Independent
Democratic
Conference

Continuing the Redesign of Medicaid: Long Term Care

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I. Introduction:

New York State faces a severe fiscal crisis, having to close a $10 billion projected deficit for Fiscal Year (FY) 2011-12. The Executive budget also points to similar deficits for years to come unless action is taken now. In order to close this gap, the State will have to control spending to ensure that our expenditures align with our expected revenues. It would be impossible for the State to control spending without tackling the escalating costs of the Medicaid program, which accounted for $53.8 billion[1] of the $136.5 billion All Funds budget for FY 2010-11, or 39.4% of the All Funds budget.

The cost of the Medicaid program is split between the federal government and the state government. For New York, this is meant to be an even split with the federal government, though the American Recovery and Reinvestment Act of 2009 (ARRA) increased the federal match to around 63% for New York for a two year period as a way to deliver fiscal relief to the state. The higher Medicaid match expires this year, which means a significant increase in state fund spending for next year. New York is unique in the country in splitting the state share of Medicaid between the state government and local governments equally. This split has placed a significant budget burden on local governments (particularly counties) and in the FY 2006-07 budget a local share cap for Medicaid spending was passed, which capped the county share of Medicaid to 2005 plus a low annual percentage increase. The local share cap means that the share of Medicaid paid by local governments has declined in the last few years, and the state share has increased. The Executive Budget proposal for FY 2011-12 proposes spending $18.5 billion in state funds (excluding matching FMAP funds) out of a All Funds Medicaid budget of $52.8 billion. This would make the state portion of the Medicaid program 35% for FY 2011-12.

New York spent more on Medicaid than any other state in the country, spending billions more than California, which not only has a much larger population but more people enrolled in their Medicaid program than New York. New York was second in per capita Medicaid spending in the country in Federal FY 2007[2], just behind Rhode Island and well above the national average. As our population ages, it will be especially important that we find ways to manage the growth of long term care costs in New York State. In this policy brief we look at what the costs of long term care are to Medicaid and explore some ways to help lower the escalation of costs.

II. Long term care and New York's Medicaid program

According to the United Hospital Fund's Medicaid Institute[3], in February 2010 Medicaid covered 4.7 million New Yorkers, or 24% of the State's 19.4 million residents. The number of Medicaid recipients have increased not only because of the financial hardships imposed on many by the recession but also by several expansions of the Medicaid program that have made benefits available to more and more residents. In 2000 there were 2.7 million recipients out of a state population of 19 million, or 14%. While the state's population grew by only around 2%, the number of Medicaid recipients grew by 57%. This growth in recipients has increased cost. As

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[1] Division of Budget, "2011-2012 Executive Budget Briefing Book", pg. 34.

[2] The Lewin Group, "Analysis of the New York State Medicaid Program and Identification of Potential Cost-Containment Opportunities" pg. 13.

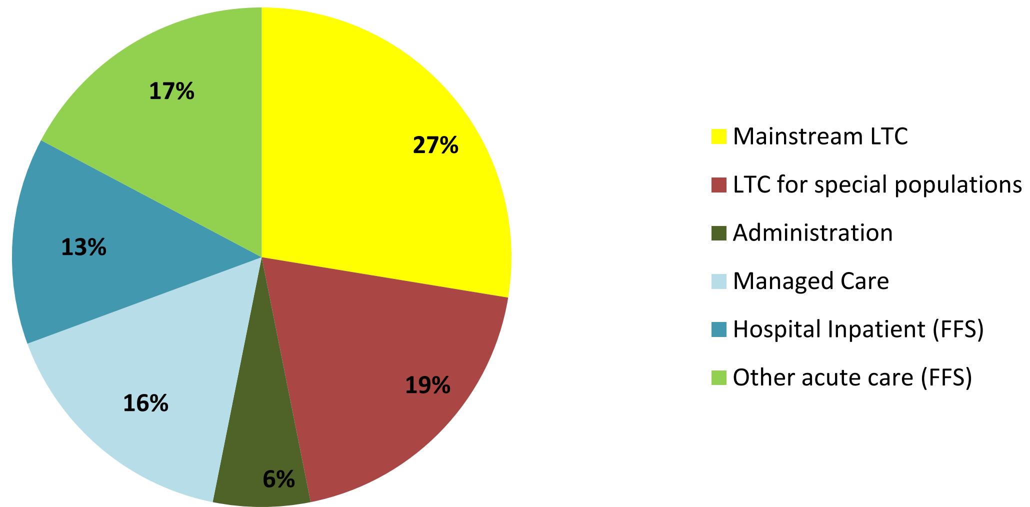
[3] Medicaid Institute, "Medicaid in New York, Looking Back 2000-2010." Pg. 3

noted before, the current All funds cost of the Medicaid program in New York is $53.8 billion – back in the year 2000 the costs were closer to $30 billion, a number than back then was seen as too high. That $20 billion plus growth in spending in the last decade was not spread evenly amongst all recipients. While the number of elderly and disabled enrollees grew by around 11% in this time period, spending on this group grew by 55%. By Federal FY 2008 elderly and disabled individuals accounted for 24.3% of enrollees but they accounted for 71.6% of the costs of the program.[4] While New York's share of enrollees in these two categories was actually below the national average, they consumed a 7% higher share of our Medicaid spending than the national average. The single highest cost in caring for these populations is the cost of long term care. In fact, New York had the highest per capita spending on elderly recipients and individuals with disabilities, spending 77% per elderly recipient and 95% per disabled recipient than the national average. One study found that even if we take into account New York's inherently higher costs, our spending on elderly and disabled recipients was 46% and 60% higher than the national average[5].

Long term care refers to ongoing care provided to individuals to help them deal with what are known as the activities of daily living, such as feeding, toileting, bathing, mobility, and grooming, as well as the instrumental activities of daily living, such as household chores, meal preparation and shopping, and errands. A permanent disability, chronic disease, cognitive impairment, temporary disability due to an acute medical event, or frailty due to advanced age are all reasons why an individual might need assistance with these activities. Many providers of long term care also assist individuals to deal with any ongoing medical needs that may stem from any of these possible conditions. Nursing and group homes are the classic providers of long term care and these institutional settings have proven themselves to be quite costly for the state. There is currently a push to increase the amount of community based long term care assistance an individual can access, not only to lower costs but to meet the desire of many individuals to remain in their own homes and community, close to those they love and care about.

