A Review of Assisted Living Programs in "Impacted" Adult Homes

June 2007

NYS Commission on Quality of Care and Advocacy for Persons with Disabilities

EXECUTIVE SUMMARY

This report describes the Commission's review of the programmatic and financial practices of Assisted Living Programs (ALP) operated in 13 adult homes which serve individuals who had received mental hygiene services ("impacted" homes).

The Assisted Living Program (ALP) was established by law in 1991 to provide a cost effective alternative to individuals eligible for nursing home placement. Beginning in 1994, the Department of Health has been issuing new operating certificates for ALP beds in order to reach its initial need estimate of 4,200 beds. As of January 2006, operating certificates have been issued to 60 ALP facilities with a total capacity of 3,747 beds. In 2005, annual Medicaid charges for ALP statewide totaled $63 million.

The ALP is essentially an "add-on" of services to supplement the residential care provided by an adult home or enriched housing program. The additional services of an ALP include nursing, therapy and supplementary personal care. Such extra services are covered by a Medicaid rate that is set in law at 50 percent of the nursing home rate. This rate varies depending upon two factors: regional location of the home and the need assessments of its residents. Because the homes also receive SSI congregate care funding to cover the residential requirements of the assisted living facility, the total funding at the homes examined in this study was, on average, approximately 75 percent of the nursing home rate.

The Commission on Quality of Care and Advocacy for Persons with Disabilities has jurisdiction over certain ALP facilities defined as "impacted" because they house a significant number of residents who had received mental hygiene services. The Commission examined both the program and fiscal operations at 13 such facilities containing a total of 885 beds. The program study involved an in-depth look at 78 residents residing in these homes, while the fiscal review involved an examination of the revenues, expenses and staffing patterns.

The following is a brief summary of the findings discussed in this report:

- At the thirteen homes reviewed by the Commission, Medicaid payments for ALPs averaged $60 per day per resident, while the ALP program spending was about one-half that amount. The disparity between the funding and program cost was greatest at homes in New York City, where providers received higher rates, despite spending less than the rest of the state. This finding raises serious concerns about the cost effectiveness of this program, as the additional services provided were not commensurate with the increased charges to Medicaid.
- The Commission believes that in some instances Medicaid payment levels were inflated due to unsupported level of need assessments that indicated residents needed substantial assistance with toileting.
- The Commission found substantive disparities between level of need ratings and plans of care and between plans of care and actual services provided.
- The Commission found that the annual financial reports filed with the Department of Health by the homes did not contain adequate disclosures on related party transactions, thus diminishing the usefulness of the report.

During the course of this study, the Commission worked with the Department of Health to improve the financial reporting requirements for related party transactions so that previously undisclosed information, critical for decision-making, will be available. Given the findings in this report, the Commission recommended that the Department of Health take the next step by utilizing the latest financial reports to conduct a statewide fiscal analysis on all ALP facilities. If such an analysis demonstrates that the extraordinary profits the Commission found in the homes studied, particularly those in New York City, are typical, the Department should take such actions as are necessary to more closely align ALP funding levels with the program costs.

Regarding the concern that needs assessments, particularly around toileting assistance, were unjustifiably inflated in the programs reviewed, the Commission recommended that the Department of Health review this matter and issue guidelines to impacted adult homes which are ALP providers and others responsible for approving ALP level of care certifications in such facilities clarifying its expectations related to the components of this assessment (interviews, observations and documentation review). These guidelines should include a requirement for a narrative section on the Patient Review Instrument (PRI) form in which the nurse provides a rationale for all scores above the base score, citing both personal observations and findings from reviewing patient records. Reassessments should address the success or lack of success of bladder incontinence training.

Finally, the Commission recommended that the Department of Health identify and implement enhanced surveillance protocols that address discrepancies among RUGs scores, plans of care, and services provided in impacted adult homes which are ALP providers.

In response to Commission recommendations, the Department of Health suggested that a broader study would be necessary in order to draw any conclusions concerning the profitability of adult homes which are valid beyond the homes reviewed. The Department also described the steps it was taking to implement more accurate assessment instruments and strengthen surveillance activities to assure the provision of appropriate services. Finally, the Department noted that in cooperation with the Commission the adult home annual cost reports have been revised to more clearly describe related party transactions, which will, in turn, allow the State to better gauge the financial stability of individual providers and the industry as a whole.

BACKGROUND

This report describes the Commission's review of the programmatic and financial practices of Assisted Living Programs (ALP) operated in 13 adult homes which serve individuals who had received mental hygiene services ("impacted" homes).

The Assisted Living Program (ALP) was established by Chapter 165 of the Laws of 1991 to serve individuals who are medically eligible for nursing home placement, yet who can be cared for appropriately in a less restrictive and lower cost residential setting. In 1993, the Department of Health identified an initial need for 4,200 ALP beds for people who historically would have been admitted to skilled nursing facilities but who did not require the highly structured medical environment of a nursing facility. The Department began issuing ALP operating certificates in the fall of 1994, with new beds coming on line every year since. As of January 2006, operating certificates have been issued to 60 ALP facilities with a total capacity of 3,747 beds.

ALPs operate within an approved adult care facility, either an adult home or an enriched housing program. Such facilities may have some or all of their capacity classified as ALP beds by getting a second authorization as either a licensed home care services agency (LHCSA), a Certified Home Health Agency (CHHA) or, an authorized long-term home health care program (LTHHCP).[1] The ALP is required to provide aide assistance, nursing and therapy services to its residents.[2] In the typical configuration, home care services are provided directly by the ALP under its authorization as a LHCSA, while the nursing and therapy services are delivered by an independent CHHA under contract with the ALP.

Eligibility

To qualify as an ALP resident, a person must require more care and services to meet their health and functional needs than can be provided by an adult care facility alone. They must also be medically eligible for a nursing home, have a stable medical condition and be able, with direction, to take action assuring self-preservation in case of an emergency. ALPs are prohibited from caring for individuals who are chronically bedfast or chairfast, require continual nursing or medical care, or are impaired to a degree that their safety or the safety of others would be endangered.

