



FAX TRANSMISSION

U.S. Department of Health and Human Services
Office of the Secretary

To: Chris Jennings

Organization: _____

From: John Monahan
Intergovernmental Affairs

Date: _____

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Number of pages including this sheet: 8

Remarks: Here are the 2 letters we have sent to New York regarding the 1115 waiver proposal. We are working on getting the health stats for the State.



THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

MAR 28 1995

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

Dear Governor Pataki:

Thank you for your Medicaid section 1115 demonstration proposal entitled "The Partnership Plan," which we received on Monday, March 20th. My staff are currently reviewing the proposal in detail and will be in touch with State health officials shortly to begin the evaluation process.

I understand that you have already responded to initial public concerns regarding the waiver by slowing down your implementation schedule and delaying until January 1997 enrollment of some of New York's most vulnerable citizens.

Based on my experience with other waiver applications and my own knowledge of the health care system in New York State, I wanted to bring to your attention some initial issues that will be addressed as part of this Department's review of your State's proposal. We will be able to provide a more comprehensive list of issues after my staff and I have had time to fully review your proposal.

Even with full implementation delayed until 1997, we will need to examine carefully whether managed care plans in New York have the capacity to fully sustain such a broad-based expansion. I will be particularly interested in understanding how the State plans to monitor quality and effectiveness of care, and what systems the State will put in place to limit enrollment should problems develop. We will also pay close attention to the treatment of the numerous chronically ill persons who will be moved into managed care. We will also want to evaluate very carefully the proposed program's impact on the State's most vulnerable populations, particularly the frail elderly and individuals with HIV and other chronic diseases. These special populations have a great deal to gain from organized systems of care and a great deal to lose if new service systems do not have the sensitivity and capacity to deal with their very special needs.

Page 2 - The Honorable George E. Pataki

In addition, we will want to ensure that patients treated by existing service providers such as public hospitals, community health centers and other essential community providers, as well as academic health centers receive quality health care services. We will also want to consider the ability of these institutions to continue to maintain quality workforces. The transition to managed care should give these institutions an appropriate opportunity to participate in the new system, as well as maintain their contributions to the community.

Finally, it has been our experience that successful health care demonstrations turn upon a state's effective consultation with the public, including elected and appointed officials, beneficiaries, and all those in the New York health care industry from the design through the implementation of the demonstration.

We are looking forward to working with you on this proposal. If Commissioners DeBuono or Glass have any questions during the review process, they may contact Lu Zawistowich, Sc.D., Director, Office of State Health Reform Demonstrations, Health Care Financing Administration, at (410) 966-6649 or John Monahan, my Director of Intergovernmental Affairs at (202) 690-6060. If you have any questions, please do not hesitate to call me.

Sincerely,



Donna E. Shalala



8325 Security Boulevard
Baltimore, MD 21207

MAY 2 8 1995

Barbara DeBuono, M.D.
Commissioner
New York State Department
of Health
Corning Tower Building
Albany, New York 12237

Dear Commissioner DeBuono:

We are pleased to have received New York's section 1115 waiver proposal, entitled "The Partnership Plan," and have distributed it throughout the Department of Health and Human Services for review. To facilitate the review process, we are informing you of several key concerns and issues which have been identified. You will be receiving an additional list of questions in early May which will provide greater detail on these and other issues.

The key issues are outlined below:

o 1915(b) Waiver Programs

We understand that the State has proposed to expand its current 1915(b) waiver. It is not clear how the State intends to incorporate the 1915(b) waiver programs that are either currently operational, or pending, into a statewide 1115 waiver program. The proposal indicates that these programs will be subsumed into the 1115 waiver program, but does not specify how or when this will be accomplished. In particular, it is not clear when beneficiaries who are currently enrolled in managed care plans which are not selected as part of the Statewide procurement process under the section 1115 demonstration will be transferred to selected plans.

We want to ensure that the process for subsuming the existing 1915(b) programs into the section 1115 waiver program is not disruptive to the beneficiaries.

We are working with HCFA's Office of Managed Care to ensure that issues common to both waiver requests are addressed consistently. However, we do not identify issues unique to the 1915(b) waiver request in this letter. The Office of Managed Care will address these issues as part of its review process.

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o **Implementation Schedule**

New York is proposing to begin enrollment of certain eligible groups in November 1995. Although the State intends to phase in enrollment, the schedule, as outlined in the proposal, appears overly ambitious, particularly given the magnitude of the proposed program. We understand that New York anticipates enrolling approximately 700,000 Home Relief and AFDC-related individuals into the program in less than one year from today. Between the date that New York obtains approval for the section 1115 waiver, and the beginning of the initial enrollment, a competitive procurement process must be initiated, contracts with health plans must be secured, and approaches to marketing and enrollment must be addressed. We must assure that the program can be developed in the time frame presented in the proposal.

Issues of appropriate timing, transition, and further development of the existing infrastructure (particularly for special needs populations) must be considered, especially in light of the Governor's proposed Medicaid budget cuts. We will need to assure that adequate capacity and access exist under the demonstration, particularly as the proposal acknowledges that the State currently has a geographic maldistribution of providers.

We encourage the State to work with providers that have traditionally served the Medicaid and low-income populations to ensure that these populations have adequate access to care under the demonstration. It is important that plans consider the role of these providers as they develop networks.

New York must also consider the systems modifications and enhancements that it must undertake to adapt to a managed care environment and insure that the system has the capability of generating required person-level encounter data. In addition, a realistic assessment of the time frames needed to develop and adequately test the modified system's ability to collect accurate plan enrollment information from the local department of social services offices, and to track and reconcile capitation payments to managed care entities throughout the State, will be necessary.

o **Budget Neutrality**

A number of preliminary issues regarding budget neutrality have been identified, and will require resolution in the course of reviewing your proposal. First, agreement will have to be reached on inflation factors to be used to estimate what future spending would be in the absence of the waiver; our budget neutrality

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discussions routinely evaluate the appropriateness of national, state-proposed, and other rates. Second, it is not clear whether baseline cost estimates in the absence of the waiver reflect the current and pending 1915(b) and other managed care activity. Third, we are concerned that New York is proposing to increase Disproportionate Share Hospital (DSH) payments at a rate that is higher than projected in the absence of the waiver. It is not clear how New York will track DSH monies that are redirected to the managed care delivery networks and ensure that the combined redirected and residual DSH expenditures do not exceed projected DSH expenditures in the absence of the waiver. Finally, we will need to discuss how Medicaid budget cuts will affect budget neutrality calculations.

o **Quality Assurance Standards**

We will want to ensure that there is an adequate infrastructure capable of providing continuous quality assurance monitoring for all individuals enrolled into the program. In particular, comprehensive quality assurance standards must be developed to monitor the care that is being provided through the special needs plans (SNPs) that are to be established for specific sub-populations (i.e., Seriously and Persistently Mentally Ill adults, Seriously Emotionally Disturbed children, and individuals who are HIV-positive). Both the State Department of Health (DOH) (through the AIDS Institute) and the State Office of Mental Health will be developing systems of quality assurance for the special needs populations that will be offered services through SNPs. We will need more information regarding how these efforts will be linked to avoid duplication and ensure consistency.

o **Encounter Data**

We will require detailed information about New York's plans for collecting the required encounter data. We must ensure that complete and accurate encounter data is obtained, both to monitor the quality of care provided to program enrollees, and to assess the impact of the demonstration, as part of the independent evaluation that we will conduct.

o **Institutions for Mental Diseases (IMD)**

New York is requesting a waiver of the IMD exclusion, up to a total annual limit of 90 days per enrollee. While the Health Care Financing Administration (HCFA) technically cannot "waive" the IMD exclusion, it may authorize Federal matching payments for IMD residents that would not otherwise be matchable. The State should be aware that, while this authority has been exercised in order to permit matching payments for IMD services, HCFA has limited such matching to 30 days per episode, with an annual limit of 60 days.

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o **Drug Reimbursement**

The proposal indicates that rural districts that have partially capitated plans that do not provide pharmacy benefits may establish mail-order arrangements for the provision of prescription drugs on a fee-for-service basis. While mail-order arrangements for pharmacy benefits are used widely, New York should be aware that it is subject to drug rebate and drug utilization review requirements under fee-for-service reimbursement. We will require additional information about how drug benefits will be offered in different parts of the State, and how access to medically necessary drugs for all targeted populations will be assured.

o **Enrollment Process**

It appears that enrollment activities, including marketing and beneficiary education, potentially will vary by county or region. Some counties or regions may contract with a health benefits manager to undertake certain enrollment activities, which could include answering beneficiary questions, while other localities may not. Regardless of the enrollment procedures that are used, we will want to ensure that individuals eligible for the program receive complete and accurate information on which to base their selection of health plan. We are particularly concerned about approaches to informing persons eligible for enrollment into SNPs of their enrollment options.

o **Items Requiring Clarification**

Further clarification will be necessary with regard to several issues.

- o New York City's eligible population, health care delivery system, and managed care market constitute such a large proportion of the State's current and proposed programs that the City merits special focus. We will need a New York City-focused analysis of fundamental components of the plan related to changing utilization, service delivery, managed care capacity, and financing.
- o We will need additional information about how enrollment into SNPs will be operationalized; how the needs of individuals eligible for enrollment into an SNP will be addressed during the transition period; and how the needs of persons who may require access to services available through both types of SNPs will be addressed, both during the transition period and throughout the demonstration program.

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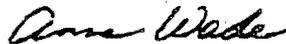
- o There is some confusion regarding the timing for inclusion of the Home Relief population as a covered group under Title XIX. When we met with you on April 10, you indicated that New York expects to receive Federal matching payments for the Home Relief population as these individuals are enrolled into managed care. However, the proposal indicates that the Home Relief population will be covered under the Title XIX program, effective July 1, 1995, suggesting that the State anticipates receiving Federal matching payments for these individuals as of this date, regardless of their enrollment status, even though enrollment for this group will be phased in over a 24-month period. If this is your intention, it is not clear why Federal matching payments for the Home Relief population should begin prior to their enrollment into managed care, and how this advances the goals of the demonstration. We will need clarification about this aspect of the proposal.

- o At our meeting of April 10, you indicated that individuals who are eligible for the Home Relief program, yet are determined to be "employable," will be limited to receiving Home Relief benefits for a 90-day period, and will not be enrolled into the program. This is not addressed in the proposal.

Although there are additional issues that we will need to address, in order to expedite the review of New York State's waiver request, we would like to begin now to work with your staff to resolve these major issues. If your staff has any questions concerning budget neutrality, Paul Boben is available to assist them, and can be reached at (410) 966-6629. Debbie Van Hoven is also available to provide assistance on programmatic issues. She can be reached at (410) 966-6625.

We look forward to working with you in resolving these issues.

Sincerely,



for Lu Zawistowich, Sc.D.
Director
Office of State Health Reform
Demonstrations

New York File

MEMORANDUM

TO: Laura Tyson
FR: Chris Jennings
RE: New York State and Health Care
cc: Paul Deegan

May 18, 1995

In preparation for your interview with The New York Times tomorrow, I am enclosing some background information on health care issues relating to the State of New York. Because of the Medicaid budgetary politics at the national and state level, your discussion with the Times Board is particularly timely.

Also timely is yesterday's Medicaid state-by-state analysis released by the Center on Budget and Policy Priorities. In it, a copy of which is enclosed, they conclude that **New York would lose \$19.4 billion (under Domenici) and \$20.9 billion (under Kasich) of Federal Medicaid dollars over seven years.** Tomorrow, the Kaiser Foundation is scheduled to release their state by state Medicaid impact analysis; they too conclude that New York would lose about \$19 billion over seven years. **This reduction in Federal health care dollars would be on top of the loss of incoming Medicare dollars; we recently estimated the Kasich cuts would significantly reduce -- by \$18.5 billion -- the amount of Medicare funds coming into New York.** (See attached.)

It is important to note that Governor Pataki's recent proposed cuts in Medicaid are creating firestorms of protest from our traditional "base." Many of the inner-city hospitals and the unions that represent them are claiming that the Governor's proposals (they haven't even focused yet on the possible Federal reductions) could result in significant layoffs, particularly in New York City. This controversy has already attracted the personal attention/involvement of Harold Ickes and Donna Shalala. In short, there are some major league politics here. As a result, other than discussing the macro issues of what the Congress is considering vis a vis Medicaid and its likely impact on New York, I advise caution in delving too far into the issues surrounding the Pataki Medicaid cuts.

Other background information enclosed for your use/review include: (1) a quick summary of New York and the Medicaid program; (2) a broader review of general New York health care stats and reform status; (3) some background information on the Pataki Medicaid issue, with some recent correspondence from and to the Governor, and (4) copies of some recent New York Times articles on the Pataki Medicaid proposals. If you have any questions, please don't hesitate to call me at 6-5560.



CENTER ON BUDGET AND POLICY PRIORITIES

May 17, 1995

STATE IMPACTS OF THE HOUSE AND SENATE BUDGET PROPOSALS FOR MEDICAID

By Cindy Mann and Richard Kogan

Both the House and the Senate Budget Committee would cut federal Medicaid spending deeply. The cuts would grow over time, and the depth of the cuts would vary widely among states.

The House Budget Committee would cut federal Medicaid payments to states \$187 billion over seven years, while the Senate Budget Committee would cut \$175 billion. Both Committees would impose an aggregate *cap* on federal Medicaid spending. Under the House plan, in fiscal year 1996 the federal government would pay 8 percent more than it did in 1995. Federal payments would rise by 5.5 percent in 1997, by 4 percent in each of 1998-2001, and by less than 2 percent in the year 2002.¹

The Senate Budget Committee would limit the growth of federal Medicaid payments, other than disproportionate share hospital ("DSH") payments, to 8 percent in 1996, 7 percent in 1997, 6 percent in 1998, 5 percent in 1999, and 4 percent per year thereafter. DSH payments would be retained but frozen at 1995 levels.

Both Committees characterize their Medicaid proposals as only slowing the rate by which federal Medicaid spending will grow, a characterization that tends to obscure the depth of the cuts in federal Medicaid payments that states would sustain over time, compared with the federal payments states could expect under current law. Under the House proposal, by the year 2002 the average cut would grow to 32 percent. The Senate cut is almost as harsh; by 2002, it would reach 30 percent.