This paper will concern itself with what is considered mainstream long term care, which accounts for long term care for the elderly and non-elderly adults with physical disabilities. These programs are overseen by the Department of Health (DOH) here in New York. Long term care programs for individuals with developmental disabilities, run by the Office for People with Developmental Disabilities (OPWDD), which are also primarily funded by Medicaid, provide care for a much different group of individuals with needs distinctly different from those receiving mainstream long term care and are therefore considered a very different program. Costs for mainstream long term care in 2009 were estimated between $12.4 billion[6] and $13.6 billion[7] (depending what one counts as an expenditure by the Medicaid system), accounting for 27% of all Medicaid spending in 2009.

[4] The Lewin Group, "Analysis of the New York State Medicaid Program and Identification of Potential Cost-Containment Opportunities" pg. 14
[5] Ibid, pgs. 13-14.
[6] " Paying for Long Term Care in NYS", presentation by Deputy Commissioner Mark Kissinger, pg. 5.
[7] Medicaid Institute, "Medicaid in New York, Looking Back 2000-2010." Pg. 4



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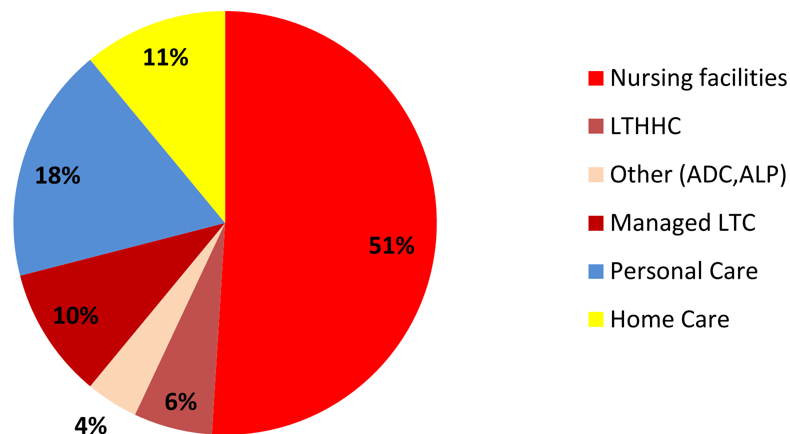

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In looking at the many reports conducted over the last five years into the escalating costs for long term care in New York State, and the policy changes recommended by a variety of think tanks and organizations, a few policy recommendations stood out, most of them garnering support from the majority of the studies conducted. The first recommendation considered in increasing

[8] Ibid.
[9] " Paying for Long Term Care in NYS", presentation by Deputy Commissioner Mark Kissinger, pg. 5.

the use of long term care insurance to pay for long term care, thereby relieving some of the pressure on the Medicaid system. Other recommendations examine ways to make the long term care system more efficient and effective here in New York. These include creating a common assessment tool for long term care providers, increasing the use of programs that coordinate long term care delivery in order to reduce total costs, simplifying the long term care system here in New York, and doing more to incorporate the work of informal caregivers.

III. Increasing the use of long term care insurance

Medicaid funded 49% of all long term care services nationally in 2008[10] – finding a way to shift more of this cost to the private sector would lead to significant savings. The most obvious way to force this shift would be to stop paying for services, which would force individuals to use their own assets to fund long term care. The problem with this method is that it ignores the basic reason for the existence of Medicaid in the first place: many, if not most residents in the state simply could not afford to pay for their long term care needs without exhausting all their assets, assuming they even had sufficient assets to fund this kind of care for as long as they needed it. The solution to this dilemma is to encourage policies that allow individuals to create and set aside assets that they can use specifically for long term care costs in the future. Increasing the use of long term care insurance will be critical in order to create the private asset pools that will allow the residents of this state to cover a greater portion of the costs of their own long term care.

Long term care is very expensive for anyone thinking of paying out of pocket. According to the survey of long term care costs nationwide by Met Life in 2010[11] put the average daily cost of private room at a nursing home at $350 a night, or $127,750 a year (assuming 365 days of service). That is compared to a national average of $229, making New York's nursing home costs 52% higher than the national average. The same survey put the average cost of being in an assisted living facility at $3,701 a month, or $44,412 annually, though this was much closer to the $3,293 a month national average. The average rates for home health aides in New York equaled the national average while our rates for adult day service facilities were $99 daily, compared to a national average of $67 daily. These kind of costs can quickly eat through the assets of any family. Families are either driven into paying through Medicaid once their assets are exhausted or they plan ahead and shift assets in order to be Medicaid eligible.

Medicaid is a means tested program, meaning that individuals cannot exceed a certain income threshold and hold more than a specified limit on assets if they are to be eligible for Medicaid. In order to prevent individuals or their families from becoming fully impoverished before they can claim Medicaid, certain assets have been exempted from these limits, including home equity and the value of certain primary vehicles. Policies have also been implemented that allow the spouse of someone needing benefits to protect certain income level and assets from the spend down process. Spouses in New York can also go to court and claim the right of spousal refusal, in which a spouse goes to court and has the State assume responsibility for the costs of caring for their spouse. This approach is not without controversy, as Lt. Governor Ravitch in his September 2010 Medicaid report called for an examination of this policy in order to curb any possible

[10] "Paying for Long Term Care: Families or Taxpayers". Presentation by Courtney Burke, pg. 2.
[11] Met Life. "The 2010 MetLife Market Survey of Nursing Home, Assisted Living, Adult Day Services, and Home Care Costs."

abuse.[12] There have been more recent suggestions for the elimination of this policy. Long term care insurance can create an alternative method of protecting assets from the spend-down process, allowing a family to pass on wealth to younger generations if they wish.

