TRANSFORMING MEDICAID: OPTIONS FOR NEW YORK

MAKING MEDICAID MORE EFFECTIVE AND EFFICIENT

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EXECUTIVE SUMMARY

In the mid-1990's, New York State faced a Medicaid crisis and the new governor at the time, George Pataki, created the Comprehensive Medicaid Task Force to study Medicaid and make cost-containment recommendations. At the same time, CGR and the New York State Association of Counties (NYSAC) studied the underlying challenges of Medicaid in New York State and published recommendations for reform in 1995 that were used extensively in Task Force debates.

Once again, in 2003, New York State faces a Medicaid crisis. Consequently, CGR has prepared this new report to reflect how Medicaid has evolved since our last report. Our intention is to provide information on how the Medicaid program functions currently, including how program implementation varies across New York counties, and to recommend reforms based on the experiences in other states and across New York State. We hope that these findings and recommendations will inform the deliberations of the recently formed New York State Senate Medicaid Reform Task Force and other groups that are discussing the need to reform Medicaid.

Because Medicaid is such a large share of state budgets across the country, typically 15% or more of the general fund budget, changes in Medicaid spending have a large impact on state finances. During the strong economy of the 1990's, many states expanded Medicaid eligibility and increased the number of services covered by the Medicaid program, with the result that Medicaid has increasingly become a vehicle for providing publicly funded universal health care.

Consequently, the number of people eligible for Medicaid and Medicaid expenditures has increased because of these program expansions. Compounding this problem, Medicaid costs have been directly affected by across-the-board increases in health care costs in general. Finally, current economic conditions have created revenue shortfalls for state and local governments and put pressure on the private sector to cut costs to remain competitive in the worldwide marketplace.

The result is a costly convergence of a rising number of people eligible for Medicaid benefits, increasing health care costs, and precipitously falling state revenues. Thus, CGR's focus in this report is to identify ways to control New York State's escalating Medicaid expenditures.

Where possible, CGR has used the most recent data available, however, much of the publicly available data is several years old. Still, anecdotal information from the field suggests that recommendations based on these data continue to be valid. In particular, CGR wishes to acknowledge the assistance of the New York State Association of Counties (NYSAC) for reality testing drafts of this report and supporting its dissemination to leaders who can help transform Medicaid in New York State.

Medicaid Basics

Medicaid is a health insurance program that gives beneficiaries access to a range of health care services from providers. This is a critical point – Medicaid money is ***not*** given to beneficiaries. It is paid to companies, institutions and individuals who provide a service or products (such as drugs and medical equipment) to individuals. Individuals become eligible to receive Medicaid benefits based upon meeting both income and asset requirements, except in the Child Health Plus and Family Health Plus programs, which only consider income.

Medicaid costs, in simplest terms, are driven by four variables: the number of users (beneficiaries), the number and types of services covered, the unit costs of all the services and products being consumed by those users, and the cost of administering the program. Since the average cost of administering the program is estimated to be only approximately 5% of the total, key strategies for reducing Medicaid costs need to focus on reducing the

number of people receiving benefits, the number and types of ***services covered***, and/or the ***unit costs*** of those services.

It is important to understand that Medicaid has effectively become three programs, one for the health care needs of low-income, able-bodied adults and children, one for low-income disabled adults under age 65 and one for the low-income elderly. Therefore, attempts to transform Medicaid in New York need to recognize the implications of the dynamics of providing services to these three diverse populations.

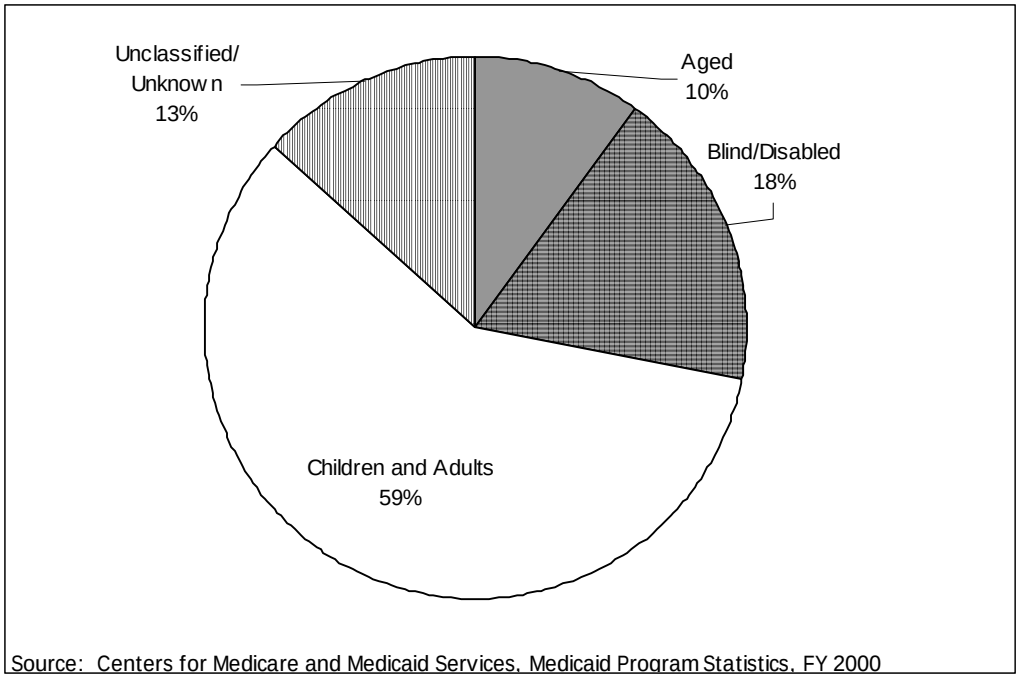
Two examples will illustrate this point. First, the average length of time a beneficiary receives Medicaid benefits is only approximately 9 months. Since this average includes beneficiaries who receive long-term, continuous care (mostly elderly and significantly disabled), it is estimated that able-bodied adults and children are coming into the system for only about 6 months. This fact suggests a significant amount of churning in this population group. Second, the rising cost of care for the disabled and elderly is projected to account for approximately three-quarters of the increase in total Medicaid costs over the next few years, and demographic projections indicate that New York's elderly population will grow by nearly 30% in the next twenty-five years. Thus, Medicaid cost management strategies must take into account the special need and service usage profiles of these groups.

The most important factor driving costs in Medicaid is the variation in service needs of these three populations. Conventional wisdom holds that Medicaid is a program for low-income families and children. However, while families and children make up the largest proportion of those eligible for Medicaid, they are not the key cost-drivers.

Figures 1 and 2 illustrate that while almost two-thirds of Medicaid recipients in New York State are low-income adults and children, they represent less than one-quarter of Medicaid expenditures. On the other hand, Medicaid beneficiaries classified as aged represent 10% of the recipients, but they account for about one-third of the costs, and those classified as blind/disabled represent less than one-fifth of the recipients but account for fully one-half of the costs. Looked at in another way, the aged Medicaid recipients are the most costly on a per-unit basis. New York State spent $22,138

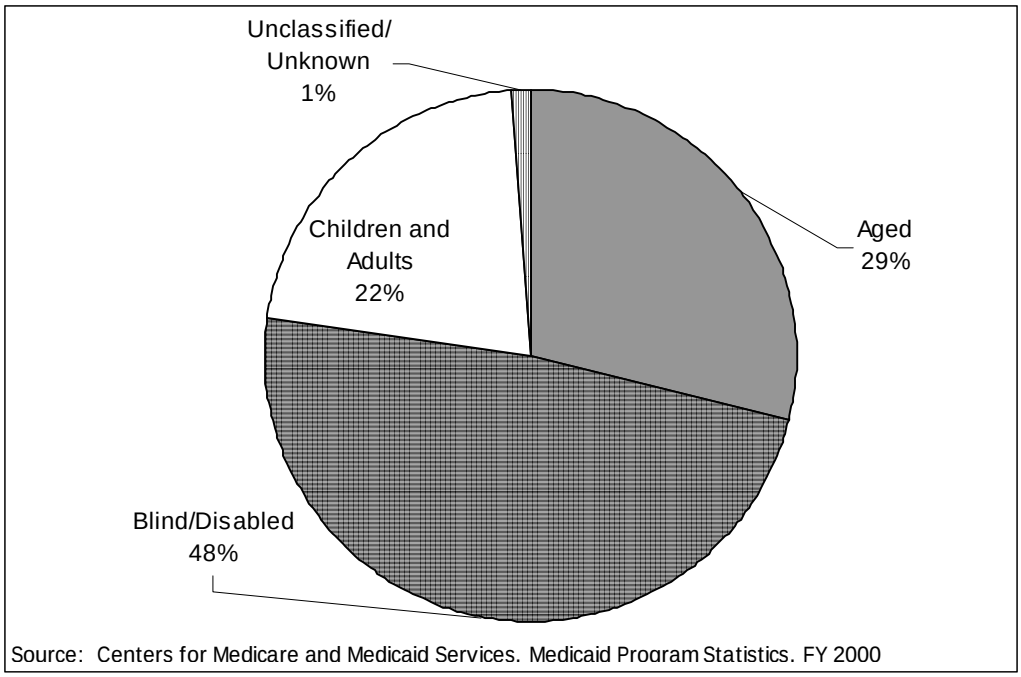
per aged beneficiary and $20,400 per disabled beneficiary in 2000, compared to $4,059 for an able-bodied adult and $2,142 for a child.

Figure 1: Percent of Medicaid Beneficiaries by Category of Eligibility in New York State, FFY 2000



Source: Centers for Medicare and Medicaid Services, Medicaid Program Statistics, FY 2000

Figure 2: Percent of Medicaid Expenditures by Category of Eligibility in New York State, FFY 2000



Source: Centers for Medicare and Medicaid Services, Medicaid Program Statistics, FY 2000

CGR believes that in order to truly transform how Medicaid is managed in New York State, and to significantly change the Medicaid cost structure, management attention should shift from the traditional method of focusing on programs, (which are identified as cost buckets such as hospital inpatient, drugs and supplies, managed care, skilled nursing facilities, etc. in the Medicaid cost tracking system) and focus more attention on the service needs and costs of beneficiaries in the beneficiary populations. Data on who uses what services are available, however, this information is largely untapped and unused. Innovative state and local (county) initiatives are just beginning to use beneficiary data to understand how to transform provision of Medicaid services to these populations in a more effective and efficient manner. These initiatives should be significantly expanded and accelerated.

How Medicaid is Funded in New York State

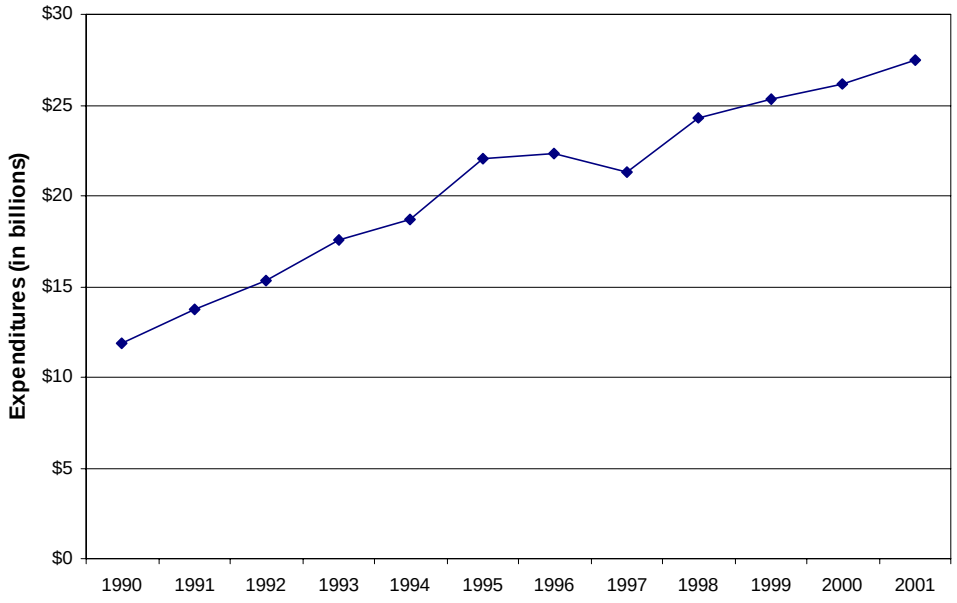
The cost of Medicaid in New York State has grown dramatically in the last five years. Medicaid is a federal-state partnership with the federal government matching state (and local) funds on at least a 1:1 basis. The federal medical assistance percentage (FMAP) is based on a formula that takes into account the three year average per capita income in the state compared to the national average. State FMAP's currently range from a low of 50% to a high of 76.62% in 2003. New York is one of twelve states that receive the federally mandated minimum 50% match rate.

A 2002 survey by the North Carolina Association of County Commissioners found that eighteen states have some local share (non-state) contribution to Medicaid. New York and North Carolina are the only two states with a significant local share. New York counties pay 25% of all Medicaid expenditures except long-term care costs, and North Carolina has a 15% local share requirement. For long-term care, New York counties pay 10% of the total costs. Due to the blended average of long-term care and other Medicaid costs, on average, each New York county pays approximately 16% to 18% of the total Medicaid expenditures in that county each year. In State FY 2002, counties paid 16% of total Medicaid costs for the state as a whole - counties outside of New York City contributed to approximately 4% and New York City contributed to approximately 12% of the total. Federal funds

paid for just over half (51%) of the total Medicaid expenditures in New York, and the state paid the remaining 33%.

Figure 3 shows Medicaid expenditures in New York, based upon federal Centers for Medicare and Medicaid Services (CMS) information. In 2001, New York's Medicaid expenditures (local, state and federal funding combined) was nearly $27.5 billion.

Figure 3: Trends in Medicaid Expenditures over Time in New York State, Calendar Year 1990-2001



Source: 1990-1998: CMS Medicaid Medical Vendor Payments by Fiscal Year 1999-2001: CMS Table 3: Medicaid Expenditures for Fiscal Year.

Unfortunately, the CMS data do not reflect the dramatic increases in Medicaid spending in New York State since 2001, both in terms of absolute and percentage growth. These changes in Medicaid costs have been a major cause of the fiscal stress being expressed at both the state and county levels for the last two years. Counties in particular have been affected, because Medicaid costs have become more difficult to predict with the increase in new and expanded programs and benefits, and because counties have very limited options (essentially property and sales taxes) for raising the revenues required to pay their Medicaid expenses.

Table 1 shows that total state spending grew from 3% to 5% per year after total spending started to trend up again in 1998. In the same period, county Medicaid costs increased from 6% to 9% annually. However, in 2002, county costs increased by almost 15%, and are projected to continue growing at 15% for 2003 and 2004, based upon state Medicaid spending budget estimates, according to NYSAC.

Table 1: Year-to-Year Change in Medicaid Expenditures

Year	Total Medicaid Expenditures[1]	Year to Year Percent Change	Total Local Share[2]	Year to Year Percent Change
1998	$24,298,610,635		$3,518,000,000	
1999	$25,357,204,784	4.4%	$3,721,000,000	5.8%
2000	$26,147,613,087	3.0%	$3,994,000,000	7.3%
2001	$27,497,918,486	5.2%	$4,355,000,000	9.0%
2002			$4,999,000,000	14.8%
Est. 2003[3]			$5,749,000,000	15.0%
Est. 2004[3]			$6,612,000,000	15.0%

[1] 1990-1998: CMS Medicaid Medical Vendor Payments by Fiscal Year 1999-2001: CMS Table 3: Medicaid Expenditures for Fiscal Year.

[2] NYSAC using NYSDoH data

[3] NYSAC projections

One of the challenges to understanding the cost impact of Medicaid in New York is that the state has developed a number of strategies to fund Medicaid costs in order to meet a variety of state policy objectives. To accomplish these objectives, over time, state costs have been distributed among several budget categories, including the State General Fund budget and HCRA (Health Care Reform Act). As a result, CGR found different figures for total Medicaid spending among various budget presentations from the state. While the state has been able to mitigate its net Medicaid expenditures through budget strategies, these appear to be masking true increases in Medicaid costs.

For example, the State 2003-2004 Enacted Budget Report (dated 5/28/03) indicates that State General Fund Medicaid spending is expected to grow at a net 5.3% over the prior year, and all state funds Medicaid spending is expected to grow at a net 5.2%.

However, the same document indicates that the state expects an underlying spending growth of approximately 8% in Medicaid.

On the other hand, projected Medicaid cost figures published by the New York State Department of Health for State FY 2003-04 indicate that the estimated local (county) share is projected to be $6.23 billion. As shown in Table 1, actual net county costs for 2002 were $4.99 billion. These figures indicate that net county costs are estimated to increase by $1.24 billion from 2002 to 2004, or by just under 25%, which, split evenly between 2003 and 2004, implies an annual 12+% rate of cost growth, compared to the state's 8% estimate. To further complicate matters, the state and county fiscal years do not correspond. This discussion demonstrates how difficult it is to have an informed debate about changing Medicaid without current, consistent and comprehensive spending and budget forecast information which could be provided by the state.

How New York Compares To Other States

While the actual total amount spent on Medicaid in New York is subject to debate (for reasons noted previously), the data that are available make it clear that total Medicaid spending in New York State is the highest in the nation. In order to benchmark Medicaid costs in New York State, CGR selected eleven states for comparison based on various factors such as population size, major industries and innovations in the administration of Medicaid. Cross-state comparisons based on the most recent complete information available (2000 or 2001 depending on the comparison) show significant differences among states. Further analysis of these differences will suggest opportunities for New York to change some of its Medicaid practices. Here are some key comparisons:

- **Total Medicaid Enrollment:** New York State has the second highest absolute number of people enrolled in Medicaid. In 2001, more than 2.5 million New York State residents were enrolled. Of the comparison states, only California had a higher total number of people (almost 4 million) enrolled in Medicaid.
- **Medicaid Enrollment as a Percentage of Total Population:** New York ranks in the middle in terms of percentage of its state population enrolled in Medicaid. In 2001, 14.3% of New York residents were enrolled in the Medicaid program. Four of the

eleven comparison states had a higher percentage of their population enrolled in Medicaid. Among the comparison states, Pennsylvania had the highest percentage (17.0%), followed by Ohio (15.0%), Tennessee (14.8%) and Wisconsin (14.7%), and Texas (11.0%) had the lowest percentage.

- **Medicaid Expenditures per Recipient:** New York State spent the most per recipient of the comparison states. New York spent over $7,000 per recipient, compared to a median among the comparison states of approximately $4,600. New York's spending per recipient is three times that in California and almost twice the spending in Texas.
- **Medicaid Expenditures per Capita:** New York spent $1,378 per capita, more than twice the median per capita spending in the comparison states.
- **Hospital Inpatient:** New York spent approximately $8,000 per recipient for hospital inpatient services, second only to Illinois among the comparison states. Median spending among the comparison states was almost $5,000.
- **Hospital Outpatient:** New York, Maryland and Illinois all spent over $700 per beneficiary, compared to a median of $460 among the comparison states.
- **Other Practitioners' Services:** New York spent $60 per recipient for these services, compared to a comparison group median of $122.
- **Dental Services:** New York spent $253 per recipient, about $50 above the median for the comparison group states.
- **Physician Reimbursements:** New York spent $228 per recipient, about $100 less than the median of the comparison states.
- **Clinic Services:** New York spent over $1,700 per recipient for clinic services. Michigan leads the comparison states, spending over $10,000 per recipient, compared to a median among the comparison states of $374.

How New York Counties Compare

While the percentage of people enrolled in Medicaid in New York counties ranges from approximately 3% to 17% of the county population, there was considerably more variation in Medicaid expenditures among New York counties in 2000. Means and

medians for data presented below are calculated for all New York State counties outside of New York City; only the 57 "upstate" or "rest of state" counties are included.

- **Cost per Beneficiary:** The median cost per beneficiary in New York counties was $6,648, but costs ranged from $4,687 in Allegany County to almost four times that, $16,162, in Putnam County.
- **Hospital Inpatient:** The median cost of hospital inpatient care in New York counties was almost $5,000 per beneficiary. Costs ranged from a high of over $9,000 in Nassau County to a low of slightly more than $3,500 in Tioga County.
- **Dental Services:** The median cost per recipient was $236, but counties spent as little as $135 in Tioga County and as much as $351 in Rockland County.
- **Primary Care Physicians:** The median expenditure per recipient was $166, ranging from $116 in Albany County to $224 in Clinton County.
- **Clinic Services:** The median expenditure per recipient was $323, but ranged from $186 in Chemung County to $642 in Putnam County.
- **Emergency Room Services:** Spending ranged from $145 in Tioga County to $223 per beneficiary in Clinton County. Median spending was $184 per beneficiary.
- **Transportation:** Median spending was $374. Spending ranged from a low of $114 per recipient in Ontario County to a high of $1,081 in Nassau County.
- **Clinic-Based Alcohol Services:** Spending ranged from $633 in Schuyler County to $3,345 in Hamilton County. The median cost per recipient was $1,246.
- **Psychological Clinics, including Alcohol Treatment:** Costs ranged from a low of $984 in Delaware County to $4,698 in Rockland County. In half of upstate counties, average cost per recipient was $1,559 or higher.
- **Physician Mental Health Services:** Median spending was $207. Costs ranged from a low of $78 in Schenectady County to a high of $398 in Warren County.

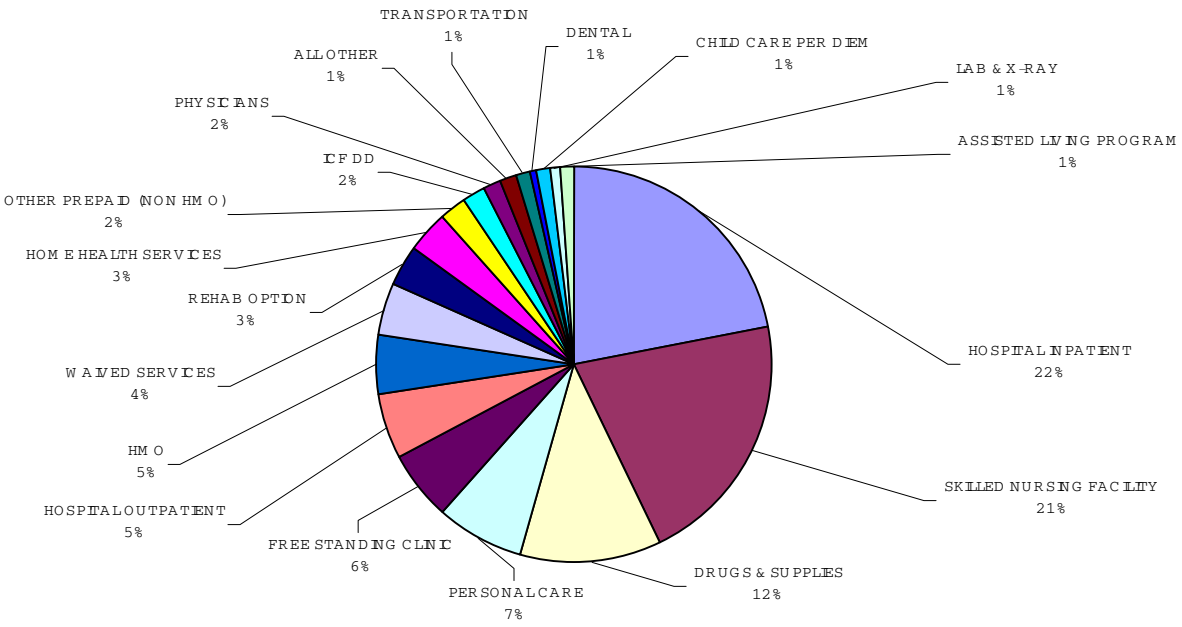
- **Community and Rehabilitation Services:** The median cost per recipient in New York Counties was $24,105. Costs ranged from a low of $16,322 in Lewis County to a high of $33,996 in Essex County.
- **Case Management Services:** Costs per recipient varied from $1,194 in Niagara County to $2,079 in Hamilton County. The median expenditure per recipient was almost $1,500.

Generally accepted reasons for these variations include: local variations in state approved reimbursement rates, demographic and economic variations among counties, variations in access to service providers and differences in treatment patterns. However, in addition, CGR has found clear differences among counties in how they utilize strategies to pro-actively manage Medicaid costs. While New York State counties cannot influence eligibility criteria or the package of services available to Medicaid recipients, counties can influence service patterns at the margins and allocate staff resources in ways that can impact Medicaid costs.

Major Program Components

Medicaid is a fabric of many different related and complementary programs designed to offer health care to those who meet the eligibility criteria. However, as Figure 4 illustrates, the costs are grouped primarily into a few major categories. In fact, hospital inpatient, skilled nursing facilities and drugs and supplies accounted for almost 55% of Medicaid spending in New York in calendar 2001.

Figure 4: Total New York State Medicaid Spending by Category, CY 2001



Source: NYSDoH:Medicaid Expenditures for Selected Categories of Service by Category of Eligibility, Calendar Year 2001

While each of the cost categories shown in Figure 4 could be investigated in more detail, CGR suggests that the state focus initially on the following general areas: managed care, long term care and prescription drugs.

Managed Care

Despite the fact that all states now offer managed care, states vary widely in the percentage of their Medicaid population enrolled. By 2000, both Michigan and Tennessee had moved their entire Medicaid population into managed care. New York State has been slow to move Medicaid recipients into managed care, especially in New York City and rural parts of Upstate New York. In addition, New York State exempts or excludes a portion of the Medicaid population from participation in a managed care plan.

Across New York State, almost 2.5 million Medicaid eligibles are required to enroll in a managed care plan if one is offered in their community. As of March, 2003, 1.5 million were actually enrolled in managed care. Considerable variation in enrollments exists across counties. Rockland, Niagara, Oswego, Greene and Rensselaer all have more than three-quarters of the eligible Medicaid population enrolled in managed care. However,

Cortland, Delaware, Schoharie, Tompkins and Tioga counties have less than 10% of the eligible population enrolled in managed care. Thirteen counties (Otsego, Cayuga, Chenango, Clinton, Essex, Franklin, Hamilton, Jefferson, Lewis, Madison, St. Lawrence, Schuyler, and Wyoming) do not have the required two managed care providers and have none of their eligible Medicaid population enrolled in managed care.

New York State counties annually spent an average of $890 per managed care recipient in 2000. These costs varied from $100 in Schuyler County to $1,500 in Rockland County. In 2000, the median length of enrollment in a Medicaid managed care was 8 months.

Managed care may be a cost efficient alternative to the traditional fee-for-service model, however, in New York, the mixed system of managed care and fee-for-service makes comparisons complex. Optional enrollment in managed care can lead to enrollment by those who are healthier and thus have lower costs. Further study would help determine what will happen to the total cost picture if the higher cost population is shifted from fee-for-service into managed care programs.

Long-Term Care

While conventional wisdom tends to regard Medi*care* as a program for the elderly and Medi*caid* as a program for the poor, there is considerable overlap between the two programs. Some low-income seniors and disabled people, called "dual-eligibles", receive both Medi*care* and Medi*caid*.

Medicare does not cover certain services, most notably prescription drugs and long-term care. For dual-eligibles, Medicaid will pay for these services. The rising cost of prescription drugs and long-term care for dual-eligibles has resulted in substantial cost-shifting across the two programs and is a leading factor behind increased Medicaid spending. Because Medicare is a fully federally-financed program, the shift to Medicaid has put additional strain on state, and in New York, local, budgets.

Long-term care consists of both services provided in homes and the community and services provided in an institution. While New York had a higher proportion of elderly state residents

receiving Medicaid long-term care services (almost 10%), the cost per recipient was lower than in many of the comparison states ($12,456 in New York compared to a median of $16,073 in the comparison states). New York has made extensive use of home health care. In 2000, New York's Medicaid program funded almost three people receiving home health care services for every two people receiving institutional long-term care.

The percentage of the Medicaid population using institutional long-term care services varied across New York counties. The median percentage was 7%, but ranged from a low of 4.4% in Clinton County to a high of 13.6% in Putnam County. Most recipients remained in the institution for about eight months. Per recipient expenditures varied from $19,000 in Allegany County to over $40,000 in Nassau County. Non-institutional care was considerably less expensive, with per recipient costs ranging from a low of $886 in Allegany County to a high of $19,013 in Nassau County.

Prescription Drugs

Drugs and supplies (primarily prescription drugs) is the third largest expense category of Medicaid expenditures, after skilled nursing facilities and inpatient hospital care. A driving force behind increased Medicaid costs is the rapid growth in prescription drug costs. These expenditure increases are the result of several factors:

- ***More pharmaceuticals on the market:*** Increasingly, conditions that had no treatment or had been treated through invasive methods in the past are being managed or treated using prescription drugs.
- ***New, name-brand drugs do not yet have a generic alternative:*** Brand name drugs are more expensive than their generic equivalents in order to compensate the pharmaceutical company for the cost of research and development.
- ***Increased demand:*** For all health care consumers, including Medicaid recipients, the average number of prescription drugs is increasing.

Several states, including Wisconsin, Pennsylvania, Minnesota and Ohio, spent more per recipient than did New York on prescription drugs. Yet, at $1,089 per recipient, New York still

spent above the median of $961 for the comparison states. Among New York counties, drug expenditures varied from $909 per recipient in Rockland County to $1,888 per recipient in Putnam County.

Child Health Plus and Family Health Plus

All fifty states and the District of Columbia offer publicly funded health insurance to children in low-income families through programs with broader income and asset limits than traditional Medicaid. In New York, children who qualify for Medicaid are enrolled in Child Health Plus A, which has a 25% local share. Children in families with slightly higher incomes qualify for Child Health Plus B, which has no local share. Outreach to encourage families to enroll their children in Child Health Plus has resulted in over half a million children (as of 2001) being enrolled in Child Health Plus in the state.

In order to expand health care coverage to low-income adults who do not qualify for Medicaid, New York instituted Family Health Plus in the fall of 2001. Family Health Plus has a 25% local share. The Family Health Plus program has seen explosive growth, which has been a major factor in the recent overall growth of Medicaid costs. By October 2002, one year after the program started, 148,019 adults were enrolled in Family Health Plus across the state. As of July 2003, (the latest figures available), 267,289 adults were enrolled in the program.

Three elements of the Family Health Plus program in particular have had an impact on the cost of this program for local governments:

- ***The program is heavily advertised in New York State.*** This publicity makes a concerted effort to emphasize that the program is not Medicaid or "welfare" in an attempt to reduce the stigma of applying for assistance. To that end, non-governmental organizations have been hired as "facilitated enrollers" to take applications for assistance away from DSS offices. This combination of advertising and efforts to de-stigmatize enrollment has resulted in a high volume of applications. At least a portion of applications is made by families whose incomes qualify them for traditional Medicaid. As a result, Family Health Plus advertising has increased both the Family Health Plus and the traditional Medicaid rolls.

- ***The program was inaugurated just as the recession began to hit full force.*** Unlike Medicaid, Family Health Plus has no asset limit. In applying for assistance, people only need to demonstrate they are income-eligible. As workers lost their jobs due to the recession, their families became income-eligible for Family Health Plus and Child Health Plus, resulting in higher than anticipated caseloads.

- ***There is some evidence that the effort to provide health care coverage to uninsured or underinsured people through an expansion of Medicaid has shifted costs from the private sector to the public sector.*** Offering government-financed health insurance to low-wage workers provides an incentive for companies, also facing large health care cost inflation, to eliminate health insurance coverage for their employees, knowing that the government will pick up the tab. In addition, employees may choose to forgo employer-provided health insurance that is expensive or less comprehensive in favor of a government-sponsored plan. These "crowd out" effects result in New York State and counties paying for the health insurance of people who would otherwise be covered by the private sector, although it is difficult to assess the extent of the "crowd out" effect.