The Depth of Cuts Would Vary Among States

The attached tables assume that payments to *each state* would be made on the basis of the House or Senate formula, using payments in fiscal year 1995 as the base. In 1996, for example, each state would receive 8 percent more than in 1995. This approach has

¹ One House Budget Committee document claims that "the increase in Medicaid payments would be restrained to 8 percent in fiscal year 1996, 5.5 percent in fiscal year 1997, and 4 percent a year thereafter." (The Budget Resolution for Fiscal Years 1996-2002: Discussion of Policy Assumptions, House Budget Committee, May 10, 1995. Emphasis added.) The Medicaid dollar figures in other Committee documents make clear that in 2002, however, the cap would limit the growth of federal Medicaid payments to less than 2 percent, not 4 percent.

been suggested by several prominent Republican governors.² Under this assumption, the cuts would be substantial for all states. But the depth of the cuts would vary widely among states, as the attached tables show.

- Under the House Budget Committee caps, 26 states would lose at least one-third of their federal Medicaid payments by 2002. The largest cuts would occur in West Virginia (a loss of 39 percent) and Florida, Georgia, and North Carolina (38 percent). In contrast, New Hampshire's federal payments would be cut only 10 percent; every other state would lose at least one-fifth of its federal payments.
- Under the Senate Budget Committee caps, 25 states would lose at least 30 percent of their federal funds by 2002. Federal Medicaid payments to West Virginia and North Carolina would be cut by 36 percent, while Florida and Georgia would suffer cuts amounting to 35 percent. New Hampshire, in contrast, would lose 15 percent of its federal funds, and Missouri and Kansas would lose 21 percent and 22 percent, respectively.

The variation in the percentage cuts reflects the expectation that growth in the number of beneficiaries and in costs will vary from state to state. For example, sunbelt states, with growing populations, are expected to have faster beneficiary growth than other states. Over time, a state-by-state cap will bear less and less relationship to current health care needs in the states.

A state-by-state cap also locks in place the inequitable distribution of *current* funding since all future federal payments are based on current payments. Medicaid spending per beneficiary averaged \$3,900 in 1993, but spending per beneficiary ranged from highs of \$9,700 in New Hampshire, \$7,100 in New York, and \$6,900 in Connecticut to lows of \$2,400 in Mississippi and New Mexico, and \$2,800 in California and Florida. In part, this results from the highly inequitable distribution of DSH funds.

Conclusion

Claims that the proposed Medicaid cuts are only slowing the rate of growth should not obscure the fact that the cuts in both the House and the Senate budget plans are very deep, and that these cuts will have a substantial impact on state budgets and states' ability to pay the cost of health care for children, elders, and disabled persons. Moreover, if the cuts are achieved through an aggregate cap based on historical spending patterns, the level of these cuts will vary among states in ways that do not reflect state health care costs over time. Federal savings and state flexibility can be achieved without resorting to approaches that can lead to such damaging and inequitable results.

² House and Senate Budget Committee documents say that the distribution of federal funds among states could vary from the 1995 distribution or from existing law. This analysis assumes state-by-state block grants based on 1995 payments to states, as suggested by some Republican governors; no specific alternative basis has been suggested.

HOUSE

Federal savings from capping Federal Medicaid payments
(using House Budget Committee caps. Dollars in millions)

Assumed cap =>	8.0%	5.5%	4.0%	4.0%	4.0%	4.0%	1.9%	7-yr Total	% In 2002
	1996	1997	1998	1999	2000	2001	2002		
Total	-2,939	-8,368	-16,342	-24,882	-33,772	-43,712	-56,569	-186,584	-32%
Alabama	-20	-73	-161	-258	-353	-459	-608	-1,931	-24%
Alaska	-10	-24	-43	-63	-83	-104	-132	-460	-35%
Arizona	-47	-122	-231	-351	-477	-616	-795	-2,638	-34%
Arkansas	-58	-142	-254	-370	-483	-606	-764	-2,678	-36%
California	-202	-636	-1,297	-2,017	-2,881	-3,875	-5,148	-16,054	-31%
Colorado	-35	-89	-164	-243	-324	-413	-526	-1,795	-35%
Connecticut	-9	-53	-132	-220	-314	-437	-601	-1,766	-25%
Delaware	-6	-17	-32	-49	-66	-85	-110	-366	-33%
DC	-15	-43	-83	-128	-175	-227	-293	-965	-34%
Florida	-244	-591	-1,039	-1,496	-1,939	-2,426	-3,036	-10,771	-38%
Georgia	-151	-362	-642	-928	-1,205	-1,509	-1,890	-6,686	-38%
Hawaii	-14	-33	-60	-88	-115	-145	-184	-639	-35%
Idaho	-11	-28	-54	-81	-109	-140	-179	-601	-33%
Illinois	-110	-304	-593	-913	-1,249	-1,624	-2,102	-6,895	-33%
Indiana	-76	-213	-414	-632	-866	-1,122	-1,449	-4,772	-33%
Iowa	-19	-57	-118	-185	-257	-335	-439	-1,410	-30%
Kansas	-4	-24	-61	-101	-146	-195	-267	-798	-24%
Kentucky	-75	-195	-364	-546	-734	-941	-1,202	-4,058	-35%
Louisiana	-97	-278	-537	-805	-1,056	-1,333	-1,717	-5,824	-28%
Maine	-2	-22	-59	-102	-150	-206	-289	-831	-25%
Maryland	-52	-139	-263	-398	-537	-693	-890	-2,971	-34%
Massachusetts	-67	-203	-411	-642	-892	-1,167	-1,520	-4,902	-31%
Michigan	-103	-294	-574	-883	-1,218	-1,587	-2,057	-6,715	-33%
Minnesota	-25	-91	-199	-321	-458	-609	-805	-2,509	-29%
Mississippi	-52	-132	-245	-366	-485	-616	-785	-2,681	-33%
Missouri	3	-33	-107	-191	-281	-382	-530	-1,522	-20%
Montana	-22	-52	-90	-127	-162	-199	-246	-899	-37%
Nebraska	-12	-34	-68	-107	-147	-192	-250	-810	-30%
Nevada	-9	-24	-47	-71	-98	-129	-168	-545	-32%
New Hampshire	10	9	-2	-13	-26	-40	-67	-130	-10%
New Jersey	-44	-159	-348	-555	-769	-1,005	-1,329	-4,210	-26%
New Mexico	-31	-77	-138	-201	-264	-334	-423	-1,467	-36%
New York	-179	-744	-1,662	-2,698	-3,831	-5,073	-6,684	-20,871	-30%
North Carolina	-182	-428	-742	-1,056	-1,348	-1,666	-2,066	-7,488	-38%
North Dakota	-6	-17	-35	-55	-77	-100	-130	-419	-29%
Ohio	-129	-364	-714	-1,092	-1,493	-1,934	-2,499	-8,225	-32%
Oklahoma	-53	-133	-240	-351	-459	-578	-727	-2,540	-34%
Oregon	-46	-112	-199	-287	-372	-465	-584	-2,064	-35%
Pennsylvania	-57	-236	-546	-887	-1,250	-1,648	-2,169	-6,793	-30%
Rhode Island	-14	-42	-87	-138	-192	-251	-327	-1,053	-31%
South Carolina	-43	-121	-236	-354	-467	-592	-762	-2,574	-27%
South Dakota	-6	-18	-36	-57	-79	-103	-134	-431	-31%
Tennessee	-87	-238	-473	-714	-947	-1,203	-1,533	-5,195	-34%
Texas	-212	-576	-1,080	-1,591	-2,090	-2,742	-3,578	-11,869	-32%
Utah	-21	-54	-100	-149	-198	-253	-323	-1,097	-34%
Vermont	-5	-15	-31	-49	-69	-90	-118	-378	-31%
Virginia	-69	-169	-302	-440	-572	-718	-904	-3,175	-36%
Washington	-83	-206	-373	-544	-716	-905	-1,145	-3,972	-35%
West Virginia	-83	-199	-349	-501	-647	-808	-1,008	-3,594	-39%
Wisconsin	-51	-145	-282	-435	-597	-776	-1,005	-3,291	-32%
Wyoming	-5	-13	-24	-35	-46	-59	-75	-256	-33%

SENATE

Federal savings from capping Federal Medicaid payments
(using Senate Budget Committee caps. Dollars in millions)

Assumed cap ==>	8%	7%	6%	5%	4%	4%	4%	7-yr Total	Percent cut in 2002
	1996	1997	1998	1999	2000	2001	2002		
Total	-3,619	-8,246	-14,689	-22,514	-31,649	-41,844	-52,528	-175,088	-30%
Alabama	-39	-88	-160	-252	-357	-473	-594	-1,963	-24%
Alaska	-10	-23	-38	-56	-76	-97	-120	-420	-32%
Arizona	-52	-114	-201	-309	-436	-576	-725	-2,413	-31%
Arkansas	-59	-127	-215	-317	-428	-549	-678	-2,373	-32%
California	-268	-629	-1,149	-1,805	-2,693	-3,713	-4,785	-15,042	-29%
Colorado	-39	-85	-146	-218	-299	-389	-483	-1,658	-32%
Connecticut	-24	-60	-120	-201	-301	-431	-565	-1,701	-23%
Delaware	-7	-15	-26	-41	-58	-77	-97	-321	-29%
DC	-17	-40	-72	-112	-160	-212	-267	-880	-31%
Florida	-256	-555	-926	-1,342	-1,785	-2,272	-2,781	-9,917	-35%
Georgia	-167	-357	-597	-863	-1,146	-1,456	-1,781	-6,367	-35%
Hawaii	-15	-32	-53	-79	-106	-137	-168	-589	-32%
Idaho	-11	-24	-43	-66	-94	-124	-155	-516	-28%
Illinois	-121	-274	-498	-783	-1,119	-1,495	-1,887	-6,177	-30%
Indiana	-90	-204	-365	-564	-801	-1,061	-1,333	-4,419	-30%
Iowa	-20	-46	-88	-145	-215	-292	-373	-1,178	-25%
Kansas	-11	-26	-54	-91	-138	-190	-248	-756	-22%
Kentucky	-78	-175	-307	-469	-656	-861	-1,076	-3,621	-31%
Louisiana	-161	-348	-584	-854	-1,140	-1,451	-1,782	-6,320	-29%
Maine	-9	-25	-53	-93	-144	-203	-271	-798	-24%
Maryland	-57	-129	-228	-351	-491	-647	-811	-2,715	-31%
Massachusetts	-86	-201	-368	-581	-838	-1,120	-1,414	-4,607	-29%
Michigan	-129	-294	-524	-810	-1,156	-1,535	-1,933	-6,381	-31%
Minnesota	-27	-71	-147	-250	-385	-534	-688	-2,102	-25%
Mississippi	-61	-131	-224	-336	-458	-592	-734	-2,536	-31%
Missouri	-25	-62	-123	-207	-311	-428	-549	-1,705	-21%
Montana	-22	-47	-78	-111	-144	-181	-219	-803	-33%
Nebraska	-12	-28	-53	-85	-125	-169	-215	-687	-26%
Nevada	-11	-25	-43	-65	-94	-125	-158	-521	-30%
New Hampshire	-3	-9	-20	-35	-55	-76	-99	-296	-15%
New Jersey	-78	-179	-331	-525	-754	-1,007	-1,270	-4,144	-25%
New Mexico	-31	-69	-117	-173	-236	-305	-378	-1,308	-33%
New York	-267	-728	-1,447	-2,390	-3,555	-4,830	-6,159	-19,376	-28%
North Carolina	-201	-425	-697	-991	-1,290	-1,615	-1,955	-7,173	-36%
North Dakota	-6	-14	-26	-43	-64	-86	-109	-348	-25%
Ohio	-151	-344	-619	-960	-1,367	-1,813	-2,278	-7,532	-29%
Oklahoma	-54	-119	-202	-300	-407	-524	-643	-2,249	-30%
Oregon	-47	-101	-169	-246	-330	-422	-518	-1,834	-31%
Pennsylvania	-86	-233	-482	-794	-1,168	-1,577	-2,009	-6,350	-28%
Rhode Island	-18	-41	-76	-122	-177	-238	-301	-973	-28%
South Carolina	-65	-140	-239	-354	-478	-614	-756	-2,647	-27%
South Dakota	-6	-14	-27	-45	-66	-90	-115	-362	-26%
Tennessee	-106	-239	-437	-662	-903	-1,165	-1,443	-4,955	-32%
Texas	-275	-607	-1,030	-1,511	-2,038	-2,719	-3,430	-11,610	-30%
Utah	-21	-47	-83	-125	-173	-227	-284	-959	-30%
Vermont	-6	-13	-26	-42	-61	-83	-106	-336	-27%
Virginia	-75	-160	-270	-395	-528	-676	-829	-2,933	-33%
Washington	-95	-204	-343	-502	-678	-871	-1,073	-3,765	-33%
West Virginia	-91	-195	-324	-465	-614	-777	-948	-3,415	-36%
Wisconsin	-52	-121	-221	-353	-512	-688	-870	-2,817	-28%
Wyoming	-5	-11	-19	-29	-40	-52	-65	-221	-29%

MAIN MEDICAID POINTS

REPUBLICAN PROPOSALS

HOUSE:

Policy: States will receive a fixed grant beginning in FY 1996

Based on FY 1995 federal expenditures, grown at:

8% in 1996;

5.5% in 1997;

4% in 1998 and subsequent years.

Federal Savings: \$187 billion between 1996 - 2002
\$54 billion (30% reduction from baseline) in 2002 alone

Impact on NY: Kaiser Commission
\$19 billion between 1996 - 2002: this is almost 10% of the total savings
\$6 billion (27% reduction from baseline) in 2002 alone

SENATE:

Policy: States will receive a fixed grant beginning in FY 1996.

Based on FY 1995 federal expenditures, grown at:

8% in 1996;

7% in 1997;

6% in 1998;

5% in 1999;

4% in 2000 and subsequent years.

This cap would apply to non-DSH expenditures
Disproportionate Share payments would be frozen at 1995 levels.

Federal Savings: \$175 billion between 1996 - 2002
\$53 billion (almost a 30 % reduction from baseline) in 2002 alone

Impact on NY: Kaiser Commission
\$19 billion between 1996 - 2002: this is almost 11% of the total savings
\$6 billion (27 % reduction from baseline) in 2002 alone

NEW YORK WAIVER GROWTH

New York has applied for an 1115 waiver to:

- o Managed care for all recipients except aged and institutionalized disabled;
- o New health plans for special needs populations.

New York projects its expenditure growth rate under the waiver to be 11%.

