

Medicaid in New York

**Citizens
Budget
Commission**



**Why New York's Program
is the Most Expensive
in the Nation
and What to Do About It**

A Report
by the
Citizens Budget
Commission

April 2006

Introduction

Medicaid, a federal-state program intended to help people with limited income obtain medical and related health care, covers 4.4 million New Yorkers. While its benefits are clear and widely supported, Medicaid's costs are far more controversial. New York is noted for having the nation's highest aggregate and per beneficiary costs. These Medicaid costs are squeezing the State budget, consuming an ever-growing share of public expenditures.

This report summarizes and updates a study prepared by the Citizens Budget Commission (CBC), *Confronting the Tradeoffs in Medicaid Cost Containment*, released in 2004 and available on the Commission's website, www.cbcny.org. It makes the case that it is possible to lower Medicaid expenditures by about \$5.8 billion annually, without reducing the program's effectiveness in helping low-income New Yorkers obtain needed care. These significant savings are feasible by addressing the three main areas where New York's program differs drastically from those of other states:

- ▶ New York extends Medicaid eligibility to the non-poor or middle class for long-term care.
- ▶ New York pays some institutional providers, specifically hospitals, nursing homes and institutions for the disabled, at rates above competitive costs.
- ▶ New York allows excessive use of some types of services, specifically personal care and inpatient hospital care.

This report describes these differences and makes three recommendations to bring New York's program more in line with national norms:

- ▶ Limit Medicaid eligibility to the poor.
- ▶ Reduce payment rates to competitive levels.
- ▶ Reduce excessive use of personal care and hospital inpatient care.

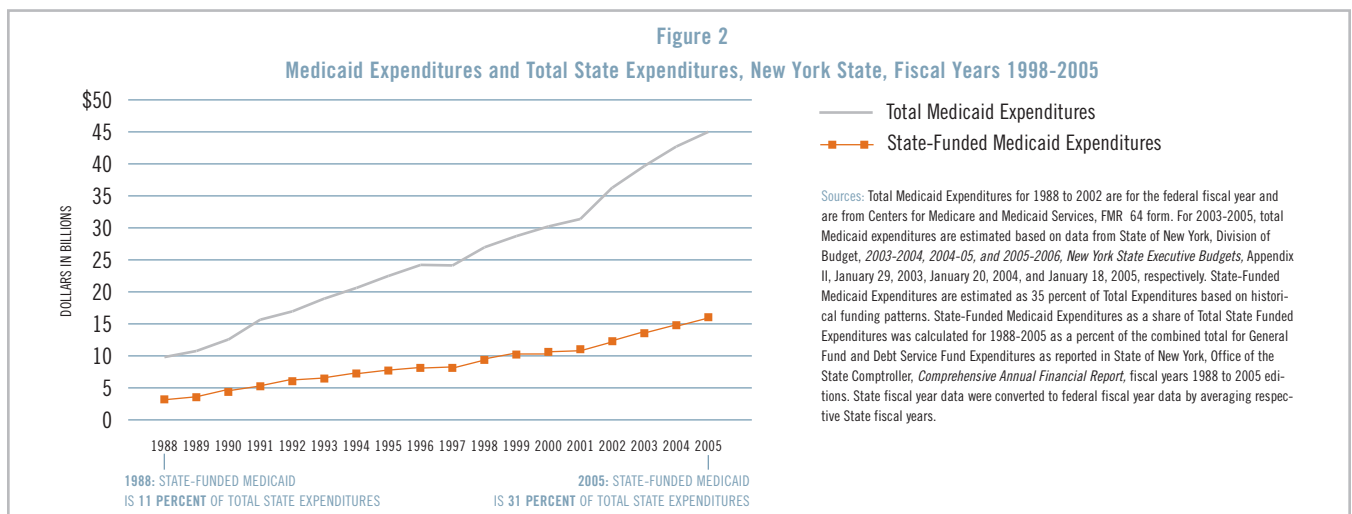
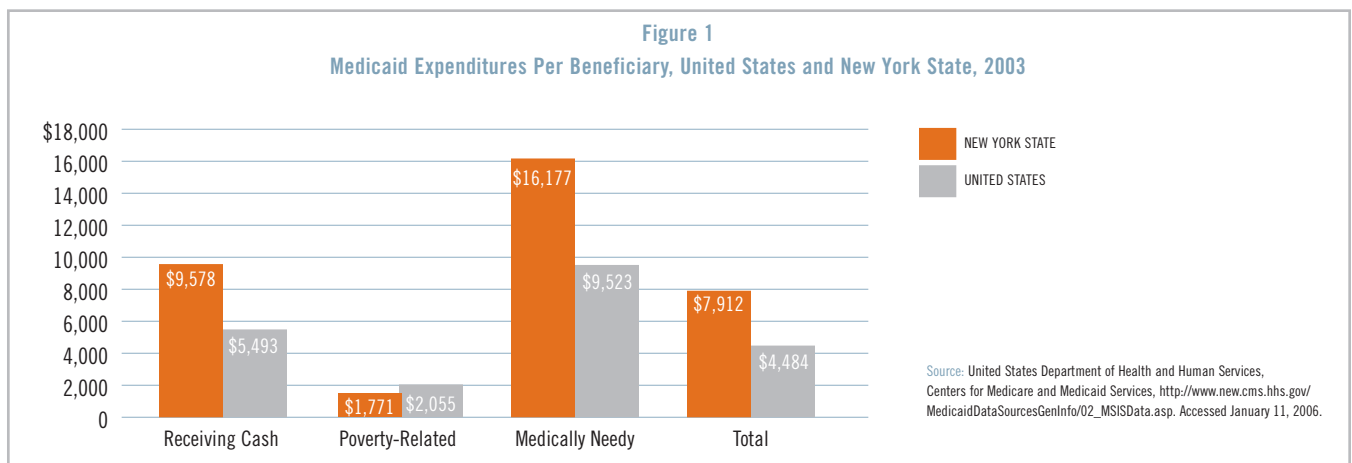
Founded in 1932, the Citizens Budget Commission (CBC) is a nonpartisan, nonprofit civic organization committed to influencing constructive change in the finances and services of New York State and New York City governments.