The state has taken previous steps to encourage the use of long term care insurance, particularly with the creation of the Partnership for Long Term Care in 1993. New York was one of four initial states to form a Partnership. The Partnership's goal is to create an incentive for individuals to purchase long term care insurance by giving individuals a chance to protect more of their assets from the spend down process. Individuals who purchase policies supported by the Partnership are assured that if the policies purchased cover a certain pre-determined minimum amount of care and this proves inadequate to cover their full long term care needs, that they will be able to apply for what is called Medicaid Extended Coverage, which would not apply the regular spend down process but instead excludes from consideration some of their assets. What assets are excluded from consideration is determined based on the type of policy that a family chose. It should be noted that asset protection is not absolute – it is possible that in some instances a family will have too many assets to qualify for Medicaid Extended Coverage (MEC) even after having purchased a policy, and in these circumstances a family will still have to undergo some amount of spend down. Also, while these policies protect assets, these protections do not apply to income. To be eligible for Medicaid individuals will still have to limit their income to around $700 a month, in this case with the rest going to pay for treatments in conjunction with Medicaid. Currently four companies sell individual long term care insurance policies under the partnership.

According to the latest update from the Partnership, since 1993 there have been 129,788 applications for policies under the partnership, of which 92,819 were approved and purchased. Of these, approximately 70,420 are currently in force. According to data from DOH, 3,465 policies have actually gone into effect since the program started, and of these only 240 individuals moved on to collect MEC benefits.[13] In those cases, only 33% needed a nursing home stay while the remaining two thirds used a community based program. Most individuals passed away before their full private benefits ran out, which would have forced them to rely on MEC. From this perspective, the Partnership has shown itself to be successful as a means of lowering long term care costs. The problem has been the relatively small number of policies that have been sold.

Partnership policies have been much more popular outside New York City than within it, with only 7,708 active policies in all five boroughs, compared to 6,489 in Erie County and 9,099 in Monroe County. A study done back in 2005[14] estimated that the relatively low popularity of these policies in New York City stemmed from the fact that people in New York City are less likely to own assets, such as cars and homes, that they would want to protect with partnership policies and depend more on their income, which is not protected by Partnership policies. **In order to increase the popularity of Partnership policies in New York City, the Partnership may have to develop policies that replace asset protection with income protection**, perhaps modeling them on the dollar for dollar asset protection models, basing the amount of additional

[12] "Lieutenant Governor's Report on Controlling Increases in the Cost of New York Medicaid." Pg. 16.
[13] "Paying for Long Term Care in NYS", presentation by Deputy Commissioner Mark Kissinger. Pg. 15
[14] Insurance Department. "Long Term Care Insurance Options in New York State"

income an individual would be allowed to have while being able to access MEC benefits to an amount linked to the size of the benefits under the policy. **New York State should examine whether it should join into a compact with other states offering Partnership for Long Term Care policies**. Federal law was changed so that starting January 1, 2009, State could join a compact that would make dollar for dollar asset protection policies reciprocal in all states that are participating members of the compact as of the time an individual applies for MEC benefits . Individuals must still meet all existing requirements for MEC benefits in whatever state they have moved to. Thirty-nine states currently have Partnership programs, and of those, only 2 have not yet joined the compact, California and New York[15]. There are concerns that given the generosity of New York's Medicaid program as compared to other states, people may seek to venue shop and come to New York to use our system. While this is a plausible concern, as noted before, in the vast majority of cases individuals who purchase Partnership policies have their full long term care needs met by those policies and never apply for MEC benefits.

Private long term care insurance is relatively new in New York State, with the first policies being offered in 1986. By 2009, 18 companies offer long term care policies in New York State. According to the Insurance Department's latest report, 321,011 non-Partnership private policies for long term care were active in New York as of the beginning of 2009, even though our state had over 19 million residents at the time.[16] There are several factors that have limited the market for long term care insurance.[17] Many individuals, especially younger individuals, discount the idea that they will need long term care in their advanced age, even if studies show that there is a good chance they will need some form of long term care later in life. Others worry that they might buy a policy and never end up needing long term care, which would then be regarded as a waste of money. Many individuals seem to believe that Medicare will pay for long term care, which is incorrect, since it pays for nursing home care only under limited circumstances and only for a limited time. Others assume that Medicaid will pay for it, and while this is correct, they likely do not understand the spend down process and the fact that until they have used most of their assets, Medicaid will not in fact cover long term care. Finally, premiums for long term care can be high and deters a lot of people, with annual premium costs in 2006 coming in between $3,424 for individuals and $2,306. In late 2010 one of the larger long term care insurers in the state, Met Life, announced that it would no longer write long term care policies. Many other long term care insurers in the state have asked for permission from the Department of Insurance to increase premiums significantly, some up to 40%. The reason for these actions was that since long term care is such a young market, many of the actuarial assumptions used to set rates were untested, and that as time has gone on, the costs to the companies have been higher than expected. These events point to even higher premiums for long term care insurance in the future, which will only act as a deterrent for a lot of individuals who might benefit from having long term care insurance.

[15] "Long Term Care partnership reciprocity map", available at http://www.dehpg.net/ltcpartnership/StateReciprocity.aspx (last accessed 2/23/11).

[16] Insurance Department, "A Report by the Superintendent of Insurance to the Governor and the Legislature on the Implementation of legislation Permitting Approval of Certain Long Term Care Health Insurance Plans."

[17] Insurance Department. "Long Term Care Insurance Options in New York State"

Examinations of those who purchase private long term care insurance policies and Partnership policies[18] show that individuals under 45 years old do not purchase long term care insurance in large numbers, and that the bulk of individuals purchasing these policies fall between the ages of 45 and 69. As individuals age, their initial premiums increase, as does the possibility of being denied, since long term care policies are actuarially underwritten, and this takes medical history and risk into account. Having an underlying condition also makes it far more expensive or impossible to acquire long term care insurance. The state and insurance companies are left with the dilemma that while the best possible situation for the viability and success of private long term care would be for individuals to sign up while young in large numbers, in fact individuals are likely to think about purchasing for these kinds of policies only as they age and become more cognizant of the possibility of needing long term care, by which time many of them might not be able to pay the premiums.

