NEW YORK LEGAL ASSISTANCE GROUP

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March 14, 2014

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RE: Delay Needed in NYS 1115 Waiver Expansion to Include Nursing Home Population – Mainstream Medicaid Managed Care and Managed Long Term Care

Dear Ms. Mann, Mr. Helgerson, et al.,

We write to highlight some of our concerns with the impending carve-in of nursing home (NH) residents into the mandatory mainstream Medicaid managed care (MMC) population and mandatory enrollment into managed long term care (MLTC) plans, which is pending CMS approval to begin on April 1, 2014. Many unresolved systems and policy issues demonstrate the roll out of this initiative must be delayed.

On March 10, 2014, the New York State Department of Health (DOH) held a meeting to present details of the roll-out to nursing home providers, managed care plan representatives, and consumer advocates. This meeting underscored both the unanswered questions and the high demand for more information on this initiative; over 600 people attempted to attend the webinar, crashing the online system as a result. Fortunately, a few consumer advocates were permitted to attend the March 10th meeting in person, but there was limited time to address all consumer concerns. As such, this letter serves as a list of outstanding questions and concerns that still need to be addressed. Please note that this letter is not intended to be exhaustive.

Below is a list of our principle concerns; details follow.

1. **People in nursing homes who are not enrolled in MMC or MLTC must be protected from marketing pressures to enroll into plans without fully understanding the implications of enrollment.**
2. **Policies that clearly identify responsibility for protecting Medicaid and SSI benefits to ensure that return to the community is financially feasible must be developed.**
3. **Procedures and policies must be developed that promote community integration and ensure due process rights when a plan determines to place a member in a nursing home.**
4. **Exceptions to in-network requirements are necessary due to concerns about the adequacy of network's MLTC members.**
5. **Contracts and Readiness Review are essential.**
6. **29-day short-term rehabilitation benefit must be included as part of the benefit package.**

We believe that the nursing home transition to managed care must be delayed. Inclusion of the NH in the MMC and MLTC benefit provides an opportunity to improve the delivery of LTSS to New York's Medicaid beneficiaries. However, we fear that without more planning this massive transition may inflict needless harm to a vulnerable population.

1. People in nursing homes who are not enrolled in MMC or MLTC must be protected from marketing pressures to enroll into plans without fully understanding the implications of enrollment.

The mandatory enrollment of thousands of individuals who newly become permanent residents in nursing homes must include robust consumer protection from potential marketing abuse. Similarly, even though current nursing home residents are protected by being grandfathered into FFS, and may stay in their current nursing homes, they are still vulnerable to marketing pressures; in six months, their *exclusion* from enrollment in MLTC plans will change to an *exemption* from enrollment – and they will also be vulnerable to misleading or pressured marketing.

There is no guidance on enrollment marketing tailored to the special circumstances of nursing home residents, who are disproportionately impaired by cognitive and other mental impairments. DOH policy requires only that after long term eligibility is approved by the Local Department(s) of Social Services (LDSS) for new people who become NH residents, the individual will be "contacted by NY Medicaid Choice to assist with enrollment in order for the beneficiary to stay at the current NH."[1] If the individual does not enroll within 60 days s/he will be auto-assigned to an MMC or MLTC plan that contracts with that nursing home. During that "choice" period, various plans and/or the nursing home, serving as the plans' contractor, often engage in marketing, which has the potential for abuse.

[1] NYS DOH Office of Health Insurance Programs, "Transition of Nursing Home Population and Benefit to Managed Care" (January 2014) hereafter referred to as "DOH NH Transition Policy."

a. **Given that a high percentage of NH residents have cognitive and other mental impairments, any so-called "voluntary" enrollment into a *fully capitated* plan should be prohibited**. Most companies that sponsor MLTC plans are also sponsoring Medicaid Advantage Plus (MAP) or PACE plans and have applied for approval of FIDA plans. These companies—or the nursing home contracting with them—often market their full-capitation MAP/PACE plans, resulting in "voluntarily" enrollment in the fully capitated MAP/PACE plans rather than the MLTC plans. Few if any residents will understand that their Medicare providers are now restricted to a closed network. While NY Medicaid Choice may not auto-assign them to a fully capitated plan, the marketing pressure to "voluntarily" enroll in these plans will be high. Just as home care recipients were told they would lose their aides unless they enrolled in a particular MLTC plan, NH residents will be told they will have to move to another NH if they do not enroll in certain plans.