A person is determined eligible for an ALP based on a series of evaluations and assessments including a medical examination by a physician and a nursing assessment conducted by a nurse from the designated CHHA or LTHHCP. The nursing assessment is summarized on the Patient Review Instrument (PRI), which contains a standardized scoring form used to evaluate the individual's level of need. The PRI results are then translated into a Medicaid

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[1] NY Social Services Law §461-1(a)

[2] Services covered under the ALP Medicaid rate include the following: Title XIX personal care services, home health aide services, personal emergency response services, nursing services, physical therapy, occupational therapy, speech therapy, medical supplies and equipment not requiring prior approval, and adult day health care in a program approved by the Commissioner of Health.

payment category based upon the concept that when more care is needed, Medicaid will pay more. PRI reassessments are required every six months or whenever there is a change in the person's clinical status.

Funding

ALP beds are funded from two public sources. First, under the primary certification as an adult care facility, ALPs receive Congregate Care Level SSI benefits to provide room & board, housekeeping, supervision and some personal care. In addition, ALP beds receive a Medicaid payment set by law at 50 percent of the nursing home rate in the region in which the ALP is located. This Medicaid payment covers personal care, home health aides, nursing, therapy and medical supplies above and beyond the adult care facility requirements. The cost for such services, including the nursing and therapy provided by the CHHA, cannot be billed to Medicaid separately, but instead must be paid for by the ALP out of the funding it receives.

The SSI rate is essentially a flat amount. However, New York City and surrounding counties receive a slightly higher rate than the rest of the state (less than a dollar per day more). In contrast, the variability of the ALP Medicaid rate is much greater. As will be discussed in this report, rates vary by region, with New York City facilities receiving a significantly higher rate than all others. The ALP Medicaid rate is further adjusted, as previously mentioned, based upon the PRI nursing assessments.

The SSI rate was $28 per day and the Medicaid payment averaged $60 per day for the homes covered in this study.[3] When combined, the average payment level equates to about 75 percent of the nursing home rate. As of 2005, the annual Medicaid outlay for the ALP program statewide had grown to about $63 million.

SCOPE OF COMMISSION STUDY

The Commission's study examined 13 adult homes with 885 ALP beds, accounting for about one-quarter of the ALP beds in New York State and about $17 million in annual Medicaid billings. The Commission limited its review to "impacted" adult homes which were, at the time of the Commission's review, defined as those in which at least 25 percent of the residents receive or have received mental hygiene services.[4] Further, it only included those ALP programs

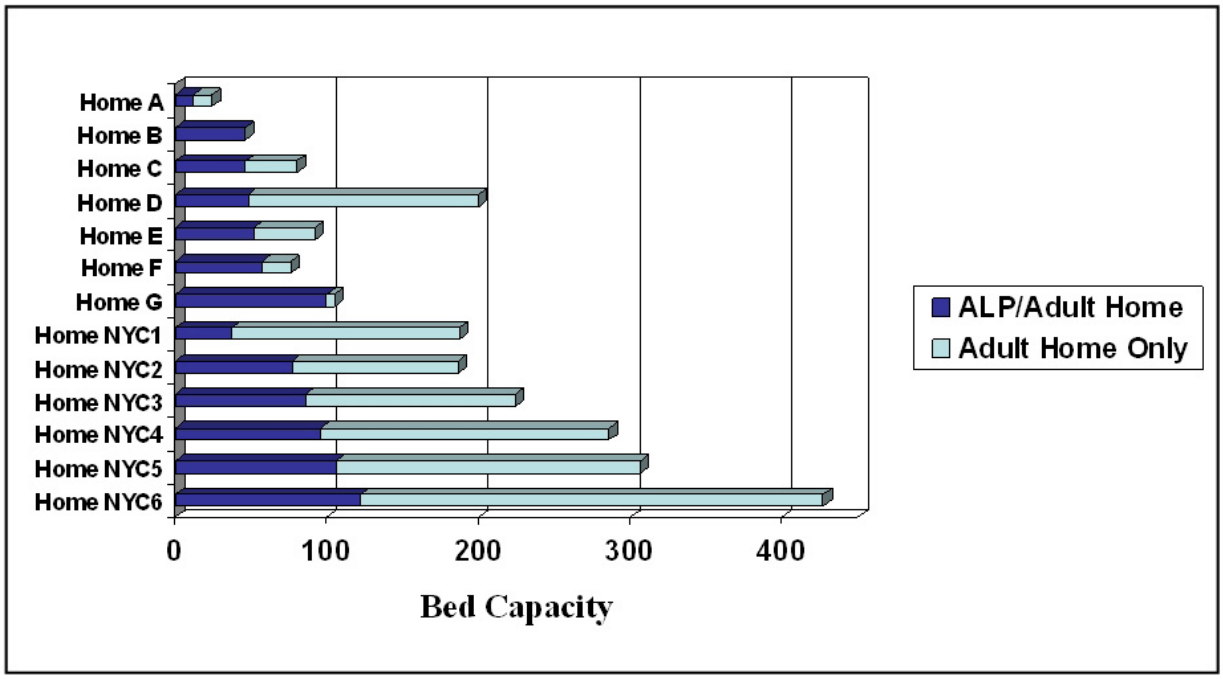
[3] Unless otherwise stated, the payment rates used in this report are for the year 2001. The SSI payments received modest increases until January 1, 2006, when adult homes and enriched housing programs were reclassified from Level 2 to the Level 3 SSI category increasing funding from about $29/day in 2005 to $32/day in 2006. Regarding current ALP Medicaid funding, the rates have simply been trended based upon cost of living adjustments (COLAs).

[4] Prior to Chapter 58 of the Laws of 2005, Mental Hygiene Law §45.07(k) authorized the Commission's review of those homes where twenty-five percent or more residents have at any time received or are receiving services from a mental hygiene provider. Chapter 58 Part H rewrote this subsection to authorize Commission review where at least twenty-five percent or twenty-five residents, whichever is less, have at any time received or are receiving services from a mental hygiene provider. In order to determine which homes were to be included in this review, the Commission relied upon statistical reports submitted by adult care facilities to the Department of Health. Those reports include a quantification of residents who receive mental health services. One of the thirteen ALP homes showing in excess of 25 percent refused the Commission access to its facility claiming that it was not impacted. The Commission reviewed the reported financial data for this home, but did not include any residents in its sample.

operating prior to 2002, in order to incorporate an examination of the annual financial reports on file with the Department of Health. The program component of the study included record reviews of 78 residents, interviews with selected residents and interviews with administrators. The fiscal component of the review studied the cost-effectiveness of the program at the selected sites.