Besides the Partnership for Long Term Care, the state has taken other measures to encourage the use of long term care policies. The State makes long term care insurance available to state employees as a group insurance option through the New York Public Employee and Retirement Long Term Care Insurance Plan, or NYPERL. Access to NYPERL is also available to municipal employees. The program had, as of the end of 2008 only 4,410 participants, which out of a State workforce of at least 160,000 employees, without taking into account the even larger number of municipal employees. The state should do all it can to expand NYPERL in order to build a larger pool of participants in long term care insurance that might entice new companies to write policies and drive down overall prices. **Some very good suggestions from the Department of Health[19] include allowing New York State employees to use accrued sick time to purchase long term care insurance,** as they are currently allowed with health insurance. **The state should seek additional carriers to participate in NYPERL**, as currently only one insurer is writing policies for the plan, and the State should then allow open enrollment at set intervals so that employees might be allowed to purchase long term care once they view it as a more pressing issue. **The state could also examine creating other large long term care insurance pools** in an effort to again lower premiums by increasing the pool of participants. It could work with large employers and private unions to set up pools for their employees, or work to set up pools for self-employed individuals who don't have access to group policies and might not afford individual policies.

The state also has created tax benefits for having long term care insurance. Most long term care insurance policies meet federal regulations that make them tax qualified, which allows an individual to deduct long term care insurance premiums as a medical expense if the individual files an itemized tax return. Employers are also allowed to deduct long term premiums as a business expense if they offer it to their employees. New York State allows individuals who have purchased a federally tax qualified long term care policy to apply for a tax credit equal to 20% of their long term care premiums. This credit is available to all individuals who have purchased one of these policies, even if they did not deduct their premium expenses on their federal income tax return. **New York State should do all it can to publicize this very generous tax credit, which can help lower the individual sting of high premiums.**

[18] Insurance Department. "Long Term Care Insurance Options in New York State", pg. 96
[19] "Paying for Long Term Care in NYS", presentation by Deputy Commissioner Mark Kissinger. Pg. 19

Given the existing market issues noted above that have limited the appeal of long term care policies here in New York, even with our long standing participation in the Partnership for Long Term Care, the state needs to think of new strategies to make some form of private long term care insurance more appealing and accessible to a larger number of New Yorkers.

One alternative to long term care insurance policies are hybrid insurance policies that include a long term care benefit along with some other form of insurance benefit. These kinds of policies allow individuals to bundle different insurance risks into one policy. While the underwriting needs of writing policies might mean that the cost of these policies might be high like the cost of long term care insurance, these hybrids can help to overcome some of the issues with selling long term care policies mentioned above. For one, if an individual is able to buy a policy with multiple possible benefits, depending on what their circumstances in life turn out to be, they might be more willing to bear the costs, as they are far less likely to consider the money spent on premiums as wasted. Also, while long term care insurance has shown itself as not particularly popular with individual under 45, other types of policies have had greater success with younger individuals. By bundling benefits, younger individuals and families might be more willing to accept the possibility that long term care is something they might need to pay for in the future. In these ways, these hybrid policies might help to break down some of the false beliefs and psychological barriers that have kept sales of long term care insurance low.

One prime candidate for hybridization with long term care insurance is life insurance. As of late 2008 there were around 9 million life insurance policies in the state. Current New York State law already allows for life insurance companies to sell insurance policies with optional riders that allow an individual to access an accelerated death benefit to pay for long term care if they meet the following conditions: becoming chronically ill (as defined by the federal government) and being unable to carry out two of the activities of daily living. The Department of Insurance here in New York also requires that this accelerated death benefit be tax qualified, which means that it is not treated as taxable income. This alternative was stimulated by a white paper prepared by the Southern New York Association encouraging personal responsibility for long term care planning.

In 2010 the legislature passed Senate bill 7196, Sponsored by Sen. Klein, which eventually became Chapter 563 of the laws of 2010. This legislation expanded the circumstances under which life insurance companies would have the ability to pay out accelerated death benefits in order to pay for long term care needs. It finally made it possible in New York for companies to offer an accelerated death benefit to anyone who, after spending three months in a nursing home, was expected to remain in a nursing home for the rest of their lives. Before this legislation passed, New York was the only state in the union not to allow companies to make such a rider available. This legislation was supported by the Life Insurance Council of New York, as well as by New York State Health Facilities Association and the New York State Center for Assisted Living.

The bill also calls on the Insurance Department to promulgate the rules necessary to make such policies available here in New York State. In the past the Insurance Department has been wary of these kinds of riders, not wanting to label them as long term care insurance. **Given how slowly long term care insurance has spread in New York, the Insurance Department should be**

working to maximize the options available for individuals wanting to use private funding to pay for their long term care needs.

Based on information about the size of the life insurance policy market here in New York State and on information from the Department of Insurance and Department of Health on the likelihood of individuals needing to pay for long term care, the IDC estimates that by 2015, over 2000 individuals in New York that would otherwise need Medicaid to pay for their long term care needs would instead be able to use an accelerated death benefit to for their care, saving the state over $60 million in Medicaid spending. The number of individuals diverted from the Medicaid program will continue to grow as the number of policies with these riders and the need for long term care from policy owners increase[20].

Year	# individual diverted from Medicaid	Average annual Medicaid costs to State & Localities	Savings
2015	2,177	$28,299.71	$61,603,438.16
2016	2,595	$29,431.70	$76,360,608.15
2017	3,007	$30,608.97	$92,052,153.10
2018	3,415	$31,833.32	$108,721,770.81
2019	3,818	$33,106.66	$126,414,784.92
2020	4,217	$34,430.92	$145,178,186.10

There are a number of additional steps that the Insurance Department could take to encourage the further sale of long term care insurance**. The Department should review the standards used to admit life, long term care, health and other carriers that would like to offer long term care insurance in New York**. **It needs to explore whether the standards or qualifications are too onerous and discourage new insurers from entering into the New York market, or encourage insurers that currently write in the New York market to leave this market place**. If a carrier has the perception that the Insurance Department is hostile to allowing more companies to come in, they generally do not apply for admittance in the state to write new types of coverage. It is very expensive to get admitted into the New York market, so a carrier will not do so unless it believes that there is some hope of getting approval and that they will be free to sell policies to make a profit.