   i. **RECOMMENDATION: Plans should not be permitted to market fully capitated plans to nursing home residents. No "voluntary" enrollment should be permitted.**

   ii. **RECOMMENDATION**: At a minimum, a written acknowledgement of a family member or other personal representative should be required to confirm understanding that the plan will now control access to Medicare services, that all Medicare providers must be in the plan's network, and understanding that that the individual has the option of enrolling in a partially capitated plan that does not cover Medicare services.

b. **Enrollment procedures must include reasonable accommodations and verified informed consent.** Many NH residents have cognitive or other mental impairments and are entitled to reasonable accommodations in the manner they receive information on enrollment. No guidance has been publically provided on this issue, nor have advocates had the opportunity to review draft notices or consumer education materials. Many questions about NY Medicaid Choice's role remain: How will NY Medicaid Choice contact nursing home residents? How will NY Medicaid Choice be available for counseling of nursing home residents—many of whom have multiple impairments and do not have phones—to assist with plan selection and enrollment?

   Further, informed consent of enrollees must be required. Nursing home residents are entitled to a designated representative.[2] The "designated representative" must receive copies of notices from NY Medicaid Choice. NY Medicaid Choice must develop a system to obtain the contact information to communicate with these representatives. To assure that consumers are properly advised, and properly informed of these "consumer centered" services, there must be a way to accurately confirm that their rights have been upheld and that the system is working the way it was intended. The primary tool for providing this crucial level of accountability is through documented, verifiable (preferably witnessed) notifications and informed consent.

[2] See 10 NYCRR Part 415

c. **Procedures must protect resident confidentiality**. What policies have been developed that protect the rights of residents to confidentiality?

2. **Policies must be developed that clearly delegate responsibility for protecting Medicaid and SSI benefits to ensure that return to the community is financially feasible.**

With all the attention paid to the goals of community integration, some very mundane steps are necessary regarding Medicaid and SSI benefits to ensure that the individual can pay rent or other expenses to maintain their home during a temporary hospital and nursing home stay. No mention has been made as to whether the NH or the MMC/MLTC plan is responsible for taking these steps.

a. **Continuation of SSI benefits.** After an SSI recipient is in a hospital and/ or nursing home for a full calendar month, his or her SSI benefits may only continue if a physician certifies in writing that his or her medical confinement will not last for more than 90 consecutive days. This form must be submitted to the Social Security office before the 90th day of the institutionalization or before the discharge home, whichever is earlier. If submitted, SSI benefits may continue for three months. This is called "Temporary Institutionalization" benefits.[3] Over 300,000 MMC members in NYS, and some MLTC members, rely on SSI benefits to pay their rent. Part of care management must be obtaining and filing these forms for both MMC and MLTC members who receive SSI. Whether the MMC/MLTC plan fulfills this duty or delegates it to the nursing home, it must be made clear in contracts. In absence of any such contractual language, DOH must clarify that the plans have this responsibility.

b. **Community Medicaid budgeting.** Similarly, Medicaid recipients admitted to a nursing home who expect to be discharged home have the right to "community budgeting," which allows them to keep the same income allowance they would have in the community ($829/month in 2014 for singles), during the temporary nursing home stay.[4] Without this budgeting, the individual may keep only $50/month of their income, with the rest paid toward the cost of nursing home care. As such, "community budgeting" is critical in allowing Medicaid recipients to pay rent and maintain their housing during a temporary nursing home stay.

In order to access this budgeting, the nursing home must submit a form to the LDSS with the institutional Medicaid application, on which a physician certifies that discharge home is expected.[5] If this form is not submitted, there is a presumption that every nursing home stay is permanent, and beginning with the very first full calendar month of the nursing home stay, the resident may keep only $50/month of income. Failure to follow the proper

[3] See Social Security Administration, POMS Section SI 00520.140, available at http://policy.ssa.gov/poms.nsf/lnx/0500520140

[4] See 18 NYCRR §§ 360-1.4(k), 360-4.9.

