MEDICAID COST CONTAINMENT
OPTIONS FOR NEW YORK

Prepared in collaboration with:
New York State Association of Counties

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Interim Report: February 1995

Summary

New York State is the nation's leader in both absolute and relative spending for Medicaid. With over 3 million eligible recipients, calendar year 1993 spending was $19.3 billion (federal, state and local share). In per capita terms, New York spent 2½ times the average of the rest of the fifty states in 1991 and overall costs have increased by an average of 12% annually since 1989. Furthermore, in New York the burden of Medicaid is not shared equally across the state's tax base. As up to half of the non-federal Medicaid burden is placed on the counties, communities with a high proportion of poor and/or elderly residents pay a disproportionate share of the cost.

This interim report is the result of a collaboration between the Center for Governmental Research and the New York State Association of Counties. The fact that Medicaid is costly is well-known. Our principal goal in this report is to document the cost by expenditure category, showing how spending in New York compares to that of other states. In selected areas we have been able to make recommendations for structural reform. We hope to issue future reports that assess sectors of the industry left relatively unexplored in this effort.

In a comparison with eleven other states (California, Texas, Ohio, Illinois, Pennsylvania, Michigan, North Carolina, Tennessee, Minnesota, Wisconsin and Maryland), we found that New York's total Medicaid spending (combined federal, state and local share) led the group by every measure.

The growth of spending on long term care is New York's most critical health care problem. As more and more of the state's middle class have discovered ways to qualify for Medicaid instead of using their savings, demand for Medicaid funding has risen astronomically. By 1993, fully 83% of resident days in New York nursing homes were paid by federal, state

and local taxpayers through Medicaid. This problem will not go away by itself. The looming retirement of the Baby Boomers demands that it be solved soon.

Much of the controversy over NYS Medicaid concerns optional services offered to recipients. In addition to looking at spending on optional services in New York and the other states, we compared the New York Medicaid "benefit package" to the health care plans of several private employers. If Medicaid recipients had been covered by IBM's insurance in calendar year 1993, the total cost would have been only $12.8 billion, a savings of $6.5 billion. Had Medicaid been provided under the same conditions as a typical Blue Cross and Blue Shield plan, the total expenditure would have been $13.4 billion, a savings of almost $6 billion.

We applaud Governor Pataki's commitment to tame the Medicaid monster. Bold action and political courage will be needed to effect fundamental, lasting reform. Lawmakers, providers and advocacy groups must work together to plan for the future, not protect the past. The future economic vitality of the state is at stake.

Table of Contents

Acknowledgments

Many experts in the field of health care and social services in New York State contributed to this project. Their contribution is deeply appreciated.

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Staff Team

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MEDICAID COST CONTAINMENT: OPTIONS FOR NEW YORK

Introduction

This report is the first step in an ongoing partnership between the Center for Governmental Research (CGR) and the New York State Association of Counties (NYSAC) to study the underlying problems of Medicaid in the State of New York. As demonstrated below, the health care cost crisis in the country pales when compared to the problem in New York State. Our goal in this report is to document the cost of the New York program, comparing spending in the Empire State to spending in the rest of the country. The advent of a new executive administration in Albany drove the timing of the report. Governor Pataki has recognized that control over the fiscal affairs of the State of New York is impossible if Medicaid spending is not tamed significantly. We applaud his willingness to challenge the considerable political power of providers, advocacy groups and other institutions in the state who stand to win or lose from Medicaid reform. We urge the Governor to vigorously work for fundamental, lasting reform that will reduce the structural growth in future Medicaid spending.

Previous Medicaid reform initiatives have foundered as the Governor, the Assembly and the Senate have all acted to protect their traditional constituencies. The Governor and the Assembly refused to entertain most Senate proposals to limit eligibility and reduce benefits to the indigent Medicaid population. The Senate has refused to consider proposals from the Governor that would restrict eligibility for long term care services under Medicaid, services which increasingly support the state's middle class. Reductions in reimbursement to hospitals and nursing homes have been supported by the Executive and opposed by the Senate.

It is an understatement to observe that the health care system in the state is complex. A thorough explanation of New York's Medicaid morass would require endless speculation on relative political power, administrative expediency and misplaced idealism, followed by an in-depth dissertation on the "law of unintended consequences." Our principal goal is to place New York's costs in context, particularly those related to optional services and long term care options. Where time and information allow, we make recommendations for structural reform.

The report is not complete, nor is a "complete" report likely on this vast subject. Future efforts will provide more specific recommendations for reform and will address sectors of the industry that are left relatively untouched in the present volume.

This report is based on analysis of public records and countless interviews with individuals in the provider industry, regulatory agencies (particularly state and county departments of social services and health), providers and agencies in comparison states and other interested parties. We believe the data and the assertions in this report to be fair and accurate. Nonetheless, alternative interpretations to our attention will be considered in subsequent reports.

New York's Medicaid Empire

New York State is the nation's leader in both absolute and relative spending for Medicaid. With over three million eligible recipients in New York, calendar year 1993 spending was $19.3 billion. In per capita terms, New York spent 2½ times the average of the rest of the 50 states in 1991; overall costs have increased by an average of 12% annually since 1989. Not only did this program cost state taxpayers $5.6 billion in fiscal year 1993, but county taxpayers spent an additional $3.1 billion due to the unusually large share of total cost borne by local government.

New York’s Medicaid costs are vastly greater than the costs of other states in virtually all categories. Taxes paid by the residents and businesses of the state are dramatically higher as a result of this and other programs. In 1991 state and local taxes per capita in New York were 68% above the average for the rest of the states, second only to Alaska.

New York's Medicaid program satisfies few constituencies. Most agree that despite combined federal, state and local spending of $19.3 billion, the poor have inadequate access to care, charges for private pay patients are often raised to offset losses on Medicaid clients (indirectly adding to the tax burden of New York residents) and entire industries have been spawned by the lure of public subsidy.

New York's instinctive response when parts of the health care system don't work has generally involved yet more spending. Limiting benefits and imposing fiscal discipline on

recipients and providers alike is technically demanding and politically risky, particularly as groups who stand to lose benefits or access to public reimbursement are far better organized and far better informed than the typical taxpayer.

Yet the tax climate of the State of New York must be improved if New York is to retain a shred of its claim to the "Empire State" title. To ensure that the state remains competitive with other key industrial states such as Michigan and New Jersey, New York State must follow their lead in reining in spending and reducing tax rates. If for no other reason, the Medicaid program must be reformed simply because it costs too much. The money spent on the long term care of the middle class elderly (who become legally "poor" through the clever use of trusts and other financial ploys) is not wasted, but paying the costs of 83% of all nursing home resident days in the State of New York[1] contributes to state tax rates far above those of states with whom we compete. Paying emergency room rates for the non-emergency needs of the poor pays for the real expenses of public and private hospitals (sometimes subsidizing the cost of other hospital obligations), yet there are better and less expensive ways to provide care. Supporting personal care services like housekeeping and cooking to the infirm meets real physical and social needs, but New York no longer has the luxury of providing a wide range of services to all Medicaid beneficiaries when other states offer the same services only to very restricted groups. In general, personal care services should be provided with the narrow objective of preventing unnecessary institutionalization.

Our state's continued ability to provide a basic level of social service to the needy members of our state community depends on the continued strength of the New York economy. Bold action to change our reputation as the nation's "#1 Tax Hell" is critical to the attraction and retention of business. Our taxes needn't be the lowest in the nation—the natural and human resources of the state combined with a wealth of high quality public and industrial infrastructure are a significant attraction to current and prospective employers—but long term stability and growth demand that they no longer be the highest.

The goal of this report is to assist state policymakers to design a Medicaid system that provides a reasonable range of health and long term care services to the truly needy in a way that does not undermine the state's ability to compete.

[1]The Guide to the Nursing Home Industry, 1994. HCIA and Arthur Andersen.

Underlying Assumptions

Health Care Costs Must Be Managed

The essential problem with Medicaid costs—just as in private health care—is that few participants in the health care system have an incentive to manage or control the cost of care. The only effective limitation on use is imposed by those providers and recipients who can afford to avoid the system altogether. For example, as New York has one of the lowest physician reimbursement schedules in the country, most physicians choose not to serve Medicaid patients. In response, large numbers of Medicaid beneficiaries have little choice but to seek care in hospital emergency departments. New York has also responded to problems of access by encouraging the growth of a clinic system (which is reimbursed on the basis of reported costs, not a fee schedule) that spends almost 50% more per recipient than any of the comparison states.

We recommend—as have many others—that incentives be incorporated into the system to encourage cost-effective treatment. For instance, providers should have an incentive to aggressively market pre-natal and well-baby care (including immunizations) and other treatments that demonstrably reduce long term costs. The cost of diagnostic procedures should be considered when care is provided. Treatment for long term problems such as addiction and mental illness should be limited to coverage typical of comparison states. We believe that open-ended access to care of this type is simply unaffordable, given the state's current economic condition.

A proven approach to managing cost is the placement of recipients in a "managed care" setting in which the provider receives a fixed fee per capita (a "capitation" fee) for all services to the beneficiary. The provider thus assumes the risk of unusually-costly care and receives the benefit of cost-saving innovations. Many of the issues raised by capitated reimbursement schemes are discussed below.

Personal Responsibility For All

The new credo among policy analysts is the need for personal responsibility on the part of welfare recipients. Many ideas for Medicaid reform in NYS provide incentives for recipients to take responsibility for their own health care. Managed care, for example, only works if the recipient agrees to work with a primary provider.

We suggest that the need for personal responsibility does not stop with the poor. The conversion of the long term care program into an entitlement for anyone with a good lawyer is an egregious violation of this principle. The widespread "virtual impoverishment" of the middle class elderly makes a mockery of our social welfare system.

Balancing Needs and Costs

If the vitality of the state's economy requires tax rate parity with the rest of the nation, then some measure of service parity is also necessary. New York has traditionally offered specific services that are optional under federal legislation to *all* who qualify for Medicaid. We must adopt the pattern of other states: Provide an extra level of service only to specific populations who are either particularly needy or provide care when an irrefutable case can be made that withdrawing care will drive costs higher in the long run.

Furthermore, public support for Medicaid spending depends on the perception of equity among taxpayers. This requirement demands some rough parity between services provided to the poor and services available to the general public through private health insurance.

Mental Health & Addiction: Limits to Public Funding

A trend toward treating certain social ills as *medical* instead of *social* problems has led to a dramatic increase in the use of treatment programs for mental health problems and alcohol and substance abuse. The following principles should be incorporated into New York's Medicaid policy:

- Less costly treatment should be the first course of action, thus out-patient treatment should precede in-patient treatment.
- Effective treatment depends on a personal commitment by the individual to the course of treatment, not the conviction that treatment is a less undesirable alternative; treatment should not be provided as an alternative to incarceration unless there is a well-founded expectation that the treatment will be effective.
- Long term treatment should be the rare exception; the principle of personal responsibility demands that treatment programs provide a "helping hand" to those who seek it, not a crutch.

Separating the Two Medicaids

The Medicaid program, as presently structured, is an unholy union of services provided to two different constituencies. The popular notion of Medicaid is as a public welfare program, principally meeting the needs of the poor. Yet 38% of the total was spent on nursing home, home care and personal care in 1993. Given the ease with which the middle class achieves Medicaid eligibility for long term care, much of the spending was for a broader population.

Differences in asset and income eligibility rules between home care and nursing home care highlight the inequities and inefficiencies created by the union of what is, in effect, two separate programs. To prevent spousal impoverishment, the "community spouse" can retain almost $75,000 in assets and unlimited home equity to qualify an institutionalized spouse for Medicaid. Yet assets in excess of $3,300 will make a couple ineligible for home care. On the other hand, the "lookback" period for asset transfers is 36 months for simple transfers and 60

months for trusts in the case of institutional care. There is no lookback period whatsoever for home care.

It is time to consider setting up two separate programs that will ensure equitable institutional care and home care eligibility and will encourage cost-effective use of these two modes of care. A formal separation of these programs will also make it clear who the beneficiaries of the two programs are. This issue will be studied in greater depth by CGR and NYSAC under a future analysis of the long term care problem in NYS.

Cost of Medicaid Services

What are we buying with our 19 billion tax dollars? This report will summarize how the Medicaid bill is divided up between services, such as spending for hospital care and services for physician care versus long term care services. We then examine how New York's costs compare across states and how the state total is spent county-by-county.

Cost containment is a priority both for the state and for New York counties which, in partnership with the state, bear a significant share of the Medicaid cost burden. Table 1 shows a partial breakdown of Medicaid spending in New York State for federal fiscal year 1993. Total Medicaid spending in New York for this period was just over $17.5 billion (calendar year spending was $19.3 billion). The top two rows show total spending for the categorically needy, those receiving some form of maintenance assistance, and the medically needy, who do not meet the financial standards for inclusion in federally mandated coverage. The table shows that only $5.6 billion (31.8%) of combined federal, state and county Medicaid spending was federally mandated. New York State spent $4 billion providing services not required by the federal Medicaid statute to the categorically needy and $7.9 billion on services for the more broadly defined medically needy population. New York also spent $4.6 billion (27% of total Medicaid spending) on long term care services for the elderly not mandated by the federal government. This included optional services for the categorically needy aged and services for the medically needy aged.

Table 1: Medicaid Spending in New York State, Federal Fiscal Year 1993				
	Federally Mandated Spending	% of Total	NYS Optional Spending	% of Total
Categorically Needy	$5,583,593,541	31.8%	$3,996,628,110	22.8%
Medically Needy	na	na	$7,855,126,219	44.7%
Long Term Care Component:				
Nursing Home Care for Aged	$332,547,970	1.9%	$3,016,182,237	17.7%
Home Care for Aged	$518,023,115	2.9%	$1,640,406,531	9.3%
Source: Health Care Financing Administration Form 2082, Statistical Report on Medical Care, FY 1993.				

Since Medicaid was enacted in 1965, New York State has endeavored to generate federal matching funds for the health care needs of the poor and elderly. This has resulted in a generous Medicaid plan with a variety of optional services many states choose not to provide. It has also resulted in more lenient income requirements than many states. As Table 1 shows, only one third of the total New York State Medicaid expenditure was actually required by federal law. While increasing services and coverage may once have been an affordable strategy for the state to pursue, the dramatic increase in the cost of care has become an increasing financial burden on state and county governments.