Medicaid in New York was written by Charles Brecher, Research Director, Elizabeth Lynam, Deputy Research Director, and Sheila Spiezio, Research Consultant. Dr. Brecher is also a Professor at New York University's Wagner School.

New York Has the Nation's Most Expensive Medicaid Program

New York has the highest Medicaid spending among the 50 states, accounting for 15 percent of the national total, although it covers only 8 percent of beneficiaries.¹ By comparison, California accounts for 11 percent of national spending while covering 18 percent of the beneficiaries. New York's cost per person enrolled in the program, \$7,912 annually, is 75 percent higher than the national average of \$4,484, and nearly three times the California average of \$2,770. (See Figure 1.)

Moreover, these costs continue to escalate. Over the last 18 years, Medicaid spending in New York grew at an average annual rate of more than 9 percent, compared to total State spending growth of 3.3 percent. Total Medicaid spending in New York was nearly \$45 billion in federal fiscal year 2005. (See Figure 2). The portion of the Medicaid program paid for with State-raised revenues (as distinct from federal aid and local government contributions) totaled nearly \$15 billion, or more than 30 percent of all State spending financed with State revenues.



How Does New York Differ From Other States?

NEW YORK PROVIDES LOOPHOLES FOR MIDDLE CLASS MEDICAID ELIGIBILITY

Medicaid is a joint federal-state program authorized in 1965. States have the option of whether or not to establish a program; New York has had one since 1967, and all 50 states have had one since 1982. Once a state opts to create a Medicaid program, it must abide by federal rules. These rules relate to who is eligible and what services they must be given. But in each case, the federal rules allow the states considerable flexibility.

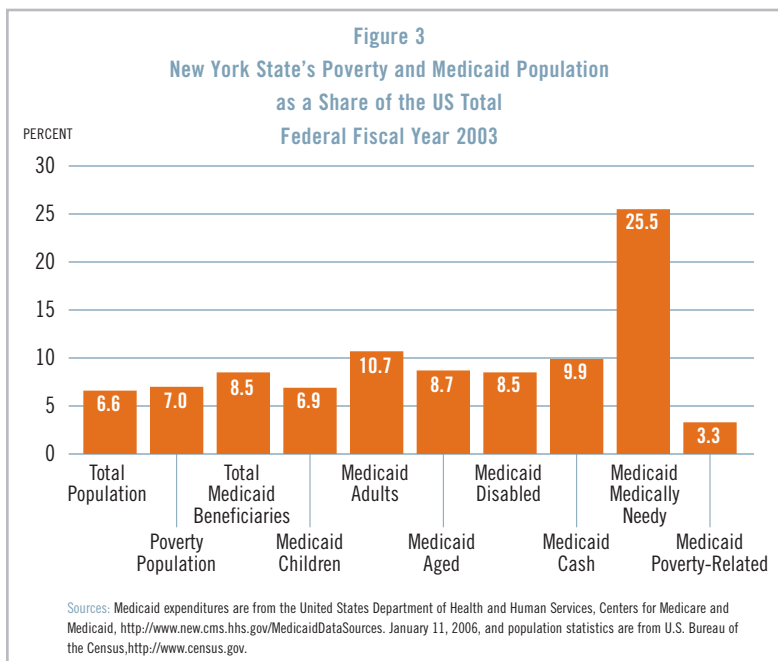
People generally become eligible for Medicaid because they are poor. Eligibility is based on an applicant’s income relative to the Federal Poverty Level (FPL). The FPL is uniform nationally but varies by household type and family size. It is updated annually. To illustrate, the FPL was \$10,160 annually for a one-person household in 2005. Applicants must also meet federal asset standards.

Three categories are widely used to distinguish among those who can be eligible:

Public Assistance. Those receiving public assistance in most states are automatically enrolled in Medicaid, because the asset and income standards for both programs are similar. Public assistance is what was formerly “welfare” for families, as well as Social Security related assistance for the elderly and disabled. Federal law mandates coverage for this group.

Poverty-Related. Those who do not qualify for cash benefits, but whose assets are within public assistance standards and whose incomes fall below income thresholds set by federal guidelines, are eligible for coverage. Coverage for pregnant women and children in this category is federally mandated.