[5] The MAP-259d form used by NYC HRA is available at http://www.wnylc.com/health/download/132/.

procedure can also lead to participants being personally and inappropriately billed substantial amounts – and to losing their homes.

Even now, nursing homes often do not advise their short-term residents of their right to request community budgeting and fail to submit the necessary forms. With an MMC or MLTC plan now responsible for care management and for ensuring discharge back to the community where possible, responsibility for filing the requisite forms must be specifically assigned to the plans.

3. **Procedures and policies must be developed that promote community integration and ensure due process rights when a plan determines to place a member in a nursing home.**

   a. **Clear procedures and notice templates are needed to ensure that "long-term placement" determinations are made with adequate notice including notice of appeal rights.** The DOH NH Transition Policy is not sufficiently clear about the MCO/MLTC plan's duty to provide notice of the determination to place a member into a nursing home, with notice of appeal rights, and about *when* notice must be provided. DOH has recently recognized that mainstream managed care plans have not been compliant with notice and transition requirements in providing various LTSS services, and is taking steps to reinforce these vital requirements. Now, before there is time to implement these changes, nursing home care is being added to the benefit package of LTSS services. Adequate notice is more important than ever, given that the plan's determination that placement in a nursing home is medically necessary can obviously be cataclysmic, and has major *Olmstead* implications.

   Model notices should be developed with input of various stakeholders, including consumers. The timing of notices also must be addressed. A series of notices is needed in most cases: one notifying of a temporary nursing home placement for rehabilitation or sub-acute care – most commonly following a hospital stay, and a second one when the plan determines that a temporary nursing home stay should become permanent. The DOH NH Transition Policy vaguely talks about nursing home transitions as if a determination to place an individual in a nursing home happens at one moment during a hospital stay. The reality is that for both MLTC and MMC the majority of nursing home admissions are short term. [6] In many cases, the MCO/MLTC cannot determine until after a period of rehabilitation whether a long-term placement is medically necessary. Written notice with appeal rights must be provided at both times –at the temporary admission and when a decision is made for permanent placement. A copy should also be provided to the individual's "designated representative" in the nursing home. The content of these notices must be carefully developed with stakeholder input, not left to each plan.

[6] See Thomas H. Dennison, New York's Nursing Homes: Shifting Roles and New Challenges (United Hospital Fund August 2013) at pp 5-6 (ratio of short-stay to long-stay residents doubled over the decade from 2000 to 2010 from about 1:2 in 2000 to 1:1 in 2010, but because the short-stay residents go home, the number of short-stay admissions is far greater than admissions for long-stay).

i. **Discontinuance of home care service plan prior to the hospital/rehab stay requires advance notice and aid continuing rights**. When a member was receiving community-based long term care services (home care) prior to a hospital and/or nursing home stay, the plan's determination not to reinstate those services – and instead to make a permanent nursing home placement is also a DISCONTINUANCE of the prior community-based service plan. As such, the notice to the consumer must provide the right to request a hearing and "aid continuing," which in this context means discharge home with reinstatement of the prior service plan pending a hearing. *Granato v. Bane*, 74 F.3d 406 (2d Cir. 1996).[7]

b. **Capabilities Matrix should be shared with the public**. The DOH NH Transition Policy on discharge planning from hospitals identifies a "standardized capability matrix" that will include each nursing home's specialty services and populations, and that will be updated, to help hospitals and MCOs identify appropriate NHs for short- or long-term nursing home stays.[8] This matrix must be publicly available with updates posted online.

c. **PASSR Screenings.** The purpose of a PASSR screen is to determine not only that the person meets nursing home level of care requirements, but that the particular facility is properly equipped to address the individual needs of the person in regard to their mental disorder. The DOH NH Transition Policy stated position is that the PASSR screen will be performed "as it is today."[9] Since a PASSR screening can have a direct impact on what facility is appropriate for a particular individual, how that will be addressed in terms of MCO enrollment must be explained. Nursing home admission for those with serious mental disorders is different than for the general population, a fact that PASSR screening is intended to address. The role of the PASSR screen in the determination by the nursing home and MCO for long term care placement must be addressed.

