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MEDICAID

IN NEW YORK STATE

Separating Fact from Fiction

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Healthcare Association
of New York State

MARCH 2007

MEDICAID

IN NEW YORK STATE

Separating Fact from Fiction

New York State's Medicaid program has established an unparalleled record of caring for the most vulnerable people in our communities. Medicaid and the associated Child Health Plus and Family Health Plus programs provide health care coverage for children and adults, expectant mothers, disabled individuals, the elderly, and people struggling with mental illness. In all, almost one in five New Yorkers receives health care through one of these programs.

The Medicaid program benefits all New Yorkers through improved community health, through support for health care workers who treat all patients, and by keeping our health care system economically sound. Medicaid also ensures that the safety net hospitals and community health centers that serve a disproportionately higher share of the uninsured have the resources they need to survive.

The Medicaid program has been widely misunderstood and perception of it is sometimes misguided. Medicaid has an unfair reputation of being a broken program that consumes an uncontrollable amount of New York State tax dollars. As a result, it is an easy target for politicians and budgeters looking for savings in years when the state faces budget deficits and shortfalls. And every year, the extended network of individuals, providers, and communities impacted by the program are forced to defend it. This paper intends to clear the fog by separating fact from fiction.

Fact OR Fiction?

Medicaid Cost Growth Has Significantly Decreased

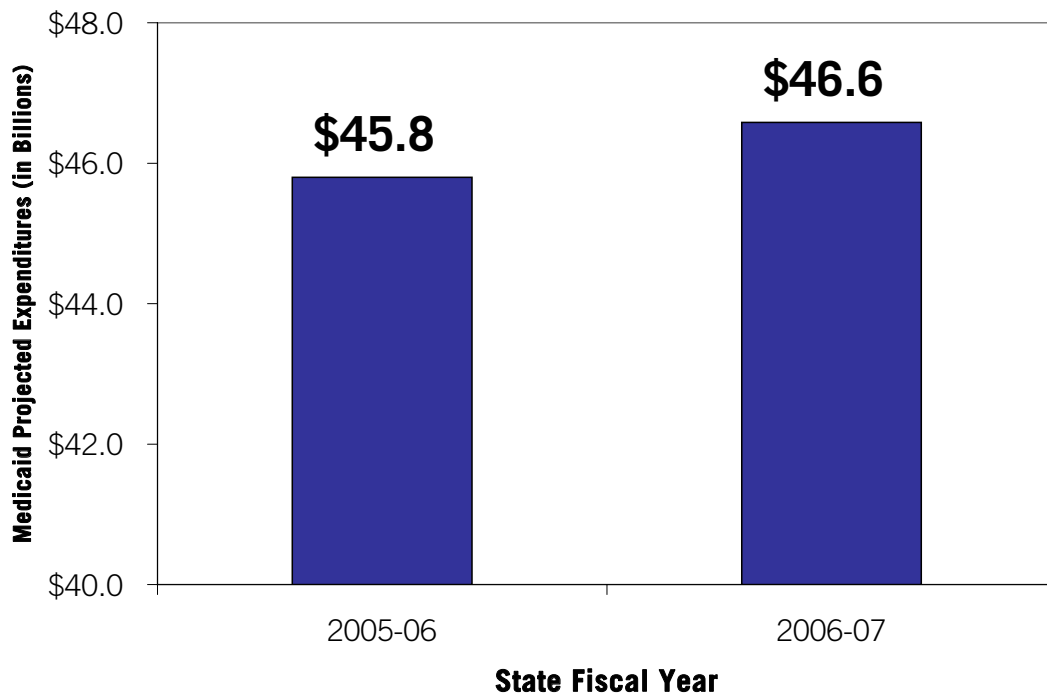
Fiction

New York's Medicaid budget growth is out of control.