Recommendations

New York State's Medicaid program has relatively generous eligibility criteria, provides an extensive array of optional medical services and, in many cases, reimburses providers at a level higher than in other states. The cost of these services strains federal, state and local budgets.

This report does not address "why" New York State's Medicaid program has evolved to this point. But the report does address "what is", i.e. the current state of Medicaid. The picture that evolves is that clearly, Medicaid in New York is an incredibly complex fabric of interwoven threads that represent years of give and take among client advocates, service providers, public officials and legislators in local, state and federal governments. The whole system has evolved in much the same way as a major computer operating system. What starts out as a basic integrated system, over time gets upgrades grafted onto the initial system, with patches on patches to repair upgrades. Medicaid is of course much more complex, but the general analogy holds, in that

Medicaid is a "system of systems", all somewhat integrated, but with each mini-system optimized for its own particular requirements. Optimization of mini-systems may, but in many cases does not result in an optimized solution for the whole, and there are many instances of this conflict in Medicaid within New York.

The big picture question that policymakers need to address is whether or not to try to repair pieces of the fabric through the patchwork approach, or to truly reinvent the system to ultimately create a new fabric using those threads which are worth re-using and adding new threads where appropriate. If the decision were made to pursue a true re-invention of the system, the state would need to carefully manage this process. It would need to develop a model of the new system, test the model, develop crosswalks and then transition from the current to the new model. Clearly, this will be a complex, costly and time-consuming project that will take several years. However, this is the path that will have the highest probability of making truly significant changes to Medicaid in New York.

Based on the descriptions of "what is" outlined in this report, as well as our own experience in working with individual counties to manage Medicaid, CGR recommends that the state undertake a combination of fundamental, "system wide" changes for the longer term, complemented by several changes that could immediately begin to help control the growth of Medicaid costs. All of these changes could be initiated immediately, but the designations "long term" or "short term" are used to indicate when it is likely that the changes will start to reduce costs. Additional detailed analysis will be required to develop specific cost/benefit estimates for these recommendations, however, enough is now known in each area to convince us that each recommendation will produce significant improvements over the "current state". All of CGR's recommendations are listed at the end of the full report. The key recommendations to achieve direct cost savings follow.

Recommendations for New York State – Long Term Changes

L.T. 1. Re-align full fiscal and administrative responsibility with the state. Of all the states, New York requires by far the largest contribution toward Medicaid costs from local

governments (counties). The state sets policy and controls most aspects of the Medicaid program in New York. However, counties pay for approximately one-third of the total local share (in 2002, for the total Medicaid spending in the state, federal funds paid 51%, state funds paid 33% and county funds paid 16%). Thus, state policy makers are in a position where they have full authority without having to accept full fiscal responsibility for their policy directives. For these reasons, the state should assume control of the entire Medicaid program, relieving counties of both the financial and administrative responsibilities.

Although a reasonable argument can be made against creating a new state bureaucracy, doing so would solve many problems with the system as it exists today, and would have a high probability for significantly reducing overall costs. There are many advantages to such a change. As some examples, it would:

- Relieve counties of the costs of "unfunded mandates,"
- Place full responsibility for paying for Medicaid on the state government,
- Reduce the size of county budgets by 20% or more and provide significant property tax relief, thereby improving the financial stability of counties across the state,
- Permit counties to reduce their payroll. Shifting full responsibility to the state will result in a realignment of Medicaid workers from counties to the state, and CGR believes that a statewide administration of Medicaid will create opportunities for regional or statewide economies of scale that should result in a net workforce reduction,
- Standardize provision of benefits across the state. CGR believes that managing provision of Medicaid services (along with other inter-related supportive services) with a statewide perspective will reduce the regional differences that have clearly occurred in the current system in areas such as allocation and use of facilities, client assessment (certification) processes and approaches to providing services. An integrated statewide management approach will create opportunities to standardize the provision of services and achieve significant economies of scale.

Clearly, three major conceptual challenges to achieving this shift need to be addressed. Opponents to change will question the financial impact (on the state and the counties), the organizational impact (on the state and counties) and the service impact (on both Medicaid recipients and service providers). As noted above, a substantial amount of planning will be required, and the transition is likely to take many years. However, the outline of the desired end state can be defined, and transition steps identified to achieve that objective.

Previous Transition Strategies

There are numerous options which should be evaluated in developing a comprehensive plan to transition full administrative and financial responsibility for Medicaid to the state. Within the state, a number of transition alternatives have been proposed, with primary objectives being to minimize any financial burden caused by the shift of local costs to the state government and to allow a smooth transition of costs over a multi-year period.

One of the first major transition plans was proposed by then Governor Cuomo in the early 1990's, which would have incorporated a swap of a penny sales tax from the counties to the state in exchange for the state accepting responsibility for Medicaid costs. This strategy has been periodically revisited, although at this point in time a penny sales tax would not offset the increased cost to the state. Another recent strategy proposed by the counties would be to cap the county contribution at a set amount, and have the state absorb future increases. A third strategy proposed by Governor Pataki would be to shift responsibility for certain program costs between the counties and the state to gradually transition counties out of high cost services.

A recent study by the North Carolina Association of County Commissioners found that since the inception of Medicaid, five states have eliminated county funding for either administrative or actual service (program) costs. These states may also provide useful templates for developing transition strategies for New York.

A New Transition Paradigm

CGR believes that a new transition strategy should be considered, based upon focusing attention on populations being served rather than programs being delivered. As discussed previously, different populations have vastly different service needs, different service use patterns and different cost profiles. Cost management strategies should be developed to identify the most cost effective ways to provide the specific service needs of specific population groups.

The starting point for this strategy would be to conduct the research needed to stratify Medicaid recipients into groups and subgroups based upon clearly defined service need characteristics, and identify the costs associated with and services provided to each group. Once the groups have been identified, full fiscal responsibility would be allocated to counties or the state on a group by group basis in order to achieve an equitable distribution of costs at the outset, to minimize cost shifting and to mitigate the impact on administrative structures already in place and Medicaid beneficiaries.

Initially, beneficiary groups would be assigned to either the state or counties based upon both an equitable distribution of costs and determination about whether provision of services could be best administered from a local perspective (county responsibility) or regional or state perspective (state responsibility). It is clear that some Medicaid services can best be managed from the local level (for example, specialized fee-based services to children and families or local transportation services), while other Medicaid services would benefit from a regional or statewide management approach that could achieve economies of scale (for example, regional managed care contracts designed to provide coverage in counties currently without such coverage).

The intended long term objective would be to shift complete responsibility for serving all populations to the state. However, experience may dictate that counties can or should be responsible for services to some groups. Or, as other states have found, it may be most efficient for counties to provide some administrative services rather than having a state bureaucracy provide them. Any

number of potential variations could develop over time, but the important point would be to start down the path, focusing on provision of cost effective integrated services to client population groups rather than managing Medicaid as a collection of program driven cost centers.

L.T. 2. Pursue a supply chain management strategy. Supply chain management (SCM) is a key cost management strategy used by companies of all sizes in the private sector. Essentially, the strategy is to develop partnership rather than adversarial relationships with suppliers, and using financial incentives, work with the suppliers to suggest and implement continuous cost reductions. Further, in the long run, SCM attempts to rationalize the supply base, to drive services to the lowest total cost suppliers, where total cost reflects the appropriate balance of price, service and quality. Except for administrative overhead costs, essentially all Medicaid payments are made to suppliers. Thus, the state should determine how to utilize the skills and knowledge of its suppliers to recommend ways to reduce Medicaid costs. In addition, as the state transitions into becoming fully responsible for Medicaid, it should develop strategies to rationalize the supply base to lower its total cost structure.

This strategy could be employed immediately to begin to identify short term cost reduction opportunities. However, CGR believes that a long-term shift in relationships with service providers should be embedded in the system as it is reinvented in New York.

Recommendations for New York State – Short Term Changes

S.T. 1. Promote managed care. New York State has been slower than many states to move Medicaid recipients into managed care. In addition, New York State's managed care plan currently only requires that able-bodied adults and children enroll; high-cost users such as disabled and elderly people are exempt or excluded from managed care participation. If counties face difficulties finding a second managed care provider as required by law, they should encourage Medicaid recipients to enroll in a managed care plan voluntarily. The state should provide access to optional services only to Medicaid recipients enrolled in a managed care plan. The state should review its decision to "carve out" prescription drug coverage and transportation costs from the Medicaid managed care capitation rate.

S.T. 2. Change the formulas that drive Medicaid costs. The quickest way for New York to have substantial impact on Medicaid costs is to address one or more of these cost-drivers: the number of people eligible for Medicaid services, the package of services offered through the Medicaid program, and the costs per beneficiary. Examples of strategies that would directly reduce costs include: restricting eligibility, limiting the types of services provided, re-structuring reimbursement rates and requiring co-pays. This would require the state to make a conscious decision to limit or reduce services or change eligibility requirements. For example, the state could initiate an asset threshold in order to qualify for Family Health Plus benefits.

Much has been made of the fact that New York provides a high number of optional Medicaid services, especially compared to other states. The comparison chart included in the main report identifies the categories of services which are by law considered "optional", and how many states provide optional services compared to New York. The chart shows, however, that New York is hardly alone in the provision of optional services, thus, many other states are in the same predicament of needing to identify what services can be reduced or eliminated in order to reduce Medicaid costs.

S.T. 3. Improve oversight of specific, high-cost services. For example, New York should manage Medicaid beneficiaries, viewing patient care more comprehensively rather than individual services in isolation. By better identifying high-cost medical service users, and managing their care more comprehensively, the Medicaid program could save significant costs. In addition, New York should aggressively utilize a preferred drug list as a means to control pharmacy expenditures. The state should also impose new thresholds and time limits on the delivery of Medicaid-funded alcohol and drug abuse treatment. New York should continue to encourage elderly and disabled Medicaid recipients to remain in the community as long as home-based services are less expensive than institutional care. These and other improvements should be based on identifying cost and utilization trends through analysis of the Medicaid recipient database described previously.

S.T. 4. Review provider reimbursement rates to optimize use of the lowest cost service. New York State should consider increasing primary care physician reimbursement rates, which will likely produce a net reduction in total Medicaid costs. Currently, physician reimbursement rates are among the lowest in the nation. As a result, many doctors restrict the number of Medicaid patients they accept or refuse to accept any Medicaid patients at all. This can result in expensive cost-shifting, with Medicaid recipients unable to make an appointment for an office visit with a primary care physician turning to more costly ambulatory clinics or emergency rooms for routine care. Raising reimbursement rates may allow primary care physicians to accept more Medicaid patients, reducing the use of clinics and emergency rooms by Medicaid patients.

Recommendations for New York Counties

While counties cannot influence the "big ticket" items, such as eligibility criteria and services offered, it is clear that counties can influence their Medicaid costs, at least "at the margins". CGR is working with several New York counties to evaluate their Medicaid expenditures. Those counties which are being most aggressive in managing Medicaid costs have focused on utilizing client utilization data to identify high cost clients and providers and opportunities for change. Based on its observations, CGR suggests that all counties should:

C. 1. Tightly manage certification. Medicaid eligibility criteria are complex and many applicants have incomes that fluctuate across the eligibility threshold, based on whether or not an applicant can find work in a given month. Accurately determining eligibility and continuing eligibility is challenging and overworked examiners can make mistakes. Thus, quality control (QC) management can affect the number of eligibles being approved. In addition, some counties have made administrative determinations to strictly follow eligibility certification documentation and process requirements, which effectively slows down approval of new applications. This strategy runs counter to the social policy objective of getting needy recipients coverage as quickly as possible, however, it helps achieve the cost management objective. In the Health Care Reform Act of 2002 (HCRA 2002), the state substantially changed the re-certification process, simplifying the process and allowing clients to mail in their forms in most cases.

These changes make it even more difficult for counties to exercise their "gatekeeper" roles effectively.

Revenue recovery strategies can be considered to fall within the certification management function. Recovery of amounts paid or due from estates, fraudulent applications and other changes reflect a change in status of a beneficiary. County staff need to identify, measure and act upon these changes in a systematic and comprehensive process.

C. 2. Pursue diversion strategies. Counties can devote management attention to ensure that Medicaid is the payer of last resort. Many examples of these strategies exist. Veterans can be encouraged to make use of VA hospitals. Applicants can be monitored to insure that they utilize private (third party) health insurance rather than using Medicaid. Counties can assist disabled people in gathering the documentation necessary to apply for Supplemental Security Income. Medicaid can pay Medicare Part B premiums for low-income disabled people or senior citizens. For dual-eligibles, Medicare should be billed before Medicaid pays for any health care services, although currently, both Medicaid and Medicare appear to have created an administrative quagmire to discourage attempts to collect funds from the appropriate agency. Able-bodied adult applicants can be directed to employers known to be hiring workers. Counties should actively pursue insurance settlements if a Medicaid recipient is injured through no fault of his or her own.

C. 3. Promote lower-cost substitutions. County staff in different departments (at least DSS, Health and Mental Health) can pursue strategies to ensure that beneficiaries are using the most cost-effective services to meet their needs. Many different strategies are being tried by counties to identify lower-cost services or lower-cost providers, such as using and promoting in-county versus out-of-county services to lower transportation costs and using home-based services rather than institutional care where appropriate. Ultimately, identifying the lowest cost solution requires a comprehensive assessment of services available across the entire community and integrating these services into a cost effective unified network.

C. 4. Engage suppliers in cost reduction strategies. Just as the state could actively engage suppliers to assist in reducing costs through supply chain management strategies, counties could pursue the same strategies at the local level.

Conclusion

In order to control its escalating budget and improve its cost structure, New York must make tough decisions if it wants to bring its Medicaid costs in line with comparable states. Some recommendations made in this report, if implemented, would reduce the level of services provided by the state. They would reduce the number of people eligible for Medicaid services and limit the types of medical services Medicaid recipients can receive. Other recommendations, however, focus on cost efficiencies by reducing administrative costs, utilizing opportunities suggested by providers to reduce costs, and achieving economies of scale. These could be achieved on a smaller scale by immediately pursuing some of the strategies identified, and on a larger scale by transferring administration of the program to the state.

New York State clearly needs to address its Medicaid cost structure, especially in light of the predictable increase in demand from the rising elderly population. However, this report is intended to demonstrate that there are in fact many different opportunities to address the problem of rising Medicaid costs. The task is certainly not hopeless, it is simply daunting because of the complexity of Medicaid. By using data to identify opportunities and incorporating ideas from the many experienced professionals at all levels of government who are trying to ensure that the Medicaid program meets the public policy objectives set forth by the Congress, the State Legislature and the courts, New York State can improve Medicaid so that it can become more effective and efficient.

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ACKNOWLEDGMENTS

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Staff Team

This project was directed by Charles Zettek Jr., Director of Government Management Services. Marilyn E. Klotz, Research Associate, served as the principal research analyst for and primary author of this report. Sarah Boyce, Kent Gardner, Susan Lepler, Patty Malgieri and Donald Pryor assisted with and provided guidance throughout the project.

PURPOSE OF REPORT

In the mid-1990's, New York State faced a Medicaid crisis and the new governor at the time, George Pataki, created the Comprehensive Medicaid Task Force to study Medicaid and make cost-containment recommendations. At the same time, CGR and the New York State Association of Counties (NYSAC) studied the underlying challenges of Medicaid in New York State and published recommendations for reform in 1995 that were used extensively in Task Force debates. That report, *Medicaid Cost Containment: Options for New York*, outlined the challenges New York State faced in getting Medicaid spending under control and made recommendations for future cost-containment efforts. The report won the Governmental Research Association's Certificate of Merit for Effective Citizen Education.

Once again, in 2003, New York State faces a Medicaid crisis. Medicaid spending has skyrocketed, putting additional strain on state and county budgets during a recession. The State Senate has formed a task force to address Medicaid spending and make recommendations for cost-containment. CGR saw the opportunity to contribute to the Medicaid debate by preparing this new report to reflect how Medicaid has evolved since our 1995 report. This report provides information on how the Medicaid program functions currently, including how program implementation varies among New York State counties, and to recommend reforms based on the experiences in other states and across New York counties. We hope that these findings will inform the deliberations of the recently formed New York State Senate Medicaid Reform Task Force and other groups that are discussing the need to reform Medicaid.

BACKGROUND

Budget Context

Across the country, states are facing budget crises, largely fueled by sharply increasing Medicaid spending. Because Medicaid is such a large share of state budgets across the county, typically 15%

or more of a state's general fund budget, changes in Medicaid spending have a large impact on state finances. In many states, Medicaid is the second largest (after education) single component of state general fund spending.[i] Medicaid is the "800-pound gorilla" in the state budget process. Because Medicaid is so large, and because as an entitlement its budget is particularly unpredictable, many states must "guess-timate" their Medicaid expenditures and routinely pass a supplemental spending bill to fill in any gaps in Medicaid financing mid-year.

The Medicaid program for families and children is intentionally counter-cyclical, meaning that it is anticipated that spending for families and children will expand in times of an economic downturn, although that portion of Medicaid which is designed to meet the needs of the elderly and disabled is less tied to economic cycles. When the economy is weak, more people will qualify for Medicaid and program expenditures will increase. The program was specifically designed to provide a social safety net in challenging economic times. Some observers have argued that an economic downturn is precisely the time **not** to cut Medicaid because reducing benefits or restricting eligibility will compound the problem of people losing employer-sponsored health insurance. In addition, Medicaid spending cuts may have a deleterious effect on an already shaky economy by reducing the economic stimulus impact of public health care spending[ii].

During the strong economy of the 1990's, many states expanded Medicaid eligibility and increased the number of services covered by the Medicaid program, with the result that Medicaid has increasingly become a vehicle for providing publicly-funded universal health care. State budgets were well in the black and many states felt they were in a position to be generous with health coverage for the disadvantaged. The federal government supported these efforts through such programs as the State Child Health Insurance Program (SCHIP) and waivers to expand coverage to previously uninsured categories of people. In addition, in light of the failure of national health care reform in the early 1990's, some states viewed the Medicaid program as a means to reduce their number of uninsured or underinsured residents.

Due in part to program expansion and in part to the economic downturn, both the number of people eligible for Medicaid and Medicaid expenditures have increased since the end of 2001. Compounding the budget challenges faced by states, Medicaid costs have been directly affected by across-the-board increases in health care costs. Finally, current economic conditions have created revenue shortfalls for state and local governments and put pressure on the private sector to cut costs through downsizing in order to remain competitive in the worldwide marketplace. The result is a costly convergence of a rising number of people eligible for Medicaid benefits, increasing Medicaid costs and precipitously falling state revenues.

Medicaid Demographics

Conventional wisdom holds that Medicaid is a program for low-income families and children. In most states, children are the largest category of persons enrolled in Medicaid and the largest share of Medicaid beneficiaries. ***However, while families and children make up the largest proportion of those eligible for Medicaid, they are not the key cost-drivers.***

Data presented below refer at various times to either Medicaid "eligibles" or Medicaid "beneficiaries." While "eligibles" means all people who have successfully completed the certification process for Medicaid, beneficiaries are the subset of eligibles who actually use services. Data on expenditures, therefore, apply only to beneficiaries. Further, in some cases data on beneficiaries or expenditures are missing; which results in the designation listed as "unknown."

As Figure 5 below indicates, the majority of Medicaid recipients in New York State are low-income adults and children. However, as the figure also illustrates, a sizeable proportion of Medicaid beneficiaries and the majority of Medicaid expenditures are for people who are elderly or disabled. Figure 6 shows that while only 10% of Medicaid beneficiaries are elderly (65 years of age or older), they account for a third of Medicaid expenditures in New York State.

Elderly and disabled Medicaid beneficiaries are more costly on average than their younger, able-bodied counterparts. New York State spent $22,138 per aged beneficiary and $20,400 per disabled beneficiary in 2000 compared to $4,059 for an able-bodied adult

and $2,142 for a child.[1] While families and children tend to rely on Medicaid for a short period during an economic downturn, disabled and elderly people are more likely to receive Medicaid regardless of the economy. The aging of the general population over the coming decades means that the Medicaid population will increasingly be skewed toward older people, likely resulting in higher Medicaid costs.

Figure 5: Percentage of Eligibles, Beneficiaries and Expenditures by Category of Assistance in New York State.

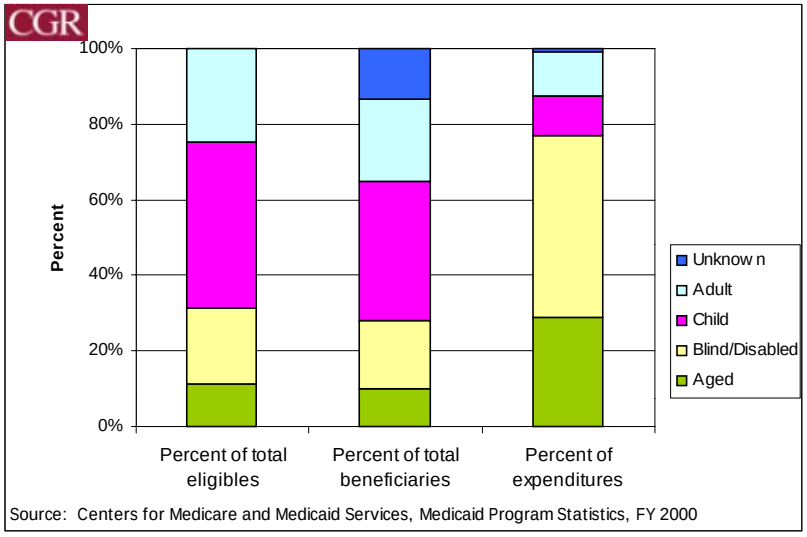
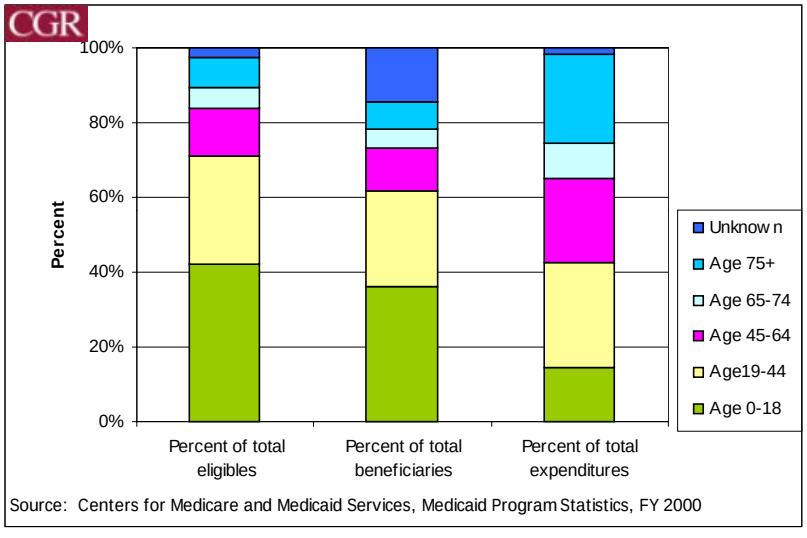


Figure 6: New York State Medicaid by Age



[1] CGR calculation based on CMS data for New York State 2000, Maintenance Assistance Status, Basis of Eligibility data.

The Center on Budget and Policy Priorities finds that a large portion of Medicaid expenditures go to fund health care for senior citizens and disabled people eligible for Medicare[iii]. More than three-quarters (82 percent) of the Congressional Budget Office projected growth in Medicaid benefit expenditures from 2002 to 2004 is attributable to the cost of care for elderly and disabled beneficiaries. These low-income, "dual eligibles," while a minority of the Medicaid population, account for a large portion of Medicaid spending. At least 50% of Medicaid drug costs, more than $6 billion nationally, are for Medicare-eligible clients. While a sizeable proportion of seniors are eligible for both Medicare and Medicaid, only a small portion of disabled people are eligible for both programs. A disabled person must have had a work history and must be severely disabled to qualify for Medicare benefits.

Federal Funding Issues

Attempts to reduce the cost structure of Medicaid must recognize and determine how to reconcile some inherent public policy conflicts in the current system. First, cutting benefits to vulnerable populations, such as disabled people, poor women and children or senior citizens, is not popular politically and conflicts with the policy of providing minimum levels of care to the least fortunate members of society. Second, adding further complexity to any efforts to cut Medicaid costs is the Federal Medical Assistance Percentage (FMAP). Because the non-federal share of Medicaid spending is at most only half of total Medicaid costs, any effort to reduce state Medicaid spending by $1 will result in at least a $2 reduction in overall Medicaid spending within the state. States must therefore consider the full impact of proposed cuts on persons receiving Medicaid benefits, the impact on the private sector of reduced revenues to service providers, and the overall reduction in health care dollars flowing to the state from federal sources.

To conclude, there will be clear service and economic consequences to unraveling the fabric of the Medicaid system as it has evolved in New York.

HOW MEDICAID IS FUNDED IN NEW YORK STATE

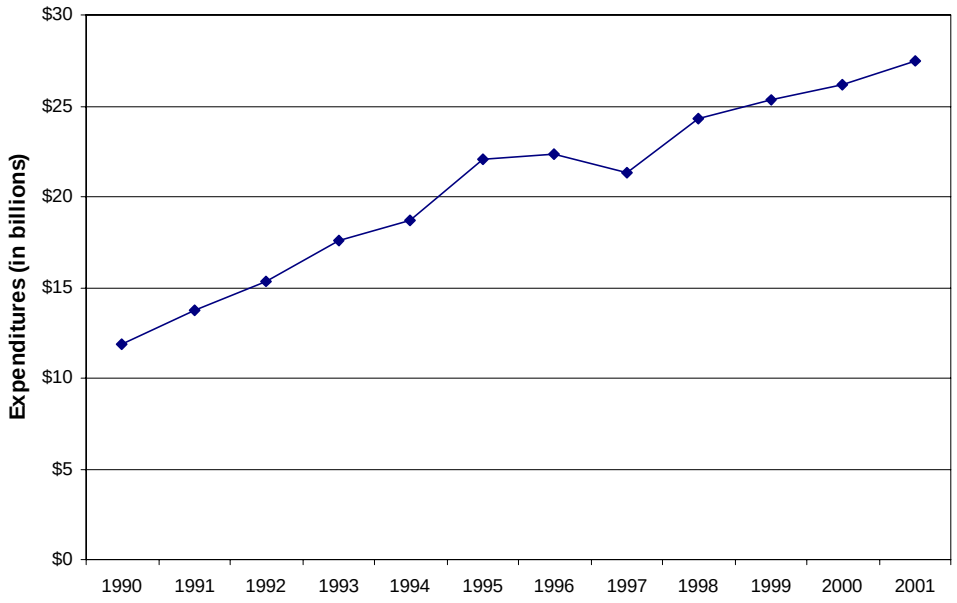
Medicaid is a federal-state partnership with the federal government matching state (and local) funds on at least a 1:1 basis. The federal medical assistance percentage (FMAP) is based on a formula that takes into account the three year average per capita income in the state compared to the national average. Higher income states have a lower federal match rate. State FMAPs currently range from a low of 50% to a high of 76.62% in 2003. New York is one of twelve states that receive the federally mandated minimum 50% match rate (although the FMAP was temporarily increased in 2003 to 52.95%.)

A 2002 study by the North Carolina Association of County Commissioners found that eighteen states have some local share (non-state) contribution to Medicaid. New York and North Carolina are the only two states with a significant local share. New York counties pay 25% of all Medicaid expenditures, except long-term care costs. For long-term care, New York counties pay 10% of the total costs. Due to the blended average of long-term care and other Medicaid costs, on average each New York county pays approximately 16%-18% of the total Medicaid expenditures in that county each year. North Carolina has a 15% local share requirement.

In State Fiscal Year 2002, counties paid 16% of total Medicaid costs for the state as a whole – counties outside of New York City contributed approximately 4% and New York City contributed approximately 12% of the total. Federal funds paid for just over half (51%) of the total Medicaid expenditures in New York. The remaining funding came from the following sources: state funds - 33%; funds from counties outside of New York City - 4%; funds from New York City - 12%.[iv]

Figure 7 shows Medicaid expenditures in New York, based upon federal Centers for Medicare and Medicaid Services (CMS) information. In 2001, New York's Medicaid expenditures (local, state and federal funding combined) were nearly $27.5 billion.

Figure 7: Trends in Medicaid Expenditures over Time in New York State, Calendar Year 1990-2001



Source: 1990-1998: CMS Medicaid Medical Vendor Payments by Fiscal Year 1999-2001: CMS Table 3: Medicaid Expenditures for Fiscal Year.

Unfortunately, the CMS data do not reflect the dramatic increases in Medicaid spending in New York State since 2001, both in terms of absolute and percentage growth. These changes in Medicaid costs have been a major cause of the fiscal stress being expressed at both the state and county levels for the last two years. Counties in particular have been affected, because Medicaid costs have become more difficult to predict with the increase in new and expanded programs and benefits, and because counties have very limited options (essentially property and sales taxes) for raising the revenues required to pay their Medicaid expenses.

Table 2 shows that total state spending grew from 3% to 5% per year after total spending started to trend up again in 1998. In the same period, county Medicaid costs increased from 6% to 9% annually. However, in 2002, county costs increased by almost 15%, and are projected to continue growing at 15% for 2003 and 2004, based upon state Medicaid spending budget estimates, according to NYSAC.

Table 2: Year-to-Year Change in Medicaid Expenditures

Year	Total Medicaid Expenditures[1]	Year to Year Percent Change	Total Local Share[2]	Year to Year Percent Change
1998	$24,298,610,635		$3,518,000,000	
1999	$25,357,204,784	4.4%	$3,721,000,000	5.8%
2000	$26,147,613,087	3.0%	$3,994,000,000	7.3%
2001	$27,497,918,486	5.2%	$4,355,000,000	9.0%
2002			$4,999,000,000	14.8%
Est. 2003[3]			$5,749,000,000	15.0%
Est. 2004[3]			$6,612,000,000	15.0%

[1] 1990-1998: CMS Medicaid Medical Vendor Payments by Fiscal Year 1999-2001: CMS Table 3: Medicaid Expenditures for Fiscal Year.

[2] NYSAC using NYSDoH data

[3] NYSAC projections

One of the challenges to understanding the cost impact of Medicaid in New York is that the state has developed a number of strategies to fund Medicaid costs in order to meet a variety of state policy objectives. To accomplish these objectives, over time, state costs have been distributed among several budget categories, including the state General Fund budget and HCRA (Health Care Reform Act). As a result, CGR found different figures for total Medicaid spending among various budget presentations from the state. While the state has been able to mitigate its net Medicaid expenditures through these budget strategies, these appear to be masking true increases in Medicaid costs.

For example, the State 2003-2004 Enacted Budget Report (dated 5/28/03) indicates that State General Fund Medicaid spending is expected to grow at a net 5.3% over the prior year, and all state funds Medicaid spending is expected to grow at a net 5.2%. However, the same document indicates that the state expects an underlying spending growth of approximately 8% in Medicaid.

On the other hand, projected Medicaid cost figures published by the New York State Department of Health for State FY 2003-04 indicate that the estimated local (county) share is projected to be $6.23 billion. As shown in Table 2, actual net county costs for 2002 were $4.99 billion. These figures indicate that net county costs are estimated to increase by $1.24 billion from 2002 to 2004,

or by just under 25%, which, split evenly between 2003 and 2004, implies an annual 12+% rate of cost growth, compared to the state's 8% estimate. To further complicate matters, the state and county fiscal years do not correspond. This discussion demonstrates how difficult it is to have an informed debate about changing Medicaid without current, consistent and comprehensive spending and budget forecast information which could be provided by the state.