d. **Incentives to arrange for least restrictive setting.** In the DOH NH Transition Policy includes a section on Transition Planning which states:

> … Discharge planning must be patient centered and should focus on the needs of the enrollee. Creating incentives to NHs and MCOs in arranging for the least restrictive setting based upon the enrollee's health care needs would help to assure this occurs…[10]

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[7] NYS DSS 99 OCC-LCM-2 (Apr. 20, 1999) available at http://www.wnylc.net/pb/docs/99OCCLCM2.pdf, reaffirming effectiveness of 96-MA-023, "New Notice, Aid-Continuing and Related Procedures Applicable to Hospitalized MA Recipients Who Received Personal Care Services Immediately Prior to Hospitalization," implementing *Granato v. Bane*, 74 F.3d 406 (2d Cir. 1996), available at http://www.health.state.ny.us/health_care/medicaid/publications/docs/gis/96ma023.pdf.

[8] DOH NH Transition Policy Policy Section II(1)(e)(iii) at p. 10.

[9] DOH NH Transition Policy, Section I at p. 3.

[10] Id., Sec. II (1)(b) at p. 9.

DOH needs to articulate the incentives for arranging for the least restrictive setting. It is insufficient to articulate the lofty goal of patient-centeredness and community integration that lack sufficient specific policy or procedural details that make it a reality.

e. **MLTC and MCO plans must assess nursing home residents for potential discharge home, including those not yet enrolled in the plans but seeking enrollment for discharge home.** As we have previously brought to DOH's attention, many MLTC plans have refused to send assessors to a nursing home to assess a nursing home resident who is not yet in a plan for potential enrollment, in order to be discharged back to the community with services. DOH has promised to issue clarifying guidance on this, since there is some ambiguity in existing contract and policy language. No clarification has been issued and these problems still exist. This setting presents an opportunity to create incentives for NHs and MCO/MLTC plans – but none have been established. Of course as more long-term nursing home residents are enrolled in managed care plans while remaining in the nursing home, they must also have a clear procedure to request that the plan assess them for potential discharge to the community with necessary supports, and an appeal procedure for plan determinations to deny services in the community.

f. **Consumer rights in discharge planning and education of consumers as well as hospital discharge planning staff**. The consumer and his or her designated representative must be fully apprised of his or her rights during each type of transition to and from a NH. Now that nursing home care will be part of the MMC and MLTC benefit packages, the model member handbooks must be revised and consumer educational materials prepared, translated and distributed. And again, plans and providers must obtain informed consent during transitions from the consumer, or in some cases, his or her designated representative.

Before rolling out this huge change, DOH must ensure that hospitals and other community-based health care providers, and other organizations that provide services to this population are educated about these changes. Just in the last week we have been invited by two major New York City hospitals to train their social work and discharge planning staff on the myriad changes involving MLTC and managed care – they asked us because no one else is doing it. Other than the arcane policy information on the state's MRT website, there is no clear information about these changes for the public. Education of the vast network of professionals who work with dual eligibles as well as Medicaid managed care members is a vital part of readiness to implement these changes.

4. Exceptions to in-network requirements are necessary due to concerns about the adequacy of networks and access to care.

Please confirm that prior policy continues per DOH FAQ dated 8/16/2012,[11] that the MLTC plan must pay the member's Medicare coinsurance for rehabilitation services provided in an SNF, regardless of whether the facility is in the MLTC plan's nursing home network. This should continue, since Medicare pays for most NH admissions for MLTC members, which are for short-term rehab stays.

