

*Medicaid*  
**Medicaid Matters New York**  
*Matters*

# **Finding a Better Way**

**Ten consumer-friendly ideas to improve  
New York's Medicaid program and  
save money for New York taxpayers**

**February 2004**

This report was prepared by Medicaid Matters New York, a consumer-oriented coalition that advocates on behalf of New York's Medicaid program and the people it serves.

## Who Is Medicaid Matters New York?

Medicaid Matters New York (MMNY) is a consumer-oriented coalition that advocates on behalf of New York State's Medicaid program and the people it serves. This statewide coalition of over 100 organizations is founded on the premises that "Medicaid matters" and that reform proposals resulting in drastic cuts at the federal or state levels will adversely affect all New Yorkers.

Access to Independence of Cortland County  
Action for a Better Community, Rochester NY  
AIDS Treatment Data Network  
AIDS Day Services Association  
Alianza Dominicana  
Alzheimer's Association, New York City Chapter  
American Cancer Society  
Aspire of Western New York  
Bronx Health Link  
Brooklyn-wide Interagency Council of the Aging  
Brooklyn Perinatal Network  
Cancer Care  
Care for the Homeless  
Catholic Charities AIDS Services, Albany NY  
Center for Disability Rights, Rochester NY  
Center for Independence of the Disabled, NY  
Cerebral Palsy Associations of New York State  
Citizen Action of New York  
Citizens' Committee for Children of New York  
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Coalition of NYS Alzheimer's Association Chapters  
Coalition of Voluntary Mental Health Agencies  
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Community Healthcare Network  
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District Council 37/Local 1549  
East Harlem Community Health Committee  
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Harlem Interagency Council for the Aging  
Health and Welfare Council of Long Island  
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Hispanic Senior Action Council  
Hospice and Palliative Care Association of NYS  
Housing Works  
Independent Living Center of the Hudson Valley  
Institute for the Puerto Rican/Hispanic Elderly  
JPAC for Older Adults  
Legal Action Center  
Long Island Association for AIDS Care  
Lower East Side Health Care Coalition  
Manhattan Boroughwide Interagency Council on Aging  
Medical and Health Research Association of NYC  
Medicare Rights Center  
Mental Health Association of NYC and Westchester  
Mental Health Association in New York State  
Metro New York Health Care for All Campaign  
Metropolitan Council on Jewish Poverty  
Morris Heights Health Center, Bronx NY  
Mothers & Babies Perinatal Network, Binghamton NY  
NARAL Pro-Choice New York  
National Association of Social Workers, New York State and New York City Chapters  
National Multiple Sclerosis Society, NYC Chapter  
New York AIDS Coalition  
New York Citizens' Committee on Aging  
New York City AIDS Housing Network  
New York City Providers of Health Care for the Homeless  
New York City Task Force on Medicaid Managed Care  
New York Immigration Coalition  
New York Network for Action on Medicare and Social Security  
New York State Association of Retarded Citizens  
New York State Catholic Conference  
New York State Health Care Campaign  
New York State Nurses Association  
New York State Psychological Association  
New York StateWide Senior Action Council  
New Yorkers for Accessible Health Coverage  
Northern Queens Health Coalition  
Nurses United CWA Local 1168, Buffalo NY  
Nursing Home Community Coalition of New York State  
Planned Parenthood of Buffalo/Erie County  
Planned Parenthood of New York City  
Planned Parenthood of Rochester/Syracuse  
Providers of Health Care for the Homeless  
Public Health Association of New York City  
Roberto Clemente Center  
Schuyler Center for Analysis and Advocacy  
Selfhelp Community Services  
Southern Tier AIDS Program  
Staten Island Welfare Advocacy Network  
The Children's Health Fund  
The Floating Hospital  
The Legal Aid Society  
The National Alliance for the Mentally III—NY  
The New York Forum for Child Health  
United Neighborhood Houses  
University Settlement  
Urban Justice Center  
Visiting Nurse Service of New York  
Voices of Women of Color Against HIV/AIDS  
Westchester Disabled on the Move  
Westchester Health Action Coalition  
Western New York Health Care Campaign  
William F. Ryan Community Health Center  
Women's City Club of New York

*As of February 26, 2004*

# Table of Contents

Executive Summary	2
Introduction	5
Why Does Medicaid Matter? The Story of Lady J	8
Separating Fact from Fiction: Myths and Truths about New York’s Medicaid Program	10
Recommendations for Consumer-Friendly Medicaid Reform	13
Recommendation #1: Streamline the enrollment process to improve preventive care and disease management while reducing administrative costs.	13
Recommendation #2: Increase health literacy and language access to achieve cost savings and improve health outcomes.	14
Recommendation #3: Strengthen Family Health Plus (FHPlus), New York’s commitment to coverage for uninsured adults.	17
Recommendation #4: Permit state take-over of Medicaid long-term care costs by shifting resources out of expensive institutional settings.	19
Recommendation #5: Create a new funding source for health care for the uninsured by giving employers in New York an incentive to contribute to the cost of insuring their workers.	20
Recommendation #6: Ensure that Health Care Reform Act (HCRA) funds for Medicaid and programs for the uninsured are used exclusively for those programs; increase public accountability in the entire HCRA funding system.	21
Recommendation #7: Leverage New York’s prescription buying power through bulk purchasing and reimportation to bring down the cost of prescription drugs.	22
Recommendation #8: Provide strong consumer protections if implementing a Preferred Drug List (PDL).	23
Recommendation #9: Roll back provisions of the 2003 federal Medicare bill that reduce coverage for dually eligible Medicare/Medicaid beneficiaries and limit state savings.	24
Recommendation #10: Demand legislation that requires the federal government to assume more financial responsibility for Medicaid; oppose any federal block grant initiatives.	25
Conclusion	28

# Executive Summary

## Who Is Medicaid Matters New York?

Medicaid Matters New York (MMNY) is a consumer-oriented coalition that advocates on behalf of New York State’s Medicaid program and the people it serves. This statewide coalition of over 100 organizations is founded on the premises that “Medicaid matters” and that reform proposals resulting in drastic cuts at the federal or state levels will adversely affect all New Yorkers.

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### *A better way exists to save money and improve the Medicaid program.*

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MMNY includes within its coalition a diverse set of organizations united in their determination to ensure that the concerns and needs of Medicaid beneficiaries are understood, included, and met in any discussion of Medicaid reform.

MMNY represents and speaks for the millions of New Yorkers who rely on Medicaid for their health insurance, including mothers and children, adolescents, the working poor, the disabled, seniors, HIV positive individuals, homeless people, and individuals with mental disabilities. While many coalitions exist that advocate on behalf of providers, MMNY’s uniqueness is that it is perhaps the only organized statewide coalition that speaks solely for Medicaid beneficiaries.

## Background

Medicaid is a New York success story. It is the largest payer for births in our state, an integral part of the health care of children and adolescents, and the primary source for long-term care coverage for New York’s elderly, disabled, and chronically ill. Medicaid is vital to the health care of all New Yorkers of all ages. Medicaid is also important to New York’s economy, supporting thousands of jobs in the health care sector.

This year the debate about the rising cost of Medicaid is at a fever pitch in Albany and in counties around the state. The release of the Senate Medicaid Reform Task Force report and the Governor’s proposed Executive Budget make it clear that concerns about the rising cost of Medicaid and what this means for state and local governments—and for taxpayers—are being taken very seriously. MMNY supports some of the proposals that have been advanced by both the Senate’s Task Force and by the Governor, including making greater use of disease management programs within existing public insurance programs. MMNY also supports a Family Health Plus (FHPlus) buy-in.

Unfortunately, the Governor and Senate also proposed hard-hitting cuts that—if enacted—will be hard for Medicaid beneficiaries to swallow. MMNY strongly opposes the cuts proposed by the Senate’s Task Force and by the Governor’s budget that would put millions of individuals in harm’s way and would

weaken New York's health care infrastructure. A better way exists to save money and improve the Medicaid program. MMNY intends to open legislative minds to the idea of saving dollars through implementing consumer-friendly reforms.