Medically-Needy. Individuals with incomes above the federal poverty-related thresholds, who incur large medical expenses may subtract these expenses from their actual incomes to enable their adjusted incomes to fall below eligibility thresholds. Once the expenses reach this level, then all medical care expenses may be covered by Medicaid. Federal rules do not require states to provide eligibility to medically-needy individuals, and 15 states have no provision for this type of eligibility. For states



opting for this part of the Medicaid program, the federal rules set limits on the maximum income and assets, and these criteria vary among types of individuals. States also are given latitude in the types of services they may cover for the medically-needy, with the requirements less comprehensive than for the other eligibility categories.

In general, New York's eligibility standards are generous. The evidence for this is summarized in Figure 3. Although New York State is home to 7.0 percent of the nation's population living below the federal poverty threshold, it covers 8.5 percent of the nation's Medicaid enrollees. In this sense, New York is more generous with respect to eligibility than the rest of the country.

Among children, New York's share of the nation's Medicaid enrollees is just below its share of the overall poverty population; however, New York helps offset this limited coverage through a relatively generous Child Health Plus (CHP) program that supplements Medicaid. For non-disabled and non-elderly adults, Medicaid coverage in New York has been expanded significantly through a Medicaid waiver program called Family Health Plus; the expanded program covers nearly 11 percent of the non-elderly and non-disabled adults in Medicaid nationwide.

New York also does well in reaching the neediest, covering nearly 10 percent of public assistance recipients and over 8 percent of all elderly and disabled, nationally. Because Medicaid eligibility for these groups is linked to a relatively rigorous administrative process enforcing income and asset limits, abuses are scarce and those receiving benefits are highly likely to be truly in need.

New York's share of medically-needy beneficiaries represents over a quarter of the national total. This large enrollment is due to New York's unusual eligibility rules. In the rest of the country, a large majority of elderly and disabled Medicaid enrollees who are not receiving public assistance qualify under the poverty-related rules. That is, they have very limited income and assets. In contrast, the vast majority of elderly and disabled New York enrollees not getting public assistance qualify for Medicaid under the medically-needy provisions; they seek assistance for expensive care while having incomes higher than the poverty-related standards. Unlike the rest of the nation, New York uses the medically-needy provisions as the dominant route for helping the elderly and disabled, rather than poverty-related standards. New York has just 3 percent of the national total for poverty-related beneficiaries.

The medically-needy beneficiaries generally fit one of two profiles. The first are people of modest income who lack health insurance and suffer an acute spell of illness or an accident. They require hospitalization or other expensive services, and they may lose their regular source of income while sick. These individuals can, and often do, recover from the illness and return to work. Thus, their "medically-needy" eligibility is limited to a relatively brief time period, but involves substantial expenses.

The second medically-needy group is elderly and disabled individuals who have high expenses primarily for nursing home or home care services. Although most elderly and some disabled qualify for and are enrolled in the federal Medicare program, that program provides limited long-term care benefits. Medicare limits nursing home coverage to 100 days, and pays only if the patient is admitted directly from a hospital. Medicare also provides limited home care coverage, and does not provide any coverage for “personal assistance” with non-skilled care such as bathing or housekeeping. In addition, the Medicare program charges recipients premiums, coinsurance and deductibles for its covered services. Medicaid covers these out-of-pocket expenses for “dual-eligibles” enrolled in both programs.

The federal rules establish separate, complicated income and asset restrictions for the elderly seeking coverage for nursing home care under Medicaid. Two of these rules related to asset transfers and spousal responsibility bear significantly on how so many people become Medicaid eligible as “medically-needy” in New York.

Asset transfers to gain Medicaid eligibility

Individuals may transfer assets to spouses or children before applying for Medicaid, thereby bringing their assets below the eligibility levels. For people seeking home care, assets may be transferred immediately before application without any penalty. For people seeking nursing home care, assets transferred during a three-year “look-back” or penalty period prior to the application are counted toward the limit. However, assets transferred in the three-year period are treated like income and subject to a “spend down” test. For example, if an applicant living on Long Island had transferred \$200,000 immediately before application, this amount would be divided by the average monthly Medicaid nursing home rate on Long Island (\$9,855), resulting in 20 months of disqualification for nursing home coverage.² However, if the applicant applied for home care services first, there would be no penalty for the asset transfer; the applicant would be immediately eligible to receive Medicaid home care services. Moreover, after receiving home care services for 20 months, the applicant would be considered to have “spent down” the \$200,000 while receiving home care. At this point, the home care recipient would be eligible for Medicaid nursing home coverage, without any penalty related to the asset transfer. In the 15 states without a medically-needy program, this same applicant would actually have to spend the \$200,000 for services before they could gain access to Medicaid for home care or nursing home care.

Financial abandonment of spouses

Individuals may also become medically-needy in New York, despite their spouse having substantial income or assets, if that spouse formally refuses to contribute to the individual’s support. New York has a unique interpretation of federal abandonment law, whereby a spouse or parent can refuse to provide financial support to a relative receiving long-term care service and the “abandoned” spouse/child

becomes eligible for Medicaid immediately. That is, New York allows Medicaid coverage for a spouse or child whose legally responsible adult simply refuses to support them. The assets of the Medicaid applicant can be transferred to the spouse or parent prior to Medicaid application; the spouse or parent then signs a refusal form, and the applicant gains access to Medicaid. There has been limited study of the extent of “spousal refusal” in New York. One study in Nassau County found that approximately 95 percent of spouses remaining in the community had refused to support their spouse at the time of Medicaid application. Another study found that in 2000 in New York City, 3,101 Medicaid nursing home residents had spouses who had signed support refusals.