KEY TRENDS AFFECTING MEDICAID IN NEW YORK

In the mid to late 1990's, New York State Medicaid expenditures were held in check as the result of a number of factors: national welfare reform, the *Personal Responsibility and Work Opportunities Reconciliation Act*, restricted benefits for legal aliens and de-linked cash assistance from Medicaid. One result, anecdotal evidence suggests, was that public assistance recipients eligible for Medicaid may not have applied for or received Medicaid benefits to which they may have been entitled.

In addition, states began to implement managed care, moving certain categories of recipients into programs with capitated payments in the 1990's. HMOs, under pressure from both public and private health insurance providers, kept fees in check during this period, absorbing the cost of health care inflation. Many states have used managed care as a mechanism to control health care cost inflation without restricting eligibility. However, as a larger percentage of Medicaid-eligibles are moved into managed care, the potential future cost-savings is reduced.

Starting in 2000, total Medicaid expenditures increased as other factors began to exert an influence. Health care cost inflation, which had been held in check somewhat by the shift to HMOs, re-asserted itself. Prior to 2000, health care costs continued to rise, but the cost increases were at least partly offset by the savings of moving people from fee-for-service to managed care. As the private sector completed this shift to managed care, related cost-savings diminished. In 1999, New York State increased the county

share of HMO payments to 25% from 10%. While this change had no impact on total Medicaid expenditures, it did shift a significant portion of Medicaid costs to the counties.

Meanwhile, the increase in the number of brand-name prescription drugs has resulted in large increases in prescription drug spending. In addition, the proliferation of prescription drug therapies means that the average Medicaid beneficiary uses an increasingly large number of prescriptions. Medicaid now covers a wide range of prescription drugs, from smoking cessation products to Viagra. In 1999, New York State "carved out" prescription drug costs from skilled nursing facility (SNF) reimbursement rates. In other words, SNF fees used to encompass the cost of prescription drugs, however, now SNFs charge separately for prescription drugs. The state has also "carved out" prescription drugs from HMO payments. These "carve-outs" increase expenses to the Medicaid program by allowing for separate billing rather than having the providers' fixed rates cover the risk of high prescription drug costs.

In addition, beginning in the late 1990's, New York began expanding Medicaid eligibility for children through the Child Health Plus program. In February 2001, over half a million children were enrolled in Child Health Plus in New York State. In late 2001, the state began expanding the income eligibility for health coverage to low-income parents through the Family Health Plus program. By October 2002, one year after the program was initiated, just over 148,000 adults in New York State were enrolled in Family Health Plus. As of July 2003 (the latest figures available), 267,289 adults were enrolled in the program. Both Child Health Plus and Family Health Plus allow families whose income and assets exceed Medicaid eligibility requirements to qualify for health care. In fact, Family Health Plus has no asset limit to qualify for benefits. As more people became eligible for benefits through these programs, the overall caseload increased. There is no local share for Child Health Plus, but counties pay 25% of the costs associated with Family Health Plus*. At the same

* Child Health Plus A is actually Medicaid. Recipients in this program are income-eligible for Medicaid. For Child Health Plus A/Medicaid, there is a local cost share. Child Health Plus B, for children who are not income-eligible for Medicaid, has no local share.

time, both the national and New York economies have declined, making more people eligible for traditional Medicaid. The result is increasing health care costs at a time of increasing enrollments, leading to large increases in Medicaid expenditures.

COST OF MEDICAID SERVICES

Comparison States

Total Medicaid spending in New York State is the highest in the nation. In order to benchmark Medicaid costs in New York State properly, for the 1995 report, CGR and NYSAC selected eleven states for comparison based on various factors such as population size, major industries and innovations in the administration of Medicaid. The comparison states were California, Illinois, Maryland, Michigan, North Carolina, Ohio, Pennsylvania, Tennessee, Texas, and Wisconsin. For the 2003 report, Florida is added to the group of comparison states. In certain cases, Tennessee is dropped as a comparison state because the state's shift toward managed care capitation makes comparisons impossible. The 2001 data for Pennsylvania are not yet available, so 2000 data are used.

Table 3 shows total FY 2001 Medicaid expenditures by state and details expenditures for selected spending categories. Inpatient hospital expenditures, skilled nursing facility (SNF) services, and physician services are federally mandated, while intermediate care facilities for the mentally retarded (ICF/MR) are optional. Home health services include both federally mandated services such as home health aides, and optional services, such as personal care. Prescription drug coverage is an optional service that all states offer. New York spends the most of all these states in every category, except inpatient hospital, physician services and prescription drugs.

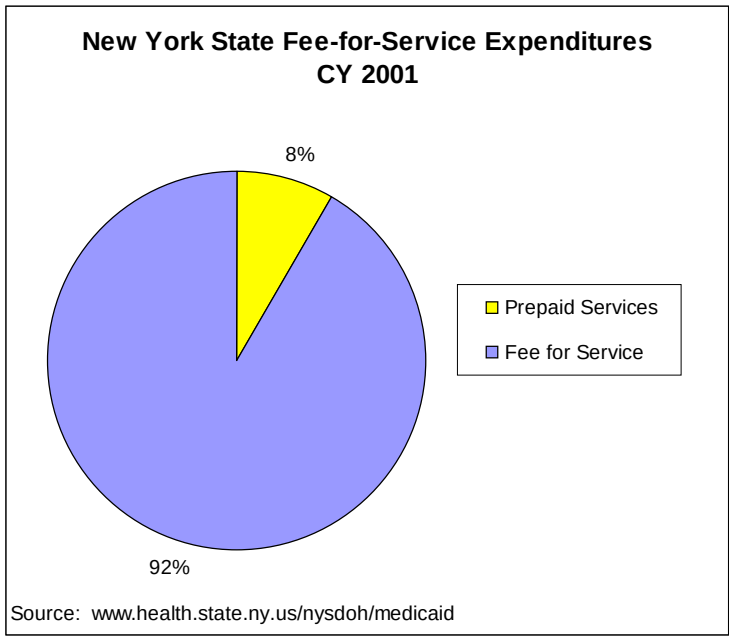
Table 3: Medicaid Expenditures by Major Service Category, Fiscal Year 2001 (Values in Billions of Dollars)

	Total Medicaid Expenditures	Inpatient	Percent of Medicaid Spending	ICF/MR	Percent of Medicaid Spending	SNF	Percent of Medicaid Spending	Physician Services	Percent of Medicaid Spending	Home Health	Percent of Medicaid Spending	Prescribed Drugs	Percent of Medicaid Spending
California	$19.82	$2.73	14%	$0.64	3%	$2.73	14%	$0.82	4%	$0.17	1%	$2.81	14%
Florida	$8.40	$1.61	19%	$0.29	3%	$1.53	18%	$0.42	5%	$0.20	2%	$1.49	18%
Illinois	$14.84	$7.84	53%	$0.28	2%	$1.87	13%	$0.36	2%	$0.07	0%	$0.98	7%
Maryland	$3.86	$0.52	14%	$0.06	2%	$0.69	18%	$0.16	4%	$0.27	7%	$0.42	11%
Michigan	$5.32	$0.52	10%	$0.04	1%	$1.06	20%	$0.11	2%	$0.02	0%	$0.60	11%
Minnesota	$3.77	$0.28	7%	$0.23	6%	$0.89	24%	$0.10	3%	$0.06	2%	$0.27	7%
New York	$27.50	$4.84	18%	$2.13	8%	$5.37	20%	$0.36	1%	$0.90	3%	$2.78	10%
North Carolina	$5.50	$0.82	15%	$0.40	7%	$0.85	15%	$0.50	9%	$0.08	2%	$0.97	18%
Ohio	$7.77	$1.03	13%	$0.53	7%	$2.25	29%	$0.36	5%	$0.06	1%	$1.09	14%
Texas	$9.64	$1.82	19%	$0.77	8%	$1.60	17%	$0.76	8%	$0.20	2%	$1.33	14%
Wisconsin	$3.03	$0.26	9%	$0.20	7%	$0.78	26%	$0.03	1%	$0.03	1%	$0.39	13%

Source: Centers for Medicare and Medicaid Services, Medicaid Program Statistics, FY 2000

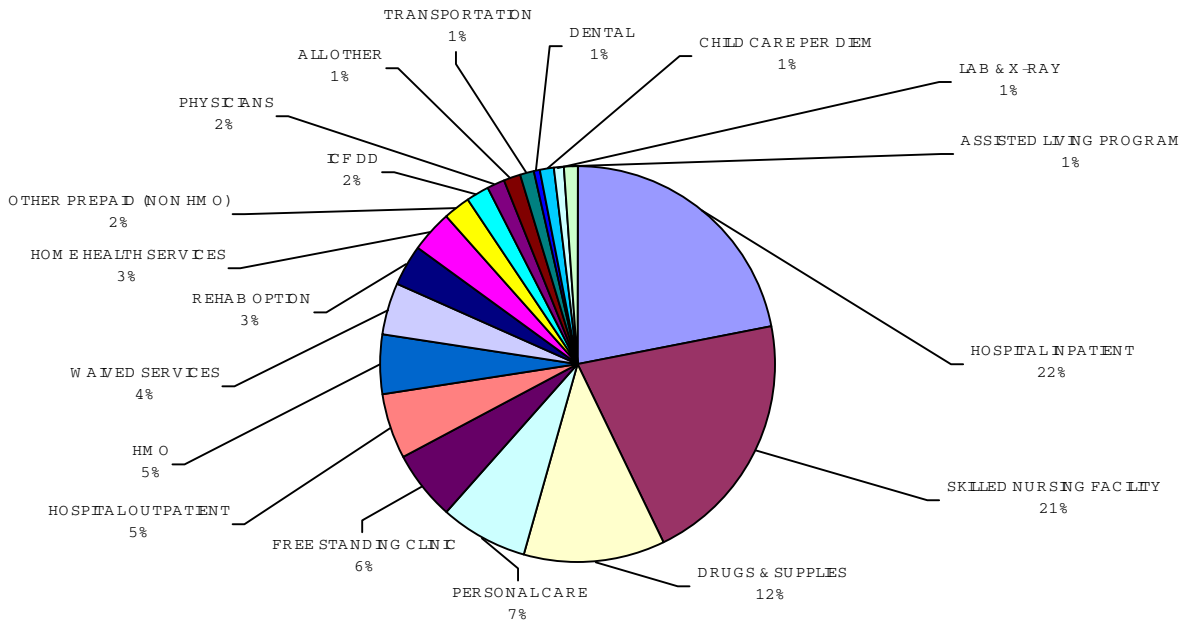
As illustrated in Figure 8, the vast majority of Medicaid funds in New York State (excluding New York City) in 2001 were paid directly for services provided to recipients (fee-for-service.) Less than 10% of Medicaid expenditures supported managed care services (pre-paid.)

Figure 8: Medicaid Expenditures, Rest of the State, CY 2001



As illustrated in Figure 9, three categories are the primary cost drivers for Medicaid spending: skilled nursing facilities, hospital inpatient and prescription drugs. Together, they represent over half of all fee-for-service Medicaid spending in New York State (55%). Each of these cost categories is addressed in greater detail in separate, subsequent chapters in this report.

Figure 9: Total New York State Medicaid Spending by Category, CY 2001

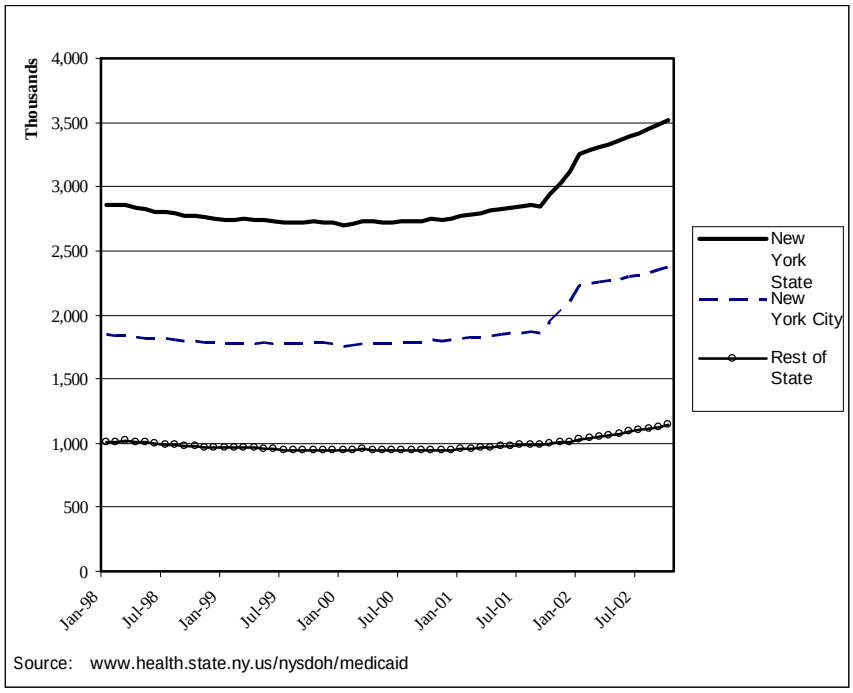


Source: NYSDoH:Medicaid Expenditures for Selected Categories of Service by Category of Eligibility, Calendar Year 2001

Medicaid cost increases reflect a combination of changing enrollment demographics and overall health care cost inflation. Using data available from the New York State Department of Health, Figure 10 illustrates the large increase in Medicaid enrollments since autumn 2001 in New York State. A combination of factors explains this sudden increase in Medicaid enrollments. Child Health Plus and Family Health Plus expanded enrollment and also helped identify and enroll people eligible for traditional Medicaid. The economic downturn made more people income-eligible for Medicaid benefits. In addition, in New York City, people affected by the September 11 terrorist attack were

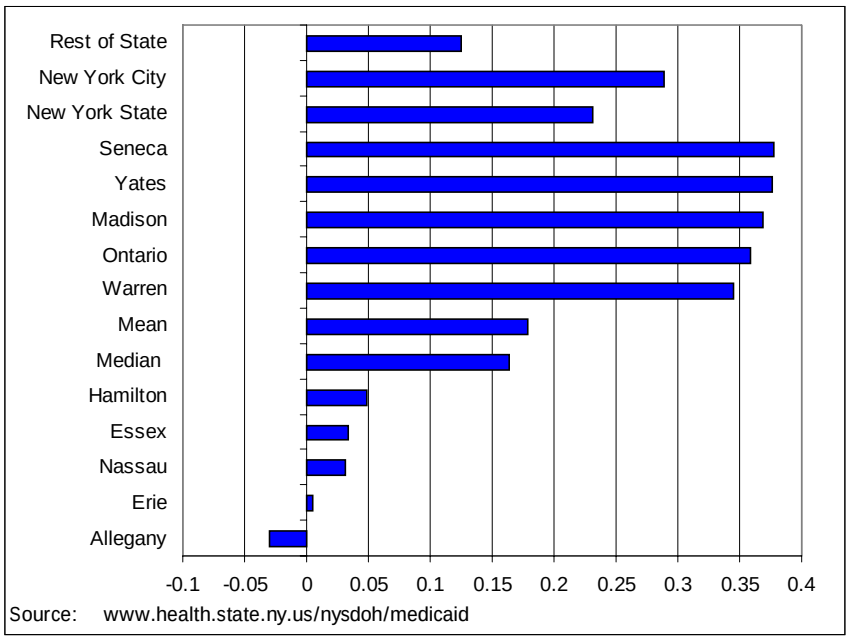
eligible for emergency Medicaid, with fewer documentation requirements. As Figure 10 illustrates, increases in enrollment in New York City have driven a large portion of the statewide Medicaid enrollment increases.

Figure 10: Total Number of Medicaid Eligibles January 1998- October 2002



However, Upstate New York has also seen its share of enrollment increases. Figure 11 shows the Upstate counties with the largest and smallest changes in Medicaid enrollment between January 1998 and October 2002. Allegheny is the only county in the state to experience an enrollment decline during this period. Partially explaining this decline, perhaps, is the fact that Allegheny experienced a 1.1% population decline between 1990 and 2000, according to Census figures. Similarly, Erie County also lost population recently, which may partially account for the county's relatively small increases in enrollment. Statewide, enrollment increased 23% during this time period. Upstate overall had a 12% increase in Medicaid enrollment, with Seneca leading the way with a 38% increase in enrollment. In fact, during this period, thirteen Upstate counties had percentage increases in enrollments equal to or higher than New York City, although New York City's larger absolute numbers clearly drove the statewide enrollment increases.

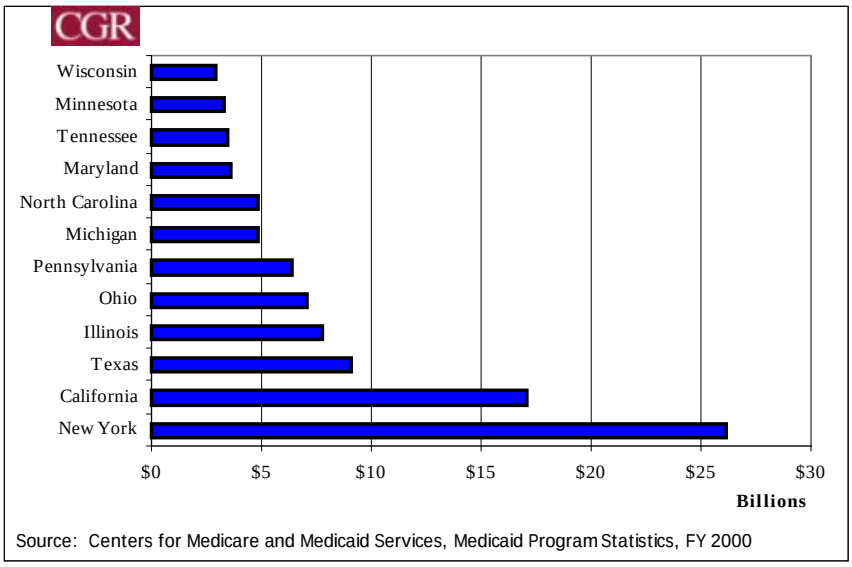
Figure 11: Counties with Highest and Lowest Percentage Change in Medicaid Enrollment, January 1998 –October 2002



Interstate Comparison

Total Medicaid spending in each of the comparison states is shown in Figure 12. New York State's FY 2000 spending was higher than those of the other states. In fact, New York State's spending was almost three times Texas' spending and $9 billion more than California's spending, despite the fact that both those states have a higher population than New York. Among New York and the eleven comparison states, median Medicaid spending was approximately $5.5 billion. In FY 2000, New York spent approximately $10 billion more on Medicaid than it spent in FY 1993.

Figure 12: Medicaid Expenditures Fiscal Year 2000



Source: Centers for Medicare and Medicaid Services, Medicaid Program Statistics, FY 2000

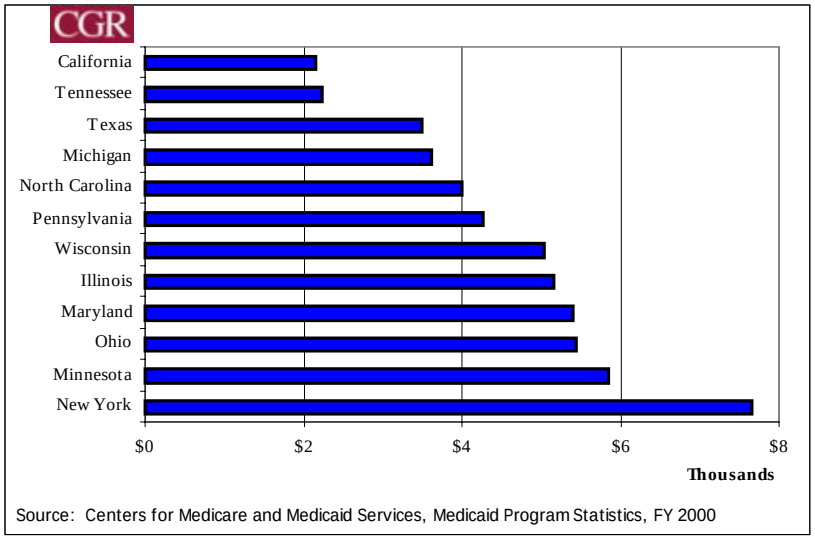
There are many possible reasons to explain the fact that New York has higher total costs, and it was beyond the scope of this project to research what factors are contributing to these costs. Some reasons suggested to CGR are that New York has a high proportion of AIDS patients, more elderly and more disabled people who qualify for Medicaid. New York may also have higher service quality standards, as well as an overall higher unit cost structure due to the underlying cost of doing business in the state, including higher salaries and benefits for service providers. These and other factors will skew average expenditures as well as total cost comparisons.

Total spending does not tell the whole story. More revealing is how much states are spending per recipient, per capita, as a percentage of gross state product and as a share of overall state spending. As detailed below, New York is a leader in these categories also, although to less of an extent than was true in FY 1993.

Figure 13 reflects spending per person enrolled in the Medicaid program. In FY 1993, New York State spent slightly over $6,000 per Medicaid recipient, compared to an average of less than $4,000 in the comparison states in FY 1993. By FY 2000, New York State was spending over $7,500 per recipient, compared to a

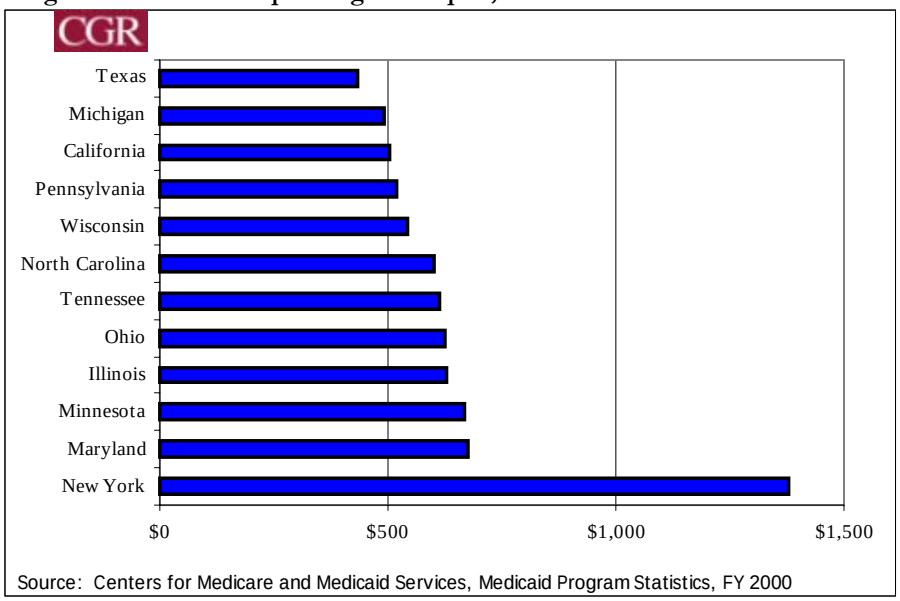
median of approximately $4,600. New York State spending per recipient is three times that spent in California and almost twice the spending in Texas.

Figure 13: Medicaid Cost Per Recipient FY 2000



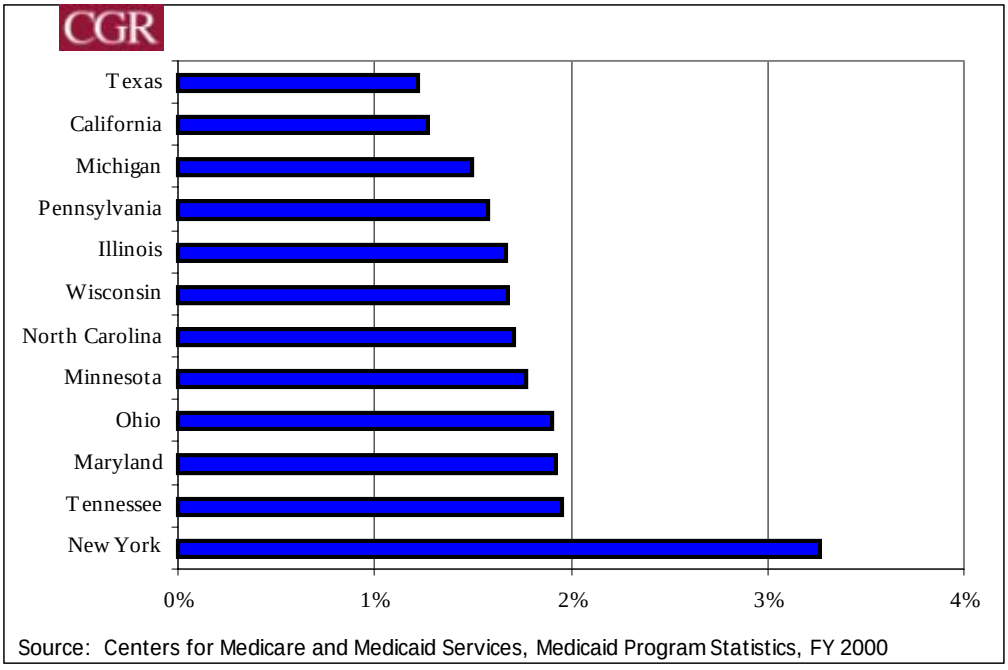
As in FY 1993, New York continues to be an outlier in per capita spending as illustrated in Figure 14. In 1993, New York spent $965 per state resident, almost three times the median spending on Medicaid per capita in the comparison states. The spending gap has decreased since then, however. In 2000, the state spent $1,378 per capita, still more than twice the median per capita spending of $607.

Figure 14: Medicaid Spending Per Capita, Fiscal Year 2000



Likewise, New York State led the comparison states in Medicaid spending as a percent of gross state product, in Figure 15. In FY 1993, New York State spent 3.8% of gross state product on Medicaid, compared to the median of 1.7% for the other states. By FY 2000, New York State had reduced its Medicaid spending as a share of gross state product to 3.3%, while the median of the comparison states remained 1.7%. Still, New York State's share is more than twice the median.

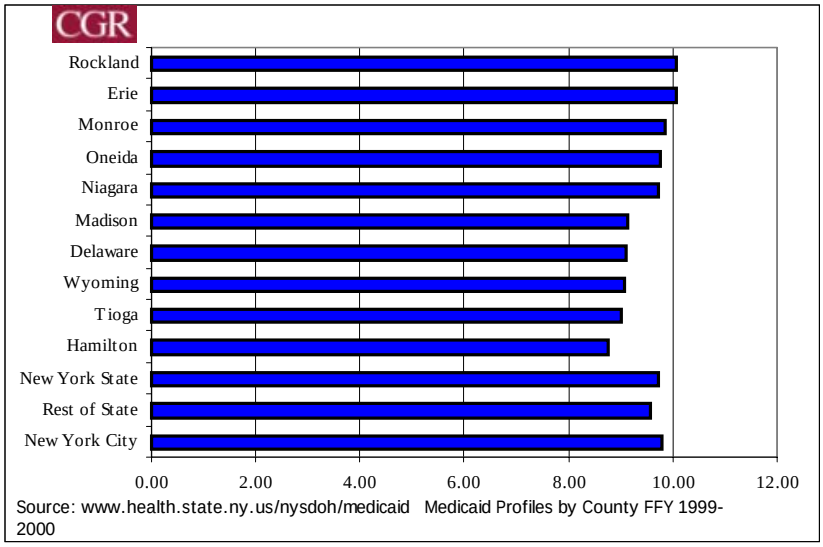
Figure 15: Medicaid Spending as Percentage of Gross State Product, Fiscal Year 2000



Source: Centers for Medicare and Medicaid Services, Medicaid Program Statistics, FY 2000

CGR also examined variations in Medicaid usage within New York State. One point of note is that most people enrolled in Medicaid remain enrolled for less than a year. The average length of eligibility is slightly over 9 months. In practical terms, this results in considerable paperwork for County Departments of Social Services as they enroll, dis-enroll and re-enroll individuals as circumstances change their eligibility status. As Figure 16 illustrates, there is relatively little variation among counties in the average length of eligibility for Medicaid recipients.

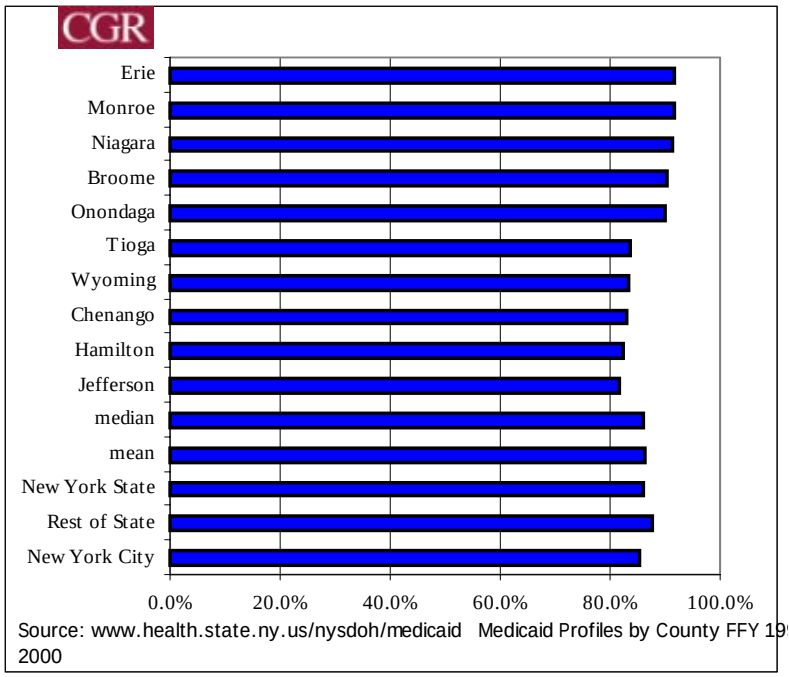
Figure 16: Counties with Highest and Lowest Average Length of Medicaid Eligibility, FFY 1999-2000



Most people enrolled in Medicaid (eligibles) use medical benefits (and thus are called "beneficiaries") at some point in time. In Upstate New York[2], the median percentage of people enrolled in Medicaid who use benefits is 86%. As Figure 17 illustrates, there is relatively little variation among counties in the percent of eligibles who are beneficiaries. In large counties, such as Monroe, Erie and Onondaga, over nine in ten people certified to receive Medicaid actually use services that are billed to Medicaid.

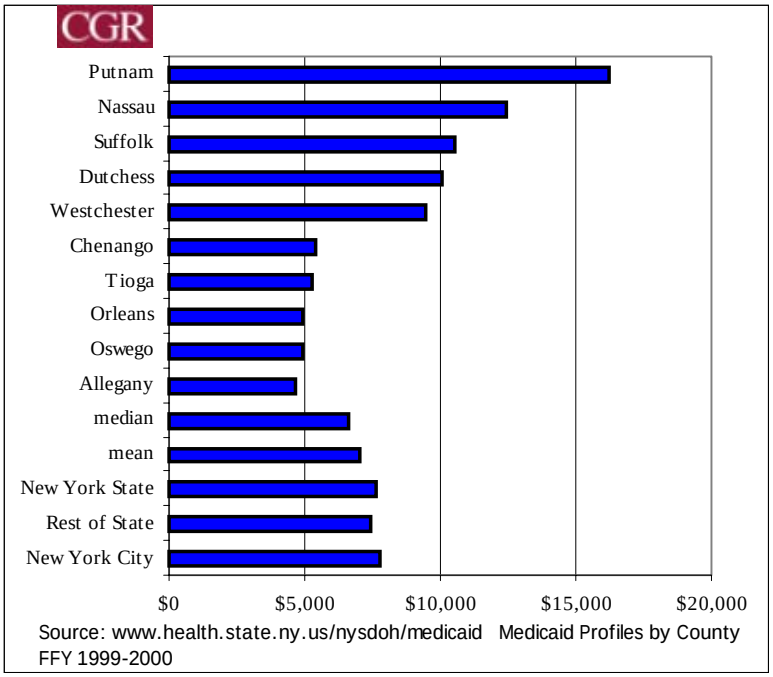
[2] We use the terms "Upstate New York" and "Rest of the State" interchangeably to refer to New York State excluding New York City.