MMNY supports Medicaid reform ideas that will slow the rate of growth without hurting beneficiaries. New York can drive a harder bargain with the pharmaceutical industry and seek more value for the dollar from hospitals and other large providers without hurting beneficiaries. New York can also realize savings by moving elderly and disabled individuals from institutional settings into the community, provided that the right supports are in place.

Primary care, which saves money and improves health status, should be the heart and pulse of the health care delivery system. Providing comprehensive primary care services is ultimately less costly to Medicaid because it reduces emergency room visits and hospitalizations. Primary care services delivered in community-based settings (such as community health centers) are more effective than hospital outpatient departments at serving hard to reach patient populations, and are more likely to be sensitive to the unique language and cultural needs of these communities. Improving the delivery of care through incentives that support community-based primary care will result in direct savings at the local level.

## Recommendations

There is no question that New York's Medicaid program needs change. In 2004, lawmakers are presented with both an opportunity and a challenge: improving New York's Medicaid program to ensure that it meets the health care needs of more than three million New Yorkers and doing so in an efficient, financially responsible manner that does not sacrifice access to quality care.

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### *The policy options lawmakers choose are, quite literally, matters of life and death.*

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This is not an easy task, but in the end, lawmakers should be guided by the impact that proposed changes will have on low-income and medically vulnerable New Yorkers. The policy options lawmakers choose are, quite literally, matters of life and death. For many New Yorkers, losing eligibility to Medicaid means not getting preventive health services, such as cancer screening or hypertension treatment, which are crucial to early detection and better treatment of disease and illness. Making it harder to obtain life-saving prescription drugs or home care services can lead to expensive and catastrophic health outcomes.

What matters most to New York's Medicaid beneficiaries is the impact these choices will have on their ability to get needed health care. What matters most to all New Yorkers is the impact these choices will have on our children and parents and neighbors, as well as the communities in which we live. With this in mind, MMNY would like to articulate the principles that guide our recommendations.

**ACCESS:** All qualified low-income individuals should be able to secure and retain health coverage under all Medicaid and other publicly funded programs without having to clear unreasonable administrative barriers.

**BENEFITS:** Benefits should include the broad range of services and supports required to achieve optimal health outcomes for the population covered.

**FINANCING:** Federal and state financing should promote appropriate, innovative, and efficient health care.

The recommendations made in this report would place the program on a sounder financial

footing, reap immediate and long-term savings, reduce local government financial obligations, and make the program easier for beneficiaries and their families to navigate. “Finding A Better Way” offers a roadmap to strengthening a program vital to the health and well-being of over three million New Yorkers.

These ideas, put forth by the only organized statewide coalition that speaks solely for beneficiaries, are informed by the experiences of everyday Medicaid beneficiaries. MMNY is dedicated to ensuring that the voices of Medicaid beneficiaries are heard during the coming debate about the future of this vital program. The solutions lie in hearing and heeding these voices.

**Recommendation #1:** Streamline the enrollment process to improve preventive care and disease management while reducing administrative costs.

**Recommendation #2:** Increase health literacy and language access to achieve cost savings and improve health outcomes.

**Recommendation #3:** Strengthen Family Health Plus (FHPlus), New York’s commitment to coverage for uninsured adults.

**Recommendation #4:** Permit state take-over of Medicaid long-term care costs by shifting resources out of expensive institutional settings.

**Recommendation #5:** Create a new funding source for health care for the uninsured by giving employers in New York an incentive to contribute to the cost of insuring their workers.

**Recommendation #6:** Ensure that Health Care Reform Act (HCRA) funds for Medicaid and programs for the uninsured are used exclusively for those programs; increase public accountability in the entire HCRA funding system.

**Recommendation #7:** Leverage New York’s prescription buying power through bulk purchasing and reimportation to bring down the cost of prescription drugs.

**Recommendation #8:** Provide strong consumer protections if implementing a Preferred Drug List (PDL).

**Recommendation #9:** Roll back provisions of the 2003 federal Medicare bill that reduce coverage for dually eligible Medicare/Medicaid beneficiaries and limit state savings.

**Recommendation #10:** Demand legislation that requires the federal government to assume more financial responsibility for Medicaid; oppose any federal block grant initiatives.

# Introduction

Medicaid Matters New York (MMNY) is a consumer-oriented coalition that advocates on behalf of New York State's Medicaid program and the people it serves. This statewide coalition of over 100 organizations is founded on the premise that "Medicaid matters" and that reform proposals that result in drastic cuts at the federal or state levels will adversely affect all New Yorkers. MMNY includes within its coalition a diverse set of organizations united in their determination to ensure that the concerns and needs of Medicaid beneficiaries are understood, included, and met in any discussion of Medicaid reform.

MMNY's mission is to ensure that policy makers understand the importance of Medicaid to low-income and medically vulnerable New Yorkers, and to ensure that Medicaid beneficiaries have a strong voice in Washington and Albany, where critical issues affecting the future of the Medicaid program are being debated.

MMNY represents and speaks for the millions of New Yorkers who rely on Medicaid for their health insurance, including mothers and children, adolescents, the working poor, the disabled, seniors, HIV positive individuals, homeless people, and individuals with mental disabilities. While many coalitions exist that advocate on behalf of providers, MMNY's uniqueness is that it is perhaps the only organized statewide coalition that speaks solely for Medicaid beneficiaries.

Medicaid is a New York success story. It is the largest payer for births in our state, an integral

part of the health care of children and adolescents, and the primary source for long term care coverage for New York's elderly, disabled, and chronically ill. Medicaid is vital to the health care of all New Yorkers of all ages. Medicaid is also important to New York's economy, supporting thousands of jobs in the health care sector.

Organized in February 2003 in response to Medicaid attacks at the state and federal levels, MMNY has worked tirelessly at every level of government to protect Medicaid. Our organized activities have led to considerable successes, including advocacy in 2003 that fought Congressional attempts to cut \$95 bil-

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***Medicaid is a New York success story... vital to the health of all New Yorkers and to New York's economy.***

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lion from Medicaid in the federal budget; stopped the Governor's proposed \$2 billion in state Medicaid cuts; and pressured the National Governors' Association to reject proposals to cap federal funding for optional populations and benefits.

This year the debate about the rising cost of Medicaid is at a fever pitch in Albany and in counties around the state. The release of the long-anticipated Senate Medicaid Reform Task Force report and the Governor's proposed Executive Budget make it clear that concerns about the rising cost of Medicaid and what this means for state and local governments—and for taxpayers—are being

taken very seriously. What is less clear is whether policy makers at all levels of government know how serious these proposed cost-cutting reforms are for Medicaid beneficiaries, the ones who will ultimately have to live with whatever reform ideas survive the legislative process in Albany.

As is evidenced in this report, MMNY supports some of the proposals that have been advanced by both the Senate's Task Force and the Governor. For example, increased utilization of disease management programs will improve both quality of care and efficiency of resource use for chronically ill adults and children. Creating the right financial incentives to move seniors and people with disabilities from institutions into community settings could permit state take-over of local Medicaid costs. Reimportation and bulk purchasing of pharmaceuticals is an obvious way to take advantage of lower drug prices. And improving coordination of the long-term care delivery system has the potential to improve quality while controlling costs. MMNY also supports a Family Health Plus (FHPlus) buy-in.

Unfortunately, also proposed are hard-hitting cuts that—if enacted—will be hard for Medicaid beneficiaries to swallow. MMNY strongly opposes the cuts proposed by the Senate's Task Force and by the Governor's budget. Cuts to Medicaid would put millions of individuals in harm's way in the event of a personal or public health catastrophe. They would also weaken New York's health care infrastructure. A better way exists to save money and improve the Medicaid program. MMNY intends to open legislative minds to the idea of saving dollars through implementing consumer-friendly reforms.