The Commission's sample homes varied greatly in size, with the NYC homes being substantially larger. The sampled homes ranged from a 24 bed adult home with 12 ALP beds, to a home, with a capacity of 427, including 122 certified ALP beds.

Chart 1
Homes in the Study



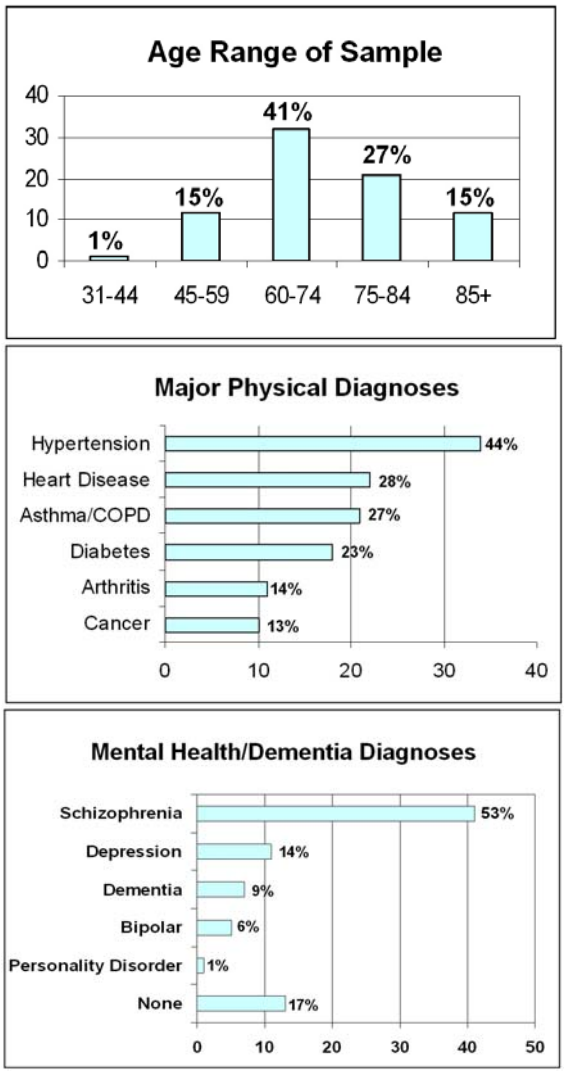
PROGRAM REVIEW

ALP Residents

As presented in the succeeding charts, the Commission sample of 78 residents was composed largely of elderly people, with over 40 percent of the sample 75 years of age or older and only one person below the age of 45. Hypertension was the most common medical diagnosis among the sample individuals, and approximately one-quarter of the sample individuals carried diagnoses of heart disease, chronic respiratory ailments and diabetes. Multiple diagnoses were not uncommon. Because we chose our sample from "impacted" adult homes, nearly three-quarters of the sample persons had a diagnosis of serious mental illness. Our review also determined that almost half of the ALP residents in the sample had previously

lived in the same facility, but as an adult home resident. If indeed these residents have avoided transfer to a nursing home, the ALP program has provided the benefit of aging in place by averting the personal disruption associated with a move of residence. Nineteen percent of the sample residents had come from hospitals, rehabilitation facilities and nursing homes. Only 10 percent of the sample individuals had come to the ALP from their private homes.

Chart 2
Resident Characteristics



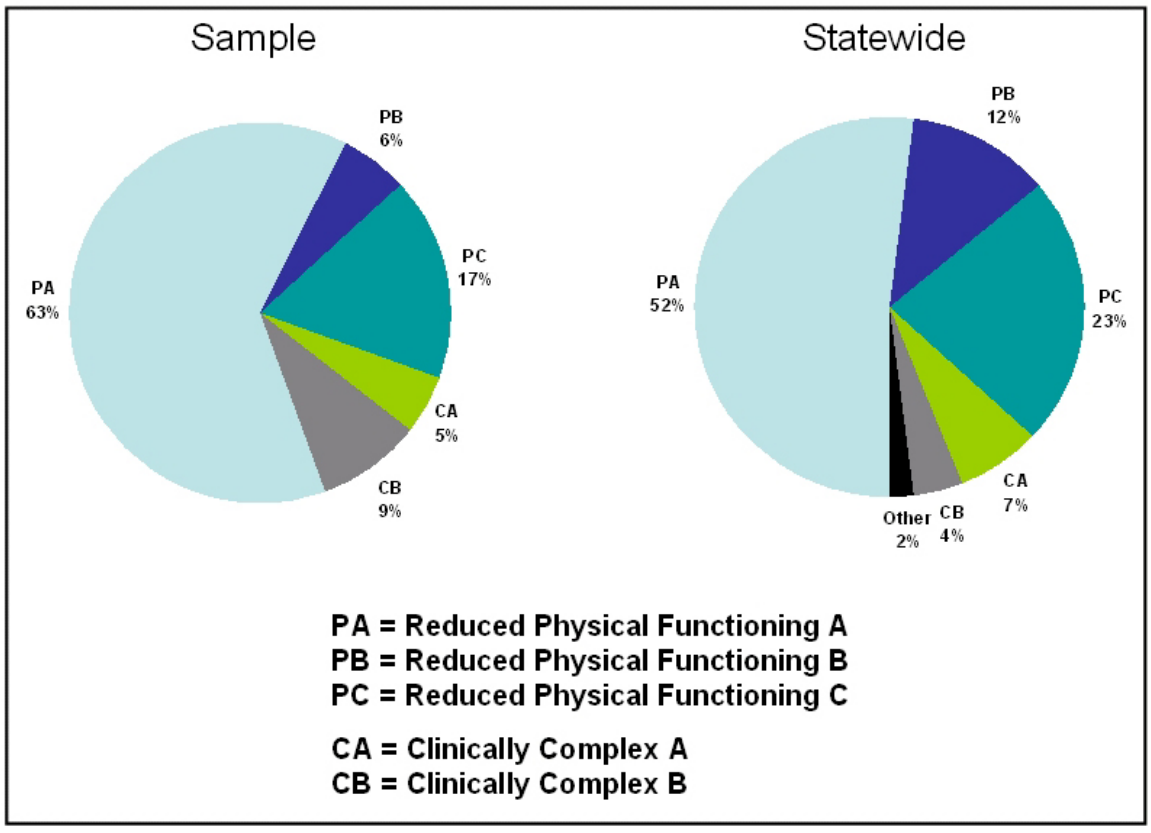
Medicaid Rates

The major concern surfacing from the program review relates to the validity of the PRI scores that are used to determine the Medicaid reimbursement rate. These scores translate into RUGs (Resource Utilization Groups) classifications, the same set of categories used to determine the reimbursement rate for nursing home patients. There are five major RUGs classifications:

Heavy Rehabilitation, Special Care, Clinically Complex, Severe Behavioral Problems, and Reduced Physical Functioning. The vast majority of ALP residents statewide, almost 90 percent, are classified as Reduced Physical Functioning. Nearly all of the remaining residents qualified because of clinically complex medical issues, such as hemiplegia, cerebral palsy or the need for oxygen therapy or wound care.