Figure 17: Counties with Highest and Lowest Beneficiaries as a Percentage of Eligibles, FY 1999-2000



While there is little variation in the percentage of people enrolled in Medicaid who use health services, there is considerable variation in the cost per beneficiary across the state. As Figure 18 illustrates, the median cost per beneficiary in Upstate New York is $6,648, but costs range from $4,687 in Allegany County to almost four times that, $16,192, in Putnam County.

Figure 18: Highest and Lowest Costs Per Beneficiary FY 1999-2000



SELECTED MEDICAID SERVICES

Interstate Cost Comparison and Analysis

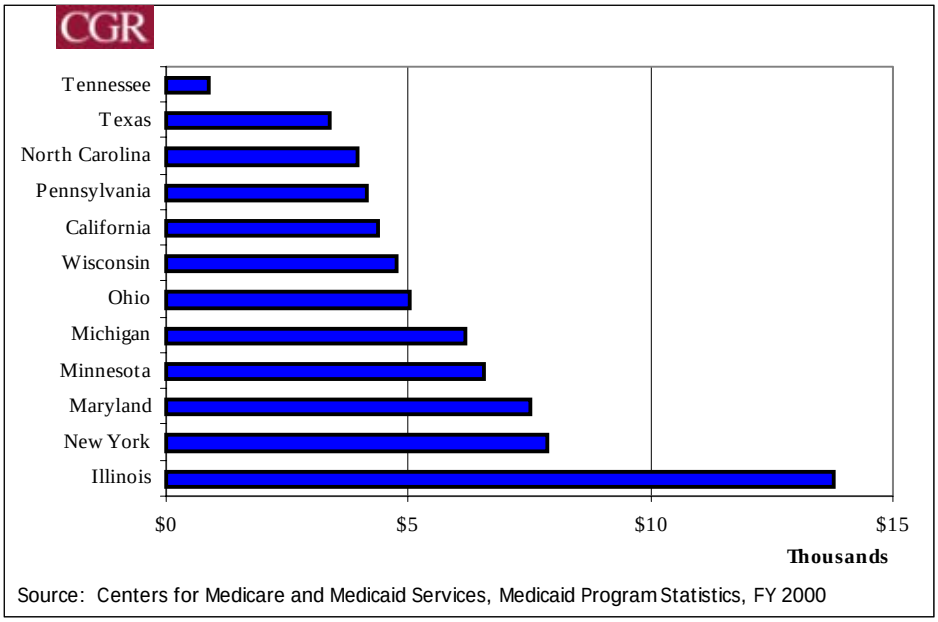
New York State has a large population and distinct demographic characteristics. Therefore, a comparison of cost per beneficiary is a useful way to benchmark the state. The next two graphs show Medicaid spending per beneficiary on two federally mandated services, inpatient and outpatient hospital treatment. As noted earlier, the extent to which states have moved their Medicaid population into capitated managed care will impact the spending they report in these categories. States often begin the shift toward managed care by moving the least costly recipients into HMOs, leaving the most expensive Medicaid recipients in fee-for-service programs. As a result, states in the midst of the shift to managed care may have a higher per beneficiary cost while these most costly beneficiaries remain in fee-for-service.

Inpatient Hospital Care

In 1993, New York led the group of comparison states, spending $8,000 per beneficiary for inpatient hospital care (total expenditures on inpatient hospital care divided by the number of recipients receiving inpatient hospital services). Surprisingly, despite health care cost inflation and other pressures, New York

continues to spend approximately the same amount per recipient in 2000. By contrast, Illinois is now the big spender in the group, averaging almost $14,000 per recipient (Figure 19). Still, New York remains above the median for the comparison group, which is $4,888.

Figure 19: Medicaid Inpatient Hospital, Costs per Recipient, Fiscal Year 2000

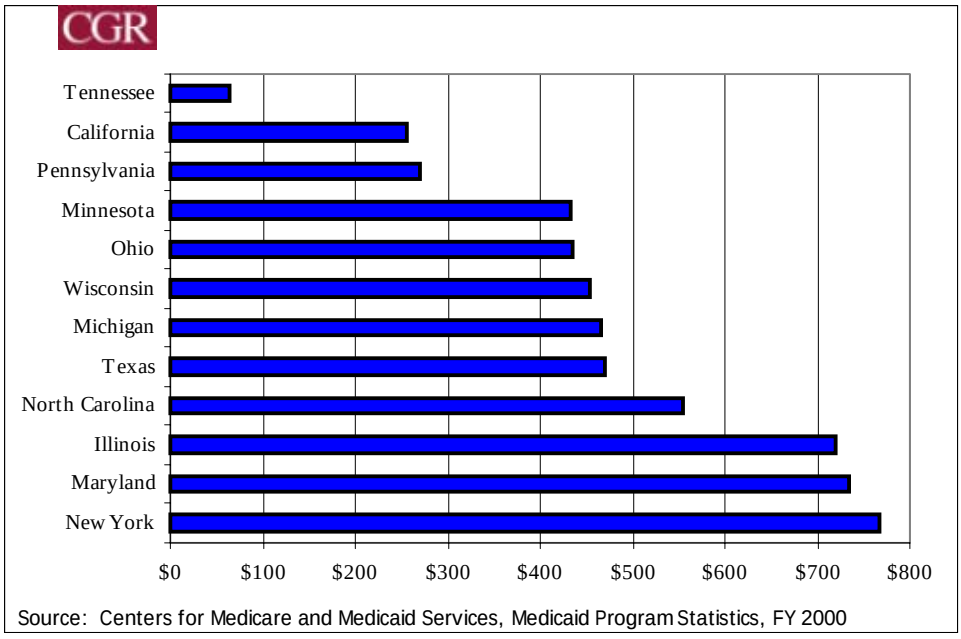


Source: Centers for Medicare and Medicaid Services, Medicaid Program Statistics, FY 2000

Outpatient Hospital Costs

New York and Maryland continue to lead the comparison group in outpatient hospital costs per beneficiary (total expenditures on outpatient hospital care divided by the number of recipients receiving outpatient hospital services). Both states spent over $600 per beneficiary in 1993. By 2000, New York, Maryland and Illinois, each spent over $700 per beneficiary for hospital outpatient services, compared to a group median of $460 (Figure 20.)

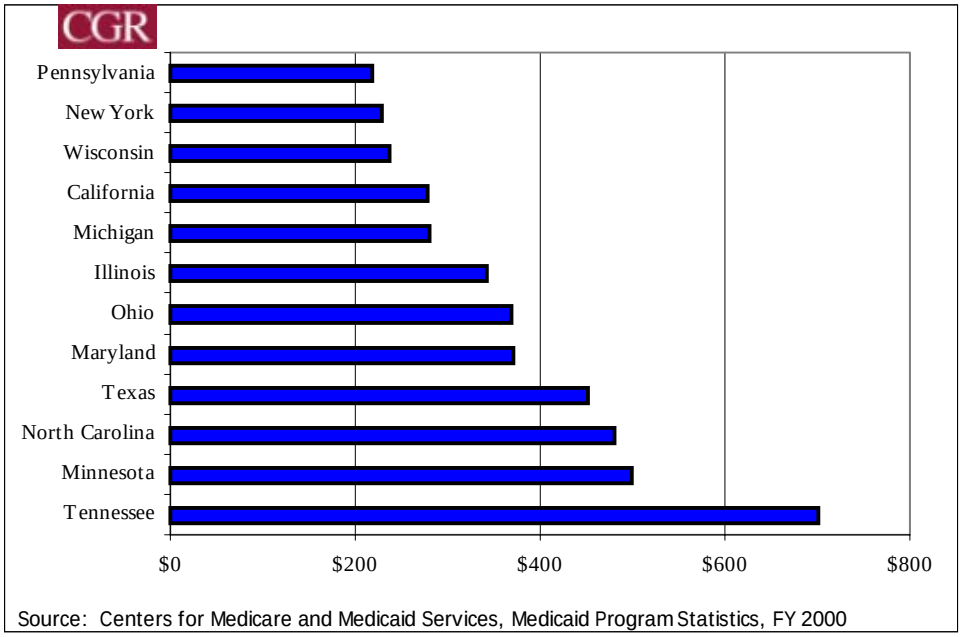
Figure 20: Medicaid Outpatient Hospital, Cost per Recipient, Fiscal Year 2000



Physician Services

New York continues to lag behind many other states in Medicaid physician reimbursements. As a natural consequence of lagging reimbursements, New York's physicians are less likely to accept Medicaid patients, and Figure 21 shows that Medicaid spending on physician services in New York is lower than in many other states. In FY 1993, New York spent less than $200 per recipient on physician services. By 2000, this amount had increased only slightly, to $228, more than $100 per recipient less than the median of the comparison states.

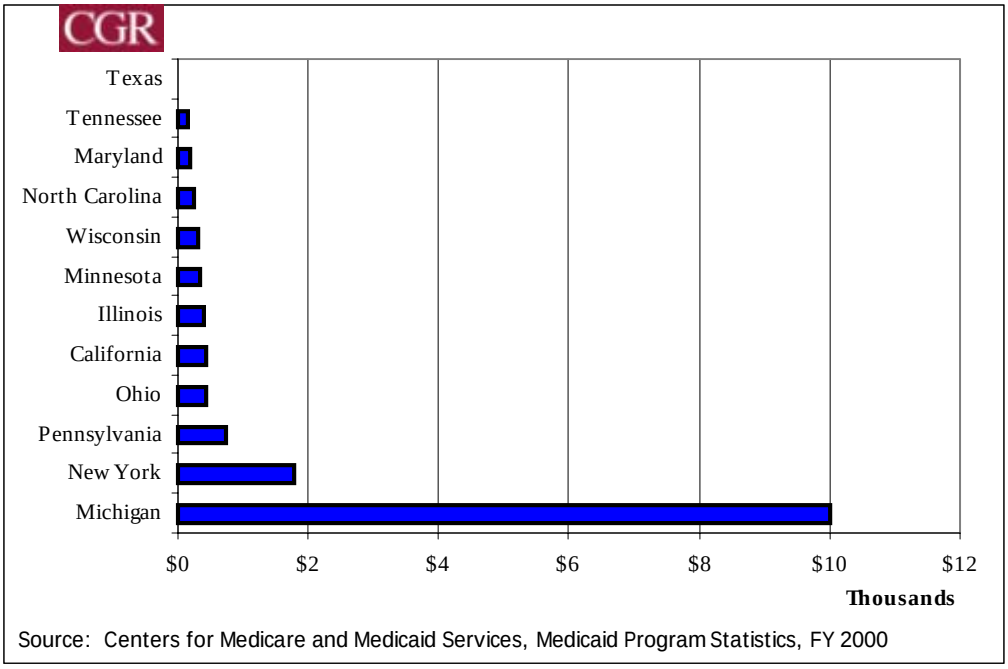
Figure 21: Medicaid Physician Services, Cost Per Recipient, Fiscal Year 2000



Clinic Services

Many services that would likely be provided by physicians if reimbursement rates were higher are provided at clinics at a higher cost. New York, as shown in Figure 22, spends more than most of the other comparison states on clinic services per recipient. In FY 1993, New York spent over $1,400 per recipient on clinic costs and in FY 2000, spent over $1,700 per recipient. However, in this category, Michigan is by far the biggest spender, averaging over $10,000 per recipient for clinic services, compared to a median for the comparison states of $374.

Figure 22: Medicaid Clinic Services, Cost Per Recipient, Fiscal Year 2000

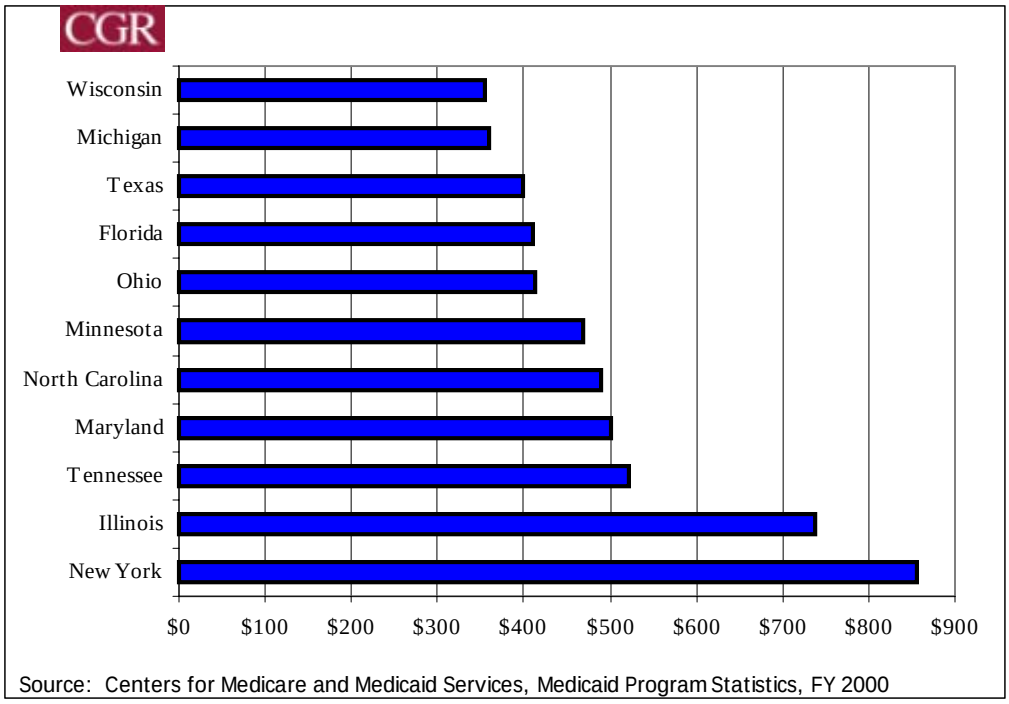


Source: Centers for Medicare and Medicaid Services, Medicaid Program Statistics, FY 2000

Clinic, Physician, and Outpatient Hospital

Clinic, physician and outpatient hospital services are somewhat interchangeable, and can be substituted for one another, so a comprehensive comparison of costs among states would look at the basket of all three services. At $1,868, New York spends the most per recipient for clinic services of the comparison states. Likewise, New York, at $852, has the second highest, after Illinois, per recipient spending on outpatient hospital services. In contrast, New York spends relatively little per recipient for physician services (see Figure 21). New York spends $259 per recipient for these services, the second lowest, after Wisconsin, of the comparison states. As Figure 23 illustrates, New York spends the most of the comparison states on these services combined.

Figure 23: Clinic, Physician and Outpatient Hospital Costs Combined per Recipient, FY 2001



Optional Services

In the 1995 report, CGR included a table illustrating the differences among the states with regards to which optional services are provided by each state. While the report that lists such comparisons (HCFA 2082) is no longer produced, CGR was able to find some information regarding optional services provided in different states. As Table 4 illustrates, New York is less of an outlier in 2002 than the state was in 1995. In only three cases (Private duty nursing, case management for primary care, and Critical Access Hospital) does New York provide optional benefits when less than three-fifths of other states do. In one case (private duty nursing), a majority of the states provide the service.

Table 4: Optional Services Provided by Eligibility Category, 2002

		All Categorically Needy		All Eligibility Groups		Other	NYS	Total
			with limits		with limits			
Licensed Practitioners	***Chiropractors***		2	2	28			32
	Podiatrists	1	4	5	36			46
	Optometrists	1	4	3	41		All Eligibility groups, with limits	50
	Psychologists	1	1	5	23	1	All Eligibility groups, with limits	32
	Nurse Anesthetist	1	1	10	16			28
	Private Duty Nursing		2	1	20	3	All Eligibility groups, with limits	27
	Physician Clinic Services	1	4	7	36		All Eligibility groups, with limits	49
Home Health Therapies	***Physical Therapy***	1	4	3	40		All Eligibility groups	49
	Speech and Language	1	5	2	39		All Eligibility groups	48
	Occupational	1	4	2	40		All Eligibility groups	48
	Audiology	1	4		38		All Eligibility groups	44
	Dental		4		40	1	All Eligibility groups, with limits	46
	Physical Therapy		3	4	34	1	All Eligibility groups, with limits	43
	Occupational Therapy		2	2	31	1	All Eligibility groups, with limits	37
	Speech Therapies		4	3	33	1	All Eligibility groups, with limits	42
	Prescribed Drugs	1	5	2	41		All Eligibility groups, with limits	50
	Denture		4	1	30	1	All Eligibility groups, with limits	37
	Prosthetic Devices		6	3	39	1	All Eligibility groups, with limits	50
	Eyeglasses		4		40	1	All Eligibility groups, with limits	46
	Diagnostic Services		4	6	22	1	All Eligibility groups, with limits	34
	Screening Services	1	2	5	22	1	All Eligibility groups, with limits	32
	Preventative Services	1	2	3	26	1	All Eligibility groups, with limits	34
Rehabilitation Services	***Mental Health Rehab***	1	3	2	36		All Eligibility groups, with limits	43
	Other Rehab		2	3	18			23
	Inpatient Hospital 65+ in Institutions for Mental Diseases	4	6	10	20	2	All Eligibility groups	43
	Intermediate Care for Mentally Retarded	3	6	12	25	3	All Eligibility groups	50
	Inpatient Psych >21	1	8	12	20	1	All Eligibility groups	43
	Personal Care Services		8	1	24	1	All Eligibility groups, with limits	35
	Home and Community- Based Services	All States (except AZ) provide at least some services.						
Case Management	***Targeted***		10	2	35	1	All Eligibility groups, with limits	49
	Primary Care		3	4	14		All Eligibility groups	22
	Hospice Care	5	2	11	24	1	All Eligibility groups, with limits	44
	Respiratory Care for Ventilator Dependent	1	2	4	7	1		15
	PACE	4		5	3	1		13
Other Services	***Religious Health Care***	1	1	5	6			13
	Transportation	1	3	2	37	3	All Eligibility groups, with limits	47
	Nursing Facility >21	2	7	11	26	2	All Eligibility groups, with limits	49
	Emergency Care (Non-Medicare participating hospitals)	1	2	13	19		All Eligibility groups, with limits	36
	Critical Access Hospital		1	5	13	1	All Eligibility groups	21

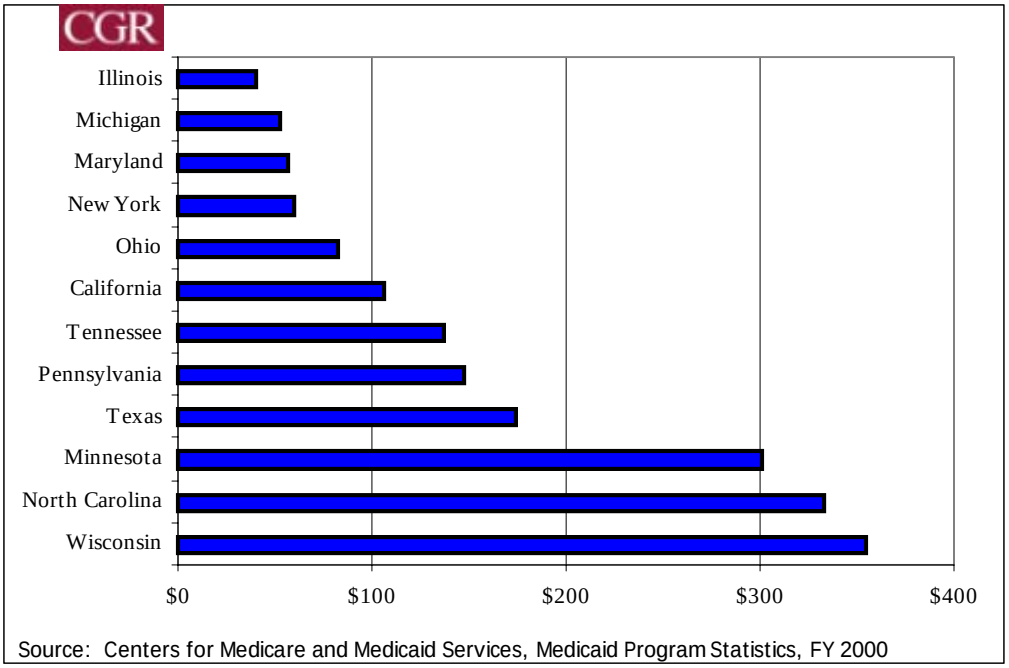
Source: Medicaid At-a-Glance 2002, Centers for Medicare and Medicaid Services
Available: http://cms.hhs.gov/states/maag2002.pdf

As Table 4 illustrates, many states offer optional health care services to their Medicaid populations. This report next looks at the costs of those services. The following two graphs detail Medicaid spending for individual optional services on a cost per recipient basis for fiscal year 2000.

Other Practitioners' Services

In fiscal year 1993, New York State led the comparison states by far in per recipient spending on Other Practitioners' Services. These costs fund medical services provided by practitioners other than physicians and registered nurses, such as optometrists. In fiscal year 1993, New York spent almost $800 per recipient on these services, while no other comparison state spent even $200 per recipient. As illustrated in Figure 24, by fiscal year 2000, the situation had changed. New York spent $60 per recipient for these services, compared to a comparison group median of $122. The big spender states in 2000 were Wisconsin, North Carolina and Minnesota, each of which spent over $300 per recipient.

Figure 24: Other Practitioners' Services, Medicaid Cost per Recipient, Fiscal Year 2000

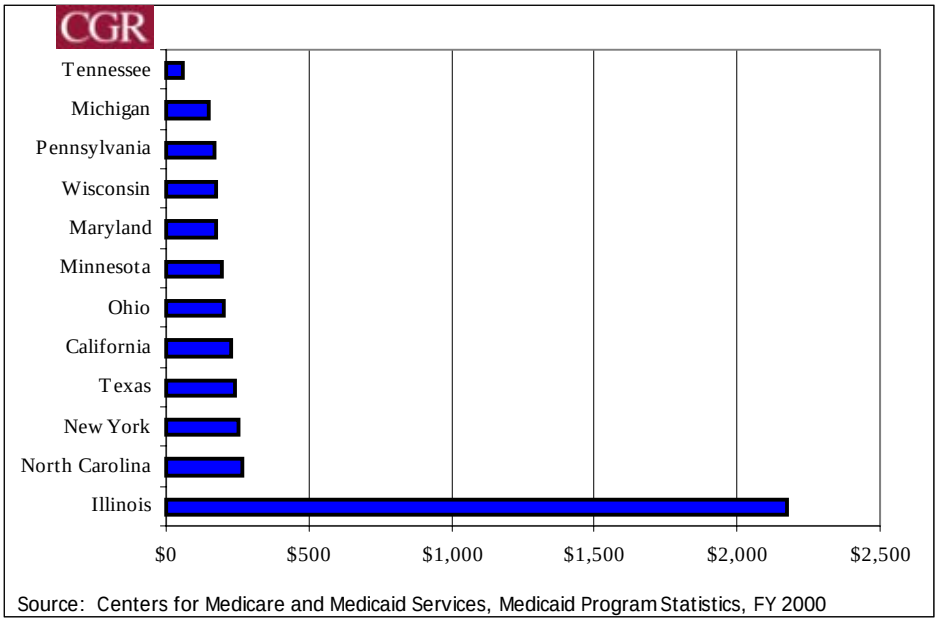


Source: Centers for Medicare and Medicaid Services, Medicaid Program Statistics, FY 2000

Dental Services

New York is among the mainstream in spending per recipient on dental services. In fiscal year 1993, New York spent about $175 per recipient, less than both Texas and California. In fiscal year 2000, New York spent $253, about $50 above the median for the comparison group states as illustrated in Figure 25.

Figure 25: Medicaid Dental Services, Cost Per Recipient, Fiscal Year 2000



County Comparison and Analysis

Counties in New York fund 10% to 25% of the Medicaid expenditures for their residents. While the county contribution is the same percentage across all counties, the cost and distribution of services varies widely across the state. This section of the report examines differences in spending on mandatory and optional health services in counties across New York State. For this analysis, New York City is listed separately and is excluded when calculating mean and median values for New York State counties. Only the remaining 57 "Upstate" or "Rest of the state" counties are included in the county-specific analysis.

Conditions are, of course, unique in each county. Generally accepted reasons for cost and expenditure variations include: local variations in state approved reimbursement rates, demographic and economic variations among counties, variations in access to service providers and differences in treatment patterns. However,

in addition, CGR has found clear differences among counties in how they utilize strategies to pro-actively manage Medicaid costs. An in depth examination of the details of Medicaid reimbursement and rate setting in each county for each service is beyond the scope of this report. The extreme variation in the per recipient cost of each service, however, clearly merits further attention as policymakers grapple with delivering services through Medicaid with greater efficiency. While New York counties cannot influence eligibility criteria or the package of services available to Medicaid recipients, counties can influence service patterns at the margins and allocate staff resources in ways that can impact Medicaid costs.

Based on what we know, CGR believes that the inter-county variations provide a strong argument for having the state take over all administration and funding of Medicaid. Consistent, statewide management of Medicaid would identify county and regional intake, cost and service variations and be able to take steps to equalize these differences toward the lowest cost common denominator. State-wide management would be able to focus on root causes of county and regional cost differences, to understand if variations are caused by demographic differences, availability of providers, regional business practices, etc., and could allocate resources regionally to change these factors to reduce Medicaid costs.

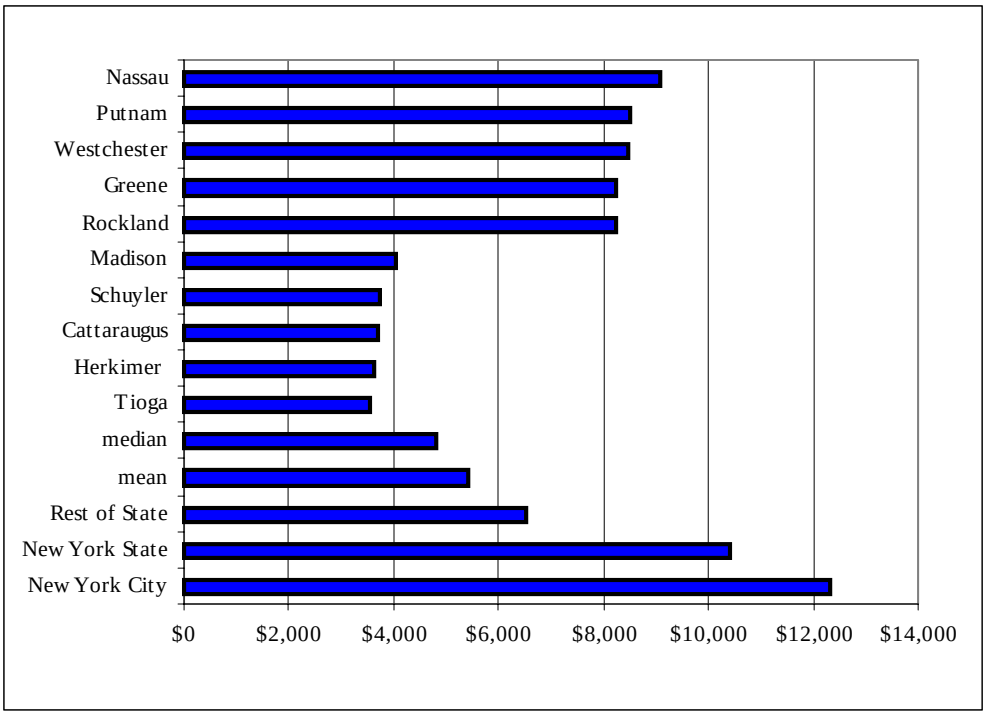
Inpatient Hospital

The cost per recipient for hospital inpatient services provided through Medicaid varies tremendously across New York State. As illustrated in Figure 26, the median cost of inpatient hospital care in New York State counties is almost $5,000 per beneficiary. Costs range from a high of over $9,000 in Nassau county to a low of slightly more than $3,500 in Tioga county. New York City inpatient costs per recipient are considerably higher than the rest of the state at over $12,000.

While superficially a high cost per beneficiary might raise concerns, it is possible that such high costs might actually reflect a conscious cost control strategy. For example, practices within a county might be to keep everyone but the most critically ill patients out of the hospital. In most cases, home care is less expensive than hospital care. At the same time, if only the sickest

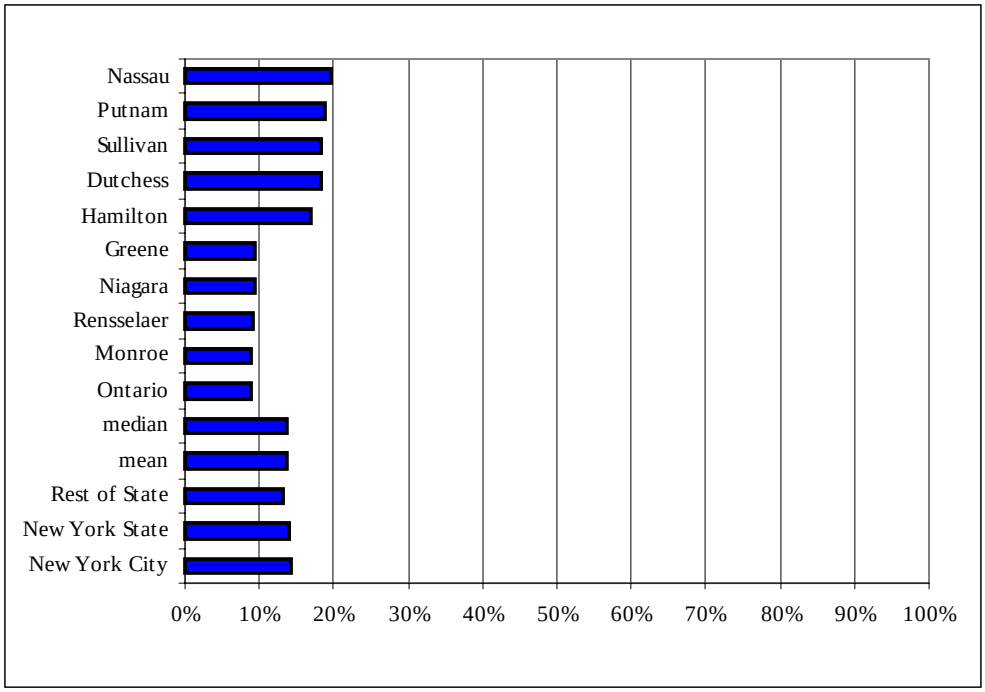
patients go to the hospital, their hospital inpatient bills will be high. Figure 26 also reflects the effect of managed care enrollments across counties. Managed care capitation rates cover hospital inpatient services, so only fee-for-service is reflected in Figure 26. Because managed care typically enrolls the healthiest categories of Medicaid eligibles, those who remain in fee-for-service tend to have higher per recipient costs.