MMNY supports Medicaid reform ideas that will slow the rate of growth without hurting beneficiaries. For example, skyrocketing prescription drug costs and rates paid to hospitals are the big-ticket items driving Medicaid growth. New York can drive a harder bargain with the pharmaceutical industry and seek more value for the dollar from hospitals and other large providers without hurting beneficiaries. New York can also realize savings by moving elderly and disabled individuals from institutional settings into the community, provided that the right supports are in place.

Often overlooked is another important way to save money while improving access to health care services and the health status of many New Yorkers. Primary care should be the heart and pulse of the health care delivery system. Primary care includes screening, diagnosing, and managing most illnesses, together with referring and coordinating more complex health problems. It is care that is best provided in communities where people live, enhancing providers' understanding of the social and cultural context of their patients' lives and the provision of culturally appropriate health education.

Providing comprehensive primary care services is ultimately less costly to Medicaid. It is a prime way of preventing trips to the emergency room and hospitalizations, particularly for Ambulatory Care Sensitive illnesses such as asthma. Primary care services delivered in community-based settings (such as community health centers) are more effective than hospital outpatient departments at serving hard to reach patient populations and are more likely to be sensitive to the unique language and cultural needs of these communities. Improving the

delivery of care through incentives that support community-based primary care will result in direct savings at the local level.

MMNY recognizes the need for local fiscal relief and supports full state take-over of the cost of long-term care and FHPlus as one step towards a long-term solution. For the past two years the federal government has provided financial aid to all states to relieve budgetary pressures. The Senate report recommends that the state work with the federal government to increase New York's federal medical assistance percentage (FMAP).

MMNY fully endorses this recommendation. MMNY fought hard for last year's temporary increase in the FMAP, directly relieving counties of a portion of their share of Medicaid costs through June 2004. We look forward to working with all interested parties to do so again this year.

It is likely that over the next few years tough choices will have to be made about how to maintain New York's health coverage programs and health care infrastructure in a fiscally responsible way. What matters most to New York's Medicaid beneficiaries is the impact these choices will have on their ability to get needed health care. What matters most to all New Yorkers is the impact these choices will have on our children and parents and neighbors, as well as the communities in which we live. With this in mind, MMNY would like to articulate the principles that guide our recommendations.

**ACCESS:** All qualified low-income individuals should be able to secure and retain health coverage under all Medicaid and other publicly funded programs without having to clear

unreasonable administrative barriers.

**BENEFITS:** Benefits should include the broad range of services and supports required to achieve optimal health outcomes for the population covered.

**FINANCING:** Federal and state financing should promote appropriate, innovative, and efficient health care.

# Why Does Medicaid Matter?

## *The Story of Lady J*



“Lady J” is a 54-year-old New Yorker with three grown children and four grand-kids. When Lady J was 14 years old, she was hit by a car and told by doctors that she would have problems with her bones as she aged. Still, she worked for about 25 years as a teacher and a nurse in Brooklyn and Manhattan, supporting her family. Now, Lady J is HIV positive. Her complicated physical situation, including a lack of marrow in her hipbone, leaves Lady J unable to retain her balance or walk for any length of time. She says, “I can get around the house pretty well, but when I’m outside of my home, I stay in the wheelchair—I don’t want to fall again.”

About 6 or 7 years ago, Lady J fell and crushed her arm. She was hospitalized and also diagnosed with diabetes. She no longer had insurance and needed prescription drugs

for diabetes and hypertension. Lady J applied for Medicaid and Social Security Disability. She says, “The services that Medicaid pays for allow me to live independently. I was able to stay at home and continue to raise my son, who is now an independent adult.

“My kids grew up with me being very active and independent. They don’t like seeing me in my wheel chair—they don’t like to know that I can’t put on my own socks and shoes, that I can’t braid my hair. They get upset because I have good days and bad days. But at least I have a home attendant five days a week who can help me get dressed, bathed and fed. Since I’m in a mobile wheel chair, I have more independence. Medicaid will also pay transportation to my clinic for physical therapy, doctors’ visits, and other needs.

“I stay active in my neighborhood and with organizations that help people who have HIV/AIDS. I volunteer at Gay Men’s Health Crisis (GMHC), teaching an art class for HIV positive people. Since I was the first person in a wheel chair volunteering at GMHC, I got involved in helping to develop evacuation strategies in case of fire or disasters. I’m on the tenant housing board where I live and I volunteer at an organization that works with people with HIV. It’s called the Living Room and people can go there and talk, write poetry, get aromatherapy, acupuncture, and social support. I also distribute literature about HIV/AIDS in my community and teach

adults how to read. A lot of people here don't really understand the virus, what's happening with it, or how to get help. I think it's important that they get the information they need.

"I, and a lot of people I know, wouldn't be here if it wasn't for Medicaid. It's really frightening what would happen if they cut or got rid of Medicaid. One thing that scared me was when they started charging for prescriptions. They started with \$3 a prescription—but I take 25-30 prescription drugs a month, so that's a lot of money. I got a waiver that means I only pay around 50 cents a prescription and that's better, but if they raise it, I'll be in trouble. I'm on Social Security Disability and the only income I get is \$570 per month. Out of that I pay for rent, food, clothing, and other living expenses. I can't afford to have medical expenses go up.

"There are people like me who are in worse conditions than I am. We've worked most of our lives, we paid into the system, and we don't want to be let down like this. I don't feel like I'm being treated like a family member—that's what being an American is to me—being part of a big family. I've put my time in to make this country a better place to live and now I'm worried about being excluded. Health and education should be the top budget priorities.

"I worry about my children and grandchildren. I worry about what would happen to my mother. Being sick is part of life and we don't all get well and stay well. That's part of being human. It's very inhuman to cut the benefits for those of us who are sick."

# Separating Fact from Fiction: *Myths and Truths about New York's Medicaid Program*

It was once said that myth is more potent than either history or the truth. In recent months, a number of “Medicaid Myths” have sprung up among the sound bites, anecdotes, and incomplete statistics reported in the media. Too often, public officials make hasty decisions based on impressions that just don’t hold water. Medicaid matters far too much to let this happen. It’s time to debunk “Medicaid Myths” and make way for good public policy that will protect New York’s over 3 million Medicaid beneficiaries and improve the fiscal health of the state.

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## *Two-thirds of Medicaid beneficiaries in New York State do not receive cash public assistance.*

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**MEDICAID MYTH:** “Medicaid is just another welfare program.”

**TRUTH:** Medicaid is a health insurance program for low-income New Yorkers. Two-thirds of Medicaid beneficiaries in New York State do not receive cash public assistance. Instead, these New Yorkers receive Medicaid because they are low-income and do not have health insurance. In 2001, 70 percent of Medicaid funding was spent on the elderly and disabled. This means that services are being provided to those in the most need and that the dollars are well spent.

**MEDICAID MYTH:** “Medicaid is too expensive, is growing out of control and—let’s face it—there is nothing we can do to control Medicaid costs that won’t hurt beneficiaries.”

**TRUTH:** Medicaid costs have risen substantially in recent years. However, this trend should be viewed in the context of a larger health care system, in which Medicaid plays a unique role as provider of care for New York’s sickest and poorest individuals. Medicaid costs have actually grown at a slower rate than private health insurance, which serves a much healthier population.

**MEDICAID MYTH:** “Medicaid and FHPlus benefit packages are too rich. People don’t really need all of these services. And why should someone with free health insurance get more benefits than what is available through an employer?”

**TRUTH:** Like Child Health Plus, the FHPlus benefit package was based on employer models and is actually very similar to what most responsible employers offer (though public programs are provided at a much lower cost to the beneficiary). Under the Medicaid fee-for-service program, New York doesn’t pay for services unless a service is actually utilized. There is no good evidence that the existence of Medicaid and FHPlus is pushing employers to drop coverage they are already offering, thereby creating a “crowd out” effect.

It costs less to cover kids with Medicaid than it does with private insurance, even though Medicaid provides access to more services. Medicaid is a very efficient program and should not be blamed for employers' inability to provide the benefits that people need.

Finally, employer-based plans do not make sense for the seriously disabled and low-income chronically ill New Yorkers who rely on Medicaid. For someone living with HIV/AIDS or chronic mental illness, co-payments for medications and medical care in employer-based plans could amount to over \$500 a month, far more than their monthly income.