The Insurance Department should also examine its criteria for approving new types of long term care policies. Helping to reduce the cost of these policies could help encourage more persons to purchase long term care coverage. Further, it could encourage those who already have such policies to retain them. Increasing the public demand for such types of policies could encourage more insurers to enter into the New York market. The Insurance Department could also review the qualification of agents and brokers that sell such policies. The Insurance Department should examine to see whether altering who is licensed to sell such policies might encourage more agents and brokers to sell long term care insurance.

[20] Estimate based on information from 2005 Dept. of Insurance report on long term care insurance, The New York State Partnership for Long Term Care's last quarterly update, 2008 report from Sen. Klein's office on long term care and accelerated death benefits.

There have also been suggestions from the Health Department[21] to create new long term care financing demonstrations, which would have to be allowed by the Federal government. These demonstrations would be programs enrolling small numbers of individuals trying out new possible private-public partnerships than encourage private financing of long term care with some amount of public backing as a form of insurance. There are also recommendations for creating special long term care savings accounts, similar to other special savings accounts created to fund health care or college costs in the future and receiving the same positive tax benefits.

Several years ago AARP issued a report[22] in which it compared the ability of different states to review and regulate long term insurance policy rates most effectively, and it found New York to be tied with Florida as one of the state's best prepared to regulate the long term insurance market. Unfortunately, New York seems now to have fallen behind in terms of being able to offer innovative insurance vehicles to New Yorkers. New York should try to lead the way in finding ways to encourage individual to take more direct responsibility for their future long term care needs, which will also give them better control of their financial future and more flexibility than is available under the Medicaid spend down process.

IV. Increasing the efficiency of long term care programs

An expansion of long term care insurance will take time to bring about significant savings to the Medicaid program. Shorter term savings will need to come from changes in the existing Medicaid program. The current long term care system was created haphazardly, with new programs being included without any central plan. This fragmentation of Medicaid decision making, something discussed by Lt. Gov. Ravitch in his 2010 report, creates opportunities for waste and a misallocation of services and makes coordinated care difficult to implement.[23] These barriers to better coordination of care, particularly in a cost driver like long term care must be addressed.

Implementation of a single assessment criteria for Long Term Care

A basic impediment to improving the coordination of long term care services in New York is the absence of a common assessment form for providers of long term care. When an individual currently is approved for Medicaid, they are evaluated in order to determine the level of care they require, including whether their situation is such that they require nursing home care or home based equivalent care. Currently, there is no single assessment tool, so one individual might be classified in one county as being eligible for nursing home care while in another county they might be judged ineligible for such care. Many times these assessments are conducted by providers, and they themselves do not have standard State-wide tools to use in order to determine care. This lack of a standard assessment tool also makes it difficult to correctly compare health

[21] "Paying for Long Term Care in NYS", presentation by Deputy Commissioner Mark Kissinger. Pg. 18.
[22] AARP. ""Long Term Care Insurance: An Assessment of States' Capacity to Review and Regulate Rates" pg. 7
[23] "Lieutenant Governor's Report on Controlling Increases in the Cost of New York Medicaid." Pg. 13

care outcomes between different counties, as the initial criteria that led to individuals being given a certain level of care vary.

Creating a single assessment tool to be used by all health care providers and counties in the State would allow the state to ensure that access to care become uniform in the state, making eligibility of service more fair and uniform. **A single assessment tool will also allow the state to accurately compare different patient populations across the state and will allow it to better judge which treatment programs are most effective, without having to worry about possible discrepancies in the data.** This will allow the state to make better use of its Medicaid dollars. The Department of Health has a current project to develop what it labels the Uniform Assessment Tool. This policy also has the support of the Home Car Association of New York[24], which represents home health care agencies. It also has the support of the Greater New York Hospital Association (GNYHA)[25] and the Hospital Association of New York State (HANYS).[26] It should be noted that this proposal would cost money to implement in the short term, as staff members would need to be trained in the use of this new single assessment tool and data programs at the Department of Health and local service departments would have to be ungraded to record this new data,[27] but if we do not make this improvement trying to effectively coordinate long term care here in the state becomes even more difficult. This is a critical investment in solving our long term care problems.

Simplify and streamline the Medicaid long term care system

New York currently has twelve different programs under its Medicaid long term care system.[28] Of these twelve, two are mandated by the federal government in the original legislation creating Medicaid, paying for nursing home care and for services from certified home health agencies. These two programs accounted for 48% of all recipients in FY 2007 and also accounted for 63% of all spending. This original federal law also allowed states to cover programs labeled as optional. The four programs that fall under this label are traditional personal care (PC), consumer directed personal care, medical adult day health care, and Medicaid assisted living program. These program account for 32% of recipients and 23% of spending as of 2007. One shared feature of all these programs is that they must be offered to all Medicaid recipients.

In the early 1980's federal law was changed and states were allowed to apply for waiver programs under section 1915(c) of the Social Security Act. These programs can be offered to limited populations, as long as the state can show that they are budget neutral. New York offers three Medicaid long term care programs under this system, the nursing home transition and diversion waiver program, the traumatic brain injury waiver program, and the long-term home health care program (LTHHCP). These three programs accounted for 11% of recipients in 2007 and 7% of spending. Finally, in the mid 1990's federal law was changed again to allow for the creation of Medicaid managed care. New York State has by now moved most recipients of Medicaid into Medicaid managed care programs, with the exception of individuals needing long

