

Report of the Senate Medicaid Reform Task Force



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December 2003



Executive Committee of the Senate Medicaid Reform Task Force

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Introduction

The Senate Medicaid Reform Task Force has completed an exhaustive process of public round table meetings, open discussions, and information gathering. We have listened to health care providers, consumers, local government officials, academics, advocates, and representatives of every imaginable sector of society impacted by our health care system regarding the role Medicaid plays within this system.

At more than \$13 billion in State spending, Medicaid now comprises the second largest single element of New York's budget, closely behind aid to public education. However, New York State is not the only financier of the Medicaid program; when Federal and local shares are included it is estimated that total Medicaid expenditures in New York State will exceed \$41 billion in the current State Fiscal Year. This massive outlay of State, local and Federal funds reflects New York's historic commitment to provide essential services to the poor and vulnerable and those in need of care. At the local level, Medicaid spending has increased in excess of 34 percent over three years, from \$3.7 billion in 1999 to \$4.9 billion in 2002. This skyrocketing growth in New York's Medicaid program poses the single most daunting fiscal challenge to our State and local governments.

The growth in Medicaid spending, coupled with problems associated with access to quality care and lack of accountability, provide the most compelling evidence that New York's Medicaid program lacks a sensible and coherent set of public policy principles to guide it. For too long, the Medicaid crisis has been addressed only during budget deliberations in the context of specific budget recommendations. Cost containment proposals which do not address the systemic problems of the program are advanced, and providers successfully press their case that these measures will destabilize the health care system. Consumer advocates contend that the quality of health care itself will be compromised. The debate has been consistently focused on appropriations,

institutions, and interests. Typically after budget restorations are made, little or no discussion takes place regarding how well the system works, the burden placed on the taxpayers who fund the program, or what level of quality and value is purchased by the State on behalf of those who depend on the Medicaid program's services. As the amount of money spent on Medicaid soars, providers contend they are inadequately compensated and pushed to the edge of insolvency. Primary care providers and specialists opt out of the program. At the same time, more than seventy five percent of all Medicaid costs go to finance care for the elderly and disabled in a long term care system where patients have too few choices and providers are hampered by too many regulations. Finally, no one asks on behalf of recipients and taxpayers what level of quality and what kind of results we are getting for our multi-billion dollar annual investment.

The members of the Senate Medicaid Reform Task Force believe that the traditional approach of incremental reforms will yield nothing except the certainty that things will never change. Accordingly, we propose a fundamental restructuring of Medicaid in New York. We reject the terms of the old discussions that have brought us to our present crisis. We believe that reform will only occur when the interests of two long ignored groups are moved to the center of the discussion: Patients, who have every right to expect quality and humane care; and Taxpayers, who have every right to expect efficiency, value, and sound judgment in the expenditure of public funds.

Change will only be accomplished if we establish a common sense policy to reform, improve, stabilize and contain Medicaid. New York needs to adopt and implement guiding principles for Medicaid policy which should include the following:

- ❖ State and local budgets, and the taxpayers who fund them, can no longer bear the explosive growth in Medicaid costs. At the same time, despite massive expenditures of public funds, the Medicaid system frequently delivers inadequate, fragmented, and inefficient care to patients. Both patients and taxpayers need and deserve relief now;

- ❖ An increase in efficiency and improvement in patient care through the use of disease management practices to provide a coordinated approach to patient care;
- ❖ A transformation of the Medicaid management system from one designed to pay bills to an effective management and planning tool which uses information technology to deliver effective care and manage and review utilization of care;
- ❖ An aggressive pursuit of federal waivers accompanied by State regulatory and program reform to develop a consumer centered, rational long term care system, which provides a spectrum of options. Overly prescriptive regulatory and funding systems, which often push both providers and patients to nursing home and other institutional care, should be dismantled;
- ❖ An insistence on a greater sense of personal and financial involvement in health care for those who have the financial wherewithal to do so; and
- ❖ The provision of fiscal relief to local governments and avoidance of future cost shifting.

Reform Recommendations

It is no exaggeration to state that as the Task Force undertook its work of examining New York's Medicaid program, it reached a startling conclusion: Medicaid in New York is a massive program without an organized guiding policy. The major goals of reaching effectiveness for taxpayers and patients can only be reached by developing and implementing such a policy. To that end, the Task Force has developed over 40 specific policy recommendations, all related by the guiding principles set forth above. Together, they envision a Medicaid system which respects patients and taxpayers, uses technology to deliver and manage effective care not just pay bills, introduces personal involvement and responsibility on the part of the recipient, and particularly reforms the long term care system to de-emphasize institutional care and to permit responsiveness to consumer needs. At the same time, these reforms will provide fiscal relief within the State budget and will enable us to provide relief to local governments.