FACT

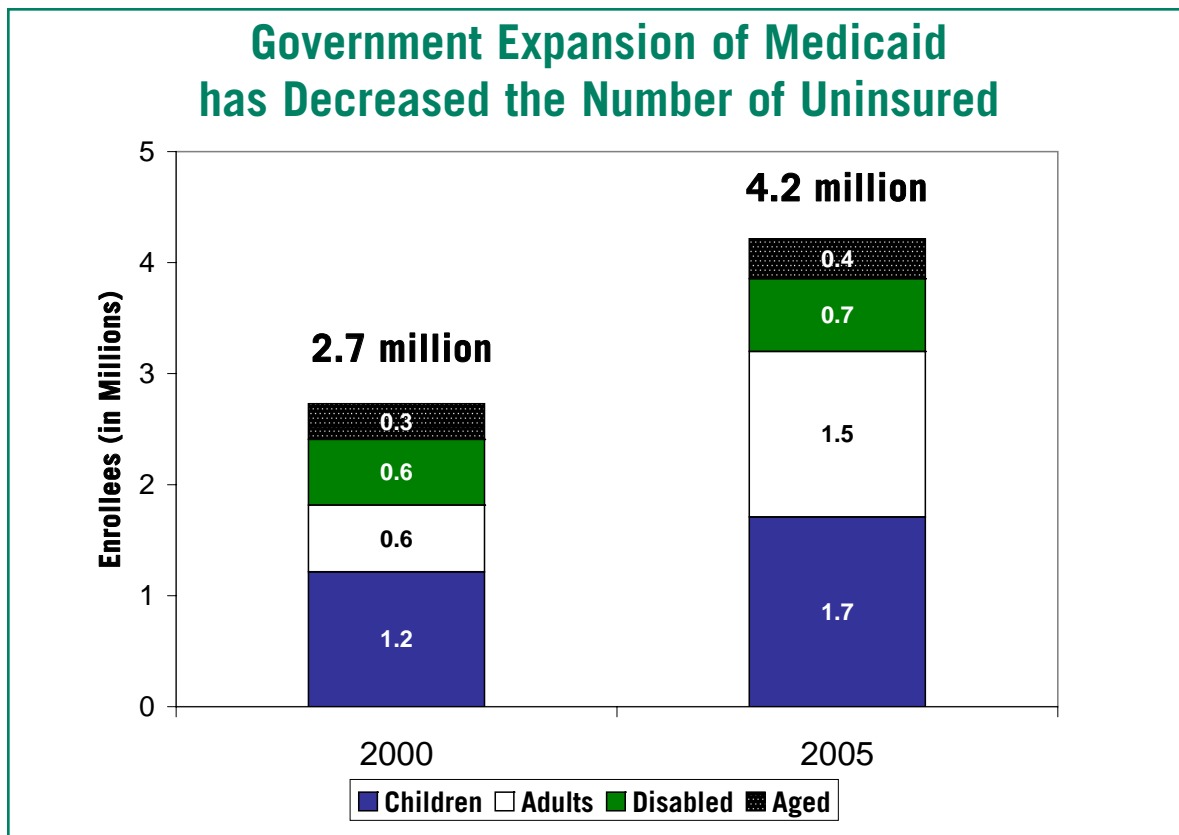
Current estimates of \$46.6 billion represent only a 1.7% increase over state fiscal year 2005-2006 spending of \$45.8 billion. This compares favorably to Medicaid spending growth nationwide. Total Medicaid spending for all states increased by an average of 2.8% during fiscal year 2006, according to the Kaiser Family Foundation.

Slower Than Inflation. Lower Than the Nation.
New York Medicaid Expenditures Increased by Only 1.7%



Between 2000 and 2005:

- The number of uninsured New Yorkers dropped from 3.1 million to 2.6 million.
- The number of Medicaid enrollees grew 54%, from 2.7 million to 4.2 million, largely through enrollment in Child Health Plus and Family Health Plus.
- Family Health Plus enrollment grew to more than 530,000 and enrollment of children in Medicaid grew by 500,000.
- Total Medicaid spending for all states increased by an average of 2.8%, while New York's grew by just 1.7%.



Expansion of this family of Medicaid programs has been a deliberate strategy that has led to a substantial decrease in the number of uninsured New Yorkers. Yet, critics of these programs would like the public to think that New York State's health care programs are out of control.

Medicaid Cost Growth Matches Enrollment Increases

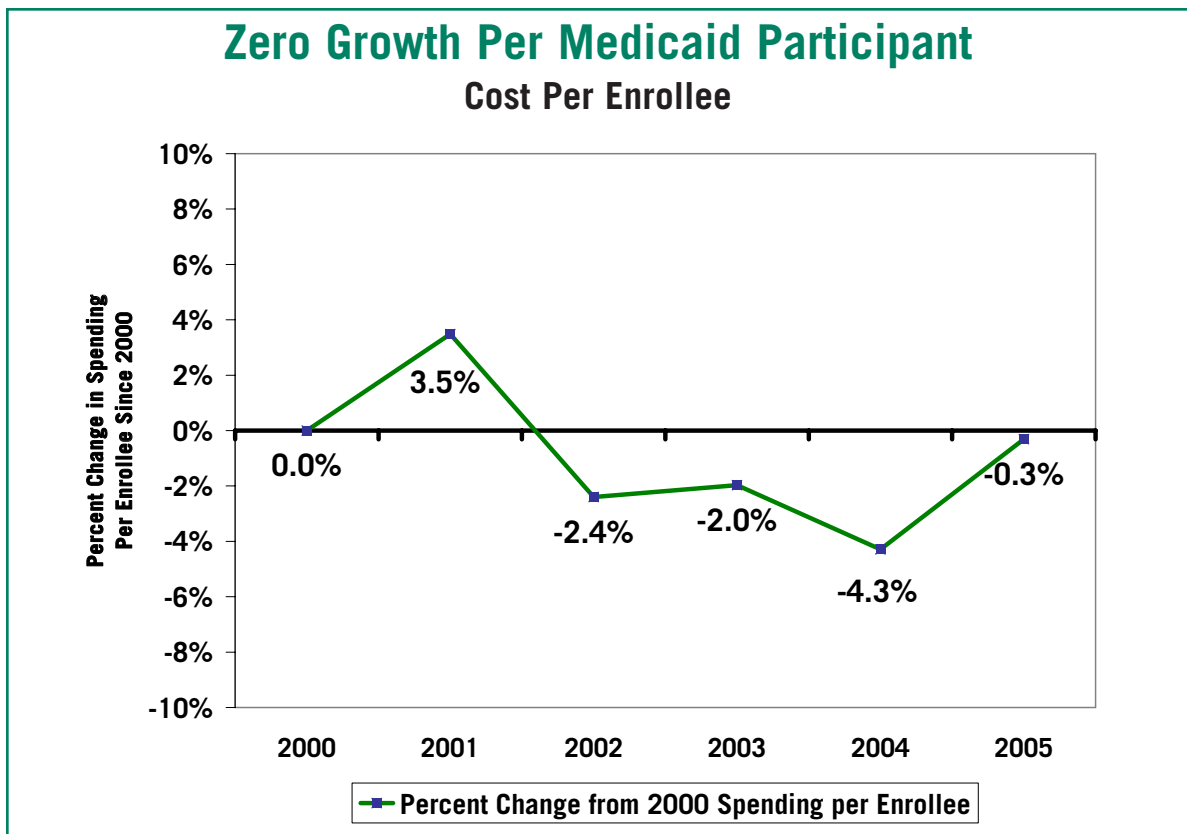
Fiction

The cost of providing health care per Medicaid enrollee is growing.