The size and growth of this burden is staggering. Between fiscal years 1983 and 1993, federal, state and county Medicaid expenditures grew from $5.7 billion statewide to over $17 billion ($19.3 billion in calendar year 1993). Figure 1 shows the growth over the 10 year period between 1983 and 1993 in New York City and the rest of the state, during which Medicaid spending nearly tripled in both regions.

Medicaid has effectively become two programs since 1965: one meeting the health care needs of the poor population and one to cover the costs of long term care needs of the elderly without strict regard to economic status. Figure 2 shows the growth in the costs of

long term care services in New York City and the rest of the state since 1983. Again, there is a near tripling in costs in both regions.

Medicaid costs in New York greatly exceed those of every other state. CGR and NYSAC have selected eleven states for comparison in this report based on various factors such as population size, major industries and innovations in the administration of Medicaid. The states selected for comparison are California, Texas, Ohio, Illinois, Pennsylvania, Michigan, North Carolina, Tennessee, Minnesota, Wisconsin and Maryland. Total Medicaid spending in each state is shown in Figure 3. New York's fiscal year 1993 costs were higher than the other states and were even $7.9 billion above those of California, despite the fact that California has 70% more people.

Naturally, total spending figures do not tell the whole story. New York State has a larger population than all other states except California and, recently, Texas. Many other demographic features distinguish New York from the comparison states. But if one looks at Medicaid spending by any reasonable standard, New York State is very much out of line. Figure 4 shows that New York spends more than twice the amount per recipient of most other states. New York's spending **per recipient** is more than double that of neighboring Pennsylvania and triple that of California.

Looking at Medicaid spending per capita, as in Figure 5, normalizes the comparison states. New York, however, is even further out on a limb of apparent excess. The median spending on Medicaid per capita in the other states was $353 in FY 1993, while New York spent $965 for every state resident. Similarly, New York led all states in Medicaid spending as a per cent of gross state product, in Figure 6. New York spent 3.8% of the gross state product of goods and services on Medicaid in 1993 while the median ratio of the other states was only 1.7%. The effect of this relative profligacy is illustrated in Figure 7, the ratio of Medicaid spending to total state spending. New York's Medicaid expenditure (combined federal, state and local) was 32% of its total budget on Medicaid in FY 1993 as opposed to an average of 15.7% for the other states in the comparison.

The alarming and unsustainable growth of New York State's Medicaid program has inspired various reform efforts in the recent past. The New York State Department of Social Services has initiated several specific reforms, most of which have been litigated. The

Comprehensive Medicaid Task Force appointed by Lieutenant Governor McCaughey recently issued its report with a list of options to reduce Medicaid spending. This report and recent DSS initiatives are summarized in Appendix A.

Acute & Ambulatory Care Services

Acute and ambulatory care includes both in-patient and out-patient hospital care and care to individuals in physicians' offices and clinics. The other major category of Medicaid costs is long term care services, both care in the home and care in a nursing facility.

Overview of Mandatory and Optional Services

Acute and ambulatory care services provided to the poor under Medicaid fall into two categories, federally mandated services and services provided at the states' option. States can offer optional services, defined in Title XIX of the Social Security Act, that are eligible for the same level of reimbursement from the federal government as mandated services. New York State is reimbursed for half of all Medicaid services, mandated and optional.

The following services are federally mandated:

- Inpatient hospital services,
- Outpatient hospital services,
- Rural health clinic services[2],
- Federally qualified health center services,
- Other laboratory and X-ray services,
- Nursing facility (NF) services for age 21 or over (categorically needy),
- Home health services for those entitled to NF care,
- Early and Periodic Screening, Diagnostic and Treatment (EPSDT) for under 21,
- Family planning services,
- Physicians' services,

[2]Rural health clinics provide health services in rural areas with shortages of personal health services or primary medical care manpower. Rural health clinic services are mandatory consistent with state law permitting such services. New York State does not operate any rural health clinics with Medicaid funding.

- Nurse midwife services, and
- Certified pediatric and family nurse practitioners' services.

The Medicaid statute also defines a number of population groups as potentially eligible to receive benefits. Just as states may include certain optional services in their Medicaid plans for federal reimbursement, states may also expand coverage to optional population groups. The population groups covered by Medicaid have been divided into two classes, the "categorically needy" and the "medically needy." The Federal government defines what groups are categorically needy, generally based on eligibility for other welfare benefits. States can define their own medically needy populations using more generous income and resource tests than the federal government. Some states do not exercise this option, while New York defines the medically needy as those with incomes within 133% of the level needed to qualify for AFDC.

States can choose to offer the optional services with certain limitations. Many states choose to offer optional services to only the categorically needy. New York State has traditionally provided the categorically and medically needy the same set of benefits with no distinction. Table 2 shows the cost of these optional services as reported to HCFA for the categorically and medically needy in New York State.[3]

[3]The data comes from the HCFA 2082 form, a standard reporting form states use to report Medicaid expenditures. HCFA defines 31 discrete optional services which are grouped together in this form. These services are listed in Table 4.

Table 2: Costs of Optional Services in New York State (Federal, State and Local)			
	Categorically Needy	Medically Needy	Both Groups
Mental Hospital Services for Aged	$268,659,457	$508,841,308	$777,500,765
Inpatient Psych. for under 21	$129,782,572	$107,674,275	$237,456,847
Intermediate Care Facility for Mentally Retarded	$868,931,515	$1,471,791,743	$2,340,723,258
Dental Services	$114,547,725	$29,219,917	$143,767,642
Clinic Services	$566,998,738	$225,200,332	$792,199,070
Prescribed Drugs	$488,430,016	$144,632,137	$633,062,153
Other Practitioners	$288,053,189	$84,115,334	$372,168,523
Home Health Services	$679,926,913	$909,752,847	$1,589,679,760
Other Care	$591,297,985	$162,556,606	$753,854,591
Total Optional Services	*$3,996,628,110*	*$3,643,784,499*	*$7,640,412,609*

Source: Health Care Financing Administration Form 2082, Statistical Report on Medical Care, FY 1993.

Total spending on optional services in fiscal year 1993 for New York State was $7.6 billion. Spending on optional services for the medically needy was nearly equal to spending on the categorically needy, even though the medically needy number less than 750,000 recipients and the categorically needy represent 1.8 million.

Interstate Cost Comparison and Analysis

In order to benchmark Medicaid costs in New York State properly, CGR and NYSAC selected a set of suitable comparison states. These states were chosen to include most major industrial states plus several states known to be experimenting with major reforms. The comparison states are California, Illinois, Maryland, Michigan, Minnesota, North Carolina, Ohio, Pennsylvania, Tennessee, Texas and Wisconsin. Table 3 shows the total 1993 Medicaid expenditure by state and details expenditures for the six largest spending categories. Inpatient

hospital expenditures, skilled nursing facility (SNF) services and physicians services are federally mandated while intermediate care facilities (ICF) for the mentally retarded (MR) are optional. Home health services include federally mandated services, such as home health aides, and optional services, such as personal care.

Table 3: Medicaid Expenditures by Major Service Category (Millions)

State	Total	Inpatient Hospital	SNF Services	ICF Svcs. for MR	Prescribed Drugs	Home Health Svcs.	Physicians Svcs.
MD	$1,721	$551	$248	$58	$111	$51	$98
WI	$1,786	$270	$666	$207	$163	$75	$44
MN	$1,930	$243	$752	$289	$111	$158	$110
TN	$1,977	$341	$69	$115	$240	$15	$254
NC	$2,452	$553	$575	$302	$190	$172	$237
MI	$3,077	$804	$662	$1,455	$0	$239	$229
PA	$3,886	$947	$1,365	$477	$389	$22	$155
IL	$4,625	$1,740	$1,153	$522	$331	$131	$241
OH	$4,667	$992	$790	$444	$384	$108	$254
TX	$5,575	$1,678	$1,048	$536	$445	$248	$606
CA	$9,650	$3,427	$1,953	$523	**$992**	$48	**$850**
NY	**$17,557**	**$3,928**	**$4,022**	**$2,341**	$636	**$2,158**	$288

Source: Health Care Financing Administration Form 2082, Statistical Report on Medical Care, FY 1993.

As previously noted, Medicaid costs in New York greatly exceed those of every state in the comparison set. New York's fiscal year 1993 costs were $7.9 billion above those of California, a state with 70% more people. New York State also led spending in four of the six categories, spending less than California only in prescribed drugs and physicians' services.

A comparison of costs per recipient in these services is more meaningful, because New York State has a large population and distinct demographic characteristics. Figures 8 and 9 show Medicaid spending per recipient on two federally mandated services, inpatient and outpatient hospital treatment. New York State and Illinois spend significantly more than other

states on inpatient hospital services and for outpatient services New York and Maryland each spend about twice as much for each beneficiary.

Continuing the process of benchmarking, we now compare the optional services provided to NYS Medicaid recipients with those provided in a set of comparison states. HCFA defines 31 discrete optional services that may be provided in state Medicaid programs. (These are lumped into broader categories in the HCFA 2082 form states use to report Medicaid expenditures.) States have the option of providing selected optional services to the categorically needy population only or to both the categorically and medically needy populations. New York offers 26 of these optional services to both the categorically and medically needy.

Table 4 details the services offered by New York and the comparison states. Minnesota, Wisconsin and California each offer a few more services than New York, although Wisconsin offers several services to only the categorically needy. All of the states offer at least 19 optional services each and most states offer all optional services to both the categorically and medically needy. Pennsylvania provides prescribed drugs to the categorically needy only, Wisconsin limits 13 of 29 optional services to the categorically needy only and Ohio does not offer any optional services to the medically needy.

Table 4: Optional Services in Comparison States

	CA	IL	MD	MI	MN	NY	NC	OH	PA	TN	TX	WI
Podiatrist's Services	X	X	X	X	X	X	X	C	X	X	X	X
Optometrist's Services	X	X	X	X	X	X	X	C	X	X	X	C
Chiropractor's Services	X	X			X		X	C	X		X	C
Other Practitioner's Services	X		X	X	X	X		C		X	X	C
Private Duty Nursing	X	X	X		X	X	X	C				C

Table 4: Optional Services in Comparison States												
	CA	IL	MD	MI	MN	NY	NC	OH	PA	TN	TX	WI
Clinic Services	X	X	X	X	X	X	X	C	X	X	X	X
Dental Services	X	X	X	X	X	X	X	C	X	X		C
Physical Therapy	X	X	X	X	X	X		C			X	X
Occupational Therapy	X	X		X	X	X		C				X
Speech, Hearing and Language Disorders	X	X	X	X	X	X		C				X
Prescribed Drugs	X	X	X	X	X	X	X	C	C	X	X	X
Dentures	X	X	X	X	X	X	X	C	X			C
Prosthetic Devices	X	X	X	X	X	X	X	C	X	X	X	X
Eyeglasses	X	X	X	X	X	X	X	C	X		X	C
Diagnostic Services	X	X		X	X	X	X				X	C
Screening Services	X				X	X	X					C
Preventive Services	X	X			X	X	X					C
Rehabilitative Services	X	X		X	X	X	X	C	X	X	X	C
IMD Inpatient for over 65	X	X	X	X	X	X	X		X	X		C
IMD NF for over 65	X	X	X	X	X	X	X	C	X	X		X
ICF Services for MR	X	X	X	X	X		X	C	X	X	X	C

Table 4: Optional Services in Comparison States												
	CA	IL	MD	MI	MN	NY	NC	OH	PA	TN	TX	WI
Inpatient Psych. for under 21	X	X	X	X	X	X	X		X	X		C
Christian Science Nurses	X											
Christian Science Sanitoriums	X	X		X	X			C		X	X	X
NF for under 21	X	X	X	X	X	X	X	C	X	X	X	X
Emergency Hospital Services	X	X	X	X	X	X		C	X	X	X	X
Personal Care Services			X	X	X	X	X				X	X
Transportation Services	X	X	X	X	X	X	X	C	X	X	X	X
Case Management Services	X		X	X	X	X	X	C	X	X	X	X
Hospice Care Services	X	X	X	X	X	X	X	C	X	X	X	X
Respiratory Care Services	X			X						X	X	X
Total Services Offered	29	25	23	26	28	26	23	23	19	19	20	29

Note: C = Categorically Needy only, X = Categorically and Medically Needy.
Source: Health Care Financing Administration

On balance, the selected states are relatively generous in the quantity of optional services offered. However, many states are much more selective than New York in providing services through Medicaid and many offer optional services to the categorically needy only. California, Minnesota and Wisconsin each offer more optional services than New York State,

however New York spends vastly more on the services it *does* provide. Figure 10 shows overall state spending on optional services, Figure 11 shows spending per recipient and Figure 12 shows state spending per capita. The figures show that New York State is substantially more generous in terms of inclusion and spends more on each average recipient. NYS also serves more of its population.

The next set of figures breaks out Medicaid spending for individual optional services on a cost per recipient basis for fiscal year 1993. Figure 13, for example, shows New York State spent over $120,000 in Medicaid funds for each person receiving intermediate care facility level treatment for mental retardation. Other states spent less than half of this per person. New York State also spent vastly more Medicaid money per person for services provided by practitioners other than physicians and registered nurses, such as chiropractors, as shown in Figure 14. One area where New York State appears not to lead the pack in Medicaid spending is dental services, shown in Figure 15. Texas and California each spent slightly more per person.

One area where New York has lagged behind other states is Medicaid physician reimbursement. Medicaid physician reimbursement rates in New York State are among the lowest in the country. As a natural consequence, New York's physicians tend not to take Medicaid patients, and Figure 16 shows that Medicaid spending on physician services in New York is lower than other states. Many services that would probably be provided by physicians if reimbursement rates were higher are provided at clinics at a much higher cost. These clinics, as shown in Figure 17, are considerably more expensive on a per recipient basis than those in other states.

In light of these comparisons, New York State policymakers are strongly urged to bring these costs under control. It is vitally important for the state's economic competitiveness to purposefully restructure New York State Medicaid in order to bring costs into line with those of our competing states.

Medicaid Coverage and Private Insurance

Medicaid services in New York State are generous when compared to many states, both in terms of the number of optional services provided and in the inclusion of the medically

needy population. But how does New York State's Medicaid plan compare with private insurance? Such comparisons have been drawn in recent political discourse on the issue. The following tables compare the level of coverage of New York State Medicaid federally mandated and optional services with three selected private insurance plans: one of IBM Corporation's most popular employee medical plans, a comprehensive managed medical plan for Fleet Bank employees and Blue Cross and Blue Shield in Monroe County.

