

Honorable George E. Pataki
Governor, State of New York
Executive Chamber
Albany, NY 12224

January 13, 2004

Dear Governor:

Thank you for the opportunity to review the New York State Medicaid program and make recommendations for program improvement. We are honored to be presented with this challenge and hope that our recommendations will be thoroughly considered by state policymakers, as well as the healthcare industry as we work toward your goal of providing the best health care for all New Yorkers.

We began this process by reviewing the State's health care system and considered how New York's program compared and contrasted to similar programs in other states. We researched initiatives being implemented across the country and considered how they may be applied to New York's Medicaid program. Additionally, we met with, and received valuable input from, more than 20 organizations representing various segments of the healthcare industry.

The Medicaid system is large and complex. Therefore, we decided to start by concentrating on key areas of the program that needed to be addressed. Our focus for this time period, and this report, has been the rising cost of prescription drugs and the ever-increasing demand for, and cost, of the long term care system in New York. These two components provide long term risk to the stability of the Medicaid program. The costs of prescription drugs have increased substantially and now constitute one of the largest components of Medicaid; and costs in long-term care could rise astronomically as our growing "baby boomer" generation soon begins to need such services as home care and nursing homes.

In this interim report we have made recommendations for comprehensive reform of these two key areas of the health care system.

We believe these recommendations will not only make the Medicaid program more cost effective, but more importantly, they will improve the quality of care for recipients - especially New York's rapidly expanding elderly population. If implemented, these recommendations will save the overall state Medicaid program more than \$4.2 billion gross during the next five years. Local governments, through a state takeover of the local share of long-term care costs, which this group recommends, would save more than \$2 billion.

Our work is not done, however. In the coming months, we plan to thoroughly review other areas of the Medicaid system, including, primary care and hospitals - and study how advanced technology can provide better and more cost effective care in these settings. Additionally, we will review waste, fraud and abuse, the administration of Medicaid, and other areas of healthcare.

Once again, thank you for this opportunity. We hope the recommendations contained in this report are helpful in your efforts to make State government more effective and efficient.

Sincerely,

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Health Care Reform Working Group

Interim Report

Submitted:
January 13, 2004

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I. Executive Summary

While New York continues to enjoy the finest health care system in the nation, we are faced with an indisputable fact that health care costs continue to rise sharply each year, placing greater financial pressure on the State and local governments, private employers and consumers.

In this period of fiscal difficulty, we must closely review government operations, including our health care system, in a comprehensive manner to ensure high quality and affordable service delivery.

The Medicaid program has grown into an extremely complex system -with a maze of federal regulations and laws. This coming fiscal year, if left unchecked, Medicaid will grow by approximately \$2 billion, becoming a \$44 billion program. State and local governments can no longer afford the current Medicaid program without substantive reforms.

In order to examine this multifaceted problem, Governor Pataki convened a Health Care Reform Working Group -- calling upon the experience and knowledge of business and government leaders, past and present, to provide recommendations to make our health care system more effective and efficient. This group, together with staff from state agencies and the Executive Chamber, was asked to:

- (i) review ways to control and reduce health care costs;
- (ii) identify reforms to improve the effectiveness and efficiency of government health care programs including Medicaid;
- (iii) explore the availability of additional federal resources and the feasibility of additional federal Medicaid waivers;
- (iv) analyze existing efforts to curtail fraud, waste and abuse within the health care system;
- (v) examine current State payment methodologies including the creation of incentives for providers delivering high quality services; and,
- (vi) research options for reforming the current cost-sharing system to reduce the burden on local governments.

Due to the complexity, size and scope of today's Medicaid program, the Working Group chose to review broad subject areas to reach conceptual agreement first on topics to address, and then to review proposals developed to address the problems in these areas. The Working Group identified specific areas or key issues that needed to be explored and reviewed. In this initial report, the Working Group addresses key areas such as long term care, certificate of need, local share of Medicaid costs, and prescription drug costs. If the recommendations the Working Group has made are implemented, the Medicaid program will save more than \$4.2 billion in total over the next five state fiscal years. Additionally, local governments through these recommendations and a state takeover of long term care costs, would save more than \$2 billion.

The report's major recommendations, within those key areas, include:

- Changing the design and delivery of state and Medicaid-funded long term care programs by implementing NY ANSWERS, which creates a single point-of-entry into the long term care system and focuses on providing in community settings. It will provide unbiased, comprehensive and accurate information to individuals and families trying to access appropriate long term care services. The system will support self-determination, promote personal responsibility, provide services that meet consumer needs, provide quality care, and ensure efficiency and affordability. NY ANSWERS will reduce the need for, and delay entry into, more costly institutional care by encouraging the use of most integrated settings, recognizing and using informal supports in the home, better coordinating care and finding alternative non-medical services to lessen the need for medical services.
- Modifying the Medicaid eligibility requirements for long term care by closing eligibility loopholes. Specific changes include imposing an asset transfer penalty on home and community-based care, eliminating "spousal refusal," and strengthening the existing penalties for individuals who transfer assets to qualify for Medicaid in nursing homes.
- Expanding and improving long term care insurance options by stimulating the marketplace. Specific recommendations include: modifying the Partnership Model; creating a government funded reinsurance mechanism; introducing long term care savings accounts; encouraging employer and union participation; and allowing children and families to access tax incentives when paying for long term care premiums on behalf of another family member.
- Enrolling dual eligibles in a new program, Medicaid Advantage, a hybrid product of Medicare + Choice and Medicaid Managed Care that would include long term care services in the benefits package. This program will address the major problems of the current structure of coverage - two payers, fragmented care and misaligned financial incentives.
- Creating a new nursing home model. The development of NY ANSWERS presents an opportunity to rightsize nursing homes and encourages innovative approaches to state-of-the-art nursing home construction and renovation.
- Developing enhanced home and community-based services through demonstration projects. This will help to ensure that an appropriate

infrastructure of both services and affordable housing exists during the transition from an institutional-based to a community-based long term care system.

- Reducing Medicaid costs for local governments. The Working Group recommends a state takeover of the local share of long term Medicaid costs contingent upon the adoption of cost saving measures contained in this report. This will relieve counties of a component of the Medicaid program that will grow exponentially with the advancing age and needs of our "baby boomer" generation.
- Implementing preferred and prior authorization drug programs that encourage the use of drugs that are therapeutically appropriate and cost effective.
- **Enrolling Supplemental Security** Income (SSI) recipients in Medicaid Managed Care **to give them the same primary and** preventive care services that other Medicaid Managed Care recipients receive.
- Working with the federal government to reinvest the federal share of the savings resulting from the report's recommendations into New York State.

This report serves as interim recommendations to the Governor. As previously stated, the Medicaid program is vast and complex. More work needs to be done to address the size, cost and efficiency of the program. The Working Group will continue its efforts and will review the following areas in the coming months:

Waste, Fraud and Abuse - Are there strategies/initiatives being used elsewhere in the nation which could help to ensure that only appropriate services are being paid for by New York State?

Technology - Can New York State make its health care system more efficient, responsive, and affordable by investing in information technology while also safeguarding patients' privacy?

Hospitals - Is there a way to right-size New York's hospitals while ensuring appropriate access to care?

