes: Household size for the Eligibility Track 3a (Aged, Blind, and Disabled) population.

Box 7: Patient Review Instrument (PRI) and SCREEN

The PRI has 5 distinct sections:

1. Administrative data: Patient identification information (e.g., name, Social Security number, Medicaid number)
2. Medical Events: Medical conditions (e.g., internal bleeding, diabetes) and treatments (e.g., tracheostomy care)
3. ADLs: Assessment of patient's capability level to perform each ADL 60% or more of the time performed
4. Behaviors: (e.g., verbal disruption, physical aggression)
5. Specialized Services: Patient's receipt of specific services (e.g., physical therapy, physician visits)

The SCREEN determines the patient's potential to be appropriately cared for in a setting other than an institution, in which case the patient would be referred for a different assessment following the completion of the SCREEN. Secondly, the SCREEN assesses the patient for possible mental illness or developmental disabilities with an additional review if they are being recommended for institutional placement. These additional reviews include a Level 1 Review, which identifies a person suspected of having serious mental illness or developmental disability, and a Level II Pre-Admission Screen (PAS). The SCREEN can provide the patient with a referral to a Level II PAS if the Level I Review identifies the person as suspected of having a serious mental illness or developmental disability.

There are 4 components to the SCREEN, which are broken up by item number:

1. Items 1-6: Identification information
2. Items 7-21: Determine the person's potential for placement in a community setting
3. Items 22-35: Level 1 Review —Persons suspected of having serious mental illness or developmental disability must be referred for the Level II PAS to determine if there is a need for specialized services
4. Items 36-38: The person's disposition based on items 1-35 and acknowledgments by the person and the Screener

Many of the items in the SCREEN are arranged in such a way that either a YES or NO answer is the only possible outcome. Whether the screener answers YES or NO determines which item is answered next. Thus, the items must be answered in the appropriate sequence.

Source: NYSDOH (2005); NYSDOH (2009)

Box 8: Semi-Annual Assessment of Members (SAAM)

Sections of the SAAM include:

- Diagnosis/prognosis/surgeries, including severity ratings (0-4)
- Nursing therapies received (e.g., parenteral nutrition, suctioning, inhalation therapy)
- Rehabilitation therapies received (e.g., physical, occupational, and speech therapies)
- High risk factors (e.g., smoking, underweight, overweight, alcohol dependency)
- Flu immunization status in the past year
- Living arrangements (e.g., alone, with family)
- Supportive assistance (e.g., relatives, paid help) along with amount and duration of care received by caretakers
- Type of caregiver assistance received if applicable (e.g., ADL and IADL assistance, clinical assistance, psychosocial support)
- Sensory status (e.g., vision, hearing, speech)
- Integumentary status (e.g., skin lesions, open wounds, ulcers)
- Respiratory status (e.g., short of breath, respiratory treatments)
- Elimination status (e.g., urinary tract infections (UTIs), incontinence, catheters)
- Falls: number of falls and severity if applicable
- Neuro/emotional/behavioral status (e.g., cognitive functioning, anxiety, confusion, memory)
- ADL and IADL assessment (e.g., grooming, dressing, bathing, feeding)

During reassessments, assessors also must list emergent care utilization, hospitalizations, and nursing home admissions if they've occurred since the patient's last SAAM.

Source: NYSDOH (2005b)

Box 9: Patient Review Instrument - ADL Scoring Criteria

For each ADL, the assessor will provide a score ranging from 1 through 5.

Eating: Process of getting food by any means from the receptacle into the body (e.g., plate, cup, tube)

1. Feeds self without supervision or physical assistance. May use adaptive equipment.
2. Requires intermittent supervision (i.e., verbal encouragement/guidance) and/or minimal physical assistance with minor parts of eating, such as cutting food, buttering bread, or opening a milk carton.
3. Requires continual help (i.e., encouragement/teaching/physical assistance) with eating or meal will not be completed.
4. Totally fed by hand, patient does not manually participate.
5. Tube or parenteral feeding for primary intake of food. (Not just for supplemental nourishments)

Mobility: How the patient moves about

1. Walks with no supervision or human assistance. May require mechanical device (e.g., a walker), but not a wheelchair.
2. Walks with intermittent supervision (i.e., verbal cueing and observation). May require human assistance for difficult parts of walking (e.g., stairs, ramps).
3. Walks with constant one-to-one supervision and/or constant physical assistance.
4. Wheels with no supervision or assistance, except for difficult maneuvers (e.g., elevators, ramps). May actually be able to walk, but generally does not move.
5. Is wheeled, chairfast or bedfast. Relies on someone else to move about, if at all.

Transfer: Process of moving between positions, to/from bed, chair, standing (excluding transfer to/from bath and toilet)