a. **Out of Network Coverage Should Continue During Balance of Short-Term Stay, After Medicare Coverage Ends**. If the MLTC member is in an out-of-network NH and Medicare coverage ends, the MLTC plan under existing guidance is required to help the member transfer to an in-network facility.[12] This FAQ mistakenly presumes that any stay after the period of Medicare coverage is a "long-term" stay. As many attendees stated at the March 10th meeting, the reality is that short-term nursing home stays often continue after Medicare coverage ends; reasons may include the need for additional rehabilitation or medical stabilization, or time needed to plan for services upon discharge. It would be extremely disruptive to require an individual to transfer to an in-network nursing home for what may be a short period. The MLTC plans must be required to continue to cover the out-of-network stay if discharge back to the community is reasonably expected. Even if the individual could transfer to an MLTC plan that does contract with the NH, since enrollment is effective only on the 1st of the next month, and often not until the 1st of the second following month, it is impractical to require individuals slated for short-term stay to change plans. Also, if they had home care services through the MLTC plan prior to the hospital and rehab stay, the same MLTC plan can reinstate these prior services after discharge home. It would disrupt continuity of care to require changing MLTC plans.

b. Out-of-network NH discharges for MMC Members. A hospital could discharge a Medicaid-only MMC member into an out-of -network NH without the member having any knowledge or control. In such a case, there must be a clear policy in regard to who will pay for the cost of care and ensures that member will not be forced to move to a different NH or be liable for the cost of care.

c. Adequacy of nursing home networks. In many upstate counties, we understand individuals often seek placement in nursing homes in adjoining counties, not just their own county. This is also true for the two Long Island counties and five boroughs in NYC. We continue to be concerned that the network requirements are inadequate to ensure consumer choice and continuity of care.

[11] http://www.health.ny.gov/health_care/medicaid/redesign/docs/2012-08-16_mltc_faq.pdf, see Question 42.
[12] Id. 8/16/12 FAQ at Question 49.

Further, there is no requirement that every Medicaid-certified nursing home contract with MMC and/or MLTC plans. **Nursing homes should be required to contract with at least two of each type of plan, in order to provide adequate consumer choice.**

d. **Specialty nursing homes.** The requirement that plans contract with at least two nursing homes of each type in the county, where available, is not adequate. Outside of NYC and Nassau County, no county has more than 2 homes of any specialty type. As we understand the policy, the plans must grant member requests to receive services at a non-participating NH. However, we are concerned that members will not be informed of their right to access these out-of-network nursing homes. Given that 37 upstate counties do not have a specialty nursing home, and another 6 upstate counties have only one specialty NH—ventilator beds—plans in upstate counties should be required to contract with every specialty nursing home, at least in a multi-county region. Additionally, plans should be required to provide the option of 12-24 hour/day home care at the appropriate level (personal, home health, private duty, Consumer-directed) in the community to members that do not have access to in-network specialty nursing homes.

   In NYC, the minimum of two nursing homes in any specialty fails to take into account the variation in capacity among different facilities. In Queens, for example, while eight nursing homes have ventilator beds, the number of beds in these eight facilities ranges from 10 to 80 (see attached spreadsheet, which adds data from DOH website showing number of specialty beds). A plan could satisfy the network requirement with 2 nursing homes that have only 20 vent beds between them. Additional utilization data should be used to determine the adequate number of beds required for each specialty nursing home type given enrollment. Again, plans should be required to provide members with the option of 12-24 hours of personal care in the community if an in-network nursing home is at capacity. Of course, the option of in-home services must always be considered to comply with community integration requirements.

5. **Contracts and Readiness Review**

From the vocal participation of nursing home representatives at the March 10th meeting, it was clear that the system is far from ready to go live on April 1st. Many aspects of contracting between nursing homes and plans are not even finalized. Contracts that may have existed before must now be updated since the nursing home benefit is being dramatically changed. Just as important as the contracts are the systems for billing and for communicating authorizations for care and many other elements of a complex system. Indeed, in NYC there are 25 MLTC plans, 12 MAP and PACE plans, and 10 MMC plans, so it is not surprising that nursing homes as well as hospitals are scrambling to set up these systems for literally dozens of plans. Nursing homes asked the State to establish templates for many of the terms that must be established, but DOH indicated it would leave this to the plans and nursing homes.

All of this uncertainty and lack of readiness impacts consumers. Consumers can be pressured to transfer to a different plan, or to a different nursing home, or to pay part of a bill if the systems fail.