**MEDICAID MYTH:** “People don’t need programs like Medicaid and FHPPlus. The poor and uninsured can always get free health care from a hospital emergency room.”

**TRUTH:** Hospitals do not have to provide health care except in emergency situations. New York State law only requires that if a patient comes to an emergency room for care, they must be stabilized so they are in no danger. Hospitals are not required to provide ongoing care.

Hospital emergency rooms rarely provide truly free care. Instead, low-income families who use emergency rooms for medical care routinely face an aftermath of daunting bills from the hospital, followed by collection agency letters and lawsuits. Fear of medical debt is a significant barrier to accessing medical attention. As a result, uninsured patients often postpone or go without necessary care, and their conditions become more serious and more expensive when finally treated.

**MEDICAID MYTH:** “Why is New York’s Medicaid program a ‘Cadillac’ while other states, like California, make do with a jalopy?”

**TRUTH:** There are very good reasons why New York spends more on Medicaid and offers a more comprehensive program than other states, including California.

In New York, long ago we decided to make an investment in the health of our residents, especially for the elderly and disabled men, women, and children, as well as the working poor and their children. Medicaid has been the most effective way to get federal funding to help in this effort. Other states push even higher costs onto local governments, while failing to maximize federal funding.

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### ***Medicaid costs have actually grown at a slower rate than private health insurance.***

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For example, in states like California, the financial burden of caring for poor adults, the mentally ill, and the developmentally disabled falls on local governments and doesn’t show up in the Medicaid budget. In 1991, the New York State Senate Majority admitted as much—they said then that:

Many items New York State counts as Medicaid appear elsewhere in California under other names and budgets, making it appear that they are doing more with less when in fact they are not, and what they are doing may not be of the caliber of New York State’s program.<sup>1</sup>

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1 New York State Senate Majority Research Service, Medicaid: New York State versus California—A Comparative Analysis, April 1991.

New York has a larger population of elderly and disabled citizens than other states, which skews comparisons based on mean spending per beneficiary. In fact, due to our comparatively extensive use of home health services, New York's cost per beneficiary of long-term care services is lower than in many comparison states. Furthermore, the cost of health care in New York is higher than it is in many other parts of the country, including California, due to underlying differences in cost of living. A more apt comparison of New York's program is with states like Connecticut and Massachusetts where per beneficiary costs are similar.

# Recommendations for Consumer-Friendly Medicaid Reform

## **Recommendation #1: Streamline the enrollment process to improve preventive care and disease management while reducing administrative costs.**

Preventive care and disease management should be critical components of the Medicaid program. Both seek to more efficiently utilize scarce health care resources in the quest for better health outcomes and cost savings. However, coverage that is highly unstable works against the potential benefits offered by preventive care, early diagnosis, and disease management. New York should first streamline the eligibility and renewal process to ensure that those who can most benefit from a coordinated, comprehensive approach to care are able to get enrolled and stay enrolled in public coverage programs, especially Medicaid. Current administrative barriers make it difficult for people who are eligible for coverage to actually enroll in the program, making it unnecessarily hard for people to get needed health care.

Furthermore, the current renewal system results in as many as half of all clients failing to successfully complete the process. This creates “churning” as coverage is lost, wasting administrative resources. The overall outcome is that it is harder for eligible New Yorkers to receive the ongoing preventive care and case management that contribute to better health outcomes. It also generates unnecessary

administrative costs. In fact, a recent study shows that the cost of enrolling children in Medicaid could be reduced by forty percent if documentation requirements were simplified.<sup>2</sup>

To streamline the enrollment process for public coverage programs, MMNY recommends the following:

- Continue strong support for community-based facilitated enrollment. The effectiveness of facilitated enrollment agencies cannot be overstated. Facilitated enroll-

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***Current administrative barriers make it difficult for people who are eligible for coverage to actually enroll in the program, making it unnecessarily hard for people to get needed health care.***

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ment agencies are open during non-traditional hours to encourage appointments for working applicants who cannot take time off work. These agencies provide unparalleled language access, with staff who speak more than 35 different languages. By using a patchwork system of four different programs (Medicaid, Child Health Plus, FHPlus and Women, Infants and Children), facilitated enrollment serves as the glue to hold these programs together, preventing people from slipping through the cracks found among these programs.

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2 Gerry Fairbrother, Melinda J. Dutton, Deborah Bachrach, Kerry-Ann Newell, Patricia Boozang and Rachel Cooper. “Costs Of Enrolling Children In Medicaid And SCHIP” Health Affairs Vol 23, No. 1, January/February 2004.

- Eliminate all documentation not federally required for health care enrollment, including residency, income, and assets.<sup>3</sup>
- Exercise the state’s authority under existing law to dramatically simplify and streamline the current document-heavy and administratively burdensome process for determining and verifying eligibility, in favor of quicker, paperless, more cost-effective, electronically-based, and consumer-friendly processes. Examples include the NYC Model Office Initiative, which offers shorter wait and processing times based on document imaging and electronic access to other case records and databases to verify eligibility; and the Child Health Plus e-application, which uses an eligibility calculator.
- Enroll eligible New Yorkers quickly and efficiently into the appropriate coverage program from the very beginning (e.g., implement children’s presumptive eligibility for Medicaid, and ensure that adults with excess resources are not incorrectly enrolled in Medicaid).
- Improve the transition process between programs to eliminate significant gaps and/or the loss of coverage for eligible children and adults.
- Monitor and improve the new mail-in renewal processes to significantly reduce the wasteful and excessive rates of “churning” of eligible children and families.
- Explore more “automatic” methods of linking children and families to coverage and care, including expedited eligibility through other means-tested programs (e.g., food stamps, earned income tax credit).

## **Recommendation #2: Increase health literacy and language access to achieve cost saving and improve health outcomes.**

Health literacy is defined as the ability to read, understand, and act on basic health information.<sup>4</sup> People with low health literacy have limited ability to read and understand instructions on prescription bottles, appointment slips, insurance forms, informed consent documents, and health education materials. Although there are no national studies directly measuring health literacy levels in the United States, estimates indicate as many as 90 million adults are low health literate.<sup>5</sup>

In addition to the concern about health literacy levels, there must be attention paid to the special needs of people with disabilities and those whose primary spoken language is other than English. These people are doubly hindered from an understanding of health information if their language needs are not addressed. Despite the radical reduction in federal admissions of refugees, 125,000 immigrants will move into New York each year, most of whom will not speak English. Most of these immigrants will be working and unable to take English-as-a-Second-Language (ESL) classes, for which there are long waiting lists. Language access for the disabled and foreign language speakers in health care facilities

3 Health and Human Services (HHS), Centers for Medicaid and Medicare Services (CMS), “Continuing the Progress: Enrolling and Retaining Low-Income Families in Health Care Coverage,” August, 2002. The only federal requirement is documentation of non-citizen immigration status. See also 42 C.F.R. Sec. 435.902- the state must determine eligibility in a manner “consistent with simplicity of administration and the best interests of the applicant or recipient.”