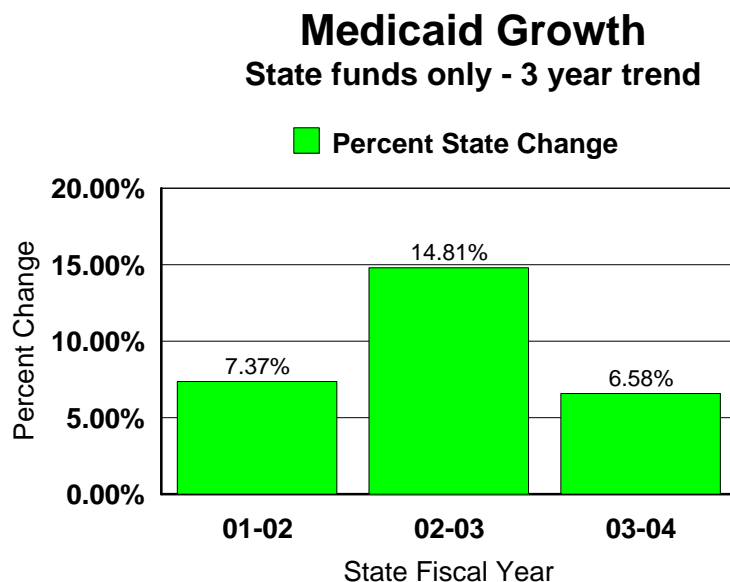
- ✓ The Task Force recommends establishing disease management programs, as well as undertaking comprehensive utilization review.
- ✓ The Task Force recommends modifying Family Health Plus, authorizing mandatory Medicaid managed care in rural areas, and providing for the use of medical savings accounts.
- ✓ The Task Force recommends establishing a preferred drug list for Medicaid and expanding the use of generic drugs, along with other proposals to control the spiraling cost of pharmaceuticals.
- ✓ The Task Force recommends providing fiscal relief to local governments through a State assumption of the local share of Medicaid costs for the Family Health Plus program.
- ✓ The Task Force recommends reform of the long term care system, including expanding options for private financing of long term care and reform of estate planning practices. In addition, a seamless and coordinated long term care system would be promoted through a variety of recommendations, including improving support to caregivers and improving access to non-institutional long term care services.

The recommendations reflect the Task Force's commitment to providing access and quality of care to participants, while at the same time promoting cost effectiveness and efficiency for the State's taxpayers. Patients and taxpayers deserve primacy in our efforts to reform Medicaid. Toward that end, we direct our attention during the coming legislative session to the goals outlined on the following pages, with a specific recommendation for each.

MEDICAID - FACTS

Expenditures

Medicaid, the nation's health insurance program for low income persons, was created by the Federal government in 1965 pursuant to Title XIX of the Social Security Act. Medicaid is an entitlement program for individuals who meet specific eligibility standards. The Federal government establishes general requirements concerning funding, quality and scope of services, while states have flexibility to determine eligibility, reimbursement rates, benefits and service delivery. In the 38 years since inception, Medicaid in New York State has grown from a health insurance program for the needy to a program offering a multitude of services to a wide range of population groups. The result is that in New York State the Medicaid program is estimated to cost \$41 billion in 2003. Over the past three years, New York's State share alone has grown at an average annual rate of 10.5 percent. Inflation, in comparison, has increased at an average annual rate of 2.2 percent¹ throughout the same time period.

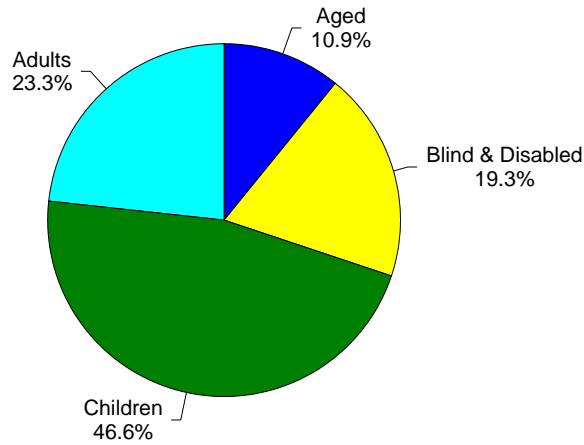


Medicaid is the
State's primary

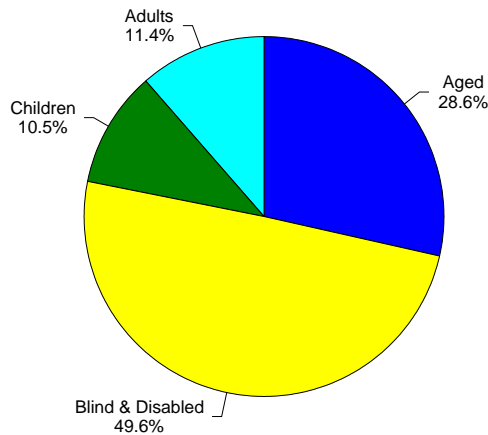
¹ Bureau of Labor Statistics, <<ftp://ftp.bls.gov/pub/special.requests/cpi/cpi.ai.txt>>

source of funding for nursing home care. Nearly 80 percent of all nursing home residents in New York are Medicaid beneficiaries as compared to a national average of 64 percent. To put this into a national perspective, 10 percent of New York’s population over the age of 65 receives Medicaid benefits for long term care services, compared to a median of 4.6 percent in all other states. In addition to the elderly, Medicaid provides services to people with disabilities; together these populations comprise 30 percent of the State’s Medicaid recipients and account for 78 percent of all Medicaid costs.