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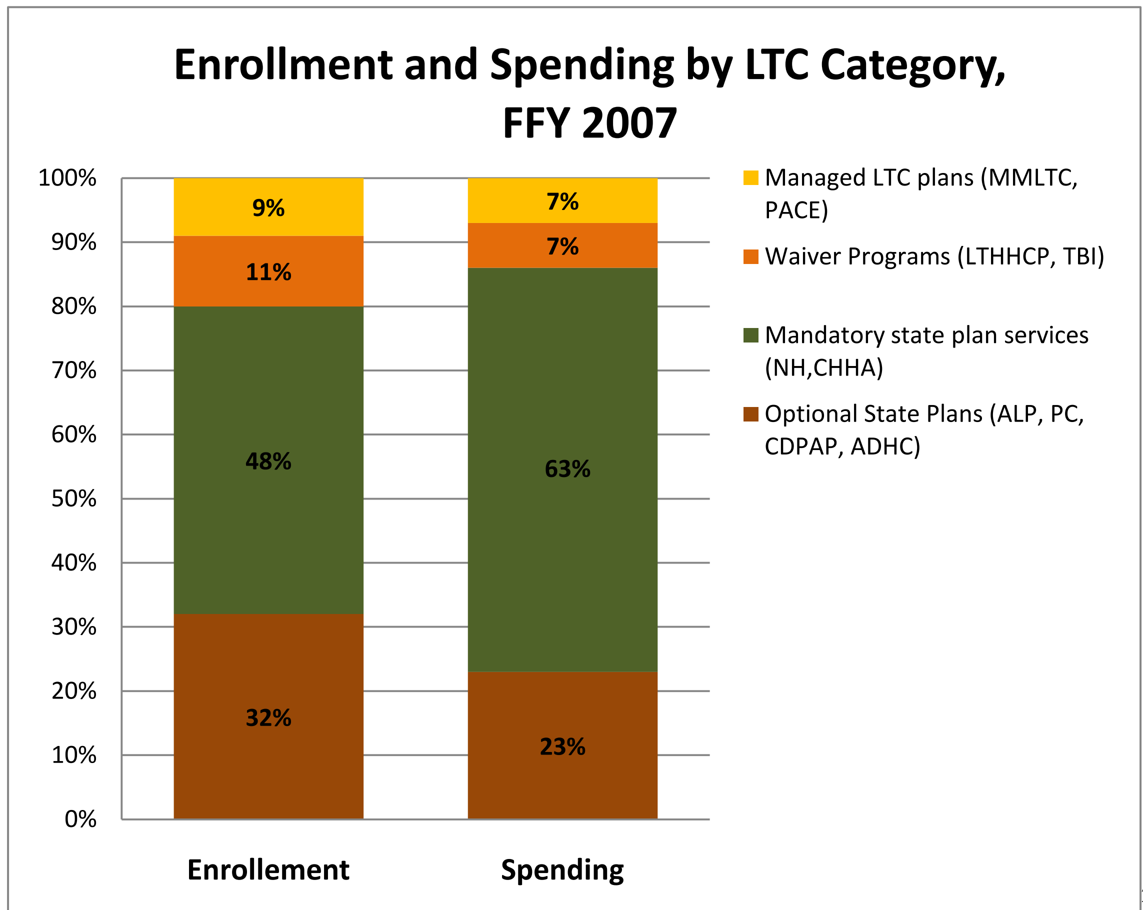
[24] HCA, "A Blueprint for Home Care Reform and Efficiency", pg. 4
[25] GNYHA, "Reforming New York's Medicaid Program. Preliminary Report." Pg. 16
[26] HANYS, "Recommendations of HANYS' Task Force on Improving New York State's Medicaid Program." Pg. 12
[27] Medicaid Redesign Team. "Proposal to Redesign Medicaid." Pg.79.
[28] Medicaid Institute. ""An Overview of Medicaid Long Term Care Programs in New York." Chapter 1, Pg. 4

term care. Three Medicaid managed long term care programs exist, Medicaid managed long term care, Medicaid Advantage Plus, and programs for all-inclusive care for the elderly (PACE) programs. These accounted for 9% of all recipients and 7% of all spending in 2007.

Over the last few years the medical community has tried to implement a more personalized approach to delivering care, which takes into account the unique nature of each patient. Having a lot of diverse programs makes sense in this approach if each of those programs covered very different populations, but the fact is that the populations served by many of the programs outlined above overlap and are not very distinguishable from each other. One example is the population served by the traditional personal care program (PC) as compared to individuals served by LTHHCP. Both these programs provide individuals with assistance with assistance at home for what are classified as activities of daily living (feeding themselves, going to the bathroom, grooming and dressing, and moving around) as well as activities such as household chores, preparing meals, and carrying out errands. Traditional PC only provides assistance with these activities, while LTHHCP also provides managed health care services, such as nursing services and therapy. One would expect then that the population of recipients of traditional PC would be healthier than those receiving LTHHCP, since Medicaid is paying to assist them only with daily activities at home and is not providing coordinated medical assistance, but this turns out not to be the case.



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[29] Medicaid Institute. ""An Overview of Medicaid Long Term Care Programs in New York." Chapter 1, Pg.21

One of the few studies of the traditional personal care population, which was conducted by the United Hospital Fund back in 1997[30] found that back then over half of the recipients of PC had some amount of cognitive impairment and that 65% of them had needs comparable to those of individuals judged to have nursing home levels of care. When this study examined actual spending, it was found that while for 72% of PC recipients Medicaid was spending less than it would if those individuals were in a nursing home, for 23% of PC recipients there were no significant savings as compared to having these individuals in nursing homes, and 5% of PC recipients cost the program more than the average cost of treating individuals in a nursing home. Since 1997 the population receiving PC care has only gotten more frail. It is in fact likely that many individuals receiving PC care would in fact benefit more from being in a program like LTHHCP, or Medicaid managed long term care, or specially a PACE program. These programs not only provide the service PC recipients get now, but by coordinating and managing their full health care needs, lower the incidence of the most drastic problems that end up leading otherwise to hospitalizations and then nursing home care, which is far more costly than community based programs.

There are also several programs that treat equivalent populations, and whose differences are based on the way that the programs are compensated by Medicaid or the rules that a program provider must meet to qualify for funding. PACE programs, Medicaid managed long term care programs, LTHHCP programs, and Medicaid Advantage Plus all cover similar populations. All these programs were created in order to provide individuals with coordinated health care coverage while working to keep the need for more expensive nursing home care and instances of hospitalizations down. These programs have had different levels of success enrolling individuals in different parts of the state**. The state should examine whether it is necessary to have so many different programs covering similar populations.** Particularly with individuals receiving traditional PC care, it could be possible that they would be better served and that the state would incur greater savings from having them participate in LTHHCP or Medicaid managed care programs.