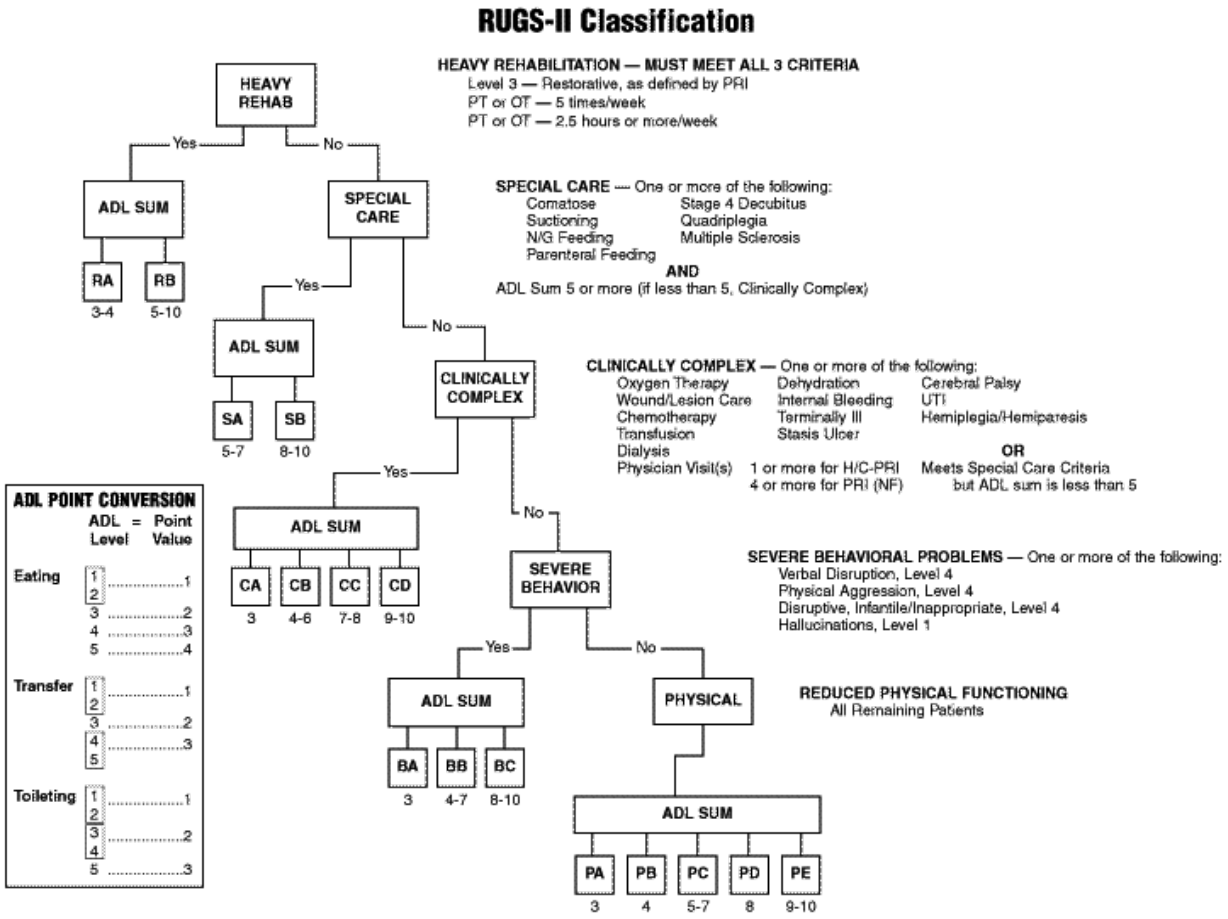
1. Requires no supervision or physical assistance to complete necessary transfers. May use equipment, such as railings, trapeze.
2. Requires intermittent supervision (i.e., verbal cueing, guidance) and/or physical assistance for difficult maneuvers only.
3. Requires one person to provide constant guidance, steadiness and/or physical assistance. Patient may participate in transfer.
4. Requires two people to provide constant supervision and/or physically lift. May need lifting equipment.
5. Cannot and is not gotten out of bed.

Toileting: Process of getting to and from a toilet (or use of other toileting equipment, such as bedpan). Transferring on and off toilet, cleansing self after elimination and adjusting clothes.

1. Requires no supervision or physical assistance. May require special equipment, such as a raised toilet or grab bars.
2. Requires intermittent supervision for safety or encouragement, or minor physical assistance (e.g., clothes adjustment or washing hands).
3. Continent of bowel and bladder. Requires constant supervision and/or physical assistance with major/all parts of the task, including appliances (e.g., colostomy, ileostomy, urinary catheter).
4. Incontinent of bowel and/or bladder and is not taken to a bathroom.
5. Incontinent of bowel and/or bladder but is taken to a bathroom every two to four hours during the day and as needed at night.

Source: NYSDOH (2005a)

Figure 1: RUGS-II Classification System - Patient Review Instrument (PRI)



Source: HCM (2001)

Note: The figure depicts the category descriptions and scoring system associated with the PRI assessment used for nursing facility admission.

Table 4: Implementation of the UAS-NY: Programs and Their Replaced Assessment Tools

Program	Forms Replaced With the UAS-NY
Adult Day Health Care (ADHC)	Registrant Assessment Instrument (RAI)
Long-Term Home Health Care Program (LTHHCP)	Long-Term Care Placement Form (DMS-1)
Managed Long-Term Care (MLTC)	Semi-Annual Assessment of Members (SAAM)
Personal Care Services Program (PCSP)/Consumer-Directed Personal Assistance Program (CDPAP)	Long-Term Care Placement Form (DMS-1)
Personal Care Services Program (PCSP) —New York City only	Registered Nurse Task Based Assessment (M27-R) Social Assessment (M11-S)

Source: NYSDOH (2013b)

Box 10: Mandatory Managed Care Enrollment: Nursing Home Population (2015)

The following policies are detailed for different populations:

- Individuals eligible for Medicare and Medicaid (known as dual eligibles)
  - Adults must enroll/remain in an MLTC plan if not already permanently placed in the nursing facility and Medicaid eligible prior to August 2014 for New York City, Long Island, and Westchester, and February 2015 for rest of state. If both conditions are met, person remains in state plan nursing facility care for the duration of their permanent placement, unless they voluntarily enroll in an MLTC plan.
  - Adults already placed in a nursing facility on a short-term basis or new to a nursing facility either remain in an MLTC plan if already enrolled, enroll in an MLTC plan if new to Medicaid, or remain in state plan nursing facility care until eligibility for permanent placement is determined and then enroll in an MLTC plan if currently in state plan nursing facility care.
- Medicaid only (known as non-dual eligibles)
  - Adults assessed as nursing facility eligible who are enrolled in MMC plans may opt out and enroll in an MLTC plan
  - Adults must enroll/remain in an MLTC plan or MMC plan if not already permanently placed in the nursing facility and Medicaid eligible prior to August 2014 for New York City, Long Island, and Westchester, and February 2015 for rest of state. Otherwise, person remains in state plan nursing facility care for the duration of their permanent placement, unless they voluntarily enroll in an MMC plan.
  - Adults already placed in a nursing facility on a short-term basis or new to a nursing facility either remain in an MMC/MLTC plan if already enrolled, enroll in an MMC plan if new to Medicaid, or remain in state plan nursing facility care until eligibility for permanent placement is determined and then enroll in an MMC plan if currently in state plan nursing facility care.

Source: Leading Age NY (2014)

Box 11: Community First Choice Option (CFCO) Implementation (2016)

Under section 1915(k) of the Social Security Act, States have the option to provide certain home and community-based LTC services and supports to specific Medicaid beneficiaries who would otherwise qualify for a nursing facility level of care (NFLOC). Following the Affordable Care Act (ACA), the CFCO population would receive an additional 6% in federal matching funds, called the enhanced Federal Medical Assistance Percentage (FMAP). CMS approved New York's CFCO program and proposed methodology to claim enhanced FMAP in 2016. Because these services were offered under the state plan prior to the ACA, New York's methodology consisted of comparing service data with demographic data (e.g., level of care assessments and residential information), identifying CFCO services received by eligible beneficiaries who meet an NFLOC, and claimed enhanced FMAP for this population both in state plan health benefit programs and managed care. Because this functioned more as an implementation of a process to receive enhanced matching funds rather than the launch of a new program, CFCO is not detailed as a separate LTC program in this policy document.

Source: Leading Age NY (2014); HHS (2015)

Box 12: UAS-NY: Community Health Assessment

The CHA assesses 6 different areas:

- Cognition: Assesses short term (e.g., what did you eat for breakfast?) and procedural (e.g., asking patient to perform a multi-step sequence) memory
- Communication and Vision: Expression, comprehension, and vision test
- Mood and Behavior: Indicators of possible depressed, anxious, or sad mood, self-reported mood
- Functional Status: Ability to perform ADLs, IADLs, and general mobility. Scoring for functional status ranges from independent (no help, setup, or supervision) to total dependence (full performance by others during entire period) for both performance (actual ability) of the item, and capacity (capability to perform based on the opinion of the evaluator).
- Continence: Bladder and bowel continence (e.g., catheter or ostomy)
- Nutritional Status: Nutritional issues (e.g., weight loss or dehydration) and mode of nutritional intake

Source: NYSDOH (2022)

Box 13: Exempt and Excluded Populations: Managed Long-Term Care (MLTC)

The following individuals are exempt from MLTC enrollment:

- American Indian/Alaskan Native
- Adults aged 18-20 who need more than 120 days of community-based long-term care
- Adults who are nursing home eligible and enrolled in the Medicaid Program for the working disabled

The following individuals are excluded from MLTC enrollment:

- People enrolled in an Assisted Living Program
- People enrolled in the Traumatic Brain Injury (TBI) or the Nursing Home Transition and Diversion programs
- People receiving hospice services or who are residents of a psychiatric or residential care facility or nursing home
- People who have a developmental disability and receiving care in a facility, in the community or through a waiver program
- People who live in Family Care Homes licensed by the Office of Mental Health
- Residents of alcohol and drug abuse residential treatment programs
- People who have Medicaid eligibility only for tuberculosis-related services
- People who are uninsured and receiving breast and cervical cancer services and those who are under age 65 and eligible for the early detection program
- People who have Medicaid eligibility only for breast and cervical cancer services
- People who are eligible for family planning expansion program
- People with less than 6 months of Medicaid eligibility or eligible for emergency Medicaid only

Source: NYMC (2022b)

Box 14: Exempt and Excluded Populations: Mainstream Managed Care (MMC)

The following individuals are exempt from managed care enrollment:

- American Indian/Alaskan Native
- Residents of an Article 819 long-term alcohol or substance use facility
- People who live in facilities for the developmentally disabled
- People being treated for a chronic medical condition for 6 months or longer by a Medicaid specialist who is not in a Medicaid health plan. (This exemption is limited to a 6-month period and for one time only)
- Adults in waiver programs: Nursing Home Transition and Diversion (NHTD), Office of People with Developmental Disabilities (OPWDD), Traumatic Brain Injury (TBI) —those in the LTHHCP were transitioned to managed care in 2012

The following individuals are excluded from managed care enrollment:

- People who are in a hospice program at the time of enrollment
- Children or adults who live in state psychiatric or residential treatment facilities
- People who will get Medicaid only after they spend some of their own money for medical needs (spend-down cases)
- People with other full benefit health insurance
- Infants living with their mothers in jail or prison
- Children who are blind or disabled and living apart from their parents for 30 days or more
- People eligible for TB services only
- People eligible for the Medicaid Cancer Treatment Program: Breast, Cervical, Colorectal and Prostate Cancer (MCTP)