Table 5: Medicaid and Private Insurance Comparison for Federally Mandated Services

Federally Mandated Services	**NYS Medicaid**	**IBM Corporate Medical Plan** (NYS residents)	**Fleet Bank Medical Plan**	**Blue Cross and Blue Shield** (Monroe County)
Inpatient Hospital	Fully Covered ($25 co-pay)	Fully Covered after $355 Deductible	Fully Covered after $200 Deductible per admission	Fully Covered
Outpatient Hospital	Fully Covered ($3 co-pay)	20% Deductible ($355 maximum) 80% reimbursement	Fully Covered	$100 Deductible 80% reimbursement(1)
Laboratory and X-ray	Up to 18 tests/yr ($1 co-pay)	$250 Deductible(2) 80% reimbursement	Fully Covered	$100 Deductible 80% reimbursement(1)
Nurse Practitioner	Fully Covered	$250 Deductible(2) 80% reimbursement	Fully Covered ($10 co-pay)	$100 Deductible 80% reimbursement(1)
Adult SNF and Home Health	Fully Covered	$250 Deductible(2) 80% reimbursement Full Coverage if in lieu of hospital care	Fully Covered ($200 co-pay if SNF, $10 co-pay if home care)	Fully Covered
Family Planning	Fully Covered	None	Fully Covered ($10 co-pay)	None
Physicians	Up to 10 visits/yr	$250 Deductible(2) 80% reimbursement	Fully Covered ($10 co-pay)	$100 Deductible 80% reimbursement(1) No maximum visits
Nurse Midwife	Fully Covered	$250 Deductible(2) Fully Covered	Fully Covered (as long as a doctor is also involved)	None

Table 5: Medicaid and Private Insurance Comparison for Federally Mandated Services				
Federally Mandated Services	**NYS Medicaid**	**IBM Corporate Medical Plan** (NYS residents)	**Fleet Bank Medical Plan**	**Blue Cross and Blue Shield** (Monroe County)
Early Childhood Screening	Fully Covered	$250 Deductible(2) 80% reimbursement	1st year: 10 visits 2nd year: 4 visits 3rd year: 2 visits after 3 yrs: 1 visit/yr ($10 co-pay)	Fully Covered

Sources: Health Care Financing Administration, Monroe County Personnel Dept., IBM National Benefits Office, Fleet Bank Corporate Benefits Office

(1) Member is liable for a maximum expense of $600 per year.

(2) Deductible is based upon salary (3/10 of 1%); $250 is the minimum possible.

Medicaid provides full coverage, or full coverage with a nominal copayment, for all of the federally mandated services, as required by law. Any restrictions on the number of visits can be waived on a physician's recommendation. IBM's plan provides full coverage for only two services, and then only under certain conditions. Five services are covered by a $250 deductible with 80% reimbursement, and the rest are not covered. Fleet provides full coverage for all services, but with higher deductibles and co-payments than Medicaid, and some additional restrictions as well. Blue Cross and Blue Shield provides full coverage for only three services, four are covered by a $100 deductible and 80% reimbursement, and the rest are not covered. The next table compares the optional services offered through Medicaid and the same selected private plans.

Table 6: Medicaid and Private Insurance Coverage for Optional Services				
Optional Service	**NYS Medicaid**	**IBM Corporate Medical Plan**	**Fleet Bank Medical Plan**	**Blue Cross and Blue Shield**
Podiatrist Services	Fully Covered(1)	$250 Deductible with 80% reimbursement(2)	Fully Covered ($10 co-pay)	$100 Deductible with 80% reimbursement(3)

Table 6: Medicaid and Private Insurance Coverage for Optional Services				
Optional Service	**NYS Medicaid**	**IBM Corporate Medical Plan**	**Fleet Bank Medical Plan**	**Blue Cross and Blue Shield**
Optometrist Services	Fully Covered	If medically related to another condition, $250 Deductible with 80% reimbursement(2); Not otherwise covered.	1 visit every 2 years ($10 co-pay)	None
Chiropractor Services	None	$250 Deductible with 80% reimbursement(2)	Fully Covered ($10 co-pay)	$100 Deductible with 80% reimbursement up to $800
Private Duty Nursing	Fully Covered	None	Fully Covered If medically necessary ($10 co-pay)	$100 Deductible with 80% reimbursement(3)
Clinic Services	Up to 10 visits/yr ($3 co-pay)	$250 Deductible with 80% reimbursement(2)	Fully Covered ($10 co-pay)	$100 Deductible with 80% reimbursement(3)
Dental Services	Up to 3 visits/yr	None(4)	None(4)	None(4)
Physical Therapy	Fully Covered	$250 Deductible with 80% reimbursement(2)	Fully Covered ($10 co-pay)	$100 Deductible with 80% reimbursement(3)
Occupational Therapy	Fully Covered	$250 Deductible with 80% reimbursement (2,5)	Fully Covered ($10 co-pay)	$100 Deductible with 80% reimbursement(3)
Speech, Hearing and Language Disorders	Fully Covered	$250 Deductible with 80% reimbursement(2)	Fully Covered ($10 co-pay)	$100 Deductible with 80% reimbursement(3)
Prescribed Drugs	Up to 43 visits/yr ($1 co-pay)	$250 Deductible with 80% reimbursement(2)	Co-pay: $5 for generic drugs $10 for name brands	$3/$6 co-pay
Dentures	Fully Covered	None(4)	None(4)	None(4)
Prosthetic Devices	Fully Covered	$250 Deductible with 80% reimbursement(2)	Fully Covered	80% paid

Table 6: Medicaid and Private Insurance Coverage for Optional Services				
Optional Service	**NYS Medicaid**	**IBM Corporate Medical Plan**	**Fleet Bank Medical Plan**	**Blue Cross and Blue Shield**
Eyeglasses	Fully Covered	None	None	None
Diagnostic Services	Fully Covered	Inpatient Fully Covered after $355 Deductible; Outpatient/Preventative $250 Deductible with 80% reimbursement(2)	Fully Covered	$100 Deductible with 80% reimbursement(3)
Screening Services	Fully Covered	$250 Deductible with 80% reimbursement(2)	$10 co-pay (subject to a frequency schedule)(6)	$100 Deductible with 80% reimbursement(3)
Preventive Services	Fully Covered	$250 Deductible with 80% reimbursement(2)	$10 co-pay (subject to a frequency schedule)(6)	$100 Deductible with 80% reimbursement(3)
Rehabilitative Services	Up to 30 visits/yr for Mental Health Clinics	None	Inpatient: $200 co-pay Outpatient: $10 co-pay	50% co-pay to $2,000 maximum
IMD Inpatient for over 65	Fully Covered	None	90% Coverage (10% co-pay)	Fully Covered
IMD NF for over 65	Fully Covered	None	None	None
ICF Services for MR	Fully Covered	None	Fully Covered ($200 co-pay)	None
Inpatient Psych. for under 21	Fully Covered	None	90% Coverage up to 60 days/yr (10% co-pay)	Fully Covered - 60 days/yr
Christian Science Nurses	None	None	None	None
Christian Science Sanitoriums	None	None	None	None
NF for under 21	Fully Covered	None	Fully Covered if medically necessary ($10 co-pay)	$100 Deductible with 80% reimbursement(3)

Table 6: Medicaid and Private Insurance Coverage for Optional Services				
Optional Service	**NYS Medicaid**	**IBM Corporate Medical Plan**	**Fleet Bank Medical Plan**	**Blue Cross and Blue Shield**
Emergency Hospital Services	Fully Covered	Fully Covered ($355 Deductible)	Fully Covered ($25 co-pay)	Fully Covered
Personal Care Services	Fully Covered	None	None	None
Transportation Services	Fully Covered	None	None	None
Case Management Services	Fully Covered	None	Fully Covered	Fully Covered
Hospice Care Services	Fully Covered	Fully Covered up to $5,000/yr (5)	Fully Covered	Fully Covered
Respiratory Care Services	None	Considered part of Hospice Care	Fully Covered (if medically necessary)	None

Source: Health Care Financing Administration and Monroe County Personnel

(1) Podiatry services are not covered as a discrete service but are fully covered if they are given in conjunction with clinical visits.

(2) Deductible is based on salary (3/10 1%); $250 is the minimum.

(3) Member is liable for a maximum expense of $600 per year.

(4) Separate dental insurance is offered.

(5) Subject to utilization review.

(6) Subject to a schedule of frequency based on the age of the patient.

Table 6 shows that Medicaid coverage of optional services is *broader and more extensive than any of the given private insurance packages*. The IBM plan does not provide full coverage for any of the optional services without restriction, and no coverage is provided for 10 services fully covered by NYS Medicaid. Fleet provides full coverage without restriction for five services, and does not cover six of the services fully covered by NYS Medicaid. Blue Cross and Blue Shield provides full coverage without restriction for only four of the optional services, and no coverage at all for eight services fully covered by New York State Medicaid.

New York State Medicaid expenditures in calendar year 1993 were roughly $19.3 billion. Table 7 shows what New York State Medicaid paid for various services in calendar year 1993. The other columns show what the sample private plans would have paid by applying their deductibles, copayments and reimbursement rates to the same services. If Medicaid recipients had been covered by IBM's insurance, the total cost would have been only $12.8 billion, a savings of $6.5 billion. If those expenditures had been limited to what Fleet would have provided, the total would have been about $16.2 billion, a savings of over $3.1 billion. Finally, if Medicaid had been provided under the same conditions as a typical Blue Cross and Blue Shield plan, the total expenditure would have been $13.4 billion, a savings of almost $6 billion.

Table 7: Medicaid Expenditures and Estimates of the Cost for the Same Services if Provided by the Sample Private Insurance Plans in Calendar Year 1993

	Medicaid	IBM Medical Plan	Fleet Bank Medical Plan	Blue Cross/ Blue Shield
Inpatient Hospital	$6,169,807,622	$6,146,324,727	$6,156,577,822	$6,169,807,622
Outpatient Hospital	$1,160,262,332	$796,565,074	$1,160,262,332	$891,126,826
Lab and X-ray	$54,275,648	$6,348,518	$54,275,648	$28,088,518
Nursing Facilities	$3,833,285,532	$3,816,272,132	$3,816,272,132	$3,833,285,532
Home Health Aide	$358,939,302	$275,951,442	$358,379,302	$358,939,302
Home Nursing Services	$139,832,165	$104,972,132	$139,487,485	$109,108,292
Clinics	$1,017,432,559	$763,019,047	$1,014,886,209	$793,575,247
Other Practitioners	$532,353,118	$409,745,294	$531,546,258	$419,427,614
Drugs	$776,996,610	$446,345,888	$770,739,615	$773,242,413
Dental	$121,166,179	$0	$0	$0
Eyeglasses & Prosthetics	$39,608,429	$19,804,215	$19,804,215	$19,804,215

Table 7: Medicaid Expenditures and Estimates of the Cost for the Same Services if Provided by the Sample Private Insurance Plans in Calendar Year 1993				
	Medicaid	**IBM Medical Plan**	**Fleet Bank Medical Plan**	**Blue Cross/ Blue Shield**
Rehabilitative Services	$19,833,447	$0	$17,850,102	$9,916,724
ICF for MR	$2,203,725,529	$0	$2,202,982,929	$0
Personal Care	$1,597,335,715	$0	$0	$0
Other Services	$1,324,077,607	$0	$0	$0
Total	$19,348,931,794	$12,785,348,469	$16,243,064,049	$13,406,322,305
Source: Estimates based on figures from the New York State Department of Social Services, Monroe County Personnel Department, IBM Corporate Benefits, and Fleet Bank Corporate Benefits				

For many reasons, including the differences in the populations, it is difficult to make cost comparisons with Medicaid and private insurance. Medicaid recipients may constitute a population that is less healthy than private insurance policy holders, they may also use medical services less consistently, and they are entitled to more covered services than private policy holders. For example, neither Blue Cross nor IBM covers stays in intermediate care facilities for the mentally retarded (ICF for MR in the table), and one might suppose that very few Fleet Bank employees require this service, which is a particularly large Medicaid expense.

All of these comparison problems notwithstanding, *the difference in expenditures per recipient between private insurance and Medicaid is striking*. A good private insurance plan can cost between $2,000 and $3,000 per person annually if the person is single or in a smaller family. The cost per person drops as family size increases. In contrast, New York State Medicaid spent $6,402 per recipient in fiscal year 1993.

These comparisons highlight the need for restructuring and cost saving in Medicaid optional services. Medicaid simply should not be the premier insurance plan in New York State. Policymakers are urged to adopt cost saving measures that will bring Medicaid optional services more in line with what private insurance plans provide.

Intrastate Comparison

The cost per recipient for acute and ambulatory care provided through Medicaid varies tremendously across New York State. Chenango, Orleans, Jefferson and St. Lawrence Counties each spend less than $2,000 per recipient on all acute and ambulatory service, while Putnam and Nassau Counties each spend over $5,000 per recipient. Figure 18 shows the 10 lowest and highest spending counties per recipient for all acute and ambulatory care. Figures 19 and 20 show Medicaid spending per recipient for inpatient and outpatient hospital services respectively. There is a striking variation between the two services across counties. New York City, for example, is the cost leader in inpatient hospital services at over $100,000 per Medicaid recipient but spends close to the state median for outpatient services. Conversely, Rockland County spends far more than any other county for outpatient hospital services for Medicaid patients but has relatively reasonable (but high) inpatient costs.

Conditions are, of course, unique in each county. Figure 21 shows the spending per recipient on Medicaid acute and ambulatory care by county, and Figure 22 shows the allocation of all Medicaid spending among counties. An in depth examination of the details of Medicaid reimbursement and rate setting in each county for each service are beyond the scope of this effort. The extreme variation in the per recipient cost of each service, however, clearly merits further attention as policymakers grapple with delivering services through Medicaid with greater efficiency.

Optional Services: Recommendations

New York must make choices regarding the extensive number and scope of benefits offered. While Wisconsin, Minnesota and California do offer more optional services than New York, they are still offering all services at a less expensive rate than New York and placing limitations on the services. Optional services categories which are not commonly provided by other states include: occupational therapy, screening services, preventive services, occupational therapy services for speech, language and hearing disorders and private duty nursing.