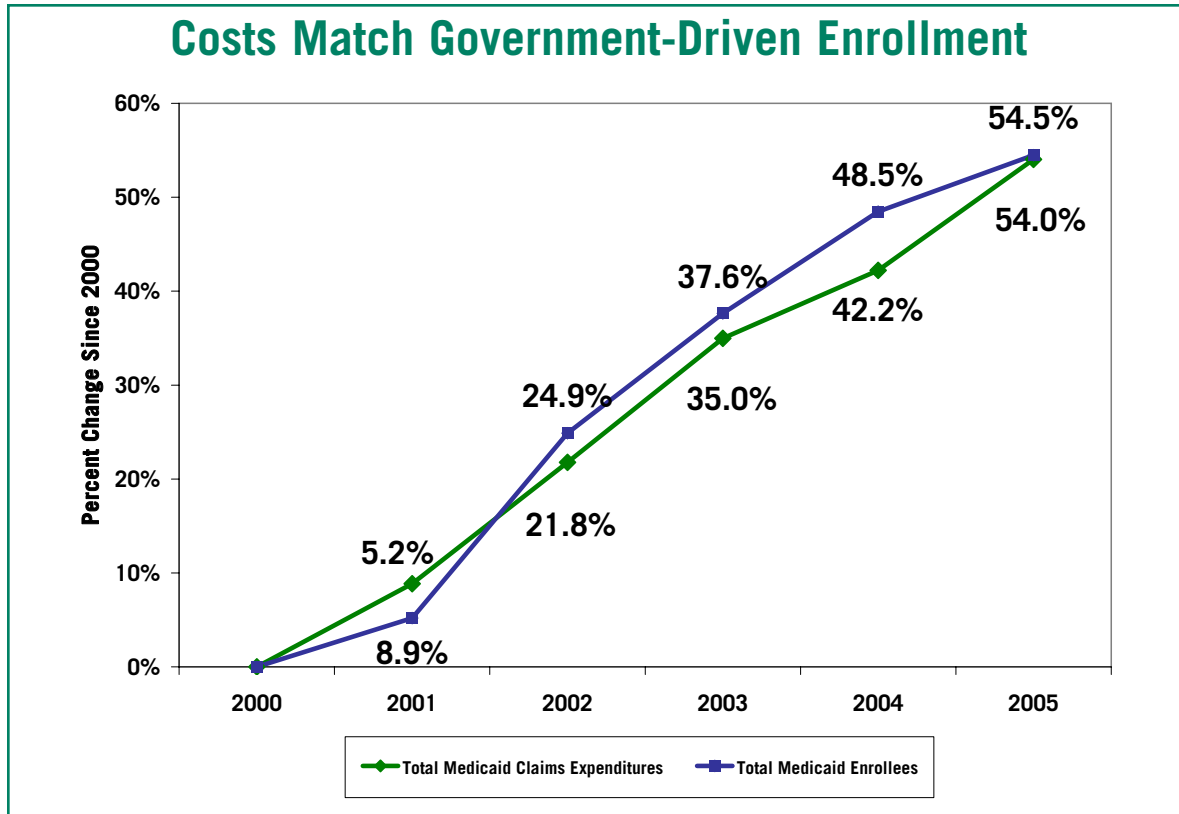
FACT

Medicaid spending per enrollee did not increase between 2000 and 2005. From 2000 to 2005, Medicaid programs were significantly expanded and enrollment increased by 54%. Over the same time period, total Medicaid expenditures grew proportionately.

For the entire period, Medicaid’s cost per enrollee remained virtually unchanged. However, if the 2000 cost per enrollee was adjusted for inflation using the Consumer Price Index for All Urban Consumers (CPI-U) for the period, the cost per enrollee should have increased by 13.5% by 2005.



It would be impossible to expand coverage by 1.5 million additional New Yorkers without expecting an increase in cost. But contrary to popular perception, that growth in cost has been reasonable and proportionate to the increase in new enrollees.



Medicaid enrollment and growth in Medicaid claims expenditures since 2000 have been almost identical, indicating that the dominant reason behind Medicaid growth has been the enrollment of uninsured New Yorkers.