Figure 26: Expenditures per Recipient for Hospital Inpatient care by County (5 highest and 5 lowest), Fiscal Year 2000



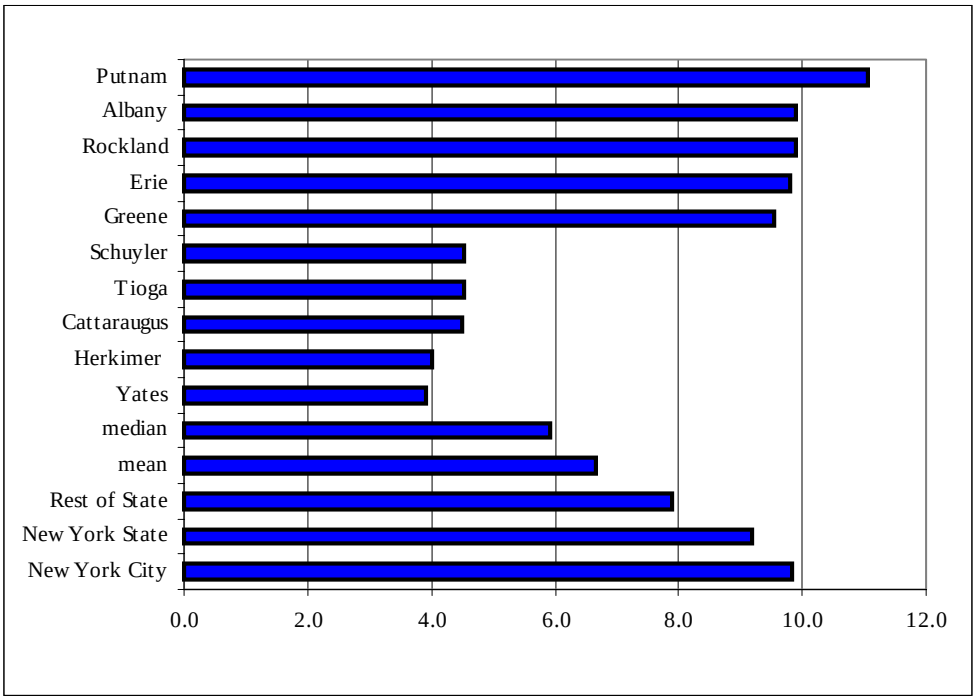
As illustrated in Figure 27, the large majority of people receiving Medicaid benefits do not use hospital inpatient services in a particular year. Slightly over one in ten people eligible for Medicaid actually uses hospital inpatient services each year. For Upstate counties, 13.6% is the median of beneficiaries as a share of eligibles and ranges from a high of 19.5% in Nassau county to a low of 8.8% in Ontario county. In New York City, 14.4% of Medicaid eligibles use hospital inpatient services, for an average cost of over $12,000 per recipient.

Figure 27: Percentage of Medicaid Eligibles using Hospital Inpatient Services by County (5 highest and 5 lowest), Fiscal Year 2000



The average length of stay in the hospital also varies across counties as illustrated in Figure 28. The median length of stay for Upstate counties is slightly less than 6 days, but ranges from a high of 11 days in Putnam county to a low of slightly less than 4 days in Yates county. In New York City, the average length of stay is almost 10 days (9.8 days).

Figure 28: Average Length of Stay for Hospital Inpatient Services by County, (5 highest and 5 lowest counties), Fiscal Year 2000



Dental Services

Considerable variation in dental costs exists across New York State counties, as shown in Figure 29. For example, the median cost per recipient for Upstate counties in $236, but counties spend as little as $135 in Tioga County and as much as $351 in Rockland County. On average, about one in five people receiving Medicaid benefits uses dental services during a year (see Figure 30). In Westchester county, 12.% of eligibles received dental benefits and in Rockland county, 29% of eligibles used dental benefits. Of those who use benefits, most have slightly more than 4 dental expenditures per year as illustrated in Figure 31, however, this ranges from a low of 2.9 in Onondaga county to a high of 6.1 in Nassau county.

Figure 29: Expenditures per Recipient for Dental Care by County, Fiscal Year 2000

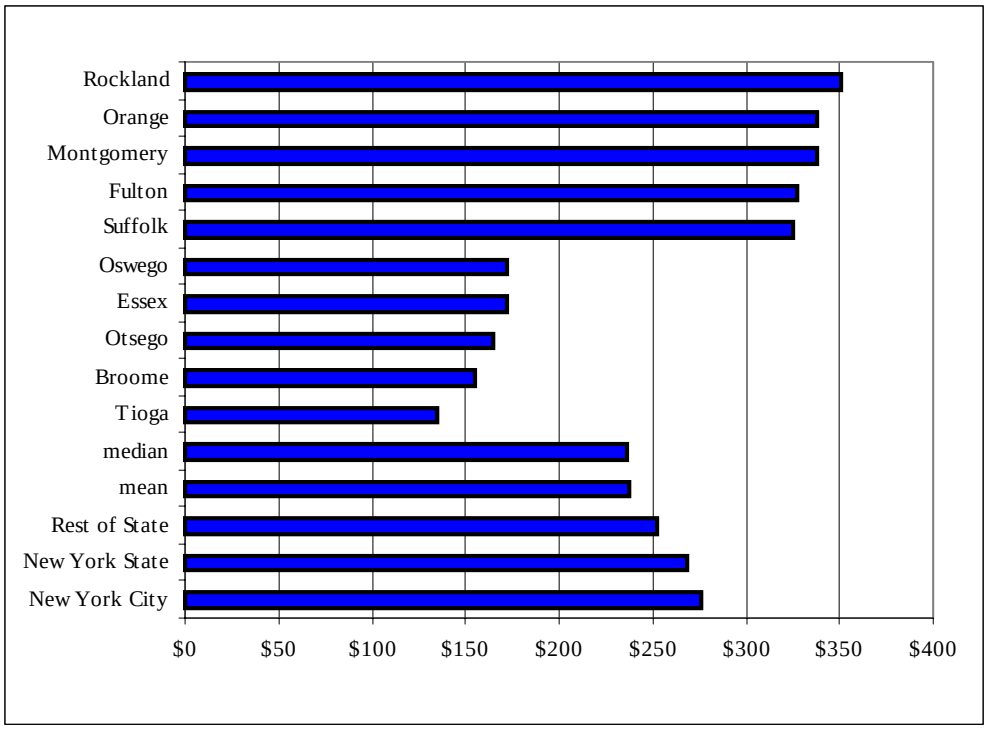


Figure 30: Dental Services, Beneficiaries as a Percentage of Medicaid Eligibles by County , Fiscal Year 2000

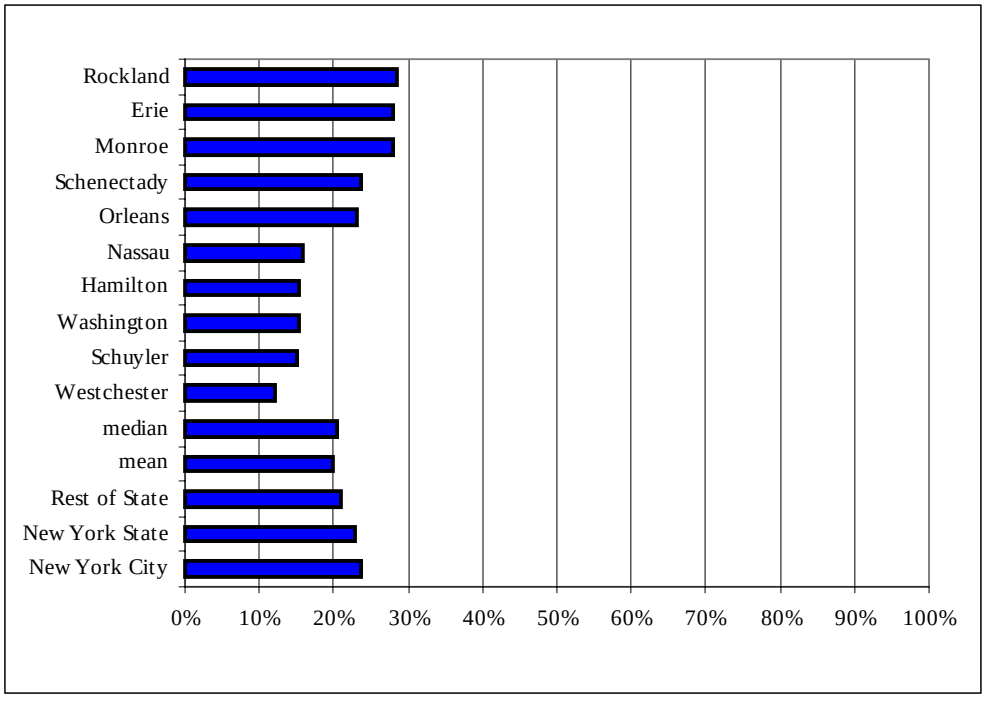
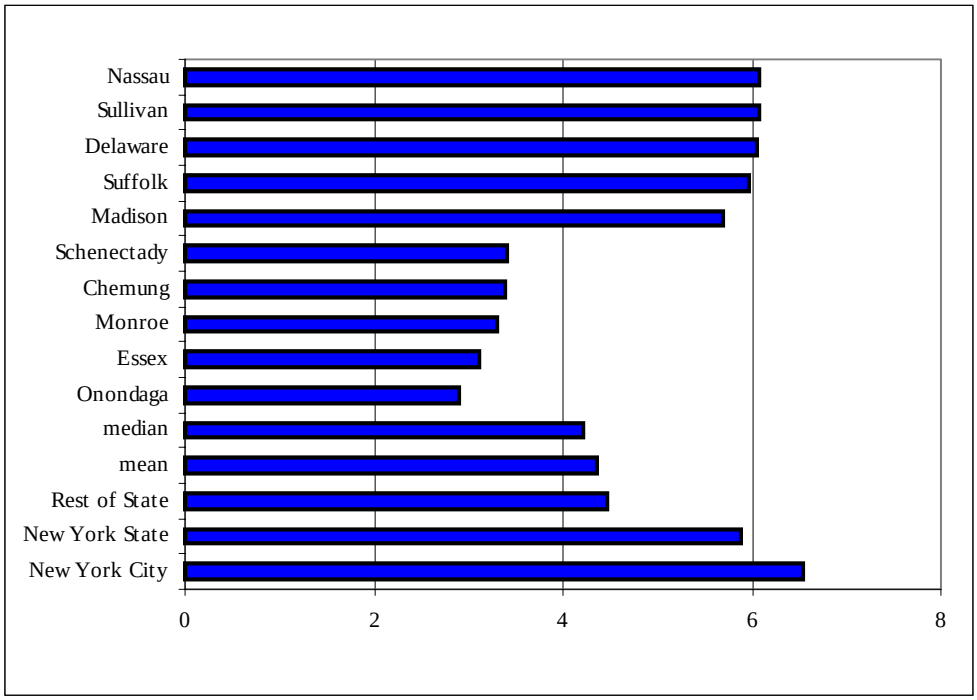


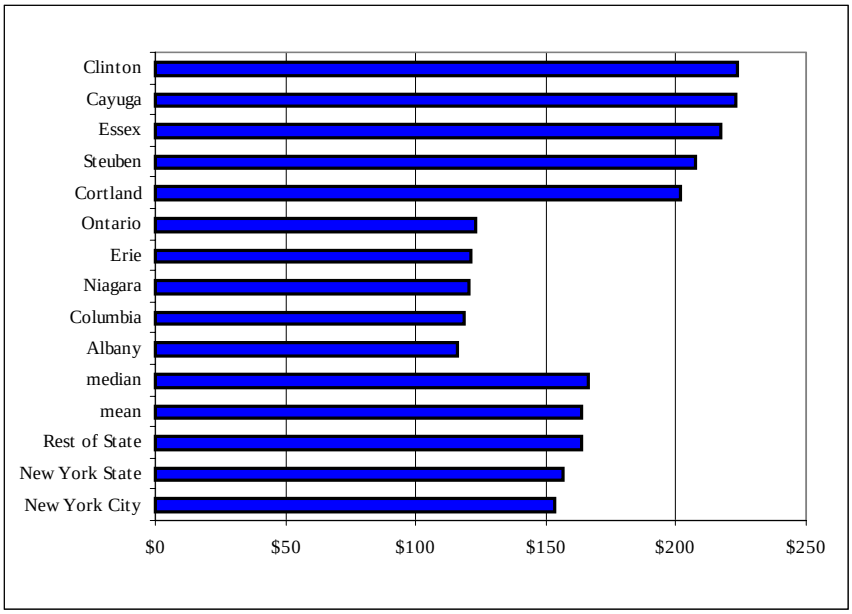
Figure 31: Service Units per Recipient by County, Fiscal Year 2000



Physician Services

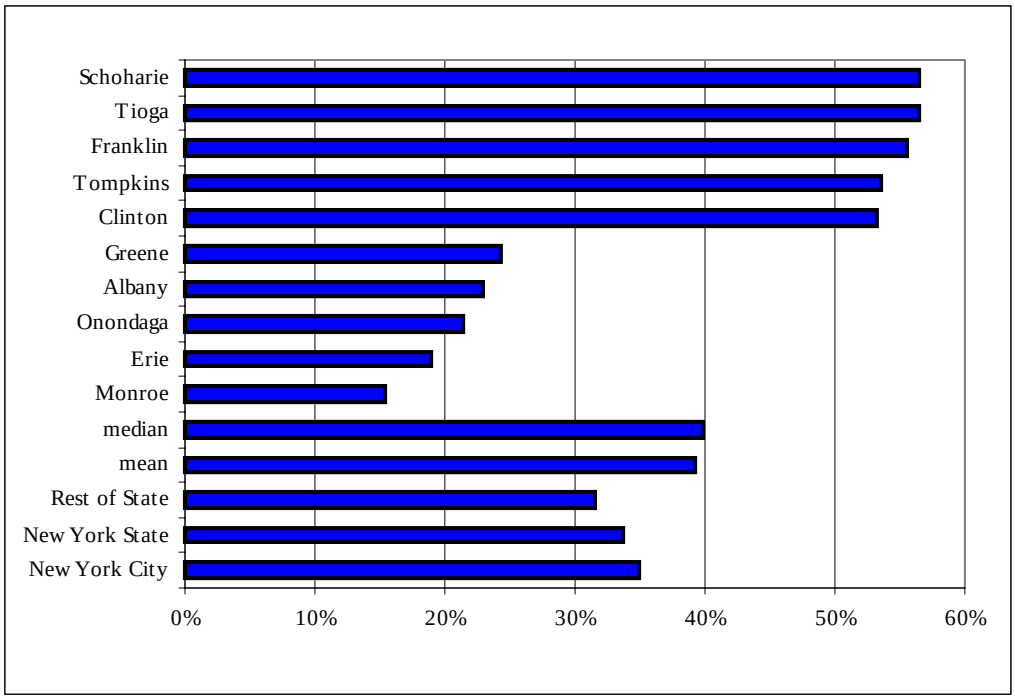
As detailed in the interstate comparison section, expenditures on physicians' services are relatively low in New York. Figure 32 illustrates variations in expenditures per recipient for primary care physicians across New York State counties. The median expenditure per user in Upstate counties is $166, but it ranges from $116 in Albany county to $224 in Clinton county.

Figure 32: Expenditures per Recipient for Primary Care Physicians by County, (5 Highest and 5 Lowest), Fiscal Year 2000



On average, slightly more than one in three Medicaid recipients visits a primary care physician during the course of a year, as illustrated in Figure 33. However, in Schoharie county, over half of recipients use primary care physician services each year while in Monroe County, less than one in five recipients do. However, it is important to understand that managed care affects how this data should be interpreted. For example, Monroe county has more recipients in managed care – so primary care physician visits are part of managed care rate and not broken out separately. Only fee-for-service recipients are reflected here.

Figure 33: Primary Care Physician Beneficiaries as a share of Total Medicaid Eligibles by County, Fiscal Year 2000

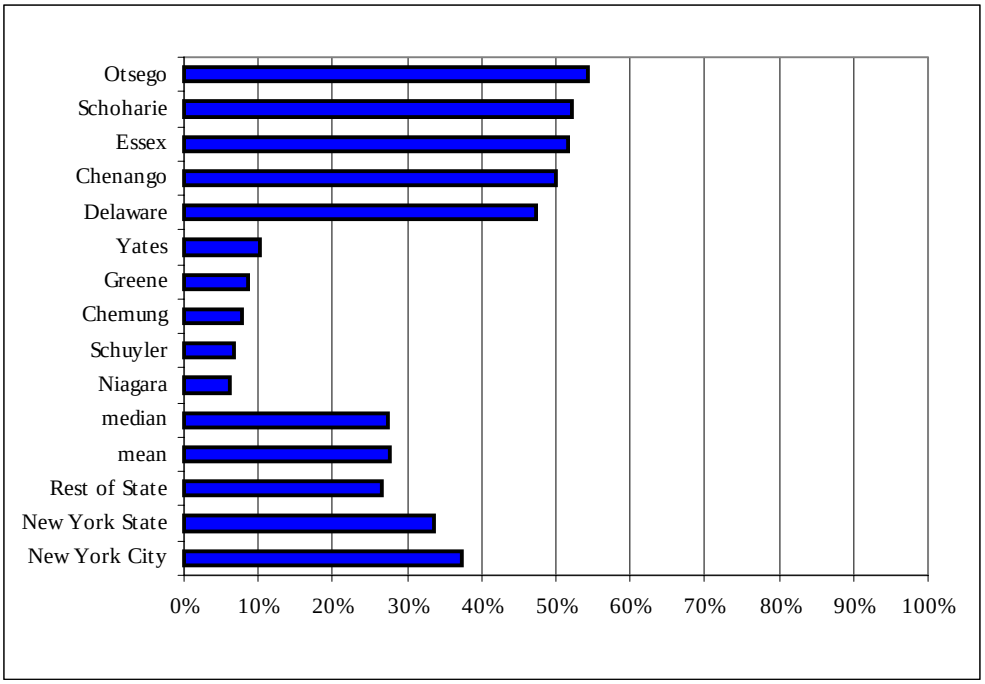


Of those Medicaid eligibles who use primary care physician services, the median number of visits in Upstate counties is slightly less than six. However, the number of visits ranges from a low in Erie county of 4.7 to a high in Jefferson county of 8.0.

Primary Care Clinics

Slightly over a quarter of people receiving Medicaid benefits use a primary care clinic as illustrated in Figure 34. In Otsego county, over half of people receiving Medicaid benefits used a primary care clinic over the course of 2000, while in Niagara county, only 6.2% of people receiving Medicaid benefits used a clinic. Of those who do use clinic services, the median number of visits each year for Upstate counties is slightly over 4. However, in Chemung county, the average number of visits was 2.4 while in Westchester county, the average number of visits was 5.6. Primary care clinic costs per recipient vary considerably. While the median expenditure per recipient in Upstate New York is $323, it ranges from $186 in Chemung County to $642 in Putnam County.

Figure 34: Users as Percent of Eligibles for Clinics - Primary Care by County, Fiscal Year 2000



Emergency Room Visits

Spending for emergency room visits is lower per recipient than spending for primary care clinics. In Upstate counties, the median cost per recipient for emergency room visits is $184. Spending ranges from $145 per beneficiary in Tioga county to $223 per beneficiary in Clinton county (Figure 35). Across Upstate New York, about one in five people receiving Medicaid benefits uses an emergency room over the course of a year. This percentage ranges from a high of 36.2% in Clinton county to a low of 8.6% in Rockland county (Figure 36). The number of visits is less variable. The median number of emergency room clinic visits in Upstate is 1.8 per user, and ranges from a low in Rockland county of 1.5 to a high in Clinton county of 2.2.

Figure 35: Expenditures per Recipient for Emergency Room Visits by County, fiscal year 2000

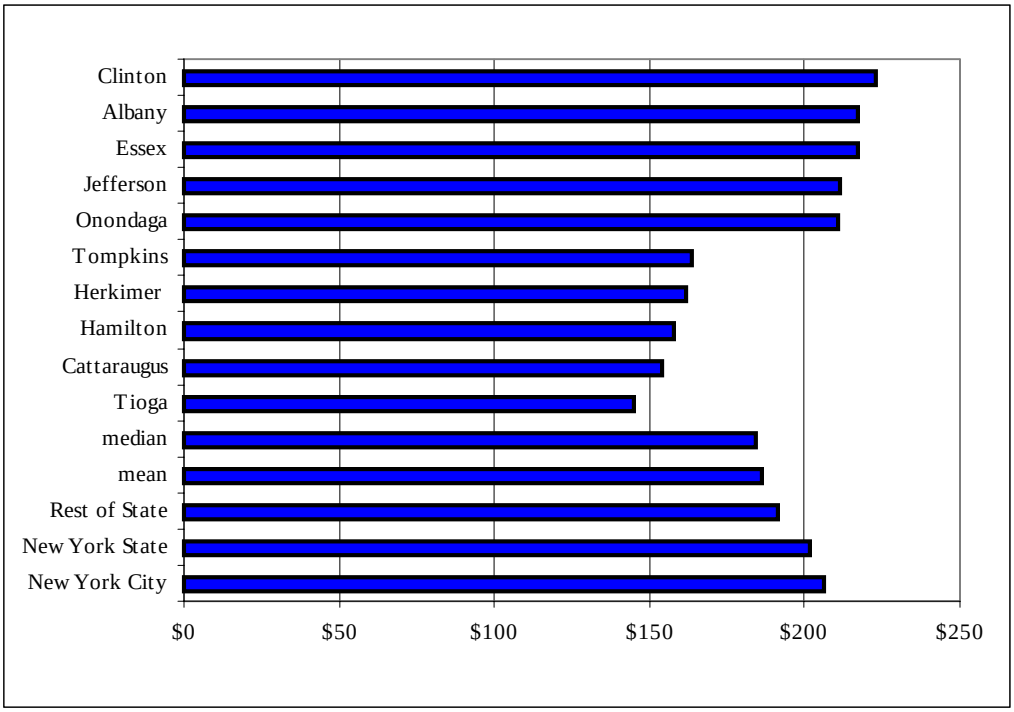
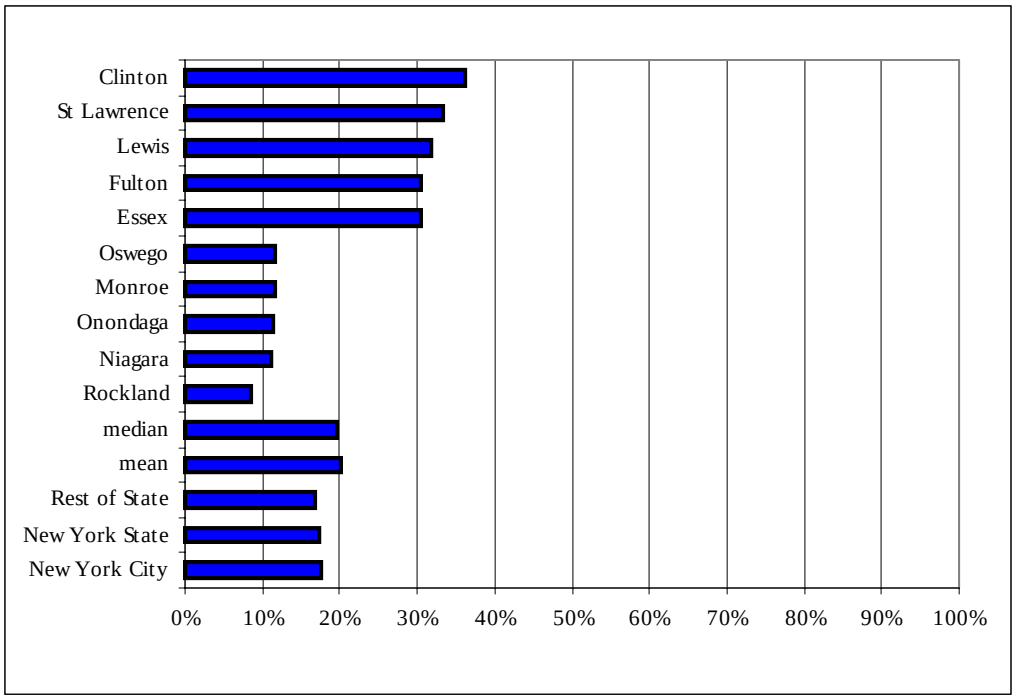


Figure 36: Users as Percentage of Eligibles for Emergency Room Visits by County, Fiscal Year 2000



MANAGED CARE

Since the 1990's, various states have encouraged both voluntary and mandatory enrollment of Medicaid recipients in systems in which the overall care of a patient is overseen by a single provider or organization. The hope is that the managed care concept will change those provider and recipient behaviors that contribute to rising costs under a fee-for-service system.

Since CGR's last report in 1995, all 50 states have adopted the managed care model in some form and applied it to at least a portion of their Medicaid population. In addition, states no longer need a waiver to institute Medicaid managed care. Despite the fact that all states now offer managed care, states vary widely in the percentage of their Medicaid population enrolled. In 1991, the New York State Legislature passed the statewide Medicaid Managed Care Act, designed to improve the delivery of quality, cost-effective health care through the expansion of managed care. The act encouraged local departments of social services to voluntarily participate in managed care and established participation goals that increase over time. New York State has been slow to move Medicaid recipients into managed care across the state. In addition, New York State exempts or excludes a portion of the Medicaid population from participation in a managed care plan. In contrast, by 2000, both Michigan and Tennessee had moved their entire Medicaid population into managed care.

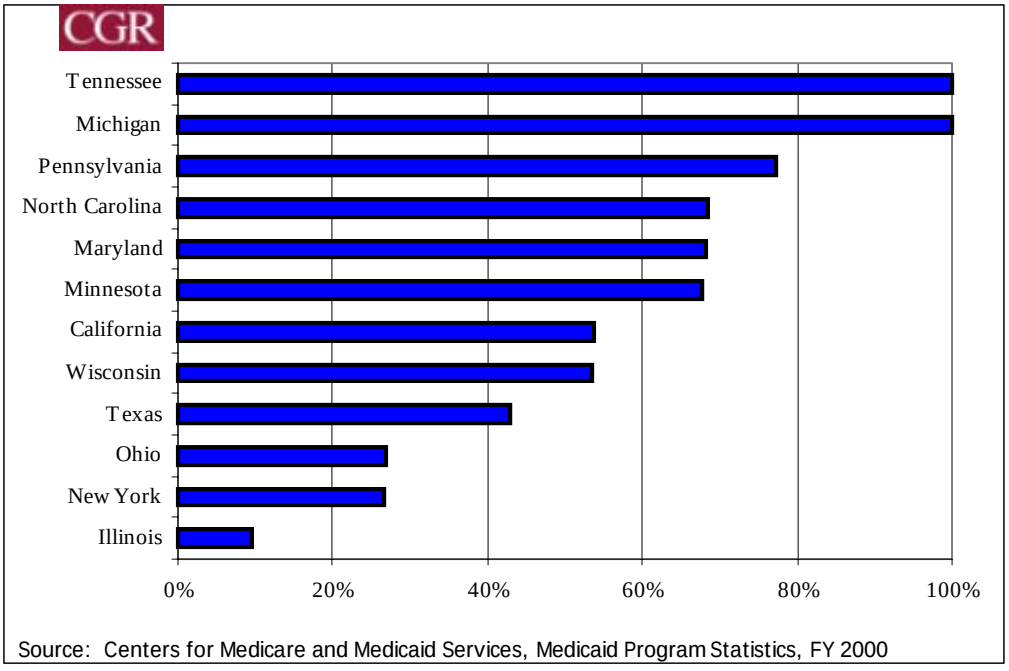
Interstate Comparison

Figure 37 shows the percentage of Medicaid eligibles enrolled in managed care by state for fiscal year 2000. As the figure illustrates, 100% of the Medicaid populations in Tennessee and Michigan have moved into managed care. The pace of change has varied significantly among states. In 1993, Tennessee had no Medicaid eligibles enrolled in managed care and Michigan had only slightly over 25% of the Medicaid caseload enrolled in managed care. That same year, New York had less than 5% of Medicaid eligibles enrolled in managed care, while by 2000 it had 27%. Of the comparison states, only Illinois has made little progress in

enrolling Medicaid eligibles in managed care. In both 1993 and 2000, Illinois had approximately 10% of the Medicaid population enrolled in managed care.

New York State has been slow to move Medicaid recipients into managed care, especially in New York City and rural parts of Upstate. Because New York City constitutes approximately two-thirds of the total Medicaid population in the state, difficulties there have had a large impact on the state averages. In addition, New York State, unlike comparison states, exempts or excludes a portion of the Medicaid population from participation in a managed care plan. In turn, these exemptions and exclusions reduce the total number of Medicaid recipients required to enroll in a managed care plan. (Note: exempt eligibles can enroll if a managed care plan offers coverage and they choose to participate. Managed care plans do not offer coverage for recipients in an excluded category.) For these reasons, New York has a relatively small proportion of the Medicaid population enrolled in managed care.

Figure 37: Percent of Medical Assistance Eligibles enrolled, Fiscal Year 2000



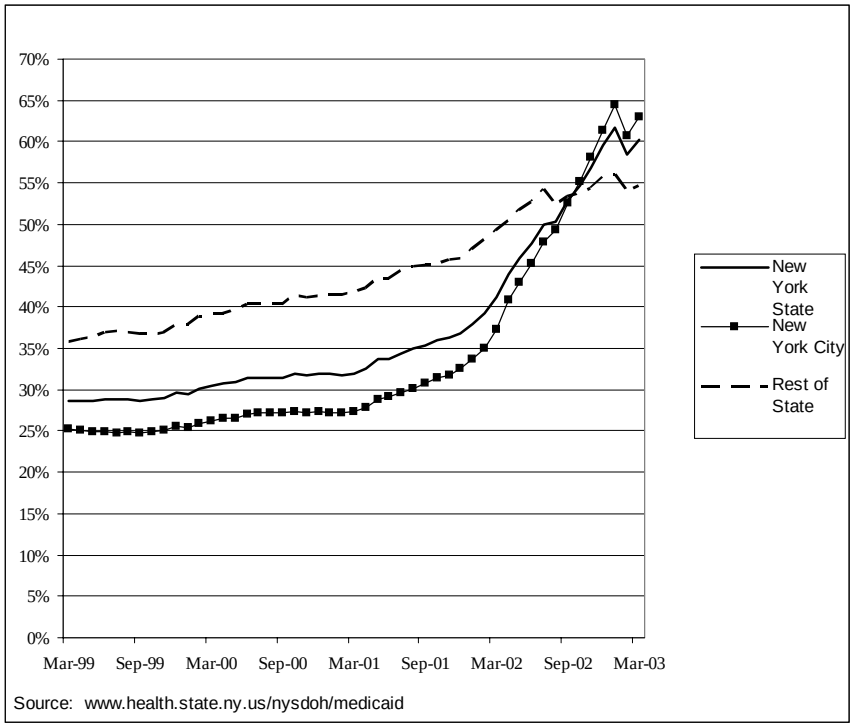
Source: Centers for Medicare and Medicaid Services, Medicaid Program Statistics, FY 2000

One example of New York's ability to increase federal funding for Medicaid (Medicaid "maximization") is that the state applied for and received a waiver to enroll Safety Net recipients in managed care plans. General assistance (Safety Net) recipients are not usually eligible for Medicaid benefits, so the state has managed to "Medicaid-ize" this population. Other states that provide health coverage for their general assistance population are paying for health care using state and/or local dollars exclusively. New York's strategy has been successful in obtaining federal dollars for these expenses.

County Comparison

Across the state, almost 2.5 million Medicaid eligibles are required to enroll in a managed care plan if one is offered in their community. As of March 2003, almost 1.5 million (60% of those eligible) were actually enrolled in managed care. Between 25% and 33% of the Medicaid population in each county is elderly and/or disabled and unlikely or unable to join a managed care plan. Between two-thirds and three-quarters of the Medicaid population in each county is children and able-bodied adults who are required to join a managed care plan if one is offered in the county where they reside. Medicaid recipients in a "mandatory" category may be unable to enroll if the county where they reside does not offer managed care. Figure 38 reflects trends in the percentage of Medicaid eligibles who could join a managed care plan who are enrolled with a managed care provider.