The RUGs classifications are further broken down into subcategories based upon the level of assistance needed for eating, transferring, and toileting functions. Specifically, scoring is based on the person's capability to perform these tasks 60 percent of the time within the last seven days. Below is a breakdown of the five RUGs categories most frequently billed by ALP programs. The statewide percentages have been constant throughout 2001 to 2005. The Commission's sample of 78 residents roughly approximates the statewide breakdown, though the sample does have more individuals in the PA category, indicating the sampled individuals had a greater level of independence.

Chart 3
RUGs Billing Categories



As one moves from level A to level B to level C, one's needs increase and one's ability to meet those needs independently decreases. The Medicaid rates are structured to provide higher funding for residents with greater needs.

Chart 4
Medicaid Billing Categories

	Medicaid Rate (NYC)
Base Payment Levels	
PA (Reduced Physical Functioning – Level A)	$61
CA (Clinically Complex – Level A)	$74
Elevated Payment Levels	
PB (Reduced Physical Functioning – Level B)	$80
PC (Reduced Physical Functioning – Level C)	$90
CB (Clinically Complex – Level B)	$97

The chart above lists the New York City Medicaid rates. These rates are lower in other regions of the state. The base level for Reduced Physical Functioning, Level A, is the lowest paying category. As compared to base payment levels, Medicaid pays substantially more for the Levels B and C. For example, a New York City home will receive $61 for the Reduced Physical Functioning base rate, but for the higher Level C rating will be paid $90, or nearly 50 percent more.

Problematic RUGs Scoring

In the Commission's sample, it was most often the toileting score that put people in the higher care levels. Of the 25 people in the higher care levels, 20 reached this category solely as a result of their toileting score.

Toileting scores are higher when the PRI indicates that the resident is incontinent or needs *constant* supervision or assistance. If one of these two conditions applies, then a base level score is raised to Level B (higher care rate). If an incontinent person is taken to the bathroom every two to four hours during the day and as needed during the night, the rating may be raised to Level C.

Chart 5 below is a replication of the toileting section of the PRI completed as part of the nursing assessment. Persons whose needs are described requiring no or intermittent supervision or minor assistance (items #1or #2 on the form) qualify for the base payment level. Persons with greater toileting needs qualify for higher care levels B or C. The need for reminders, intermittent supervision, or some assistance does not move an individual to a higher level. Note that the level of supervision and assistance required for ratings #3 and #5 are very similar; the distinction lies in whether the individual is considered continent or incontinent. No one in the Commission sample received a #3 rating, even though the records of several persons receiving a #5 rating suggested they were, in fact, continent.

Chart 5
RUGs Scoring of Toileting

Resident's Capability	Reduced Physical Functioning	Clinically Complex
1) Requires no supervision or physical assistance. May require special equipment, such as raised toilet or grab bar. Or **2)** Requires *intermittent* supervision for safety or encouragement, or *minor* physical assistance (for example, clothes adjustment or washing hands).	**PA ($61)**	**CA ($74)**
3) Continent of bowel *and* bladder. Requires constant supervision and/or physical assistance with major/all parts of the task, *including* appliances (i.e., colostomy, ileostomy, urinary catheter). Or **4)** Incontinent of bowel *and/or* bladder and is not taken to a bathroom.	**PB ($80)**	**CB ($97)**
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.	**PC ($90)**	**CB ($97)**

When the CHHA nurse is assessing the individual and completing the PRI, he/she gathers the necessary information by observation, interview, and review of documentation. The Commission's study found evidence that many high toileting scores in the sample were not supported by clinical evidence. In our review of the records of the 22 persons whose PRI score was raised solely or in part because of their toileting score, there was insufficient clinical information to support the score or contradictory information in nearly two-thirds (64 percent) of the cases. Specific problems included:

- No diagnosis of incontinence on the medical evaluation or conflicting information regarding incontinence status;
- No regular reassessment of incontinence, despite evidence that the person may be regaining bladder control;
- Written care plans for aides requiring them to remind the resident to use the bathroom, but which did not require escorting or assisting, although the toileting score indicated the individual was to be taken to the bathroom every two to four hours; and
- No documentation that the individual was actually taken to the bathroom every few hours, as required by their PRI score.

Examples drawn from the sample illustrate these problems:

- Ms. F, a 73 year-old woman, had been in the ALP program since 1998. She was scored on the PRI as incontinent and taken to the bathroom every two to four hours during the day, placing her in Higher Care Level C. Ms. F went out to lunch and dancing at the Senior Citizens' Center regularly. The home's records were inconsistent: some records

noted she had occasional bladder incontinence only at night, while others cited bowel incontinence. She did not carry a medical diagnosis of incontinence. There was no documentation (aide, nursing or other notes) in the record suggesting she was incontinent 60 percent of the time.

- The Plan of Care for Mr. H stated that he was bowel incontinent and should be taken to the bathroom every four hours. His medical evaluation cited bladder incontinence, but bowel continence, and the nursing assessment stated that he required minimal toileting assistance. He was scored as Level C, requiring escort to the bathroom every two to four hours with commensurate payments to the provider.
- 52 year-old Ms. S entered the ALP program in June of 2000. She had a long history of psychiatric illness and hospitalizations, but was stable. The PRI cited only occasional incontinence, and the Plan of Care called for aides to remind her to use the bathroom. Nonetheless, she was scored as though she were incontinent and taken to the bathroom every few hours. Additionally, she did not use Attends or a bed protector, further suggesting she was not incontinent 60 percent of the time. Since the need for reminders to use the bathroom does not qualify an individual for a higher score, there is reason to question the toileting score and the consequently higher payment level.
- Mr. J, 62 years-old, attends day program at a sheltered workshop four times a week. He entered the ALP in early 2000. Like Ms. S, Mr. J requires only reminders to use the bathroom and may need assistance with Attends during the day. He uses a urinal independently at night. There is no evidence in the record that he is taken to the bathroom every few hours, as required by his toileting score on the PRI.