Hospitals and Nursing Homes are Losing Ground to Inflation

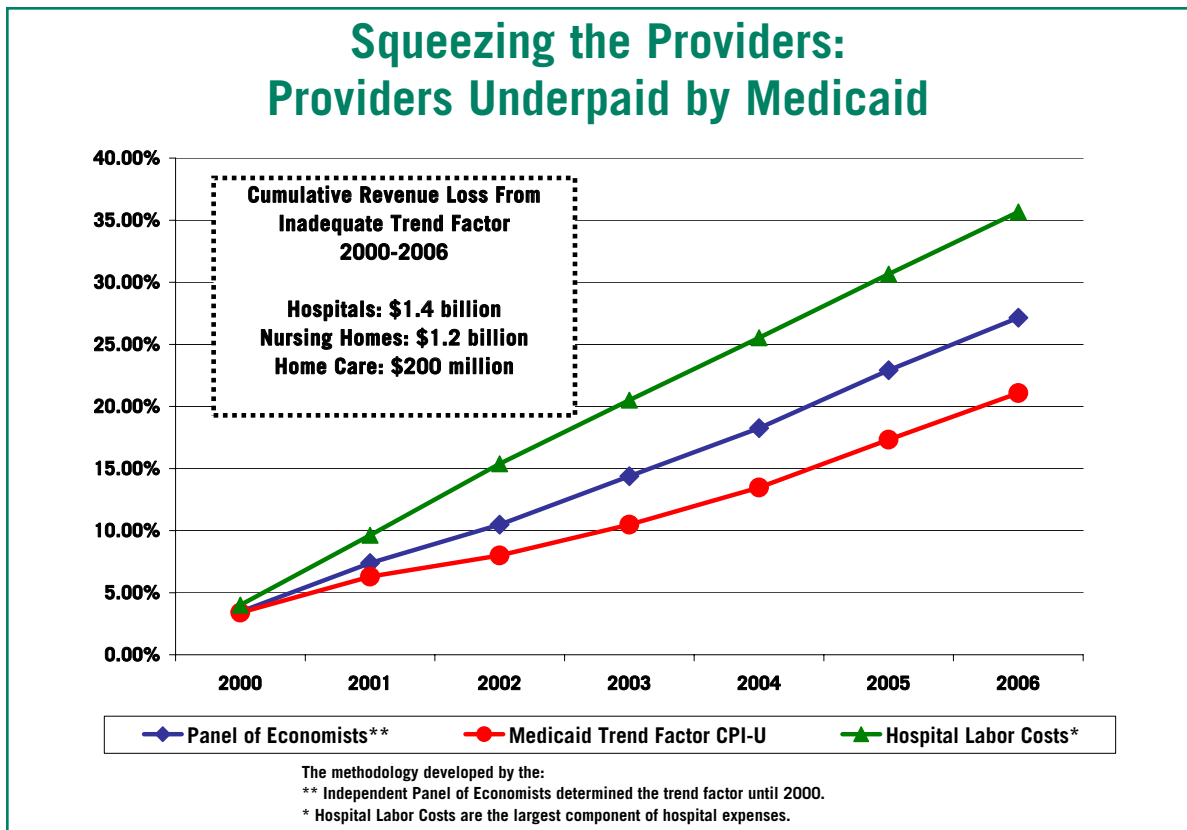
Fiction

Annual Medicaid trend factor rate adjustments cover health care providers' costs.

FACT

The Medicaid trend factor has underpaid health care providers \$2.8 billion since 2000.

In 2000, the state chose to link the Medicaid trend factor with the CPI-U; previously, the Medicaid trend factor was determined by an independent panel of economists that measured actual cost increases. As a result of this change, New York has deprived hospitals, nursing homes, and home care agencies of nearly \$3 billion in funding necessary to keep pace with inflation.



The CPI-U, which is not a health care-specific index, grossly underestimates the cost increases that health care providers must factor into their annual budgets.

The current Medicaid trend factor does not provide hospitals, nursing homes, and home care providers with the cost-of-living adjustment necessary to help them cope with the ever-increasing costs of pharmaceuticals, medical devices, energy, labor, and other necessary purchases.