Figure 38: Percentage of Mandatory Medicaid Population Enrolled in Managed Care

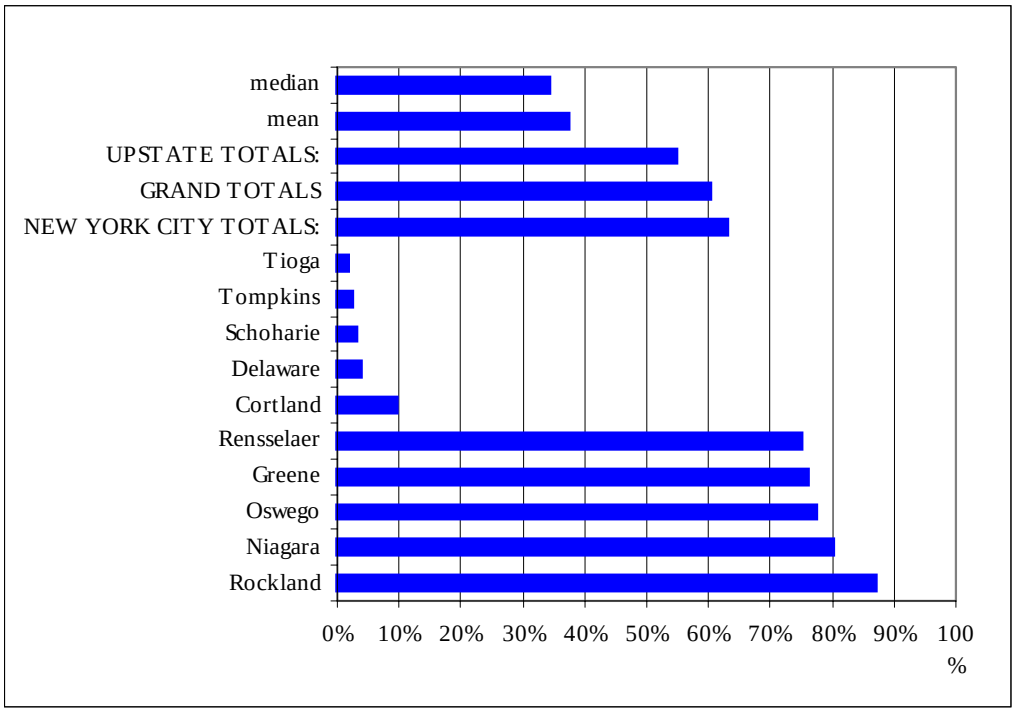


Considerable variation exists in enrollments across counties, as illustrated in Figure 39 below. Rockland, Niagara, Oswego, Greene and Rensselaer counties all have more than three-quarters of the eligible Medicaid population enrolled in managed care. However, Cortland, Delaware, Schoharie, Tompkins and Tioga counties have less than 10% of the eligible Medicaid population enrolled in managed care. Thirteen counties (Otsego, Cayuga, Chenango, Clinton, Essex, Franklin, Hamilton, Jefferson, Lewis, Madison, St. Lawrence, Schuyler and Wyoming) do not have the required two managed care providers and have none of their eligible Medicaid population enrolled in managed care.

Counties are required to have a minimum of two managed care plans offering benefits before they can implement mandatory enrollment. However, many rural counties have difficulty attracting two managed care plans to offer services. As a result, some counties still have not instituted mandatory enrollments and other counties have only recently begun enrolling Medicaid eligibles in managed care. This delay in finding providers is at least in part the reason for low managed care enrollments. CGR

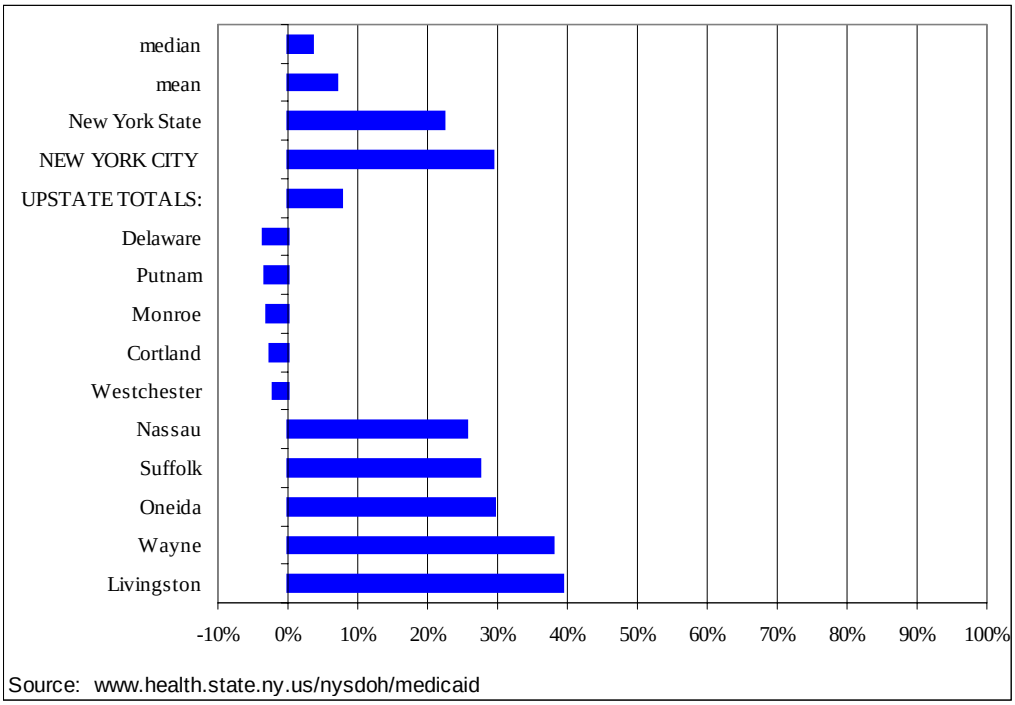
believes that this is another example of the opportunities for reducing costs through statewide management of Medicaid. A single administration could develop regional or state-wide incentives and/or regulations that could bring managed care plans into under-served areas.

Figure 39: Counties with the Greatest and Lowest Percent of the Eligible Medicaid Population Enrolled in Managed Care, March 2003



While many counties increased their percentage of the eligible Medicaid population enrolled in managed care from January 2002 to March 2003, six counties actually experienced decreases in the percent enrolled. Otsego, Westchester, Cortland, Monroe, Putnam and Delaware counties all experienced minor reductions in the percentage of the eligible Medicaid population enrolled in managed care as illustrated in Figure 40 below.

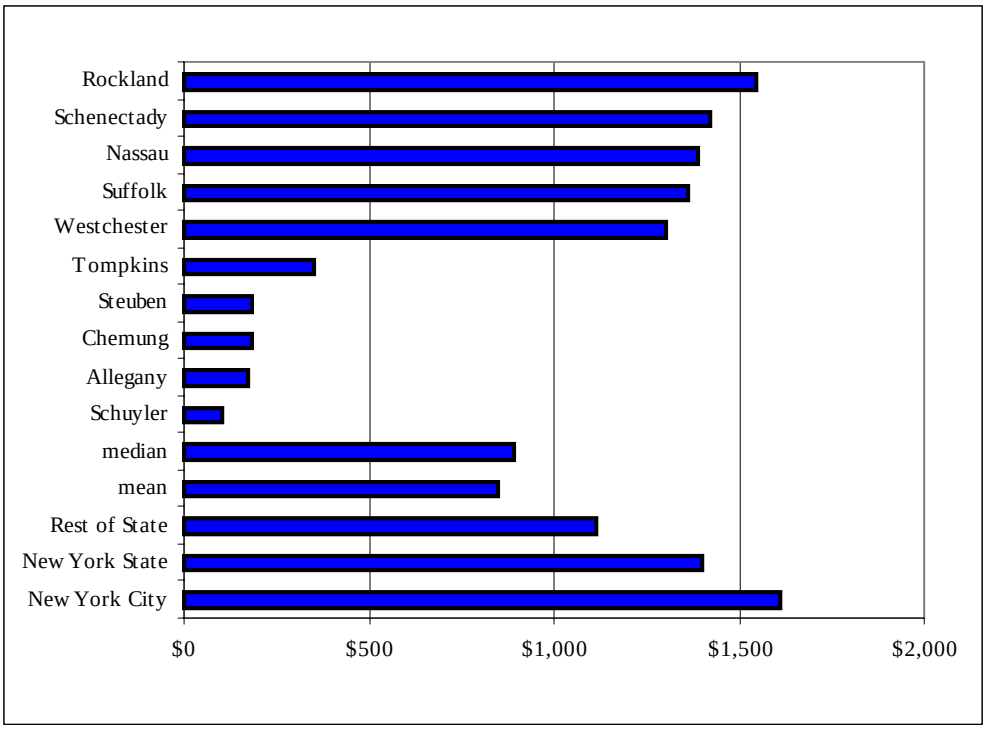
Figure 40: Counties with the Greatest and Smallest Percentage Change in Medicaid Managed Care Enrollments



Source: www.health.state.ny.us/nysdoh/medicaid

As illustrated in Figure 41, Upstate counties annually spend a median of $890 per managed care recipient. In 2000, however, these costs ranged considerably across the state. For example, Schuyler county spent only $100 per Medicaid recipient in managed care in fiscal year 2000, while Rockland county spent over $1,500 per recipient. Managed care expenditures are considerably higher in New York City, averaging over $1,600 per recipient. A portion of this variation is explained by the distribution of enrollments in the Medicaid program. A Medicaid caseload with more children would have a lower average cost than a caseload with more adults because capitation payments vary by age category. Maximum capitation rates are set by New York State, while counties have some discretion to negotiate within these parameters.

Figure 41: Expenditures per Medicaid Managed Care Enrollee by County, (5 highest and 5 lowest counties), Fiscal Year 2000

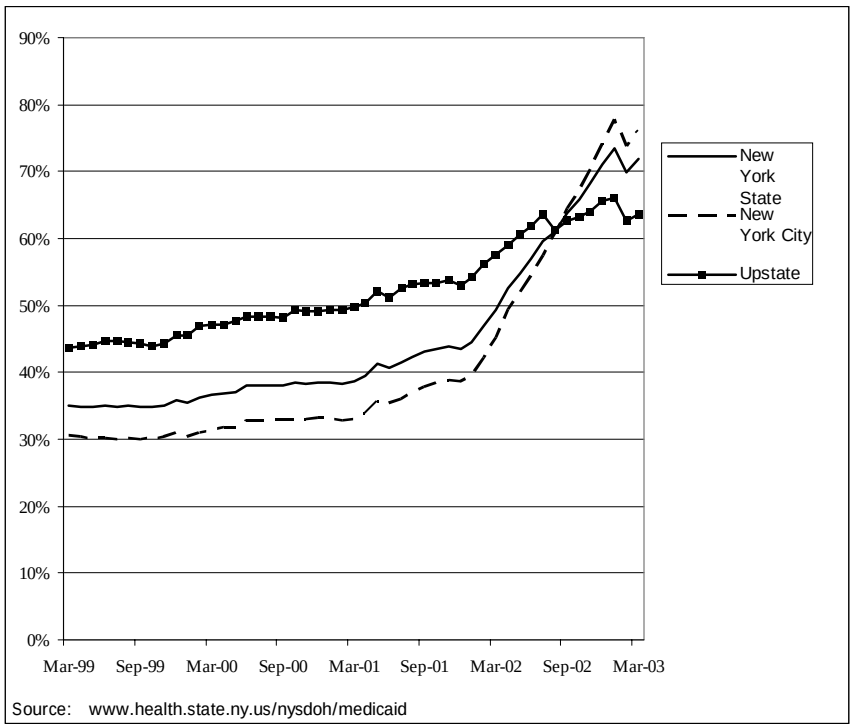


Most Medicaid managed care beneficiaries remain enrolled in the program for less than a year. For Upstate counties, the median number of months enrolled in managed care is slightly under 8. Still, there is considerable variation across the state, with Medicaid eligibles in Clinton county receiving managed care benefits for an average of 3.5 months, while Medicaid managed care enrollees in Chemung county remain enrolled for an average of over 9 months. As described earlier, New York State has divided the Medicaid population into various categories. Some categories are required to enroll in managed care to receive Medicaid benefits (the "mandatory" population). Others are either excluded (cannot enroll in managed care) or exempt (they can choose whether or not to enroll in managed care). Families and children receiving Temporary Assistance to Needy Families (TANF) or Aid to Dependent Children (ADC) are required to enroll in a Medicaid managed care program if it is available where they live.

For TANF ADC and MA ADC beneficiaries, a managed care mandatory population, over 70% of mandated participants statewide (over 1.2 million people) had joined a managed care plan

by March 2003 as illustrated in Figure 42. This group is often the first category of Medicaid recipients moved into managed care as they tend to be healthier overall and to require less health care. As the graph indicates, New York State does have a majority of these recipients in managed care, but in many other states, everyone in this category is in a managed care plan. The medical assistance ADC category consists of people who do not receive cash assistance, but are eligible for Medicaid. Some people in this category have a "spend down", for which it is particularly difficult to set a capitation rate.

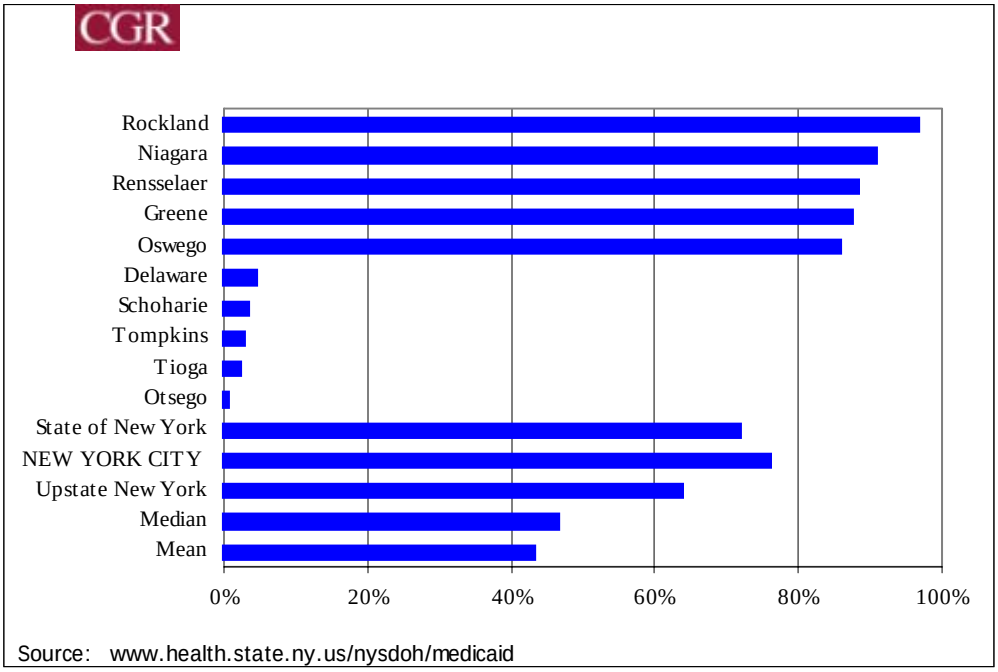
Figure 42: Percent of TANF ADC and MA ADC Medicaid Eligibles Receiving Cash Assistance Enrolled in Managed Care



Among Upstate counties, the median percentage enrolled for this population is 46% as of March 2003. As Figure 43 below illustrates, there is wide variation across New York State. Rockland and Niagara counties both have more than nine in ten members of this target population enrolled in managed care. At the same time, other counties have struggled to implement managed care, often due to a lack of managed care providers and an inability to provide recipients with a choice of providers. As of March 2003, Cayuga, Clinton, Chenango, Essex, Franklin,

Hamilton, Jefferson, Lewis, Madison, St. Lawrence, Schuyler and Wyoming counties had no one from this beneficiary category enrolled in managed care. Counties such as Otsego, Tioga, Tompkins, Schoharie and Delaware, have only recently begun to shift recipients into managed care. The New York State Department of Health currently provides technical assistance to these counties so that they can move a greater proportion of their Medicaid population into managed care.

Figure 43: Counties with Greatest and Smallest Percentage of Medicaid Eligibles Receiving Cash Assistance Enrolled in Managed Care



Statewide, there has been a 27% increase in enrollments in managed care by TANF ADC and MA ADC Medicaid recipients from January 2002 to March 2003. As Figure 44 below illustrates, Livingston and Wayne counties have both increased the percentage of TANF ADC and MA ADC Medicaid recipients enrolled in managed care by more than 40%. At the same time, several counties have actually experienced a decrease in the percent of TANF ADC and MA ADC Medicaid recipients enrolled in managed care. Putnam, Delaware, Cortland and Otsego all had a smaller percentage enrolled in March 2003 than they did in January 2002.

There is no definitive, generally accepted research that answers the question as to whether managed care saves counties money when applied to the Medicaid population. Putting a generally health population, such as low-income children and adults, into capitated managed care may cost more money than having them remain in fee-for-service because they are likely to use relatively few health services. Thus, the capitated fee may exceed the actual cost of services for most plan participants.

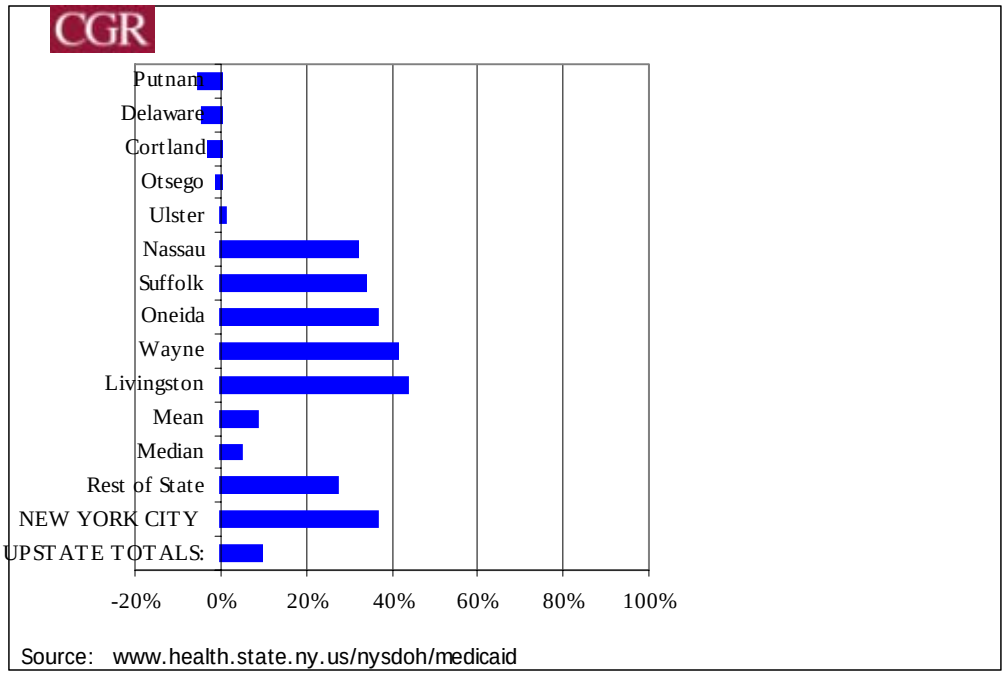
Managed care may be a cost efficient alternative to the traditional fee-for-service model, however, in New York, the mixed system of managed care and fee-for-service makes comparisons complex. Optional enrollment in managed care can lead to enrollment by those who are healthier and thus have lower average costs for their eligibility category. Further study would help determine what will happen to the total cost picture if the higher cost population is shifted from fee-for-service into managed care programs.

It is widely believed that moving Medicaid eligibles into managed care programs is a good strategy, and certainly that has been the case in the comparison states. The New York State Department of Health has a methodology to compare the cost of managed care services to equivalent fee-for-service services, and prepares this comparison for counties periodically. According to this calculation, for one upstate county CGR recently evaluated, the state estimated that the county saved $2.2 million in the most recent year through using managed care. These types of savings, spread across the state, likely run into hundreds of millions of dollars.

In voluntary managed care programs, often the healthiest consumers enroll in managed care, while those needing more medical care already have relationships established with health care providers and choose to remain in fee-for-service plans. New York State makes enrollment mandatory for certain Medicaid population categories in order to distribute the risk as much as possible. At the same time, it can be very difficult to estimate a fair capitation rate for disabled or elderly people, because their average health care costs can vary widely depending on the type of health care services they require. Currently in New York State, disabled people can voluntarily enroll in managed care, but are not

required to do so. Most elderly Medicaid recipients are not able to enroll in managed care.

Figure 44: Counties with Greatest and Smallest Change in Percentage of Medicaid Eligibles Receiving Cash Assistance Enrolled in Managed Care

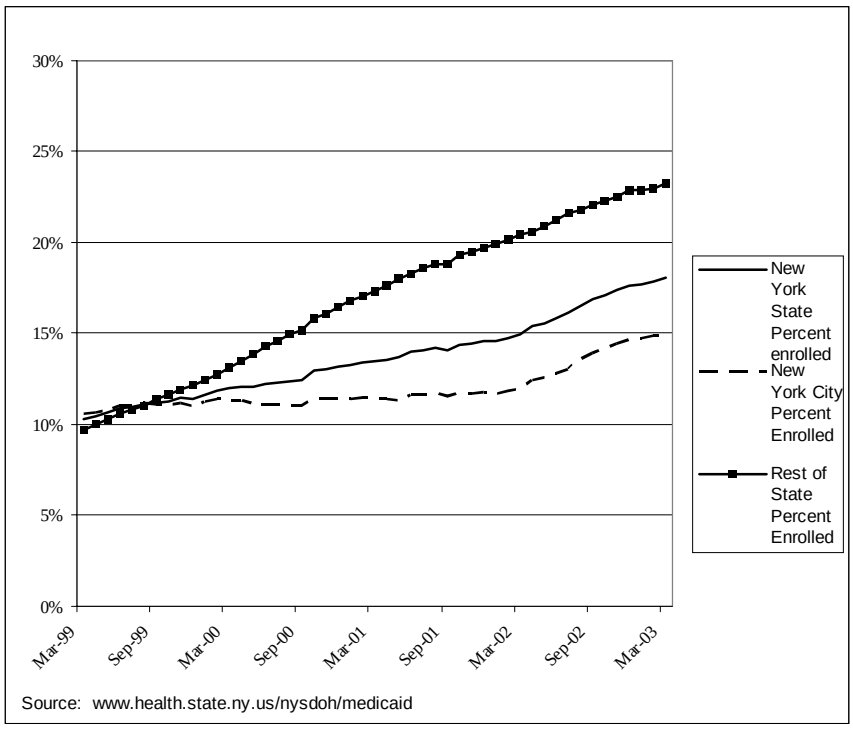


Managed care in the private sector has demonstrated cost savings over fee-for-service health care plans. Debate continues as to whether cost savings are realized when managed care is applied to the disabled or elderly populations. Because health care costs for these populations are generally higher on average, and because costs per recipient can range greatly (outpatient mental health treatment or outpatient physical therapy compared to nursing home care or day treatment for the developmentally disabled), it is more difficult to calculate the appropriate managed care capitation rate. Too high a rate will not produce cost-savings, but too low a rate will force managed care providers out of the market. Cost-savings are more likely to accrue if the managed care program is mandatory because it will distribute the financial risk across the entire population, rather than allowing selection bias. In addition, disabled Medicaid recipients may resist enrollment in a managed care plan if it restricts access to their current specialists.

Even with those considerations in mind, many states have moved these categories of Medicaid beneficiaries into managed care in an

attempt to reduce costs. In New York State, Medicaid recipients who are disabled are not required to join a managed care plan, but in most cases, have the option of doing so if they choose. Statewide, slightly less than one in four Supplemental Security Income Medicaid recipients was enrolled in a managed care plan as of March 2003, as illustrated in Figure 45. This represents over 71,000 Medicaid recipients.

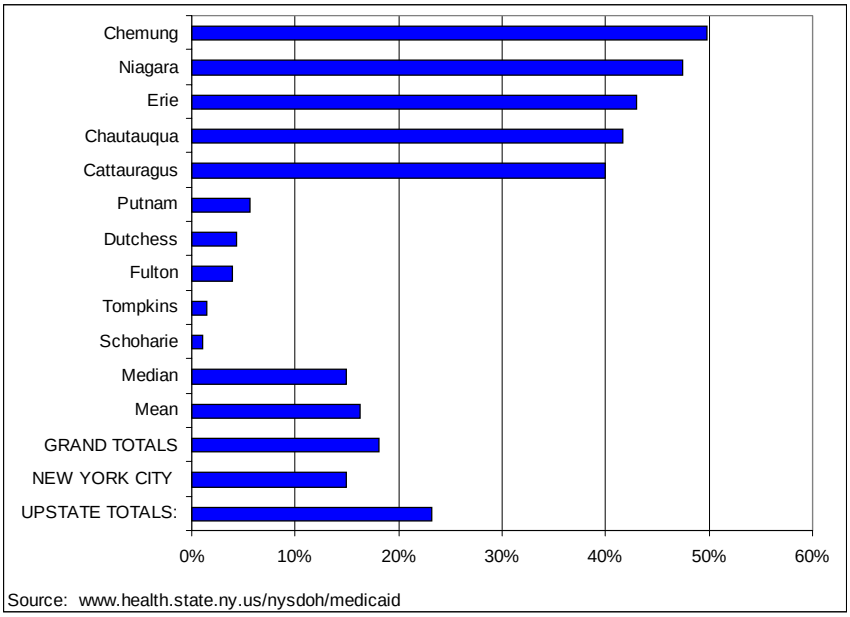
Figure 45: Percent of SSI Medicaid Eligibles Enrolled in Managed Care



Because Medicaid recipients in these eligibility categories are not mandated to participate in a managed care plan, counties can not require them to join, but can encourage them to do so. Likewise, managed care providers are not required to provide coverage to these categories of eligibles, but can negotiate capitation rates with counties if they choose to provide benefits. As a result, some counties have a much higher percentage of eligibles in these categories enrolled compared to other counties. As illustrated in Figure 46, for example, Chemung county has half its disabled Medicaid recipients enrolled in managed care and Niagara county

has almost half enrolled. In contrast, Schoharie and Tompkins counties each have only 1% enrolled[3].

Figure 46: Counties with Greatest and Smallest Percentage of SSI Medicaid Eligibles Enrolled in Managed Care (5 highest and 5 lowest counties), January 2002-March 2003

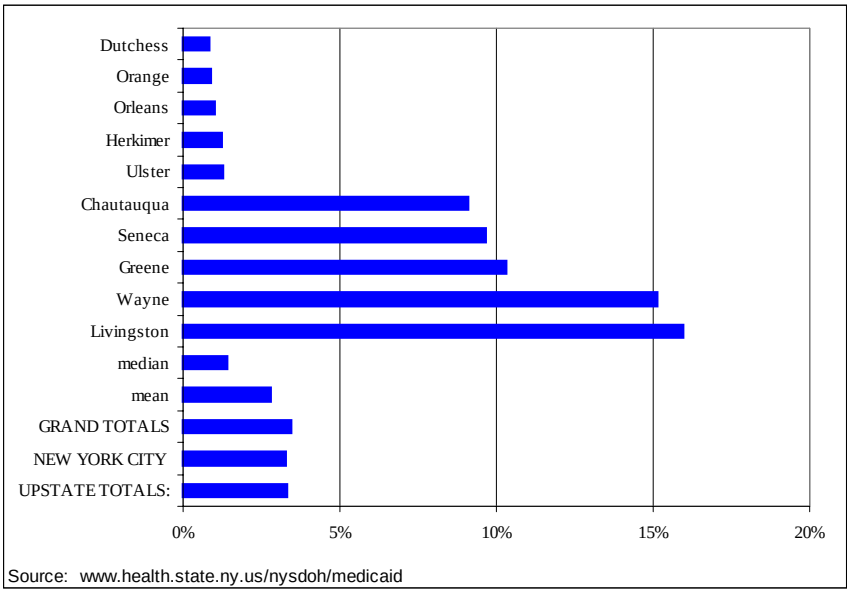


Source: www.health.state.ny.us/nysdoh/medicaid

Not surprisingly since counties cannot require these categories of recipients to join managed care plans, counties have been slow in increasing the percentage of these categories of Medicaid recipients to enroll in managed care. Since January 2002, statewide, half of all Upstate counties have had only a 1% increase in the percentage of eligibles enrolled in managed care. As Figure 47 below illustrates, certain counties have made greater strides than others in increasing managed care enrollments.

[3] Cayuga, Chenango, Clinton, Delaware, Essex, Franklin, Hamilton, Jefferson, Lewis, Madison, Otsego, St. Lawrence, Schuyler, Tioga, and Wyoming counties do not have any SSI Medicaid recipients enrolled in managed care.

Figure 47: Counties with Greatest and Smallest Change in Percentage of SSI Medicaid Eligibles Enrolled in Managed Care (5 highest and 5 lowest), January 2002-March 2003



LONG-TERM CARE

While conventional wisdom tends to regard Medi*care* as a program for the elderly and Medi*caid* as a program for the poor, there is actually considerable overlap between the two programs. Some low-income seniors and disabled people, called "dual-eligibles," receive both Medi*care* and Medi*caid*. A February 2003 report by the Center for Budget and Policy Priorities finds that "almost all elderly Medicaid beneficiaries and about two-fifths of disabled Medicaid beneficiaries are also on Medicare."[v]

Nationwide, 5.9 million Medicare recipients, 14.6%, live below the poverty level[vi]. An additional 11.6 million Medicare recipients, 29.3%, have incomes above poverty, but below 200% of poverty. In other words, of the 40 million Medicare recipients, nearly half live below 200% of the poverty ($17,960 income annually for a family of three. Of these people, more than half are women.

Medicare does not cover certain services, most notably prescription drugs and long-term care. For dual-eligibles, Medicaid will pay for these services. The rising costs of prescription drugs and long-term care for dual-eligibles has

resulted in substantial cost-shifting across the two programs and is a leading factor behind increased Medicaid spending. Because Medicare is a fully federally-funded program, the shift to Medicaid has put additional strain on state, and in New York, local budgets. Most low-income elderly people who qualify for Medicaid also receive Medicare. The same is not true, however, for disabled people. Only a small proportion of low-income disabled people also qualify for Medicare[4].

A recent Center on Budget and Policy Priorities[vii] report found that:

- Dual-eligibles were responsible for 35% of all Medicaid expenditures.
- The rising cost of care for the elderly and disabled accounts for approximately 75% of increased Medicaid costs.
- The share of expenses covered by Medicaid rather than Medicare has increased. In 1984, Medicare paid 70% of public health care expenditures for the aged and Medicaid paid the rest. The Congressional Budget Office predicts that by 2012, Medicaid's share will rise to 45%.