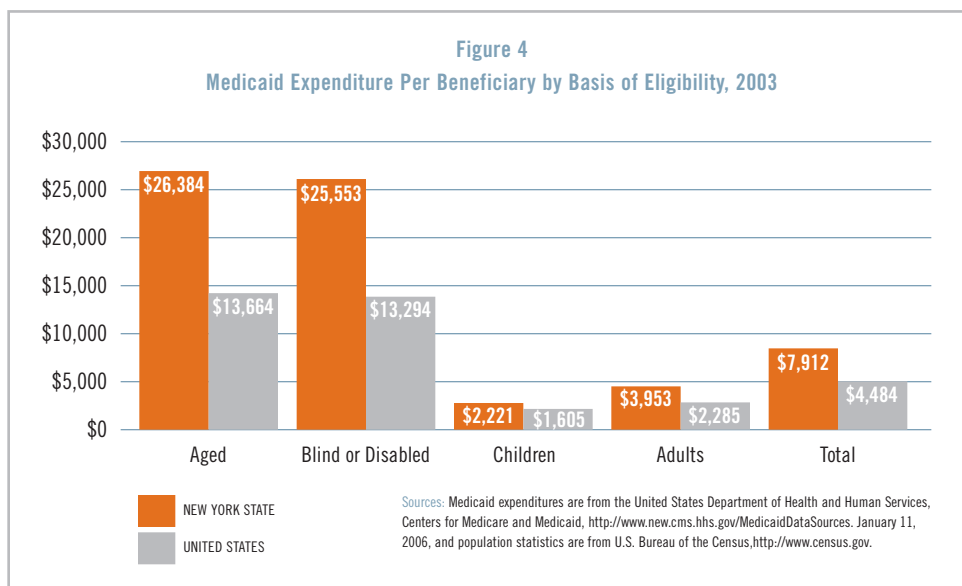
In New York total expenditures for the 773,600 people qualifying as medically-needy in 2003 were \$12.5 billion (more than a third of the total), for an average annual expenditure per beneficiary of \$16,000. These high costs are driven by expensive long-term care for the elderly and disabled whose expenditures per beneficiary were even higher, over \$26,000 and \$25,000, respectively. (See Figure 4.) The disabled account for over \$16 billion, nearly half of all Medicaid spending, and the elderly account for over \$9 billion, more than a quarter of the total.

NEW YORK PAYS NON-COMPETITIVE RATES TO SOME PROVIDERS

New York pays three types of service providers more than other states pay, even after adjusting for the cost of living in New York. Specifically, hospitals, nursing homes and institutions for the disabled are paid at comparatively high rates.

Hospital payments

For hospitals, the Medicaid program pays rates linked to historical costs that are updated annually to reflect rising prices and other factors. When the State regulated rates of virtually all hospital funders, the Medicaid rates were set to be on a par with those of private companies, helping to secure access for Medicaid enrollees equal to that for others. However, the State has since 1996 deregulated private insurance payments to hospitals, leading to privately negotiated



arrangements that most observers believe are lower than the previous, historic-cost related rates. But Medicaid has continued to follow the historic pattern. As a result, many believe Medicaid is now the program with the most favorable rates, and in many cases these rates are above competitive costs.

In 2004, the most recent year for which comparative data are available, the mean cost for a hospital admission in New York State was \$10,667. Nationwide, the comparable figure was \$8,166.³ Two factors help explain this difference. First, on average, hospitals in New York traditionally treated people for conditions that were more complex than was the case elsewhere. However, in recent years, New York’s caseload has become more similar to national norms; as a result, the complexity of cases or “casemix” now justifies expenditures only about 1 percent above the national average. Second, the cost of living in New York State is about 13 percent higher than the national average. Thus, when these two adjustments are taken into account, the cost of a hospital admission in New York ought to be about 14 percent above the national average or \$9,309. However, as shown in Figure 5, the actual figure is still about \$1,360 or 15 percent above the adjusted average.

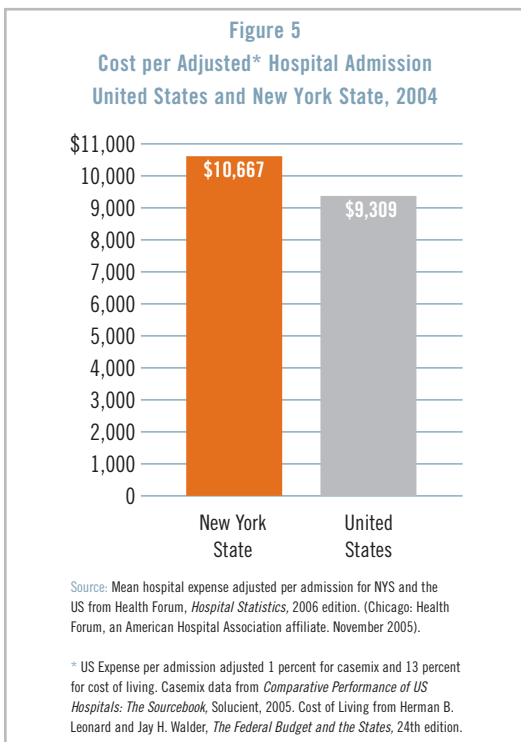
What else explains New York’s unexpectedly high costs? Two factors are important.