Under either the House or Senate block grant proposals, the federal expenditures to New York would grow at less than half the rate proposed under the waiver. This would make it impossible for New York to run its demonstration as planned.

New York

Current activity: Legislative leaders have signed on as sponsors of a comprehensive HMO "due process" bill. The bill is aimed at forcing HMOs to disclose in detail information about the distribution of revenues, the claims denial rate, and results of internal appeals. It would also lay the burden of proof upon HMOs to justify their selection or exclusion of providers.

Insurance reforms: (IHPP, 1994-95; Blue Cross/Blue Shield, 1994)

Small group and individual market reforms: (Enacted in 1992.) For firms with 3-50 employees: requires pure community rating (rates vary by plan type and geographic location only); open enrollment and guaranteed issue for individuals and small groups. Insurers are required to contribute to a reinsurance pool to help pay for high cost conditions such as AIDS. Another provision, which has not yet been implemented, requires insurers to contribute to another pool which would be used to subsidize insurers with a disproportionate number of high risk enrollees.

Impact: Although the evidence on the effect of reforms is incomplete, the NY Department of Insurance claims that the average insurance rates did not rise dramatically in the wake of pure community rating. However, the average masks fairly wide swings in rates (older enrollees generally received rate decreases, while younger ones received rate increases). There is controversy surrounding the enrollment impact of the reforms. It appears that more high risk individuals gained access to insurance and that some low risk individuals dropped their coverage. There is some evidence that the reforms enhanced price competition and spurred increased managed care penetration.

Other access measures: Child Health Plus - a state-subsidized private insurance program for uninsured low-income children under age 14.

Cost containment measures: New York has a multi-payer hospital rate-setting system based on diagnosis related groups (DRGs); Maryland is the only other state with a comprehensive system like this.

Medicaid:

High disproportionate share program state.

Proposed Medicaid 1115 demonstration would place the current Medicaid population (except the elderly and the institutionalized disabled) into managed care programs. It would also establish new health plans to serve special needs populations.

Proposed expansion of existing mandatory Medicaid Managed Care waiver to all of New York City.

Insurance Coverage, 1993 (March 1994 CPS)**	State	US
Employer-Sponsored Insurance	57%	57%
Medicare	9%	9%
Medicaid	11%	9%
Other	8%	10%
Uninsured	14%	15%
Enrollment in HMOs (% population) (AARP, 1994)	21.4%	17.4%
Health Expenditures		

Health Spending Per Person, 1994 (AARP, 1994)	\$3,742	\$3,068
Percent Population with High Out-of-Pocket Costs, 1992 (AARP, 1994)	9.0%	9.9%
Medicaid Costs per Recipient, FY 1993 (HCFA)	\$7,049	\$4,123
Health Status and Utilization (AARP, 1994)		
Low birth weight babies (%): White rate	6.2%	5.8%
Black rate	13.7%	13.6%
AIDS cases per 100,000, FY 1993	88.4	37
Hospital admissions per 1,000, 1992	137.4	131.5
Emergency unit visits per 1,000, 1992	379.4	375.6

** Note: These categories are mutually exclusive. If a person has both employer-sponsored insurance and Medicare or Medicaid, then that person is considered covered by employer-sponsored insurance. If a person has both Medicare and Medicaid, then that person is considered covered by Medicare. Thus, the Medicare and Medicaid counts do not match program data. Percents may not sum to 100% due to rounding.

THE WHITE HOUSE
Office of Media Affairs

FOR IMMEDIATE RELEASE
May 12, 1995

Contact: 202/456-7150

**Republican Budget Proposals:
A Broken Contract with American Families and their Parents in New York**

Medicare

"The Republican budget is wrong for working families, it is wrong for the elderly, it is wrong for the economy and I think it is wrong for the country...These Medicare cuts are being used to fund the crown jewel of the 'Contract,' which is the huge tax cut for the wealthy." White House Chief of Staff Leon Panetta, 5/10/95

Republicans are proposing the largest Medicare cuts in history. The House Republican proposal calls for \$279 billion in Medicare cuts over the next seven years. This means that on average Medicare beneficiaries would pay \$1,028 more in 2002 alone and \$3,447 over seven years. (This analysis assumes that 50% of the total proposed Medicare cuts would come from beneficiaries and 50% from providers.)

More than 2.6 million Medicare enrollees in New York would pay \$986 more in 2002 alone and \$3,423 more over seven years. Overall, the state of New York would lose \$5.3 billion in Medicare funding in 2002 alone and \$18.5 billion over seven years.

Tax Increase

Republicans are increasing taxes on millions of working families by scaling back the Earned Income Tax Credit (EITC). The Senate Republican budget proposal would raise taxes by \$21 billion over the next seven years on more than 12 million working households.

This would mean an average tax increase of \$1,506 over seven years on 718,506 working families in New York.

College Costs Increase

By eliminating the in-school interest exemption, House Republican proposal would raise college costs for four million students nationwide by up to \$3,000 each.

In New York, 383,394 students would have to pay up to \$3,000 more in costs for college loans or 18 percent per month in higher repayments.

CHAPTER ONE

INTRODUCTION & EXECUTIVE SUMMARY

New York State operates the nation's largest Medicaid program, serving a population whose needs and diversity are unmatched. With 3.6 million recipients and a program budget exceeding \$22 billion, New York Medicaid spending is more than double the national per capita expenditure and nearly equal to that spent by the next two highest States together. Growth in state spending for Medicaid has averaged nearly 11 percent a year over the past ten years. The local tax base can no longer support this unbridled growth, and taxpayers have lost confidence in the program's ability to provide quality health care at a price they can pay.

The State has proposed bringing the Medicaid program into line with available resources, through a combination of program reform, service realignments, and reimbursement changes. Even with these changes, New York will still rank at or near the top in per capita Medicaid expenditures and will continue to lead the nation in overall medical assistance expenditures.

The linchpin of New York's Medicaid reform effort is the statewide Section 1115 demonstration project described in the following pages. This initiative reflects the State's firm belief that it can provide better health care to its low-income and disabled citizens, including hundreds of thousands of poor children and pregnant women, in a more rational and cost-effective manner. This is to be accomplished by capitalizing on the competitive forces in the New York health care marketplace and employing the principles of managed care.

Over the past decade, New York has developed significant experience at the local level in managing the care of the Medicaid population. These local efforts have resulted both in significant savings and in improved quality of care for beneficiaries. New York now seeks to implement these reforms statewide, in order to construct, deliver and finance a system which will remain viable into the next century.

A. Background and Policy Context

Despite the large expenditure of public funds in the New York Medicaid program, significant numbers of Medicaid recipients continue to experience difficulty in accessing primary health care and many rely on hospital emergency rooms and outpatient departments for basic services. Over the years New York has implemented many programs in an attempt to correct this critical shortcoming. Programs like the Prenatal Care Assistance Program ("PCAP"), which provides comprehensive prenatal care and has improved birth outcomes for pregnant Medicaid eligible women, have made a difference for some individuals, however, they are at best a partial solution. A more comprehensive, all-encompassing strategy is needed to ensure that New York can assist its low income and disabled citizens in obtaining essential health care services.

The first step in this process involves developing a rational approach to purchasing health care services on behalf of those for whom the State has accepted responsibility. The current fee-for-service system of health care has proven problematic. Inherent in the fee-for-service model are financial incentives which drive care delivery to the more costly end of the service continuum. Reimbursement for primary and preventive care in a physician's office -- the most appropriate and efficient site of care delivery for basic services -- is woefully low. However, given current budget conditions, improvements in the level of reimbursement for these services can only be accomplished by re-allocating existing program dollars. Such re-allocations are not effectively accomplished within the regulatory model, and New York must rely more heavily on market forces to achieve these goals rapidly.

In re-structuring its Medicaid program, New York proposes to convert its delivery and financing system, which is characterized as one in which providers "do well by doing more," to one in which providers are rewarded for keeping patients healthy, thereby reducing the need for more invasive and costly medical interventions. Through the use of fully-capitated managed care plans, the State will ensure that each Medicaid recipient has a "medical home" and a rational way in which to obtain health care services. In return, they will be required to ensure that each enrollee has a primary care provider, adequate access to a full continuum of quality health care and 24 hour access to emergent and urgently needed services.

New York State's Medicaid population includes large numbers of individuals with special health care needs. The State currently has approximately 100,000 Medicaid recipients with HIV/AIDS, the largest number of any State. Another 100,000 recipients are diagnosed with serious mental illnesses or behaviorally disturbances. Significant numbers of recipients suffer from substance abuse, homelessness, and tuberculosis. The program reform model proposed by New York thus includes special initiatives directed at meeting the needs of those individuals with extensive and complex needs, while at the same time accommodating others with demands which more closely mirror a traditional, commercially insured population.

B. Managed Care Infrastructure

The managed care industry in New York State has grown exponentially during the past decade. In January 1984, there were a total of 13 HMOs operating in the State, with a total enrollment of slightly more than 1 million individuals. This number included fewer than 25,000 Medicaid recipients.

In 1985, comprehensive HMO regulations addressed certification of for-profit HMOs in New York State for the first time. This opened the door to significant market growth. At roughly the same time, the initial piece of legislation in New York's evolving effort to reform the Medicaid program was enacted. The Medicaid Reform Act of 1984 authorized and provided funding for the development and implementation of Prepaid Health Service Plans (PHSPs). PHSPs are generally formed by private not-for-profit providers, principally community-based organizations, to serve public assistance beneficiaries. PHSPs are required to meet the same reserve requirements and general fiscal solvency requirements as commercial HMOs,

although they may begin operating with a lower level of capitalization than is generally required by an HMO. Like HMOs, PHSPs are fully capitated and, like HMOs, they must demonstrate to the State Department of Health that they have comprehensive, accessible provider networks; the capacity to provide integrated and coordinated care across a broad spectrum of services; a formal enrollee grievance and complaint resolution process; and formal and systematic utilization review and quality improvement programs.

By January 1991, with a number of HMOs and PHSPs already in operation, the New York Legislature enacted legislation requiring every LDSS to develop a managed care program in its district, with the goal of enrolling 50% of the Medicaid population over five years.

Today, 30 comprehensive HMOs operate statewide, complemented by an additional 11 Prepaid Health Services Plans (PHSPs), serve almost 5 million New Yorkers, including approximately 500,000 Medicaid recipients. Forty-three of New York's 58 local districts have managed care programs, with an additional 5 to 8 districts ready to implement prior to the start of this Demonstration. Thus, throughout the State, both managed care plans and local governments have already garnered significant experience in serving Medicaid recipients through managed care.

C. Highlights of the Demonstration Design

The New York Demonstration is a statewide initiative. All fifty-seven counties and the five boroughs of New York City will be involved in the reform program.

Virtually all Medicaid recipients except those receiving long term care and those who are dually eligible for Medicare will be enrolled in fully-capitated HMOs and PHSPs. These plans will offer comprehensive benefits, with an emphasis on primary and preventive care and acute care services. In less populated areas of the State that may not have sufficient HMO/PHSP capacity for fully-capitated plans, the State will use partially capitated plans.

In addition, the State will contract with Special Needs Plans (SNPs) for the provision of care and case management services to persons infected with HIV and persons with AIDS, and to Serious and Persistently Mentally Ill (SPMI) adults and Seriously Emotionally Disturbed (SED) children. These SNPs will also be fully capitated. The HIV/AIDS SNP will provide all covered services, including personal care and nursing facility care, under a methodology which takes into account the degree of impairment of the individual. A local social services district may choose between two models for the mental health SNP, based on the needs of that jurisdiction. Those enrolled in the first model will receive all their health care, both physical and mental health care, through these entities. In the second model, the SNP will provide only mental health benefits and will coordinate with the HMO/PHSP for the provision of the basic health benefits.

Contract awards with managed care organizations -- HMOs, PHSPs, and SNPs -- will be based on several factors including quality of care, cost, and demonstrated capacity to serve Medicaid clients, including appropriate geographic distribution of health care providers. The

State will implement contracting strategies and policies specifically designed to encourage linkages between managed care plans and traditional community resources such as school-based clinics and federally qualified health centers.

Some aspects of the proposed program, most notably eligibility determinations and re-determinations, will be administered by the Local Department of Social Services (LDSS) or New York City's Human Resource Administration (HRA), as they are today. In addition, in several key areas, the Demonstration Project will give the LDSS or HRA various implementation options from which to choose. Local districts will select the health plans with which they wish to contract, based on locally developed selection criteria, from among a universe of plans pre-screened and designated by the State. Local districts will also be able to select the model for providing mental health benefits to the seriously and persistently mentally ill in their area. Moreover, local Commissioners will decide whether to carve out school-based general acute care health services and continue to pay for this care on a fee-for-service basis or to incorporate this primary care in the capitated plans.

This Demonstration will develop and test measures of access, processes and outcomes of care that are keyed to unique characteristics and health problems of the Medicaid population for all types of managed care plans. The State Department of Health will monitor the provision of primary and preventive care, treatment of illnesses and disease and the provision of all other health care in general. Cognizant agencies, including the AIDS Institute in the Department of Health, the Office of Mental Retardation and Developmental Disabilities, the Office of Mental Health, and the Office of Alcohol and Substance Abuse Services will work with the Department of Health to promulgate clinical standards of care in their areas of expertise and to monitor compliance with those standards.

D. Purpose and Value of the Demonstration

The proposed New York Demonstration Waiver program offers the federal government, through HCFA, the opportunity to implement comprehensive reform of a program that represents nearly one-fifth of all Medicaid program expenditures nationally. By working in collaboration with the State, HCFA can ensure the public significant savings over the existing entitlement program, while achieving substantial improvements in the areas of service delivery, access and quality of care.

The New York Demonstration Project also affords the unique opportunity to evaluate the benefits of serving large groups of individuals with special health care needs in a managed care environment. The fully capitated SNP model which will serve the HIV/AIDS Medicaid population will be unique in the country. Both of the proposed Mental Health SNP models offer unique mechanisms to serve the needs of seriously mental ill and emotionally disturbed populations when they are in a phase of their illness requiring a higher intensity of services.