Administration of Medicaid - Is there a way for New York State to operate its Medicaid program more efficiently and cost-effectively?

Pharmaceutical Benefits Managers (PBM) - Should New York State implement regulations or seek national leadership on creating transparency in PBMs?

Primary Care - Can we encourage greater utilization of primary care in community-based settings and improve the delivery of such care through the use of technology?

II. Reforming New York State's Long Term Care System

A. The Current System

The current long term care system has developed incrementally over time and can be difficult to access, navigate, comprehend and manage for all citizens -- whether receiving government assistance or not. The numerous long term care programs, administered and operated by a wide variety of entities, each have discrete statutory and regulatory requirements governing eligibility, target populations, scope of service and funding. Thus, the system lacks coordination, allows for duplicate services, is inefficient and expensive, and often fails to provide care that is optimum or appropriate.

In addition to the problems associated with a complex and arcane system, New York State is experiencing a dramatic growth in the demand for and cost of long-term care services. The elderly population is increasing in numbers and older New Yorkers are living longer. This will place extraordinary demands on the long-term care financing and delivery system. The number of people in New York State aged 65 and older will increase from 2.3 million in 1995 to 3.3 million in 2025, while during the same time period the number of people aged 75 and older will grow from 1.07 million to 1.4 million.

Long term care spending includes skilled nursing facilities, home nursing services, home health aides, and personal care services. In State fiscal year 2003-04, gross New York Medicaid spending on long term care is projected to be \$10.4 billion, growing from \$9.5 billion in State fiscal year 2002-03. This represents a year-to-year increase of nine percent.

The Olmstead Supreme Court decision, which requires that individuals receive care in the most integrated settings appropriate to their needs, provides an unprecedented opportunity to reshape our long-term care system to more effectively and affordably meet the needs of the disabled and elderly. Shifting the long term care system from an institution-based to a home- and community-based system parallels the desires of the disabled and the growing elderly populations to remain at home.

These trends make reform critical at this time.

B. Long Term Care Vision

The Working Group envisions a new long term care system that is accessible, coordinated and person-centered. The system will support self determination; promote personal responsibility; provide services that meet consumer needs; provide quality care; and ensure accountability, efficiency and affordability.

It is important to note that the components of the Working Group's proposal to reform the long term care system are intertwined. If disconnected, negative

unintended consequences may result. Therefore, we urge implementation of this proposal in totality.

Integral to this process is creating a structure that is easy for consumers and their caregivers to understand and use; respects consumer choice by providing unbiased comprehensive information about available long term care options and provider performance; and that involves consumers and their caregivers in planning, evaluation and decision making, so that supports are guided at all levels by consumer needs and preferences.

Providing services that meet consumer needs is also critical to a new long term care system. A new system must foster social and physical wellness by keeping people functional and connected with their communities; make comprehensive and coordinated service options available in a wide variety of settings; support all persons to live as independently as possible as long as they desire and are able; and support innovation through technology and new delivery and flexible financing models.

Most important to the creation of a new system, given the coming surge in the state's elderly population, is making it efficient and affordable. It must support the informal care system, including family, friends, volunteers, and existing community resources, and takes no action that erodes those supports.

Family members, friends, neighbors and other informal caregivers play a predominant role in assisting disabled, chronically ill, or elderly people to address the long-term care needs they face. The vast majority of impaired older, chronically ill, or disabled people receive the long-term care they need from informal caregivers. Approximately 80 percent of the care received by people age 65 or older in New York State is provided by informal caregivers at an estimated value of \$11.2 billion.

The strength or weakness of a disabled, chronically ill, or older person's informal supports has been shown to be a better predictor of nursing home placement than that person's own physical and mental health status. However, national studies show that the unrelieved burden of caregiving can become overwhelming and result in a breakdown of informal supports, shifting caregiving responsibilities and increased costs to the public sector.

Incorporating informal caregiving in the care plans and services for elderly, chronically ill, and disabled persons and providing supports to sustain caregivers, enables them to continue to be a major resource in meeting the long-term care needs of their loved ones.

Developing such a long term care system requires:

- changing the design and delivery of state and Medicaid-funded programs,
- creating a point of entry into the system,
- changes to the Medicaid long term care eligibility requirements,

- expanding and improving the current long term care insurance options,
- developing more home and community-based services,
- rightsizing nursing homes, and
- state and federal legislation as well as federal waivers.

C. NY ANSWERS (Access New York Services **With Effective, Responsive Supports)**

The Working Group proposes a long term care system that best incorporates these reform ideas. The system, called NY ANSWERS (Access New York Services With Effective, _Responsive _Supports), would be State-sponsored and coordinated by independent parties, where appropriate, following State guidelines which will be designed to guarantee statewide consistency.

NY ANSWERS will provide:

- Comprehensive and unbiased information and assistance in all services and supports;
- The opportunity for consumers, regardless of payer source, to be screened to ascertain an individual's general social and medical needs and financial status and to direct them to available service options;
- After an initial screening, a comprehensive needs assessment will identify the supports needed to maintain the highest level of functionality. It should be available for all individuals requiring it. The assessment will be mandated for those seeking publicly financed long term care services;
- All consumers, regardless of payer source, with assessments prior to, and as a condition of, nursing home placement;
- Service/care coordination and utilization management;
- A public education component that will assist consumers to prepare financially for their long term care needs; and
- An interdisciplinary team approach to more effectively coordinate and manage services for those individuals in the system.

We propose creating a Task Force to provide recommendations concerning the transition, administration and implementation of this shifting of responsibility from the counties to the State.

D. Reforming the State Plan Services and Creating a Waiver

Title XIX of the Social Security Act (the Act), sets forth the rules for operating the Medicaid Program. Inherent in these rules are the requirements that a state's Medicaid program must be statewide, comparable and offer freedom of choice. "Statewide" means that, program eligibility and benefits must be the same in every political subdivision of the State (same in New York City as it is in Hamilton County). "Comparable" generally means that similarly situated individuals must be treated the same (can't provide separate benefit packages to different groups).

"Freedom of choice" means that a person must have the right to obtain services from any enrolled Medicaid provider.

To permit states the opportunity to experiment and evaluate alternative ways of providing care under the program, Congress has provided the Department of Health and Human Services through the Centers for Medicare and Medicaid Services (CMS) the authority to grant waivers of the Act's requirements as well as requirements found in the Federal Regulations.

Federal waivers give states the option to institute some flexibility into their programs. Waivers allow states to create programs that provide services not traditionally covered by Medicaid (e.g. home modifications, home-delivered meals) and that "waive" certain federal requirements.

An array of services and supports are needed to meet the needs of individuals with chronic illnesses and disabilities. Public and private sources fund a range of health, social service, housing, mental health, nutrition, and transportation programs. The system restructuring will curtail artificial limitations that payer sources currently impose on service configurations.

Current State Plan services serve as entitlements with modest restrictions on quantity, cost, or length of service. The Plan operates under different dynamics than capped or privately financed programs with limited benefits. Financial caps and service limitations can influence program managers and consumers to maximize informal supports, use other appropriate and potentially less costly services and negotiate services within defined spending limits.