Transportation services should also be offered with more restrictions. We support the federal waiver permitting counties to coordinate transportation services across programs. Outside of Medicaid, no other insurer in New York State will pay for taxi service. Local social services districts should also have the authority to prior-authorize ambulette and day treatment transportation services offered in New York. Greater local control over how these expensive services are utilized and the elimination of less efficient modes of transport would yield significant savings.

Medicaid and Managed Care

A cost comparison with managed care programs and Medicaid reduces the problem of different services and populations involved in comparing Medicaid to fee for service private insurance. Various states have encouraged voluntary and occasionally mandatory enrollment of Medicaid recipients in systems where the overall care of a patient is overseen by a single provider or organization. The hope is that the managed care concept will change provider and recipient behaviors which contribute to rising costs under a fee for service system.

In 1991, the New York State Legislature passed the statewide Medicaid Managed Care Act, designed to improve the delivery of quality, cost-effective health care through the expansion of managed care. The act encourages local departments of social services to voluntarily participate in managed care and establishes participation goals which increase over time. The McCaughey report recommends speeding up this process by requiring nearly all non-elderly recipients to be under such a plan by summer 1996. New York State has also mandated enrollment in managed care programs in a demonstration project in Southwest Brooklyn.

The Monroe Plan in Rochester, under contract to the local Blue Cross-Blue Shield affiliate, has accepted Medicaid patients since 1974. Every patient in the plan is assigned to an individual physician by mutual agreement and all services other than emergency room visits are coordinated by that physician. These services include a range of specialist services not otherwise accessible to Medicaid patients. Participating physicians are reimbursed at their usual and customary rates less a 15% withhold that acts as a risk pool. About 14,000 Medicaid recipients are enrolled in managed care through this plan.

The Monroe Plan regards engaging providers as critical to success in managed care for Medicaid patients. Another important factor is the local flexibility to provide creative and diverse member services to Medicaid enrollees. These can include authorizing transportation and babysitting to ensure appointments are kept, member education services and measures to facilitate compliance. Managers of the Monroe Plan emphasize, however, that there are subgroups that cannot be managed, such as addicts.

Financially, the Monroe Plan has been successful. Reimbursed at 95% of the estimated cost of care for the enrolled population, Monroe Plan pays participating physicians "usual and customary" fees while arguably providing greater access to services for its enrolled population. The 15% "holdback" has always been returned to the physicians at the end of the year. Some suggest that managed care enrollees are likely to be better educated and more concerned about their health than the general Medicaid population. Monroe Plan managers suggest that some adverse selection is also likely, as access to specialists is much more difficult for Medicaid beneficiaries outside the Plan.

Figure 23 shows the percentage of Medicaid eligibles enrolled in HMOs by state for fiscal year 1993. The pace of change is extremely rapid in this area and some of these states have increased enrollment in 1994 and will continue to do so in 1995. Figure 24 shows the average Medicaid premium payment for qualified and provisional HMOs for fiscal year 1993. The states with a smaller percentage of the Medicaid eligible population enrolled in HMOs appear to have lower costs per recipient, however, this may reflect efforts of initial providers to enroll healthier eligibles. As the enrollment goes up, the costs per recipient appear to increase somewhat, but the annual premium payments appear to be significantly lower than the annual average cost per recipient under Medicaid.

Synopses of progress in key comparison states follow as a guide to NYS policymakers as they move to require managed care participation:

- **California** originally enrolled recipients of Medi-Cal, the state's Medicaid program, in managed care programs to decrease expenditures. This was accomplished by setting capitation rates at or below the fee-for-service (FFS) cost. By 1993, Prepaid Health Plans (PHP's), HMO's, Primary Care Case Management (PCCM) Plans, and Health Insuring Organizations (HIO's) were all components of the program. Approximately 610,000 Medi-Cal

recipients were enrolled in PHP's, HMO's, and PCCM's in 1993, and an additional 78,700 were enrolled in the HIO's. Enrollment in HIO's was mandatory in two counties, but for all other programs enrollment was voluntary. As the efficiency of FFS Medi-Cal has improved in recent years, the savings due to managed care programs has decreased. However, California is still aggressively pursuing expansion of managed care programs for Medi-Cal recipients. The argument for expansion is based not only on savings, but also the ability of managed care programs to improve access to medical care--especially primary care and preventive services--and to alleviate some of the administrative burden imposed on providers by the FFS system.

In 1993, **Illinois** enrolled roughly 103,000 Medicaid recipients in a fully capitated HMO program. Enrollment was voluntary, although only AFDC recipients were eligible for the program at the time. Payment was made according to a capitation structure based on the age and sex of the recipient to discourage enrollment of only low-cost recipients, and to avoid paying more than what FFS care would cost. Illinois is currently developing a multi-year managed care implementation plan with the goal of enrolling as many Medicaid eligibles as possible throughout the state.

Maryland operated two major managed care programs for Medicaid recipients in 1993: Maryland Access to Care (MAC), and access to HMO's. MAC is essentially a fee-for-service primary care case management program, where Medicaid recipients are linked with a primary care provider who also serves as a gatekeeper for the provision of specialty care. Approximately 225,000 Medicaid recipients were enrolled in MAC in 1993. Maryland also operates a much smaller mandatory coordinated care program for Medicaid recipients who misuse the system.

Until recently, Medicaid HMO's only operated in the Baltimore metropolitan area. Enrollment is voluntary, with 67,347 recipients enrolled in fiscal year 1993. Capitation rates are set according to 19 different categories developed from FFS equivalents. Statewide participation in the HMO program was approved in 1994.

Michigan operates one of the largest managed care systems for Medicaid recipients. The state has contracted with HMO's to provide Medicaid covered health services since 1972. Enrollment in HMO's was voluntary everywhere but in Detroit for most of the program's history, and 1992 legislation paved the way for mandatory enrollment elsewhere. In January

of 1993, enrollment was mandatory in four counties and Medicaid recipients were enrolled in managed care programs in 24 of the 83 Michigan counties.

Studies show that managed care in Michigan has resulted in significant cost savings. Through 1990, the state reports an estimated savings of $96 million for the HMO program compared to FFS costs. Savings estimates reported for 1989 and 1990 were $12.7 million and $15.9 million, respectively. An independent study concluded that the combined savings for AFDC/SSI beneficiaries covered by Medicaid in fiscal year 1990 was $24.2 million, or 17.5% of combined expected Medicaid FFS expenses.

In addition to the HMO's, Michigan operates a Capitated Clinic Plan and Physician Sponsor Plan for Medicaid recipients. The Clinic Plan is partially capitated, while the PSP is mainly FFS but the recipient's physician acts as both a provider and a case manager. While enrollment in these plans is limited, studies show that both are successful at controlling costs, improving access, and encouraging proper usage of medical care.

Minnesota's Prepaid Medical Assistance Program (PMAP) provided mandatory managed health care to recipients in three counties in 1993, and six other counties had voluntary programs. Total enrollment was about 79,500 in January 1993 - approximately 20% of Minnesota's Medicaid population. Currently, Minnesota is in the process of expanding managed care enrollment, with hopes of covering the entire state by 1995-96.

Savings figures for Minnesota's program are not as dramatic as for Michigan, but the studies are encouraging. The Dept. of Human Services reported estimated savings of $5.7 million in 1987, $6.5 million in 1988, and $1.5 million in 1989. These numbers suggest that managed care can help to control health care costs, even when the programs are relatively limited in size.

North Carolina had two managed care programs for Medicaid recipients in 1993: a prepaid contract with an HMO, and a coordinated care program called Carolina ACCESS. The HMO program serves the AFDC population in three counties. Enrollment is voluntary, and in 1993 there were nearly 3,500 participants. Medicaid pays the premium for those enrolled, and all regular Medicaid services are provided except dental care. Problems have been scarce and the program is considered a success.

Carolina ACCESS links Medicaid recipients with primary care physicians, who then serve both as providers of basic health care and gatekeepers for other services. Enrollment is mandatory for some recipients (AFDC & AFDC related, indigent children, and the aged, blind, and disabled). Others are welcome on a voluntary basis, although some people in institutions and foster care are excluded. In 1993, roughly 85,000 recipients were enrolled in the program in 17 counties. Statewide expansion is currently underway.

Ohio operates a HMO managed care program for Medicaid eligible AFDC recipients. HMO enrollment is voluntary in 13 counties, with about 114,000 participants in 1993. Enrollment is mandatory in one county, and approximately 44,600 people participated in 1993; in all, about 15% of Ohio's AFDC-Medicaid eligible population of just over 1,000,000. Medicaid pays a pre-determined monthly capitation payment for each enrollee. Mandatory enrollment is legislated to be in effect in three more counties by July, 1996, and all non-aged, blind, and disabled will be required to enroll. Expansion into rural areas, where HMO's are not as viable, will likely take more of a coordinated care approach.

Pennsylvania is committed to increasing the number of medical assistance recipients enrolled in managed care plans. In 1993, six HMO's and one community health center had agreements with the state to provide services to Medicaid eligibles. Enrollment in HMO's is voluntary, and in 1993 over 171,000 of the state's 1,450,000 eligible recipients were enrolled. The CHC enrolled another 4,000 on a voluntary basis. While the percentage of total recipients enrolled in managed care is low, lower costs are reported and the state is pursuing expansion into more areas.

Pennsylvania also has a program known as HealthPASS, which is a primary care case management program in Philadelphia County. The program enrolls nearly all Medicaid recipients in five Philadelphia districts, for a total of over 76,000 in 1993. Payment is based on a fixed-rate capitated contract, and services not provided by the HealthPASS are paid for through normal FFS means. The state is currently seeking to expand the program to cover all of Philadelphia County, and five additional counties as well. Both the HMO and HealthPASS programs are reported to be successful in saving money, improving access, and limiting misuse.

Medicaid in **Tennessee** contracted with the Tennessee Primary Care Network to create an HMO for Medicaid recipients. AFDC recipients in certain areas of the state are eligible for the program, and enrollment is voluntary. Approximately 16,000 recipients participated in 1993. Savings are built in to the program because the monthly capitation rate paid to PCN cannot exceed 95% of what it would cost to provide the same services to non-enrolled recipients. Tennessee also runs two case management programs for pregnant women, infants, and children up to age two who are Medicaid recipients.

Only recently has **Texas** began to look towards managed care as a solution to control Medicaid costs. Two pilot programs are currently in use. The first is an all-inclusive care program for the elderly on Medicaid called PACE. The program is only available in El Paso, and it is in the process of making the transition from a partially to a fully capitated system. What makes this program unusual is it concentrates on the high risk elderly population, instead of the lower risk AFDC participants, as most HMO plans do.

Texas is also piloting an HMO program in Travis County. Medicaid recipients have a choice between a federally-qualified HMO and a non-comprehensive PHP. The HMO is fully capitated, and the PHP is capitated only for primary care services. A primary case management program (PCCM) is also in the works.

Wisconsin enrolls Medicaid recipients in Dane, Eu Claire, and Milwaukee Counties into HMO's to receive their medical care. Nine HMO's served approximately 120,000 MA/AFDC recipients in 1993. All MA/AFDC recipients in Milwaukee County are mandatorily enrolled, whereas due to a lack of providers only enough AFDC recipients to fill the HMO's are required to enroll in the other two counties. A study in 1987 claimed that the HMO program saved over $100 million in Medicaid dollars for the period from 1984-87, and an addition $20 million in savings was projected for the following two years.

Plans are underway to implement a primary care provider case management program, a high-cost case management program targeted a long term and chronic care recipients, and a pilot program to provide coordinated medical and social services to disabled Medicaid recipients. Wisconsin will also participate in the OnLok project for nursing-home eligible elderly, and is discussing managed care plans to cover areas of the state where these other plans may be unfeasible.

Managed Care: Recommendations

New York State must follow the lead of other states in implementing aggressive managed care plans. In fact, 15 states nationwide have applied for or received 1,115 waivers from HCFA to implement managed care on a mandatory basis statewide. The fact that New York State has continued to offer an abundant range of optional benefits outside the confines of a managed care arrangement and with little effort to impose control over how the services are approved and paid for, has contributed substantially to the program's costs.

Additionally, New York State's Medicaid program spends millions of dollars on the delivery of treatment to clients with chronic alcohol abuse problems. These individuals are not required to enroll in managed care programs and therefore do not have access to a primary care physician. New thresholds and time limits on the delivery of Medicaid-funded alcohol and drug abuse treatment should be considered.

As NYS DSS has recommended, we believe that managed care enrollment be a pre-requisite for access to optional services. This may serve as an incentive for accelerated managed care growth.

We further recommend that the state apply for a federal waiver to transfer the Home Relief (HR) population to Medicaid with the condition that they would be enrolled mandatorily in managed care programs. The state would be meeting the federal test for providing coverage to an uninsured population for federal purposes while at the same time entitling the state to Federal Financial Participation (FFP) for HR coverage. Currently, the state receives no FFP for its coverage of the HR population and loses its Federal Disproportionate Share Payments for every HR recipient enrolled in managed care. Making services to the HR population part of the FFP part of Medicaid will provide immediate savings to state and local governments. Additional savings will be realized by putting this population into managed care. FFP for HR would place HR and ADC cases on an equal footing, enabling across-the-board reductions in access to optional services.

Long Term Care

Some of the costs of long term care, like nursing facility services and home health services, are federally mandated. New York State also provides non-medical personal care services for the elderly as an optional service. Long term care is the fastest growing part of Medicaid, as illustrated previously in Figure 2. Between 1983 and 1993, the cost of long term care has grown from $2.0 billion to $5.7 billion, now nearly a third of total Medicaid spending in New York State.

Long Term Care: Interstate Comparison & Overview

We have seen that New York State spends more than other states in providing most Medicaid services. This is true in the area of long term care as well. Medicaid has effectively become two programs, one for the health care needs of the poor and the other a program for the elderly, many of whom are middle class. Figure 25 shows Medicaid spending by social security recipient (as a proxy for total population over age 65) for the states under consideration. Against this measure, New York State spends more than double any comparison state.

Nursing Home Care

Nursing home expenses dominate long term care expenditures in each state. State Medicaid expenditures for SNF care per recipient basis are shown in Figure 26. New York State spends more than double most other states for each nursing home resident. The different states employ complex and diverse methods for nursing home reimbursement. Table 8 gives the average rate for each state, rate for different levels of care where applicable, and the range of reimbursement rates where available.