Source: NYMC (2022a)

Box 15: New York Independent Assessor: Clinical Exam

The following takes place during the clinical exam:

- Examination the patient, and, if necessary, consult with providers and others who may have insight into the members needs
- Review of the diagnoses and medications to ensure they are documented accurately, and thoroughly
- Attestation to the patient's need for assistance
- Indication of whether the patient is self-directing, or has identified an appropriate self-directing other
- Indication pf whether the patient can complete the consumer's roles and responsibilities if they are authorized for and enroll in CDPAS
- Determination of whether patient's medical condition is stable to receive personal care services and/or CDPAS

Source: NYSDOH (2022)

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Glossary of terms

This section summarizes key definitions from the main text. To facilitate switching back and forth, this document is designed with hyperlinks. Most PDF readers have shortcuts that permit a reader to return to the previous location after selecting a hyperlink. In Adobe Acrobat on a PC: "Alt" + "←"; In Adobe Acrobat on a MAC: "command" + "←"; In Preview on a MAC: "command" + "[".

Activities of Daily Living (ADLs): Tasks performed on a daily basis that are considered necessary to live independently, including bathing or showering, dressing, toileting, eating, and transferring (mobility).

Adult Day Health Care (ADHC): A community-based long-term care program that provides comprehensive health care services in a congregate day setting. Services include nursing, case management, clinical management, medical, diagnostic, social, rehabilitative, recreational and personal care services on a routine or daily basis. Services are provided according to the assessed needs of the beneficiary.

Affordable Care Act (ACA) expansion states: States that have adopted and implemented the ACA's Medicaid expansion, which expanded Medicaid coverage to nearly all adults with incomes up to 138 percent of the Federal Poverty Level (FPL) and provided states with an enhanced federal matching rate percentage (FMAP) for their expansion populations.

Affordable Care Act (ACA): The Patient Protection and Affordable Care Act (ACA) made a number of changes to Medicaid, most notably the expansion of eligibility to adults with incomes up to 133 percent of the federal poverty level (FPL). Originally a requirement, the June 2012 Supreme Court ruling in National Federation of Independent Business v. Sebelius effectively made the Medicaid expansion an option. To date, over three-quarters of states have opted to expand.

Capitation: A payment arrangement for health care services where an entity (e.g., a managed care organization - MCO) receives a risk adjusted amount of money for each Medicaid beneficiary enrolled in the plan. States typically pay MCOs for managed care services through fixed, periodic payments (capitation payments) for a defined package of benefits.

Centers for Medicare and Medicaid Services (CMS): A federal agency within the United States Department of Health and Human Services that administers the Medicare program and works in partnership with state governments to administer Medicaid.

Certified Home Health Aide (CHHA): Certified Home Health Aides are the providers of Home Health Services. They provide part-time, intermittent health care and support services to individuals who need intermediate and skilled health care.

Community First Choice option (CFCO): An optional set of services under Medicaid that was authorized in the Affordable Care Act allowing for long-term services and supports that were previously only available through a waiver to be Medicaid State Plan Services. CFCO provides additional federal money to expand home and community-based services and supports to individuals in need of long-term care for help with everyday activities and health-related tasks that can be performed by an aide or direct care worker and would otherwise be at risk of institutionalization if these services weren't available.

Community Spouse Resource Allowance (CSRA): Upper limit on disregarded assets for a spouse residing in the community if their spouse is institutionalized or requires home and community-based long-term care.

Conflict Free Evaluation and Enrollment Center (CFEEC): The Conflict Free Evaluation and Enrollment Center (CFEEC) decides if a New

York State Medicaid beneficiary may join a Managed Long Term Care (MLTC) plan. The CFEEC sends a nurse to the beneficiary's home to evaluate whether they need long term care services such as home care.

Consumer-Directed Personal Assistance Program (CDPAP): Medicaid home health care benefit program allowing beneficiaries to hire and manage the aide of their choice, including some relatives. The services provided through the CDPAP are referred to as Consumer-Directed Personal Assistance Services (CDPAS). The terms CDPAP and CDPAS are often used interchangeably.

Cost of Living Allowance (COLA): An annual increase in retirement benefits based on the Consumer Price Index. The ensures that retirement benefits adjust with the rate of inflation.

Eligibility Track 1a. Supplemental Security Income (SSI) Recipients: Mandatory coverage group under Medicaid that automatically guarantees Medicaid coverage to individuals that receive SSI, a federal cash assistance benefit for aged, blind, and disabled individuals with limited means.

Eligibility Track 2c. Affordable Care Act (ACA) Expansion Adults: Optional coverage group under Medicaid that allows for expanded income and asset limits for individuals ages 19-64 who are ineligible for Medicaid through any other group. States that choose to cover this group may cover adults up to 138 percent of the federal poverty level. There is no asset test for this population.

Eligibility Track 3a. Medically Needy Aged, Blind, or Disabled: Optional coverage group under Medicaid for aged, blind, or disabled individuals who would qualify for Medicaid under a different track if not for excess income. This track allows these applicants to "spend down" their excess income on medical bills and other related expenses in order to become eligible for coverage.

Eligibility Tracks: Requirements for an individual to qualify for Medicaid and start receiving long-term care benefits. An individual must satisfy only one eligibility track to qualify for Medicaid.