We propose that New York State Plan services and waivers be modified to produce a more rational approach to care and utilization management under the Medicaid program which would complement NY ANSWERS' coordinated care approach. Federal waiver authority will be used to create a new system under which long term care is provided to Medicaid consumers who are not yet nursing home eligible as well as those who are.

This waiver will also include a limited benefit package for individuals who are not now income-eligible for Medicaid so that Medicaid funding will be available for programs and services which now are only State-funded (e.g., State Office For the Aging's Expanded In-Home Services for the Elderly program). This approach will also delay entry into the expensive long-term care system, thereby contributing to overall cost-savings.

As previously discussed, the federal government requires states to demonstrate that the new program will not cost any more in the experimental mode than it would have otherwise. Under this proposal, waiver costs will be controlled through the use of budgets for each individual linked to the plan of care. Care managers will be required to cost-effectively manage care plans through the use of a consumer-centered

strength-based needs assessment. Such assessments will identify each waiver participant's functional disability level and needs.

E. Service Options under the New Waiver

The new waiver construct will include a comprehensive menu of service options from which each individual's plan of care will be established. This assessment, will identify the services and supports that are needed by an individual to best maintain his or her independence at the least cost with the highest quality care. (In contrast, under the current long-term care system, individuals are eligible to receive a long list of services whether they need it or not). These services will enhance, but not replace, existing family and community supports. It is intended that waiver participants will use only those services they need, not the complete array available.

Current Medicaid State Plan Services

The service menu will include long term care services formerly available under the Medicaid State Plan but which will now be available only through the new waiver construct. The State Plan services to be accessed only through the waiver are:

- Private Duty Nursing
- Certified Home Health Agency Services (long term)
- Nursing Facility Services
- Adult Day Health Care
- Personal Care Services
- Consumer Directed Personal Assistance Program
- Assisted Living Program
- Personal Emergency Response Services

Note: This recognizes the continued role of the services (e.g. the importance of the Consumer Directed Personal Assistance Program to individuals who wish to have more control over and personal involvement in their care) while placing them in the context of a more flexible but coordinated service menu.

Home and Community Based Services

The menu will also include services available under existing Home and Community Based Services waivers (1915c). These waiver programs - the Long Term Home Health Care Program, Care at Home and Traumatic Brain Injury waivers -- will be subsumed under the new construct. Services included in these existing waivers include:

- Social Day Care
- Community Integration Counseling
- Behavioral Management
- Home and Community Support Services
- Independent Living Skills Training
- Moving Assistance

- Nutritional Counseling (dietician)
- Home Delivered Meals
- Respite
- Medical Social Work
- Respiratory Therapy
- Home Adaptations & Maintenance
- Structured Day Program
- Special Medical Equipment and Supplies

Non-Medical Services

Finally, the new waiver includes services which are not now in the State's Medicaid program but which should help maintain individuals in their communities and provide cost-effective substitutes for more medical-model services:

- Informal Caregiver Support
- Short Term Assistance with Activities of Daily Living
- Mobility Training
- Community Transition Services
Transportation (to LTC Waiver Services)
- Care Plan (waiver and non-waiver) Coordination.

Acute Care Services

While Medicaid consumers will continue to access long term care services under the new construct, they will have access to Medicaid State Plan services to meet their acute care needs. These services are:

- Short Term Home Health Services
- Optometrists
- Psychologists
- Clinic Services
- Durable Medical Equipment
- Dental
- Physical Therapy, Occupational Therapy
- Therapies for Speech, Hearing and Language Disorders
- Prescribed Drugs and Over the Counter (OTC) Drugs
- Prosthetic/Orthotic Devices and eyeglasses
- Mental Health Rehab Services
- Inpatient Hospital
- Targeted Case Management
- Hospice Care
- Transportation (Medical Only)
- Emergency Room Services
- Physician

- Lab
- X-Ray
- Nurse Midwives and practitioners
- Family Planning
- EPSDT (Early Periodic Screening Diagnostic Treatment)

Individuals in Medicaid managed care plans will eventually see those plans changed to include long term care services. Individuals not participating in Medicaid managed care will have their long term care services provided under the new waiver construct.

F. Infusing the System with Personal Responsibility- Reforming Long Term Care Insurance and Medicaid Eligibility Loopholes

Medicaid was originally intended as a means-tested program for people who cannot afford to pay for their medical care; it was not designed to be a universal long term care payment plan for the middle class.

Fundamental to the objective and outcome of NY ANSWERS is overcoming the current environment which fails to encourage personal responsibility. Personal responsibility should be an integral part of the long term care system. Just as citizens have been educated and incentivized to plan for their own retirements (through IRAs and other savings, investment and insurance mechanisms), they must be educated and incentivized to plan for their potential long term care needs. With medical inflation, the aging of the baby boomers, advanced medical technology and lengthened lifespans, the Medicaid program cannot sustain future demands without such reform.

1. Reforming Eligibility Requirements

Frequently people utilizing long term care services, with the assistance of attorneys, place their assets out of the reach of the Medicaid program. The most commonly used asset protection methods include; transferring assets to a third party and individuals refusing to support the spouses with whom they reside.

By closing the eligibility loopholes, the perception of Medicaid as "the easy way" to fund long term care services will be altered.

Some cases experienced in New York, as documented by the Department of Health, include:

In Nassau County, a husband with more than \$1 million in assets wanted to donate the money to a nearby university to have a bench named in his memory. He refused to make the assets available for his wife's care in a nursing home. The district had no alternative but to authorize Medicaid and at their option, pursue a recovery from the husband for the wife's care. Such pursuit involves extra time and legal costs for the county.

A New Jersey resident suffered a catastrophic injury while on a business trip in New York. He was hospitalized in Suffolk County and later transferred to a medical facility in Rockland County. The wife successfully applied to be appointed guardian and transferred her husband's assets to herself. These assets were in excess of the \$90,000 allowed under Medicaid for a community spouse. She applied for Medicaid in New York and refused to pay for her husband's medical care. Although New Jersey considered him to be a resident of their State, the family's attorney successfully argued in court that the New York State Medicaid program was responsible for his care, which exceeded \$800,000. In New Jersey, the wife's assets would have been included in determining her husband's eligibility, despite her refusal to provide support.

Changes to the eligibility loopholes should include:

- *The imposition of an asset transfer penalty for home and community-based care analogous to the asset transfer penalty for nursing homes:*

While New York has an asset transfer penalty period on nursing homes (36 months), under current law individuals can transfer their assets up to the day before applying for home and community-based long term care services supported by Medicaid. We propose making the law congruous for nursing homes and home and community based services. In addition, this proposal will increase the penalty period to five years and impose the penalty as of the date that an individual seeks home and community base services.

- *Eliminate "spousal refusal" -- the "and/or" provision:*

Under current law, a spouse or a parent can simply refuse to pay for care for their relative and the Medicaid program is required to provide the needed care. This change will eliminate this loophole. In effect, people with financial means will not be eligible for Medicaid, except under very limited exceptions authorized under Federal law. The state will have to request a waiver of these Federal provisions to further strengthen this change.