First, New York hospitals have a larger commitment to educational programs for physicians in graduate training (known as residents). Second, New York’s hospital managers may rely on less efficient practices than their counterparts elsewhere. It is worth noting that the ratio of full-time equivalent staff to output in terms of adjusted discharges at New York hospitals (7.12) is 25 percent higher than the national average (5.66).⁴ The ratio of full-time nursing staff to beds is actually higher nationally than in New York. The higher staffing in New York is for physicians and residents, which is double the national average per bed, and for non-professional staff (3.7 versus 3.5 workers per bed).⁵

Medicaid should not pay the higher hospital costs attributable to managerial inefficiencies. A more complex policy issue is whether Medicaid should continue to pay hospitals in New York State an estimated \$800 million annually to train physicians.⁶ The case against such financing is that the benefits of training a large number of physicians are not realized by New Yorkers, but are benefits to the places in which the new physicians ultimately practice. By paying to “export” new physicians, New Yorkers are paying for benefits received by future patients elsewhere in the country.

Nursing home payments

Nursing homes are paid on a per diem basis, rather than a per admission basis. But, like hospitals, their rates are based on historical



costs with updates for trend factors. Two data sources point to unusually high nursing home costs in New York. The latest comprehensive survey by the federal government covering all states is from 2002, showing the average Medicaid reimbursement for a nursing home in New York State was \$172 per day; the comparable figure nationwide was \$118. If allowance is made for the previously noted statewide cost-of-living adjustment (13 percent), then the expected figure for New York would rise from \$118 to \$133 – still leaving a \$39 per day or 29 percent unexplained difference.

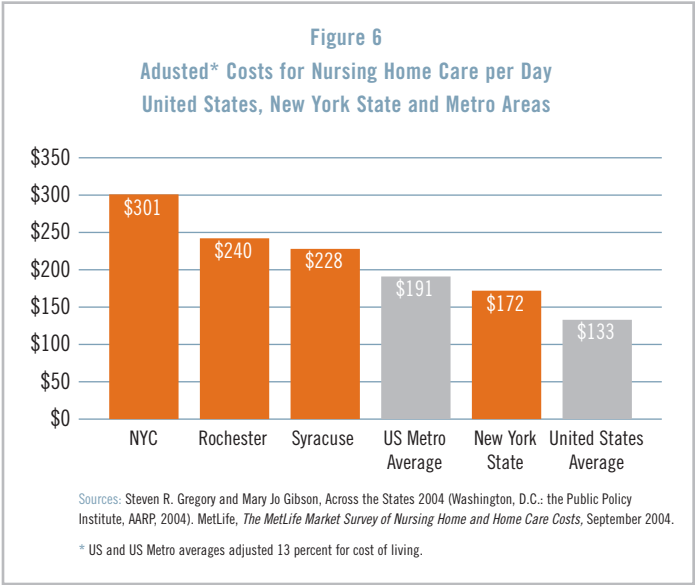
More recent (2004) data on nursing home costs in 87 metropolitan areas in the country also indicate New York areas are characterized by unusually high costs. The average daily cost adjusted for cost of living among all the metropolitan areas was \$191. New York City had the highest average city cost among metropolitan areas at \$301, and Rochester and Syracuse also were well above average at \$241 and \$228, respectively. Other large metropolitan areas had much lower costs; for example, in Chicago the figure was \$124, in Los Angeles \$137, and in Boston \$266.

There is no clear explanation for the exceptionally high costs in New York. However, more staff caring for patients is not the explanation. A recent report by the New York State Attorney General’s Office found that 98 percent of nursing homes in New York State did not meet federally-recommended staffing levels.⁷ The Medicaid program need not underwrite such practices by paying rates linked to non-competitive costs.

Intermediate care facilities

Intermediate Care Facilities (ICFs) are residential settings in which individuals with developmental disabilities are provided supervision and care. The cost of staying in these facilities is covered by Medicaid for eligible individuals. When the facility is operated by the State, the State collects the federal share of the costs as if it were a Medicaid payment. When the ICF is a private facility, Medicaid covers the cost like other services. The private facilities are paid daily rates based on their costs.