**Medicaid Eligibility
FFY 2001**



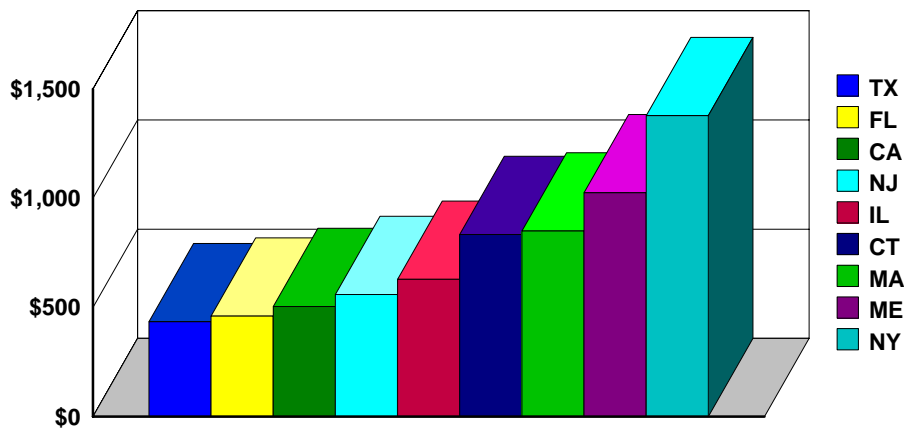
**Medicaid Spending
FFY 2001**



New York’s Medicaid expenditures exceed those

of any other state by any measure. Recent data shows Medicaid spending in New York at \$1,378 per capita. This rate is more than double the national average of \$598 per capita. As seen in the chart below, New York State leads the nation in per capita Medicaid spending. The state with the next highest per capita spending is Maine at \$1,025, 26 percent less than New York. In per capita spending Maine is followed by Rhode Island at \$1,021, Massachusetts at \$850, and California and New Jersey at \$504 and \$559, respectively². Notwithstanding all the disparities between New York and other states, fully exploring why these disparities exist should be aggressively pursued.

**Per Capita Medicaid Spending
FY 2000**



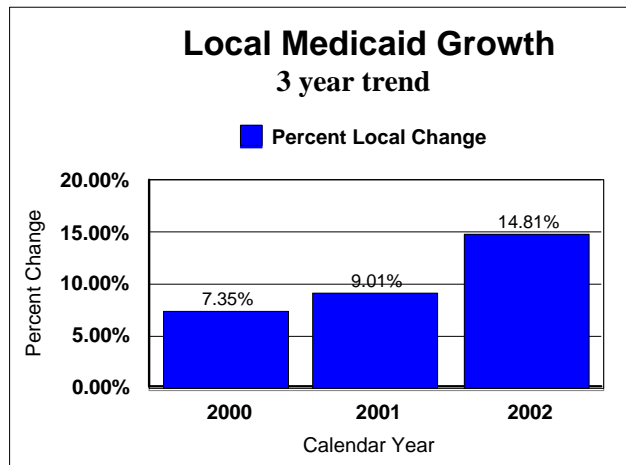
**Financi
ng**

The State of New York relies primarily on personal income tax, sales tax and corporate tax revenues to finance the State’s budget and thus the State’s share of the Medicaid program. New York’s share of Medicaid costs is also supported by revenues generated from the Health Care Reform Act (HCRA). The burden placed on the State’s taxpayers to finance the Medicaid program does not end at the State level. Counties are required to pay for a share of the program, ranging from 25 percent of the cost of providing hospital

² Per Capita Medicaid Spending, FY 2000 - Federal Health Source Book

and home care services to 10 percent of the cost of providing long term care services. Local governments are therefore responsible for approximately 16 percent of the total program costs on average. Counties must rely on property and local sales tax revenues to finance their Medicaid bills. As a result, New York's taxpayers carry the burden of financing the State and local shares, as well as the Federal shares of the Medicaid program. In addition, New York receives the lowest Federal Medicaid matching rate in the country, thus State taxpayers are contributing more than their fair share to Medicaid than in other parts of the country.

As the chart below indicates, local government Medicaid expenditures are exploding. Counties are forced to make tough decisions on non-Medicaid spending and property tax rates since they have little control over their Medicaid costs. For example, the Family Health Plus program, enacted by the State in 1999 and implemented in 2001 and 2002, has added significant costs to local government budgets. In the past 12 months, Family Health Plus has added almost \$220 million to the Medicaid budgets of local governments. Not surprisingly, local governments are requesting not only relief from the costs of this program but from future mandates as well.



Total Growth Over 3 Years: 34.36%
Average Growth: 11.45%

Senate Medicaid Reform Task Force

Summary of Recommendations

Promote Cost Effectiveness and Efficiency

- Establish Disease Management Programs
- Establish Comprehensive Utilization Review
- Maximize Use of Technology
- Amend Family Health Plus
- Shift Children from Medicaid to Child Health Plus
- Authorize Mandatory Medicaid Managed Care in Rural Areas
- Promote Greater Consistency and Standardization of Managed Care Programs
- Authorize Use of Medical Savings Accounts
- Authorize EMS Dispatch Triage and Field Treatment programs
- Authorize Development of Transitional Care Units
- Establish a Health Care Monitoring Entity to Track Financial Stability of Providers
- Review the Certificate of Need Process
- Implement Regulatory Reform
- Explore Tort Reform
- Improve the Medicaid Pharmaceutical Program
 - Establish a Preferred Drug List and Prior Authorization Process
 - Expand Use of the 340 B Federal Drug Discount Program
 - Explore Reimportation of Pharmaceuticals
 - Expand the Use of Generic Drugs
 - Explore Varied Reimbursement Rates for Drugs to Better Reflect Acquisition Costs
 - Establish “Trial Periods” for Pharmaceuticals
 - Allow Re-use/Return of Unopened Pharmaceuticals Used in Institutional Settings

Provide Fiscal Relief to Local Governments

- Assume the Local Share of the Family Health Plus Program
- Reallocate a Portion of Facilitated Enrollment Funds to Counties
- Authorize Local Demonstration Programs
- Provide Greater Financial Incentives for Counties to Pursue Asset Recovery
- Provide Better Local Access to State Databases
- Work with the Federal Government to Increase the Federal Share of Medicaid Funding