- *Strengthen the existing penalties for individuals who transfer assets to qualify for nursing home:*

Under existing law, if you transfer assets to receive Medicaid-funded nursing home care within the current 36-month penalty period, the penalty is imposed as of the date on which the transfer was made. This proposal will make two changes: increase the penalty period to five years and impose the penalty as of the date that an individual is admitted to a nursing facility. This will make it substantially more difficult for individuals who plan to use loopholes in the existing system to do so and should encourage appropriate financial planning. A shorter look-back period will be tied to the purchase of long term care

insurance. In order to tie Medicaid eligibility rules to the purchase of long term care coverage the state would need a federal waiver.

These loopholes can and should be closed before the State applies to the federal government for the restructuring waiver integral to NY ANSWERS. As part of the restructuring waiver, the State should move to apply uniform spousal budgeting for all individuals in the waiver. In order to afford such uniformity, the income and resource limits must be lower than those now allowed for individuals in nursing facilities. This change removes spousal budgeting as an incentive for institutionalization.

2. Making Long Term Care Accessible and Affordable

As important as changing the perception of Medicaid as the primary financier of long term care is guaranteeing the availability of a wide range of options for non-Medicaid financing of long term care services. By modifying the state's Long Term Care Partnership Plan; stimulating the Non-Partnership long term care insurance market; creating a government funded long term care reinsurance mechanism; introducing long term care savings accounts; encouraging/incentivizing employer and labor union participation; and making state and federal tax incentives available to family members who purchase long term care coverage on behalf of another family member, we recommend a wide range of measures to make long term care insurance more attractive and affordable.

Implementing a Public Education Campaign

In order to create viable alternative financing options for long term care services, a public education campaign should be commenced while "baby boomers" are still able to secure long-term care coverage or otherwise prepare financially for their long term care needs.

Insurers currently direct long term care marketing at those with significant resources to protect. New York needs to reach the general population with the same message. Consumers must fully understand the potential need for long term care coverage, the risks and sacrifices which may accompany going without such coverage, and what is, and is not, covered by the Medicare program. Consumers should also be educated as to how long term care insurance serves to foster independence and self-control. Consumers should fully understand that early purchase of long-term care coverage can result in a more affordable premium rate and that waiting too long to purchase the coverage can result in a lack of access to the long term care market.

Consumers should be educated about the range of long term care product options (partnership, non-partnership, 10 year paid in full, life insurance policies with flexible benefits for long term care, cash value policies, etc.) Consumers should be advised about more affordable, less comprehensive options, such as nursing home and home care insurance, nursing home insurance only and home care insurance only.

New York's financial planners should be educated about New York's long term care market and its consumer protections. Consumer Reports magazine recently issued a study finding that long term care insurance is "too risky and too expensive." This type of negative press emerging from problems in other states needs to be confronted. New York's employers should be educated about the benefits of assisting their employees with accessing the group long term care market, given that group coverage is generally less expensive than individual.

Modifying the Partnership Plan

The broader range of financial options for long term care coverage should include modifying the Partnership Model. The New York State Partnership for Long-Term Care (the Partnership) is a unique and innovative program that combines private long-term care insurance and Medicaid to help New Yorkers prepare financially for the possibility of needing nursing home or home care. The program allows New Yorkers to protect their assets while remaining eligible for Medicaid if their long-term care needs exceed the period covered by their private insurance policy.

For example, if an individual buys a long-term care insurance policy under the Partnership program, and uses three years of nursing home care, or six years of home care, or some combination of the two, the individual may apply for New York State Medicaid benefits and still retain all their assets but will have to contribute their income to the cost of your long-term care. The Partnership was created to help New Yorkers finance long-term care without impoverishing- themselves or signing over their life's savings, with the accompanying loss of dignity.

New York's Partnership for Long Term Care program public/private model is designed to stimulate the investment of private insurance dollars and ensure efficient use of limited government resources. We recommend expansion of this model, and other non-Partnership models in order to incentivize more individuals to purchase long term care coverage.

Any private investment in long-term care coverage has the potential for saving the resources of the Medicaid program. Partnership resource protection could be offered to incentivize the purchase of more affordable long term care policies which include more limited benefit periods. The typical consumer may be better able to afford a policy covering one year of nursing home care and three years of home care. If the coverage period provided by a given Partnership long term care policy exceeds the average resource spend down period for Medicaid eligibility, it would be beneficial to the Medicaid program to encourage the policy's sale.

We recommend the inclusion of a *full* range of benefit packages, including less comprehensive benefits. We also recommend scaled down limited benefits Partnership coverage be made available to all New Yorkers with partial, rather than *full*, resource protection.

We recommend that the federal government expand federal law to promote partnership policies nationwide. Participation in the Partnership program is currently limited to four states. Nationwide promotion of long term care partnership insurance would increase awareness, education and participation in such coverage. Such an expansion would also increase choice of states with asset protection thereby reducing the financial incentive for aging consumers to rely on select states to meet their long term care planning needs. We also recommend applying for a federal waiver in order to make income protection available in connection with the purchase of Partnership Coverage - or non-Partnership coverage that meets specific criteria.

Stimulating the Non Partnership Model

The working group also recommends stimulating the non-partnership long term care market. If an insured purchases a non-partnership long term care policy, ordinary Medicaid eligibility rules regarding resources and income continue to apply if the insured needs to apply for Medicaid after they exhaust the benefits of their policy. However, even without the Medicaid incentives of the Partnership program, an insured can maintain or extend financial independence through the purchase of non-partnership long term care coverage. As with the Partnership Model plans, any private investment in long term care coverage can benefit the Medicaid program. Non-partnership policies can be more affordable and more available.

Hundreds of thousands of New Yorkers have taken steps to prepare for their long-term care needs through the purchase of non-partnership insurance policies. Citizens currently use non-partnership policies to work with the Medicaid transfer rules in order to protect their resources and plan for their long term care needs. For example, some consumers may purchase a non-partnership policy with a three year nursing home benefit period with a view towards transferring their resources to a loved one immediately prior to entering a nursing home. Under the current Medicaid transfer rules, such a non-partnership long term care policy can permit the insured to allow the Medicaid look-back period to expire while they are utilizing the nursing home benefits provided for in their private insurance policy.

As we recommend modifications to the Medicaid look-back rules with a view towards closing inappropriate eligibility loopholes which encourage avoidance of personal responsibility, we should not disrupt responsible planning efforts relying on the purchase of non-partnership long term care coverage. To preserve the integrity of existing planning efforts while encouraging the purchase of long term care insurance, we recommend retaining the current more favorable look-back rule for those who have purchased some form of long term care coverage.

We recommend additional steps be taken to attempt to stimulate the non-partnership long term care market with a view towards increasing enrollment in long term care policies. For example, the State should require all insurers to offer more affordable long term care policies with limited benefits that may be attractive to typical

consumers. Insurers should also be directed to make benefits available for practical items which may extend a consumer's ability to remain living in their own homes (i.e., transportation, meals on wheels, nurse call systems, etc.).

Instituting a Government Funded Reinsurance Mechanism

A government funded reinsurance mechanism, although an up front investment of public funds could result in savings for the Medicaid program in the future.

Such a reinsurance mechanism could insulate long term care premiums from the impact of high claims. The availability of this reinsurance protection would lower the premium due from consumers over the life of the insurance policy. This mechanism could effectively leverage minimal public dollars while bringing significant private dollars into the healthcare economy. The reinsurance mechanism can be applied to either the Partnership or non-Partnership models.