The remainder of this document describes in detail the proposed New York demonstration program, identified as The Partnership Plan. Chapter 2, "Demonstration Design," is the heart of the proposal and describes in detail the structure of the program. Chapter 3, "Program

Administration and Management," sets forth the proposed management and administrative structure for the demonstration. Chapter 4, "Evaluation," presents a framework for structuring an evaluation to assess the effectiveness of the demonstration's design and operations. Chapter 5, "Caseload and Cost Estimates," presents caseload and cost projections, with and without the Section 1115 waiver, and demonstrates budget neutrality. Chapter 6, "Waivers Requested," list those sections of the Social Security Act and accompanying regulations which must be waived in order for the State to implement the demonstration project. Finally, Chapter 7, "Disposition of Existing and Pending Waivers," catalogues New York's current and proposed waiver projects and how they will be affected by the statewide initiative proposed in The Partnership Plan.

THE NEW YORK STATE PARTNERSHIP PLAN

On March 20, 1995, the State of New York submitted a section 1115 Medicaid demonstration proposal that would permit Federal financial participation for a demonstration entitled, "The Partnership Plan." The State is proposing to move approximately 2.8 million currently eligible individuals and approximately 400,000 Home Relief (General Assistance) recipients from a primarily fee-for-service delivery system to a managed care environment.

The New York State initiative incorporates three broad initiatives as part of The Partnership Plan:

- The transition of the State's acute care program from fee-for-service to one of prepaid managed care.
- The development of special needs plans (SNPs) to serve certain sub-populations that require intensive and heavily case-managed care regimens:
- The conversion of the State's Home Relief population (low income adults with no categorical linkage to Medicaid) to a Federal Title XIX eligibility group.

The State anticipates securing Federal approval for the program in July 1995, and intends to begin enrollment, using a phased-in approach, in November 1995.

Under The Partnership Plan, New York State will procure contracts both with State-certified Health Maintenance Organizations (HMOs) and State-certified Prepaid Health Services Plans (PHSPs). In addition, fully capitated SNPs will be established for the provision of care and case management services to individuals who are HIV-positive or who have AIDS, Seriously and Persistently Mentally Ill adults, and Seriously Emotionally Disturbed children.

Managed care enrollees will be entitled to the same benefits as are available under the fee-for-service Medicaid program and will receive a comprehensive benefits package. However, certain services, e.g. long term care services, will continue to be provided on a fee-for-service basis.

New York State is proposing to use \$1.5 billion of its Disproportionate Share Hospital allotment to fund coverage of the Home Relief population under Medicaid. The State expects to realize significant savings attributable to the managed care initiative over the 5-year demonstration program.

The State expects a pending section 1915(b) waiver that would provide for mandatory managed care enrollment for all AFDC and AFDC-related Medicaid recipients in New York City (over 500,000 individuals) to be approved and become operational in the summer of 1995 (and eventually be subsumed under the section 1115 waiver).



STATE OF NEW YORK
EXECUTIVE CHAMBER
ALBANY 12224

GEORGE E. PATAKI
GOVERNOR

March 17, 1995

Dear Secretary Shalala:

I am submitting on behalf of the State of New York an application under Section 1115 of the Social Security Act for approval of a Demonstration Project to implement a statewide managed care program. This project is an integral element of the State's overall strategy for reforming and restructuring its health care programs to comport with available state resources, to improve the system of delivery of health care, and to provide for more responsive and focused care that is likely to produce better health outcomes for those in need of health care services.

The submission of this application follows the completion of a process of public meetings, comment and involvement that was previously approved by your Health Care Financing Administration as consistent with your Department's policies on public participation in section 1115 demonstration project development.

In our Demonstration Project, we combine the existing Medicaid population (other than the elderly and disabled that are served in institutional settings or in alternative arrangements, and certain other excluded categories) together with the Home Relief population (those that are financially needy but do not meet federal categorical eligibility requirements), and provide for their health care through a system of managed care networks that will be selected after a competitive bid process and will be paid on a capitated basis. We believe that this reliance on private market structures will lead to greater reliance on primary and preventive care and less use of inappropriate and costly alternatives. At the same time, we are building a sound quality assurance system into our project, to assure that the promise of higher quality care and better health outcomes is realized.

-2-

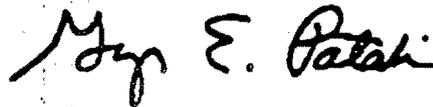
For those populations that have special needs and require more intensive services, our project will utilize special needs plans, which also will be focused on managing the care of their enrollees and will be paid for on a capitated basis.

We have considerable experience with managed care in New York, and we believe the capacity is available to handle the additional caseload that we propose to make available to that method of care. Further, our proposal will meet federal budget neutrality standards. It is my hope that we will be able in New York to effect significant savings in the overall level of Medicaid spending. The demonstration project will assist in that effort, both by making it possible to deliver necessary services in a more cost efficient manner and by enhancing the quality of service provided and improving the health of the people that we serve.

We in New York are committed to begin implementation of the program this year, and we therefore are asking that your Department give priority attention to our proposal. Dr. Barbara DeBuono, Commissioner of Health, and Mary Glass, Commissioner of Social Services, are jointly responsible for the overall direction of the Demonstration Project. I ask that you and your Department work with them in the waiver approval and implementation process. They fully understand and are in accord with the importance of early action on our proposal and are prepared to respond immediately to any requests of your staff.

We look forward to working with you and your Department in the speedy processing of our application and in the implementation of the demonstration program.

Very truly yours,



Honorable Donna E. Shalala
Secretary
Department of Health and Human Services
200 Independence Avenue
Washington, D.C. 20201



THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

MAR 28 1995

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

Dear Governor Pataki:

Thank you for your Medicaid section 1115 demonstration proposal entitled "The Partnership Plan," which we received on Monday, March 20th. My staff are currently reviewing the proposal in detail and will be in touch with State health officials shortly to begin the evaluation process.

I understand that you have already responded to initial public concerns regarding the waiver by slowing down your implementation schedule and delaying until January 1997 enrollment of some of New York's most vulnerable citizens.

Based on my experience with other waiver applications and my own knowledge of the health care system in New York State, I wanted to bring to your attention some initial issues that will be addressed as part of this Department's review of your State's proposal. We will be able to provide a more comprehensive list of issues after my staff and I have had time to fully review your proposal.

Even with full implementation delayed until 1997, we will need to examine carefully whether managed care plans in New York have the capacity to fully sustain such a broad-based expansion. I will be particularly interested in understanding how the State plans to monitor quality and effectiveness of care, and what systems the State will put in place to limit enrollment should problems develop. We will also pay close attention to the treatment of the numerous chronically ill persons who will be moved into managed care. We will also want to evaluate very carefully the proposed program's impact on the State's most vulnerable populations, particularly the frail elderly and individuals with HIV and other chronic diseases. These special populations have a great deal to gain from organized systems of care and a great deal to lose if new service systems do not have the sensitivity and capacity to deal with their very special needs.

Page 2 - The Honorable George E. Pataki

In addition, we will want to ensure that patients treated by existing service providers such as public hospitals, community health centers and other essential community providers, as well as academic health centers receive quality health care services. We will also want to consider the ability of these institutions to continue to maintain quality workforces. The transition to managed care should give these institutions an appropriate opportunity to participate in the new system, as well as maintain their contributions to the community.

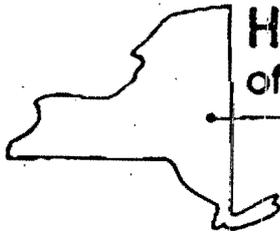
Finally, it has been our experience that successful health care demonstrations turn upon a state's effective consultation with the public, including elected and appointed officials, beneficiaries, and all those in the New York health care industry from the design through the implementation of the demonstration.

We are looking forward to working with you on this proposal. If Commissioners DeBuono or Glass have any questions during the review process, they may contact Lu Zawistowich, Sc.D., Director, Office of State Health Reform Demonstrations, Health Care Financing Administration, at (410) 966-6649 or John Monahan, my Director of Intergovernmental Affairs at (202) 690-6060. If you have any questions, please do not hesitate to call me.

Sincerely,



Donna E. Shalala



Healthcare Association of New York State

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MEDICAID REFORM IN THE 104TH CONGRESS BLOCK GRANTING PROPOSALS

The Congressional Leadership and a group of Governors have been meeting to draft a Medicaid reform plan. Discussions have been centered on reducing Federal spending and turning program control over to the States. Squarely on the table are proposals to repeal the entitlement status of the Medicaid program and to curb growth through a "block grant" or "capped entitlement" approach.

Under a block grant approach, Congress would set an annual target for growth in Medicaid spending and increase the grant to each State by that amount. Proposals for the annual growth target are between four and 8.8 percent. Medicaid spending is currently increasing at a national average of about 11 percent.

HANYS does not support repealing the entitlement status of the Medicaid program and moving to block grants. Limiting Medicaid growth to a fixed percentage does not allow States the flexibility necessary to cope with future conditions beyond local control such as an economic downturn or a change in the health status of communities -- such as the large increase in tuberculosis cases currently burdening the New York health care system. Enacting such a proposal would severely curtail the Federal funds available to New York for treatment of Medicaid beneficiaries.

The often mentioned five percent cap on Medicaid spending would reduce Federal Medicaid spending by about \$193 billion between 1996 and 2002 (Congressional Budget Office estimate). New York State's share of this reduction could reach over \$21 billion during this period. In 1996 alone such a cap would cut Federal Medicaid payments to New York by more than \$500 million. That number would grow to over \$6 billion in 2002.

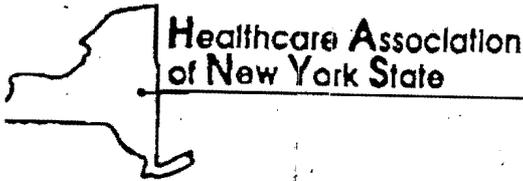
While the imposition of a cap on Federal spending that greatly restrains growth would drastically cut the Federal funds made available to States, New York is also threatened by how the funding formula and baseline for any block grant proposal would be calculated. If such a proposal were to be enacted, it is in the best interests of New York State to ensure that the block grant formula maximizes the amount of Federal Medicaid funds that flow to the State.

MEDICAID REFORM IN THE 104TH CONGRESS
BLOCK GRANTING PROPOSALS

Page 2

FACTORS IMPORTANT TO NEW YORK

1. It is critical to New York that the baseline include Medicaid disproportionate share payments and an adjustment mechanism for increases in a states' uninsured and Medicaid-eligible population. If the baseline for a five percent Federal Medicaid growth cap were to exclude Medicaid disproportionate share payments, New York could lose an additional \$10 billion in Federal Medicaid funds, resulting in a \$31 billion reduction for New York over seven-years.
2. Another critical issue for New York is the time period that will be used to calculate the base amount that future grants will be based on so New York's share of the available funds is maximized. For example, if State Fiscal Year (SFY) 94-95 [which corresponds with Federal Fiscal Year 1994] were used to calculate future grants, the Federal grant would be based on the level of Medicaid spending prior to any of the proposed State Medicaid reductions. If SFY 95-96 [which corresponds with Federal Fiscal Year 1995] were used, the Federal grant would be based on New York Medicaid spending that has already been reduced by the Governor's budget proposals. Under the later scenario, New York's future Federal grants would be reduced by more than \$2 dollars for every dollar of State cuts. In such a case, New York could lose an additional \$9 billion in Federal Medicaid funds, making the total seven-year reduction for New York \$30 billion.
3. The maintenance of an adequately-financed emergency pool to finance indigent care at times when severe economic distress depletes spending under the baseline is a key responsibility that should remain with the Federal government.
4. Current assurances that require States to pay hospitals Medicaid rates that provide reasonable and adequate payments for efficiently and economically operated facilities should be maintained.
5. States should be required to maintain their current contributions to Medicaid programs, even if the program no longer has a Federal matching provision, rather than divert medical care funds for other state operations.



FACTS AND STATISTICS ON THE MEDICAID PROGRAM

New York State

Of the 2.56 million New Yorkers who receive Medicaid benefits {federally eligible}:

- 1.32 million {51.8 percent} are children;
- 342,000 {13.4 percent} are blind and/or disabled; and
- 315,000 {12.3 percent} are elderly.

National

Of the 32.1 million individuals who receive Medicaid benefits throughout the U.S.:

- 16.1 million {50.15 percent} are children;
- 4.9 million {15.3 percent} are blind and/or disabled; and
- 3.7 million {11.5 percent} are elderly.

The remaining 7.4 million {23 percent} are adults in families.

More than three-quarters of Medicaid recipients in the U.S. are children, blind, disabled, or elderly.

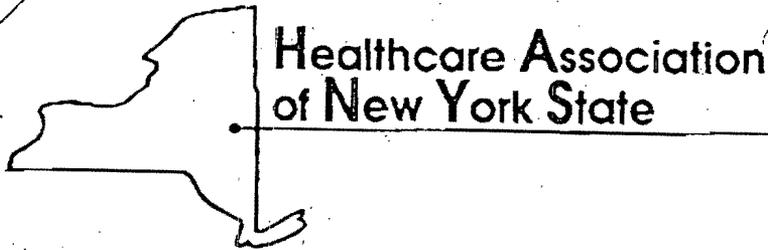
Less than one-quarter of the people on Medicaid are adults who are not elderly, blind, or disabled.

Other Facts

The elderly, blind, and disabled account for 67 percent of all Medicaid spending in the U.S.

Nationally, one of the fastest growing groups of Medicaid beneficiaries is the blind and disabled. A primary reason for the increase in this group is the increased number of AIDS patients who have lost or can't obtain health insurance and the court-required coverage of disabled children.

Source: Kaiser Commission on the Future of Medicaid and the Healthcare Association of New York State



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FOR IMMEDIATE RELEASE
WEDNESDAY, MARCH 8

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EVERY \$13,020 CUT IN STATE MEDICAID FUNDS = ONE LOST JOB

Albany, March 8 -- One New York State job would be lost for every \$13,020 cut in the State share of Medicaid, according to a study conducted by Lewin-VHI, a Washington D.C.-based health care consulting firm, and Regional Economic Models, Inc. (REMI), a developer of multi-region forecasting and policy analysis models. This means that New York State will experience a loss of 122,000 jobs in 1996 and 95,000 jobs in the year 2000 if the proposed State Budget cuts are enacted.

The study, "Analysis of the Economic Impact of Proposed Medicaid Budget Cuts in New York State," was commissioned by the Healthcare Association of New York State (HANYS) and the Greater New York Hospital Association to assess the impact on New York's economy as well as the immediate impact on health care providers.