Reform the Long Term Care (LTC) System

Expand Private Financing of Long Term Care & Reform Estate Planning Practices

- Encourage Purchase of Long Term Care Insurance
- Allow Acceleration of Life Insurance Benefits and Reverse Mortgages to Pay Costs
- Encourage Development of Privately Financed Care Models, Like CCRCs
- Maximize Third Party Insurance Coverage for LTC
- Substantially Restrict “Spousal Refusal”
- Restrict Asset Transfers and Extend Look Back Periods for Transfers
- Reexamine Maximum Income and Resource Limits for Non-institutional Spouses
- Require Direct Payment of Federal SSI Funds to Nursing Homes

Develop a more seamless and coordinated Long Term Care delivery system

- Expand Existing Federal Waivers
- Implement a “Cash and Counseling” Demonstration Program
- Review Institutionalized Patients for Community Based Appropriateness
- Authorize Controlled “Right Sizing” for Nursing Homes
- Develop Single Access Points, a Uniform Assessment Tool and a Single License for Multiple Levels of LTC Service
- Review and Expand Managed Long Term Care Programs
- Improve Access to Non-institutional Long Term Care Services
- Explore Improvements to Case Management Services
- Provide More Comprehensive LTC Information to Consumers and Providers
- Improve Support to Caregivers
- Promote Integration of Hospice and Palliative Care into the LTC Continuum
- Authorize Regional Demonstration Programs to Create a LTC Continuum

Goal: Improve the cost effectiveness and efficiency of the system in order to provide for the best use of resources.

Recommendation: Establish Disease Management Programs

- The existing Medicaid program has evolved into what is mainly a payment system for health care providers. Generally, this system is not accountable for the quality or cost effectiveness of care provided to Medicaid recipients. While managed care has presumably introduced some effort to measure outcomes, it has had limited success. A small proportion of the Medicaid population, most of whom are chronically ill, are responsible for the overwhelming majority of Medicaid spending. It is this population that is specifically exempted from managed care. There is virtually no coordination or monitoring of the care provided to these chronically ill populations. Consequently, services are often fragmented, resulting in the potential for wide variations in approaches to treatment (or non-treatment) of several disease states, and opportunities for misuse of the health care system.

Development of several disease management demonstration programs would represent a major shift in the way the Medicaid program approaches health care for chronically ill populations by changing it from a system focused mainly on paying providers, to a system which emphasizes coordinated, patient-centered and evidence-based care for a number of high prevalence and high cost chronic disease states. Utilizing this approach, the system would become accountable for improved outcomes, in both quality and cost effectiveness.

Recommendation: Establish Comprehensive Utilization Review - (Quality)

- In order to assure quality care, and personal and fiscal responsibility within the Medicaid system, appropriate utilization of medical care should be a goal of patients, providers, and payers alike. Numerous studies indicate that over-utilization and under-utilization of medical services can produce negative outcomes for patients. The establishment of a comprehensive utilization review program, that focuses on medical necessity and outcomes, can help determine the appropriate frequency, mix and intensity of Medicaid services. This information would allow the development of best practice strategies and coordination with the development of disease management programs to respond to over-utilization, under-utilization or poor patterns of care. Currently, there are several programs addressing appropriate utilization including: medical necessity and quality of care reviews; Medicaid Utilization Thresholds; the Recipient and Provider Restriction Programs; and the Drug Utilization Review program. These programs should all be strengthened to form the basis of a more comprehensive structure for utilization review. Regional differences in per capita

spending and utilization of services should also be analyzed to discern opportunities to provide more effective care.

Recommendation: Maximize Use of Technology

- Current advances in both medical and information technology have made possible tremendous enhancements in the State's ability to improve care. Appropriate use of technology can result in the reduction of medical errors, assure appropriate utilization and coordination of services, and control fraud. These changes could make the Medicaid system an effective management and planning tool and, in the process, lead to substantial Medicaid savings. It is therefore recommended that the State maximize the use of existing technologies, including the piloting of telemedicine and computerized physician order entry systems in high volume Medicaid sites and the implementation of a smart card system.

Recommendation: Amend Family Health Plus

- During the 12 month period between November 2002 and October 2003, Family Health Plus spending totaled \$797 million, including \$218.7 million each for the State and local governments. This spending level represents a 625 percent increase over the previous 12 month period, when State and local costs totaled \$30.1 million each. In October 2003, 283,019 individuals were enrolled in Family Health Plus, reflecting an increase of 135,000 individuals, or 91 percent, from October 2002. State and local governments can no longer bear the financial burden of the extraordinary growth rate in this program without compromising other essential services.

In an attempt to control the growth of this program, while continuing to provide health care coverage to those in need, modifications should be made to Family Health Plus. While income eligibility levels would remain the same, the existing benefit package would be modified and modest cost sharing measures, on a sliding scale according to income, would be required. An asset test for eligibility should also be established. Crowd out provisions should be enforced to assure that the program does not become a substitute for employer-sponsored insurance coverage. Finally, a buy-in provision at full cost for individuals above the eligibility limit should be authorized.

Recommendation: Shift Children from Medicaid to Child Health Plus

- To assure the most efficient use of resources, children eligible for Medicaid under the program expansion enacted in 1998 should be enrolled in the Child Health Plus program, upon recertification. Child Health Plus is less costly to the State and is generally preferred by families over the Medicaid program.