Their discharge back to the community can be delayed or blocked altogether if plan authorizations for home care cannot be obtained. Moreover, if a nursing home is not paid for the care provided consumers will likely suffer the adverse effects of declining quality in the facility overall.

All of these contract and systems details must be assessed carefully in a readiness review by the DOH before this system goes live. From the comments made the March 10th meeting, it seems that DOH does not find it necessary to conduct a detailed readiness review and is instead relying on the "good faith" of the plans and nursing homes to take care of these details. We believe much more oversight from the State is needed to ensure that these complex systems are ready to go live and that consumers receive quality care.

6. **Benefit Package -- 29-day short-term rehabilitation benefit.**

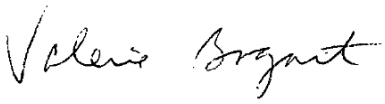
After Medicare coverage of an SNF stay ends, the NYS Medicaid 29-day rehabilitation benefit[13] should cover additional days of NH care without requiring a full application for chronic care/institutional Medicaid coverage. (Example: If Medicare covered 20 days, Medicaid should pay nine days under short-term rehabilitation benefit without requiring the five-year look-back). Individuals without Medicare in MMC plans should not be referred to the LDSS for a full five-year look-back until this 29-day benefit is exhausted. Since one purpose of this 29-day period is to simplify Medicaid coverage for short-term NH stays, anyone eligible for this benefit should receive coverage under community-based Medicaid. Guidance is needed to require that MLTC and MMC plans are responsible for paying for this benefit. As a practical matter, even under FFS we have not seen this benefit utilized as much as it could be, and people have been required to submit the full five-year look-back application even when it should not be necessary, since coverage should be available under this benefit. Now, eligibility for the 29-day benefit should delay the requirement to enroll in a managed care plan, since by definition this coverage is short-term.

The above unresolved questions and concerns demonstrate that the transition of the nursing home benefit to managed care must be delayed. The inclusion of this benefit in the MMC and MLTC plans poses the opportunity to improve the delivery of LTSS to New York's Medicaid beneficiaries. However, we fear that without more planning this vulnerable population will face needless harm. The undersigned organizations remain willing to assist in development of improved policies and procedures to make the transition a success.

[13] Section 366-a(2) of the Social Services Law, 04 OMM/ADM-6 (July 20, 2004).

We look forward to your response and an opportunity to discuss these and other concerns.

Sincerely,



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Empire Justice Center
MFY Legal Services, Inc.
NYC Long Term Care Ombudsman Program
New York Lawyers for the Public Interest
Southern Tier Independence Center

Enc. Nursing Home Network Requirements by County - (combines charts provided by DOH and data from http://nursinghomes.nyhealth.gov/)

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Nursing Homes Network Requirements by County (9-23-13 draft) (Combined by Valerie Bogart)