Emergency Room and Outpatient Services are Grossly Underpaid by Medicaid

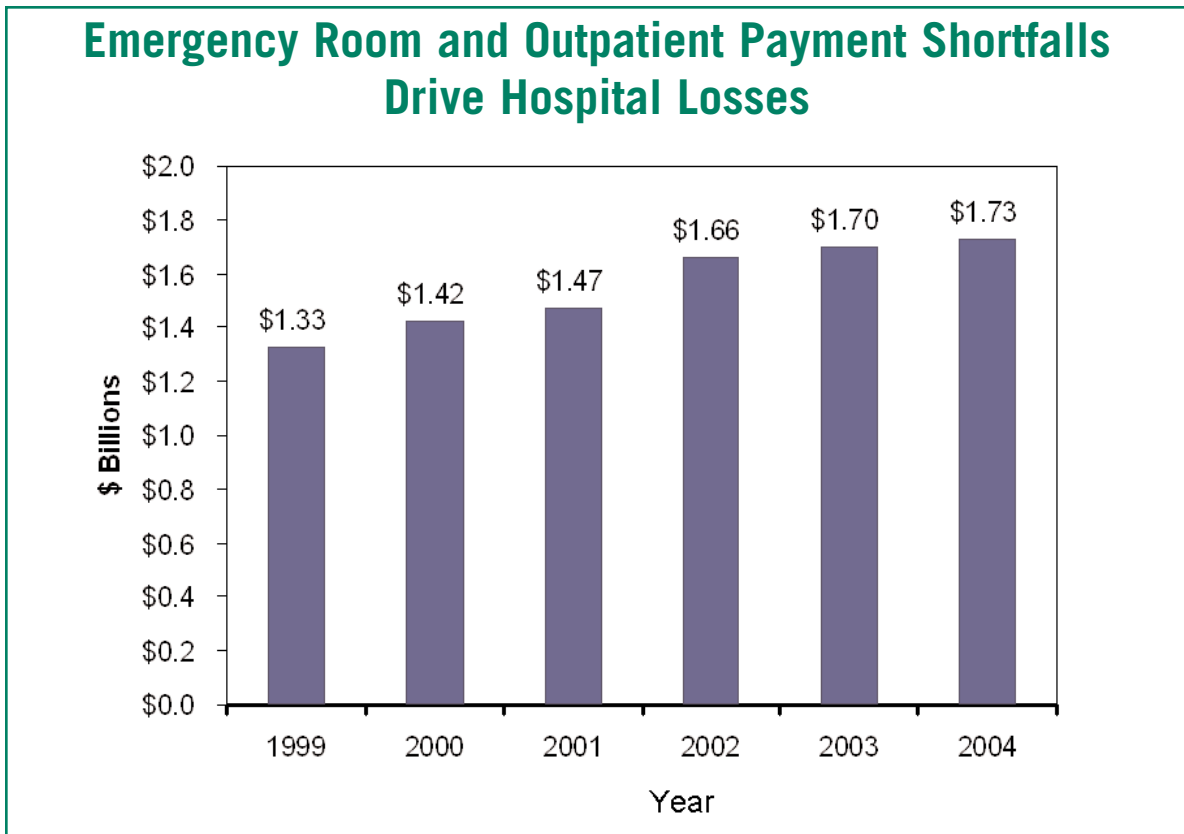
Fiction

Medicaid payments reflect the cost of providing care.

FACT

Medicaid hospital outpatient and emergency department rates are well below the cost of providing care. In 2006, the state authorized a rate increase for emergency room payments to reach \$150 at the end of a three-year phase-in. This much-needed rate increase was the first in 15 years; however, the total payment amount is still insufficient in meeting the \$400 average cost of an emergency room visit.

After the rate increase is fully implemented, Medicaid will still only pay 37% of the cost of an emergency room visit. Similarly, Medicaid clinic payments amount to only 30 cents on the dollar. In 2004, emergency room and outpatient payment shortfalls resulted in hospital revenue losses of about \$1.7 billion. Even after the emergency room increases that will take effect in 2007, provider losses will be \$1.6 billion.



The emergency room is just one area where Medicaid payments are based on outdated payment systems and old data. Policymakers are hard at work searching for any area where an institution may have received a Medicaid payment that exceeded the cost of providing that service. However, there has been little attention paid to the many areas that need updating to reflect the cost of care.

Hospitals and Nursing Homes are Not Primary Drivers of Medicaid Cost Growth

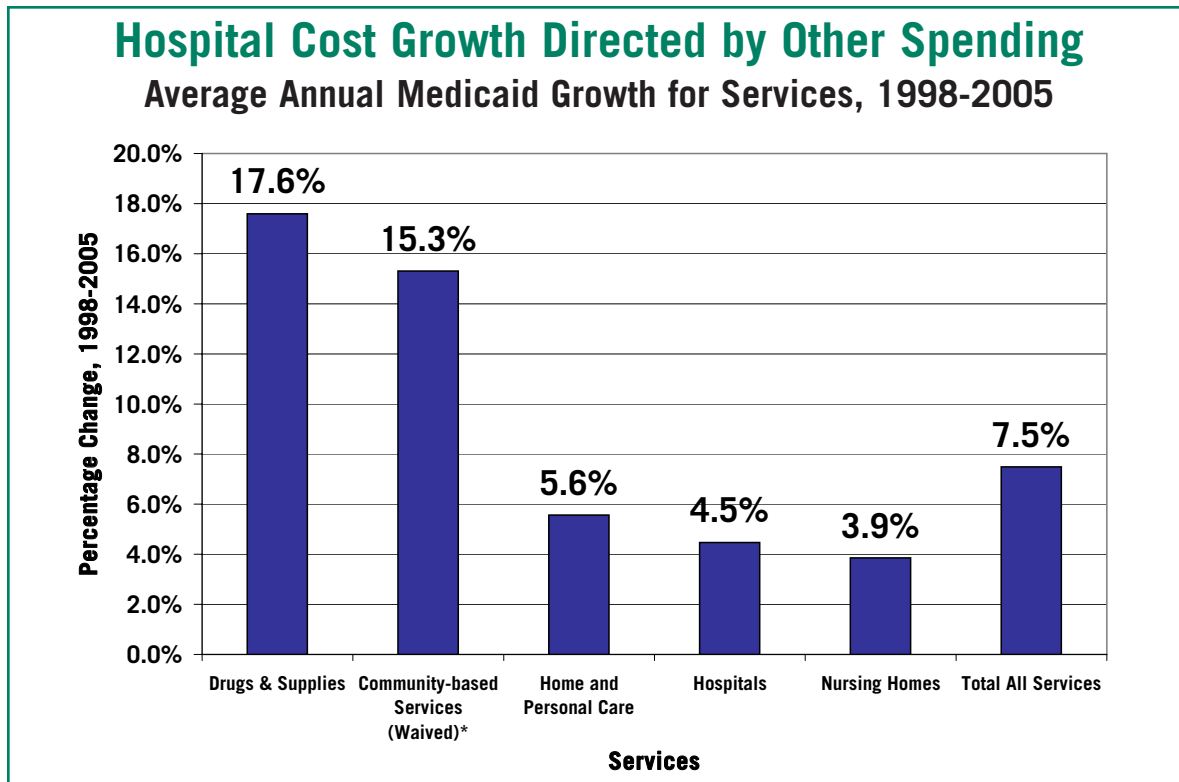
Fiction

Hospitals and nursing homes are the main drivers of Medicaid growth.

FACT

Hospital and nursing home spending is growing slower than many other aspects of the Medicaid program.