Review of the toileting schedule logs, which staff initial when they have provided toileting care/assistance, also raised questions. For example, the sheets for two individuals indicated that they were toileted consistently every three hours throughout the night, suggesting these individuals never get an uninterrupted night's sleep. The toileting sheet for another sample individual, Ms. P, revealed that in a one-week period, she was taken to the bathroom every three hours during the day and her incontinence briefs were changed at night when wet. Over the seven days, her toileting needs were attended to (per the toileting log) on 64 occasions, and staff documented she was dry in all but six instances or 91 percent of the time. Either Ms. P's assessment was in error and she was not regularly incontinent of urine or staff documentation was inaccurate.

Because Commission staff were not able to observe the actual provision of care over a period of time, we looked for other indicators that a person's incontinence needs were being addressed. We determined that the provision of specific incontinent care, the use of incontinence briefs and bed protectors, and the frequency of bathing were reasonable measures to use to validate that an individual was incontinent. The results of this review again raised questions about the validity of the PRI scores. Specifically, the record of one individual stated she was incontinent of both bowel and bladder, but also indicated she did not wear incontinence briefs. Similarly, the records of a second individual indicated that she was incontinent of urine and was not on a toileting schedule, i.e., she was not taken to the bathroom every few hours, and she also did not use incontinence briefs.

Our review of the bathing schedules of persons scored as incontinent on the PRI also raised concern that some toileting scores were inflated. As Chart 6 illustrates, 77 percent of the people in Level C were bathed only two or three times a week, according to their aide care plans, even though one would have expected them to need more frequent bathing because of incontinence.

Chart 6
Frequency of Baths per RUGs Score

	Reduced Physical Functioning			Clinically Complex	
Frequency of Bathing	**Level A** (n=49)	**Level B** (n=5)	**Level C** (n=13)	**Level A** (n=4)	**Level B** (n=7)
Every Day	**8** (16%)	**2** (40%)	**2** (15%)	**1** (25%)	**2** (29%)
Three Times a Week	**7** (14%)	**1** (20%)	**6** (46%)	**1** (25%)	**2** (29%)
Twice a Week	**7** (14%)		**4** (31%)		
As Needed	**24** (49%)	**2** (40%)	**1** (8%)	**2** (50%)	**3** (43%)
Independent	**2** (4%)				
Unspecified	**1** (2%)				

Other Concerns

While inconsistency between individuals' toileting scores and the record documentation supporting them was the most common problem identified in the study, the review of treatment records suggested that some individuals were not receiving the services they needed or were not receiving all of the services identified in their care plans. In some instances, the service was not being provided competently or attentively or not provided with the frequency specified. In other instances, the service was identified as necessary at so low a frequency as to raise questions.

- Commission staff observation of two individuals in one ALP program who were supposed to be receiving 1:1 staffing attention at meals to prevent choking revealed that the responsible staff members were not in sight when lunch was served.
- Vital signs had been ordered twice weekly for one individual, but they were not being done.
- The record of one individual indicated that the aide had not provided assistance with oral hygiene (as required by the Plan of Care) for a seven-day period.
- Two individuals in one ALP program were assisted in bathing only once a week, with no rationale for why bathing was not more frequent.
- At one ALP, the care plan implementation sheets for three of the eight aides were blank for the week prior to our visit.

These findings suggest that individuals in these programs would be better protected and cared for if monitoring of care plan implementation was strengthened.

Program Study Conclusions

In summary, the study results, though limited, document inconsistencies among the medical evaluations, aides' plans of care, nursing notes and other documentation sufficient to raise serious questions related to toileting scores and, further, suggest that some residents may not be receiving adequate care to meet their needs. Additionally, the study found evidence that monitoring of the implementation of care plans in some programs is lax and fails to ensure residents are consistently receiving all of the services called for in their care plans.

In view of the large premium paid by Medicaid for higher care categories and the Commission's finding of problems in nearly two-thirds of the higher care need scores in its sample, the Commission estimates that if the overrating of toileting scores for ALP residents documented in our sample is common throughout the statewide ALP network, the inflated toileting scores may be costing the Medicaid program one million dollars annually. Moreover, if this scoring problem has affected the nursing home industry as well, there would be a much greater impact.

FISCAL FINDINGS

As part of its study, the Commission sought to determine how impacted ALP providers were spending the Medicaid funds for ALP services.[5] Overall, the Commission found that the amount of Medicaid funding provided was far in excess of what it actually cost to provide ALP services. The excess funding was largest in the New York City homes, which not only spent less on services but also received a higher regional Medicaid rate. Fundamentally, the figures presented in this section call into question the appropriateness of setting the ALP rate at 50 percent of the nursing home RUGs rate. Recall that when the Legislature passed the law setting this level of funding, there was no historical cost data to rely upon because the ALP program was new. Now that most of the allotted beds are up and running, charging Medicaid over $60 million annually, it would be appropriate to reevaluate the funding methodology.

The Commission further noted that in order to get a true picture of the finances, it was necessary to look behind the many related party transactions that are commonly found at the homes. Such transactions tended to mask the true costs of the program.

What Did We Get For Our Medicaid Dollars?

The Commission examined how the selected homes spent the Medicaid revenue generated by the ALPs, which averaged $60 per resident per day, and found that most of the spending was for home care aides who were paid about $8.00 per hour and provided, on average, nearly two hours of care per day per resident. These services extended beyond the level of

[5] To some degree, reliance was placed upon the annual financial reports filed with the Department of Health; however, further on-site record reviews were often necessary.

personal care that must be provided to adult home residents which, by regulation, is about one-half hour per day per resident. To a much lesser degree, there was spending on other staffing, primarily for supervising nurses. In total, the ALPs spent on average $20 per day per resident on wages, of which $15 was for aides. Adding in related fringe benefits, the cost of program staffing averaged about $23 per day per resident.