Recommendation: Authorize Mandatory Medicaid Managed Care in Rural Areas

- If a local government cannot provide Medicaid recipients with a choice of at least two different health plans, mandatory Medicaid managed care is not permitted. This policy leaves most rural areas of the State unable to implement a managed care model. In order to provide rural counties with greater flexibility and the potential for improving coordination of care of their Medicaid populations, rural areas should be allowed to implement mandatory Medicaid managed care, even in instances where at least two health plans are not available.

Recommendation: Promote Greater Consistency and Standardization of Managed Care Programs

- Although Medicaid, Child Health Plus and Family Health Plus are statewide programs, the administrative requirements imposed upon managed care plans by the State (and imposed upon health care providers by managed care plans) for implementation differ from plan to plan and between social services districts. This dynamic presents unnecessary administrative complexities to local social services districts, managed care plans and health care providers. Greater consistency and standardization across programs is recommended. Standardization would allow: creation of a unified enrollment and eligibility database for all programs; the State to execute a standard single contract with health plans instead of the current practice of executing separate contracts between the plan and each local district in which the plan operates; all managed care plans to utilize the same set of administrative rules and procedures (in areas such as billing, reimbursement, utilization review, appeals and grievances) in their contracts with health care providers for all of the publicly-sponsored health care programs in which they participate.

Recommendation: Authorize Use of Medical Savings Accounts

- Medical Savings Accounts (MSAs) are accounts established to pay for health care costs. On a voluntary demonstration program basis, use of Medicaid MSAs (managed by the recipient) would establish a more direct connection between utilization of health care services and their costs, thereby promoting greater personal responsibility for, and control over, health care for MSA participants. Participants would be encouraged to make choices among health care services and providers, potentially leading to more cost effective decision making on the part of the participant. Greater competition among providers to meet participants' needs would result in improvements to quality of care.

Recommendation: Authorize EMS Dispatch Triage and Field Treatment Programs

- Outside of New York City, ambulance services are required to transport patients to emergency rooms on demand. In many instances, patients could be effectively treated and released at the scene or transported to more appropriate, non-emergency settings. In order to assure that ambulance services are used for emergencies only, and to promote the most effective use of medical resources, it is recommended that the State develop several emergency medical services (EMS) Dispatch Triage and Field Treatment demonstration programs. The focus of these programs is to direct patients who do not need an ambulance to a less costly form of transport. Patients who do not need emergency room services could be treated at the scene or in a more appropriate setting.

Recommendation: Authorize Development of Transitional Care Units

- In many instances, patients who are no longer in need of acute hospital care but are still in need of short term services to recuperate, remain in hospital medical/surgical beds because no alternative exists. As many of these patients exhaust the Medicare reimbursement for their hospital stay, the hospital often provides the short term services, such as physician and other ancillary care services, without receiving Medicare reimbursement. In order to provide a more appropriate level of care for these individuals, the State should explore the development of Transitional Care Units on a pilot program basis, for patients no longer requiring acute hospital care.

Recommendation: Establish a Health Care Monitoring Entity to Track Financial Stability of Providers

- The financial stability of health care institutions is critical to assure access to quality care. Monitoring, tracking and effective reporting of the financial and operating indicators of these institutions can help avoid unforeseen fiscal crises as institutions falter and potentially disrupt service delivery. Past experiences highlight the need for the creation of an independent monitoring entity to provide a financial early warning system. This entity would monitor health care institutions' financial conditions, so that appropriate action can be taken in a timely and orderly fashion. Institutions would be guided through a redesign, reorganization, or redirection process (if necessary). As a result, access to high quality health care services would be maintained in an efficient and effective manner.

Recommendation: Review the Certificate of Need Process

- The Certificate of Need (CON) process is utilized by the State to review applications for the development or expansion of health care services. During review, the CON

process considers, among other things, the local public need for such development or expansion, together with the appropriateness of such application. Various changes and trends in the health care system, including increased competition in the marketplace and increased instances of need for restructuring, merit a comprehensive reexamination of the structure and circumstances of the CON process in order to assure that it best meets the State's public health policy needs and the needs of the current health care environment. This examination should include the identification and correction of aspects of the process which may currently hamper the system's cost efficiency, as well as, those which upon revision could otherwise further facilitate such efficiency.

Recommendation: Implement Regulatory Reform

- After listening to ongoing and repeated concerns, mainly from the health care provider community, regarding the regulatory burden of Medicaid, the Task Force requested that Advisory Panel members and other interested parties identify the five most onerous regulations associated with Medicaid. Twenty-three responses were received. As part of the effort to increase the efficiency of the Medicaid system, it is recommended that regulatory reform be explored. Reforms identified by the provider community, consumers, counties and/or health plans, focused on reducing paperwork burdens and duplication wherever possible, in keeping with requirements to protect patient safety. In addition, regulatory reform along with the aggressive pursuit of federal waivers should be utilized to permit providers to implement innovative programs for patient centered and more cost effective care.

Recommendation: Explore Tort Reform

- Our civil justice system allows individuals to seek damages for injuries suffered because of the negligent act of another. The current tort system has been viewed by some health care providers as a contributing factor to the rising costs in our health care system. Often, the increasing costs of liability coverage and its influence on care patterns necessitates the practice of defensive medicine. The increased costs associated with these practices must be weighed against the potential benefit to patients or patient care. Although the Task Force did not develop a specific proposal related to tort reform, it emerged in discussions during the course of the Task Force's work as an issue to explore in an effort to minimize unnecessary expenditures by the Medicaid program.