Estate Recovery: State Medicaid programs must recover certain Medicaid benefits paid on behalf of a Medicaid enrollee. For individuals age 55 or older, states are required to seek recovery of payments from the individual's estate for nursing facility services, home and community-based services, and related hospital and prescription drug services. States may not recover from the estate of a deceased Medicaid enrollee who is survived by a spouse, child under age 21, or blind or disabled child of any age.

Federal Medical Assistance Percentage (FMAP): The percentage of Medicaid payments that the federal government pays as a share of both federal and state government payments for Medicaid services. The FMAP is computed from a formula that takes into account the average per capita income for each State relative to the national average. The minimum FMAP is 50 percent.

Federal Poverty Level (FPL): Poverty threshold established by the Department of Health and Human Services (HHS) for administrative purposes, such as determining financial eligibility for federal programs. The FPL is determined annually for different household sizes and financial eligibility for a program is generally a percentage of the FPL (e.g., 100 percent of the FPL), meaning households with annual/monthly income at or below 100 percent of the FPL would qualify based on financial eligibility.

Fee-for-service (FFS): A health care delivery system where providers are paid for each service performed. This was the dominant form of long-term care service delivery until New York's transition to managed care.

Health Related Facility (HRF): A facility providing lodging, board, and social and physical care including the recording of health information, dietary supervision, and supervised hygienic services to six or more residents. In federal terminology, an HRF is often referred to as an intermediate care facility (ICF), which provides a lower level of care than a skilled nursing facility (SNF).

Home Assessment Resource Review Instrument (HARRI): New York state assessment required for the Personal Care Services Program (PCSP). The assessment evaluates the applicant's health, social, and environmental needs to determine if home care services are appropriate. Based on the assessment, the applicant is referred to the most appropriate and cost-effective home care services or to other long-term care services.

Home Health Aide Services: Home health aides assist with personal care as well as some semi-skilled tasks, such as observing vital signs, administering medication under the direction of a nurse, and more.

Home Health Services: Medicaid health benefit program that provides services in the patient's home to promote, maintain, or restore health or lessen the effects of illness and disability. Services may include part-time or intermittent nursing care, speech, physical and occupational therapies, and home health aide services (personal care and semi-skilled tasks such as ostomy care). This service also includes medical equipment and supplies if medically necessary.

Home-and Community-Based Services (HCBS): Services designed to assist individuals in a home or community setting, such as an adult day center. HCBS are often designed to enable people to stay in their homes in lieu of nursing home admission.

Instrumental Activities of Daily Living (IADLs): Tasks related to independent living including preparing meals, managing money, shopping for groceries, performing housework, and using a telephone.

Level 1 Personal Care Services: New York Medicaid term for assistance with Instrumental Activities of Daily Living (IADLs), such as personal laundry, light housekeeping, shopping, meal preparation, and medication administration.

Level 2 Personal Care Services: New York Medicaid term for assistance with Activities of Daily Living (ADLs), such as eating, toileting, bathing, grooming, dressing, ambulation, and transferring

Long-Term Care Placement Medical Assessment Abstract (DMS-1): New York state assessment tool used to determine medical eligibility for the Long-Term Home Health Care Program (LTHHCP) and Nursing Facility Care. While it remained the assessment tool for the LTHHCP, it was later replaced with the Patient Review Instrument (PRI) for Nursing Facility Care.

Long-Term Home Health Care Program (LTHHCP): New York's Medicaid 1915(c) Home and Community-Based Program that provided a coordinated plan of medical, nursing, and rehabilitative care at home to individuals who were medically eligible for placement in a nursing home. This program was phased out beginning in 2013 with the introduction of mandatory managed care enrollment.

Mainstream Managed Care (MMC): One of two main types of Medicaid managed care plan offered by New York State. Mainstream managed care provides comprehensive medical services including hospital care, physician services, dental services, pharmacy benefits, and limited long-term care. MMC primarily serves non-dual eligibles.

Managed Care: A health care delivery system organized to manage cost, utilization, and quality. Under Medicaid, managed care provides for the delivery of state plan services through contracted arrangements between state Medicaid agencies and managed care organizations (MCOs) that accept a set per member per month (capitation) payment for these services. While there are several types of managed care plans available under Medicaid, the majority of beneficiaries receiving long-term care through Medicaid managed care are either enrolled in Mainstream Managed Care (MMC) or Managed Long-Term Care (MLTC).

Managed Long-Term Care (MLTC): The second main type of Medicaid managed care plan offered by New York State specializes in long-term care. Most people in managed long-term care plans are enrolled in the partially capitated plan which only covers long-term care services while the acute care and others are covered by Medicare and/or Medicaid fee-for-service. MLTC primarily serves dual eligibles (those with Medicaid and Medicare) in need of home and community-based long-term care.

Mandatory Categorically Needy: Groups that states are required to cover through Medicaid, which include low-income families, pregnant women, low-income children, and individuals receiving Supplemental Security Income (SSI).

Maximum Monthly Maintenance Need Allowance (MMMNA): Upper limit on disregarded income for a spouse residing in the community if their spouse is institutionalized or requires home and community-based long-term care.

Medicaid Redesign Team (MRT): See Partnership Plan Medicaid Section 1115 Demonstration

Medicaid State Plan: Every state has a Medicaid State Plan, a comprehensive document that outlines the amount, scope, and duration of all services offered under the State's standard benefit package. All beneficiaries may receive all services in the standard benefit package (e.g., personal care, home health), however, benefit programs may have varying eligibility criteria (e.g., level of dependence). If eligible, some beneficiaries may enroll in an HCBS program. HCBS program enrollees may receive all state plan benefits as well as additional services under the program. If a beneficiary is enrolled in managed care, they may receive all state plan benefits through their managed care plan and may receive additional benefits as available.