4 National Academy on an Aging Society. Fact Sheet: Low Health Literacy. 2003. [http://www.agingsociety.org/agingsociety/publications/fact/fact\\_low.html](http://www.agingsociety.org/agingsociety/publications/fact/fact_low.html)

5 *ibid*

is required as part of Title VI of federal civil rights law and the New York State Patients Bill of Rights. (10 NYCRR Part 405.7)

Low health literacy and limited language access have been recognized as important barriers to maintaining an efficient health care system. One objective set forth in Healthy People 2010 is to “improve the health literacy of persons with inadequate or marginal literacy skills.”<sup>6</sup>

It is important for New York’s leaders to recognize the role that low health literacy and limited language access play in increased Medicaid costs and decreased quality of care. When patients are unable to follow through on medical advice, or postpone obtaining care until the severity of their illness intensifies and the cost of treatment increases, Medicaid bears the burden. To illustrate the effectiveness of improving health literacy as a means to cost savings, a pilot study in California aimed to reduce non-urgent pediatric ER visits by improving parent confidence in responding to their child’s non-urgent health problem. Intervention was a simple booklet entitled “What to Do When Your Child Gets Sick.” The book was written at a third- to fifth-grade reading level and presented easy to understand information with many illustrations. The program documented a statistically significant decrease (6.7 percent) in non-urgent ER visits among children of parents who received this book through the program.<sup>7</sup>

Underscoring the impact on the Medicaid system is a 1996 survey of 400 Medicaid managed care clients in New York. Over 30 percent did not know that managed care

limited them to a specific network of doctors, 60 percent were unaware that a referral was required to see a specialist, and 80 percent did not know that their use of the emergency room was limited under the terms of their health coverage.<sup>8</sup>

These findings bring some of Medicaid’s most complicated problems into focus. Problems like high rates of no-shows; overuse of emergency facilities, physician offices and specialists; and more frequent prescription drug utilization may have roots deeper than simple lack of knowledge. Many Medicaid clients do not have access to the information that they need

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***It is important for New York’s leaders to recognize the role that low health literacy and limited language access play in increased Medicaid costs and decreased quality of care.***

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in order to use the health care system effectively. In too many cases this information has not been translated or shared in a language that clients can understand. It continues to be difficult or impossible to obtain applications and other forms and notices in New York State’s most common languages, such as Spanish, Russian, Chinese, Haitian-Creole, Bengali, Urdu, Polish, Korean, and Arabic. The Medicaid program and health care providers

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- 6 U.S. Department of Health and Human Services, Healthy People 2010, 2nd ed. 2 vols. Washington DC: U.S. Government Printing Office, November 2000.
  - 7 Institute For Healthcare Advancement. “Health Literacy: An Overview and Research-Supported Solutions”. [www/iha4health.org](http://www/iha4health.org)
  - 8 “Knowledge Gap: What Medicaid beneficiaries understand—and what they don’t—about managed care.” Community Service Society of New York, December 1996.

do not have adequate systems in place to match case loads to workers with appropriate language skills, and have not done enough to ensure that staff who provide translation and interpreting have appropriate language skills.

One study has quantified the economic costs of low health literacy. The analysis, prepared by the Center for an Aging Society at Georgetown University, estimates that low health literacy costs the health care system \$30–\$73 billion annually.<sup>9</sup> This analysis indicates that as much as 63 percent of the total cost of low health literacy is borne by public insurance programs. For example, the author estimates that the average annual medical cost for a Medicaid client is \$3,499. For a Medicaid client who has low functional literacy, the average annual cost is \$5,158, 47 percent higher than for people classified as literate. While it is difficult to identify the specific services that are driving the increased expense, it is clear that improving health literacy will play a critical role in controlling Medicaid costs.

MMNY makes the following recommendations to improve the health literacy and language access of Medicaid and other consumers in New York State:

- Ensure that New York State makes legislative changes to enable reimbursement of language services through federal Medicaid, and require the availability of translated materials and trained interpreter staff. Although translation of documents and interpretation services are now required in federal and state regulations, hospitals have not lived up to this mandate,

and state agencies are not enforcing these requirements. Community-based health care providers are often the most culturally and linguistically competent in responding to the communities that they serve.

- Conduct a comprehensive review of all Medicaid materials and correspondence. Written materials must be written at a reading level that is accessible for even the low literate and must be translated into all of the most common spoken other-than-English languages. Studies show that materials with increased white space, appropriate graphics, large font, friendly tones, and culturally competent language improve the likelihood that a client will be able to understand the message. New technologies, such as computer assisted learning, could provide better access to medical information in clinic and hospital settings.
- Increase the availability of case managers to provide individualized care for clients who have difficulty navigating the health care system. Navigators who are culturally and linguistically competent help to ensure appropriate use of Medicaid services by intervening to avoid overuse of benefits and help clients obtain necessary medical services in a timely manner.
- Assure beneficiaries' right to information about the Medicaid program. In order for beneficiaries to realize the maximum benefits of their Medicaid coverage, they need to understand what the program offers. Individuals and communities need comprehensive, up-to-date information about what benefits are covered and how to obtain them. Medicaid beneficiaries have the right to information about how the Medicaid system works, how to navigate the system, and where to turn if they have problems accessing Medicaid-covered services. Understanding how to use the health care system appropriately fosters people's ability to obtain preventive care and to seek care earlier in their illnesses

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9 Friedland, Robert B. "The Costs of Low Health Literacy." The Center for and Aging Society, Georgetown University. Presented at the Council of State Governments Conference on Health Literacy. Newport, RI, September 15, 2003.

when treatment is less costly. It also decreases reliance on emergency departments.

### **Recommendation #3: Strengthen Family Health Plus (FHPlus), New York's commitment to coverage for uninsured adults.**

Family Health Plus (FHPlus) has been a remarkable success story. In only two years, 340,000 low-income New Yorkers have enrolled in FHPlus and are now able to receive the health care services they need without fear of economic devastation. While the number of New Yorkers without health coverage remains unacceptably high, it appears to have stabilized over the last year. This is especially notable given the continued stagnation in the economy and the ongoing high rates of unemployment. FHPlus can take credit for this. According to an analysis of Current Population Survey (CPS) data performed by the Center on Budget and Policy Priorities, the percent of low-income New York parents who were uninsured fell from 30.7 percent to 28.0 percent between 2000 and 2002, a statistically significant decline.<sup>10</sup> The main reason for this improvement was that Medicaid and FHPlus coverage among low-income parents grew by more than two percent, due in part to Disaster Relief Medicaid, which attracted many New York City residents because of the dramatically simplified eligibility determination process. It is also a clear indication that FHPlus is achieving its goal of reducing the number of uninsured in New York.

MMNY strongly believes in making the application, enrollment, and renewal processes for public health coverage programs as easy and user-friendly as possible. We believe New York made the right decision when it chose not to include an asset test as part of the FHPlus eligibility determination. Research from around the country indicates that elimination of the asset test greatly reduces the administrative burden for local district offices, and does not compromise program integrity or increase consumer fraud.<sup>11</sup> Asset tests impose a significant burden on the applicant, require extensive

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### ***It is clear that Family Health Plus is achieving its goal of reducing the number of uninsured in New York.***

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staff resources at the county level, and yet generate very few denials of coverage. Rather than add an asset test for FHPlus, we would like to see the asset test removed from the Medicaid application process.

In order to help reduce the cost of FHPlus to states and counties, some are suggesting that New York introduce some elements of cost-sharing into the program. MMNY strongly opposes cost sharing for FHPlus. Cost-sharing can pose significant financial barriers to those in need of care. A recent study concludes that states should avoid cost-sharing in Medicaid because the poor then avoid all care, including essential medical services.<sup>12</sup> Moreover, recent

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10 Personal communication from L. Ku, Center on Budget and Policy Priorities, December 30, 2003.

11 "Eliminating the Medicaid Asset Test for Families: A Review of State Experiences," Kaiser Commission on the Future of Medicaid and the Uninsured, Washington, DC, May 2001

12 Ku, Leighton. "Charging the Poor More for Health Care: Cost Sharing in Medicaid." Center on Budget and Policy Priorities, Washington, DC, May 2003.

court decisions have ruled that cost-sharing in programs like FHPlus above the levels set out in federal statute is illegal. If New York considers raising co-payments within FHPlus, for example, not only would low-income New Yorkers be less likely to obtain needed care, but the state may lose federal matching dollars when overall Medicaid spending is reduced. While modest cost-sharing can be appropriate in some circumstances, New York should support federal limits that ensure coverage remains affordable, insulating individuals from premiums and cost-sharing obligations at levels that would deter access to services.