NYS DOH - Office of Health Insurance Programs

Division of Health Plan Contracting and Oversight

	General Beds		SPECIALTY Nursing Homes (Blank = 0) (Minimum of 2 if exists)					Specialty BEDS*				
County	Number of Nursing Homes ("NHs")	Minimum # of Participating NHs required Per Plan	Pediatric	AIDS	Vent	Behavioral	TBI	Pediatric	AIDS	Vent	Behavioral	TBI
QUEENS	55	8	1		8		2	95		210		40
BRONX	43	8		5	7				417	139		
SUFFOLK	43	8	1	0	2		1	41		48		20
KINGS	42	8		1	5				120	133		
ERIE	38	8	1		2			13		39		
WESTCHESTER	38	8	2		2			180		23		
MONROE	35	8			2	1				30	15	
NASSAU	35	8		1	6				20	124		
ONEIDA	17	4										
NEW YORK	16	5	1	4	1			21	430	20		
DUTCHESS	13	4			2					146		
ONONDAGA	13	4			1		1			13		20
ALBANY	12	4	1					58				
BROOME	10	3								12		
NIAGARA	10	3										
ORANGE	10	3										
RICHMOND	10	5		1	3	1	1		80	136	72	21
ROCKLAND	10	3			2					40		
RENSSELAER	9	3										
CHAUTAUQUA	8	3										
SCHENECTADY	7	3	1		1		1	36		8		70
ULSTER	7	3			2	1	1			61	20	180
ONTARIO	6	2			1							
ST LAWRENCE	6	2										
STEUBEN	6	2			1					8		
CATTARAUGUS	5	2										
CAYUGA	5	2										
CHEMUNG	5	2										
CHENANGO	5	2										
COLUMBIA	5	2			1					40		
MONTGOMERY	5	2										
OSWEGO	5	2										
TOMPKINS	5	2										
ALLEGANY	4	2										
CLINTON	4	2										
GENESEE	4	2										
HERKIMER	4	2										
JEFFERSON	4	2										
MADISON	4	2			1					11		
SARATOGA	4	2										
SULLIVAN	4	2										
WARREN	4	2										
WASHINGTON	4	2										
WAYNE	4	2			1	1				10	20	
CORTLAND	3	2										
ESSEX	3	2										
FRANKLIN	3	2										
FULTON	3	2										
LIVINGSTON	3	2										
ORLEANS	3	2										
OTSEGO	3	2										
DELAWARE	2	2										
PUTNAM	2	2										
SENECA	2	2										
TIOGA	2	2										
WYOMING	2	2										
YATES	2	2				1					20	
GREENE	1	1										
LEWIS	1	1										
SCHUYLER	1	1										

* Source: http://nursinghomes.nyhealth.gov/

Specialty Nursing Homes by County			
Specialty	**County**	**Provider Name**	**No. beds**
Pediatric	ALBANY	ST MARGARETS CENTER	58
AIDS	BRONX	BRONX-LEBANON SPECIAL CAR	120
AIDS	BRONX	CASA PROMESA	108
AIDS	BRONX	HELP/PSI INC	66
AIDS	BRONX	HIGHBRIDGE-WOODYCREST	90
AIDS	BRONX	ST BARNABAS REHABILITATIO	33
Ventilator	BRONX	CONCOURSE REHABILITATION	22
Ventilator	BRONX	DAUGHTERS OF JACOB NURSIN	24
Ventilator	BRONX	EASTCHESTER REHABILITATIO	16
Ventilator	BRONX	FIELDSTON LODGE CARE CENT	10
Ventilator	BRONX	SPLIT ROCK REHABILITATION	27
Ventilator	BRONX	ST BARNABAS REHABILITATIO	22
Ventilator	BRONX	WAYNE CENTER FOR NURSING	18
Ventilator	BROOME	BRIDGEWATER CENTER FOR RE	12
Ventilator	COLUMBIA	WHITTIER REHABILITATION &	40
Ventilator	DUTCHESS	WINGATE AT ST BEACON	120
Ventilator	DUTCHESS	WINGATE OF DUTCHESS	26
Pediatric	ERIE	HIGHPOINTE ON MICHIGAN HE	13
Ventilator	ERIE	ELDERWOOD HEALTH CARE OAK	20
Ventilator	ERIE	ERIE COUNTY MEDICAL CENTE	19
AIDS	KINGS	SCHULMAN AND SCHACHNE INS	120
Ventilator	KINGS	CONCORD NURSING HOME INC	17
Ventilator	KINGS	FOUR SEASONS NURSING AND	20
Ventilator	KINGS	PALM GARDENS CENTER FOR N	38
Ventilator	KINGS	RUTLAND NURSING HOME CO I	30
Ventilator	KINGS	SCHULMAN AND SCHACHNE INS	28
Ventilator	MADISON	ONEIDA HEALTHCARE CENTER	11
Behavioral	MONROE	THE HIGHLANDS AT BRIGHTON	15
Ventilator	MONROE	THE HIGHLANDS AT BRIGHTON	20
Ventilator	Monroe	UNITY LIVING CENTER	10
AIDS	NASSAU	A HOLLY PATTERSON EXTENDE	20
Ventilator	NASSAU	A HOLLY PATTERSON EXTENDE	20
Ventilator	NASSAU	COLD SPRING HILLS CENTER	24
Ventilator	NASSAU	MEADOWBROOK CARE CENTER I	10
Ventilator	NASSAU	SOUTH SHORE HEALTHCARE	24
Ventilator	NASSAU	TOWNHOUSE CENTER FOR REHA	20
Ventilator	NASSAU	WOODMERE REHABILITATION A	16
AIDS	NEW YORK	(THE) ROBERT MAPPLETHORPE	28
AIDS	NEW YORK	RIVINGTON HOUSE-THE NICHO	206
AIDS	NEW YORK	ST MARYS CENTER INC	40
AIDS	NEW YORK	TERENCE CARDINAL COOKE HE	156
Pediatric AIDS	NEW YORK	INCARNATION CHILDRENS CEN	21