Medicaid spending for hospitals and nursing homes was not the driver of Medicaid growth between 1998 and 2005.



*Community-based waiver services include health-related services delivered to Medicaid beneficiaries living in the community through one of the following programs: Care at Home, Office of Mental Retardation and Developmental Disabilities Home and Community-Based Services Waiver, DOH Traumatic Brain Injury (TBI) program, Long-Term Home Health Care Program, and Office of Mental Health home- and community-based services programs for children. These services may include medical, social, housekeeping, or rehabilitation services that an individual would need in order to remain at home or in the community.

In fact, Medicaid spending growth for hospitals and nursing homes was substantially lower in comparison to pharmaceuticals and community-based waiver services. Average annual Medicaid spending grew by 7.5% (reflecting the growth in total enrollment each year), while spending for hospitals and nursing homes grew by 4.5% and 3.9%, respectively—effectively driving down the total average annual growth.

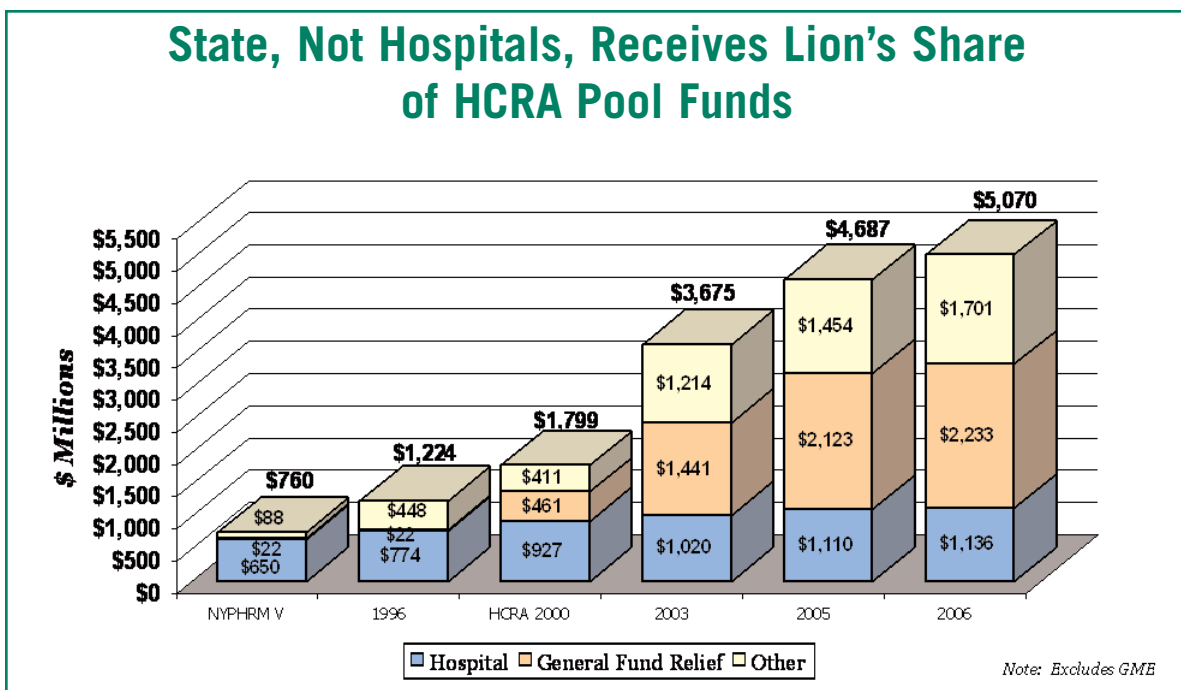
HCRA Priorities Have Been Expanded

Fiction

Hospitals are the largest beneficiary of Health Care Reform Act (HCRA) pools.

FACT

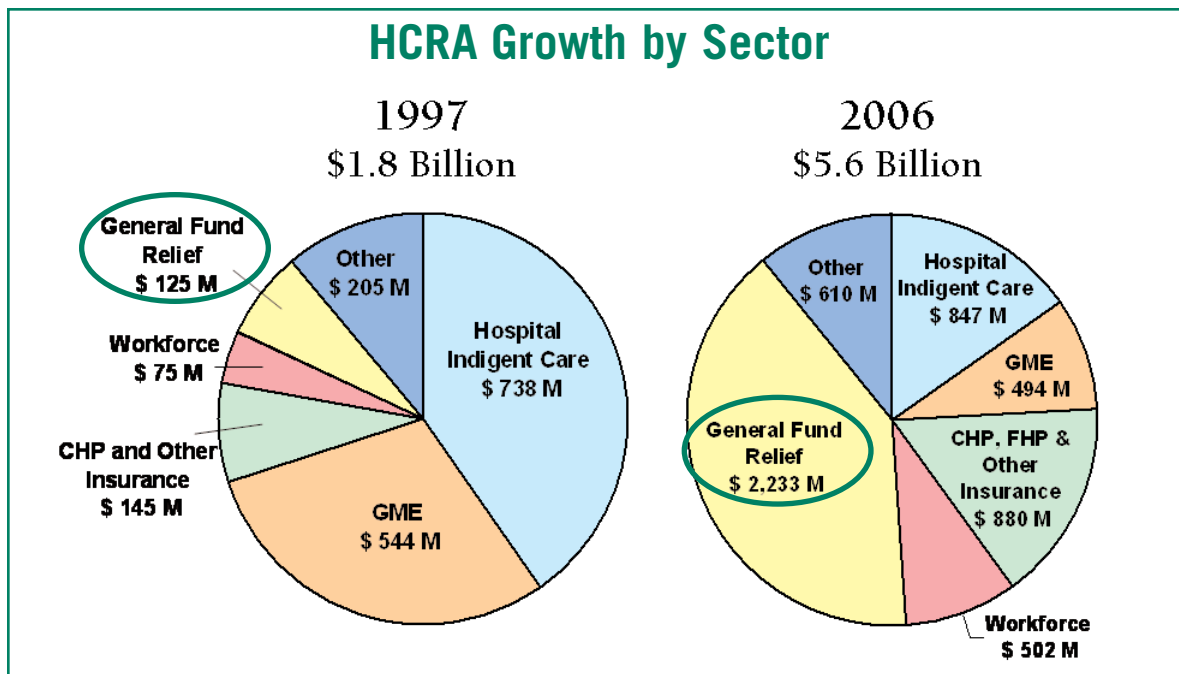
The state “general fund” is currently HCRA’s top beneficiary.