There is some concern that FHPlus is causing employers who currently provide health insurance to drop their coverage and encourage their employees to enroll in FHPlus (a practice referred to as “crowd-out”). MMNY has seen no data indicating that crowd-out is a significant problem in New York. In fact, CPS data indicate that in the first year of FHPlus, the number of New Yorkers covered by employer-sponsored plans actually increased slightly.<sup>13</sup> And while communities upstate may have large numbers of low-wage jobs that actually provide health insurance as an employee benefit, in New York City that is not the case. According to a recent survey conducted by the Community Service Society, only 36 percent of full-time workers whose income was below the poverty level worked at a place where they were offered family health insurance. Moreover, an even smaller percent could actually afford to sign up for that coverage.<sup>14</sup>

FHPlus offers a comprehensive, but not overly generous, benefit package. FHPlus is modeled after employer-based insurance, and as such does not include health benefits such as long-term care and case management, and offers limited mental health, substance abuse, and physical therapy benefits. Reducing the benefits would make this program unresponsive to critical health needs of low-income New Yorkers.

In order to maintain New York’s commitment to health coverage, regardless of health care needs, MMNY recommends the following:

- Maintain the commitment to expanding health coverage for low-income New Yorkers, especially those making the transition from welfare to work, by raising the eligibility level for FHPlus to 250 percent of the federal poverty level.
- Reject any cuts to the FHPlus benefit package, refuse to implement an asset test for eligibility, and oppose additional cost-sharing requirements within the program.
- Create a buy-in program for FHPlus so that individuals who are not eligible for the program can buy into it, thereby further reducing the number of New Yorkers who are uninsured.

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13 Personal communication from L. Ku, Center on Budget and Policy Priorities, December 30, 2003.

14 “The Unheard Third: Bringing the Voices of Low-Income New Yorkers to the Policy Debate,” Community Service Society of New York, November 2003.

## **Recommendation #4: Permit state take-over of Medicaid long-term care costs by shifting resources out of expensive institutional settings.**

Local governments are encountering extreme financial difficulties in helping finance our state's Medicaid system and should be relieved of this burden, though not at the expense of reduced access and fewer services for beneficiaries. Local relief could be obtained through state take-over of the long-term care costs for Medicaid beneficiaries currently borne by localities.

MMNY supports tying state take-over of the local share Medicaid expenditures for institutional placements to the creation of strong incentives that move people with disabilities and seniors from institutional settings into the community. Financial incentives need to be aligned so that counties can provide more home and community-based services without bearing a larger financial burden than they do for institution-based services. Currently, Medicaid beneficiaries who could live in the community are often cared for in nursing homes, despite the fact that institutionalization is a more costly alternative.

New York State could further minimize the costs of long-term care by implementing approaches that will allow institutional care to be delivered in the community in keeping with individuals' preferences. MMNY supports the creation of a new Medicaid waiver dedicated to transitioning people from nursing home placements of 60 days or longer. If New York transitioned one percent of its

current nursing home population (1,300 people) to the community through such a waiver program, Medicaid expenditures would decrease by \$25 million in the first year alone. Transitioning one percent of the nursing home population per year for five years would result in savings of over \$304 million.<sup>15</sup>

Funding from the waiver should make it possible to shift from reimbursement for care in a nursing home to reimbursement for care in the community. This idea is sometimes

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referred to as a "money follows the individual" concept: funding currently dedicated to an individual receiving services in an institution is shifted to his or her services in the most integrated setting. Also, to the extent that waiver funding is based on comparing the cost of community care to the cost of institutional care, such comparisons should be done in the aggregate. In this way, savings realized by serving an individual whose care is less costly in the community can be used to offset the expense of caring for an individual whose care is more expensive in the community than it would be in an institution.

To fully implement the Supreme Court's *Olmstead* decision and overcome the obstacles

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<sup>15</sup> New York State Traumatic Brain Injury Medicaid Waiver saves \$1,624 per person per month as compared to the cost of skilled nursing facility placement. Center for Disability Rights, 2003.

Medicaid beneficiaries face in attempting to access long-term care services in the community, MMNY recommends the following:

- Focus inspection of nursing homes on discharge planning to make sure that individuals who want to and can live in the community are helped to do so by the nursing home.
- Review federal and state health and safety regulations to ensure that they permit an appropriate allocation of authority for assuring the safety of individuals receiving long-term care. Competent individuals have the right to take risks. Long-term care providers have the right to do all they can to keep their clients safe, while respecting the individual's right to choose.
- Modify existing Medicaid waivers (Traumatic Brain Injury and Office of Mental Retardation and Developmental Disabilities waivers) to take advantage of the flexibility authorized by the federal government to provide case management and planning to better facilitate transitions from institutions to the most integrated setting.
- Apply to the federal Centers for Medicare and Medicaid Services (CMS) for authority to permit Consumer Directed Personal Assistance Program providers to receive a "personal assistance retainer" payment like those available to home care providers under Medicaid waivers. Amend overly restrictive state regulations governing selection and payment of personal attendants.
- Oppose proposals that extend the "look back" period for transfers of assets, make penalty periods prospective, and apply transfer penalties to persons applying for home care. Such proposals will have the unintended consequence of forcing elderly and disabled individuals to choose costly nursing home care over community care because the proposed restrictions for institutional applicants cannot be enforced

unless a federal waiver is granted, a lengthy and uncertain process. In addition, low-income individuals who make small transfers of resources without the benefit of legal counsel will bear the brunt of the penalties.

- Oppose proposals to eliminate spousal refusal in Medicaid long-term care cases. This proposal would force an increase in nursing home admissions, because spousal refusal for institutional applicants is required under federal law but spousal refusal for home care recipients is not; and because income allowances available to the healthy spouses of institutionalized Medicaid recipients are not available to the spouses of recipients of home care services.

**Recommendation #5: Create a new funding source for health care for the uninsured by giving employers in New York an incentive to contribute to the cost of insuring their workers.**

The problem of low-wage New Yorkers without health insurance is growing. The ranks of New Yorkers holding low-paying jobs have tripled since the 1970s. Since many low-income workers do not have access to employer-based insurance, public programs have been the only source for health care outside of costly emergency rooms. FHPlus was established, in part, as a response to this problem, in recognition of the large number of working New Yorkers who do not have employer-sponsored coverage, and as a critical support in helping people make the transition from welfare to work. Programs like FHPlus,

and Medicaid in general, have played a crucial role in limiting the growth of the uninsured in New York.

Employers who provide health coverage to their employees are disadvantaged by doing the right thing. Not only do they provide coverage, but they contribute to the cost of providing services to the uninsured through insurance premium increases. Employees also contribute indirectly through lower wages and increased cost-sharing for health insurance. Employers who do not provide coverage to their workers pay nothing.

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*Since many low-income workers do not have access to employer-based insurance, public programs have been the only source for health care outside of costly emergency rooms.*

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Given the size of the problem of the uninsured in New York, this un-level playing field must be addressed. Employers must be provided an incentive to contribute to the costs of health insurance for their employees.

MMNY recommends the following:

- Explore programs that would level the playing field by giving employers who do not provide health insurance for their employees an incentive to contribute to the costs of covering uninsured workers in New York.
- Build in safeguards to ensure that employer contribution proposals dedicate new revenues exclusively to health care for uninsured workers. MMNY recognizes that workers ultimately pay employer contributions to the cost of health care coverage because such expenses effectively decrease worker compensation. Therefore,

it is critical that every dollar collected go directly into providing health care for the uninsured.

- Include mechanisms that will give employers who are currently providing affordable, comprehensive coverage incentives to continue to do so.

**Recommendation #6: Ensure that Health Care Reform Act (HCRA) funds for Medicaid and programs for the uninsured are used exclusively for those programs; increase public accountability in the entire HCRA funding system.**

New York State finances many of its health care programs, including programs within Medicaid and care for the uninsured, through the Health Care Reform Act of 1996. This legislation supports an array of health initiatives in New York State, ranging from Graduate Medical Education to FHPlus and Child Health Plus, to the workforce retention programs, to care for the uninsured. The “pools” of funds in HCRA come from several sources, including tobacco settlement funds, cigarette taxes, the covered lives assessment, taxes on hospital revenues, and federal support. The money that flows in and out of HCRA is largely a mystery to the public, the press, and many lawmakers. There is little accountability for how HCRA funds are allocated once they come into the system, and how they are being spent once they flow out.