Table 8: Medicaid Nursing Home Care				
State	Level of Care (State Classif.)	Average Medicaid Per Diem Rate	Range of Medicaid Per Diem Payments	Per cent Medicaid Resident Days (1992)
Tennessee	Level II	$106.31	$66.98 - $116.46	82.64
	Level I	$65.41	$48.14 - $68.09	
Texas		$59.70	$47.45 - $100.57	75.56
Illinois		$70.17		61.25
Michigan	Class III	$94.16		72.96
	Class I	$68.78		
North Carolina	SNF	$90.39	$70.55 - $97.04	72.71
	ICF	$68.02	$58.40 - $72.49	
Wisconsin		$75.03	$33.88 - $91.16	69.76
Maryland		$81.80		70.03
California	Level B	$76.82	$71.10 - $86.89	69.24
	Level A	$57.04	$55.17 - $60.21	
Ohio		$90.00		73.32
Pennsylvania	SNF	$81.41		60.05
	ICF	$68.85		
Minnesota		$88.21	$44.37 - $229.88	63.17
New York		$130.00	$55.00 - $244.00	83.43

Source: HCIA and Arthur Andersen

The table shows that New York State has the highest average per diem Medicaid reimbursement of any state in the comparison, and an exceptionally wide range of reimbursement rates to individual facilities. Along with Tennessee, which also has a high Medicaid reimbursement, over 80% of New York State's nursing beds are filled with Medicaid patients at any given time. Figure 27 shows the percentage of Medicaid resident days for the states with the highest and lowest for 1993.

While the cost of care in New York State's skilled nursing facilities greatly exceeds other states, the labor costs in those facilities do not appear to, according to surveys taken by the Hospital and Healthcare Compensation Service. Categories of employees with varying skill levels are listed in Table 9, which shows that the median hourly wages in New York State's nursing homes are below the national median, in some cases substantially lower. Only the Certified Nurse Aide is paid above the national median. The hourly wages are representative of all types of homes, proprietary and not for profit, and all bed sizes. It should be noted that the number of respondents in some states in some labor categories was not sufficient to make the survey authoritative for all labor categories for all states. However, this research is a valuable tool that allows comparison across states.

Table 9: Median Hourly Wages for Nursing Homes						
State	Staff Nurse (RN)	Charge Staff Nurse (RN)	Practical Nurse (LPN)	Charge Nurse (LPN)	Certified Nurse Aide	Nurse Aide (w/o Cert.)
California	$17.63	$18.20	$14.06	$13.66	$6.26	$7.28
Illinois	$15.16	$13.00	$10.53	$10.66	$5.92	$4.38
Maryland	$17.87	$16.60	$11.76	$13.67	$6.73	$5.65
Michigan	$14.52	$15.00	$12.80	$13.70	$6.34	$6.90
Minnesota	$15.02	$15.04	$11.41	$10.37	$7.99	$7.56
New York	$15.07	$14.13	$9.10	$9.41	$7.33	N/A(1)
N. Carolina	$15.69	$14.13	$11.85	$11.64	$6.02	$6.47
Ohio	$16.42	$14.94	$12.86	$12.29	$6.68	$6.58
Pennsylvania	$15.71	$15.43	$11.25	$11.42	$7.52	$6.30
Tennessee	$16.21	$14.91	$10.74	$10.12	$5.13	$5.30
Texas	$13.55	$16.05	$11.37	$10.57	$4.87	$4.51
Wisconsin	$14.74	$14.45	$11.98	$11.08	$6.49	$7.18
U.S. Median	$15.26	$15.33	$11.13	$10.82	$6.03	$6.24

Source: Hospital & Healthcare Compensation Service, Nursing Dept. Compensation Report 1994-95
(1) New York State Law prohibits long term care institutions from hiring uncertified nurse aides

Other characteristics of the nursing home industry in New York State may account for the increased costs. New York has a reputation as a heavily regulated state, where the costs of compliance with state regulations are higher than in other states. These costs of compliance translate into general and administrative costs, and Figure 28 shows the states with the highest and lowest general and administrative costs for nursing homes.

Certain types of homes tend to have higher general and administrative costs. The national average for general and administrative costs was $18.72 per resident day for all types of homes in 1993. System affiliated homes have the lowest administrative cost, $17.67 per

resident day, and not for profit homes have the highest, $21.30 per resident day. Freestanding facilities without system affiliation had higher administrative costs, $18.51, and government owned homes had expenses of $20.87 per resident day. Only 29 of New York State's 630 nursing homes are system affiliated, according to HCIA, an industry consulting firm. About half of New York's homes are proprietary, 262 are not for profit, 56 are run by the state or county governments and eight do not take Medicaid patients. The relative dearth of system affiliated proprietary homes, with especially powerful incentives for cost containment, may contribute New York State's higher costs.

Home Health Care/Personal Care

Turning from nursing home care to home health care, New York State's spending is seen to be even further out of line with other states. Figure 29 shows spending per recipient in New York State is more than double any other state and more than triple most states. Part is explained by New York's personal care program to provide non-medical services to the elderly and other populations, which is unique in its scope and unparalleled in its expense.

In contrast with nursing homes, the median hourly compensation of some labor categories in the home care industry exceed the national median. This is especially true in New York City in the more highly skilled nursing positions, as shown in Table 10. Statewide, however, the median hourly wages are reasonably close to the national median in most categories. As is the case with nursing home rates, the small number of respondents in certain categories in some states does not qualify all of these data as authoritative. Nevertheless, on balance these numbers allow for reasonable comparisons across states and regions.

Table 10: Median Hourly Wages for Home Care						
State	Staff Nurse (RN)	Hi Tech Nurse	Practical Nurse (LPN)	Home-maker (HCA I)	Home Health Aide (HCA II)	Homemaker-Health Aide (HCA III)
California	$20.56	$20.95	$15.34	$7.75	$9.20	$9.00
Illinois	$18.88	$15.61	$12.49	$4.60	$8.62	$5.53
Maryland	$17.64	$18.80	$21.55	N/A	$7.94	$9.50
Michigan	$17.40	$17.55	$15.87	$4.87	$7.46	$7.18
Minnesota	$15.60	$18.37	$14.90	$7.24	$8.65	$9.10
New York	$19.00	$17.99	$16.95	$6.88	$7.00	$7.41
NY City	$27.02	$31.73	$19.62	$6.88	$7.74	$7.40
N. Carolina	$16.50	$15.95	$13.83	$6.95	$6.30	$5.53
Ohio	$16.07	$17.41	$14.50	$5.20	$7.59	$7.41
Pennsylvania	$16.64	$16.97	$14.28	$6.25	$7.75	$7.00
Tennessee	$15.16	$15.87	$10.30	$5.29	$6.86	$7.30
Texas	$17.00	$17.46	$11.00	$4.38	$7.50	$6.35
Wisconsin	$15.18	$15.18	$10.75	$5.29	$7.10	$6.97
U.S. Median	**$16.38**	**$18.13**	**$12.00**	**$5.75**	**$7.40**	**$7.17**

Source: Hospital & Healthcare Compensation Service, Nursing Dept. Compensation Report 1994-95

The use of personal care services (as an optional service under Medicaid) varies dramatically from state to state. All of the states in our study utilized mechanisms to control payment rates to providers. States not operating solely under special waiver programs have made concerted and bold efforts to maintain realistic program costs:

Services in **Michigan** are capped at $350 per month with services for recipients in group home settings, receiving a lower reimbursement rate.

California reimburses providers at a rate slightly above minimum wage and requires counties which are also payers of the service, to pre-approve all services. Counties in California pick-up 35% of the Medicaid share for these services and are therefore not likely to over prescribe services.

Maryland sets strict per diem rates for PC Level I ($10 per diem), Level II ($20 per diem) and Level III ($25 per diem). Maryland also eliminated the service for non-federal eligibility categories of recipients which eliminated 22,000 recipients from the program.

North Carolina limits services to 80 hours per month. Providers use para-professional aides and are reimbursed at a rate of $10.80 per hour. Waivers are operated for special populations including children, disabled adults and the developmentally disabled.

Wisconsin maintains the most generous program with no limitations on hours of service. However prior authorization is required after 250 hours of service per calendar year. In 1993 the state spent $28 million on PC for 7,000 recipients. Wisconsin did cut program costs for home care services across the board significantly in 1994 yielding $100 million in savings. Success was attributed to 1) strict prior authorization for all services 2) an effort to mirror Medicare guidelines as much as possible.

Asset Transfer Rules Encourage Middle Class to Seek Medicaid Eligibility

The costs of over 80% of SNF beds in the State of New York are paid for by Medicaid. Eligibility for Medicaid is determined by a complex set of rules governing income and asset levels, including the type of assets that can be retained without jeopardizing eligibility and the "look-back" period before which other assets can be transferred to other ownership. The explosive growth of the cost of long term care in New York has been attributed to relatively liberal asset transfer rules, particularly for home care.

Determining actual asset transfer behavior is extremely difficult, thus estimates of the cost effects of changes in asset-transfer regulations are highly uncertain. With an authoritative evaluation of spend down behavior, CGR and NYSAC will be able to predict the budgetary

impacts of policy changes such as more stringent asset transfer rules or increased use of LTC insurance. Funded by a grant from the Robert Wood Johnson Foundation, the State of New York has been piloting a program aimed at encouraging more extensive use of LTC insurance.

Different states have taken varying approaches to dealing with the asset transfer problem. These are summarized in the following section.

Maryland

The state has taken some steps to control Medicaid estate planning and close loopholes, e.g. 1992 regulations attribute all funds in a joint account to the Medical Assistance applicant. New regulations and policy materials have been drafted in response to OBRA 93. There is a strong Medicaid estate planning bar and the most common artificial impoverishment techniques are the use of trusts and annuities.

Divestiture control, liens and estate recovery have not been especially politically sensitive. No estate recovery is permitted if there is a surviving spouse, blind or totally disabled child or child under 21. Maryland was the first state to establish a real property lien program and expects to recover about $2 million in 1994. The Department of Health and Mental Hygiene has the authority to make claims against the estates of deceased Medicaid patients. Estate recoveries over the last 10 years have averaged $1.4 million annually.

Private long term care insurance is readily available and there are adequate home and community based care and assisted living facilities.

There has been no significant change in the percentage of Medicaid to private pay patients in nursing homes since 1986 and there have been no recent changes to the Medicaid budget and to nursing home reimbursement levels.

Minnesota

Minnesota is controlling Medicaid estate planning by seeking federal approval through waivers and state plan amendments of provisions representing the largest loopholes. A commission has also been set up to study long term care. Legislation is also being developed

to implement options permissible under OBRA 93. There is a strong Medicaid estate planning bar in the state.

The most common artificial impoverishment techniques are purchasing annuities and the making of outright cash gifts. Divestiture control, liens, and estate recoveries have been politically sensitive, but recent legislation has been successful nonetheless. The Medicaid lien program was passed in 1993 and no revenue information is yet available. Under the Medicaid estate recovery program the total state and federal funds recovered have averaged between $5 and $9 million since 1990.

The state has a variety of alternatives to nursing home care, but qualifying standards are similar to those for nursing home level care. There is no high quality long term care insurance program.

Pennsylvania

The state has recently tightened the regulation of the resource "burial reserves" as an eligibility loophole. They are developing new state legislation in response to OBRA 93. There is a strong Medicaid estate planning bar. Medicaid qualifying trusts are the most commonly used artificial impoverishment technique. Real property liens have been especially politically sensitive, but there is no overall Medicaid lien program or estate recovery program.

Personal care homes, domiciliary care homes, and other assisted living facilities are statewide alternatives to Medicaid and private long term care insurance is available.

The increase in the number of Medicaid recipients in nursing homes from 91 to 93 is greater than the increase in the state's population over 65 years of age. The increase in total Medicaid payments to nursing homes has been 201.6% between 1986 and 1993.

Illinois

It has been recently recommended that the Illinois Department of Public Assistance be given the authority to:

- file liens on property owned by Medicaid recipients
- recover the cost of medical assistance provided to a permanently institutionalized individual before age 65, and
- recover assistance from the estate of the recipient's community spouse.

Discussions are underway to strengthen the Department's ability to control Medicaid estate planning. OBRA 93 is under review and changes in state law are anticipated for implementing the 36 month "look back" period and for the trust provisions. There is a large Medicaid estate planning bar and burgeoning elder law industry in Illinois.

One of the most common impoverishment techniques is for adult children to claim services were provided over a number of years in order to justify a transfer to them. Divestiture control and estate recovery have been politically sensitive and there is ongoing concern that more restrictive Medicaid policies may affect vulnerable seniors.

The state began a Medicaid lien program in 1994. Under its Medicaid estate recovery program, the state recovered $6.2 million in 1993 and incurred $437,000 in costs. Officials state that there are cost-effective alternatives to Medicaid available, such as home care, assisted living and private long term care insurance.

The Medicaid census in nursing homes has increased from 61% in 1982 to 67% in 1992. The long term care component of medical assistance expenditures has risen from 29% in 1984 to 35% in 1992. Nursing home reimbursement levels have increased from $29.11/day in 1983 to $70.80/day in 1993.

California

Legislation was recently enacted which requires the filing of TEFRA liens and liens against the real property assets of surviving spouses. California has a federally approved Long Term Care Partnership Program that permits a disregard of certain assets, for eligibility purposes, for individuals who have approved long term care insurance. The state is in compliance with OBRA 93 requirements.

The national Academy of Elder Law Attorneys is active in Medicaid estate planning and many attorneys contact eligibility workers in order to discover loopholes. Prior to OBRA 93, the most common impoverishment technique was to transfer real property into joint tenancy or similar forms of ownership. The Estate Recovery Program has been a sensitive issue and advocates such as the California Advocates for Nursing Home Reform have been very critical of recent legislation. California is implementing a Medicaid lien program in order to comply with mandatory state legislation. Since 1990/91, its Estate Recovery Program has annually recovered between $20 and $22 million while spending between $1.5 and $1.8 million.

As a Medicaid alternative, the state supports a federally approved in-home supportive services program, as well as a federally approved long term care partnership program.

The average census of Medicaid patients in nursing homes has been between 60% and 70% over the last 10 years. A drop in the total nursing home census in the last few years has caused a higher per patient day expenditure by the Medicaid program.

New York State

New York has recently closed a loophole which involved the creation of special Medicaid-qualifying trusts. Enabling state legislation is currently pending which would implement the OBRA 93 transfer, trust and Medicaid recovery provisions.