Since its genesis in 1996, when hospitals received about 85% of the financing provided through the HCRA pools, priorities have shifted and much of HCRA funding is now dedicated to providing relief to the general fund.

Between 2000 and 2006, HCRA expanded several times to finance numerous health care-related endeavors, the most significant being the establishment of the tobacco control and insurance initiatives pool, which provided funding for programs including Child Health Plus and Family Health Plus.

During the same time, the general fund became the largest beneficiary of HCRA spending. The amount of money allocated to provide relief to the general fund increased by more than 380%, while hospital funding under HCRA saw less than a 23% increase.



Education Makes New York a Medical Leader

Fiction

New York spends “excessive and irrational” amounts on Graduate Medical Education (GME).

FACT

New York’s targeted investment in medical education has made it a leader in medical research and has produced many of the world’s finest doctors. That is a virtue, not a vice.

- New York State is home to many of the country’s most prestigious academic medical centers and community teaching hospitals. These institutions attract the highest quality professionals to the state and serve as the foundation for attracting billions of dollars in medical research. Their advances in state-of-the-art medicine make New York one of the world’s premier centers for medical excellence.
- Teaching hospitals provide millions of dollars in uncompensated care each year. The mission of teaching hospitals and academic medical centers, like all New York hospitals, includes a responsibility to care for the uninsured and the under-insured. Eighty-two percent of the uncompensated care delivered in New York annually is provided by the 30% of New York hospitals that are considered major teaching hospitals. Additionally, teaching hospitals provide 85% of hospital services to Medicaid beneficiaries.
- While there have been shifts in resident volumes among individual teaching hospitals, the total number of interns and residents increased from 14,000 in the early 1990s to more than 15,000 in 2005.
- During the 1990s, policymakers encouraged hospitals to reduce the number of medical residents they train based on the assumption that there was a surplus of physicians. Some hospitals responded to the public policy incentive and reduced their number of residents. Today, we find ourselves with a present and future shortage of physicians, in particular throughout upstate New York and in urban, low-income areas.
- In New York, medical resident programs receive significant funding through Medicaid dollars allocated to teaching hospitals, thereby receiving federal matching funds. In California, these programs are primarily subsidized by other public sources, namely the state university system and other general fund allocations—not the Medicaid program.

- GME funding experienced a severe reduction after HCRA was first enacted ten years ago. The private sector—business and insurers—was given a 46% discount on its contribution to GME. The economic activity and tax revenue generated by teaching hospitals, however, far offset contributions by business and government.
- In addition to the state funding provided to graduate medical programs under Medicaid and through HCRA pool resources, the federal government, through the Medicare and Medicaid programs, makes a significant contribution to GME.

The Workforce Shortage is Real

Fiction

There has been a “lack of accountability” associated with subsidies the state gives health care providers to recruit and retain staff.

FACT

Health care providers continue to struggle with a shortage of nurses and other direct care workers different from the cyclical shortages in the past. Affecting all provider types, the current shortage is more pervasive, as an aging population increases demand for services and the proportion of working age population continues to decline. In recent years, the Legislature and Governor responded to the ongoing severe health care labor shortage by making a targeted investment in the system.

In 2002, the Governor and Legislature responded to the shortage and added funding for the recruitment and retention of direct care and non-supervisory staff. That investment was specifically earmarked to enable health care providers to recruit and retain a qualified workforce.

THERE IS NO SUCH THING AS A “MEDICAID NURSE.” Distribution of workforce funding is formula-based to ensure it is fair and equitable. The funding is distributed proportionally on the basis of overall staff payroll expenses. A legitimate public purpose was achieved through this mechanism because providers do not distinguish between payer sources when delivering care; they do not hire “Medicaid nurses” or “Medicaid aides.” Critical staff shortages affect all patients equally and the state has a direct interest in ensuring that services are adequate for all. HANYS strongly supports a fair and equitable distribution of workforce aid that is responsive to the workforce needs that exist across the state.

HEALTH CARE PROVIDERS ARE HELD ACCOUNTABLE. In return for that investment, providers are required to attest annually that the money is spent on efforts associated with recruitment and retention of staff. The money has proved invaluable in enhancing health care providers’ ability to attract and retain their workforce. Further, the State Department of Health is authorized to conduct audits to ensure that workforce dollars are being used for recruitment and retention.