For example, hospitals receive millions of dollars through HCRA but do not have report-

ing requirements that force them to detail where and how their money is used. A recent report by the Legal Aid Society shows that millions of dollars in Bad Debt and Charity Care go virtually unaccounted for once they are dispersed to New York City hospitals.<sup>16</sup> A more transparent HCRA accounting system could identify areas of waste; any funds saved should be redirected to Medicaid to expand health coverage and/or provide more comprehensive benefits.

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***The money that flows in and out of the Health Care Reform Act is largely a mystery to the public, the press, and many lawmakers.***

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To ensure public accountability, save millions in misspent HCRA funds, and expand funding for Medicaid and programs for the uninsured, MMNY supports the following reforms to the HCRA funding system:

- Create a public accounting system detailing exactly how HCRA monies flow in and out of the system. It is absolutely essential to assure the public that funds for Medicaid and the uninsured are being used for those explicit purposes.
- Ensure that any misallocated funds are directed first and foremost to expanding health coverage under Medicaid.
- Implement reporting requirements for institutions receiving Bad Debt and Charity Care Funds.
- Disallow the use of HCRA funds to be used for general fund budget relief.
- Limit reliance on non-recurring revenue streams for HCRA.

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<sup>16</sup> Benjamin, Elisabeth, Gabriesheski, Kat, Pomykala, Anna. "State Secret: How Government Fails to Ensure that Uninsured and Underinsured Patients Have Access to State Charity Funds" Legal Aid Society, October 2003.

**Recommendation #7: Leverage New York's prescription buying power through bulk purchasing and reimportation to bring down the cost of prescription drugs.**

MMNY supports bulk purchasing and reimportation proposals to assure that New York's Medicaid beneficiaries have access to prescription drugs in a way that is efficient and cost-effective for New York. An appropriate strategy for New York to seek cost savings without compromising access would be to use its clout as one of the world's largest purchasers of pharmaceuticals to drive down drug prices for Medicaid and other insurance programs it supports.

MMNY recommends the following:

- Examine the entire range of purchasing strategies employed by other states and localities, including reimportation from Canada, to determine how Medicaid and other health care consumers could benefit.
- Use New York State's clout as one of the world's largest purchasers of pharmaceuticals to drive down drug prices for Medicaid and other public health insurance programs.
- Create mechanisms that allow private employers and self-insured plans to take advantage of lower priced drugs.

## **Recommendation #8: Provide strong consumer protections if implementing a Preferred Drug List (PDL).**

MMNY understands that the rising cost of prescription drugs is exerting increasing pressure on New York's Medicaid program. Including rebates New York receives from drug manufacturers, Medicaid will have spent nearly \$3.1 billion on pharmaceuticals in FY 2002–2003, according to the New York State Department of Health. This figure is projected to increase to nearly \$3.7 billion for FY 2003–2004 and is driven by growth rates of approximately 20 percent per year since 2000, a rate higher than the overall Medicaid growth rate.

However, New York's current focus on creating a PDL enforced by prior authorization could really be much broader. Medicaid PDLs have the effect of shifting market share to the lower priced "preferred" drug (or drugs), along with obtaining lower prices from manufacturers who want their products placed on the PDL. Bulk buying, reimportation, and other measures (see Recommendation #7 above) should be included in a comprehensive effort to bring down the unreasonably high cost of prescriptions for Medicaid.

It is essential to ensure that a PDL does not aim to control costs by reducing medically necessary utilization by Medicaid beneficiaries. The effect of Medicaid PDLs on patients' health and health care access remains largely unknown. A recent study in the journal *Health Affairs* suggests that instituting simple mechanisms to protect high-risk patients

could maximize savings and minimize harm.<sup>17</sup> Another study found that PDLs used in tandem with other cost control strategies like increased co-pays, fail-first policies, and dispensing limits significantly increase the likelihood that Medicaid beneficiaries will not obtain medications they need. This is especially the case for individuals with two or more chronic conditions.<sup>18</sup>

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### ***Bulk buying, reimportation, and other measures should be included in a comprehensive effort to bring down the unreasonably high cost of prescriptions for Medicaid.***

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Consumer-unfriendly PDLs enforced by prior authorization can easily result in inappropriate and potentially harmful reduction in drug utilization by erecting barriers to care that will cause some Medicaid beneficiaries to go without their needed medications altogether. For example, under New York State's Mandatory Generics Program, when a Medicaid beneficiary requires a medically necessary brand name drug (instead of the generic equivalent), the prior authorization process requires a 24-step process that takes place in two locations and involves both the beneficiary's medical provider and pharmacist. When a prior authorization requirement results in a prescription going unfilled at the pharmacy, Medicaid beneficiaries may very well walk away empty-handed, especially since they lack the resources to pay up-front.

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17 Soumerai, Stephen B. "Benefits And Risks Of Increasing Restrictions On Access To Costly Drugs In Medicaid" *Health Affairs* Vol 23, No. 1, January/February 2004.

18 Cunningham, Peter J. "Prescription Drug Access: Not Just a Medicare Problem" Issue Brief No. 51, Center for Studying Health System Change, April 2002.

Furthermore, Medicaid beneficiaries are much less likely than privately insured patients to pursue a denied claim with their providers, because of financial constraints, health literacy and language barriers, and unfamiliarity with the workings of the prior authorization process. In New York City, Medicaid beneficiaries tend to get their primary care from hospital outpatient departments, free-standing clinics, and private doctors who see extremely high volumes of patients and maintain limited office hours, especially in the evening and on weekends. It is unrealistic to believe that these providers are easily accessible to beneficiaries who are having problems filling a prescription. Given that these same providers and pharmacists themselves have expressed dismay and confusion over the workings of Medicaid's existing prior authorization process, it is unlikely that they can provide all the supports Medicaid enrollees would need if a PDL does not provide straightforward access to needed off-list medications.

While in some limited cases reducing utilization is appropriate, New York's current limited experiment with prior authorization and experiences from other states indicates that any PDL strategy without strong consumer protections will result in denial of access and harm to beneficiaries. A consumer-unfriendly PDL carries a high risk of disproportionate impact on seniors and beneficiaries with serious illnesses and disabilities who use more drugs than the overall Medicaid population.

MMNY believes that any PDL must include adequate consumer protections for Medicaid beneficiaries, including the following:

- Clear prior authorization override criteria with the prescriber's judgment as decisive.
- Specific protections for vulnerable

Medicaid populations like seniors and people with serious illnesses and disabilities. Medicaid beneficiaries successfully adhering to a drug regimen that could be interrupted by a new prior authorization requirement should be offered additional safeguards.

- A clear definition of emergency that is appropriate to the pharmacy context.
- Adherence to Medicaid fair hearing and notice requirements.
- Open and transparent Pharmacy and Therapeutics Committee meetings and proceedings where beneficiaries are officially represented.
- Automatic inclusion of any new drug on the PDL until the Pharmacy and Therapeutics Committee has had an opportunity to review it.

**Recommendation #9: Roll back provisions of the 2003 federal Medicare bill that reduce coverage for dually eligible Medicare/Medicaid beneficiaries and limit state savings.**

The Medicare bill passed in November 2003 will limit prescription drug access for the 411,000 low-income seniors and people with disabilities in New York who are dually eligible, i.e., those who have both Medicaid and Medicare. Usually, Medicaid works in tandem with Medicare to cover health care, including prescription drugs, for low-income seniors and people with disabilities. The 2003 federal Medicare bill eliminated Medicaid's ability to cover prescription costs that Medicare will not cover. The elimination of a Medicaid

“wrap” will affect hundreds of thousands of New Yorkers who are dually eligible and rely on both programs to access their prescriptions. Eliminating this critical layer of prescription coverage will harm beneficiaries who need drugs not available on a Medicare formulary (since proposed Medicare drug rules would permit plans to cover just one drug in a therapeutic class); impose extreme financial burdens, like co-payments, which could deter

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***The elimination of a “Medicaid wrap” will affect hundreds of thousands of New Yorkers who are dually eligible and rely on both programs to access their prescriptions.***

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low-income individuals from filling prescriptions; and would discriminate against Medicaid beneficiaries solely because they are also eligible for Medicare.