The Medicaid program cuts proposed by Governor Pataki would have a powerful negative effect on the New York State economy, principally due to the significant loss of federal funds. In addition to job losses, the analysis shows:

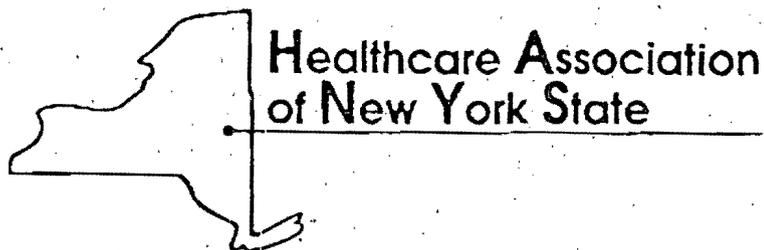
- The real gross State product would be reduced by approximately \$5.1 billion in 1996, and approximately \$3.8 billion in the year 2000.
- Personal income would be reduced by more than \$6 billion in 1996, and approximately \$8.5 billion in the year 2000.
- Disposable income would be reduced by approximately \$3.4 billion in 1996, and approximately \$5.2 billion in the year 2000.
- Real disposable income would be reduced by over \$1 billion in 1996 as well as over \$1 billion in the year 2000.

(An outline of the statewide and regional results from the study is attached.)

Noting that New York "has been tightly regulated for years," the report states that "the size and timing of the proposed Medicaid cuts are unlikely to produce orderly changes promoting efficiency, at least in the short and intermediate terms. Reductions in service and service denial are a more likely result. Thus, the overall capacity of the New York health care system to provide services to the poor and non-poor alike will be diminished. A likely result is reduced health outcomes."

"This report is further evidence that Medicaid cuts will affect all of us," said Daniel Sisto, HANYS President. "Clearly, these cuts will directly affect our access to health care services, our individual health, and the health of this State's economy."

HANYS is the principal advocate for more than 400 not-for-profit or public hospitals, nursing homes, home care agencies, adult day care programs, and other health care providers.



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**ANALYSIS OF THE ECONOMIC IMPACT OF
PROPOSED MEDICAID BUDGET CUTS IN NEW YORK STATE
PREPARED BY LEWIN-VHI**

The Healthcare Association of New York State (HANYS) and the Greater New York Hospital Association (GNYHA) commissioned Lewin-VHI, Inc. and Regional Economic Models, Inc. (REMI) to assess the net economic impact of Governor Pataki's proposed Medicaid cuts.

The proposed \$3.6 billion in Medicaid cuts (that results from reductions in federal, state, and local revenues to local health care providers) would result in \$5.1 billion in Medicaid cuts when fully phased-in in 1996, which would lead to a significant overall slowdown in the New York State economy. (There would be a loss of \$2.3 billion in Medicaid federal matching funds in 1996.) The economic slowdown would continue through the end of the study period, which is the year 2000.

Specific impacts for 1996 and 2000 are provided below. These impacts are net losses assuming that State and local savings from the proposed Medicaid budget cuts are reinvested in the economy.

● **New York State Impacts:**

- New York State would have a net loss of more than 120,000 jobs in 1996, and over 95,000 jobs in the year 2000.
- The real gross State product would be reduced by approximately \$5.1 billion in 1996, and approximately \$3.8 billion in the year 2000.
- Personal income would be reduced by more than \$6 billion in 1996, and approximately \$8.5 billion in the year 2000.
- Disposable income would be reduced by approximately \$3.4 billion in 1996, and approximately \$5.2 billion in the year 2000.
- Real disposable income would be reduced by over \$1 billion in 1996 as well as over \$1 billion in the year 2000.

- **Central New York Impacts:**

- The Central New York region would have a net loss of more than 6,000 jobs in 1996, and over 4,700 jobs in the year 2000.
- The real gross regional product would be reduced by approximately \$200 million in 1996, and approximately \$140 million in the year 2000.
- Personal income would be reduced by over \$200 million in 1996, and approximately \$300 million in the year 2000.
- Disposable income would be reduced by over \$100 million in 1996, and over \$150 million in the year 2000.
- Real disposable income would be reduced by approximately \$40 million in 1996, as well as in the year 2000.

- **New York City Impacts:**

- The New York City region would have a net loss of more than 76,000 jobs in 1996, and approximately 60,000 jobs in the year 2000.
- The real gross regional product would be reduced by more than \$3.5 billion in 1996, and approximately \$2.7 billion in the year 2000.
- Personal income would be reduced by over \$3.6 billion in 1996, and over \$5.1 billion in the year 2000.
- Disposable income would be reduced by over \$2.2 billion in 1996, and over \$3.3 billion in the year 2000.
- Real disposable income would be reduced by over \$500 million in 1996, and approximately \$450 million in the year 2000.

- **Long Island Impacts:**

- The Long Island region would have a net loss of more than 11,000 jobs in 1996, and over 9,200 jobs in the year 2000.
- The real gross regional product would be reduced by \$400 million in 1996, and over \$300 million in the year 2000.
- Personal income would be reduced by over \$800 million in 1996, and approximately \$1.2 billion in the year 2000.
- Disposable income would be reduced by over \$400 million in 1996, and approximately \$650 million in the year 2000.
- Real disposable income would be reduced by over \$200 million in 1996, and \$230 million in the year 2000.

- **Northeastern New York Impacts:**

- The Northeastern New York region would have a net loss of more than 4,900 jobs in 1996, and over 4,100 jobs in the year 2000.
- The real gross regional product would be reduced by more than \$150 million in 1996 and over \$120 million in the year 2000.
- Personal income would be reduced by approximately \$200 million in 1996, and approximately \$290 million in the year 2000.
- Disposable income would be reduced by approximately \$100 million in 1996, and over \$150 million in the year 2000.
- Real disposable income would be reduced by over \$35 million in 1996, and approximately \$50 million in the year 2000.

- **Northern Metropolitan Impacts:**

- The Northern Metropolitan region would have a net loss of more than 9,500 jobs in 1996, and over 7,500 jobs in the year 2000.
- The real gross regional product would be reduced by more than \$300 million in 1996, and over \$200 million in the year 2000.
- Personal income would be reduced by approximately \$650 million in 1996, and over \$900 million in the year 2000.
- Disposable income would be reduced by over \$300 million in 1996, and approximately \$500 million in the year 2000.
- Real disposable income would be reduced by approximately \$130 million in 1996, and over \$140 million in the year 2000.

- **Rochester Region Impacts:**

- The Rochester region would have a net loss of more than 5,200 jobs in 1996, and over 4,000 jobs in the year 2000.
- The real gross regional product would be reduced by more than \$200 million in 1996, and approximately \$130 million in the year 2000.
- Personal income would be reduced by over \$200 million in 1996, and approximately \$280 million in the year 2000.
- Disposable income would be reduced by over \$100 million in 1996, and over \$150 million in the year 2000.
- Real disposable income would be reduced by approximately \$50 million in 1996, as well as in the year 2000.

- **Western New York Impacts:**

- The Western New York region would have a net loss of more than 7,500 jobs in 1996, and over 6,100 jobs in the year 2000.
- The real gross regional product would be reduced by more than \$220 million in 1996, and approximately \$170 million in the year 2000.
- Personal income would be reduced by over \$250 million in 1996, and over \$370 million in the year 2000.
- Disposable income would be reduced by over \$150 million in 1996, and over \$230 million in the year 2000.
- Real disposable income would be reduced by over \$75 million in 1996, and over \$80 million in the year 2000.

According to the report, "In a state such as New York... which has been tightly regulated for years, the size and timing of the proposed Medicaid cuts are unlikely to produce orderly changes promoting efficiency, at least in the short and intermediate term. Reductions in service and service denial are a more likely result. **Thus, the overall capacity of the New York health care system to provide services to the poor and non-poor alike would be diminished.** A likely result is reduced health outcomes."

FOR IMMEDIATE RELEASE
MARCH 1, 1995

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BUDGET CUTS WOULD LOCK NEARLY 50,000 NEW YORKERS OUT OF NURSING HOME CARE

ALBANY, N.Y. — The proposed State Budget cuts will force an estimated 49,350 New Yorkers to compete for fewer than 3,500 available nursing home beds, the Healthcare Association of New York State (HANYS) said today.

"The proposed elimination and restriction of home- and community-based health care services will dramatically increase demands for nursing home admission at the same time that nursing home expansion will be curbed," HANYS President Daniel Sisto said. "This is a real disservice to New York's growing population of senior citizens," he said. According to the U.S. Census of 1990, the most rapidly growing age group in New York is the 65+ group. On average, the senior population uses more than one-third of all health care delivered.

"In addition, discharge-ready hospital patients who need follow-up care will have to stay in the hospital and will occupy beds needed by others," Mr. Sisto said.

HANYS estimates that no more than 3% of New York State's 109,000 skilled nursing facility beds, or 3,270 beds, will be open at any given time in 1995-96. However, the elimination and

restriction of home and day health care programs will force an estimated 49,350 New Yorkers -- both private-pay patients and those whom Medicaid assists in paying their long-term health care bills -- to apply for admission to nursing home care.

HANYS estimates that:

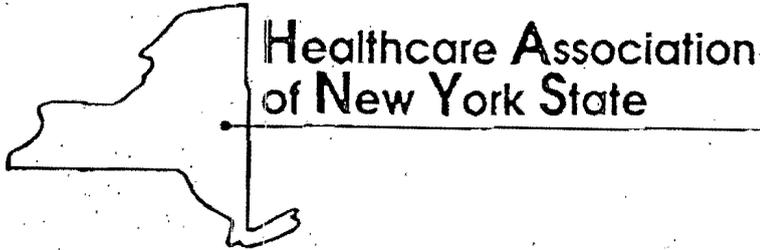
- ✓ At least 12,600 individuals now receiving personal care services (20% of the 63,000 individuals receiving personal care in New York City) will need to be transferred immediately to nursing homes if Governor Pataki's proposed cuts in personal care services are enacted.
- ✓ The 4,200 New Yorkers eligible to receive assisted-living services in adult homes and other senior housing would have to be transferred to nursing homes if the assisted-living program is terminated as Governor Pataki proposes.
- ✓ About 70% of the clients of the Long-Term Home Health Care program, or 14,000 New Yorkers, will have to be transferred to nursing homes if the program is eliminated as Governor Pataki proposes. (All of the program clients are already eligible for nursing home care.)
- ✓ At least half of the Adult Day Health Care clients, or 2,750 New Yorkers, will need nursing home services if the program is terminated as Governor Pataki proposes. (All of the program clients are already eligible for nursing home care.)

- ✓ At least 2,300 New Yorkers now residing in or applying for admission to out-of-state nursing homes would have to move into New York homes if out-of-state nursing home placements are restricted as Governor Pataki proposes.

- ✓ Some 13,500 New Yorkers who are now seeking admission to nursing home care or expect to need such care in the coming year will be unable to get into a home if the Governor's proposed moratorium on nursing home expansion or construction is enacted.

Thus, a total of at least 49,350 individuals will be seeking nursing home care at a time when only 3,270 beds are available.

HANYS is the principal advocate for more than 400 non-profit or public hospitals, nursing facilities, home care agencies, adult day care programs, and other health care providers.



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FOR IMMEDIATE RELEASE
MARCH 27, 1995

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NEW YORKERS OPPOSE CUTS IN MEDICAID, POLL SHOWS

ALBANY, N.Y. -- New Yorkers oppose cuts in Medicaid funding, according to a poll released today by the Healthcare Association of New York State.

"The poll clearly shows that while New Yorkers may have voted for smaller, more efficient government in November 1994, they were not voting for reductions in the health care system that serves us all," said HANYS President Daniel Sisto.

The poll of 500 New Yorkers was conducted on March 8 and 9 by Public Opinion Strategies of Alexandria, VA, to ascertain New Yorkers' opinions regarding both Medicaid, the federal/state/local government-funded program for the poor, disabled, and elderly persons needing long-term health care, and Medicare, the federal health care program for senior citizens. Although the poll focused primarily on federal proposals for Medicaid and Medicare, the results indicate that New Yorkers also would oppose State government reductions in Medicaid funding. The survey was commissioned by the American Hospital Association in conjunction with HANYS. The margin of error was +/- 4.4%.

LEVEL 1 - 10 OF 12 STORIES

Copyright 1995 The New York Times Company
The New York Times

March 18, 1995, Saturday, Late Edition - Final

SECTION: Section 1; Page 25; Column 2; Metropolitan Desk; Second Front

LENGTH: 1543 words

HEADLINE: Hospitals Say Cuts in Medicaid Will Mean Longer Stays

BYLINE: By ESTHER B. FEIN

BODY:

For the last several years, many hospitals in New York have made themselves more efficient by reducing the length of patient stays. But deep cuts to the Medicaid program threaten to reverse that trend, many hospital officials say.

The cuts, proposed by Gov. George E. Pataki, would reduce many of the home and community health services that have made it possible for hospitals to release patients quickly.

With less of that help -- which includes home attendants, long-term home health care, personal care and housekeeping -- hospital officials say it is likely that they will face increasing problems when they try to send patients home.

The new cuts being proposed -- part of \$1.2 billion in Medicaid reductions put forth by the Governor -- come on top of other Federal, state and local cuts to various health and social service agencies imposed last year that hospital officials say have already begun making it harder to discharge some patients.

For instance, at Columbia-Presbyterian Medical Center, the number of AIDS patients who remain at the hospital after they are medically ready to leave doubled in the first two months of 1995 compared with the same period last year. Officials say that cuts to the city's Department of AIDS Services and other agencies have squeezed options for housing and care.

Some hospitals are even paying for patients' uncovered expenses outside their walls to keep from prolonging costly stays unnecessarily. Montefiore Medical Center in the Bronx spent about \$100,000 out of its own pocket last year on prescription medicine for patients who could not be discharged without it.

Squeezed both by lower fees for caring for Medicaid patients inside the hospital and by the shrinking availability of Medicaid services on the outside, some hospitals may have to shut down wards and others may be forced to close their doors, hospital officials and other experts say.

"The threat of insolvency for many hospitals is very real," said James R. Tallon, president of the United Hospital Fund, a philanthropy in New York City focusing on health issues. "If you constrain the options for post-hospital services and cut the reimbursement rates to hospitals simultaneously, you put an unbearable strain on the system that will jeopardize the health of both hospitals and patients."

The New York Times, March 18, 1995

But some state officials say that the cuts are necessary to get soaring Medicaid costs under control, and that the hospitals are exaggerating the threat to their survival. "There is still room in the health care system at all levels to improve efficiency," said Claudia S. Hutton, a spokeswoman for the State Division of the Budget. She said that the state would "track the effects of the budget cuts on overall costs and quality of care," but that she doubted any changes would be needed.