Medicaid estate planning is extensively used in New York, both by attorneys and certified financial planners. Both groups often contact Medicaid personnel for eligibility information.

The most commonly used impoverishment techniques include transfers, purchase of exempt assets, establishing joint accounts and annuities. The transfer of assets to children is probably the most popular. Prior to OBRA 93, many elderly were able to avail themselves of the state's extensive Medicaid home care services, due to loopholes in federal Medicaid law regarding asset transfer. Approximately 55% of patients in New York nursing homes are Medicaid-eligible at admission. Based on a comparison with Connecticut, state officials have concluded that divestiture is more common in New York.

Divestiture control, liens and estate recovery have been politically sensitive. Anecdotal evidence suggests that adult children of seniors may be more concerned than their parents regarding OBRA 93 provisions in this area.

New York has a Medicaid lien program administered by 58 counties and other local jurisdictions. Recoveries are reported to the state, although they are commingled with "other refunds," precluding a cost-benefit analysis of the program. The state has also implemented a Partnership for Long Term Care Program, a public-private partnership which links private insurance to Medicaid.

Overall, about 83% of all nursing home resident days in New York are paid for by Medicaid and the percentage who are eligible at admission appears to be increasing. Projected Medicaid expenditures for nursing facilities are $4.7 billion in 94-95 and reimbursement rates have risen from $88.17/day in 1985 to $131.65/day in 1993.

Intrastate Comparison

The largest component of long term care service costs is nursing facilities. In fiscal year 1993, Medicaid spending on nursing home care was almost $4 billion, compared to $2.3 billion for personal care and home care combined. The median cost per recipient for a stay in a nursing facility in 1993 was $34,465, as shown in Figure 30. The county with the lowest expense per recipient was in Genesee County, $25,145, and the most expensive was New York City at $57,532.

Spending patterns between personal care and home care suggest that these services are duplicative. For purposes of analysis, we have combined them and call the combined category "home-based care." Spending on home-based care is heavily dominated by Downstate social service districts. The county by county variation in the costs of home-based care (including both home health care and personal care) is significantly greater than that of nursing facility care, as shown in Figure 31. NYC spending on home-based care was almost $22,000 per recipient, roughly four times the median for all the counties. Nassau, Westchester and Putnam each spent more than $15,000 per recipient. Figure 32 shows the distribution of total Medicaid spending on home based care in 1993. Spending on home-based care is heavily

concentrated in NYC and five additional counties. New York, Nassau, Westchester, Erie, Suffolk and Monroe spend 93% of the total.

When calculated as dollars spent per elderly resident, home-based care spending in New York City was over nine times the state median at $1,830 per resident over the age of 65 in 1993. (see Figure 33). Contrary to our expectations, this is not due to high wage rates. The weighted average reimbursement for Personal Care Assistants (both levels) submitted to NYS DSS is $11.35, less than the average paid in many upstate counties. In its favor, NYC also has proportionately fewer nursing home admissions, as does Nassau County, the number two spending county in home-based care. Only 3.6% of NYC elderly are in nursing homes compared with the statewide median of 3.9%. Figure 34 shows the rate of nursing home admissions for the ten highest and lowest counties. Nursing home costs are much higher than the state average, however, leaving NYC tied with Rockland County in total spending on nursing home care per elderly resident. NYC and Rockland both spent about $2,100 per elderly resident, while the statewide median was about $1,300.

The variation in Medicaid spending on total long term care (nursing facility and home-based care) across New York's counties is shown in Figure 35, a map of long term care spending by recipient. As long term care is the fastest growing component of Medicaid spending, it is critically important for policymakers to bring these costs under control.

Long term Care: Recommendations

The Medicaid-funded services providing long term care to New York State's elderly are the fastest-growing part of the NYS Medicaid budget. High costs result from a combination of perverse incentives and duplicative administration. Truck-sized loopholes have enabled a shift of clientele from the poor to the middle class, creating a new and increasingly-costly entitlement complete with a large and powerful political base. As more and more New Yorkers decide to shift their assets to their children and their long term care burden to their fellow citizens, NYS will move further down the path to virtually-universal coverage, something New York taxpayers can ill afford.

Long term care services are currently provided by a broad array of programs and providers. Services ranging from incidental personal care to skilled nursing facility admission

are offered under conflicting eligibility rules through programs with overlapping purposes and unchecked scopes. In some cases, this leads to premature admission to a nursing facility; in others, excessive use of home-based services is the result.

The separation of needs assessment from financial accountability inevitably leads to higher costs. Several initiatives across the state attempt to provide an incentive to balance need and cost. This balance is required at two ends of the spectrum of long term care:

- *More* home care and *less* nursing home care and can save taxpayers a significant amount of money *provided* that home care is used as a diversion from institutional care or as a means of delaying entry to an institution.
- In many cases, home care is approved when not strictly needed, taking money that could be used to meet other societal needs.

Institutions supervising needs assessments must have an incentive to "just say no" unless denying the service will clearly lead to more serious illness or disability. While home-based care can (and should) reduce the need for more costly institutional care, data from across the State of New York demonstrate that home-based care is being provided to many who would *not* otherwise be institutionalized. In some cases, home care would improve quality of life for the recipient and would be desirable if these services were costless. In other cases, denying home care may force a continued independence that will prevent a debilitating dependence and preserve physical and mental capability in the patient.

Link Approval of Care to Financial Accountability

Many of the services provided to the aging are provided at the recommendation of caregivers (such as physicians, hospital discharge planners or CHHA employers) who have no financial incentive to limit the total quantity of care. Unlike a broken leg, the amount of care that can be provided to assist with long term illness or the frailty of age is highly variable. Were money no object, the patient generally prefers more care to less. Yet the amount New York taxpayers can afford to spend for health care is limited. More care for one will ultimately mean less care for another. Without appropriate and realistic financial incentives, caregivers will avoid hard choices about relative need.

The agency approving care must have a financial incentive to limit cost. Providers of home-based care are often allowed to approve a level of care with virtually no oversight from those who pay the bills. Oversight needn't involve a strong-arm bureaucracy. There are many different models of ensuring financial accountability. Several alternatives are discussed below.

Single Point of Access

One model that balances need and cost is the "single point of access" model. The difference in personal care use from county to county demonstrates that differences in philosophy and practice at the social service district can influence the total cost of personal care. Suffolk County, while still one of the largest consumers of personal care services, chose to institute tighter controls on personal care services beginning in 1991. Spending on personal care fell from $58 million in 1991 to $42 million in 1993, a period when personal care spending in most counties rose. The county established "task-based care plans," arming staff nurses with a single page assessment instrument to use in approving levels of care. Suffolk County DSS is confident enough of its new model that it would like to extend its approach to CHHA and private-duty nursing services.

Hold Providers Accountable

The Monroe County Department of Social Services has proposed a different approach. In its *Long Term Care Accountability Proposal*, Monroe County DSS proposes to reduce the level of oversight of providers[4], substituting a common assessment instrument and outcome evaluation. By monitoring total cost of care and patient outcomes, Monroe County DSS believes that it will be in a better position to endorse particular models of care and will simultaneously gather data for use in future experiments with capitated reimbursement. The mere act of publishing outcomes and costs by provider is expected to spur competitive improvement among providers.

[4]Monroe County suggests that providers would be completely exempted from NYS DSS regulations and would be governed only by DOH rules. As a result, each provider—even in the personal care and Long Term Home Health Care Program—would conduct their own assessment, freeing the social service district from the costly double assessment requirement.

Capitated Reimbursement

A capitated reimbursement system has been adopted by the Independent Living for Seniors experiment in Rochester (a PACE project). Intended to maintain at home clients who would otherwise enter nursing home care, the ILS program receives a fixed reimbursement for each of its clients. While many argue that common assessment instruments—permitting both better estimates of service needs *and* better analysis of patient outcomes—must come first, we believe that there is sufficient information available for extensive experiments with capitated reimbursement in long term care. Associations of health care providers that include providers of home care and institutional care should be encouraged to propose large-scale initiatives.

As a first step, capitated reimbursement for home-based care not provided to special populations under a federal waiver should be established on a pilot basis. An agreed-upon assessment tool could assign a prospective recipient into a discrete set of service classes. A lump-sum fee would then be paid to the provider to perform a required set of services. The fee would be set lower than that expected cost of care under a traditional fee-for-service reimbursement model. Savings above and beyond the fixed fee would be retained by the provider who would also absorb losses due to higher service needs.

Provide Personal Care and Private Duty Nursing Only Under Federal Waiver

In keeping with the practice used in other states, New York should make greater use of specialized Medicaid waiver programs which allow the state to design specific care plans for similar populations requiring home care. For example, DSS could apply for a waivers to provide social day care services.

An analysis of the comparison states' participation in the personal care program indicates that New York is one of the only states to offer the program wholesale with few limitations on provider reimbursement, client eligibility or the level and scope of services offered. New York is the only state to offer private duty nursing services with few limitations and not under specialized federal waivers that allow for direct program limitations. Most states offer Personal Care to special populations under special federal waivers.

Where services are not delivered through a special waiver, strict limitations are placed on service hours, provider reimbursement rates and the payers of the services (either the state or county) are required to authorize services prior to delivery. We strongly urge New York State to adopt a similar approach to most optional services, but particularly personal care and private duty nursing.

Waivered programs could be tailored to meet the needs of AIDS patients qualifying for Medicaid home care services as well as Alzheimer patients. These groups are currently receiving standard Personal Care or CHHA level services. These populations are more expensive than the typical geriatric client and younger than the traditional home care client. As other states have found, services are delivered more efficiently and cost-effectively under specialized programs designed for more expensive client populations. None of our comparison states provided services to AIDS patients outside of waivered programs.

Waivers commonly used by other states include the following:

- 1915 (b) Freedom of choice waivers to lock target groups of recipients into particular providers;

- 1915(c) Additional home and community-based services to particular groups of Medicaid recipients to avoid institutional placement. Allows states to define an array of non-medical and supportive services as if they were Medicaid;

- 1915 (d) The "Oregon Waiver" allows a state to consider nursing home and community based alternative expenditures as one capped pool of expenditures. Expenditures which exceed the total cost cap are not federally reimbursable.

Despite a large elderly population, Florida has been tremendously successful in containing costs due to extensive use of the waivers cited above. The key to the waiver's cost-containment is the fact that expenditures are capped, the number of participants are capped and services must be authorized by case managers.

Coordinate Home-Based Care

Medicaid-funded programs serving the long term care needs of the elderly are duplicative and administered by several different state agencies. Personal care services, for example, are administered by NYS Department of Social Services (DSS) while the Long Term Home Health Care Program (LTHHCP), filling many of the same needs, is administered by the NYS Department of Health (DOH) *and* DSS. Home health services and private duty nursing are offered through certified home health agencies (CHHAs) who are generally supervised only by DOH. Nursing homes are principally under the jurisdiction of DOH. The EISEP program is supervised by the Office for the Aging.

Eliminate Duplicative Programs

Minimally, all programs providing home-based care should be merged. The *status quo* is an administrative nightmare that is itself costly and hinders reform efforts. The home-based care program that remains should have effective controls over access, standard rates of reimbursement across levels of care and a single reporting structure.

Some express concern that loss of special services now available under the federally-waivered Long Term Home Health Care Program would increase total cost. Some of these services (particularly social day care) *should* be retained through a separate Home and Community-Based Waiver. If these special services are managed to ensure that they *reduce* expense rather than increase it by displacing the contributions of family, friends and neighbors, then they should be available to all consumers of home-based care, not simply those enrolled in a special program.

Merge Departments of Health and Social Services

The problem of dual oversight is exacerbated by a sense of competition between DSS and DOH that is apparent to all who work with either agency. Both are quite "turf conscious" and, as a result, develop regulations that are not only duplicative, but conflicting. In a paper

titled *Regulatory Conflict in Home Care*,[5] Monroe County DSS itemizes the conflicts between the regulations, noting in the case of home health aide and personal care services that

> The interplay of regulations in this area is at best bewildering. It appears that Social Service Regulations expect the CHHA's to leave case control within local social services bounds as social services is to be responsible for the overall needs of the patient, compiling service requirements, arranging for the delivery of care, monitoring care and authorizing all care. At the same time Social Services Regulations allow a CHHA to provide nursing supervision as long as the plan for supervision is acceptable to the state Health Department and the CHHA assumes all responsibility for the home health aide program. Social Service Regulations require the CHHA to assume all responsibility for the home health aide program, but don't require the CHHA to assume the same responsibility for the personal care services program. According to Social Services Regulations, the CHHA is to recommend appropriate action to the social services case manager which suggests that the case manager is responsible for determining how a clinical problem should be handled. The Health Regulations clearly state that the CHHA is fully responsible for personal care and home health services.

The report continues to itemize specific conflicts between the regulations, noting the state Office for the Aging regulations governing the Expanded In-home Services for the Aging (EISEP) also conflict with DOH regulations.

A case can be made for administering the home care program either under the Department of Social Services (who pays the bills) or the Department of Health (arguably better equipped to oversee a health-related program). As suggested above, however, determination of quality and quantity of care cannot be separated from financial consideration. We recommend that these two departments be merged, eliminating a rivalry that confuses local agencies and providers, exposes social service districts to legal action (because of the volume of regulation and the conflict between DOH and DSS regulations) and increases the cost of health-related social service costs. Were DOH and DSS merged under a common administrative structure, conflicts between quality of care regulation and cost-control

[5]Richardson, Burt. *Regulatory Conflict in Home Care*. Monroe County Department of Social Services, April 1988.

initiatives could be resolved without an appeal to the governor or legislature. We further recommend that the merged department have in-house representation from the Office of Regulatory Reform that would be devoted to reviewing the probable cost of regulations promulgated by DOH/DSS.

Eliminate Cost-Based Reimbursement

While health care providers would resent the suggestion that they are simply adjuncts to government in the provision of health services to the indigent, this is how they are treated financially. In the private sector, parties to a contract agree to a price and both parties assume the associated risk: The contractor assumes the risk of agreeing to pay too much (substantially more than actual cost) while the contractee assumes the risk of cost exceeding the agreed-upon price. The health model is based on the principle of cost reimbursement, the risk apparently wholly borne by the contractor *just as if* the contractee were part of the contractor's organization. The reimbursement model is popular in health care financing for two reasons: First, many believe that competitive pressures will lead to a decline in the quality of care. Second, the contractee is often a public or non-profit entity. From this perspective, cost reimbursement seems only fair.