Recommendation: Improve the Medicaid Pharmaceutical Program

- In State Fiscal Year 2003-04, Federal, State and local Medicaid spending for pharmaceuticals are estimated at \$3.7 billion. This figure reflects an increase of 19

percent over the previous year total of \$3.1 billion. Moreover, during the most recent five years, Medicaid pharmaceutical spending has grown by over 113 percent, making it one of the fastest growing components of the Medicaid budget. While the argument has been made that increased use of pharmaceuticals leads to reduced costs for other medical services, including inpatient hospitalizations and physician services, it is still the State's obligation to assure that pharmaceutical expenditures are made in the most quality conscious and cost effective manner possible. Several recommendations are made in order to meet this obligation. While a variety of sometimes conflicting pharmaceutical related proposals were suggested and reviewed, the recommendations below reflect those which coordinate best with each other and with other broader Task Force recommendations. These recommendations provide the most comprehensive approach to implementing improvements to the Medicaid pharmaceutical program, with respect to both assuring appropriate utilization and controlling costs. Recommendations include the following:

- **Establish a preferred drug list (PDL)** and prior authorization program to assure the most effective utilization of prescription drugs and to reduce the cost of drugs by generating supplemental rebates from drug manufacturers. Under this program, a contractor would be selected to manage the PDL, the prior authorization process and the payment of supplemental rebates. It is also recommended that the EPIC program be incorporated into any Preferred Drug Program established. The PDL should be coordinated with the overall Medicaid utilization review processes and the implementation of disease management programs.
- **Expand use of the 340B Federal Drug Discount Program.** This program is designed to offer eligible drug purchasers (various types of health care providers) outpatient pharmaceuticals at discounted rates. As part of this expansion, eligible health care providers would be educated regarding the benefits of the 340B program and encouraged to participate in it.
- **Explore reimportation of drugs** from Canada, as clarified by the Medicare Prescription Drug Improvement and Modernization Act of 2003.
- **Expand the use of generic drugs**, by including: physician education programs to provide improved information regarding generic alternatives and established prescribing patterns; consumer education programs; exploring whether the substitution of generics or over-the-counter products is the least expensive alternative for high cost branded pharmaceuticals; and improving the availability of generic supplies to meet demand for such products. To achieve the greatest possible level of savings, the State's mandatory generic drug

policy must be amended to insure that it is comprehensive and coordinated with the PDL and 340B programs.

- **Explore development of varied drug reimbursement rates** to better reflect differences in pharmacies' acquisition costs.
- **Establish a “trial” period (14 day supply)** for first-time users of a long-term pharmaceutical. Under current practice, physicians authorize a larger supply that may be wasted if an individual does not respond favorably to a particular drug.
- **Explore possible re-use or return of un-opened prescription drugs**, including individually packaged pharmaceuticals, used by health care institutions, to avoid unnecessary waste of prescription drugs.

Goal: Provide Fiscal Relief to Local Governments.

- Local governments in New York State support a greater portion of Medicaid costs than the local governments of any other state. Although local governments are responsible for approximately 16 percent of the total cost of Medicaid in New York State, New York's local share of Medicaid represents 84 percent of the local share paid by all localities nationwide. Compounding this problem is the fact that counties have limited sources of revenue to cover their share of Medicaid. Currently, county revenues are generated primarily through property taxes (which are limited by the State constitution), sales taxes (which are limited by State law), and various fees. In 2003, 28 counties had to resort to property tax increases in excess of 10 percent, with an average increase for all counties of 12 percent. Although many of the counties have yet to pass their 2004 budgets, it is expected that many will again adopt double digit property tax increases which according to the counties are mainly a result of the continuing growth in the cost of Medicaid.

County executives maintain that their budget problems stem from unfunded State mandates. They cite Medicaid as the fastest growing program due to new and expanded directives. The Family Health Plus Program has seen the most dramatic growth since its inception in 2001. From the third to fourth quarter of 2002, the local cost of Family Health Plus increased from \$15.3 million to \$26.1 million, reflecting a 71 percent increase in just one quarter. It is within this context that the following recommendations to provide fiscal relief to local governments are made.

Recommendation: Takeover the Local Share of the Family Health Plus Program

- The local share of the Family Health Plus program would be assumed over a two year period beginning in State fiscal year 2004-05. Implementation of this recommendation would be dependent upon adoption and successful implementation of cost containment provisions in this report.

Recommendation: Reallocate a Portion of Facilitated Enrollment Funds to Counties

- As part of mandatory Medicaid managed care, "facilitated enrollment" funding is provided to not for profit entities to assist Medicaid recipients in enrolling in health care plans. Since the mandatory Medicaid managed care program is nearly fully operational, it is recommended that a portion of the facilitated enrollment funding be redirected to counties to help fund the cost of administering these programs.

Recommendation: Authorize Local Demonstration Programs

- Local governments have spoken at length regarding their lack of control over the Medicaid program, which they share the burden of financing. It is recommended that local governments be authorized and encouraged, to the greatest extent permitted under Federal law, to establish demonstration programs to test innovative ideas and unique approaches to managing the Medicaid population.

Recommendation: Provide Greater Financial Incentives for Counties to Pursue Asset Recovery

- Because local governments pay a small portion of the total costs for long term care services, it is not cost effective for them to pursue many asset recovery cases. In addition, they have neither the administrative staff nor the funding to support such efforts. In order to increase the number of estates on which asset recovery is pursued, it is recommended that a greater financial incentive be provided to counties to encourage such activities, and that development of a Statewide initiative be explored.