The CHHAs, which are responsible for the provision of nursing and therapy services, appeared to have been infrequently employed for this purpose. These agencies have instead been engaged mainly to supply the required six month assessments necessary to maintain the residents' eligibility for Medicaid. The fact that the cost of the CHHA must be borne by the ALP operator and cannot be billed separately to Medicaid may be a contributing factor why such services seem to be kept to a minimum. The total cost of CHHAs for both therapy and assessments averaged only about $1 per day per resident.

In total, costs for ALP staff wages and CHHA services amounted to about $24 per day, nowhere near the $60 Medicaid payment level. Although ALP overhead could not be precisely measured, as the annual financial reports pool together the administrative costs of the ALP and the adult home, assuming overhead adds another 25 percent above the $24 direct cost, the resulting $30 average cost per day is still only one-half the average Medicaid payment. Considering that ALPs bill Medicaid over $60 million annually in New York, the excess funding may be substantial.

Chart 7

What did $60/day Buy?

- Staffing
  - Substantial Increase in Aides for Personal Care
    - Nearly 2 hrs/day per ALP Resident
    - Aides wages average $8 per hour
  - Some Nursing Supervision
  - Total Staff Wages + Fringes = $23/day
- CHHA Services
  - Mostly Used Only for Required Assessments
  - CHHA Costs Average $1/day
- Direct Costs Total $24/day vs. $60 rate

Where did the extra money go? First, it was noted that some providers invested some of the profits into the adult homes. For example, there was increased spending on property, including furniture, windows, flooring, and other renovations throughout the home which typically benefited all residents. Although such costs clearly relate to the room and board requirements of the adult home program, and not the ALP, some providers are using the ALP surpluses to fund these expenditures. Nevertheless, even after such cross-subsidizing of the adult

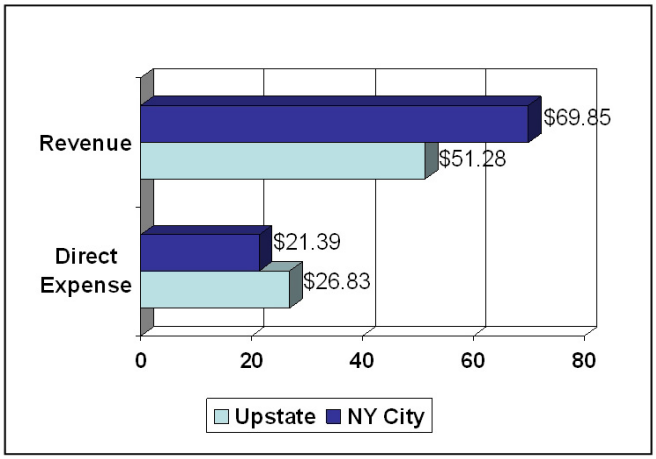
homes with ALP funding, the facilities reviewed remained quite profitable, particularly the New York City providers.

NYC Homes Spent Less, Received More

The spending patterns were noticeably different for the New York City homes in our study. The Commission found that while New York City homes spent less on services than the upstate homes, the New York City homes received higher Medicaid payments. The following chart shows a regional breakdown of the direct expenses as compared to ALP revenue per day.

Chart 8

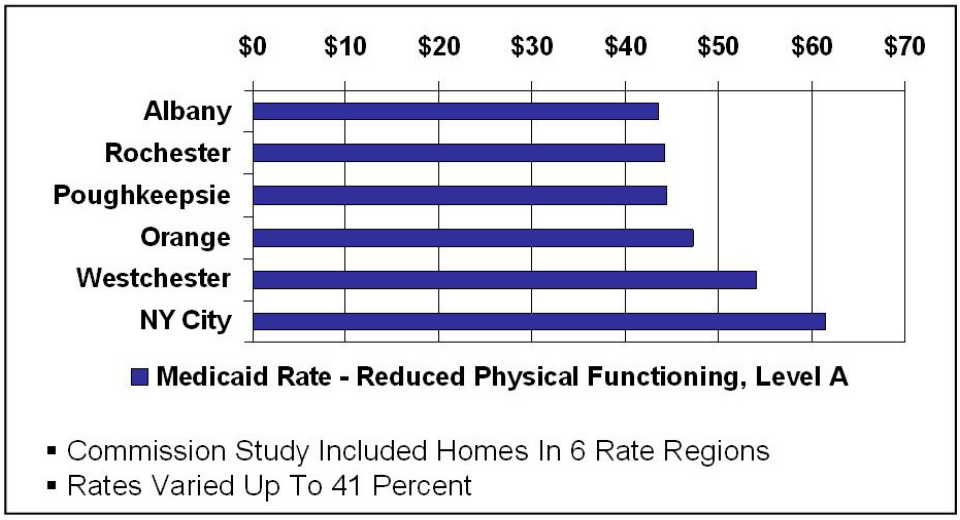
Expense vs. Revenue by Region



On average, the New York City homes spent about $5 less per day per resident, but had revenues of approximately $19 per day more than homes upstate. The disparities between revenues and expenses seen in Chart 8, especially with the New York City homes, call into question the appropriateness of tying the ALP rate to 50% of the RUGs rate.

Chart 9 shows the Medicaid payment rates for Reduced Physical Functioning, Level A -- the most frequently billed ALP rate. NYC homes were paid up to 41 percent more than homes in other regions. Given that the NYC homes were spending less than upstate homes, it is no surprise that all of the NYC homes in the study were more profitable on a per bed basis. Further, because the NYC homes tended to be larger facilities with a greater number of certified ALP beds, most of the NYC homes had profits of over a million dollars. Since over 40 percent of all ALP beds are in the NYC region, this finding is significant to the overall Medicaid outlay for the program.