"We do not believe this trend hospitals are citing will occur," she said. "We believe there are enough home care services for hospitals to discharge patients at a quicker rate."

Hospital workers who scramble each day to piece together safe discharge plans said they already had patients -- old, young, with families and alone -- who were staying in hospitals longer than they should because of budget cuts.

In the brief 11 months she has been alive, Aimee DeCastro has become a case study in what hospital officials see as the consequences of cuts in home care.

Born at Columbia-Presbyterian last April with spina bifida, a crippling congenital neural tube defect, Aimee is severely disabled mentally and physically, tethered to machines that help her breathe, eat and swallow.

Although her long-term chances of survival are dim, doctors at the hospital thought last December that with 20 hours of care a day by a registered nurse, Aimee could go home with her mother, Maria Liriano, to the stuffed animals and lacy dresses that awaited her in their small apartment in the Inwood section of Manhattan.

But Medicaid officials would approve only 16 hours of care by a licensed practical nurse. Aimee's doctors said that while her mother was trained to monitor the machines and to perform cardiopulmonary resuscitation, the baby was too fragile to survive that many hours without a nurse's care.

By law, they could not discharge her if they believed such a plan was not safe, so they kept Aimee in the hospital an extra 48 days while she grew stronger.

By the time she was discharged on Jan. 27, the hospital had spent about \$62,000 more than it was reimbursed for her care. Meanwhile, Aimee had caught a bacterial infection, a risk faced by all hospital patients, and her mother had grown despondent waiting for her baby's return.

"It made me so furious," Ms. Liriano said. "There was this high cost to the hospital, the cost to me of traveling every day to see my baby -- and that is not even to mention the emotional toll. I guess for those days, Medicaid saved itself some money, but at what cost to everyone else?"

During the last 48 days of her stay, Aimee was on an "alternate level of care," meaning she no longer needed an acute care hospital, but no safe discharge plan had yet been approved for her. Medicaid paid \$175 a day for her care at that level, but it cost the hospital more than \$1,500 a day to keep her in the neonatal intensive-care unit.

The New York Times, March 18, 1995

If proposed Medicaid cuts were passed, the hospital would be paid even less, because the Governor's budget calls for capping at 15 the number of "alternative level of care" days, while now there is no limit. After 15 days, the hospital would have to absorb the full costs until the patient is discharged.

In addition to the Medicaid cuts, hospital social workers said that cuts in other agencies had made it harder for them to get necessary help and approval for discharge plans.

When an abused child is medically ready to leave the hospital, a social worker at Montefiore said, it often takes days to get a phone call returned from the overburdened caseworkers at the city's Child Welfare Administration to coordinate the child's placement. The agency has suffered deep budget cuts over the last year and faces even more.

"So the kids stay here and wait," said the social worker, Frances Paolini. "Meanwhile, the hospital is being paid at the lower A.L.C. rates and we don't have the bed free for a new admission."

A spokeswoman for the Child Welfare Administration, Karen Calhoun, said that the delays involved only "special needs" children -- those with AIDS or psychiatric problems, for example. But social workers at other hospitals echoed Ms. Paolini's frustrations at the lag in reaching agency caseworkers.

As they struggle to devise discharge plans, social workers and hospital administrators said, they must also keep up their efforts to whittle away the length of patient stays, an important indicator of a hospital's financial efficiency.

Hospitals are paid a fixed fee for Medicaid patients, depending on the illness, so it is in their best financial interest to treat and release patients as quickly as possible. Data compiled by the United Hospital Fund show that hospitals in the city have reduced the average length of patient stays over the last four years, to 9.19 days for the first six months of 1994 from 9.97 days in 1991.

The task will grow far more difficult, hospital officials said, if the full range of Medicaid cuts are approved -- including lowering reimbursement rates to hospitals and nursing homes; limiting home attendant care to 100 hours per month; eliminating the long-term home health care program and halting the adding of new nursing home beds beyond those already approved.

"We worked so hard on improving the length of stay and on developing a humane and cost-effective home care system," said Elizabeth Streyve, a senior vice president at the Greater New York Hospitals Association. "It would be such a travesty if we did an about-face. Emergency rooms will back up with patients because the beds upstairs will be filled with nonpaying patients who are too well to be in the hospital but too sick to be sent home with the level of care the state is willing to provide."

Social workers said they would face the biggest problems trying to plan the discharges of elderly patients, who make up most of their cases and who often have limited resources.

The New York Times, March 18, 1995

"For the elderly who live alone, which is many of them, three, four hours a day of a home attendant is just not enough to safely send them home," said Tim Bryden, director of social work services and discharge planning at Montefiore. "We'll have to send many to nursing homes, and they will resist fiercely."

But if the cuts go through, there will be "gridlock in the nursing homes," said Harvey Finkelstein, president of the Jewish Home and Hospital for Aged, which has branches in Manhattan, the Bronx and Westchester.

"And if our rates drop, too," he said, "we will be forced to accept the sickest patients, whose care is reimbursed at the highest rate. So where will that leave people? Not at home, because those services have been cut. Not with us, because we won't be able to afford to take many long-term chronic custodial cases. They'll be in the hospitals, if they can even get into them once the emergency rooms start backing up."

GRAPHIC: Photo: Hospital officials say cuts in government financing for home and community health care will keep many patients in hospitals longer than necessary. Maria Luriano holds her daughter, Aimee -- who stayed in an extra 48 days -- as a licensed practical nurse, Delores Perry, writes a report. (Angel Franco/The New York Times) (pg. 28)

LANGUAGE: ENGLISH

LOAD-DATE-MDC: March 18, 1995

LEVEL 1 - 21 OF 41 STORIES

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The New York Times

March 26, 1995, Sunday, Late Edition - Final

SECTION: Section 13LI; Page 1; Column 1; Long Island Weekly Desk

LENGTH: 1634 words

HEADLINE: Pataki's Budget Cuts Threaten At-Home Care for Elderly Poor

BYLINE: By RACHEL KREIER

BODY:

CONCEPCION RODRIGUEZ, 91, and her sister Maria Mayor, 87, live in a modest ranch house in a working-class neighborhood of West Islip with their niece Georgina Corostola. Although the sisters meet Medicaid criteria to be admitted to a nursing home, they, like 1,800 other Nassau and Suffolk County residents, live at home with the support of the state's Nursing Home Without Walls program.

The state started the program, formally called the Long-Term Home Health-Care Program, in 1984. It provides home services like nursing care, rehabilitation therapy and health aides.

Each patient is assigned a case manager to oversee care within a monthly budget. Only people who meet Medicaid guidelines for nursing-home admission are eligible, and the law limits costs to 75 percent of local nursing-home costs.

The Pataki administration says taxpayers cannot afford to continue providing Medicaid money for the program and projects saving \$48.5 million a year by eliminating it.

Advocates say the Nursing Home Without Walls program not only saves patients -- and their families -- the heartbreak of institutionalization, but also saves money. They note, too, that it was one of the first managed-care programs in the state, because each patient is assigned a case manager to oversee care.

On Long Island last year the average annual cost for patients being cared for at home in the program was \$23,775, or 43 percent of the \$55,008 a year that Medicaid for nursing-home care. Nursing homes on Long Island often charge private patients higher fees.

The proposal to eliminate the program is one of a series of cuts in Medicaid, the program that assists the poor elderly, being proposed by the Pataki administration. It has particular relevance to Long Island, which has an aging population. These are other proposed cutbacks:

*Eliminating so-called Level 1 support services that help with household chores like shopping, cooking and laundry.

*Capping all home aide services at 100 hours a month, and requiring patients who receive those services to accept nursing-home placements when available.

*A two-year moratorium on approving nursing-home expansion.

The New York Times, March 26, 1995.

"Even after the reductions," said a spokesman for the State Budget Division, Jeffrey Gordon, "New York State's Medicaid program will be no lower than fourth in per capita expenditures. We give more services to more people than any other state. And in the face of a \$5 billion budget deficit we can no longer afford to provide such a range of services."

According to Mr. Gordon, 19 states offer no personal home care programs. "If advocates say, 'What will happen to these people?' " Mr. Gordon said, "our response is, 'What happens to these people in other states?' "

Mr. Gordon did not respond to requests to provide estimates of the number of patients in the program who would enter nursing homes, receive services through other Medicaid programs or have adult children or other family members pay for their care.

He also could provide no estimate of how many family members would quit jobs to stay home and care for ailing relatives. An official at the State Health Department referred questions to the Budget Department.

Ms. Rodriguez's and Ms. Mayor's care is provided through the Long Term Home Health Care Program of the Consolation Residence, which the Roman Catholic Diocese of Rockville Centre operates. The cost is \$23,952 a year for Ms. Rodriguez and \$34,937 for Ms. Mayor, 34 and 64 percent, respectively, of the cost of nursing-home care. If the alternative to the long-term home health-care program is nursing-home care, the two sisters will cost taxpayers more money.

But the sisters may still provide a fiscal, if not a humanitarian, argument for the proposed cuts, because their niece insists that she will not permit them to go to a nursing home.

Ms. Rodriguez has a clear mind but a frail body. Her stooped and tiny form shows the effects of age and osteoporosis. She has circulatory problems and develops ulcers on her legs that require continuous nursing care and monitoring. She can move about the house slowly with a walker. But a sign written with a marker reminds the people who care for her that Ms. Rodriguez "is not allowed to get up by herself without assistance."

Ms. Mayor is much sicker. She has an advanced case of Alzheimer's disease and is bedridden. She is prone to skin breakdown and congestive heart failure and requires a nurse once a week to change her catheter.

Ms. Corostola has lived with her aunts since she was an infant. Her grandfather moved with his family in 1910 from Spain to Cuba, where Ms. Corostola was born. After Fidel Castro took power, Ms. Corostola went first to Spain and then to the United States, where, she said, "I started getting them out, one by one."

First she helped Ms. Mayor, then Ms. Rodriguez, then Ms. Mayor's husband and, finally, her parents. "My father never got to this country," she recalled. "Three months after they arrived in Spain he got a stroke and died."

Mr. Mayor died 20 years ago from cancer, as did Ms. Corostola's mother did in 1968. Ms. Rodriguez cared for Ms. Corostola's mother during her long illness. Mr. Corostola and her aunts "are American citizens since 30 years ago," Ms. Corostola added. "We're proud of that."

The New York Times, March 26, 1995

"The only relative they have left in this world is me," she said. "If they separate them from me, that's the end of it. And I don't even want to mention if they are given separate care from each other. If you separate them you kill them."

Ms. Corostola, an executive secretary at a bank in the financial district, said she did not know what she would do if home care was cut back. "I'm the one that supports the house," she said. "If I stay home to care for them, who's going to pay for the mortgage, to pay for the food? But I will never put them in a nursing home. I don't know what I will do, but I will never put them in a nursing home."

Although most patients in the program are elderly, one service, affiliated with St. Mary's Hospital for Children in Bayside, serves 700 children on Long Island.

Gary Prescod, 3, who lives with his mother, Patricia, and 12-year-old sister, Denise, in Bay Shore, is one of those children. He was a healthy child until just before his 2d birthday, when he had a seizure and remained comatose for three weeks. The seizure resulted in severe brain damage.

Ms. Prescod worked as an administrative secretary, but left her job to deal with Gary's illness. She, too, vowed that she would not allow her son to be institutionalized. "I would probably have to let my daughter take a lot of the load of caring for Gary and go out and get a job to make ends meet," she said. "No one is going to put my son in a home."

In contrast, Mary Ruocco said she was fairly certain that she will go to a nursing home if the program is eliminated. Ms. Ruocco, 66, of Ridge, worked for the Century movie-theater chain until she had two strokes 10 years ago.

She now lives with a roommate in subsidized housing for the elderly. Her only family are a sister suffering from lung cancer and a retarded brother. Her care under the home health-care program costs \$25,889 a year, 47 percent of the cost of nursing-home care.

"If I had to be put away for some reason it would cost the state a hell of a lot," Ms. Ruocco said. "I want to be as independent as possible. I'm just hoping that a miracle will happen."

Nunzio Vulpis, 80 and suffering from severe Alzheimer's, is another candidate for nursing-home placement without the program. His care at home costs about \$2,750 a month, 62 percent of what it would cost in a nursing home.

"I do what I can for him," his wife, Marie, 77, said. "But I have a heart condition and asthma. When I help him I get out of breath."

Mrs. Vulpis said she hoped that she could help her husband at home. "We're going to be married 58 years," she said. "When I leave him he calls for me. It would be very hard to have him go to a nursing home, for me, and for him, too. I think he'd go down real fast."

Anthony Fresco, an engineer at the Brookhaven National Laboratory who lives in Huntington Station, also said he would seek a nursing home for his mother, Lena, if the program is eliminated. Mr. Fresco, who is separated from his

The New York Times, March 26, 1995

wife, lives with his mother and son, 14. Lena Fresco's Alzheimer's disease was diagnosed in 1986.

The home-care program pays for her to attend a day care for the elderly five days a week, as well as for nursing visits every three weeks and a personal-care aide three days a week for two hours a day. The program also pays for full-time respite care when Mr. Fresco travels on his job. The cost is 42 percent of the cost of a nursing home.

"Without this day care I couldn't be doing what I'm doing," Mr. Fresco said. "I don't have any alternatives to support my family."

But Mr. Fresco said a nursing home bed might not be available. He said he had contemplated leaving his mother at a hospital emergency room and forcing Medicaid to find a placement.

Long Island is short 4,200 nursing-home beds, according to the Nassau-Suffolk Health Systems Agency, a state-financed private group that evaluates regional health-care needs. (The Pataki administration also plans to eliminate the agency.) The state has approved plans to construct 4,200 beds, and the Pataki administration has withdrawn a plan to include those beds in the two-year moratorium on new spaces.

"The Catch-22 is that the long-term home health-care program was instituted to decrease the need and cost for nursing-home beds," said Kathleen Duffy, a community health nurse in the Nursing Home Without Walls program at the Consolation Residence. "There are 18,000 people statewide on the program. There are not 18,000 beds out there."