Many Medicaid critics make comparisons between Medicaid and Medicare, arguing that Medicare is not facing the same immediate financial pressures as Medicaid. Medicare is administered more efficiently because it is a national program. Program benefits are the same nationwide and administration is centralized. One key driver of increasing Medicaid spending is cost-shifting from the wholly federally-financed Medicare program to the Medicaid program with its federal-state shared financing mechanism[viii]. For example, while legislation is currently pending in Congress to create a prescription drug benefit for Medicare, Medicaid will still be responsible for the costs of long-term care for low-income elderly and disabled people. Long-term care is the single largest Medicaid expenditure category. The state share of this cost-

[4] Most disabled people only qualify for Medicare if they had a work history and are fully disabled. The developmentally disabled qualify for Medicare based on their parents' work history

shifting is a primary driver of increased state Medicaid spending. Medicaid spending has been increasing more rapidly than Medicare spending has.[ix]

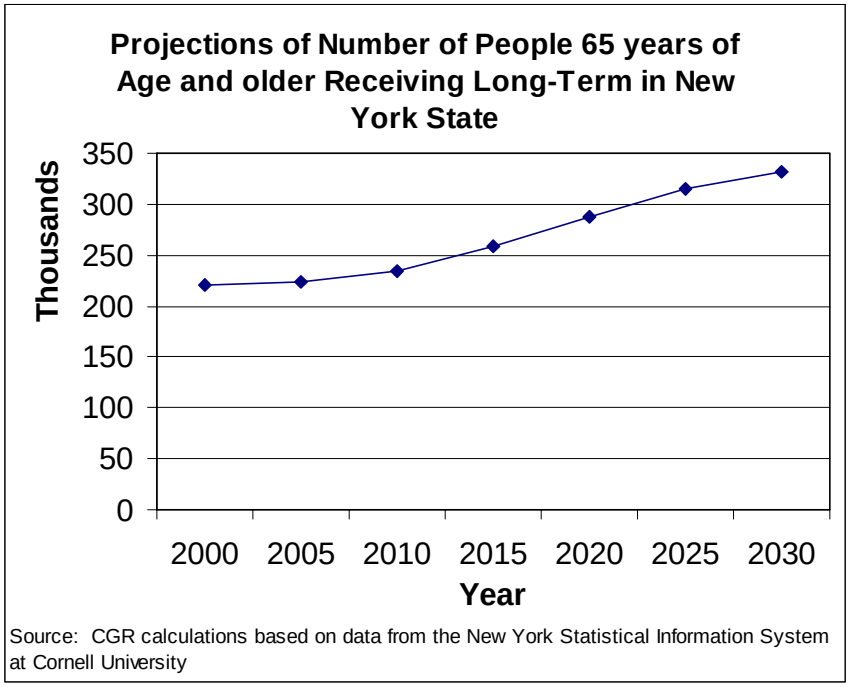
Interstate Comparison

Long-term care consists of both services provided in homes and the community, as well as services provided in an institution. Some of the costs of long-term care, such as nursing facility services and home health services, are federally mandated. In other words, the national government requires every state Medicaid program to provide these services. New York State also provides non-medical personal care services for the elderly as an optional service.

We have seen that New York State spends more than other states in providing many Medicaid services. This is true in the area of long-term care as well. Estate planning experts have developed ways to allow upper and middle-class senior citizens to qualify for Medicaid while protecting their assets for their heirs. In response, New York State has tightened eligibility requirements for elderly people to qualify for Medicaid benefits. There is now a three-year "look back" period for asset transfers and a five-year "look back" period for the creation of trusts. New York is attempting to ensure that only the most needy receive Medicaid benefits. Long-term care, however, is expensive and even middle-income seniors may spend down their resources rapidly if they need assisted living or nursing home care for a year or more.

New York, like the entire nation, faces a massive increase in the elderly population over the next few decades. According to projections by the New York Statistical Information System at Cornell University, New York will experience an increase of over 50% in the number of people age 65 and older between 2000 and 2030. Currently, 9% of New York residents age 65 and older receive Medicaid long term care coverage. coverage. Figure 48 below graphically illustrates the projected increase in the number of Medicaid eligibles 65 years of age and older who would receive long-term care if current trends continue, over the next three decades. Clearly, New York State faces a considerable Medicaid spending challenge in the future.

Figure 48: Projected Growth in Medicaid Population Age 65 and Older Receiving Long-Term Care Services 2000-2030. (Assumes Constant 9% of The Age Group Will Receive Long-Term Care Services.)

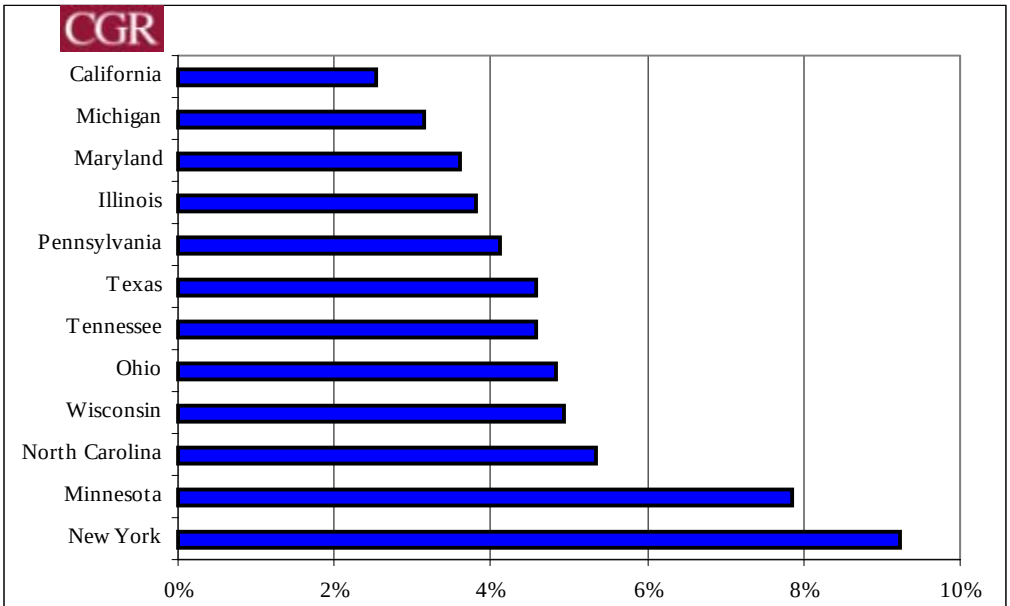


Source: CGR calculations based on data from the New York Statistical Information System at Cornell University

Recognizing that the cost of long-term care is a primary cost driver in Medicaid, New York State is making a commendable effort to encourage people to purchase private long-term care insurance well in advance of when they might need such care. To promote the purchase of private long-term care insurance, New York State offers tax incentives. A portion of the premium payments for private long-term care insurance is deductible on New York State taxes. Corporations are also offered a tax incentive for offering long-term care insurance to their employees. However, despite the tax incentives, only a small proportion of people under 65 in New York State carry long-term care insurance policies.

As illustrated in Figure 49, New York has the highest share, almost 10%, of the population over 65 receiving Medicaid Long-Term care services. Long term care services are either skilled nursing facility or home health care services. In comparison, Texas has less than 5% of the elderly population receiving Medicaid long-term care services and California has 2.5%. New York is twice the median for the comparison states (4.6%.)

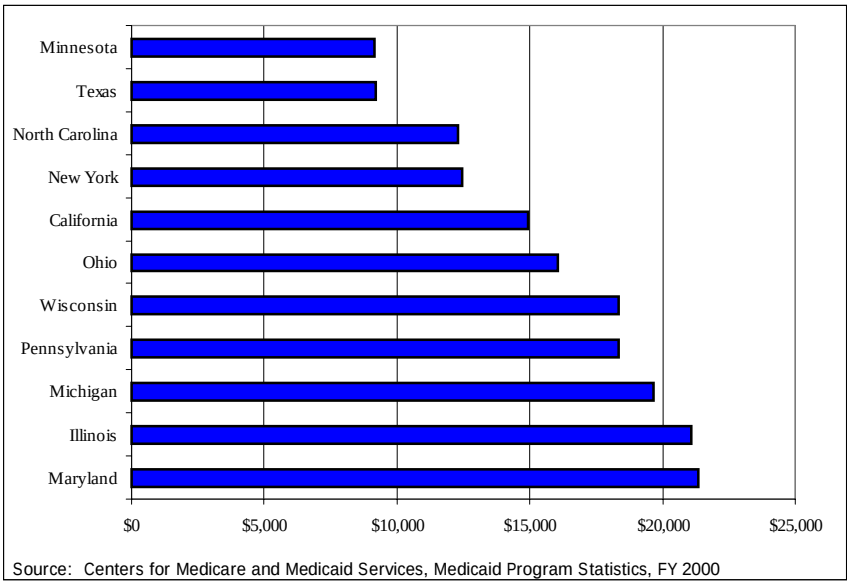
Figure 49: Percent of Population over 65 years receiving Medicaid Long-Term Care, Fiscal Year 2000



Source: Centers for Medicare and Medicaid Services, Medicaid Program Statistics, FY 2000

While New York has a higher proportion of elderly state residents receiving Medicaid long-term care services (almost 10%), the cost per recipient was lower than in many of the comparison states as shown in Figure 50. On average, New York spent $12,456 per recipient in fiscal year 2000, almost $4,000 less than the median of $16,073 among the comparison states.

Figure 50: Medicaid Long-Term Care Costs per Recipient, Fiscal Year 2000

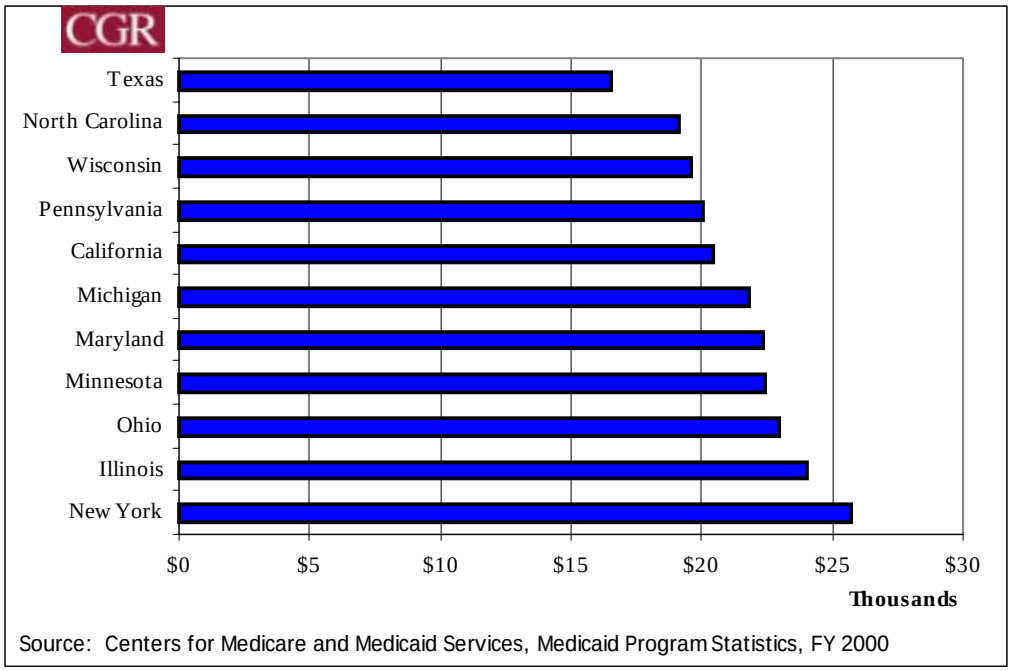


Source: Centers for Medicare and Medicaid Services, Medicaid Program Statistics, FY 2000

Nursing Home Care

Nursing home expenditures, also know as services provided in a Skilled Nursing Facility (SNF) dominate long-term care costs in each state. State Medicaid expenditures for SNF care per recipient basis are shown in Figure 51 below. While in FY 1993, New York State spent more than twice what other states spent per nursing home resident, the gap has lessened over time. In fiscal year 2000, New York State spent $25,680 per Medicaid nursing home resident, compared to a median among the comparison states of $21,818. Surprisingly, New York spent less per recipient in fiscal year 2000 than it did in fiscal year 1993 (approximately $33,000). Illinois had the next highest per resident expenditures at slightly over $24,000 while Texas had the lowest expenditures at approximately $16,500. The median cost per recipient was almost $22,000 among the comparison states.

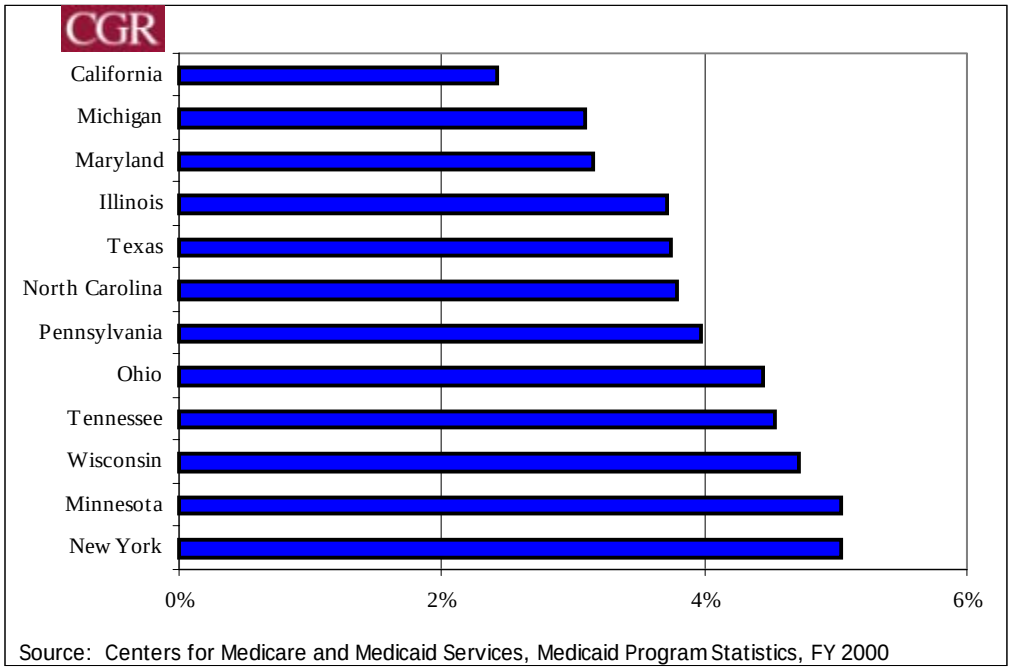
Figure 51:Medicaid Nursing Facilities, Cost Per Recipient, Fiscal Year 2000



Source: Centers for Medicare and Medicaid Services, Medicaid Program Statistics, FY 2000

New York has a higher proportion of elderly residents receiving Medicaid skilled nursing facility care compared to other states as illustrated in Figure 52. In New York, slightly over 5% of residents over 65 years of age receive services in a skilled nursing facility paid for by Medicaid. Among the comparison states, the median percentage is 3.9%. In Texas, the percentage is 3.8% and in California, 2.4% of residents over 65 receive Medicaid-funded nursing home services.

Figure 52: Percent of Population over 65 years Receiving Medicaid Skilled Nursing Facility Services



Source: Centers for Medicare and Medicaid Services, Medicaid Program Statistics, FY 2000

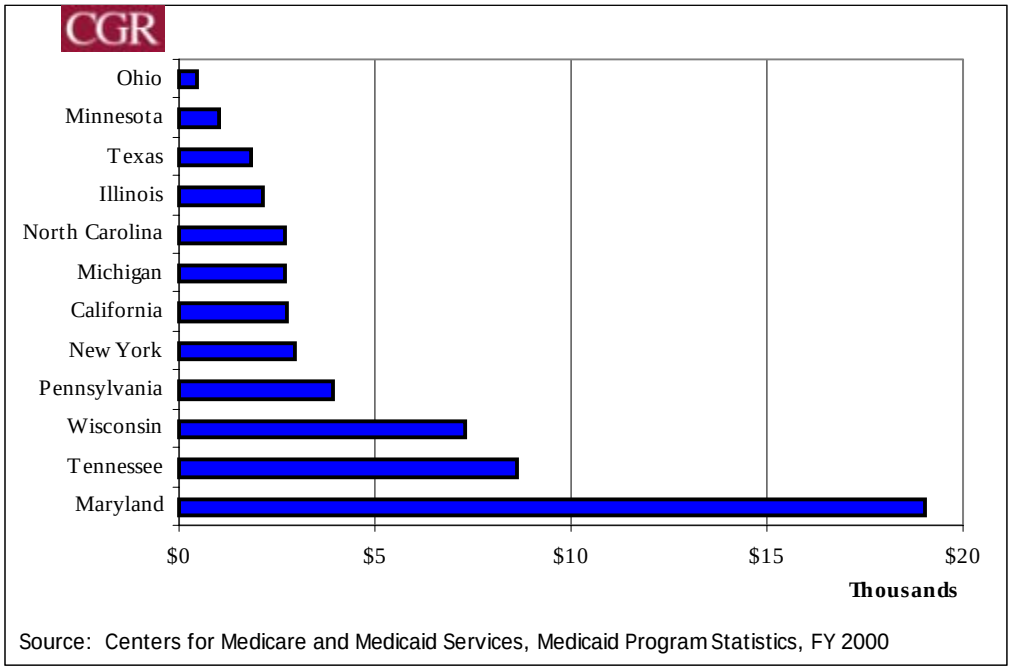
In addition to having a higher percentage of the population receiving services in a skilled nursing facility New York also has a higher cost per recipient. While on the surface these findings may not appear to bode well for New York, on closer examination a number of factors are at play. New York has been aggressive in employing home health care as a means to keep Medicaid recipients out of higher cost nursing homes. As a result, it is possible that the people who are in skilled nursing facilities in New York have greater medical needs on average than those in skilled nursing facilities in other states. Their greater health care needs will drive up average costs. Second, New York State has high quality standards for nursing homes. Quality in many cases translates into higher staffing ratios and higher average pay for health care workers. Higher wages and more staff per nursing home resident will also increase costs.

Home Health Care/ Personal Care

While New York spends more than the comparison states on nursing home care, the state is within the mainstream of the comparison states for spending on home health care. In the case of home health care spending, Maryland leads the comparison states at over $19,000 per recipient, spending almost twice that of

any of the comparison states (Figure 53). New York spends $2,944 per recipient, only slightly above the median for the comparison states of $2,737 per recipient. In fiscal year 1993, New York spent over $12,000 per recipient, so the data indicate that costs per recipient for home health care have fallen significantly over the past few years.

Figure 53: Medicaid Home Health Care, Cost per Recipient, Fiscal Year 2000

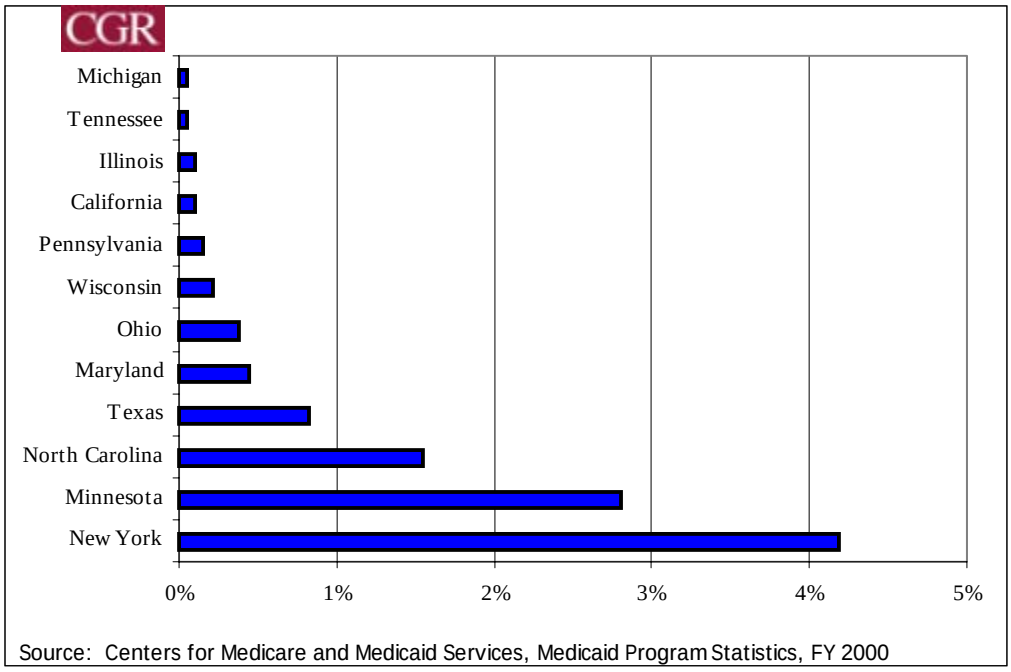


Source: Centers for Medicare and Medicaid Services, Medicaid Program Statistics, FY 2000

While New York spends only slightly above the average per recipient on home health care costs, the state does have a larger share of the elderly population receiving home health care services funded through Medicaid as illustrated in Figure 54. In New York, over 4% of residents older than 65 years of age receive Medicaid-funded home health care services. This compares to a median among the comparison states of .3%. Among the comparison states, only Minnesota and North Carolina have even 1% of their elderly population receiving Medicaid-funded home health care services. New York State extends home health care coverage to all the medically needy optional groups under Medicaid. These groups, consisting of low-income seniors and disabled people with existing medical conditions, by definition, need some type of health care services. New York's total

spending on health care services provided to Medicaid recipients in their homes is under-represented in Figure 54 because New York makes extensive use of personal care services, an optional Medicaid benefit, not reflected in Figure 54.

Figure 54: Percent of Population over 65 years Receiving Medicaid Home Health Services, Fiscal Year 2000



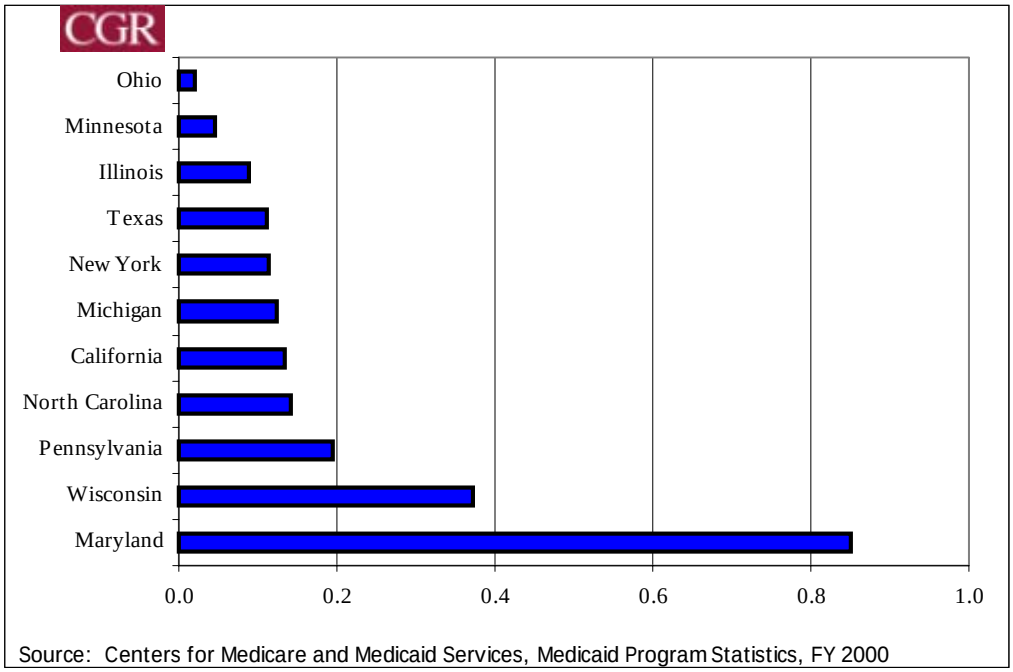
Source: Centers for Medicare and Medicaid Services, Medicaid Program Statistics, FY 2000

Home health care on average tends to be considerably less expensive than skilled nursing facility care. Therefore, states would seem to have an incentive to place Medicaid eligibles needing this type of service in a home health care setting rather than a nursing home if possible. Since the 1970's, New York and other states have received waivers to place Medicaid-eligible elderly people qualified for a nursing home in a Long-Term Home Health Care (LTHHC) program as long as the home health care costs do not exceed 75% of the costs of a nursing home. The waiver allows states to provide services in the community not normally covered by Medicaid if those services allow an elderly or disabled person to avoid nursing home care. Figure 55 illustrates how various states have allocated home health care slots as compared to skilled nursing facility beds.

Figure 55 reflects the ratio of per recipient spending on home health care to per recipient spending on skilled nursing facility

care. On average, for every dollar spent on nursing home care, only 12 cents is spent on home health care per beneficiary. In New York State, the ratio is slightly better. For every dollar spent on nursing home care, only 11 cents are spent on home health care. Only in Maryland does the ratio even approach 1:1 and even in that state, home health care is only 85 cents per recipient for every $1 spent per recipient on skilled nursing care.

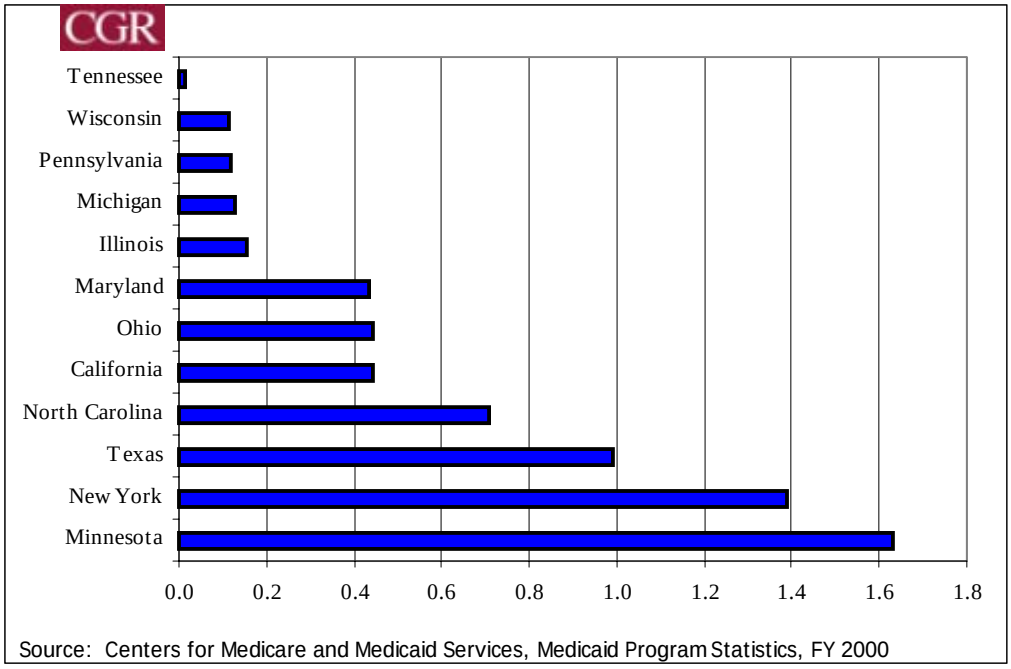
Figure 55: Ratio of Expenditures per Beneficiary for Home Health Care versus Skilled Nursing Facility Care, Fiscal Year 2000



Source: Centers for Medicare and Medicaid Services, Medicaid Program Statistics, FY 2000

New York has made extensive use of home health care. In 2000, as Figure 56 below illustrates, New York's Medicaid program funded almost three people receiving Medicaid-funded home health care services for every two people receiving institutional long-term care. Of the comparison states, only Minnesota has a higher proportion of Medicaid-funded long-term care recipients in home health care. The median for the comparison states is less than one home health care recipient for every nursing home recipient funded by Medicaid.

Figure 56: Ratio of Medicaid Recipients over 65 Years Receiving Home Health Care to those Receiving Skilled Nursing Facility Care, Fiscal Year 2000



County Comparison

Institutional Long-Term Care

The largest component of long-term care service costs, by far, is nursing facilities. In New York State in fiscal year 2000, Medicaid spending on institutional long-term care was over $5 billion, compared to over $2.5 billion on non-institutional long-term care. Median expenditures on institutional long-term care per recipient in Upstate counties were over $26,000. Per recipient expenditures varied from over $19,000 in Allegany county to over $40,000 in Nassau county as illustrated in Figure 57.

The percentage of the Medicaid population using institutional long-term care services varied across New York State as shown in Figure 58. The median for Upstate counties is 7%, but ranged from a low of 4.4% in Clinton county to a high of 13.6% in Putnam county. New York City has a much lower percentage of the Medicaid population using institutional long-term care, with only 3% of Medicaid eligibles using this benefit.

Figure 57: Highest and Lowest Counties: Dollars per User for Institutional Long-Term Care, Fiscal Year 2000

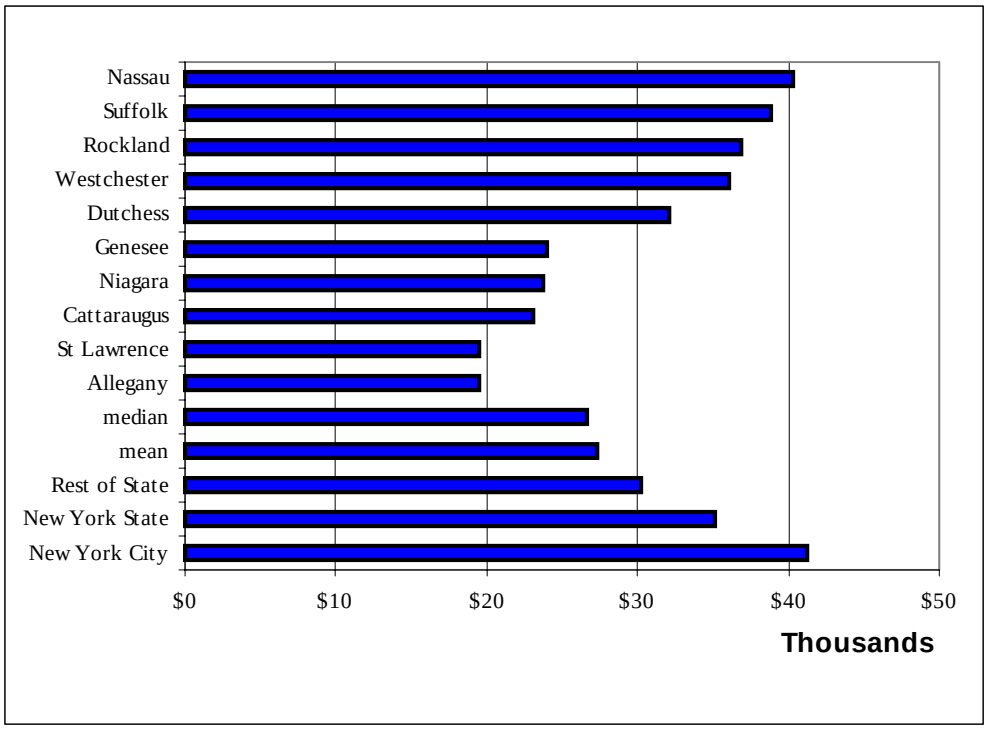
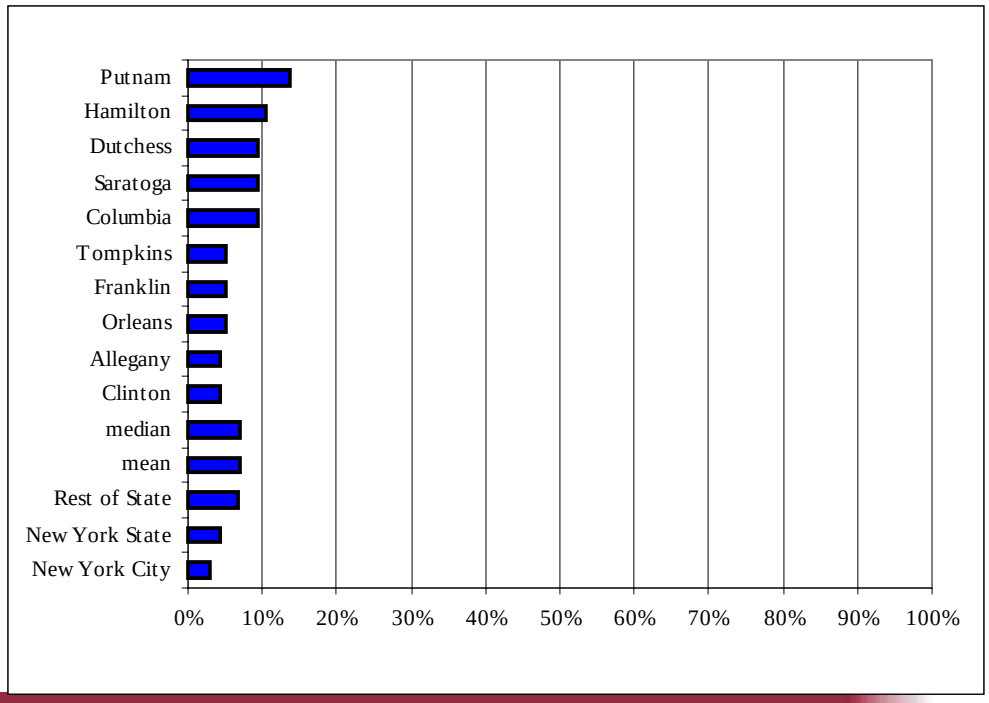
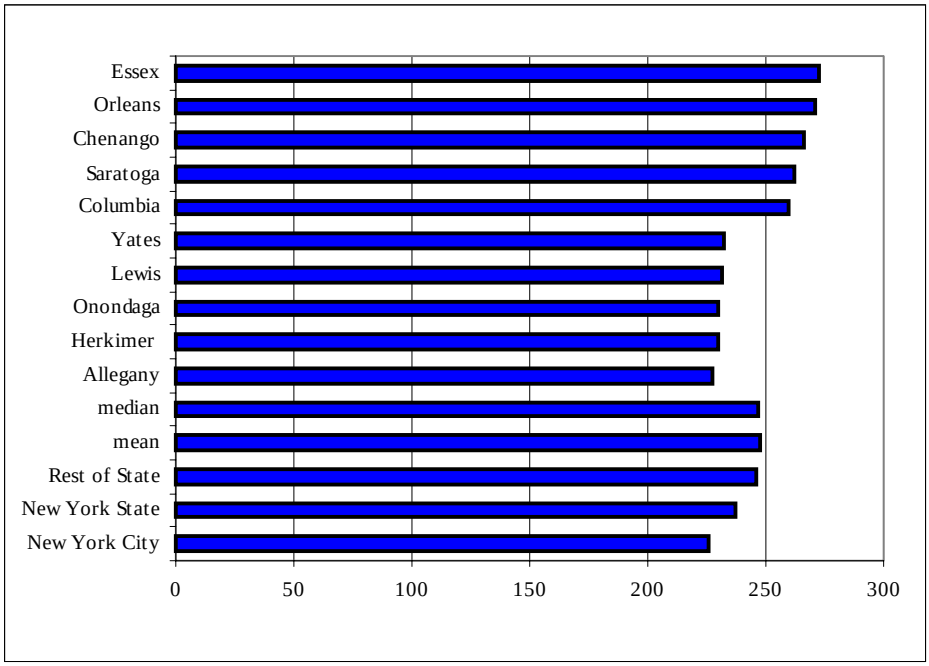


Figure 58: Users of Institutional Long-Term Care as a Percentage of Medicaid Eligibles, Fiscal Year 2000



The median length of stay in an institutional long-term care facility in Upstate counties is 247 days, or about eight months. The average stay ranges from 228 days in Allegany county to 272 days in Essex county, a difference of approximately a month and a half (Figure 59). New York City Medicaid recipients average 226 days.