In the private sector, differences in the age of plant and equipment or the cost of inputs does not affect the price the contractor is willing to pay for services. Bidders with lower costs are more likely to make a profit; bidders with a lower cost basis have a powerful incentive to either reduce costs or find another market. Yet if we believe that we have a moral obligation to reimburse health care providers for costs incurred, then differences in cost basis must lead to different rates of reimbursement. This is, in fact, how most health care providers in the State of New York are paid for services rendered to Medicaid-eligible residents.

In the case of home health and personal care services, reimbursement rates for 410 providers statewide are determined by NYS DSS through a time-consuming review of two-year old audited financial statements. Using a methodology established by the enabling legislation, DSS staff review total spending by several categories of direct care and training cost per service hour (with a ceiling imposed by the trended, centered mean regional cost), add "pass-through" costs that have no ceiling (rents, depreciation, interest on real estate debt and several other costs), add administrative costs per service hour (limited to no more than 28% of direct

cost), a fixed profit (determined by reference to treasury bill interest rates) and a complex trend factor to account for inflation. In the case of Monroe County, this methodology generates 50 separate rates for the personal care program alone for ten different providers. Different providers of the same service are paid significantly different sums as a result. Rates for a Personal Care Assistant Level II, for example, range from $11.20 per hour to $14.45, simply because the providers have a different cost basis. The higher cost provider will receive almost 30% more for providing the same service.

Clearly, the high cost provider has no incentive to reduce cost unless administrative costs exceed the 28% cap or the direct cost per hour exceeds the regional cap. Such a system also invites careful attention to the distribution of costs and internal accounting procedures. Providers who offer only home care services to Medicaid clients have less latitude; firms with a more varied product mix would be well advised to employ a skillful accountant. The methodology also leads to anomalies that are clearly irrational: Personal Care Assistant Level I reimbursement rates in some counties (such as Suffolk and NYC) are actually *higher* than the Level II rates, even though Level II requires a higher skill level. The reason given is that the administrative cost component is spread over fewer hours, driving up the hourly overhead for Level I care.

The level of effort for NYS DSS to calculate and maintain multiple rates for 410 statewide providers is also considerable. As the new governor seeks to reduce the size of the Albany bureaucracy, counter-productive regulations with significant staffing implications should be high priority target.

Establish Uniform Rates

Inefficient providers should not be guaranteed a higher level of compensation than more efficient providers. While some argue that differences in cost reflect a different case mix, different rates are already set for "hard to serve" clients. IF hard to serve clients are difficult to place after imposition of a uniform rate, the "hard to serve" category can be more carefully distinguished, based on a common assessment tool. We believe that, in the absence of competitive bidding, uniform rates should be set statewide, with regional adjustments for wage differentials.

Suffolk County has been awarded a waiver from NYS DSS regulations in this respect. Its first initiative (in 1991) involved directing care hours at low cost providers, offering the high cost providers the opportunity to unilaterally lower rates in order to continue to get business. In 1994, Suffolk received approval for a uniform county rate. While the average PCA Level II reimbursement (as calculated by NYS DSS) for all Suffolk County providers was $12.80, the county received approval to pay a uniform rate of $12.50 to all providers. In 1995, the county has applied for approval of a uniform rate of $13.00, $.43 less than the average rate calculated by NYS DSS for its providers.

Award Personal Care/Home Care Contracts Through a Bidding Process

Suffolk County staff have explored converting the "reimbursement" system to a more conventional private-sector style bid process. Given the level of competition in the personal care/home care market, the county could set up a process to award a fixed number of hours to a limited number of successful bidders. With adequate reporting and oversight, bidders who did not meet quality of care standards would be unable to bid for future contracts or, under certain circumstances, could have existing contracts severed. While uniform rates would be an improvement, we believe that quality care *and* significant cost savings could be achieved through a competitive bidding process.

Overhaul Rate Setting for Nursing Homes

While rate setting for personal care assistants appears convoluted, it is a model of rationality compared to the way reimbursement rates are set for nursing homes. It is, once again, a cost-based reimbursement system. On its face, the system offers a standard reimbursement for direct costs, case-mix adjusted, for every nursing home in the state. Indirect costs are added, based on actual reported costs. An additional factor for "non-comparables" is then added, based on actual reported costs for unusual services such as dental care or staff physicians. Finally, actual capital costs (depreciation and interest, based on historical costs) are added to the rate. The following adjustments are also incorporated into the system, however:

- Direct cost reimbursement varies in a corridor around the base price. The corridor is "asymmetrical" in that it lowers reimbursement more for low cost homes than it raises it for high cost homes. Once again, this has the effect of penalizing efficient producers.
- Indirect cost reimbursement also varies around the base price. For reported costs within the corridor, variation is based on differential wages by region. Unfortunately, the wage adjustment is based on a 1987 wage survey *unless* using the 1987 survey will result in a lower reimbursement than the original 1983 survey. Nursing homes are "held harmless" to changes in wage rates between 1983 and 1987. Relative wage changes since 1987 are ignored.
- Incredibly, all the cost data used for adjustments around the base reimbursement for direct, indirect and non-comparable expenses is based on *1983 financial reports*. All changes in relative operating costs since 1983 are ignored.

Not surprisingly, this methodology leads to significant inequities in reimbursement across the State of New York. As relative wage differentials between the NYC metro area and the rest of the state have narrowed since 1983, downstate nursing homes appear to be relatively better compensated than their upstate cousins, although further analysis is needed for this conclusion to be firm. NYC's dilemma testifies to the problem: Although share of New York's elderly in nursing homes is less than the statewide median, NYC still leads in total cost per elderly resident. This could, of course, be a reflection of an adverse case mix. The difference is striking, however.

Once again, a cost-based payment system rewards inefficiency and encourages creative financial management. As capital expenditures are reimbursed based on historical cost, there is a strong incentive to refinance property when all historical costs have been paid.

A uniform rate of reimbursement for nursing homes, adjusted by case-mix index and current wage differentials, would reward efficient providers and encourage cost-cutting among inefficient providers.

Long Term Care Providers Should Maximize Medicare Reimbursement

All long term care providers should be required to maximize Medicare reimbursement for services delivered. The fact that nursing homes and home-based care providers can receive

higher reimbursement from Medicaid than Medicare encourages premature shifting of costs from one program to the other. As the cost of Medicare is fully reimbursed by the federal government, the local and state governments would save money as a result.

Promote Competitive Climate for Health Care Provision

To what extent is the reimbursement system for NYS health care providers intended to preserve existing institutions? There appears to be strong bias in the system against allowing nursing homes, hospitals or other providers to go out of business. On one level, this is understandable. Health care institutions are major employers and are pillars of their local communities. Unfortunately, the long term health of the community is not served by protecting financially-threatened institutions.

Encourage For-Profit Health Chains to Operate in NYS

Concerns about quality of care and fear of competition among providers have combined to persuade the State of New York to prevent the growth of for-profit hospital and nursing home chains in the state. Health care is arguably the most regulated industry in the State of New York. The state has assumed powers of coercion that can cripple any hospital that violates standards of care. The principal risk from for-profit chains is the risk of streamlined management, increased capitalization (a critical issue for many of NYS's hospitals) and competition with established health care firms.

Stimulate Formation of a Market in Nursing Home Licenses

Nursing home beds, like taxi medallions in New York City, are artificially limited in number. While easing recently, the state has had a severe shortage of nursing home beds, kept limited by the conviction that cheaper care could be provided through other means and that limiting beds was an effective way of preventing costly capital growth (which would, of course, be reimbursed through the Medicaid rate). At the present time, nursing homes can grow only through acquiring another facility, bringing the assets along with the license. We believe that the state should open up the industry to market forces, enabling competitive operators to expand and permitting inefficient facilities to close.

Reduce Regulatory Burden on Agencies and Providers

All segments of the health care industry, including local social service district offices and county departments of health, suffer from costly, unnecessary regulation. The Office of

Regulatory Reform (ORR) should make DSS and DOH regulations a top priority. By convening meetings of county-level specialists, ORR should identify areas in which NYS exceeds the strict requirements of the federal code (such as the requirement that NYS social service districts make an eligibility determination in 30 days, instead of 45 days as required by the federal government) and work to reduce the requirement to the federal level.

Excessive regulation by DSS and DOH regarding specific care requirements opens up all members of the health care industry to lawsuits from advocacy groups. Fortunately, high quality care and regulatory conformity are not the same thing. The state would do a service to the industry by implementing simple, common assessment procedures and publishing the results. The risk of negative publicity for consumer-oriented institutions would encourage the highest cost-effective standards of care.

Develop Meaningful Nursing Home Cost Comparison for NYS and Comparable State Nursing Home Care

Due to differences between the services included in NYS reimbursement rates and nursing home reimbursement rates of other states, it is difficult to "benchmark" the performance of NYS homes against those in other geographic areas. As part of an effort to rationalize nursing home reimbursement/pricing, the state should conduct a thorough analysis of comparative costs. The claim by upstate homes that downstate homes are better compensated is difficult to confirm or deny with available data, for example.

Rationalize Eligibility Rules for Home Care and Institutional Care

The relatively high cost of private nursing home care (driven ever higher by below-cost Medicaid reimbursement) encourages widespread estate planning aimed at Medicaid eligibility. The appeal of "protecting your life savings" has created an industry of financial advisors and elderlaw attorneys who specialize in devices to protect assets from Medicaid. This phenomenon effectively makes Medicaid a middle class entitlement program.

Perceived inequities in the program (particularly asset and income rules between home care and institutional care) and the fact that Medicaid eligibility through "strategic impoverishment" has become the expected thing (everyone is doing it . . .) has virtually

eliminated any stigma that was once associated with Medicaid eligibility. The fact that the transition from private payment to Medicaid reimbursement is seamless within NYS nursing homes makes any remaining stigma irrelevant. As a result, the wealthiest group of retirees in United States history are paying remarkably little of the costs of their own long term care.

Use of long term care services is further complicated by eligibility requirements that vary significantly between home health care (HC) and institutional care (IC). Essentially, eligibility for HC or for single persons requiring IF are no different than eligibility for any other Medicaid service: The person receiving care and his or her spouse (in the case of HC) must be essentially destitute to qualify. As designed, Medicaid is a program for the poor.

Asset rules for institutional care for married couples are different, however. In the event that one member of a married couple household must enter an institution, the spouse remaining in the community can retain almost $75,000 in assets plus any amount of equity in a home. On its face, this difference appears to encourage institutional care in the event that one member of a married couple household requires long term care.

Unfortunately, the situation is further complicated by different "look-back" requirements in HC and IF. The state considers assets either given away within 36 months of application or put into trust within 60 months of application to be eligible to pay nursing home costs, thus delaying Medicaid eligibility. There has been no look-back period for HC, however (although this change has been proposed by Governor Pataki). This provision permits virtual instant eligibility (in terms of assets) for HC, thus encouraging use of extensive HC services when institutional care may be a more appropriate alternative.

Consider Less-Restrictive Eligibility as Trade-Off for Higher Compliance

Practicality suggests that consideration be given to eligibility requirements that are less strict, not more strict. Elderlaw attorneys are capable of finding loopholes in virtually any legislated change. The challenge for public policymakers is to make a case for compliance through a set of rules perceived to be equitable, and simultaneously increasing the cost of avoidance. Were the assets and income allowed for eligibility more generous, compliance with the clear purpose of the program might be more likely.

Eliminate "First Dollar" Coverage

The use of Medicaid to finance long term care for the middle class is not a problem limited to the State of New York. Further study of the impact of alternative eligibility rules on behavior is needed. As the average stay in a nursing facility is less than three years, many suggest that initiatives that eliminate "first dollar" coverage (i.e. have the effect of encouraging the recipient to pay for initial stages of care) can reduce total costs significantly. Present eligibility rules have an "all or nothing" quality: Medicaid coverage is only guaranteed when the recipient can demonstrate legal impoverishment.

A NYS initiative funded by the Robert Wood Johnson Foundation offers automatic Medicaid eligibility (from an asset, not income, perspective) to individuals who purchase long term care insurance that covers the first three years of need. Incentives to participate in this program should be strengthened.

Other alternatives that have the same effect should be explored. Analysis of the extent of private pay v. Medicaid coverage for nursing facility care in the state would be useful. It is difficult to determine what share of the resident population of nursing homes manipulated their assets to achieve eligibility, although with 83% of resident days now paid for by Medicaid the proportion is probably quite high. Modeled loosely on the long term care insurance initiative, the state should explore liberalizing eligibility guidelines in terms of assets in exchange for the elimination of the "first dollar coverage" characteristic the program now entails. Medicaid eligibility for long term care could be provided as a publicly-funded insurance policy with a substantial deductible. At the present time, for those who plan ahead with good legal advice, the policy carries no deductible with respect to assets.

Develop Viable Reverse Mortgage Option

The treatment of home equity in asset calculations should be restructured. Although the state attaches a lien to property at the time that eligibility is determined, the time from the period from the time the lien is attached to the point at which the estate is ultimately settled is often substantial. More aggressive *ex post* attachment of estate assets is one alternative (other states are more successful at asset recovery; New York State could learn from their experience). More effective use of a "reverse mortgage" through which home equity can be

withdrawn from a residence on a periodic payment basis. Just as New York has worked with the insurance industry to develop the long term care insurance initiative, an effort with the financial industry to develop a viable reverse mortgage option could be fruitful.

By bringing a private financial entity into the relationship, the state would secure its share more quickly and assign the residual asset value to an institution that is better-equipped to look after its continuing value. It is not uncommon to find that homes are left abandoned for years following the admission of the owner to an institution. In such cases, there may be insufficient value remaining to satisfy the state's lien. The state could contribute to the formation of the asset in various ways, acting as guarantor of a life estate in the family home, for example, insuring that the Medicaid recipient or spouse will keep their home as long as it is needed.

Tighten Controls Over Estate Planning Aimed at Medicaid Eligibility

Strict and vigorous enforcement of asset-transfer prohibitions is a necessary part of any attempt to reform eligibility standards, particularly if eligibility rules are liberalized in any way. The 36 month look-back period on transfers (which Governor Pataki recommends extending to home care) could be lengthened to conform to the look-back period on trusts. Loopholes will have to be policed assiduously, with frequent changes in statute, if necessary. The moral justification (and political will) for strict enforcement might be achieved if eligibility criteria are rationalized first, however.