GRAPHIC: Photos: Nurse, Geralyn Murn, examining an Alzheimer's patient, Nunzio Vulpis, 80, at the Vulpis home. At right are his wife, Marie, and their dog Brownie. (Vic DeLucia/The New York Times) (pg. 18); A nurse, Geralyn Murn, takes blood pressure of Concepcion Rodriguez. (Vic DeLucia/The New York Times) (pg. 1)

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Cutting Nursing Home Profits, Not Care

BYLINE: By Joyce Purnick

BODY:

THERE is quite a crowd-pleaser in Gov. George E. Pataki's rather daunting list of proposed Medicaid cuts. Halve the profits that nursing homes earn from Medicaid, says the Governor.

At first glance at least, the idea seems sound and attractive, especially since New York spends considerably more on each nursing home resident than any other state. What's more, the industry is a healthy one. Its own numbers reveal that there is indeed considerable profit to cut.

Ever since the nursing home scandal of the 1970's over Medicaid fraud and patient abuse, the industry has been so closely monitored that all nursing homes make annual financial reports to the State Health Department.

The latest, for 1993, show that a majority of the 532 nursing homes included in the report ran in the black, and that many of the proprietary (for-profit) facilities in New York City and on Long Island realized particularly large profits.

Of the 286 proprietary homes, 164 reported profits of more than \$250,000, and 60 of those cited profits of more than \$1 million. There is a cap on owners' salaries under Medicaid, and most owners pay themselves modestly. But several earn more than \$100,000 a year and a few more than \$1 million. A handful earn over \$2 million, and several owners also make equity withdrawals -- the equivalent of earning stock dividends.

No wonder the Governor wants to tap profits. His proposal, similar to others that failed to win legislative approval in the past, would save only \$25 million next year out of the \$1.87 billion in anticipated state Medicaid spending on nursing homes. But the idea of shrinking profits is so appealing.

There are, however, a few potential problems. One is a very big one.

THE Governor's plan is to get at profits by reducing the state's Medicaid payments to nursing homes. The state would make cuts equivalent to half of each home's 1993 profit. But how could the state be sure that the homes wouldn't cut care instead of their own profits? This is not, the scandal of the 1970's showed, an industry known for its generosity. But the state isn't setting up any special auditing system, and the Pataki budget would cut the number of nursing home inspectors.

The New York Times, March 16, 1995

"There is a potential danger," concedes the state's new Health Commissioner, Dr. Barbara A. DeBuono. "I don't think it will happen, but there is a potential danger that because of funding shifts, those who run facilities will cut back on staffing to the degree that quality will potentially suffer. But we have safeguards, rules and standards." Dr. DeBuono added: "We're not only doing more with less, but doing better with less."

Her spokeswoman, Lois Uttley, emphasizes that the department will respond, as it does now, she said, to allegations of patient abuse within 48 hours. But the Health Department has been losing inspectors since 1988 because of budget problems. Between 1988 and this year, the number of field surveyors has dropped from 269 to 200, and the supervising division of 900 is to lose another 100 the next year. Can they do an adequate inspection job?

Cynthia Rudder, director of the Nursing Home Community Coalition of New York State -- a consumer advocacy group -- thinks there's plenty of fat in the proprietary nursing homes. Yet she, too, worries that in practice, halving profits would hurt care. "There's nothing to stop a nursing home from cutting more staff," she said. "There's nothing to stop a nursing home operation from laying off staff and making that money."

Robert Murphy, director of legislative services for the New York State Health Facilities Association, which represents 260 mostly proprietary nursing homes, agrees. "From a methodological standpoint, they're just taking the money," said Mr. Murphy, whose organization denounces the proposed cut as a tax, and a regressive one at that. "The irony is, people showing profits or surpluses are probably people operating at the least costly number. What message are you sending to a facility that operates efficiently?"

The nonprofit institutions say they are concerned, too, in part because they consider it unfair that the calculation of profits and surpluses includes charitable donations.

But Lieut. Gov. Betsy McCaughey, architect of the Pataki Medicaid proposal and its ever-cheerful champion, tells New Yorkers not to worry. "There's no danger here of cutting into operating costs when we're only taking out of the operating surplus," she said. "That's the whole point."

Asked how she can be so sure, Ms. McCaughey advises New Yorkers, basically, to trust her: "I am confident the state oversight is more than adequate," she said. "I am totally committed to the quality of care."

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Projected Medicare Beneficiaries by State

	1995	2002
US	37,631,000	41,299,000
Alabama	641,971	703,082
Alaska	33,784	49,773
Arizona	598,737	743,525
Arkansas	422,580	450,365
California	3,638,311	4,034,936
Colorado	423,478	514,095
Connecticut	503,906	533,943
Delaware	100,545	115,722
District of Columbia	78,730	76,330
Florida	2,615,604	2,951,880
Georgia	832,454	953,079
Hawaii	150,818	184,336
Idaho	149,769	171,120
Illinois	1,625,786	1,690,497
Indiana	827,174	890,461
Iowa	476,142	484,783
Kansas	383,997	397,890
Kentucky	585,590	636,855
Louisiana	582,491	634,122
Maine	202,149	221,565
Maryland	604,202	677,465
Massachusetts	937,292	996,344
Michigan	1,354,523	1,481,749
Minnesota	632,457	671,394
Mississippi	395,768	421,671
Missouri	834,228	876,863
Montana	129,141	141,557
Nebraska	249,529	256,357
Nevada	194,035	295,417
New Hampshire	156,237	178,655
New Jersey	1,174,802	1,244,404
New Mexico	212,160	257,452
New York	2,645,176	2,718,120
North Carolina	1,028,054	1,202,196
North Dakota	103,477	106,274
Ohio	1,673,946	1,800,336
Oklahoma	487,058	519,526
Oregon	470,268	524,031
Pennsylvania	2,083,051	2,187,966
Rhode Island	168,503	175,375
South Carolina	508,854	593,614
South Dakota	117,061	122,172
Tennessee	769,041	853,930
Texas	2,090,369	2,419,444
Utah	188,349	228,000
Vermont	82,989	91,752
Virginia	818,458	936,837
Washington	687,136	771,781
West Virginia	330,115	348,402
Wisconsin	763,230	804,207
Wyoming	60,570	72,355
Puerto Rico	476,704	527,920
All Other Areas	330,201	357,073

NOTES: Based on historical state share of Medicare enrollees, trended forward with growth in the states' share of enrollees.

* Totals may not add due to rounding

Effects of the Kasich Medicare Proposal By State
 Losses by State Under the Proposal
 (Fiscal years)

	Aggregate Dollars (millions)		Per Capita Effect (\$ / benef.)	
	2002	1996-2002	2002	1996-2002
US	84,900	279,200	1,028	3,447
Alabama	1,986	6,146	1,412	4,450
Alaska	50	171	502	1,889
Arizona	1,491	4,799	1,002	3,389
Arkansas	627	2,165	696	2,435
California	11,830	37,780	1,466	4,783
Colorado	1,147	3,579	1,116	3,630
Connecticut	1,247	4,103	1,167	3,885
Delaware	281	899	1,215	4,002
District of Columbia	1,431	4,001	NA	NA
Florida	9,314	29,258	1,578	5,082
Georgia	2,077	6,754	1,090	3,649
Hawaii	432	1,311	1,173	3,710
Idaho	149	532	436	1,603
Illinois	2,652	9,301	784	2,770
Indiana	1,569	5,253	881	2,994
Iowa	495	1,786	510	1,845
Kansas	834	2,741	1,048	3,464
Kentucky	968	3,318	760	2,652
Louisiana	1,590	5,235	1,254	4,201
Maine	231	825	521	1,900
Maryland	1,066	3,752	787	2,843
Massachusetts	3,072	9,828	1,542	4,989
Michigan	2,185	7,717	737	2,657
Minnesota	1,512	4,725	1,126	3,557
Mississippi	674	2,297	799	2,758
Missouri	1,531	5,219	873	3,004
Montana	157	551	553	1,986
Nebraska	338	1,158	659	2,266
Nevada	638	1,946	1,080	3,620
New Hampshire	292	956	816	2,755
New Jersey	2,320	7,945	932	3,229
New Mexico	249	866	484	1,761
New York	5,359	18,539	986	3,423
North Carolina	2,165	6,998	900	3,012
North Dakota	159	551	750	2,604
Ohio	2,584	9,083	718	2,562
Oklahoma	757	2,625	729	2,560
Oregon	1,010	3,213	963	3,135
Pennsylvania	4,526	15,479	1,034	3,570
Rhode Island	482	1,511	1,375	4,336
South Carolina	1,103	3,495	929	3,043
South Dakota	153	530	628	2,186
Tennessee	2,378	7,537	1,393	4,509
Texas	5,428	17,608	1,122	3,757
Utah	331	1,096	727	2,511
Vermont	105	365	573	2,034
Virginia	1,052	3,711	561	2,044
Washington	978	3,377	633	2,246
West Virginia	471	1,628	676	2,362
Wisconsin	914	3,254	569	2,044
Wyoming	49	182	337	1,313
Puerto Rico	457	1,488	433	1,440
All Other Areas	3	14	4	20

Variation in the costs per beneficiary across states reflects factors such as: (1) practice pattern differences; (2) cost differences; (3) differences in health status and the number of very old persons in a state; and (4) differences in the supply of health care providers.

NOTES: Assumes that increases in beneficiary out-of-pocket costs (e.g., premiums and coinsurance) are equal to 50% of the total cuts. Based on historical state share of Medicare outlays & enrollment, trended forward with growth in the states' share of outlays & enrollment. Estimates based on Medicare outlays by location of service delivery. Thus, certain state estimates may be affected by part-year residency and state border crossing to obtain care (e.g., Florida & Minnesota). State border crossing makes the District of Columbia estimates unreliable.

These cuts may result in a 7-year total of \$282 billion.

Effects of the Domenici Medicare Proposal On States
 Losses by State Under the Proposal
 (Fiscal years)

	Aggregate Dollars (millions)		Per Capita Effect (\$ / benef.)	
	2002	1996-2002	2002	1996-2002
US	61,700	255,600	747	3,174
Alabama	1,443	5,534	1,026	4,027
Alaska	36	158	364	1,794
Arizona	1,083	4,367	729	3,125
Arkansas	456	2,007	506	2,266
California	8,597	34,302	1,065	4,369
Colorado	834	3,230	811	3,314
Connecticut	906	3,756	848	3,568
Delaware	204	816	883	3,665
District of Columbia	1,040	3,508	NA	NA
Florida	6,769	26,448	1,147	4,626
Georgia	1,510	6,161	792	3,356
Hawaii	314	1,174	853	3,361
Idaho	108	497	317	1,512
Illinois	1,928	8,659	570	2,584
Indiana	1,141	4,830	640	2,765
Iowa	360	1,676	371	1,733
Kansas	606	2,508	762	3,175
Kentucky	703	3,070	552	2,467
Louisiana	1,156	4,792	911	3,865
Maine	168	772	379	1,788
Maryland	775	3,497	572	2,669
Massachusetts	2,233	8,927	1,121	4,547
Michigan	1,588	7,199	536	2,492
Minnesota	1,099	4,265	818	3,222
Mississippi	489	2,122	580	2,558
Missouri	1,113	4,822	635	2,783
Montana	114	513	402	1,861
Nebraska	245	1,071	479	2,100
Nevada	464	1,746	785	3,331
New Hampshire	212	874	593	2,540
New Jersey	1,686	7,349	678	2,997
New Mexico	181	804	352	1,656
New York	3,894	17,196	716	3,180
North Carolina	1,573	6,375	654	2,770
North Dakota	116	511	545	2,418
Ohio	1,878	8,461	522	2,397
Oklahoma	550	2,436	529	2,385
Oregon	734	2,915	700	2,862
Pennsylvania	3,289	14,314	752	3,311
Rhode Island	350	1,365	999	3,925
South Carolina	802	3,167	675	2,783
South Dakota	112	491	456	2,032
Tennessee	1,729	6,829	1,012	4,110
Texas	3,945	16,055	815	3,456
Utah	241	1,005	528	2,329
Vermont	76	339	417	1,901
Virginia	764	3,461	408	1,923
Washington	710	3,131	460	2,098
West Virginia	342	1,510	491	2,197
Wisconsin	665	3,041	413	1,916
Wyoming	35	172	245	1,258
Puerto Rico	332	1,358	315	1,322
All Other Areas	2	14	3	20

Variation in the costs per beneficiary across states reflects factors such as: (1) practice pattern differences, (2) cost differences; (3) differences in health status and the number of very old persons in a state; and (4) differences in the supply of health care providers.

NOTES: Assumes that increases in beneficiary out-of-pocket costs (e.g., premiums and coinsurance) are equal to 50% of the total cuts. Based on historical state share of Medicare outlays & enrollment, trended forward with growth in the states' share of outlays & enrollment. Estimates based on Medicare outlays by location of service delivery. Thus, certain state estimates may be affected by part-year residency and state border crossing to obtain care (e.g., Florida & Minnesota). State border crossing makes the District of Columbia estimates unreliable.

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Medicaid Demonstrations and Reconciliation Provisions

Background

States have sought demonstration authority for primarily two purposes: (1) to expand Medicaid eligibility to population groups that are not eligible under current law; and (2) to enroll Medicaid beneficiaries in managed care delivery systems, without regard to certain contracting requirements in current law. Some States are also interested in using sole-source contractors in their managed care systems.

Pending Legislation

The reconciliation proposals that have passed the House and the Senate would cut Federal matching payments so severely that States may not be able to maintain coverage for current eligibility groups, much less expand coverage to new populations. States that have already used demonstration authority to expand Medicaid eligibility would face these funding cuts -- and their consequences -- on the same footing as other States.

States would have new administrative flexibility to develop substantial changes to their Medicaid programs. States would be free to use managed care systems -- including sole-source providers -- without waivers and current Federal contracting requirements will be eliminated. They would also be able to cover new populations, in the unlikely event that they could fund an expansion.

The Administration's Proposal

In contrast to the Republican proposals, the Administration's plan will protect Medicaid eligibility because it limits Federal matching payments on a per capita basis. This methodology will protect both expansion eligibles and current law eligibles. States will also be able to expand eligibility on a budget-neutral basis.

States will also have substantial administrative flexibility for Medicaid managed care under the Administration's proposal. States will no longer need Federal waivers to develop mandatory managed care programs and the most problematic Federal contracting rules -- the 75/25 enrollment composition rule and restrictions on lock-in provisions -- will be eliminated. However, because the Administration's proposal guarantees beneficiaries a choice of plan, States will not be able to use a sole-source contractor to deliver managed care services.