Implement policies that help cost effective programs expand

	Spending (in millions)				Number of Recipients			
Type of Care	CY 2003	CY 2008	change		CY 2003	CY 2008	Change	
			$	%			No.	%
Institutional LTC	**$6,246.6**	**$7,119.2**	**$872.6**	**13.6%**	**154,487**	**148,600**	**-5,887**	**-3.8%**
Nursing homes	$ 5,930.5	$ 6,705.6	$ 775.1	13.1%	139,081	132,620	-6,461	-4.6%
Other	$ 334.0	$ 413.6	$ 79.6	23.8%	17,222	18,869	1,647	9.6%
Non-institutional LTC	**$3,150.7**	**$4,299.9**	**$1,149.2**	**36.5%**	**187,581**	**170,662**	**-16,919**	**-9.0%**
Personal Care	$ 1,824.7	$ 2,336.1	$ 511.4	28.0%	84,823	77,861	-6,962	-8.2%
Certified Home Health Agencies	$ 760.4	$ 1,185.5	$ 425.1	55.9%	92,553	82,007	-10,546	-11.4%
Long Term HHC	$ 510.2	$ 691.5	$ 181.3	35.5%	26,804	26,470	-334	-1.2%
Other	$ 55.3	$ 86.8	$ 31.5	56.9%	29,503	26,774	-2,729	-9.2%

[30] Ibid, Chapter 3, pg. 7

Managed LTC	**$444.3**	**$1,078.9**	**$ 634.6**	**142.8%**	**12,293**	**29,979**	**17,686**	**143.9%**
Total	**$9,841.6**	**$12,498**	**$2,656.4**	**27.0%**	[31]			

The chart above shows changes in spending and use of the various long term care programs in the State between 2003 and 2008. What can be seen is that growth in spending and growth in the utilization of a variety of programs have varied greatly. For example, as the number of individuals receiving care from certified home health agencies fell by 11%, actual state spending on these services grew by 56%, which is faster than the general growth of Medicaid long term care expenditures. On the other hand, Managed Medicaid long term care had a very similar increase in both use and expenses. In fact, if we examine the expenditures per recipient, we see that Managed Medicaid long term care actually got cheaper per recipient in that period, while the expenditure for certain programs per recipient grew dramatically[32].

	Spending per Recipient		
Type of Care	CY 2008	Change	
		$	%
Institutional LTC	**$ 47,909**	**$ 7,358**	**18.1%**
Nursing homes	$ 50,563	$ 7,992	18.6%
Other	$ 21,919	$ 2,524	13.0%
Non-institutional LTC	**$ 25,195**	**$ 8,399**	**50.0%**
Personal Care	$ 30,004	$ 8,492	39.5%
Certified Home Health Agencies	$ 14,456	$ 6,241	76.0%
Long Term HHC	$ 26,122	$ 7,086	37.2%
Other	$ 3,241	$ 1,367	72.9%
Managed LTC	**$ 35,988**	**$ (158)**	**-0.4%**

Medicaid managed long term care has been slow in gaining more participants here in New York, which sets long term care apart from the rest of the Medicaid program in New York, where managed care has become the norm. Right now entering into any form of managed long term care program is optional. Since all patients have unique circumstances, managed care might not be the best option for all so making managed long term care mandatory for all recipients, but it is likely a very good option for most long term care recipients, and the fact that most long term care patients do not participate in some form of managed long term care program is unsustainable. **The state needs to expand the use of managed long term care to more recipients.**

There is resistance amongst many providers of long term care in the state to managed care programs because they fear that these will be capitated, which means that the provider receives a set payment per program participant regardless of the care each participant receives. This is an incentive for providers to keep the costs per participant down, but expose providers to possible loss if participants end up needing more care than the payment covers. Capitated payments are based on the expected need for services from participants, but as noted before, each patient is

[31] The Lewin Group, "Analysis of the New York State Medicaid Program and Identification of Potential Cost-Containment Opportunities" pg.9
[32] Ibid.

different and the actual risk of needing care from each individual is not equal. Some programs might be treating much more vulnerable populations than others, and the differences in possible cost are not only regional (one assumes higher costs in NYC than in Upstate cities for example.) **The State should examine the possibility of adjusting capitation to an organizations actual case-mix.** This is certainly more administratively difficult than creating a single regionally adjusted capitation scale, but it would lower provider resistance and perhaps increase the number of organizations and providers willing to offer managed long term care options in the state.

Several other studies of the Medicaid managed long term care program, including reports by HANYS, GNYHA, and Independent Care Systems (ICS)[33], a provider of long term care services primarily in NYC, have all recommended an increase in the use of coordinated care management, though they differ in the particular methods to be used. Several of these reports reference the recent Patient Protection and Affordable Care Act, which will make several changes in the law meant to increase the use of coordinated care, particularly with regards to individuals that apply for both Medicare and Medicaid. The new law establishes the Federal Coordinated Health Care Office (CHCO) in order to better align Medicaid and Medicare spending on individuals who are eligible for both, a population known as the dual eligible. There are around 680,000 duel eligible individuals in New York, and while they account for 13% of Medicaid enrollees, they also account for 40% of Medicaid spending. Long term care is a large portion of that 40%. The Kaiser Foundation[34] found that while Medicare pays for hospital stays and medication and is considered the primary provider, Medicaid in fact pays 56% of the costs of covering this population, primarily because it is Medicaid that covers long term care, as opposed to Medicare.

Programs for all-inclusive care for the elderly, or PACE programs, have also shown themselves nationwide to be very successful at lowering the need for hospitalizations and nursing home stays while providing individuals with the kind of personalized care that many health care advocates push for. PACE programs also coordinate Medicare and Medicaid spending, which makes them one of the few programs that try to tackle the large costs from treating the duel eligible population. These programs have certain requirements that other long term care programs do not, including the need of centralized facilities in which they provide these integrated services. This capital requirement has made the growth of PACE programs quite slow since the upfront cost is much higher than with other community based long term care models. The state also created the Medicaid Advantage Program to try to provide a managed care model that would integrate Medicaid and Medicare spending, but reception for this program has been limited, particularly because the program is voluntary.