As of 2004, in New York State 1,704 people were cared for in State run facilities, of which 1,634 were in large institutions and 70 were in smaller facilities with less than 15 residents. Another 7,236 individuals were in private facilities, of which 1,757 were in institutions with more than 15 residents and the rest were in smaller group homes.⁸



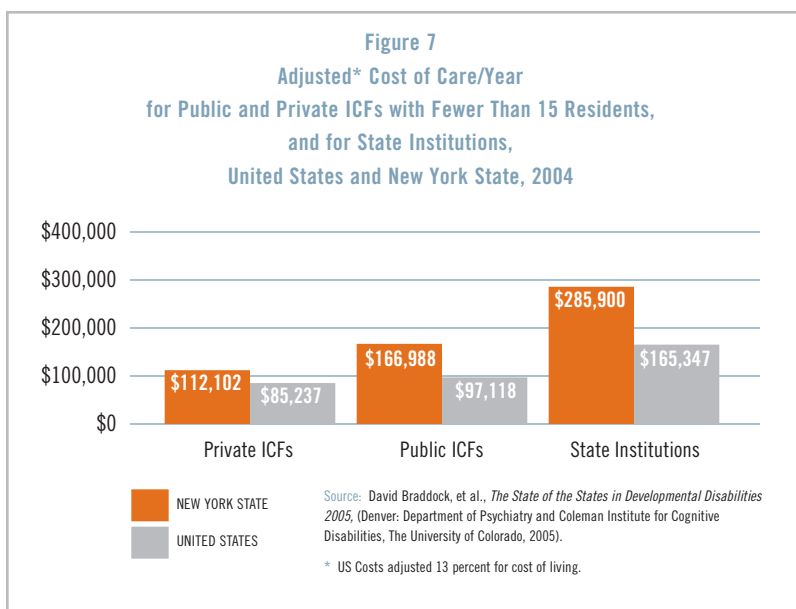
The limited available comparative data suggest that New York facilities are far more expensive than their counterparts in the rest of the country. As summarized below, after adjustment is made for the cost of living in New York, the annual cost of smaller private facilities in New York is 32 percent above the comparable national figure and the cost for state run institutions is nearly 73 percent above the national benchmark. With ICFs as with nursing homes, there is no clear reason why Medicaid should pay private operators for costs above competitive levels, or why federal and state taxpayers should fund State-run facilities with excessively high costs.

NEW YORK ALLOWS EXCESSIVE USE OF SOME SERVICES

In addition to lax eligibility for those seeking long-term care and high payment rates for some providers, New York differs from national norms in its unusually high level of use of some services. Notably, hospital utilization is unusually high, especially for elderly and disabled enrollees. They are the most expensive beneficiaries, and there is strong evidence among these groups of repeated and unnecessary hospitalizations. In addition, New York has unusually high rates of use of personal care services among the elderly living at home.

Excess inpatient hospital use

Two recent studies highlight the inefficiencies in hospital utilization in New York. A nationwide study of regional variations in Medicare spending found that average spending per beneficiary adjusted for gender, race, age, socioeconomic status and degree of illness for traditional Medicare patients (those not enrolled in a managed care program) ranged from a high of \$16,333 in New York City to under \$7,900 in the lowest cost regions. The study attributes the higher costs in New York and other high cost regions to the overall quantity of medical services provided. It noted physician practices of using more specialist referrals, diagnostic tests, and hospital-based care. The study also concluded that these practices in higher spending regions showed no evidence of improved functional status, greater satisfaction with care, or survival.⁹



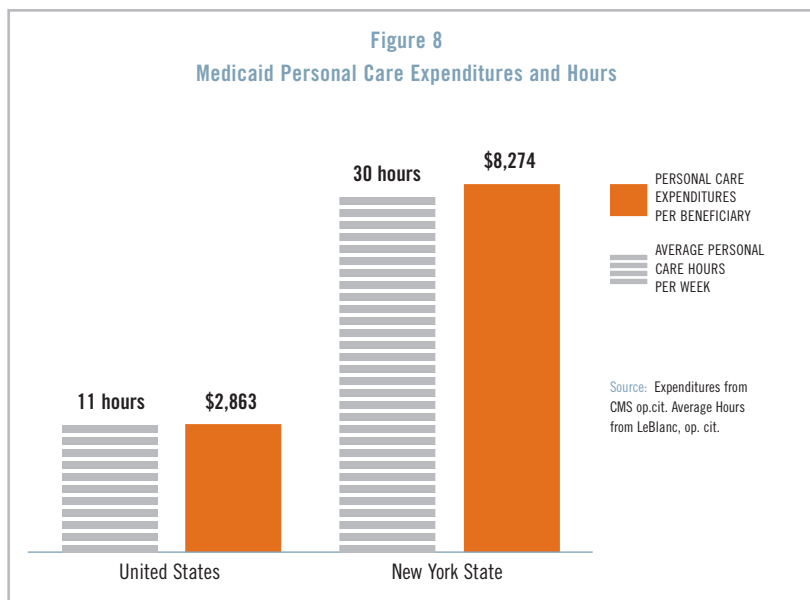
A second study specific to New York City Medicaid beneficiaries shows that the lack of management of high-cost, chronically ill patients results in repeated hospitalizations for conditions that could be treated on an

outpatient basis.¹⁰ The study also shows that these high-cost cases are readily identifiable and could be better managed either through an insurance product or through direct payments to primary care physicians to monitor the care of chronically ill patients.