Medically necessary: As defined by the U.S. Department of Health and Human Services, medically necessary services are health care services or supplies needed to diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine. This is usually the dependence threshold that must be met to receive a Medicaid benefit. However, the exact dependence characteristics needed to meet this threshold vary by state, although it usually is met through a physician's order for services.

Medically Needy: A group states can elect to insure through Medicaid that would otherwise qualify for Medicaid through a categorically needy pathway if not for their income or assets (i.e., above SSI limits but below state determined limits for income or assets). This pathway for qualifying for Medicaid is an optional pathway.

Minimum Data Set (MDS): A federally mandated tool for implementing standardized assessment and for facilitating care management in nursing homes.

Net Available Monthly Income (NAMI): This is the amount of a nursing home resident's income that s/he is expected to contribute toward the cost of his or her care.

New York Independent Assessor (NYIA): The New York Independent Assessor (NYIA) was established in 2022 and replaced the Conflict Free Evaluation and Enrollment Center (CFEEC) for MLTC members. New York State Medicaid members who want to receive community-based long-term services and supports, regardless of how they plan to access these services, must now coordinate with the NYIA for eligibility determinations. NYIA registered nurses conduct a UAS assessment of these individuals to determine whether they qualify for these services.

New York State Department of Health (NYSDOH): New York's state-level agency that administers the state Medicaid program.

Nursing facility care: Residential care that typically provides skilled nursing or medical care and related services, rehabilitation needed due to injury, disability, or illness, and health-related care and services (above the level of room and board) not available in the community, needed regularly due to a mental or physical condition.

Nursing Facility Level of Care (NFLOC): Level of care comparable to what an individual would receive in a nursing facility. This is often the minimum level of dependence required for long-term care programs.

Omnibus Budget Reconciliation Act of 1993: Legislation requiring states to recover expended Medicaid funds from the estates of Medicaid recipients at least age 55 or who are permanently institutionalized.

Optional Categorically Needy: Groups that states may choose to cover through Medicaid, which may include aged and disabled individuals not receiving SSI and some individuals receiving long-term care.

Other populations: The Gateway Policy Explorer Long-Term Care Series is primarily focused on individuals most likely to require long-term care, such as older adults or disabled individuals. There are additional eligibility tracks one may use to qualify for Medicaid that are out-of-scope for this Series. Some of these include pregnant women, children, and families with children.

Partnership Plan: New York state program approved by the federal government. The program allows the State to implement a managed care program to Medicaid recipients. It has been in operation since 1997 and was eventually renamed the Medicaid Redesign Team in 2016. Section 1115 of the Social Security Act gives the Secretary of Health and Human Services authority to approve experimental, pilot, or demonstration projects that are found to be likely to assist in promoting the objects of the Medicaid program.

Patient Review Instrument (PRI): New York state medical evaluation tool that determines whether or not an individual is eligible for nursing facility placement.

Personal Care Services (PCS): Medicaid home health benefit providing in-home assistance to recipients with housekeeping and personal care needs.

Personal Care Services Program (PCSP): New York state program that delivers Personal Care Services (assistance with ADLs and IADLs) to eligible individuals only through fee-for-service (FFS) Medicaid. Alternatively, many Medicaid beneficiaries receive these services through managed care or the Long-Term Home Health Care Program (LTHHCP). By mid-2011, provision of the program became the responsibility of managed care organizations, rather than FFS Medicaid.

Personal Needs Allowance: Income that is exempt from contribution to nursing home cost that may be spent on any personal item by institutionalized beneficiaries.

Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996: Federal legislation that restricted most legal immigrants entering the United States after August 22, 1996, from receiving federally funded Medicaid or Supplemental Security Income (SSI) for at least five years after immigration or until they attain citizenship.

Preadmission Screening and Resident Review (PASRR): A federally required assessment for nursing facility applicants to ensure that individuals are not inappropriately placed in nursing homes for long term care. The initial Level I assessment screens for mental illnesses or other related conditions. If the Level I assessment indicates that the applicant has a mental illness or related condition, they will be directed to a Level II assessment and alternative residential care. New York's Patient Review Instrument (PRI) and SCREEN satisfies the

PASRR Level I requirement.

Private Duty Nursing: Nursing services for Medicaid members who require more individual and continuous nursing care than is offered by home health. Recipients usually require nursing services that exceed the amount and scope of nursing services that home health care may provide. PDN services are not warranted for non-skilled tasks such as, but not limited to, turning and positioning, ambulation, transferring, bathing, toileting, oral feeding, dressing, and household chores.

Program of All-Inclusive Care for the Elderly (PACE): PACE provides comprehensive medical and social services to some older adults still living in the community. Most of the participants who are in PACE are dually eligible for both Medicare and Medicaid. However, enrollment in PACE programs is typically capped at a relatively low number of participants.

PRUCOL: An immigration status where Immigration and Naturalization Services knows of and permits the individual's presence in the country and does not contemplate enforcing their departure. Oftentimes, this status is for refugees or parolees.

Retirement, Survivors, and Disability Insurance (RSDI): Monthly benefits to retirees, disabled workers, and/or their surviving dependents that are intended to replace lost income following retirement, a disability that prevents an individual from working, or the death of a spouse or parent.