The CHCO will work with the also newly created Center for Medicare and Medicaid Innovation (CMMI) in order to see if new programs can be designed and then tested nationally to better coordinate the care of the dual eligible population. A study by the Lewin Group[35] examined the possibility of mandating that all dual eligible individuals be enrolled in the Managed care program, something that would require federal approval, and estimated a possible savings of 2.2% or 10.76 billion between 2011 and 2020 in combined Medicaid and Medicare savings,

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[33] ICS. " A Home and Community-Based Service System Reform Blueprint"
[34] GNYHA, "Reforming New York's Medicaid Program. Preliminary Report." Pg. 20
[35] NYS Health Foundation. ""Bending the Health Care Cost Curve in New York State." Pg. 34.

though the actual savings only to Medicaid in this period would have been $878 million, of which 50% would be savings to the State and localities. The rest of the savings would accrue to the Federal government.

The Department of Health should work with providers to start designing new programs meant to better coordinate the care of the dual eligible population so that it can take quick advantage of the new possibilities for funding such experimental programs that are coming with the new health care law. The state should in the meantime also work with providers to expand the use of Medicaid Managed care where appropriate, as the program has shown itself effective at controlling costs**. The state should examine ways to help expand the PACE programs, perhaps by giving organizations trying to set up such programs preferable treatment when it comes to acquiring surplus state property**, since the capital requirement has proven itself to be a problem for organizations trying to start new PACE opportunities.

Increasing assistance to informal caregivers

A large amount of the work of providing long term care for individuals is carried out not by medical providers but by families and friends of individuals. These informal caregivers (as compared to health and home aid personnel) spend their own time and income in providing home care for individuals with impairments. There are estimates that close to 13% of the state's population provides informal care, and that the economic value of this care is close to $20 billion a year[36], which is several billion more than is spent by the state itself through Medicaid. These family members and friends helping to take care of their loved ones save not only the state but the entire medical system billions each year. In doing so, these individuals incur significant costs to themselves. These individuals face higher stress, spend significant amounts of their incomes or savings providing care, report having to miss work or going so far as to leave work.

There are currently a variety of programs in New York meant to provide support to informal caregivers, which are run by local governments and non-for-profits, but according to a study by the New York State Health Policy Research Center in 2009 comparing New York's Medicaid long term program with that of several other states found that unlike most of those states, New York does not include an analysis into the abilities and training of informal caregivers when it accesses the needs of individuals seeking assistance funding long term care. **New York should include assessments of informal caregiver ability in its new uniform assessment tool in order to best incorporate informal caregivers into the provision of care for individuals.**

New York should examine whether providing incentives to individual informal caregivers, including the possibilities of tax credits to help cover the costs incurred that might not be covered by current tax credits or incentives might help divert costs from the Medicaid program. **One such possibility is the creation of a $1000 tax credit for working individuals using adult care services, which is part of Senate bill S.613, currently sponsored by Sen. Klein.**

The state should also examine if there are any significant negative economic consequences from the state from having a low level of support for informal caregivers – the fact that many informal caregivers miss work or undergo significant stress, something which might

[36] Excellus. ""The Facts about informal caregiving in upstate New York" Pg. 1.

increase their own care needs in the future, might speak of there being hidden costs to the state from not better supporting these informal caregivers.

V. Conclusions:

Long Term Care will continue to be a growing cost for New York's Medicaid system in the coming years, particularly as the state's population ages. If the state wishes to come to grips with its long term budget problems, it will have to find ways to effectively manage the cost of long term care.

Many groups have come out with recommendations for ways to make New York's Medicaid long term care system more efficient and effective in order to save money and simultaneously improve the care being given to those needing long term care. In this report we have tried to highlight some of the recommendations that we have found to have the most support and possibility for success. Now that the Governor's Medicaid Redesign Team has approved a proposal, which will be included in the Governor's 30 day budget revision, it is up to the Governor and the Legislature to work together and discuss a final budget. We present these recommendations as part of that discussion, and hope that the Governor, the Health and Insurance Commissioner, and our fellow members of the Legislature examine them as we work towards the redesign of our Medicaid system.

Increase the use of long term care insurance:

- Build on the passage of Senate bill 7196 by changing state insurance regulations to allow more innovative hybrid life insurance/long term care insurance policies to be written and sold in New York State. *This recommendation was included in the Medicaid redesign proposal.*
- Explore joining the interstate compact allowing reciprocity between New York and other states participating in Partnership for Long Term Care programs.
- Find ways to expand the NYPERL programs in order to build a large and effective pool of participants that have long term care insurance policies. This might include accepting Health Department recommendations to allow employees to use sick time to buy long term care insurance policies and allowing for broader intervals of open enrollment to subscribe to long term care insurance.
- Examine ways to help self-employed workers and private companies and unions to create pools of long term care insurance as a way to give more individuals access to group long term care insurance.
- Implement new experimental programs to test innovative ways of increasing private payments for long term care, including seeking federal waivers when necessary.

Making the Medicaid Long Term Care system more efficient:

- Finalize the creation of a uniform assessment tool for long term care needs in order to better assign individuals with the various existing programs providing long term care. Use of such a tool would better track care outcomes as well. *This recommendation was included in the Medicaid redesign proposal.*

- Streamline the current Medicaid long term care program, which is currently made up of many different programs, many of them having very similar demographics. The state needs to examine whether so many different and distinct programs are necessary. *The Medicaid redesign team approved plans to develop a new, more comprehensive federal voucher design for LTHHCP programs.*
- Look for ways to expand those long term care programs that are proven to be the most effective. This includes examining ways to expand Medicaid managed long term care programs where appropriate, and looking for policies that might assist more organizations to set up PACE programs. *The Medicaid redesign team proposed several wide-ranging and significant reforms to the various Medicaid managed long term care programs, including mandating mandatory enrollment in Medicaid managed long term care for individuals using community based long term care services to be phased in taking into account provider capability. The Redesign team also approved plans to develop integrated managed care programs for the dual eligible population and for the development of Accountable Care Organizations, with federal guidance.*
- Find ways to better integrate informal caregivers with the long term care system and increase the support they receive, including by examining the effectiveness of new tax credits for individual paying for care for their adult relatives.

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