MMNY recommends the following:

- Work to roll back the provisions of the Medicare law that (1) prohibit federal matching for any Medicaid wrap of dual eligibles and (2) require states to pay back the money they save from Medicare drug coverage of dual eligibles (commonly referred to as the “claw back” provision). If this cannot be accomplished, the state must prepare to assume the wrap-around role with state-only dollars as of 2006.
- Commit to providing dual eligibles with the full range of drug coverage it provides all other Medicaid eligibles, with or without federal match. We note that the 2004–5 Executive Budget specifically exempts certain life-saving drugs from its planned Preferred Drug program for Medicaid and EPIC. At the least, dual eligibles must be afforded the same protection regardless of what the Medicare program does.

**Recommendation #10: Demand legislation that requires the federal government to assume more financial responsibility for Medicaid; oppose any federal block grant initiatives.**

New York State should work with federal leaders to preserve Medicaid as an entitlement program, allowing states to address fluctuations in enrollment and increases in health care costs. Fluctuations in Medicaid enrollment are inevitable during hard economic times and when large population groups age. Likewise, increased service costs are the natural consequence of advancing medical technology. Reform proposals that include a cap on federal spending, either by a block grant or any other approach, penalize states for the rising costs associated with technological advances and enrollment surges. Without open-ended matching funding, New York will be unable to provide stable and reliable insurance coverage for its residents, and even the most innovative of service models will not succeed in saving costs and improving patient outcomes.

To achieve such cost savings and improved patient outcomes, MMNY recommends the following:

- Reform federal financing mechanisms in order to a) utilize Medicaid funding (FMAP) formulas that better reflect states’ fiscal capacity and demographics; and b) make the 2003 FMAP increase permanent. A recent GAO report documents that New York State is disadvantaged by the current per capita formula income that determines individual state FMAP rates. Congress needs to develop a funding formula that incorporates (1) a broader measure of a state’s total taxable resources,

(2) a state's poverty rate, and (3) a state's costs of providing services, particularly to the elderly.<sup>19</sup> Similarly, financing mechanisms must recognize that the federal government has a vital role to play in preventing a worsening crisis during economic slowdowns, by shoring up state Medicaid financing when enrollment increases and state tax revenues decline.

- Provide 100 percent FMAP for Medicaid services to individuals dually eligible for Medicare and Medicaid. Traditionally, the federal government has accepted the

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***A recent GAO report documents that New York State is disadvantaged by the current per capita formula income that determines individual state FMAP rates.***

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responsibility for programs that serve individuals over age 65, while states have the responsibility for low-income non-elderly and working Americans. This rational division of responsibility has broken down, however, as state Medicaid programs have been forced to fill gaps in Medicare coverage for expensive services such as prescription drugs and long-term care.<sup>20</sup> Recent estimates put spending on the dually eligible population at over 40 percent of total

Medicaid spending.<sup>21</sup> Increases in Medicare costs must be addressed by federal government financing and not by imposing cost-sharing obligations on recipients at levels that would deter access or reduce the availability of already scarce health care resources for low-income, vulnerable populations.

- Provide matching federal funds for state dollars spent on health care services for legal immigrants. The federal government greatly reduced immigrant access to public benefits, including Medicaid, as part of the Welfare Reform legislation in 1996, and New York followed suit. However, in 2001, the New York State Court of Appeals held that laws eliminating legal immigrants' eligibility for state Medicaid coverage violate the state and federal constitutions.<sup>22</sup> As a result, New York provides Medicaid coverage to legal immigrants at its own expense. Congress should repeal the federal restrictions and match New York's Medicaid expenditures on legal immigrants. Existing proposals to assure Medicaid and SCHIP coverage for legal immigrant children and pregnant women are a step in the right direction.
- Preserve waiver options that allow innovative state programs to utilize federal Medicaid funding for preventive services and other alternatives to costly institutional care. New York achieved innovative expansion of its Medicaid program in 2001 with the creation of FHPlus, which receives federal support to provide coverage to low-income adults who would otherwise be uninsured. The fact that New York's average percentage of uninsured persons did not increase over 2001–2002<sup>23</sup> is likely due to the success of FHPlus in providing coverage to New Yorkers who would otherwise be limited to the expensive care available through hospital emergency rooms. Similarly, New York has been innovative in addressing the complex needs of the elderly and disabled. The Traumatic Brain Injury and Long Term Home Health

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19 US General Accounting Office, "Medicaid Formula—Differences in Funding Ability among States Often are Widened", GAO-03-620, July 2003.

20 Drugs and supplies (primarily prescription drugs) were the third largest category of Medicaid spending in New York in 2001, after nursing home care and inpatient hospital services. Gleason Center for State Policy, Transforming Medicaid: Options for New York, Making Medicaid More Effective and Efficient, September 2003.

21 Urban Institute analysis of 2000 MSIS data applied to CMS-64 FY2002 data for the Kaiser Commission on Medicaid and the Uninsured.

22 *Aliessa v. Novello*, 96 N.Y.2d 418 (2001).

23 Nationally, the estimated percentage of the population without health insurance rose by nearly 6%, the second consecutive annual increase and the most dramatic increase in a decade. Source: U.S. Census Bureau, Current Population Survey, 2001, 202, and 20.

Care waiver programs have enhanced the state's ability to access federal funds for developing community-based care services as an alternative to costly institutionalizations. Federal waiver policies that encourage state creativity and innovation must be a central piece of any reform proposal.

# Conclusion

There is no question that New York's Medicaid program needs change. In 2004, lawmakers will consider a range of proposals to restructure Medicaid. Some will call for a tightening of eligibility rules, a cutting of the services covered under Medicaid, or a shifting of costs to Medicaid beneficiaries. Others will push for action to relieve county governments and property taxpayers of the financial burden of paying for Medicaid. Lawmakers are presented with both an opportunity and a

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challenge: improving New York's Medicaid program to ensure that it meets the health care needs of more than three million New Yorkers and doing so in an efficient, financially responsible manner that does not sacrifice access to quality care.

This is not an easy task, and New York's lawmakers will not suffer from a lack of input from varied interest groups concerned about changes in Medicaid. But, in the end, they should be guided by the impact that proposed changes will have on low-income and medically vulnerable New Yorkers. MMNY is the voice for beneficiaries, advocating on behalf of New York's Medicaid program and the people it serves. With over 100 member organizations, MMNY is committed to ensuring that the issues and needs of

Medicaid beneficiaries are heard in any discussion of Medicaid reform.

The policy options lawmakers choose are, quite literally, matters of life and death. For many New Yorkers, losing eligibility to Medicaid means not getting preventive health services, such as cancer screening or hypertension treatment, which are crucial to early detection and better treatment of disease and illness. Making it harder to obtain life-saving prescription drugs or home care services can lead to expensive and catastrophic health outcomes.

This report has sought to peel away the myths that obscure the truth about the Medicaid program. Too often, the same old, tired sound bites are used to describe Medicaid, leaving the public confused, even angry, about our state's successful program. The recommendations made here would place the program on a sounder financial footing, reap immediate and long-term savings, reduce local government financial obligations, and make the program easier for beneficiaries and their families to navigate.

These ideas, put forth by the only organized statewide coalition that speaks solely for Medicaid beneficiaries, are informed by the experiences of everyday Medicaid beneficiaries. The proposals recognize that Medicaid can be made more efficient, savings are possible, and local governments and taxpayers alike can be relieved of the financial burden of paying for this program.

Medicaid Matters New York is dedicated to ensuring that the voices of Medicaid beneficiaries are heard during the coming debate about the future of this vital program.

“Finding A Better Way” offers a roadmap to strengthening a program vital to the health and well being of over three million New Yorkers. The solutions lie in hearing and heeding these voices.









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