SCREEN Assessment: New York state secondary assessment for nursing facility eligibility (following the Patient Review Instrument). The SCREEN is used to determine the applicant's ability to be cared for in a setting other than a nursing facility and assess applicants for possible mental illness and/or developmental disabilities. The purpose of this is to assure that seriously mentally ill and developmentally disabled persons are appropriately placed in order to provide for their treatment needs.

Semi-Annual Assessment of Members (SAAM): New York state assessment tool used to determine dependence eligibility for the Managed Long-Term Care Program.

Skilled Nursing Facility (SNF): A facility (which meets specific regulatory certification requirements) which primarily provides inpatient skilled nursing care (e.g., intravenous injections and physical therapy) and related services to patients who require medical, nursing, or rehabilitative services but does not provide the level of care or treatment available in a hospital.

Skilled nursing services: Skilled nursing care consists of those services that must, under State law, be performed by or under the supervision of a licensed or certified nurse. These services include injections, tube feedings, catheter changes, observation and assessment of a patient's conditions, and more.

Social Adult Day Care (SADC): A structured program that provides functionally impaired older adults with socialization, supervision and monitoring, personal care, and nutrition in a protective setting.

Social Security Administration (SSA): United States government agency that administers public assistance programs covering disability, retirement, and survivors' benefits. The SSA administers Supplemental Security Income (SSI) payments.

State Supplemental Payment (SSP): Monthly cash payments offered by states to low-income individuals in addition to Supplemental Security Income (SSI). States offering optional SSPs may do so to account for higher costs of living or as an additional income disregard for individuals in certain living arrangements (e.g., nursing facility). In New York, optional state supplements are provided to all SSI recipients, including children, except those living in publicly operated residences having more than 16 residents, in publicly operated emergency shelters, or in medical facilities where Medicaid pays less than 50 percent of the cost of care. The state supplementation is added to the federal payment. Countable income is deducted first from the federal payment, and any income that remains to be counted after the federal payment has been reduced to zero is then deducted from the state supplementary payment.

Supplemental Nutritional Assistance Program (SNAP): Federal nutrition assistance program that provides benefits to eligible low-income individuals and families via an Electronic Benefits Transfer card. This card can be used like a debit card to purchase eligible food in authorized retail food stores.

Supplemental Security Income (SSI): The U.S. old-age cash assistance program for aged, blind, and disabled persons of limited means.

Universal Assessment System for New York (UAS-NY): An assessment system implemented to create a standard process across several home and community-based programs under New York Medicaid. The UAS contains the Community Assessment, the tool used to determine functional eligibility for long-term care programs outside of an institution.

Notes

This section reports notes from the main text. To facilitate switching back and forth, this document is designed with hyperlinks. Most PDF readers have shortcuts that permit a reader to return to the previous location after selecting a hyperlink. In Adobe Acrobat on a PC: "Alt" + "←"; In Adobe Acrobat on a MAC: "command" + "←"; In Preview on a MAC: "command" + "[".

1. Some SSI recipients may receive a State Supplementary Payment (SSP). SSP amounts vary by living arrangement. Receipt of this payment will marginally increase the income limit under this track. See Table 2 for historical SSP amounts and NY Soc Serv L § 209 (2022) for more information.
2. The look back period is 36 months prior to the date of application, except in the case of a trust treated as a transfer in which case the look back period is 60 months prior to the date of application. Although an individual's home is generally not a countable resource, for this purpose it is considered a resource and subject to transfer prohibitions unless it is transferred to the individual's spouse, minor or disabled child, or, in some circumstances, sibling or adult child (KFF, 1999).
3. Lawfully permanent residents and PRUCOL (i.e., Immigration and Naturalization Services knows of and permits their presence in the country and does not contemplate enforcing their departure, oftentimes refugees or parolees) (SSA, 1998).
4. Applicants must meet strict requirements established by the Social Security Administration in order to qualify for SSI through a disability or blindness. See SSA (2023e) for more information on these requirements.
5. Spousal considerations for income: If a beneficiary is institutionalized (e.g., staying in a nursing home) and their spouse resides in the community, there are spousal impoverishment laws that allow the community spouse to retain countable income and assets up to a certain amount. The community spouse is allowed to keep up to a Maximum Monthly Maintenance Need Allowance (MMMNA) and can allocate from the institutionalized spouse's income up to the MMMNA as the community spouse's income. The MMMNA for 1992 was $1,718 (NYSOCFS, 1992).
6. Spousal considerations for assets: The community spouse is also able to keep countable assets up to the Community Spouse Resource Allowance (CSRA), which was $68,700 in 1992 (NYSOCFS, 1992). Countable assets/property are real and personal property that are counted to determine eligibility.
7. The HRF level in New York conforms to the Medicaid definition of an Intermediate Care Facility (ICF) (AJPH, 1980).
8. Policy allows the local professional director or other designated physician of the applicant's choice to provide override justification of the indicator score limits when an individual does not score a minimum of 60. The written physician override justification must include, but is not limited to, the medical, psychosocial, and/or rehabilitative needs which would otherwise require an individual to be institutionalized if it were not for the LTHHCP services (Medicaid.gov, 2013).
9. The equity value is derived by subtracting any legal encumbrances (e.g., liens, mortgages) from the fair market value of the home. Exceptions exist if the person's spouse, child, or adult child with a disability is living in the home.
10. Spousal considerations for income: If a beneficiary is institutionalized (e.g., staying in a nursing home) and their spouse resides in the community, there are spousal impoverishment laws that allow the community spouse to retain countable income and assets up to a certain amount. The community spouse is allowed to keep up to a Maximum Monthly Maintenance Need Allowance (MMMNA) and can allocate from the institutionalized spouse's income up to the MMMNA as the community spouse's income. The MMMNA for 1997 was $1,976 (NYSDOH, 1997). From 2010, New York extended spousal impoverishment rules to spouses of individuals receiving HCBS (e.g., LTHHCP or MLTC). Authors were not able to verify whether spousal impoverishment rules applied to individuals receiving HCBS through the state plan during this time.
11. Spousal considerations for assets: The community spouse is also able to keep countable assets up to the Community Spouse Resource Allowance (CSRA), which was $79,020 in 1997 (NYSDOH, 1997). Countable assets/property are real and personal property that are counted to determine eligibility. From 2010, New York extended spousal impoverishment rules to spouses of individuals receiving HCBS (e.g., LTHHCP or MLTC). Authors were not able to verify whether spousal impoverishment rules applied to individuals receiving HCBS through the state plan during this time.
12. Services such as personal care and home health under MLTC are the same services as those detailed under the state plan. During this policy period, these benefits were transitioning to managed care and therefore exist both as a fee-for-service health benefit program and as a benefit under managed care plans.
13. Residents of nursing homes are not eligible to enroll in MLTC plans, although enrollees who come to need nursing home care may remain enrolled in MLTC (UHF, 2009).