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Demonstration State	(Demo as a % of Total Spending)	Demonstration Program	Demonstration Growth Rates ^a	House MediGrant Growth Rate ^b	Senate MediGrant Growth Rate ^b
Implemented					
Arizona	100%	Full managed care for Medicaid program including long term care benefits. Demonstration began State's Medicaid program (1983). Seeking to expand coverage to 100% of poverty: additional 150,000 at full phase in.	N/A	5.9% (1996-2002)	5.0% (1996-2002)
Hawaii	40%	Seamless coverage for enrollees in public program and the uninsured enrolled in managed care (August 1994). 300% of poverty: 47,217 new enrollees.	10.9% (1994-1999)	4.8% (1996-2002)	3.1% (1996-2002)
Minnesota	2%	Expands Medicaid eligibility for low-income and uninsured children through managed care (1995): 68,000 projected new enrollees.	19% (1995-1998)	2.7% (1996-2002)	3.1% (1996-2002)
			21% (1996-1998)	3.8% (1996-1998)	5.5% (1996-1998)
Oregon	62%	Priority list of health services to define benefit package. Enrollees receive care through managed care (1994). Expand to poor uninsured: 128,000 new enrollees.	14.2% (1995-1999)	2.8% (1996-2002)	5.0% (1996-2002)

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Rhode Island	12%	Extends Medicaid coverage for low-income pregnant women and children (< 6) through managed care plans including FQHC-formed HMOs (1994): 1,142 new enrollees.	4.2% (1994-1999)	2.5% (1996-2002)	2.3% (1996-2002)
			4.3% (1996-1999)	3.0% (1996-1999)	2.7% (1996-1999)
Tennessee	100%	Extends Medicaid coverage to low-income uninsured through managed care infrastructure (1994): 450,000 new enrollees.	6.6% (1994-1998)	4.4% (1996-2002)	5.0% (1996-2002)
			4.7% (1996-1998)	2.6% (1996-1998)	7.1% (1996-1998)
Approved, Implementation Pending					
Delaware	45%	Elderly and aged will receive acute care services through managed care. Current managed care demonstration for Medicaid children rolled in (1996). Expansion for poor adults in children: 8,000		2.5% (1996-2002)	6.4% (1996-2002)
			7.6% (1996-2000)	2.7% (1996-2000)	6.1% (1996-2000)
Florida	65%	Expand coverage through community health purchasing alliances for low-income workers. Current Medicaid beneficiaries receive care through managed care plans. 1.1 million new enrollees.	16.3% (1994-1999)	7.3% (1996-2002)	6.4% (1996-2002)
			17.8% (1996-1999)	7.6% (1996-1999)	6.8% (1996-1999)
Kentucky	66%	Unique single provider network to expand access to coverage for Medicaid beneficiaries.		5.9% (1996-2002)	6.0% (1996-2002)
			9.3% (1996-2000)	6.2% (1996-2000)	6.1% (1996-2000)

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Massachusetts	45%	Expands access to coverage through a combination of expansions and tax credits for employer-based insurance. Managed care for Medicaid beneficiaries. 160,000 projected new enrollees.	10.7% (1996-2000)	2.5% (1996-2002) 2.7% (1996-2000)	2.3% (1996-2002) 2.0% (1996-2000)
Ohio	40%	Expands Medicaid coverage to uninsured poor with capitation payments to agencies delivering special services. 500,000 new enrollees.	8.4% (1996-2000)	4.8% (1996-2002) 5.2% (1996-2000)	4.8% (1996-2002) 4.8% (1996-2000)
Oklahoma		Builds linkages between urban and rural health delivery systems to test rural managed care approaches.		7.3% (1996-2002)	6.1% (1996-2002)
South Carolina		Managed care for rural areas—partially capitated payment model. Expands coverage to poor: 280,000 projected new enrollees (Framework approved only).	Undefined	5.9% (1996-2002)	6.4% (1996-2002)
Vermont	40%	Expand coverage for low-income through managed care systems and providing managed pharmacy benefits to low-income Medicaid beneficiaries. 26,500 new enrollees.	8.7% (1996-2000)	2.5% (1996-2002) 2.7% (1996-2000)	4.7% (1996-2002) 4.6 (1996-2000)

Note: Demonstration growth rates reflect maximum growth (under budget neutrality requirements) for demonstration spending only (except in Tennessee, which includes all non-demonstration spending). Thus, growth rates apply to different types of spending (mostly acute care and DSH spending) than total spending. Such spending groups tend to grow at different rates than total Medicaid spending, which includes long term care.

^a Demonstration growth rates as reflected in the budget neutrality limits over the period of the demonstration. Where two rates are shown, the top rate reflects the average annual growth over the period of the demonstration. The other rate reflects the best comparison period to the Congressionally proposed rates.

^b House and Senate growth rates are from GAO's table calculating the annual state allotments based on the proposed formula.

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Medicaid waiver file

BACKGROUND

Section 1115 Statewide Demonstration

Overview

- Statewide Medicaid 1115 demonstrations have been approved in 6 States, in addition to the longstanding program in Arizona: Hawaii, Oregon, Tennessee, Kentucky, Rhode Island, and Florida. Kentucky and Florida require State legislation to move forward and have had difficulty getting it.
- South Carolina over the next year is working on developing the infrastructure (managed care networks, information systems) for a Medicaid 1115 demonstration. (South Carolina has not yet received official approval from HCFA.)
- Seven additional States have submitted proposals: Ohio, Massachusetts, Missouri, New Hampshire, Delaware, Minnesota, and Illinois.
- The States seem generally to be using 1115 demonstrations to experiment with the following:
 - o Simplifying eligibility. Most States are using 1115 demonstrations to break the link with welfare eligibility categories and are substituting percent of the federal poverty level in determining who is covered. States are also eliminating the Medicaid assets tests.
 - o Expanding coverage to the uninsured. All approved Statewide 1115 demonstrations would expand coverage to the uninsured, using Medicaid funding to do so. The expansions range from expansions for pregnant women and children only to eligibility for everyone under 300% of poverty. The number covered range from several thousand in Rhode Island to about 335,000 in Tennessee.
 - o Managed care. States are implementing comprehensive managed care arrangements in their programs to help finance the expansions and constrain cost growth. States are also using the 1115 authority to allow them to develop managed care approaches and lock beneficiaries into arrangements in ways not permitted under current Medicaid law.
 - o Cost Containment. A major goal of the proposals has been to control the growth in Medicaid spending or to redirect savings in Medicaid to expansions of coverage.
- Currently, 8% of total Medicaid expenditures is spent under waivers in States with approved Statewide demonstrations. Adding States with pending applications raises this percentage to about 18%.

Additional Interest from Other States

- Preliminary discussions have been held with the States of New York, Washington, Louisiana, Texas, Georgia, Kansas, Utah and Montana. Some of these discussions are at early, conceptual stages.
- It will be sometime before any clear effect is known of the recent elections on the interest in or direction of any of the proposals under review or those in the conceptual stage. In Missouri, for example, it has been suggested that the State legislature may reconsider the scope of the Statewide reform in light of the absence of action on national legislation.

Issues

- Protecting existing beneficiaries.
Current waiver policy requires existing Medicaid beneficiaries to be held harmless under Statewide 1115 demonstrations. New York and Montana would like to reduce optional benefits to the Medicaid population under 1115 authority, and the States have been informed that this causes concern. Waiver policy also maintains that cutoff of Medicaid benefits cannot be used as a sanction to enforce work provisions in welfare reform waivers.
- Maintaining quality and access to services.
All 7 States with approved demonstrations have waivers of certain managed care requirements. In exchange, States have been required to submit 100% person level encounter data and adopt focused quality assurance systems. These data are essential in evaluating availability and use of care for key vulnerable populations, such as pregnant women and children.
- Budget neutrality.
 - o Limits have been set on federal funds over the life of the demonstrations at the expected level of spending in the absence of the demonstration.
 - o The share of total Medicaid spending under 1115 authority is significant and continues to grow.
 - o Common agreement on the approach to setting budget neutrality is critical, given the long range implications for the Medicaid baseline.
 - o Some States are also looking at 1115 as a way to carry over high DSH payment levels and avoid OBRA 1993 reductions.

- Covering the Most Needy. Increasingly, States are asking that federal match be provided for services previously funded entirely by the State, or, in the case of Massachusetts, subsidize employers who already provide insurance to low-income workers. These proposals are of concern because they do not expand coverage to new populations and can leave the most needy without coverage.
- Operational feasibility. Some States have submitted 1115 demonstration proposals without having a fully developed operational framework for implementing the demonstrations. Operational readiness is critical in assuring access and avoiding beneficiary and provider confusion. This continues to be contentious, given the desire to review programs within a 120 day timeframe, even if States are not ready to implement them.

Using 1115 Demonstration Authority for Expanding Coverage

Description

- Continue to use 1115 demonstration authority to promote State flexibility and expand coverage to the uninsured. The 1115 authority provides an administrative, budget neutral approach to achieving these goals.
- Under 1115 authority, either State flexibility could be maximized, or Federal policies could direct State programs.
- Minor legislative proposals to simplify and reform Medicaid could provide States additional flexibility within the regular Medicaid program. This would lessen the incentive to States to use the waiver process as a mechanism for simplifying eligibility and circumventing managed care requirements.

Discussion

- **Budget Neutrality**

1115 demonstrations currently must be budget-neutral, providing both certainty and protection to Federal Medicaid dollars.

Budget neutrality formula is under pressure, and enforcement has yet to be tested.

Over the long term, the baseline for measuring cost neutrality is not clear.

- **Appeal to States**

Given the budget-neutrality constraint and the political changes at the State level, few States are likely to avail themselves of waivers to expand coverage.

- **Administrative Simplicity/Flexibility**

The 1115 approach does not require additional legislation to provide States flexibility to design programs that meet their particular needs.

The minor legislative proposals would also be used to take pressure off the 1115 process and promote State flexibility consistent with Federal priorities.

- **Opportunity for Feds to Guide State Reforms**

Some states' proposals are designed principally to reduce State costs and not to implement expansions or innovations that will benefit low-income populations.

In granting 1115 demonstration waivers, the Federal government could give priority to States that are seeking to expand coverage and pursue health system reform could be given priority.

- **Concerns about Substitution of Existing Coverage**

Rather than expand coverage, states may seek Federal funds for people already covered in State-only programs.

Similarly, employers may drop coverage if States create a subsidized program for their workers.

Providing Additional Funds to States for Expanding Coverage

Description

- Provide matching Federal funds to States that expand coverage of the uninsured. States would have substantial flexibility in targeting and designing the program.
- The Federal contribution to the program would be capped.
- This program is distinct from Medicaid (and Medicaid waiver programs).

Discussion

- **Simplicity and Flexibility:**
 - Provides flexibility for States to design programs to expand coverage that meet their particular needs. For example, states may choose to enroll the uninsured in private insurance or a state employee health plan.
 - Decentralizes decision making to the States.
 - Relatively free from burdensome or restrictive "strings" usually associated with the Federal financial assistance.
- **Concerns about State Financing:**
 - Rather than make new resources available for health care, States are more likely to redirect current state spending to attract federal funds.
 - States may use financial schemes like those originally used in the Disproportionate Share Program to obtain federal funds.
- **Concerns about Substitution of Existing Coverage:**
 - Employers may drop coverage if a subsidized program is available for workers.
 - Rather than expand coverage, States may use funds for people already covered in State-only programs.
- **Targeting / Equity:**
 - The States most likely to participate in the program are those that already cover a significant portion of the poor through Medicaid or state-only programs. By contrast, poorer states with the most needy populations may be financially unable to participate in the program. As a result, the program may provide fiscal relief to states that have been more generous in the past rather than expand coverage.

In any case, there will be a trade-off between fiscal relief and expanded coverage.

- **Implications for Medicaid:**

Establishment of a capped program for the uninsured may create pressure for a cap on Medicaid.

Establishment of a program with substantial State flexibility may create pressure for similar State discretion and flexibility in the Medicaid program. For example, Medicaid currently has many protections to assure access and quality of care for recipients. In a State-flexibility model with fewer Federal strings, such protections could be significantly weakened.

States may have incentives to transfer people from Medicaid to the new program if the benefits in the new program are less comprehensive, the eligibility process is less complex, Federal regulations are fewer, or the Federal match is higher.

Medicaid Restructuring

Complete State Flexibility with Medicaid Integration

Description

Replace current Medicaid financing arrangements with Federal block grant payments to States. Payments would include the Federal share of the Medicaid program and any new Federal funding. States would be responsible for using these Federal payments -- and any required or optional State contributions -- to finance health services for low-income residents.

Discussion

- Formula for determining the amount of States' grants will be both technically and politically difficult to develop.
- Broad latitude for States to change their current medical assistance programs to enhance program efficiency, target new populations and solve other State-specific problems.
- Greater certainty for the Federal Medicaid budget.
- The Federal government would have little or no ability to influence the States' use of grant funds.
- The Federal government could do less to protect current eligibles. The Federal government's ability to monitor State Medicaid programs would be diminished. Federal monitoring of quality of care, access, and fraud and abuse would be restricted.
- States would be at risk for any unexpected increases in Medicaid spending resulting from an aging population, unemployment increases, etc. If the Federal grant is insufficient, they would need to either provide more State funding or cut services or eligible populations.
- The ultimate risk for program cost increases would be borne by beneficiaries.

Medicaid Restructuring Medicaid-for-Welfare Swap

Description

Federal government takes over acute care portion of Medicaid; States take over welfare programs -- AFDC and Food Stamps.

Discussion

- Health program would be made uniform across States in eligibility, benefits, provider payments and delivery arrangements.
- Improve predictability of Medicaid spending if Federally financed program is operated on a fully capitated basis.
- Eliminate Federal/State conflict over program rules for both health and welfare programs, because of clear program responsibilities.
- The Federal costs of making health program uniform would be significant; i.e., higher eligibility and higher provider payments.
- No assurance that States would not drastically reduce commitments to welfare programs, without State maintenance of effort and/or Federal minimum standards.
- Decrease in the uniformity across States of welfare coverage. Also, the Food Stamp program, which is a Federal program that provides assistance based solely on income, and therefore reaches low-income working families, would be left to State discretion.
- Uneven State fiscal impacts -- significant number of winners and losers.
- No reduction in the perception of "Big government" running Federal programs, because of Federal health care for the poor.
- Significant administrative burden of administering a Federal health program that includes a "means-tested" eligibility requirement.