Ventilator	NEW YORK	ISABELLA GERIATRIC CENTER	20
TBI	ONONDAGA	ST CAMILLUS RESIDENTIAL H	20
Ventilator	ONONDAGA	JAMES SQUARE HEALTH AND R	5
Ventilator	ONTARIO	CLIFTON SPRINGS HOSPITAL	8
Pediatric	QUEENS	ST MARYS HOSPITAL FOR CHI	95
TBI	QUEENS	PARK TERRACE CARE CENTER	20
TBI	QUEENS	QUEENS NASSAU REHABILITAT	20
Ventilator	QUEENS	CLIFFSIDE REHABILITATION	38
Ventilator	QUEENS	DR WILLIAM O BENENSON REH	20
Ventilator	QUEENS	FRANKLIN CENTER FOR REHAB	12
Ventilator	QUEENS	LONG ISLAND CARE CENTER I	10
Ventilator	QUEENS	PROMENADE REHABILITATION	20
Ventilator	QUEENS	RESORT NURSING HOME	10
Ventilator	QUEENS	ROCKAWAY CARE CENTER	20
Ventilator	QUEENS	SILVERCREST	80
AIDS	RICHMOND	Richmond Center (formerly ST ELIZABETH ANNS)	80
Behavioral	RICHMOND	Richmond Center (formerly ST ELIZABETH ANNS)	72
TBI	RICHMOND	SEA VIEW HOSPITAL REHABIL	21
Ventilator	RICHMOND	NEW VANDERBILT REHABILITA	28
Ventilator	RICHMOND	Richmond Center (formerly ST ELIZABETH ANNS)	28
Ventilator	RICHMOND	SILVER LAKE SPECIALIZED R	40
Ventilator	ROCKLAND	FRIEDWALD CENTER FOR REHA	12
Ventilator	ROCKLAND	NORTHERN MANOR GERIATRIC	28
Pediatric	SCHENECTADY	PATHWAYS NURSING AND REHA	36
TBI	SCHENECTADY	PATHWAYS NURSING AND REHA	70
Ventilator	SCHENECTADY	PATHWAYS NURSING AND REHA	8
Ventilator	STEUBEN	MCAULEY MANOR AT MERCYCAR	8
AIDS	SUFFOLK	JOHN J FOLEY SKILLED NURS	CLOSED
Pediatric	SUFFOLK	AVALON GARDENS REHABILITA	41
TBI	SUFFOLK	ST JOHNLAND NURSING CENTE	20
Ventilator	SUFFOLK	GURWIN JEWISH GERIATRIC C	28
Ventilator	SUFFOLK	MEDFORD MULTICARE CENTER	20
Behavioral	ULSTER	NORTHEAST CENTER FOR SPEC	20
TBI	ULSTER	NORTHEAST CENTER FOR SPEC	180
Ventilator	ULSTER	NORTHEAST CENTER FOR SPEC	40
Ventilator	ULSTER	WINGATE OF ULSTER	21
Behavioral	WAYNE	WAYNE HEALTH CARE	20
Ventilator	WAYNE	WAYNE HEALTH CARE	10
Pediatric	WESTCHESTER	ELIZABETH SETON PEDIATRIC	136
Pediatric	WESTCHESTER	SUNSHINE CHILDRENS HOME A	44
Ventilator	WESTCHESTER	DUMONT CENTER FOR REHABIL	15
Ventilator	WESTCHESTER	MICHAEL MALOTZ SKILLED NU	8
Behavioral	YATES	SOLDIERS AND SAILORS MEMO	20