Current Federal and New York State laws allow a Medicaid applicant to have $3,200 in exempt resources, $1,500 burial reserve and unlimited burial items such as burial spaces, caskets, burial crypts, headstones etc... The current Federal and New York State Law allows the Medicaid applicant to buy these same items for any blood or marriage relative. There are no limits on the costs of these allowable burial items.

<u>Limit Burial Exemption</u>

We proposed that the total amount of money that is allowed for burial items be limited and that further limits be placed on relatives for whom these items can be purchased (i.e. spouses, and dependent disabled children). At the same time, while tightening the loophole

that permits the burial exemption to be used to shift assets, it is important to ensure that the allowance for an individual's burial expenses is adequate.

Extend Recovery Period

Currently, asset recoveries can only be made from the estates of deceased Medicaid clients who were 55 years or older when they died. Recovery from estates is only allowed for up to 10 years of Medicaid-paid-for medical care; many persons are in receipt of Medicaid benefits for more than 10 years. There is also a prohibition against recoveries if the Medicaid recipient is survived by a spouse, minor child or disabled child of any age.

We recommend that recoveries be made for the estates of persons for any age for an unlimited number of years of Medicaid-paid-for care. Also, these recoveries should be pursued unless the client is survived by a spouse, minor child or dependent disabled adult.

Encourage Family Responsibility

Current Medicaid law allows parents to have their income/assets exempted from consideration in the Medicaid eligibility process when their disabled child receives care in certain medical institutions (nursing homes, developmental centers) or in the Care at Home Programs. We propose disclosure of parental income/assets for these now exempt situations and development of a sliding scale support schedule that would make the parent responsible for a portion of their child’s Medical care, but not impoverish the parents.

In a related area, Section 3666(a) of the NYS Social Services Law currently permits persons who live with legally responsible relatives to receive Medicaid if the legally responsible person refuses to meet their medical needs. This contravenes existing federal regulations and permits a spouse or parent to obtain Medicaid for their spouse or child meeting other needs. This places the burden on the local district of initiating litigation against such spouse or parent to recover costs. This requirement is inconsistent with other need based programs administered by DSS and is an unnecessary burden on the legal resources of local social services districts. Medicaid expenditures would be substantially reduced on the local, state and federal levels as Medicaid eligibility could be denied to inappropriate cases where a legally responsible relative has simply refused to meet the medical needs of their dependent.

Current Medicaid regulations allow relatives (typically the adult children of the Medicaid applicant) to be credited with 50% of a joint bank account (between the relatives and the applicant). This allows the applicant to become eligible for Medicaid benefits, without first exhausting the total amount of this resource, even though most or all of the money in the account was initially and exclusively the saving of the applicant.

Consider Segregating Long term Care Services for the Elderly

The State of New York should consider developing a program for statewide implementation under federal waiver that would separate all services for the elderly from the established Medicaid program. Institutional care, home care and personal care services for eligible persons over the age of 65 would all be administered jointly. Home care and personal care services for the non-elderly would remain untouched by the waiver.

The benefits of a separate program would be twofold: First, coordination of long term care services for all levels of acuity would be easier. Second, a separate program can more easily accommodate different eligibility rules.

Conclusions

New York State can no longer afford to spend $19 billion dollars per year on Medicaid. The Medicaid program meets the needs of many and employs a large number of state residents, yet the state's capacity to fund social services in the future will depend on preserving its fiscal stability. We urge the state to take steps to foster a climate of competitiveness. The long-run well-being of the people of the state depends on a dynamic economy that continues to retain, grow and attract quality employment.

The formula for reform is complex. As all parts of the health care industry are wholly or partly dependent on public reimbursement, the state must take the lead in making lasting change. We must exchange antiquated reimbursement methodologies for simple pricing systems that reward the efficient and encourage others to reduce cost or leave. The state's restrictions on out-of-state health care investment should be lifted, allowing for-profit health

care corporations to stimulate change in our hospitals and nursing homes. Facilities must be allowed to fail.

A solution must be found to the problem of long term care. As Baby Boomers age, the pressure on systems supporting the aging will dramatically increase. If present trends continue into the next century, New York taxes will drive business and individuals from the state in record numbers. Members of the Baby Boom will not begin demanding long term care services for another decade or so. Let's reform the system while we have a chance.

Finally, the state should aggressively pursue the deregulation of this industry. While all agree that quality of care is critically important, excessive regulation takes health care providers away from patients. Nursing homes, hospitals, home care providers and social service districts spend far too much time and far too many taxpayer dollars simply conforming to regulations. The NYS Office of Regulatory Reform should convene forums across the state with providers and local officials to identify regulations that add more to cost than they add to the quality of care.

We applaud Governor Pataki's commitment to tame the Medicaid monster. Bold action and political courage will be needed to effect fundamental, lasting reform. Lawmakers, providers and advocacy groups must work together to plan for the future, not protect the past. The future economic vitality of the state is at stake.

Appendix A: Summary of Recent Reforms and Cost Control Measures

DSS Initiatives

Podiatry

Podiatry is an optional service under the federal Medicaid regulations. States are required to provide coverage for podiatry services to children under 21 as a part of the Early Periodic Screening and Diagnostic Treatment (EPSDT) program. New York State law requires coverage for all Qualified Medicare Beneficiaries and DSS decided to maintain coinsurance and deductible for all Medicare/Medicaid dual eligibles. Medicaid continues to pay for podiatry services when provided as a part of a clinic service when the all inclusive clinic rate is billed. The proposed New York State Health Access Plus initiative would eliminate this coverage.

The federal, state and local cost savings from eliminating coverage of podiatry services are estimated to be $2.5 million.

Medical Care Coordinator Program

A program scheduled for implementation in 1992 would have limited medical coverage to the Home Relief (HR) population. This program was known as the Medical Care Coordinator Program, and it gave HR recipients the option of receiving care through a managed care or primary care coordinator or receiving a reduced package of benefits through a physician who was not a part of the program. The services not covered in this instance included nursing home care and other long term care services.

A court injunction prevented the implementation of this program. The expected annual savings from this program were $29.7 million, $21.1 million in state and $8.6 million in local savings.

Home Relief Inpatient Limitation

This was proposed in 1992, and would have limited inpatient Medicaid coverage to 32 days per year maximum for the Home Relief population. It was litigated and never implemented. The expected annual savings were $86.8 million, with $43.4 million in federal and $21.7 million each in state and local savings.

Infertility Treatment

While family planning is a federally mandated service, states have the option of providing infertility treatment. DSS is in the process of eliminating this coverage with a combined federal, state and local savings of between $500,000 and $1 million annually.

Co-Payment

In 1992, nominal co-payments were implemented for certain specific services. Examples include a $25 co-payment for an overnight inpatient stay and a $3 co-payment for non- emergency room visits. The Pharmaceutical Society of the State of New York brought litigation against the co-payment for prescription drugs ($2 for brand name drugs, $.50 for generic) and this portion has not been implemented.

There are a number of exemptions mandated by the federal government, such as inability to pay, and some provided by the state. Annual savings from the co-payments are approximately $18 million federal, state and local.

Transportation

The Executive proposed to restructure non-emergency medical transportation in the 1994-95 budget. The proposal shifted all provider transportation other than emergency ambulance services and transportation for the mentally disabled from program spending to administrative spending. Under the proposal, the legislature would appropriate funds to be allocated to each district as a block grant for the district to administer. The total savings was $99 million, with a state share of $24.75 million. The legislature rejected the proposal.

Medicaid Drug Utilization Review

In accordance with the federal Omnibus Budget Reconciliation Act (OBRA) of 1990, DSS implemented a Drug Utilization Review (DUR) program for state Medicaid beneficiaries in January, 1993. There are two separate parts to the program, a Prospective DUR (ProDUR) and a Retrospective DUR (RetroDUR). Both programs are intended to insure that prescriptions for outpatient drugs, which is not a federally mandated service, are appropriate, medically necessary and not likely to result in adverse medical consequences.

ProDUR aims to prevent inappropriate prescription acquisition by patients; RetroDUR is designed to educate inappropriately prescribing physicians. The estimated annualized savings from ProDUR are $900,000 and $7.4 million from RetroDUR.

Recipient Restriction Program

DSS has administered the Recipient Restriction Program (RRP), since 1978. The program designates primary providers for selected Medicaid recipients with a demonstrated pattern of abusive utilization of services. Recipients may also be restricted for engaging in fraudulent practices, such as selling drugs obtained through Medicaid or loaning Medicaid cards. Since 1978, 42,362 individuals have been restricted to primary providers. DSS estimates the program has resulted in state savings of $200 million since 1991.

Utilization Threshold Program

In 1990, DSS developed and implemented the Utilization Threshold (UT) program for Home Relief recipients between the ages of 21 and 64. This program established thresholds or service limits on the number of physician and clinic, pharmacy and laboratory services that Medicaid would pay for. In 1991, the program was expanded to all Medicaid eligible persons.

Thresholds were established for mandatory and optional ambulatory medical services by reviewing past use by New York State's Medicaid recipients. There is a detailed procedure for threshold exemption at the request of the recipient or provider. The program is thought to have achieved its goal of reducing unnecessary use and abuse of medical services and realizes estimated total savings of $59 million annually with a state share of $17.7 million.

Personal Care Reforms

Personal care is an optional benefit under the federal Medicaid program. New York has made various attempts to curtail the benefit provided under the personal care services category and the rate of expenditure growth.

The 1992-93 Executive Budget proposed a cap on personal care service hours of no more than 156 hours per month. The subsequent statute was challenged in the courts. Projected state savings from the proposal were $200 million annually.

The 1991-92 Executive Budget proposed eliminating personal care Level I services. These are the least intensive home care services available and involve housekeeping tasks. This legislation was not enacted. Projected state savings were $25 million.

Another provision of the 1991-92 Executive Budget was an initiative to establish utilization standards in personal care services. This was prompted by a wide variation in the number of hours of personal care services prescribed throughout the state. Some high cost home care cases analyzed by DSS exceeded nursing home care. Instead of establishing standards, limits were imposed on the availability of home care which exceeded certain costs. The limits have yet to be resolved in the courts.

A 1989-90 proposal later enacted into law made Personal Emergency Response Systems (PERS) a service under the Medicaid program outside of Home and Community based service waivers. Initial savings of $5-10 million were achieved and 1992 and 1993 statutes required the use of PERS in reducing home care costs.

In order to address the problem of physicians prescribing hours of personal care unnecessarily in response to family pressure, DSS implemented limits on hours of care. Physicians could still prescribe care by service, but were prevented from specifying the number of hours. Projected state savings are $10 million annually.

The Shared Aide or Cluster Care program was implemented in the mid 1980s to reduce one-on-one care. Shared Aide programs have been increasingly utilized and savings are estimated to exceed $10 million annually.

In response to the large rate increases for personal care services that often resulted from individual negotiations, DSS developed a statewide reimbursement methodology for personal care services. The reimbursement methodology has stabilized rate growth by using an annual trend factor. No savings are projected.

Private Duty Nursing Reforms

Like personal care services, private duty nursing is also an optional benefit. The service must be authorized by a physician with the prior approval of the Department of Health. Recent Executive Budgets have proposed eliminating private duty nursing as a discreet service under Medicaid. The elimination was never enacted.

DSS developed regional payment fees in response to significant increases in the fees paid for private duty nursing services to stabilize cost growth. While the fees have not been formally implemented, the counties and the state have used them in negotiations.

Asset Transfer

The federal government has authorized states to use the same asset transfer rules for home care as for nursing home eligibility determination. DSS estimates that nearly 1,000 individuals gain Medicaid access each year by transferring assets. The necessary legislation was never seriously considered. The annual savings from applying the same asset transfer rules to home care are estimated to be $5 million.

Summary of Comprehensive Medicaid Task Force Report

The Comprehensive Medicaid Task Force, appointed by Lieutenant Governor McCaughey, recently developed and released a report containing proposals for cuts in the state's Medicaid budget. The options presented would cut $1.2 billion from the state's 1995-96 Medicaid budget if taken in total. About half of the dollar total in proposed savings comes from proposed changes in the payment rates to nursing facilities, hospitals, home care providers and personal care providers. Another large savings would come from the proposal to mandate managed care for most Medicaid beneficiaries, excepting the elderly.

The proposal to mandate managed care is based on the state's experience since the passage of the statewide Managed Care Act of 1991. Under the proposed initiative, the Department of Social Services would seek a waiver from the U. S. Health Care Financing Administration to enroll all Medicaid recipients into a form of managed care, a full or partial capitation plan or a primary care coordinator plan. The task force makes assumptions about the savings to be derived, 10% for full capitation for example, and determines the total annual savings to be $102 million.

The report contains various proposals to limit health care provider rates to hospitals. The proposals in the report are intended to reduce payment to hospitals for Medicaid patients who are not enrolled in managed care plans. There are some which alter the very complex formula used to calculate Medicaid reimbursement rates, the New York Prospective Hospital Reimbursement Methodology. Others place caps on reimbursement or length of covered stays for different services. The total of the proposed reductions from limiting rates paid to hospitals is $238.8 million.

The recommendations for limiting payments to nursing homes are similar. The report has proposals to lower reimbursement rates generally and for specific costs and services. The total proposed savings for the state are estimated to be $233.8 million. Proposals to limit rates for home and personal care providers include reimbursing at 1994 levels and an administrative and general cost cap for total estimated savings of $66.8 million. Other proposals limit rates paid to pharmacies and free standing clinics.

The personal care program in New York State provides non-medical assistance to Medicaid recipients in their homes. The report recommends eliminating Level I personal care services, basic housekeeping functions, and capping personal care at 100 hours a month. These recommendations are estimated to save the state $87.4 million.

The report also recommends reducing benefits in certain optional services. Non-emergency dental services, clinical psychologist services, private duty nursing, rehabilitation and therapy services and case management services would be eliminated for all adults. Home Relief adults would be eligible for medical care only in hospital inpatient and outpatient departments and in free standing clinics. The total savings from these service reductions would be $57.9 million.

The state could achieve $39.0 million in savings through efficiencies in transportation and other areas. The report recommends local district flexibility, copayments for transportation and incentives for home visitation. Other proposals include changes in long term care eligibility requirements, specifically eliminating the spousal right of refusal, applying asset transfer rules to home care, and reducing the resource level retained by the spouses of nursing home patients.