14. The physician's order form was revised slightly in 2010 to eliminate the necessity for the physician to provide information that "should be more appropriately obtained and documented by the nurse assessors during the completion of the home visit and assessment process" (NYSDOH, 2010b). The change did not affect the process aside from making the measurement of functional ability the sole responsibility of the nurse during the home assessment, rather than additionally assessed in the physician's order.

15. The ACA provided 100% matching for newly eligible individuals with incomes up to 138% of the FPL between 2014-2016, and phased down to 90% matching until 2020 where it remains (US Congress, 2010). It is important to note that New York State Medicaid had already included coverage for childless adults under age 65 up to 100% of the FPL. Therefore, the only newly covered individuals were childless adults between 100 and 138% of the FPL (UHF, 2014).

16. The ACA also authorized the Community First Choice Option (CFCO), and in 2015, CMS approved New York's CFCO plan. The approval allowed New York to receive an additional 6% of FMAP, referred to as "enhanced FMAP," for eligible HCBS provided to individuals that would otherwise require an institutional level of care. Because these services are available both through fee-for-service (FFS) and managed care, CFCO services receive the enhanced FMAP, while other services provided in the plan may not (HHS, 2020).

17. The look back period is 60 months prior to the date of application for all assets.

18. Household size determines income and asset limits for individuals claiming eligibility through eligibility track 3a. However, it is not intuitive. See Table 3 for household size criteria.

19. Spousal considerations for income: If a beneficiary is institutionalized (e.g., staying in a nursing home) and their spouse resides in the community, there are spousal impoverishment laws that allow the community spouse to retain countable income and assets up to a certain amount. The community spouse is allowed to keep up to a Maximum Monthly Maintenance Need Allowance (MMMNA) and can allocate from the institutionalized spouse's income up to the MMMNA as the community spouse's income. The MMMNA for 2011 was $2,739 (NYSDOH, 2013a). New York extends spousal impoverishment rules to spouses of individuals receiving HCBS (e.g., LTHHCP or MLTC). From 2014, the ACA required states to extend these rules to HCBS. Authors were not able to verify whether spousal impoverishment rules applied to individuals receiving HCBS through the state plan prior to 2014.

20. Spousal considerations for assets: The community spouse is also able to keep countable assets up to the Community Spouse Resource Allowance (CSRA), which was $109,560 in 2011 (NYSDOH, 2013a). Countable assets/property are real and personal property that are counted to determine eligibility. New York extends spousal impoverishment rules to spouses of individuals receiving HCBS (e.g., LTHHCP or MLTC). From 2014, the ACA required states to extend these rules to HCBS. Authors were not able to verify whether spousal impoverishment rules applied to individuals receiving HCBS through the state plan prior to 2014.

21. Spousal considerations for income: If a beneficiary is institutionalized (e.g., resides in a nursing home) or receiving HCBS (e.g., MLTC) and their spouse resides in the community, there are spousal impoverishment laws that allow the community spouse to retain countable income and assets up to a certain amount. The community spouse is allowed to keep up to a Maximum Monthly Maintenance Need Allowance (MMMNA) and can allocate from the institutionalized spouse's income up to the MMMNA as the community spouse's income (NYSDOH, 2019a). The MMMNA for 2020 was $3,216.00.

22. Spousal considerations for assets: The community spouse is also able to keep countable assets up to the Community Spouse Resource Allowance (CSRA), which was $128,640 in 2020 (NYSDOH, 2019a). Countable assets/property are real and personal property that are counted to determine eligibility.

23. Should the individual prefer discharge and an assessment of the individual's medical needs indicates they may be safely discharged to the community, they may remain enrolled in their MLTC plan while residing in the nursing facility on a temporary basis for more than 3 months until their discharge plans are resolved and the individual is transitioned out of the nursing facility.

24. This benefit is scheduled to be removed from the MLTC set of benefits and administered only by a government contractor through the state plan in 2023. It was originally planned for October 2021, but has been delayed (NYSDOH, 2021a).

Version information

Current Version: 1.0 (September 2023)

Version History

- 1.0 (September 2023): First version.