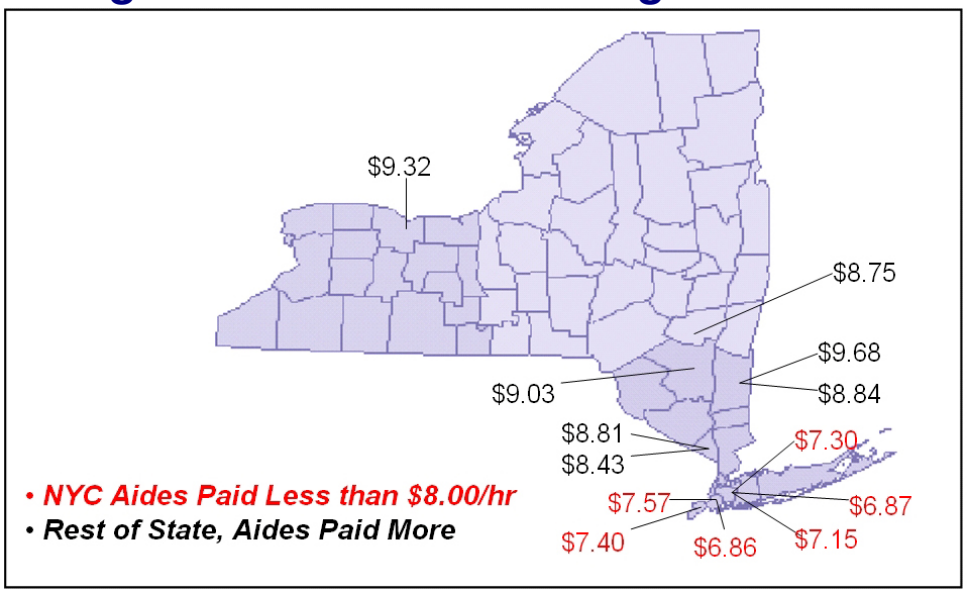
Chart 9
Regional Medicaid Rates



Home Care Wages Lower In NYC

As previously discussed, the cost for home care aides is by far the largest cost of the ALP program. As reflected in Chart 10, the Commission found that the average wage for aides and attendants in the six New York City homes was less than $8.00 an hour while the homes elsewhere in the state paid more. This differential is a significant factor in the lower spending levels of NYC homes.

Chart 10
Regional Variations in Wages of Aides



Fewer Hours of Service in NYC

When examining the overall cost of staffing, a review of the number of hours of service typically provided is also important. The Commission study found that NYC ALP spending levels remained lower than the rest of the state, not only because of lower hourly rates, but also because those homes in the sample averaged about one-quarter hour less service per resident per day than the upstate homes sampled. While the lowest level of service for an upstate home was two hours per resident day, two of the NYC homes were lower than one and one-third hours.

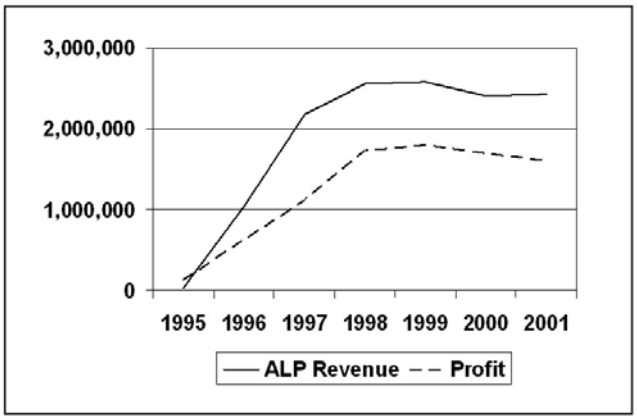
Related Party Transactions Mask True Profits

The following chart illustrates the extensive profits that resulted from the implementation of the ALP at one NYC home. Home NY6, which converted 122 beds to ALP beginning in 1995, saw its revenues from the ALP rise to $2.5 million while its overall profit rose to over $1.5 million annually.

Chart 11

Revenue and Profit Growth

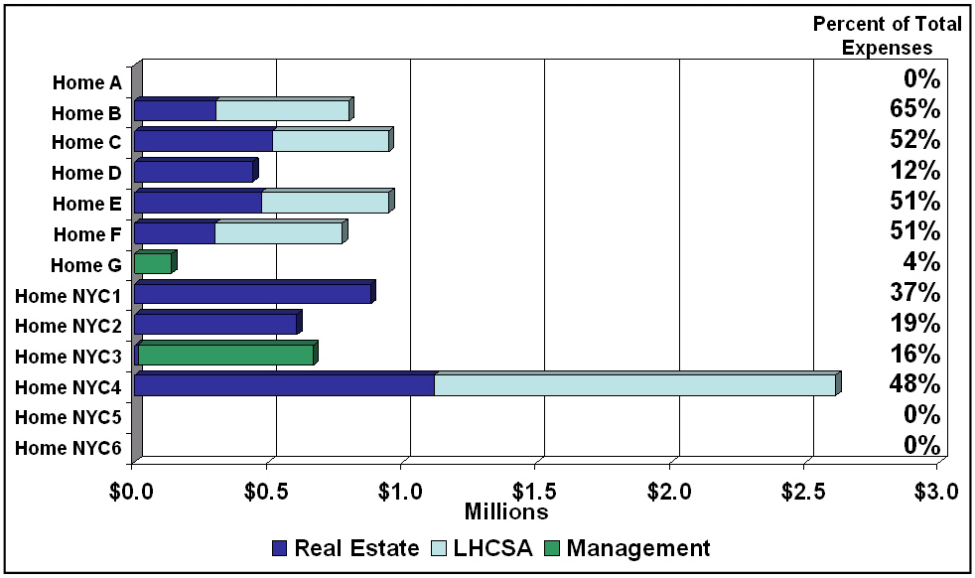
(Home NYC6)



Although the profit growth seen at Home NYC6 was similar to that at other ALPs, this home was atypical in that the revenue and profit figures came directly from its annual financial report. At most of the other homes, the Commission needed to adjust for related party transactions in order to get a true picture of the actual costs and profitability.

The most difficult aspect of examining the ALP expenditures was in the area of related party transactions, because such transactions are common and cost reporting fell short of a full accounting. Transactions with related parties include services, facilities, and supplies furnished to the provider by organizations related by common ownership or control. Chart 12 shows the prevalence of these transactions in the homes reviewed. Ten of the thirteen homes reported related party transactions. These included the rental of facilities and the provision of home care and management services. For the many homes with related party dealings, it was impossible to gain a full understanding of the real costs without looking to sources beyond the expenses reported to the Department of Health.