Waivers should be submitted to the federal government in order to achieve federal financial support for this initiative.

Creating Long Term Care Savings Accounts

The working group also recommends introducing long term care savings accounts which can be utilized alone or in combination with a long term care insurance policy to assist individuals in assuming personal responsibility for their long term care needs. We recommend changes in federal and State tax law authorizing favorable tax treatment for long term care savings accounts which may appeal to those consumers who question whether they will ever utilize long term care services.

A long term care savings account could also be utilized flexibly by the health care consumer to provide for their long term care needs. They could be utilized with an insurance policy in order to pay costs during a long term care policy's elimination period or to pay costs for necessary services after the exhaustion of an insurance policy's benefits. Money in a long term care savings account could address practical needs that may enable an individual to avoid entering a nursing home (i.e., medical or non-medical transportation, meals on wheels, nurse call systems, home modifications, etc.). We believe that savings accounts of this nature, which would involve the healthcare consumer directly in managing the cost of their own care, would help to ensure appropriate service utilization.

Encouraging or incentivizing Employers and Unions to offer Long Term Care Insurance

Long term care insurance is most affordable when purchased as group coverage. This is because the coverage is available to a presumably healthier population of younger, working individuals. Even without employer contributions, citizens would have

access to more affordable long term care coverage if their employers made group long term care policies available.

Currently, only the largest employers offer long term care coverage. Very few employers offer any form of premium contribution towards their employee's coverage. Education along with closing the Medicaid eligibility loopholes should assist in creating that demand. We recommend implementing favorable tax treatment of group long term care products and permitting group sale of certain individual long term care products.

Additional Recommendations

In addition to the federal legislation changes in the above recommendations we propose that Federal tax incentives for the purchase of long term care insurance be liberalized.

We also propose allowing children and other family members to access tax incentives when paying long term care premiums on behalf of another family member. Medicaid planning through the purchase of long term care coverage is often very beneficial to the children of those covered by the policy. The purchase of long term care insurance can provide an adult child with the resources and support they need in order to manage the demands of caring for aging parents. Additionally, Medicaid planning through the purchase of long term care insurance can help to preserve a child's future inheritance.

G. Sharing the Cost - Creating Coordination between Medicaid & Medicare

Medicaid is also seen as the primary financier for the majority of long term care consumers who are dually eligible for Medicare and Medicaid. Medicare generally pays for their primary and acute care services. Medicaid generally pays for long term care service needs. There are more than six million individuals nationally and 620,000 individuals in New York State who are dually eligible for both Medicare and Medicaid. The dually eligible tend to have more serious and complex medical and long term care needs than other Medicaid and Medicare eligibles. Having coverage divided between two payers has resulted in fragmented care and misaligned financial incentives.

The complexity of care delivery for dual eligibles has led both state and federal governments to search for better ways to coordinate their care. The primary goals have been to integrate both the delivery and financing of acute and long term care services. The primary vehicles for accomplishing this have been managed care models. The advantages behind the use of managed care to accomplish this integration have been:

- Putting a managed care entity at risk for both Medicare and Medicaid services increases incentives to reduce unnecessary care while assuring that all necessary care is provided and thereby improving cost effectiveness
- Integrated financing eliminates incentives to cost shift and allows savings accrued from management of acute care services to help finance long term care services.
- Care coordination can be maximized.
- Consumer confusion can be reduced.

Currently, dual eligibles are precluded from enrollment into Medicaid managed care plans in New York. However, State statute authorizing the program did contemplate the eventual enrollment of dual eligibles and permits enrollment when program design features are in place. Dual eligibles can enroll in the federal Medicare + Choice (M+C) program but there is presently no mechanism to integrate their Medicaid coverage with this program.

1. Medicaid Advantage

Medicaid Advantage, the new managed care program we recommend for dual eligibles would rely on managed care plans that participate in both the federal M+C program and the New York Medicaid Managed care program. Under this proposal, plans would receive capitation from the federal government to provide Medicare covered services (as well as certain extra benefits normally covered by these plans) and a capitation from the State to cover those Medicaid benefits not included in the Medicare benefit package and included in the Medicaid managed care package. Plans would be responsible for providing comprehensive services and complete care management. This program will improve the quality of care provided to dual eligibles, eliminate the complexities associated with two different coverages and generate savings to the State.

Managed care plans would be asked to participate in this program under two different benefit options. One option (standard) would have the plans responsible for a standard benefit package similar to what is currently offered under Medicaid managed care. A second option would incorporate more extensive long term care services into the benefit package. Plans that choose to participate with this benefit package would be required to demonstrate experience in providing services and managing care for frail elderly and disabled individuals.

It is assumed that initially, most plans will choose to participate under the standard benefit option. Pharmacy services are presently carved out of the Medicaid managed care benefit package. Incorporating them under either option would require statutory changes but could result in cost savings and better care coordination.

Individuals would actually be enrolling in two products offered by one plan (a Medicaid product and a Medicare product) but benefits, marketing materials and administration would be seamless to enrollees. Medicaid beneficiaries would receive

the full range of Medicaid services covered under the State plan but would receive most of these services through their managed care plan (either through the Medicaid product or the Medicare product). Any services not covered by their managed care plan would be provided through Medicaid fee for service.

Enrollment of dual eligibles should initially be voluntary. As plan capacity expands, mandatory enrollment for dual eligibles into Medicaid managed care could be implemented on a phase in basis. Enrollment in M+C cannot be mandated under federal requirements, however, incentives can be established to encourage M+C enrollment. Some states have implemented policies where Medicaid coverage of Medicare coinsurance and deductible amounts is contingent upon M+C enrollment.

H. Moving from an Institutional-Based System to a Home and Community-Based System

The development of NY ANSWERS for long term care services presents opportunities for more effective planning and management of all elements related to the long term care continuum, especially the state's nursing home bed supply and other alternative models of care. For example, home health care, adult day care, assisted living, continuing care retirement communities, senior housing, enriched housing, and residences for adults.

The potential also exists for implementation of other reforms which would more appropriately balance the effects of recent trends in nursing home demographics and patient-service mix with the need to contain Medicaid costs while rightsizing nursing homes and other community based services for the benefit of consumers.

1. Nursing Home Reform

The Current System

Nursing home occupancy continues to drop in most areas of the state to unprecedented levels. The growth of non-institutional alternatives such as assisted living, overall improvement in the health of potential consumers and caregivers, advances in medical technology, and increasing preference for less restrictive alternatives have driven these changes. The impact of initiatives aimed at compliance with the Olmstead decision may further escalate these trends.

Competition for patients is very aggressive, as facilities struggle to regain the additional utilization needed to maintain acceptable operating margins. Most nursing homes provide "sub acute" or short term rehabilitation services as a rapidly growing segment of business. Other "niche" services such as ventilator beds, neurobehavioral, and dialysis continue to expand, as the market for more traditional chronic elderly contracts.

While occupancy has dropped, discharges/admissions have grown by 60% over the past four years, with virtually all growth in the short stay rehabilitation categories of one - 90 day stays. Consequently the average length of stay has diminished by over 40%.