Recommendation: Provide Better Local Access to State Databases

- Local governments and health care providers have voiced several concerns regarding Medicaid administrative processes, including: an inability to attach expenditures to specific clients; the incompatibility of information systems between State and local governments; lack of uniform indicators to measure program effectiveness on all levels; and lack of access to patient encounter data. Based upon review of the Medicaid utilization and reimbursement processes, the technology to associate clients and providers with expenditures exists, as does much of the data to track utilization (including patient encounter data). It is also technologically possible to grant local governments access to this data, predicated upon compliance with HIPAA (Health Information Portability and Accountability Act). Therefore, in order to assist in managing patients and programs, local governments and health care providers should be provided with access to State databases, with all appropriate patient confidentiality protections applied, along with technical support from the State.

Recommendation: Work with the Federal Government to increase the Federal Medical Assistance Percentage (FMAP)

- The Federal Jobs Growth and Tax Reconciliation Act of 2003 provided financial relief to states through an increase in the Federal Medicaid matching rate. This increase in the FMAP was for a 15 month period ending on June 30, 2004. The FMAP increase is valued at \$1.5 billion in additional Federal aid to State and local governments over the 15 month period. It is recommended that the State and its counties work together to ensure that the increase in Federal Medical Assistance Percentage is made permanent.

Goal: Reform the Long Term Care (LTC) System.

Recommendation: Expand Private Financing of Coverage and Reform Estate Planning Practices

- Having to place a loved one in a nursing home is a difficult and emotional decision for families. Planning in advance for potential long term care needs is not part of the normal course of financial planning for most families; this is compounded by the fact that there are few affordable ways to plan for long term care. At an average cost of over \$200 a day, or in excess of \$70,000 per year, a family members' nursing home stay can be financially devastating. The lack of affordable and reasonable options for private financing of long term care, combined with the high cost of long term care services, creates a strong incentive for families to transfer assets in order to qualify for government financing of their long term care needs.

As a result, Medicaid has become the primary payer of long term care costs in New York State. It is estimated that Medicaid costs for nursing homes and home care will exceed \$10.5 billion in Federal, State and local spending in State Fiscal Year 2003-04. Using Federal Fiscal Year (FFY) 2001 data, the elderly represent only 11 percent of the State's Medicaid eligible population, but account for almost 30 percent of all Medicaid expenditures. Translated into actual numbers, this means that \$7.9 billion was spent on almost 386,000 seniors in FFY 2001. In contrast, in the same year, California's Medicaid program spent \$4.2 billion (47 percent **less** than New York) on almost 627,000 seniors (62 percent **more** eligibles). As New York State's senior population grows, the current publicly-financed Long Term Care system threatens to jeopardize the financial stability of the Medicaid program. However, in order for the State to reform existing estate planning practices, which allow for asset transfers and refusal to pay the cost of care, it is imperative that meaningful and affordable alternatives to publicly-financed long term care services be developed. To accomplish necessary changes, the Task Force makes the following recommendations which require **both** expansion of private long term care coverage opportunities and reform of current estate planning practices.

- **Encourage purchase of private Long Term Care insurance** by expanding existing financial incentives, along with development of alternative Long Term Care insurance benefit packages to cover a broader range of services. As long as there is unfettered access to estate planning loopholes alternatives like long term care insurance can never fully reach their potential to infuse private dollars into this system.

- **Encourage the use of equity available through life insurance** policies to cover the costs of long term care, by allowing the acceleration of life insurance benefits. The use of reverse mortgages could also be encouraged for the same purpose.
- **Encourage the development of integrated Long Term Care programs** such as Continuing Care Retirement Communities (CCRC's) and alternate models. CCRCs provide a combination of comprehensive health care and residential services along a continuum on a single site. Through a prearranged, privately financed agreement, the CCRC agrees to provide all phases of long term care for the individual. Other states have encouraged the growth of the CCRC model, however current statutory and regulatory barriers in New York State stifle their development. In addition, development of other integrated Long Term Care models, similar to PACE (the Program of All-inclusive Care for the Elderly) and managed long term care should be strongly encouraged, in order to provide alternative care models to enhance private participation in Long Term Care financing.
- **Expand efforts to maximize third party insurance coverage** for Long Term Care, and implement a system to require Medicare appeals prior to Medicaid payment being authorized, to assure that Medicaid is the payer of last resort whenever appropriate.
- **Substantially restrict the ability of a spouse to refuse to contribute to the cost** of long term care for their partner under all but very limited circumstances.
- **Restrict asset transfers** by extending the look back period, applying these restrictions to non-institutional care as well.
- **Re-examine the maximum income and resource limits** for the spouse of an institutionalized Medicaid recipient. New York State's allowances are the most generous in the country and contribute substantially to increased Long Term Care related Medicaid costs.
- **Require direct payment** of a nursing home resident's Federal SSI funds to the nursing home, in order to assure that facilities receive the full amount of funding they are entitled to.

Recommendation: Develop a More Seamless and Coordinated Long Term Care Delivery System

- The Long Term Care delivery and finance system is frequently hampered by fragmentation and gaps in, and between, levels of service. As a result, the individual is usually forced into a disconnected system, rather than a system which coherently meets the needs of the individual in a patient-centered fashion. An additional shortcoming is the frequent difficulty in accessing clear and complete information about the array of community services and options available to a consumer. This is particularly true when decisions must be made quickly during a crisis and institutional care often becomes the only option. Providers and consumers, as well as Medicaid as the principle payer, are burdened by the lack of continuity, coordination and information. This gap interferes with access, care management and cost-effectiveness. It is recommended that a number of steps be taken to improve local long term care access and coordination.