HEALTH CARE PROVIDERS CONTINUE TO STRUGGLE WITH A SEVERE WORKFORCE SHORTAGE. While the funding provided from the workforce investment has significantly helped with the retention of employees, health care providers still struggle to keep salaries and benefits competitive. Health care providers rely on this funding to ensure a stable workforce that will deliver the highest quality of care.

Why Does Medicaid Cost More in New York?

The health care community is routinely criticized for the cost of Medicaid in New York State. However, there are many factors influencing the cost of Medicaid that are beyond the control of health care providers.

- **Expanding coverage to New York’s uninsured is a priority.** New York has consistently made conscious policy decisions to ensure that more people have access to quality health care and needed services while upholding a standard of quality that everyone deserves.

- **Data show that a small number of Medicaid enrollees with very complex health care needs account for a disproportionately high percentage of Medicaid expenditures.** Although the elderly and disabled comprise only 24% of the covered Medicaid population, the cost of their care accounts for 65% of total spending. Nearly half of Medicaid enrollees with a chronic illness struggle with additional conditions, which are often accompanied by a mental health condition or substance abuse. The presence of multiple illnesses or co-morbidities increases the complexity of caring for the patient. A fundamentally different approach to care management must be implemented to coordinate appropriately the needs of these high-cost beneficiaries while controlling costs.
- **New York's Medicaid population has a higher concentration of elderly and disabled beneficiaries.** The correlation between enrollment composition and the high cost of New York's Medicaid program is best demonstrated in Medicaid's elderly and disabled population. The majority of higher per-beneficiary spending is due to public policy choices to serve a higher proportion of disabled and elderly, and to offer more benefits through Medicaid.
- **New York has a higher cost of living than most states.** New York's higher cost of living and higher cost of doing business directly influence the cost of the Medicaid program. The resources required to care for patients, on average, cost significantly more in New York. This is evidenced by the Medicare area wage index, which adjusts Medicare payments for labor costs. The average of all the area wage indices in New York State is 1.20, meaning the average labor cost for New York hospitals is 20% above the national average.
- **New York maximizes federal participation in the Medicaid program.** New York has devoted extensive efforts to maximizing federal Medicaid matching dollars to help provide health care coverage and to support health care programs. HANYS estimates that about \$9 billion of total annual Medicaid spending in New York State is attributable to state policies to obtain more appropriate federal financial support. This is critical, given New York State's low federal matching rate for its Medicaid program. Examples include:
 - securing an annual investment of \$300 million for five years with the 2006 Federal-State Health Reform Partnership (F-SHRP) agreement dedicated to restructuring New York's health care system;
 - supplementing the state's hospital indigent care pool, which is used to partially offset hospital costs incurred for providing uncompensated care;
 - providing health insurance to more than 500,000 adults who otherwise were unable to access coverage;
 - using intergovernmental transfers (IGTs) to bring additional federal Medicaid funds to the state without placing new financial burdens on localities; New York is now in a battle in Washington, D.C. to preserve IGT in support of public safety net services, with hundreds of millions of dollars at stake;

- allowing the nursing home gross receipts tax to be reimbursed by Medicaid inflates Medicaid spending on nursing home care, but the state benefits financially by receiving the tax revenue;
- obtaining federal support for state-sponsored mental health services for the developmentally disabled inflates Medicaid spending for these services—however, the state benefits financially from doing so; and
- moving the “home relief” population into Medicaid managed care has resulted in lower overall state and local expenditures.

Federal maximization efforts give the impression of higher spending, when, in reality, the need for additional state funding is reduced. Obtaining more appropriate federal financial support is critical, given the low federal matching rate for New York State’s Medicaid program.

A Rational Comparison of New York and California

New York’s health care system is often compared to other states. New York Medicaid is criticized in comparison to California’s Medi-Cal program for consistently spending more money than a state that has far more Medicaid beneficiaries. But there are good reasons why this is so:

- **New York Medicaid serves a higher percentage of elderly and disabled individuals, which directly contributes to its higher per-beneficiary spending.**

Medicaid Enrollment	New York	California
Aged	8.8%	7.0%
Disabled	15.3%	10.4%
Adult	31.7%	43.6%
Children	44.2%	39.0%

- **New York’s Medicaid program also covers the majority of the home- and community-based services provided to low-income individuals.** Part of the disparity in total Medicaid spending between New York and California can be highlighted by the difference in how each state pays for home- and community-based services. In California, Medicaid does not fund these services; instead, they are funded by Title 20 (education), resulting in lower total Medicaid spending.
- **California’s family planning waiver enrollment artificially deflates per-beneficiary Medicaid spending statistics.** California extends family planning services to more than 1.5 million low-income residents (who would not otherwise qualify for Medicaid and do not receive other Medicaid services) through a separate family planning Medicaid waiver. The minimal cost associated with an isolated family planning benefit artificially reduces California’s per-beneficiary spending by between 16% and 18%.
- **New York has a higher percentage of the most expensive Medicaid beneficiaries—those residing in nursing homes.**

Percentage of Nursing Home Residents Who Are Medicaid Beneficiaries	
New York	74%
California	66%

Conclusion

New York's Medicaid program has a long record of success in providing needed medical care to New Yorkers, particularly those who have nowhere else to turn for support. Contrary to persistent myths about the Medicaid program, its costs are not out of control. In fact, Medicaid's costs have increased in a rational manner as additional beneficiaries and services have been added. Regulations and procedures are in place to ensure accountability in the program, and enhanced efforts are under way to root out fraud. While the system is not perfect, any discussion about reform should begin from a perspective based on facts, not fiction.

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