Older homes are faced with the need to modernize and replace their physical plants to stay competitive with the newer homes. As overall demand for beds is expected to continue to contract in the foreseeable future, the pressures on homes to fill beds and remain viable increases.

According to the Department of Health, the inventory of pending Certificate of Need (CON) applications for facility infrastructure improvements is at an all time high, approximately \$750 million in construction. With the existing Medicaid reimbursement system essentially passing through capital costs, replacement of these homes will not come cheaply for any payor, especially Medicaid, a situation which is compounded by the recent retreat of the capital markets from the nursing home industry.

Demographic estimates completed for the recent nursing home bed need update performed by the State Department of Health indicate flat growth in the number of consumers potentially requiring nursing home care (until approximately 2012 - 2015), after which the nursing home eligible population is expected to spike upward as the large baby boomer segment begins to age. With the implementation of NY ANSWERS, intermediate term bed need would be further reduced, with longer term needs subject to further review over the next five to ten years.

Review of the industry reveals a delivery system undergoing unprecedented change, which, despite receiving spiraling government payments finds itself facing significant fiscal problems. Meanwhile, state and local governments face the daunting challenge of balancing the competing pressures of escalating health care costs with other needs, while striving to maintain reasonable property and income tax rates. Thus it is necessary to regain control of costs and development of incentives to rightsize and rationalize the long term care continuum of services.

We recommend convening a group consisting of the Department of Health, the Division of the Budget and Nursing Home representatives to review the current reimbursement system.

We also propose a series of changes designed to realign capacity with the ever changing needs of consumers of long term care, which entails a more rational distribution of scarce fiscal resources designed to continue quality care at a more affordable price. Concomitantly, we need to monitor and assist the multi-billion dollar nursing home industry in transitioning itself into a fiscally responsible system offering the highest quality of needed long term care services.

Reform of the health care system from the perspective of planning for adequate and affordable nursing home resources under the NY ANSWERS proposal entails implementing five initiatives.

Amending Certificate of Need (CON)

With the reduced need for nursing home bed capacity, it is recommended that CON policy, for renovation and replacement projects, be modified to meet the needs of the new system. The basic concept would be to reward operators whose applications produce quality innovations, contain Medicaid costs, design less restrictive alternative housing models, and reduce nursing home bed capacity. A system should be developed to weight each project on these criteria, as well as other financial criteria and reimbursement implications.

Traditionally, CON applications to renovate or replace existing nursing homes have been approved if they met four key criteria: current construction **codes, financial feasibility**, character and competence/current compliance, and public need. In addition, what at the time were determined to be appropriately priced per-bed caps were created to provide guidance on construction costs. However, the continuing cost to Medicaid of the annual increases of these caps now warrants further review relative to historical changes in appropriate actual construction cost indexes. Furthermore, experience indicates that the caps have effectively become the benchmark for construction costs, with all developers spending up to the reimbursable limit.

Renovation and replacement of existing nursing homes is critical to maintaining quality of care in New York State. More than 80% of existing homes were built before 1980, thus this aging stock of nursing homes clearly needs to be updated if they **are to continue providing quality** care now, and into a future affected by rapid changes in demographics. Furthermore, the need for Medicaid cost containment, the changing nature of nursing home care, and the need to recognize innovative designs and scope responsive to such anticipated factors all point to the formation of responsive changes in the CON review process.

Our recommendations are as follows:

- *Reduce bed capacity*

Preference should be given to proposals that reduce the existing number of beds, particularly in regions that are heavily over-bedded. Depending upon the particular circumstances, utilization of the bed deposit program within a project may also receive higher weighting. Conversions to needed lower-intensity services should also get priority.

- ***Encourage quality and innovation***

A new CON review process, which is designed to incentivize providers to develop service continuums that facilitate the treatment of patients in the least restrictive, most appropriate and cost effective settings, should include benchmarks. These benchmarks/criteria, which provide higher rankings (toward approval) for applications, should include consistent high levels of quality care and patient outcomes. Additional credit should be provided (or subtracted, as the case may be), based upon the relative consistency of the proposed service mix with the goals and objectives of the NY ANSWERS proposal, by encouraging expansion of New York State's supply of less-intense, less-restrictive care facilities, moving toward a more community and home care based approach and away from an institutional based system. These new factors should be assessed through an RFP process.

Reduce Medicaid costs

Applications which estimate capital cost below maximum reimbursable levels should be favored. , On construction costs, we recommend reducing current construction caps, with any higher spending being non-reimbursable and funded with cash equity.

In addition to using the above criteria to determine which applications should be recommended for approval/disapproval, we suggest that equity requirements for projects be adjusted, but provide incentives in the form of reduced equity requirements to reflect scoring on these factors.

The combination of these policy changes will permit the CON process to be more responsive to the rapidly changing nature and cost of care, while incentivizing operators to make the changes necessary on new construction projects to achieve system-wide changes.

Revising the Nursing Home Bed Need Methodology

When the current revision of governing regulation for determining statewide nursing home bed need was conceived, it took into account the availability of alternative, mostly community based, services on a fragmented, unmanaged basis, absent any substantive adjustments for the most desired distribution of community services and consumers. Thus, it did not materially consider the proposed NY ANSWERS system.

Utilization of this system would clearly reduce demand for nursing home beds and, despite its recent update, the need methodology should be revised to take this factor into account. At the same time we recommend reviewing other aspects of the bed need calculation, which may not be completely reflected in the current methodology. In particular, the state should use the opportunity to review the dramatic increase in the usage of nursing homes to provide "niche" services, such as sub-acute rehabilitative care, neurobehavioral, ventilator dependent, hemodialysis, all of which have contributed to significant declines in the average length of stay in nursing

homes, as well as changes to many long-held beliefs in the traditional role of nursing homes as havens for care of the chronic long term elderly population.

Although the change in bed need methodology would not save Medicaid dollars in and of itself, it would be a major part of the underpinning for many of the following recommended initiatives.

Reforming Capital Reimbursement

Through a relatively complex set of formulas, Medicaid capital reimbursement (commonly referred to as "capital pass through") is designed to return the cost of constructing a nursing home over the 30-40 year life of a building. Moreover, the system provides reimbursement for interest expense on mortgage debt (both proprietary and voluntary homes) and a return on invested capital (proprietary only). Because Medicaid pays, on average, for 77% of nursing home days on a statewide basis, in economic terms this procedure effectively removes the investment risk for the operators. It also creates incentives which are contrary to the economics governing market-based capital investment decision-making, and creates the potential for leaving owners with building and land, which may have significant value.

Our proposal is to change to a capital price system over a ten year period, thus, providing operators with a reasonable return on their investment but assuming that their capital is maintained in the value of the land and buildings. Medicare made a similar change in capital reimbursement for hospitals several years ago. In general, the following principles would govern the changeover to a capital pricing system:

- Developing regional per-bed prices, including a "fair return" percentage on capital invested;
- Phasing in the pricing method over a ten year period to allow a manageable transition;
Developing criteria for waivers and exceptions so that no facility is unduly harmed and high/low capital cost facilities are treated fairly; and
Appropriately consider the need to attract vs. alienate the capital markets.

