Citizens
Budget
Commission

Confronting
The Tradeoffs
In Medicaid Cost Containment

- New York State can reduce the cost of Medicaid by $4.6 billion annually without reducing the program's effectiveness in helping low-income New Yorkers obtain needed care.

- These savings are possible, because the cost per person enrolled in Medicaid in New York – $7,646 annually – is nearly double the national average of $3,936.

- These savings are crucial because in fiscal year 2003 total spending in New York for Medicaid was $36 billion, representing a major part of State and county budgets.

- At least half of the savings would revert to State and local governments in New York – with the remainder going to the federal government – but New York should be able to negotiate with the federal government for a substantial portion of the federal savings to benefit New York.

- The problem is not that New York is providing too many benefits to the needy, but that it is providing them inefficiently.

The latest report by the Citizens Budget Commission analyzes that spending and makes recommendations to reduce spending without hurting the program's effectiveness in helping low-income New Yorkers obtain needed care.

This document
is a summary of
the CBC's latest report.

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the full report,
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Introduction

From 1988 to 2003, total Medicaid spending in New York State, as a percent of total State expenditures, grew from 23 percent to 38 percent.

Medicaid is a joint federal-state program intended to help people with limited income obtain medical and related health care services. More than 3.4 million New Yorkers benefit directly from the program. In addition, Medicaid payments to hospitals and clinics help enable those institutions to provide care to New Yorkers who do not qualify for Medicaid, but who lack health insurance.

While its benefits are clear and widely supported, Medicaid's costs are far more controversial. In New York, total spending for Medicaid of $36 billion in fiscal year 2003 represented nearly 40 percent of total State expenditures. The portion of the Medicaid program paid for with State-raised revenues (as distinct from federal aid and local government contributions) totaled $12.6 billion or more than one-quarter of all State spending financed with State revenues. New York State is unique in requiring its local governments (57 counties and the City of New York) to pay a major share (averaging one third) of the non-federal costs of Medicaid.

Paying only competitive costs to hospitals and long-term care facilities would save $2.5 billion annually.

In the last 15 years, Medicaid spending grew at an annual rate of more than 9 percent, compared to total State spending growth of 3.1 percent. New York's cost per person enrolled in the program, $7,646 annually, is now nearly double the national average of $3,936, and is well above second place Maine at $6,820.

Recommendations

Limit "Medically-Needy" Loopholes. State laws and county administrative practices have created large loopholes in Medicaid eligibility standards that enable many middle-class and wealthier individuals to qualify for Medicaid-financed long-term care including nursing homes and personal care at home. These loose standards include allowing spouses to refuse to contribute to the support of individuals requiring care, and permitting individuals to transfer assets to relatives immediately before seeking home care from Medicaid. More careful design and better enforcement of eligibility rules for the elderly and disabled will reduce the number of such people receiving Medicaid-funded nursing home and home care services by about 24,000 or 8 percent of the current 300,000 individuals in New York State receiving long-term care. Given New York's high costs for these individuals ($25,137 compared to a national average of $12,647), the savings from fewer such eligibles would reach $608 million annually.

Pay Only for Competitive Costs. 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 13 percent per admission, and for nursing homes it is about 29 percent per day. For a third type of institution, intermediate care facilities for those with disabilities and requiring supervision and care, the differential ranges from 16 to 55 percent depending on the size and type of facility. Limiting Medicaid provider payments to rates based on competitive costs would save about $2.5 billion annually. Lower hospital rates would account for about $620 million; lower nursing home rates would save about $1.4 billion annually. For the intermediate care facilities the annual savings are estimated at $423 million annually.

Increase Managed Care Participation. Most states view managed care, when implemented properly, as a "win-win" arrangement under which taxpayers save money and needy clients get better care. As a result, nationally Medicaid managed care participation has risen from 40 percent of all Medicaid eligibles in 1996 to 57 percent in 2002, the latest year for which national figures are available. However, New York was slow to join the managed care movement, and in 2002 its participation rate was only 45 percent. In September 2003 the New York rate reached 47 percent, but the national rate also likely was continuing to grow.

New York's $2.9 billion expenditure for personal care for the elderly and disabled is fully 25 percent of the national total for these services under Medicaid.

New York lags national norms because it exempts most elderly and disabled Medicaid enrollees. Efforts should be made to build the capacity among managed care organizations to manage care for these groups effectively. They are the most expensive beneficiaries, and there is strong evidence of ineffective utilization patterns among these groups, particularly for acute care in the form of repeated and unnecessary hospitalizations. A suitable goal would be to enroll about one-third of the elderly and disabled eligibles, or about 350,000 individuals, in a managed care plan. A reasonable estimate is that effective managed care would reduce the acute care costs for this population by 15 percent. This would yield savings of $489 million annually.