Chart 12
Related Party Charges



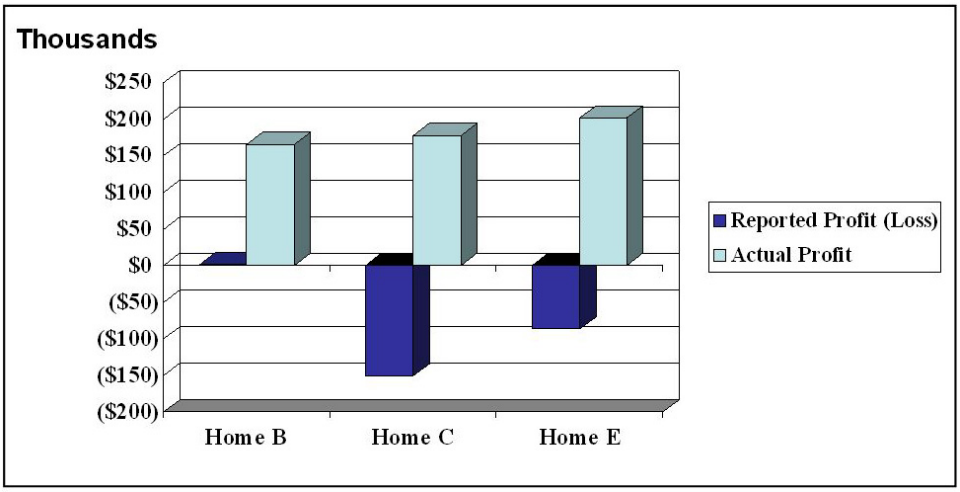
The percentages on the above chart show that the total program expenses typically include a large portion of related party charges. The dollar figures on this chart came from the annual financial reports and show the amount that the home was charged by the related party. But if such charges are greater than the actual costs, the home's reported expenses are inflated above their true cost.

The most frequent related party transaction involved a real estate holding company, which separately held the adult home real estate. This type of ownership structure is quite common throughout the adult home industry. The Commission has been told that operators often prefer to place the ownership of the land and building into a separate company in order to limit liability exposure. Those operators thus sit on both sides of the tenant/landlord relationship. As such, the rent charged to the adult home operations can be an arbitrary amount having no relationship to the actual costs incurred by the owner. For example, one home's rent tripled from $173,300 in 1998 to $513,000 in 2001. In reviewing the underlying records of the related real estate companies, the Commission suspected that the operator greatly increased the rent charges in order to fund other ventures unrelated to the home.

Three of the upstate homes reviewed by the Commission, which happen to have the same owner/operator (Homes B, C and E), were prime examples of why one must look beyond the related party rental charges in order to get a realistic picture of a home's profitability. If one were to simply rely upon the annual financial reports on file with the Department of Health it would appear that one home was breaking even while the other two were incurring substantial losses. However, when the reported related party charges were reduced to the actual costs of the homes' property, the homes each made in excess of $160,000.[6]

[6] The Commission was somewhat hindered by the operators' refusal to provide more detailed related party records. However, the Commission was able to make these conservative estimates based upon available information, erring on the side of a likely underestimation of the profits.

Chart 13
Reported vs. Actual Profits



This profitability analysis is based upon the conventional approach often taken in the health care industry which is to ignore the amount charged by the related party and instead rely upon the actual costs of the related organization.[7] The purpose of this method is to avoid the payment of a profit factor based upon artificially inflated costs generated from less than arm's-length bargaining.

Improvements to the Annual Financial Reporting Form

During the course of this study, the Commission recommended a revision of the annual financial report and worked with the Department of Health to improve the disclosures of less than arm's length transactions. Now, required disclosures include reporting the actual cost of the related entity pertaining to the goods and services it provides to the adult home (including the ALP). However, to have any value, such reporting will need to be reviewed for accuracy and, as was done in this report, incorporated into any analyses examining the costs and profitability of adult care facilities.

COMMENTS AND CONCERNS

The Commission believes the Assisted Living Program has the potential to be an efficient model for delivering services to persons who can live in the community but who need more assistance than is provided in an adult home. ALPs may prevent or postpone costly nursing home placement, thus allowing individuals to age in place. Elements of the ALP design—such as the use of a nurse from an independent CHHA to score the PRI and the requirement for county approval of the ALP application for each resident—contribute to the integrity of the program. Further, the utilization of a single daily rate discourages layering of services. The Commission also recognizes that some adult home operators have used a portion of the ALP reimbursement to finance improvements in the home that benefit all residents.

[7] CMS Publication 15-1, The Provider Reimbursement Manual – Part 1, Chapter 10 – Cost to Related Organizations

Notwithstanding these positive findings, the Commission has concerns about the financing of this care model and the alignment of services with the needs of the program participants. Specifically:

- Medicaid rates did not correlate with the programs' costs at the ALPs surveyed, particularly for New York City programs;
- Related party transactions obscured the true financial picture of adult homes and ALPs;
- Faulty RUGs scoring may be inflating payment levels in impacted adult homes; and,
- Inconsistencies among medical evaluations, RUGs scores, and plans of care and between plans of care and actual services provided in impacted adult homes suggest insufficient oversight of the program on a county level and within individual ALP programs.

RECOMMENDATIONS

1. The Commission recommends that the Department of Health evaluate the Medicaid funding levels for ALPs statewide. This evaluation should include an analysis which determines the actual costs that are obscured by related party transactions. If the Department's findings are consistent with the findings made by the Commission in the course of this review, i.e., Medicaid ALP payment levels greatly exceeded the actual costs of providing ALP services, the Department should propose appropriate adjustments to the rate methodology to more closely align funding with the program costs.

2. Regarding the concern that the RUGs scoring, particularly around toileting assistance, was unjustifiably inflated in the programs reviewed, the Commission recommends that the Department of Health review this matter and issue guidelines to impacted adult homes which are ALP providers, CHHAs, LTHHCPs and county departments responsible for approving ALP level of care certifications in such facilities clarifying its expectations related to the components of this assessment (interviews, observations and documentation review). These guidelines should include a requirement for a narrative section on the PRI in which the nurse provides a rationale for all scores above the base score, citing both personal observations and findings from reviewing patient records. Reassessments should address the success or lack of success of bladder incontinence training.

3. Finally, the Commission recommends that the Department of Health identify and implement enhanced surveillance protocols that address discrepancies among RUGs scores, plans of care, and services provided in impacted adult homes which are ALP providers.