Rightsizing Nursing Homes

As nursing home occupancy has declined, New York State has developed an excess capacity of nursing home beds, presently estimated between 6,000 to 10,000. The nursing home industry has proposed a "rightsizing" program, which would allow nursing homes to voluntarily de-certify beds or convert them to lower-intensity care services. Their proposal suggests that, for the purpose of Medicaid reimbursement, homes be permitted to either count or not count the temporarily de-certified beds toward utilization and capacity rules that govern Medicaid payments. This flexibility may mean that the prospective savings accruing to Medicaid by de-certification would be more than offset by costs associated with the proposal as structured.

Medicaid payments, however, can still be lowered if the bed reduction program results in fewer consumers utilizing nursing homes in favor of lower intensity, more convenient services. By replacing the nursing homes' customary business practice of actively marketing to fill their beds with incentives to rightsize and convert, this outcome is achievable. In Minnesota, where such a program has been in place, it was estimated that for every four beds de-certified, one less person would occupy a bed. Their experience is still short, but preliminary figures indicate that the figure could be as high as one person for every two beds de-certified.

Such a program must also be sensitive to demographic projections of an anticipated spike in demand for all long term care services beginning during 2012 - 2015 period, when upwards of 24 percent of the total population (baby boomers) will be consumers of such services. While it is unclear if this spike will result in the need for more nursing home beds, a system which includes flexibility is warranted.

We therefore propose that, in conjunction with the fourth initiative below, we allow nursing homes to either:

- ***Temporarily de-certify beds***

Permit nursing homes, on a one-time basis within two years, to temporarily decertify any number of their existing beds through a Department of Health (DOH) administrative process reported periodically to the SHRPC. Beds could be reopened after one year and up to five years, (subject to prior DOH approval) but could not be temporarily de-certified again. In effect, this would provide homes with the flexibility to meet the capacity and occupancy tests of Medicaid relative to continued reimbursement or non-imposition of penalties linked to these tests. Extending the five year period could be considered in the future if circumstances warrant.

- ***Convert beds to lower-intensity care units***

Nursing homes could permanently de-certify beds and convert them, on a one-to-one basis, into lower intensity of care services, including Continuing Care Retirement Communities, Adult Day Health Care Programs and the Assisted Living Program. Conversions should be processed through a Certificate of Need process. Medicaid or other State payment differentials could be phased in/out over a three year period to alleviate cash flow problems attributed to immediate rate changes.

In designing and administering this program, the State should be conscious of the need to avoid supporting nursing homes that, through inefficiency or lack of local demand, should otherwise be closed or downsized. Further attention should be paid to the difference in cost between filled versus vacant beds. It is also recognized that, in heavily over-bedded regions, it may be most effective to encourage some homes to close, rather than have many homes downsized. Case by case review of a particular situation should be implemented, appropriately balancing the consideration of savings

maximization through closures of entire facilities, versus closure of units in needed homes.

Modifying Medicaid Reimbursement Policies

Several existing Medicaid reimbursement policies were developed when there was a need to increase or maintain capacity of the system in New York State. Some of these policies seem illogical today, as they appear to incentivize operators to take actions that may not be aligned with the needs of the system. The policies that we recommend are as follows:

- ***300+ enhanced rate***

Medicaid pays nursing homes with more than three hundred beds an enhanced rate. This enhancement contradicts the normal economic assumption that larger size promotes efficiency. We propose to eliminate these payments.

- ***Bed-hold payments***

Medicaid pays nursing homes a bed-hold payment when residents are hospitalized or on therapeutic leave. Bed reservation for hospital stays is for up to 15 days at a time. Therapeutic leave payments are for up to 18 days per 12 month period, but have been extended under certain conditions. Payments are made if a nursing home's occupancy is 95% or more. The temporary bed de-certification proposal above will allow homes with low occupancy at their current capacity to reach that level. However, since the payments are for 100% of the Medicaid rate, it inherently includes an element for variable costs which may be reduced when a resident is temporarily relocated and not replaced. This seems inconsistent with the overall payment methodology of cost-based reimbursement. Thus, we propose reducing the bed-hold payment.

- ***Hospital-based enhanced rate***

Approximately 55 nursing homes receive an enhanced rate from Medicaid based on their affiliation with a hospital. The basis for this rate enhancement was the Federal requirement to "step down" hospital overhead costs in such a way that the nursing home operations were effectively overcharged for general hospital expenses. We recommend that this differential be eliminated.

These proposals are designed to remove illogical incentives in the current reimbursement system and to achieve some of the Medicaid savings that would be needed to fund the incremental costs associated with implementation of the "right-sizing" initiative above, while providing for a gradual reduction to cushion the impact on nursing home operators.

2. Home and Community Based Health Care

In order to transition from institutional based long term care to community based long term care, we must have an infrastructure of both services and affordable and appropriate housing in which to receive these services. Our plan is to have NY ANSWERS and a waiver that will be the basis to provide long- term medical and non- medical services. To expand the service infrastructure, we also recommend that appropriate state agencies re-examine such issues as worker shortages, reimbursement rates, reporting requirements, assessment instruments, telehealth/telemedicine initiatives, and liability to determine the need for further reform or change.

We recommend the existing State statute and regulations governing congregate and supportive housing options for individuals be examined. For example, to the extent congregate care facilities are necessary, we should examine the feasibility of having multiple levels of care within the same structure. This review should also include demonstrations that utilize technology in an appropriate and innovative manner.

Therefore, we recommend that State authority be granted to permit demonstrations and research to promote access to appropriate and cost-efficient services.

III. The Local Burden of Medicaid Costs

County governments have complained for decades that the cost of the Medicaid program puts significant pressures on local property taxes. The proposals we are considering have the potential to generate significant federal, state and local savings in the future.

Any plan to reform the Medicaid system should include a provision for the state takeover of local costs. Given the state's fiscal condition, it is unrealistic to expect a complete state takeover this year - or even next. However, with considerable savings expected to be achieved through Medicaid reform, a portion of that savings should be devoted to a state takeover.

New York State . is experiencing a dramatic growth in the cost of and demand for long-term care services. The senior population continues to increase in numbers and the geriatric population is living longer due to new medical treatments and advances in health care technology. These developments will place extraordinary demands on the long term care finance and delivery system.

As a result, State and local taxpayers carry the burden of financing a long term care system that is increasing at an annual rate of more than eight per cent, a rate of increase far greater than that in State and local revenue.

Contingent upon the savings from the implementation of the long term care proposals outlined in this interim report, the Working Group recommends that the State relieve the counties of their Medicaid long term care costs.

After the initial State takeover of local long term care Medicaid costs, we recommend the State gradually takeover the remainder of all local Medicaid costs.

IV. Prescription Drug Costs

Medicaid spending on pharmaceuticals has grown from \$1.7 billion in State fiscal year 1998-99 to almost \$4 billion in State fiscal year 2002-03 and is currently expected to exceed \$5 billion in 2004-05. Medicaid spending on drugs has increased by more than 20 percent in recent years. In absolute dollar terms, pharmacy spending continues to be the fastest growing category of Medicaid spending for State and local governments.