While New York has been a leader in developing home and community based service programs as a cost effective alternative to institutionalization, the availability of these services across the State is not uniform, varying from county to county. Therefore, not all New Yorkers have access to the continuum of services. To encourage more effective access to appropriate levels of care and more efficient use of resources, it is recommended that the State permit and foster the development of a sufficient capacity of these home and community based options. Several programs and services outlined below would be targeted for expanded capacity. The Task Force also recommends that New York build upon its existing array of long term care services through the addition of new services and mechanisms to add flexibility and individualization of patient care. Also, the State should thoroughly reexamine all of the long term care reimbursement methodologies, to determine a more rational method of financing the variety of long term care services available, ranging from care provided in the home to care provided in a nursing home.

Taken together, the recommendations outlined below should create a more seamless and coordinated Long Term Care delivery system, which provides a comprehensive range of services, from support for informal caregivers, to institutional care where necessary, to hospice and palliative care.

- **Expand existing Federal waivers.** It is recommended that existing Federal waivers, which by regulation must be at least cost neutral (for example: the Long Term Home Health Care Program , Traumatic Brain Injury, and “Katie Becket” Care at Home program), be expanded as appropriate to improve access to care for persons with more intensive, complex and/or special needs. It is

also recommended that the State explore seeking broader waivers to further facilitate the transition of disabled individuals out of institutional settings.

- **Implement a “Cash and Counseling” demonstration program** similar to a program operated in the State of Florida, where consumers have the authorization to organize and direct their own care, with flexible financing to meet diverse non-medical needs necessary to remain in their home. This model is similar in concept to Consumer Directed Home Care and could potentially be incorporated as an expansion of this program.
- **Review institutionalized patients** to determine appropriateness for return to community settings. It is recommended that a system be established whereby patients in nursing homes be reviewed for their potential to receive services in alternate settings. In addition, it is recommended that the State exploit the Federal “Going Home” initiative to help persons with disabilities return to the community setting where appropriate.
- **Authorize Nursing Home “Right-Sizing”.** The State should permit controlled “right sizing” of nursing homes, subject to cost-effectiveness and access tests. Such right-sizing would authorize facilities to convert a portion of available bed capacity to other service categories (such as assisted living, long term home health care programs or adult day care). Such right-sizing could also allow bed capacity reductions, where a smaller capacity is appropriate for the community.
- **Develop single access points, a uniform assessment tool and a single license for multiple levels of long term care service.** The State can build on existing single access point models already in operation, including PACE and Managed Long Term Care, or at least develop more uniform access with case management services. A uniform assessment tool would possess a core set of information to be used by multiple providers and programs. The core data set in a new uniform assessment tool would include the individual’s clinical assessment, functional abilities, social support system (or lack of), as well as additional patient information to most efficiently screen and effectively place a patient. The State should also develop a single license for providers of multiple levels of long term care service. Some providers operate multilevel systems, but must maintain a separate license for each level of service.
- **Review and expand Managed Long Term Care,** which currently exists as up to 24 specifically authorized demonstration programs to test the feasibility and cost-effectiveness of managing an array of long term care services for a patient. The ultimate goal of the program is to integrate both financing and services

into a cost-effective continuum of care (from home care to institutional care) for the patient. It is recommended there be a review of current program administration to eliminate regulatory barriers that prevent appropriate expansion of the managed long term care model.

- **Improve access to non-institutional long term care services.** Consumer Directed Home Care Programs allow self-directing disabled and/or chronically ill adults to direct and authorize payment for their own service plan. It is recommended that the State provide improved access to and awareness of this program. The Long Term Home Health Care Program (LTHHCP) provides nursing home level care in a person's home. The LTHHCP should be reviewed within the context of disease management, with special emphasis on the chronically ill, since they represent the most complex and costly cases. In addition, other services such as palliative care and expanded use of telehealth should be considered for inclusion in the program.

The Assisted Living Program provides supportive services to individuals who do not need skilled nursing care. The industry in New York State is largely unregulated and the term "assisted living" is undefined. The State has an assisted living program provided through adult homes in conjunction with a home care agency. The program currently has a limit of 4,200 beds which are reimbursable through Medicaid. It is recommended that this limit be increased and, more importantly, an assisted living statute be enacted. At a minimum, an assisted living registration with consumer disclosure statute should be enacted.

Lastly, Adult Day Care provides individuals with the opportunity to receive an array of therapeutic and supportive services in a nursing home-sponsored program. It is recommended that appropriate use of medical model adult day care services be encouraged as a means to increase the cost effectiveness of the Medicaid program.

- **Explore improvements to case management services.** It is crucial to the optimal recovery and care of each patient, and to the cost-effective operation of the system, that discharge planning be supported and carried out effectively. Case management is particularly important in the guidance of the patient, coordination of services, minimization of subsequent adverse health events and containment of health care expenses.
- **Provide consumers and health care providers with access to comprehensive information** about Long Term Care options in their community.

- **Improve Caregiver assistance through respite and other avenues.** Family and friends typically provide the bulk of community-based long term care. The social, clinical and financial value of this care is immeasurable and directly offsets what might otherwise be State and local Medicaid obligations. In this sense, caregiver assistance comprises a substantial private contribution toward long term care patients. It is recommended that the State encourage caregiver participation through incentives such as expanded availability of respite and caregiver support services.
- **Promote greater integration of hospice and palliative care into the Long Term Care continuum.** The State should increase its actions to encourage public education about the importance of advance directives and the benefits of hospice care as an end-of-life care option.
- **Authorize regional demonstration programs** to unify existing separate programs into a continuum of Long Term Care services.