Expenditures for personal care per beneficiary of such care in New York average $7,412 annually – more than triple the average of $2,079 in the rest of the nation.

Limit Excessive Personal Care Services. New York's program of personal care for the elderly and disabled living at home pays for many more hours of home attendant services for tasks such as housekeeping and shopping than is permitted in any other state. The number of hours of such home care paid for by Medicaid in New York averages 30 per week compared to 11 hours per week in the rest of the country. Bringing use of personal care services more in line with national norms would save about $1.0 billion annually. This assumes that the average number of hours of personal care authorized for clients, who number more than 69,000, 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.

Additional Implications

These recommendations would reduce costs significantly while protecting needy New Yorkers from loss of access to medical care. But eliminating over $4.6 billion in Medicaid expenditures would not be painless for everyone. Other constituencies have a stake in this spending, and they would need to make adjustments.

The smallest savings result from transferring long-term care costs for nursing homes and home care services from Medicaid to families with adequate means. The changes in policy should be phased in to avoid hardships or abrupt displacement of individuals, but the goal should be clearly set. Medicaid should not be a mechanism for the middle class to avoid family responsibilities or a substitute for private long-term care insurance.

The payment rate reductions would present challenges to those who now manage hospitals and nursing homes. They would have to become more innovative and find ways to maintain services with lower revenues, but they would not be asked to do any more than their counterparts in other states already are achieving. Once adjustments

are made for differences in regional costs and in case-mix, there is no justification for paying institutions in New York more than those in the rest of the country. The notable qualification to this point is that New York's hospitals make a case for higher payments based on their greater commitment to graduate medical education. But it makes little or no sense for New Yorkers to underwrite this educational mission with state and local dollars, because many physicians trained in New York practice elsewhere once they complete their residencies.

In addition to reducing revenues for institutions, these lower expenditures would also reduce the number of workers needed to provide health care services in the state: about a 5.5 percent reduction in employment in the state's health care industry. Careful plans should be made to help affected workers adjust to this change, but the goal should remain getting New York's health care costs and utilization in line with competitive standards rather than employing people inefficiently. This reduction should also be seen in the context of recent growth in the industry even during a recession period (2000-2002) when health and social services added 43,000 jobs while total employment in the State fell nearly 200,000.

One final point should be made about the responses to the proposed Medicaid savings. Because these expenditures are financed one-half by the federal government, half the savings could accrue to the federal budget. This could remove some of the money from the New York economy (depending on the assumptions made about how the federal government uses the money). In order for the adverse impacts of the Medicaid reductions to be minimized, State leaders should negotiate with federal officials to incorporate some "budget neutral" arrangement with the federal government. Such an arrangement is not unrealistic. As with many federal waiver programs, a major cost-cutting initiative in New York should allow New Yorkers to share the benefits obtained by the federal government as a result of the State's efforts.

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Founded in 1932, the Citizens Budget Commission is a nonpartisan, nonprofit civic organization devoted to influencing constructive change in the finances and services of New York State and New York City governments. The Commission conducts research and regularly issues reports and recommendations based on that research. The research is conducted by staff members and consultants, and guided by committees composed of Trustees of the CBC.

This report was prepared under the auspices of the CBC's Budget Policy Committee, co-chaired by Eugene J. Keilin and Heather L. Ruth. The other members of the Committee are: Lawrence D. Ackman, Stephen Berger, Lawrence B. Buttenwieser, Karen Daly, Evan A. Davis, Stephen DeGroat, Cheryl Cohen Effron, Roger Einiger, Laurel FitzPatrick, Paul E. Francis, Bud H. Gibbs, Kenneth D. Gibbs, James F. Haddon, Jeffrey Halis, Walter Harris, Fred P. Hochberg, Peter C. Kornman, Robert Kurtter, Stephen F. Langowski, Richard A. Levine, Jeffrey Lynford, Donna Lynne, Norman N. Mintz, Robert E. Poll, Lester Pollack, Carol Raphael, Laraine S. Rothenberg, Edward L. Sadowsky, William G. Salter, Bart Schwartz, Teddy Selinger, Jonathan Siegfried, Richard J. Sirota, Adam Solomon, Joan Steinberg, Merryl H. Tisch, Leslie Daniels Webster, Stephen H. Weiss, and H. Dale Hemmerdinger, ex-officio.

Research for this report was initiated by Elizabeth Lynam, CBC's former Director of State Studies. She worked with Sheila Spiezio, a research consultant, and Selma Mustovic, Research Associate, and they completed the data collection and analysis in the fall and winter of 2003-04. The research was conducted under the direction of Charles Brecher, Director of Research and Executive Vice President, and the report was written by Charles Brecher and Sheila Spiezio.