Excess personal care use

A second area of unusually high use is personal care at home among the elderly and disabled. Personal care is usually provided by staff of approved home care agencies and involves relatively low-skilled tasks such as help with household cleaning, shopping, bathing and personal grooming. The services are authorized and paid for in terms of the number of hours a home care aide spends with the client. The hourly rate in New York of \$8.89 is generally comparable to that in other states, where the average is \$8.77, although fringe benefits may be more generous in New York.¹¹

Although home care payment rates are competitive, New York still spends an excessive amount on these services. New York’s \$3.6 billion expenditure for personal care is fully 21 percent of the national total for these services under Medicaid. Expenditures per beneficiary receiving personal care in New York average \$8,274 annually – nearly triple the average of \$2,863 in the rest of nation. This big gap is attributable primarily to the higher average number of hours of care approved for clients in New York versus the rest of the nation – 30 hours per week versus 11 hours per week.¹²



How New York Can Save \$6 Billion Annually

Table 1 summarizes the annual savings possible from each of the three recommended strategies – limiting eligibility to the poor, reducing non-competitive rates for some institutional providers, and rationalizing utilization of personal care and hospitalization. In addition to these recommended savings, CBC supports efforts to reduce fraud within the Medicaid program. Recent estimates indicate Medicaid fraud in recent years could exceed \$1 billion. However, this is roughly equivalent to estimated rates of fraud in the Medicare program and in private insurance.¹³ Efforts should be made to better use information technology to detect and deter Medicaid fraud, but a realistic target is difficult to define given the rates prevailing in other sectors of the health care industry despite ongoing enforcement efforts.

Eliminate eligibility loopholes. Two strategies should be pursued simultaneously.

- ▶ The State’s medically-needy eligibility rules should be tightened. Spousal refusal should be permitted only under limited circumstances, and the three-year look-back provision relating to asset transfers should be applied to home care, be enforced more vigorously, and have greater financial penalties.
- ▶ At the same time, more should be done to encourage the purchase of private long-term care insurance among those with sufficient means. New York State participates in an innovative program called the Partnership for Long Term Care

that encourages purchase of private long-term care insurance by having the State provide Medicaid coverage, without any asset test, for people who purchase a qualified private policy (that has three years of nursing home benefits) and then exhaust the benefits. However, the rate of participation in this program has been low, presumably in large part because the option of getting Medicaid coverage without purchasing a private policy is so easily available.

More careful design and better enforcement of eligibility rules for the elderly and disabled would reduce the number of people receiving Medicaid funded nursing home and home care services by an estimated 44,000 or 7 percent of those in New York State receiving long-term care. Given New York’s high costs

Table 1
Summary of Potential New York State Medicaid Savings
 (dollars in millions)

STRATEGY	TOTAL	FEDERAL	STATE	LOCAL
Close eligibility loopholes	\$ 960	\$ 480	\$ 384	\$ 96
Reduce non-competitive rates	\$2,966	\$1,483	\$1,063	\$420
Hospital rates	820	410	205	205
Nursing home rates	1,600	800	640	160
ICF rates	546	273	218	54
Rationalize utilization	\$1,912	\$956	\$699	\$257
Increase managed care enrollment	436	218	109	109
Reduce personal care hours	1,476	738	590	147
TOTAL	\$5,838	\$2,919	\$2,146	\$772

Sources: See text and notes.

for these individuals (\$21,860 compared to a national average of \$11,645), the savings from fewer such beneficiaries would be \$960 million annually.¹⁴

Pay only for competitive costs. Limiting provider payments to rates based on competitive costs would save nearly \$3.0 billion annually. New York State pays hospitals and nursing homes substantially more than is required to meet competitive standards for wages and quality of care. For hospitals the excess over an appropriate benchmark is about 15 percent per admission, and for nursing homes it is about 29 percent per day. For ICFs, the differential ranges from 32 to 73 percent depending on the size and type of facility. Competitive hospital rates would save about \$820 million; competitive nursing home rates would save about \$1.8 billion annually. However, assuming half of the medically-needy eligibility reductions recommended above are for personal care and half for nursing home care, the savings from rate reductions drop to \$1.6 billion because fewer individuals would have care paid by Medicaid. For the ICFs, a reasonable goal is to save 20 percent, or \$546 million.¹⁵

Increase Managed Care Participation. Most states have viewed managed care, when properly implemented, as a “win-win” arrangement under which taxpayers save money and needy clients get better care. As a result, Medicaid managed care participation has risen nationally to almost 61 percent of enrollees in 2004; in New York, which was slow to join the managed care movement, the figure is 58 percent.¹⁶

A suitable goal for New York is to enroll about one-third of the elderly and disabled beneficiaries, or about 335,000 individuals, in managed care plans. A reasonable estimate is that effective managed care would reduce hospital costs for this population by 15 percent. This would yield savings of \$436 million annually.¹⁷

Limit Excessive Personal Care Service Use. New York’s program of personal care for the elderly and disabled living at home pays for more hours of home attendant services for tasks such as housekeeping and shopping than is authorized in any other state. Bringing use of personal care services more in line with national norms would save about \$1.5 billion annually. This assumes that the average number of hours of personal care authorized for clients can be reduced from the current average to a figure still 50 percent above the national average; that is, from an average of 30 to 17 hours per week.¹⁸

Endnotes

These endnotes provide sources for data updated from or not included in the report, *Confronting the Tradeoffs in Medicaid Cost Containments*. Readers should consult that report on the CBC website (www.cbcny.org) for more details.