SFY* Expenditures	% Increase	Gross Pharmacy
1998-99	17.2%	\$1,729,901,000
1999-00	25.0%	\$2,161,529,000
2000-01	18.9%	\$2,582,514,000
2001-02	19.0%	\$3,062,775,000
2002-03	25.8%	\$3,852,643,000
2003-04 (Projected)	16.4%	\$4,484,618,000
2004-05 (Projected)	17.7%	\$5,278,240,000

*(NYS fiscal year is April 1st through March 31st)

Higher pricing for new drugs, direct to consumer advertising, an aging population, expensive new therapies for HIV infection and advanced new medications, all continue to contribute to large pharmaceutical cost increases.

In order to contain the escalating cost of Medicaid, while ensuring appropriate, high quality care, we recommend implementation of a preferred drug program and an expanded prior authorization program that encourages the use of drugs that are therapeutically appropriate and cost effective.

Under this recommendation, an independent Pharmacy and Therapeutics (P&T) Committee including, independent clinicians, pharmacists, and utilization specialists, would evaluate clinical studies of drug effectiveness and drug cost. The process will provide opportunities for public input by holding public meetings which adhere to the Public Meetings Law and allowing for comments throughout each stage of the process. The P&T Committee will make recommendations to the Commissioner of Health and the Commissioner will be responsible for approval of the final preferred drug list.

The State would offer manufacturers the opportunity to provide additional rebates to make their products more competitive. When it has been determined that there is no demonstrated clinical advantage between drugs, the most cost effective drug would be identified as a "preferred" drug based on price and supplemental rebates.

The State would notify prescribers of which drugs had been designated as preferred. Prescribers would be required to obtain prior authorization before prescribing non-preferred drugs. The prior authorization process would be designed to be easy to use and to provide reasonably prompt approval.

The Preferred Drug Program will save the Medicaid program significant money. The bulk of the savings would result from a shift in drug utilization to less expensive, equally effective drugs. Savings also would result from additional rebates from drug manufacturers. If there are substantial changes to this proposal, such as to the covered populations, alternatives to supplemental rebates, the nature of drugs required to be "preferred," or the effectiveness of the prior authorization process, the savings could erode significantly.

Key Components of Preferred Drug Program

- The Pharmacy and Therapeutics Committee would advise the State Health Commissioner of which drugs have been identified as "preferred" drugs.
- The prior authorization process should be easy to use, timely and responsive.
- Assure maximum access to appropriate medications.
- Select the preferred drugs after consideration of the needs of the Medicaid population.
- Hire an experienced pharmacy management consultant to help the State design and implement a preferred drug program.
- Assure that providers are fully educated about the use of preferred drugs.
- Periodically evaluate the program and its impact.

V. Supplemental Security Income (SSI) and Medicaid Managed Care

Managed care plans offer numerous advantages. The Medicaid Managed Care program has improved access to quality health care for many New Yorkers. Medicaid Managed Care plans offer members significantly expanded access to qualified physicians compared to the fee for service system. In 2002, Medicaid Managed Care plan members had access to 8,000 more primary physicians and 9,500 physician specialists than under the New York State fee for service program. In addition, the Department of Health holds managed care plans accountable for the care provided to members. New York has seen a steady improvement in the health of Medicaid Managed Care members that in many cases exceeds both national benchmarks and fee for service results. More individuals are receiving appropriate treatment for diabetes, asthma and hypertension. In addition, Medicaid Managed

Care plans must make their services readily accessible to and usable by persons with disabilities in accordance with the American Disabilities Act of 1990 (ADA). Finally, the Medicaid Managed Care program has demonstrated that these improvements in quality and access can be achieved while at the same time improving cost efficiency.

Medicaid Managed Care plans are uniquely positioned to meet the diverse and special needs of the SSI population. National studies have shown that individuals with SSI enrolled in managed care are more satisfied and have better access to care than those individuals receiving care fee for service. With their managed medical systems, larger number of qualified physicians, quality improvement focus and system of accountability, these plans can provide individuals with disabilities with better quality health care.

SSI enrollment as of November 2003 was as follows:

	Total Eligible	Total Enrolled	% Enrolled
NYC	252,281	37,897	15.0%
Rest of State	148,709	36,070	
<u>Statewide</u>	<u>400,990</u>	<u>73,967</u>	<u>18.4%</u>

We propose a more aggressive campaign to increase voluntary enrollment of SSI recipients in Medicaid Managed Care. An outreach campaign to educate SSI recipients about the opportunity to enroll in Medicaid managed care and to encourage such enrollment on a voluntary basis should occur. It is expected that such a campaign would result in increased SSI enrollment in managed care plans and increased savings for the Medicaid program.

VI. Federal Medical Assistance Percentage (FMAP)

The FMAP is the share of total Medicaid program costs that the Federal government will pay. The FMAP formula calculates the Federal matching rate for each state on the basis of that state's per capita income (PCI) in relation to national PCI, with a floor of a 50 percent minimum Federal matching rate. The rate range is from 50 percent to 77 percent. One of the goals of the formula is to narrow the differences among states in their ability to fund Medicaid services.

The United States General Accounting Office (GAO) issued a report in July 2003 stating that the formula often widens the gap between states in their ability to fund Medicaid services. In fact, the formula disadvantages 21 states, including California, Florida and New York, three states that have 30 percent of the nation's population in poverty. In these states, the formula actually makes it more difficult to fund Medicaid on a relative basis. The GAO blames this result on the use of PCI versus a more representative measure such as one measuring a state's resources, the number of people in poverty and the cost of providing services to this population.

Based upon the GAO findings, a strong argument can be made for changing the formula and discarding the use of PCI. Instead, the formula could be developed by combining the states' resources and number of people in poverty in order to more accurately measure a state's ability to pay. This would create a more rational approach towards developing a Federal matching rate.

If changing the formula to a more representative measure is not feasible, the Federal government should either raise the 50 percent floor on a permanent basis or continue the 2.95 percent temporary FMAP increase enacted in the spring of 2003. The FMAP increase provided New York State with an annual benefit worth \$1.1 billion (\$760m State, \$358m local).

Additionally, if the Working Group recommendations are implemented, these reforms will save the federal government more than \$2.1 billion. We recommend the federal government reinvest a portion of these savings in New York State through an FMAP increase.

VII. Senate Medicaid Task Force Recommendations

The recently released Senate Medicaid Task Force report contained many recommendations this group supports. The work of the Senate Task Force and the Governor's Health Care Working Group are complementary. We urge the Governor and the Senate to work together, and gain Assembly support in bipartisan cooperation -- to implement the recommendations contained in both the Senate Task Force report and in this report.

Among the specific and supportable ideas contained in the Senate report, but not addressed by the Governor's Working Group are:

- Maximize Use of Technology
- Amend Family Health Plus
- Authorize Medicaid Managed Care in Rural Areas
- Promote Greater Consistency and Standardization of Managed Care Programs

IX. Conclusion

The proposals contained in this report are far reaching and significant. Yet, because of the size and scope of the Medicaid program, they only begin to address some of the issues that the state must grapple with if it is to ensure an efficient, sustainable health care program.

More work needs to be done, specifically, the Working Group plans on focusing on greater use of technology in hospitals, nursing homes, clinics, and other health care settings. Additionally, the Group will also address the concept of rightsizing for New York's hospital system.

A full report containing interim report recommendations, as well as recommendations on these other topics will be delivered to the Governor this spring.