1. The analysis of Medicaid spending is based on the most recent federal data (MSIS State Summary Data, FFY 2003) that provides spending by type of beneficiary and by service. This data set excludes Disproportionate Share Hospital (DSH) payments. These payments are not direct reimbursement for services; rather, they are made to hospitals with large shares of uninsured patients to provide fiscal relief. DSH payments in New York totaled \$2.9 billion in 2003.

2. Monthly nursing home rates on Long Island are for 2004 and are from the New York State Partnership for Long Term Care, <www.nyspltc.org> Accessed March 29, 2006.

3. Mean hospital expense adjusted per admission for NYS and the US from Health Forum, *Hospital Statistics*, 2006 edition. (Chicago: Health Forum, an American Hospital Association affiliate, November 2005).

4. Solucient, *The Comparative Performance of U.S. Hospitals: The Sourcebook 2005*. (Evanston: Solucient LLC, 2005).

5. *Hospital Statistics*, 2006 edition., *op. cit.*

6. Deborah Bachrach and Anthony Tassi, "Funding Available to Support Safety Net Providers, Subsidized Insurance Programs, and Other Public Goods, In New York State," an analysis prepared for the Citizens Budget Commission, September 1998.

7. Office of the New York State Attorney General, Medicaid Fraud Control Unit, "Staffing Levels in New York Nursing Homes," (Albany: Office of the New York State Attorney General, January 2006). <www.oag.state.ny.us/press/2006/jan/final.pdf. > Accessed March 29, 2006.

8. David Braddock, et al., *The State of the States in Developmental Disabilities 2005*, (Denver: Department of Psychiatry and Coleman Institute for Cognitive Disabilities, The University of Colorado, 2005).

9. Elliot Fisher et al., "The Implications of Regional Variations in Medicare Spending, Part 1: The Content, Quality, and Accessibility of Care and Part 2: Health Outcomes and Satisfaction with Care," *Annals of Internal Medicine*, February, 18, 2003, Volume 138, Number 4. <www.annals.org/cgi/content/full/138/4/273> Accessed March 29, 2006.

10. John Billings et al., "Managing High Cost Patients: A Profile of New York City Medicaid High Cost Patients," presented at the United Hospital Fund Conference, Medicaid and Managed Care, December 10, 2003.

11. Steven R. Gregory and Mary Jo Gibson, *Across the States 2004* (Washington, D.C.: the Public Policy Institute, AARP, 2004), <www.research.aarp.org/health>. Accessed March 29, 2006.

12. Allen J. LeBlanc, M. Christine Tonner, and Charlene Harrington, "State Medicaid Programs Offering Personal Care Services," *Health Care Financing Review*, Summer 2001, Volume 22, Number 4, p. 155.

13. See: Government Accounting Office, *Medicare Improper Payments*, September 2000, GAO/AIMD/OSI-00-281; GAO, *Health Insurance Fraud*, May 1992, GAO/HRD-92-69; and Clifford Levy and Michael Luo, "New York Medicaid Fraud May Reach Into Billions," *The New York Times*, July 18, 2005.

14. Savings calculated as follows: Eligibility restrictions will reduce the percentage of dual-eligible beneficiaries in New York receiving full Medicaid benefits to the national level, a reduction of 18.7 percent or 44,000 individuals. The average expenditure for dual-eligibles receiving the full Medicaid package in New York was \$21,860 in 2003, based on CMS, MSIS data. Eliminating coverage for 44,000 individuals at \$21,860 each saves \$960 million. For a fuller discussion of dual-eligibles and Medicare benefits see the previous CBC report, *Confronting the Tradeoffs in Medicaid Cost Containment*.

15. Savings calculated as follows: for hospitals, a 15 percent reduction in total hospital expenditures of \$5,520 million; for nursing homes, a 29 percent reduction in total nursing home spending of \$6.2 billion saves \$1.8 billion, but is reduced to \$1.6 billion because of reduced eligibility; for ICFs, savings are based on a 20 percent reduction of total IFC spending of \$2.7 billion. Total expenditures for each institutional provider from CMS, MSIS 2003 data.

16. Centers for Medicare and Medicaid, *2004 Medicaid Managed Care Enrollment Report*, <www.new.cms.hhs.gov/MedicaidDataSourcesGenInfo/Download/mmcer04.pdf> Accessed March 29, 2006.

17. Managed care savings based on reducing the average expense per hospital inpatient beneficiary (\$8,674) by 15 percent (\$1,300) for 335,000 beneficiaries resulting in savings of \$436 million. Because this is a conservative estimate of hospitalization costs (per disabled and aged beneficiary inpatient hospital expenditures are not available) per beneficiary spending was not first reduced by the recommended rate change prior to calculating savings.

18. Savings for personal care estimated as follows: The recommended change in medically-needy eligibility reduces the personal care load by 22,000 individuals or 5 percent. A proportional reduction in expenditures is \$3,344 million. The change in hours from 30 to 17 is a 43 percent reduction, applied to \$3,444 million yields savings of \$1,476 million.

H. Dale Hemmerdinger, Chairman
Diana Fortuna, President
Charles Brecher, Executive Vice President

Citizens Budget Commission
One Penn Plaza, Suite 640
New York NY 10119
tel 212.279.2605 *fax* 212.868.4745
web www.cbcny.org *email* info@cbcny.org