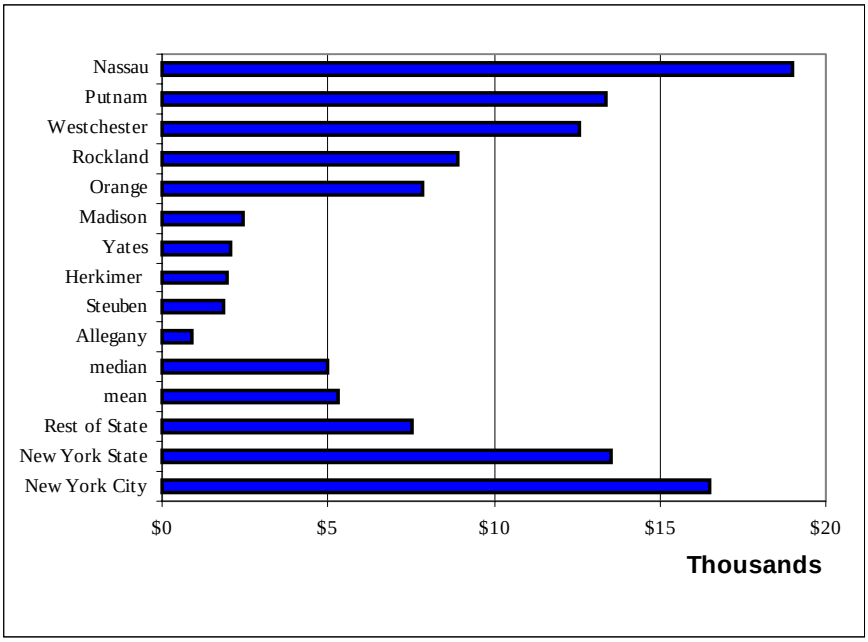
Figure 59: Units per User for Institutional Long-Term Care, Fiscal Year 2000



Non-Institutional Long-Term Care

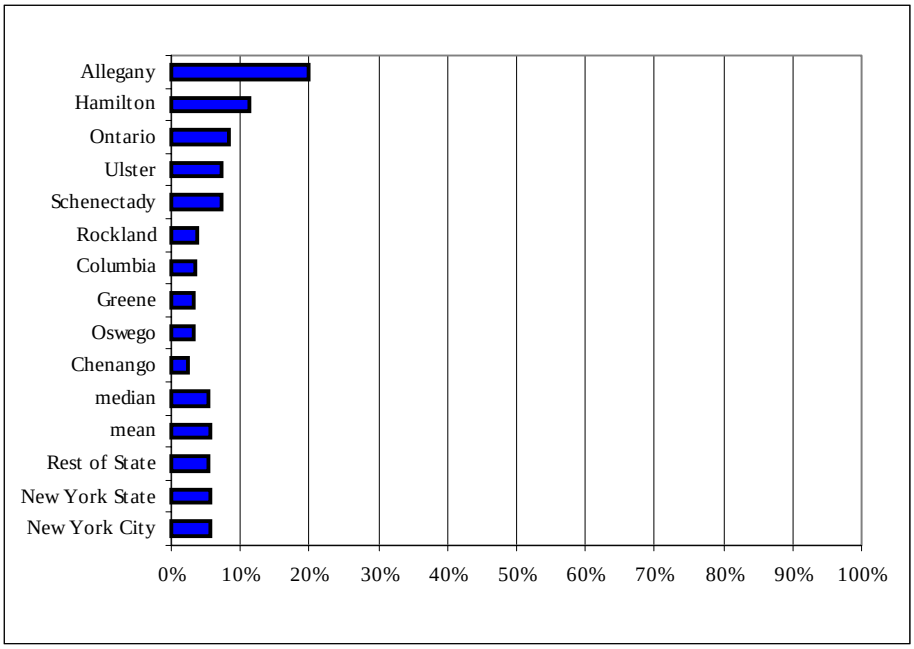
Non-institutional long-term care is care provided in the community rather than at a facility. In most cases, the purpose is to allow the recipient to remain in his or her own home. Non-institutional long-term care is considerably less expensive than institutional long-term care. The median cost of non-institutional long-term care in Upstate counties is slightly under $5,000 per recipient (Figure 60). However, in New York City, the cost is considerably higher, averaging over three times that amount at $16,492 per recipient. At the same time, this is still less expensive than institutional care in the City. There is wide variation in costs across Upstate, with an average cost of $886 per recipient in Allegany county to a high of $19,013 in Nassau county. Even at the higher end of the spectrum, non-institutional care is less expensive than institutional long-term care.

Figure 60: Non-institutional Long-Term Care cost per Recipient, fiscal year 2000



In Upstate counties, the median number of Medicaid eligibles who use non-institutional long-term care is a little over one in 20 (Figure 61). This ranges from a low of 2.5% in Chenango county to a high of one in five Medicaid eligibles in Allegany county. In New York City, 5.6% of Medicaid eligibles use non-institutional long-term care services.

Figure 61: Users as a Percentage of Eligibles for Non-Institutional Long-Term Care Services, fiscal year 2000



PRESCRIPTION DRUGS

In calendar year 2001, New York State, excluding New York City, spent 13.2% of fee-for-service Medicaid expenditures on drugs and supplies. This category was the third largest expense category, after skilled nursing facilities and inpatient hospital care. A driving force behind increased Medicaid costs is the rapid growth in prescription drug costs. According to the Kaiser Commission on Medicaid and the Uninsured, Medicaid prescription drug spending has increased at rates well over 10% annually in recent years. These expenditure increases are the result of several factors:

- ***More pharmaceuticals on the market:*** Increasingly, conditions that had no treatment or had been treated through invasive methods in the past are being managed or treated using prescription drugs.

- ***New, name-brand drugs do not yet have a generic alternative:*** Brand name drugs are more expensive than generic drugs in order to compensate the pharmaceutical company for the cost of research and development.

- ***Increased demand:*** For all health care consumers, including Medicaid recipients, the average number of prescriptions is increasing.

National legislation currently being debated in Congress may alleviate some of the burden on Medicaid. In June, both the U.S. House of Representatives and the Senate passed legislation to add a prescription drug benefit to Medicare, in part to help relieve Medicaid of the burden of paying for prescription drugs for low-income seniors. The two chambers must still agree on a compromise bill and the President must sign it before it can become law. Under both proposals, seniors would have the option as of 2006 to enroll in private or public health insurance programs offering a prescription drug benefit. Seniors would pay approximately $35 a month in premiums and have an annual

deductible of about $250[x]. Most likely, Medicaid would pay the premiums for low-income Medicare recipients.

The fact that Medicare does not currently offer outpatient prescription drug coverage means that many elderly people must turn to Medicaid to pay for their prescriptions. These "dual eligibles" may have sufficiently low incomes to be eligible for Medicaid in any case or they may become medically needy as their prescription costs reduce their incomes to eligible levels. In fact, nationwide, Medicaid spends more than $6 billion annually for drugs for dual-eligible recipients. Over 50% of the drugs Medicaid buys are for Medicare recipients. Senior prescription drug assistance programs, such as EPIC in New York State, help reduce the burden on seniors and Medicaid.

The Centers on Medicare and Medicaid Services (CMS) anticipates prescription drug costs to be the fastest growing component of Medicaid spending[xi]. States can receive federal funds for coverage expansion through waivers, rather than relying solely on state dollars to pay for providing prescription drug benefits to people who don't qualify for Medicaid. For instance, Pharmacy Plus waivers (in effect in Illinois, Wisconsin, Maryland, South Carolina, and Florida), offer Medicaid prescription drug coverage to low-income seniors not eligible for the complete package of Medicaid benefits. Providing these prescription drugs under the aegis of Medicaid increases overall state Medicaid spending, but also helps leverage federal dollars.

Pharmacy Plus waivers require states to accept a cap on the amount of federal support they receive for all health care services for the elderly. As a result, the waiver program may create additional pressure to reduce long-term care spending.

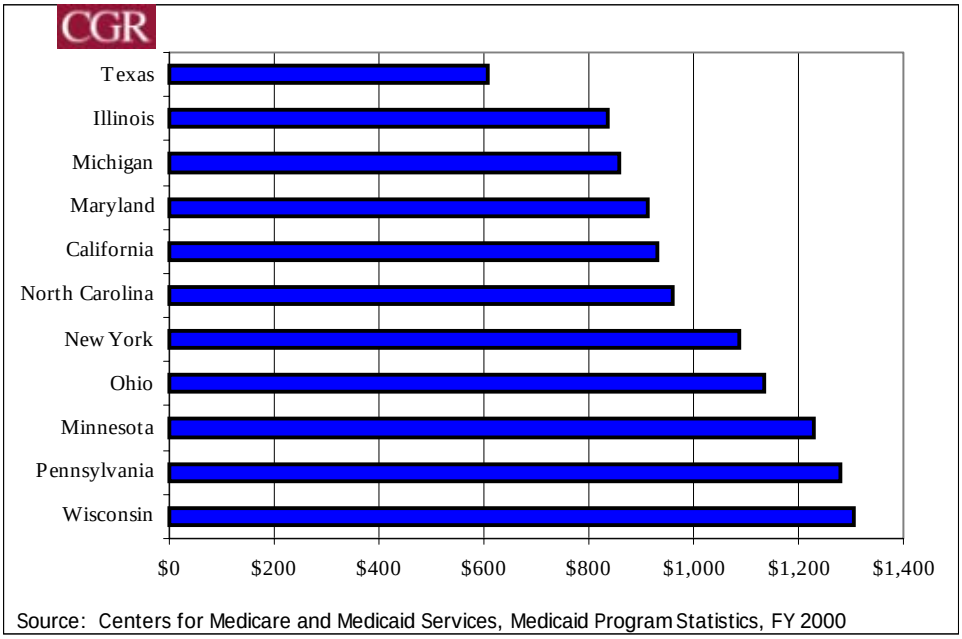
A Supreme Court case (*Pharmaceutical Research and Manufacturers of America v. Concannon, 01-188)* recently affirmed Maine's ability to use the state's buying power under Medicaid to force drug manufacturers to lower prescription prices by 25% for the working poor, retirees and others who do not have employer provided prescription drug coverage.[xii]

Interstate Comparison

Several states, including Wisconsin, Pennsylvania, Minnesota and Ohio, spent more per recipient than did New York on

prescription drugs. Yet, at $1,089 per recipient, New York still spent above the median of $961 for the comparison states. Tennessee is not included in Figure 62 below because prescription drug costs are included in the managed care capitated rate. Prescription drugs are "carved out" of managed care capitation rates in New York State, meaning that Medicaid managed care plans do not have a prescription drug benefit. As a result, drug prescriptions continue to be a fee-for-service cost for Medicaid in New York.

Figure 62: Pharmacy Costs per Recipient, Fiscal Year 2000



A number of states have instituted methods to control prescription drug costs. Preferred drug lists are developed by committees of doctors and pharmacists who examine drugs in particular classes, review the clinical literature and decide in which cases it would be appropriate to recommend a cheaper drug as a replacement for a more expensive drug. Preferred drug lists do not require that doctors prescribe the cheaper medication, but in certain states, doctors must receive prior authorization before prescribing drugs not on the preferred list. Private sector health plans make wide use of preferred drug lists to reduce pharmaceutical costs.

Washington State has a contract with a private firm, ACS, to monitor Medicaid prescriptions.[xiii] When a doctor prescribes medication not on the preferred drug list, or prescribes more than four brand-name drugs in a month for the same patient, the pharmacist contacts the doctor prior to filling the prescription. The doctor must then call ACS and explain why he or she chose the more expensive drug. The system does not forbid doctors from prescribing certain drugs and takes into account the special needs of patients, but makes it more convenient for doctors to prescribe the less expensive drugs.

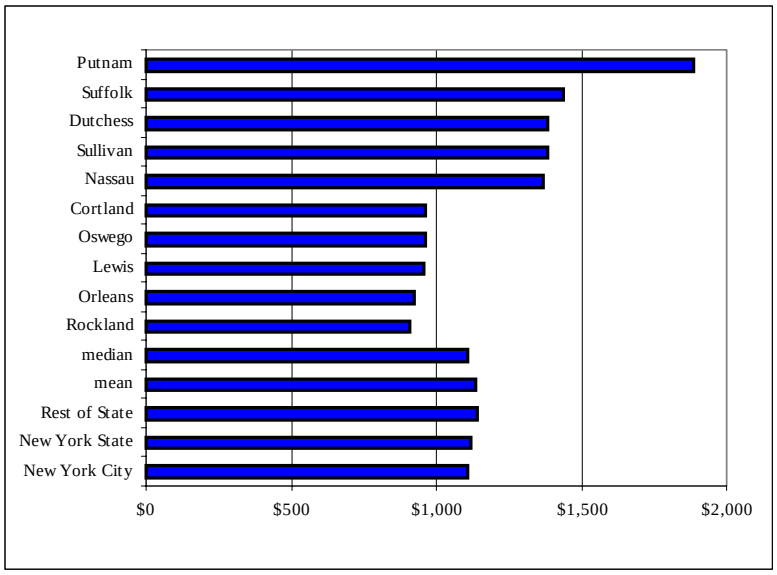
Several states use systems to identify doctors who prescribe an unusually large number of prescription drugs or who are more likely than usual to prescribe brand-name drugs. In an effort to counteract the marketing of pharmaceutical salespeople, these states send pharmacists out to visit these doctors and present clinical evidence regarding drug efficacy. The pressure for doctors to change their behavior is subtle. Other states are more direct, sending warning letters to doctors they have identified as writing an unusually high number of brand-name prescriptions.

New York State requires prior authorization before certain drugs can be prescribed to Medicaid clients. New York also requires that generic drugs be prescribed when available. The state is currently in the process of developing a preferred drug list.

County Comparison

Within New York State, there is a wide variation in prescription drug expenditures across counties. Rockland County spends $909 per recipient for prescription drugs, while Putnam County spends twice that amount at $1,888 per recipient (Figure 63). Half of Upstate counties spend more than $1,108 per recipient.

Figure 63: Highest and Lowest Counties: Dollars per User for Prescription Drugs, fiscal year 2000



In half of Upstate counties, about two-thirds of Medicaid eligibles have received prescription drug benefits. Across counties, this ranges from a low of 58% of eligibles in Nassau county to a high of 71% in Clinton county. Not only do a majority of Medicaid eligibles use prescription drugs, more than half of Medicaid prescription drug users fill over 22 prescriptions per year, including refills of maintenance drugs. The combination of a high proportion of benefit users and a high number of units per beneficiary leads to increased costs.

OTHER MEDICAID COST CATEGORIES

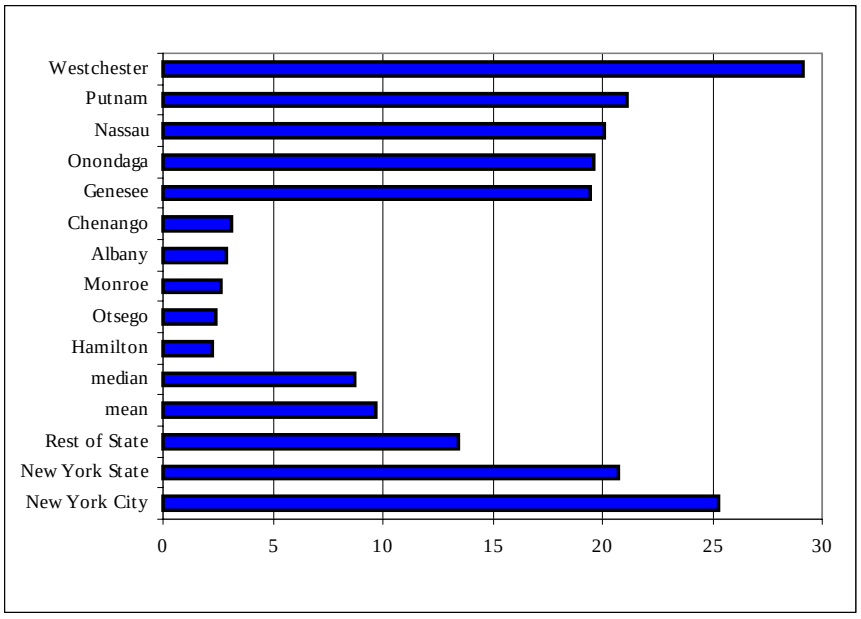
This section describes additional Medicaid cost categories not described in earlier sections. Only county comparisons are made here; data on interstate comparisons were not available. As in previously discussed cost categories, data presented below show that wide variation exists in spending across counties.

Transportation

Medicaid pays for public transportation costs related to medical care and also provides transportation to medical appointments for Medicaid recipients who do not have their own transportation and are not able to take public transportation. Only a small portion of Medicaid eligibles, 8% on average, use Medicaid-funded transportation benefits. In Tioga county, less than 1% of

Medicaid eligibles use the transportation benefit, while in Putnam county, over one in five Medicaid eligibles receives transportation services. Half of Medicaid transportation beneficiaries use the service nine times or less per year. However, as illustrated in Figure 64, on this variable too, there is wide variation. In Hamilton county, recipients use an average of slightly over two trips per year, while in Westchester county, recipients average over 29 Medicaid-funded trips per year (or over 2 trips per month on average).

Figure 64: Average number of Medicaid-funded trips per beneficiary, fiscal year 2000



In New York counties, Medicaid spends a median of $374 per person who receives Medicaid transportation services. However, there is a considerable range in expenditures, from a low of $114 per recipient in Ontario county to almost ten times that, $1081, in Nassau county.

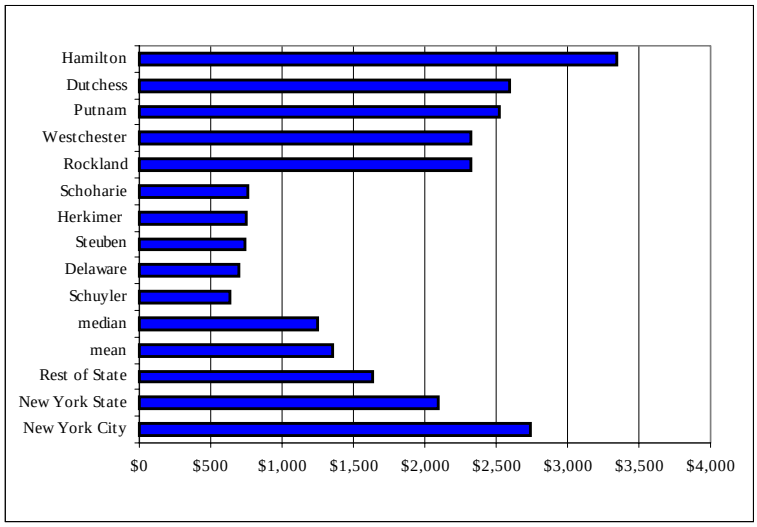
Chemical Dependency

New York State's Medicaid program spends millions of dollars on the delivery of treatment to clients with chronic alcohol and drug abuse problems. Only a small proportion of Medicaid eligibles use alcohol treatment clinics. In fact, half of all Upstate counties have less than 2% of their Medicaid population receiving alcohol

services at a clinic. These proportions range from .9% in Hamilton county to 4% in Ulster county.

While the proportion of people who use clinic-based alcohol treatment services is relatively small, the cost per recipient is quite high. Half of Upstate counties spend more than $1,246 per recipient on clinic-based alcohol services. These costs range from a low of $633 in Schuyler county to a high of $3,345 in Hamilton county, as illustrated in Figure 65 below. Not surprisingly, these per beneficiary costs are directly linked to the length of time recipients spend in treatment as well as local cost of treatment variations. The average number of clinic visits per beneficiary ranges from a high of 56 in Hamilton county to a low of 11 in Schuyler county. The median number of clinic visits in Upstate counties is slightly over 20.

Figure 65: Dollars per User for Clinic-based alcohol services, fiscal year 2000



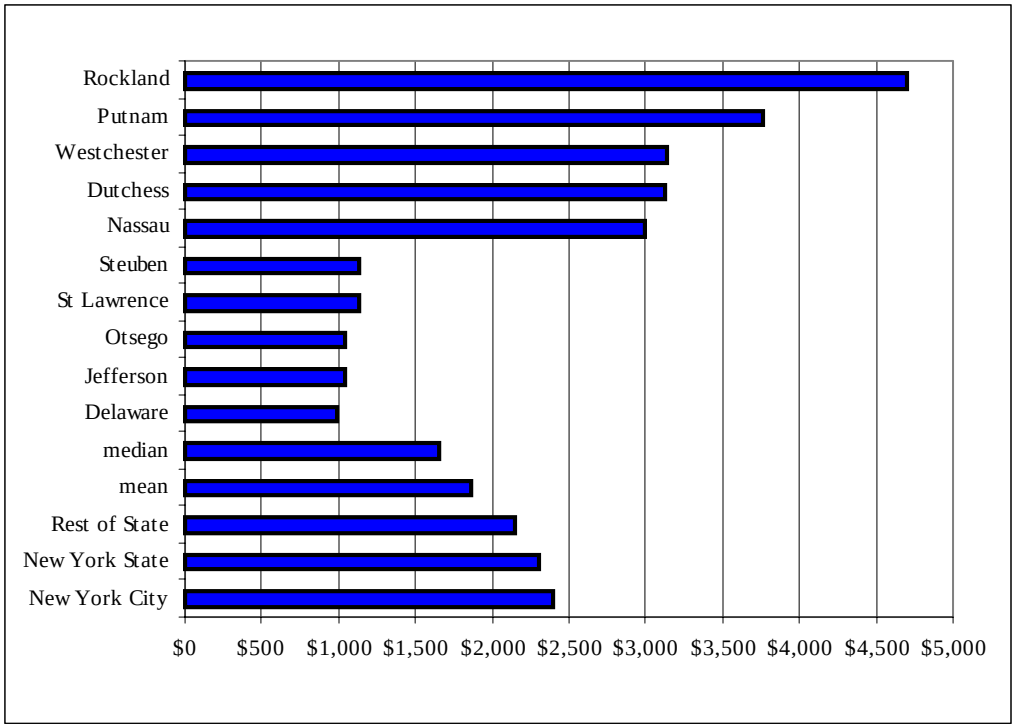
Mental Health and Developmental Disability

While the cost of health care for elderly Medicaid recipients has been the primary factor in rising expenditures, the new "sleeper" factor influencing current and future Medicaid costs is expenditures for mental health care and services for the developmentally disabled. While the majority of long-term care recipients are elderly, an increasing number of recipients are disabled people under 65 years of age. In the past, many severely mentally or physically disabled people received care in institutions or group facilities. More recently, however, care plans have increasingly shifted toward community-based services.

As a result of advances in modern medicine, disabled people are living longer and more productive lives. At the same time, these medical advances have a financial cost. New technologies are expensive and disabled people will need care for a longer period of time as lifespan increases. In addition, the Olmstead decision and other recent court action mean that, increasingly, disabled people will live independently or in community settings with community-based support services often covered by Medicaid. In theory, home-based care is less expensive than institutional care, but it must be sufficiently distributed to be easily accessible to recipients.

About one in ten Medicaid eligibles receive psychological services from a clinic, including alcohol treatment. This proportion ranges from 3.7% in Hamilton county to 16.7% in Putnam county. As illustrated in Figure 66, the average cost per recipient ranges from $984 in Delaware county to $4,698 in Rockland county. In half of Upstate counties, the average cost per recipient is $1,559 or higher.

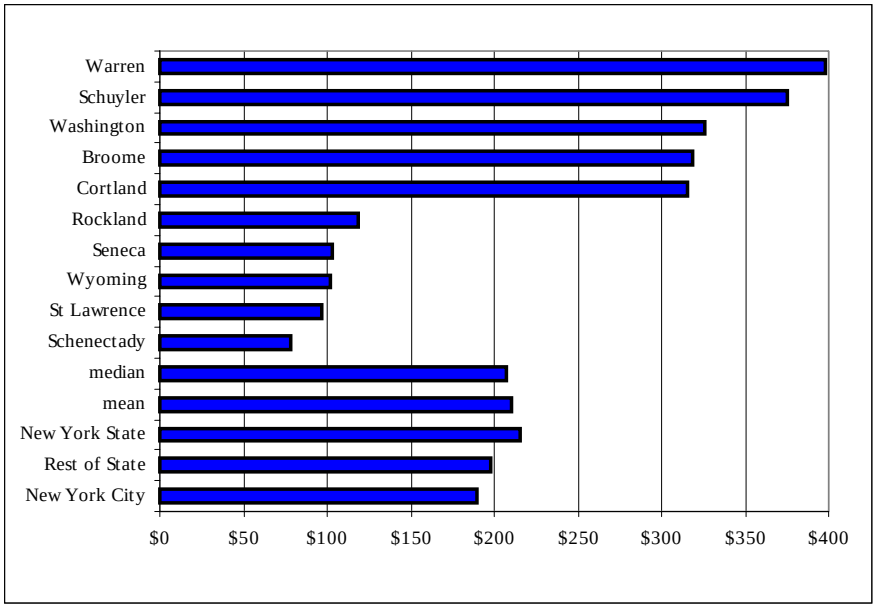
Figure 66: Cost per User for Psych clinics, including alcohol, fiscal year 2000



Medicaid also pays for mental health services provided by physicians. The proportion of Medicaid eligibles who use these

services in any given year is quite low; in half of Upstate counties, about 1% of Medicaid-eligibles use physician-provided psychological services. Costs per recipient are also relatively low, with half of Upstate counties spending less than $207 per recipient. There is a wide variation in per recipient costs, though, from a high of $398 in Warren county to a low of $78 in Schenectady county as illustrated in Figure 67.

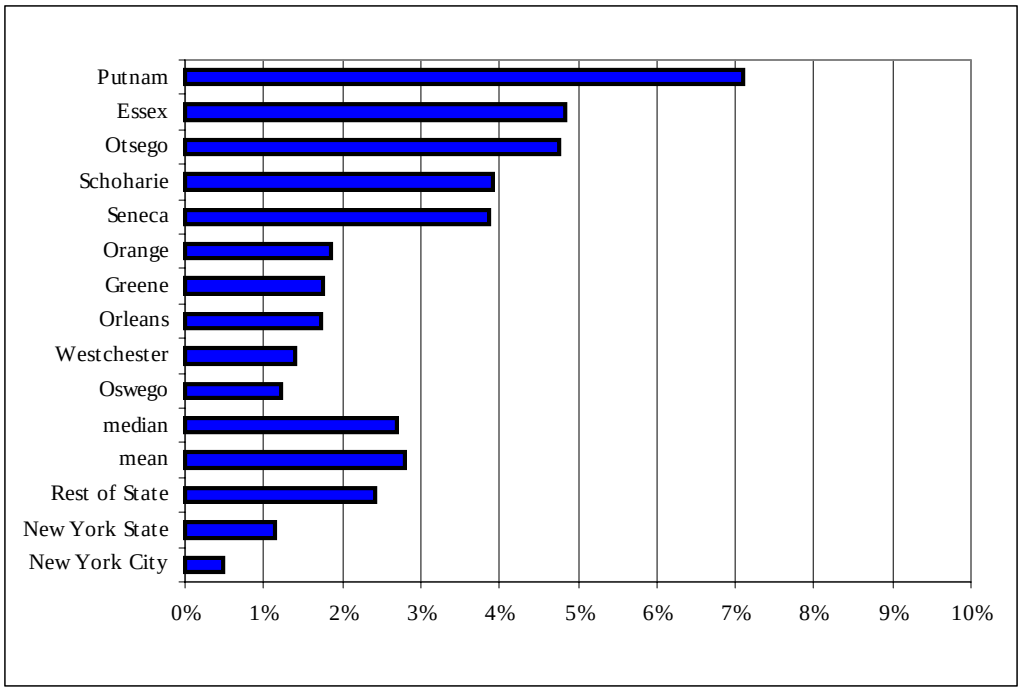
Figure 67: Dollars per user for Physician -psych services, fiscal year 2000



The median number of visits in Upstate counties is 8.1, ranging from 2.8 in St. Lawrence county to 14.3 in Schuyler county.

While the proportion of Medicaid eligibles receiving community and rehabilitation services is quite low, the cost per recipient is quite high. The median cost per recipient in Upstate counties is $24,105. Costs range from a low of $16,322 in Lewis county to a high of $33,996 in Essex county.

Figure 68: Users of Community and Rehabilitation Services as a Percent of Medicaid Eligibles, fiscal year 2000



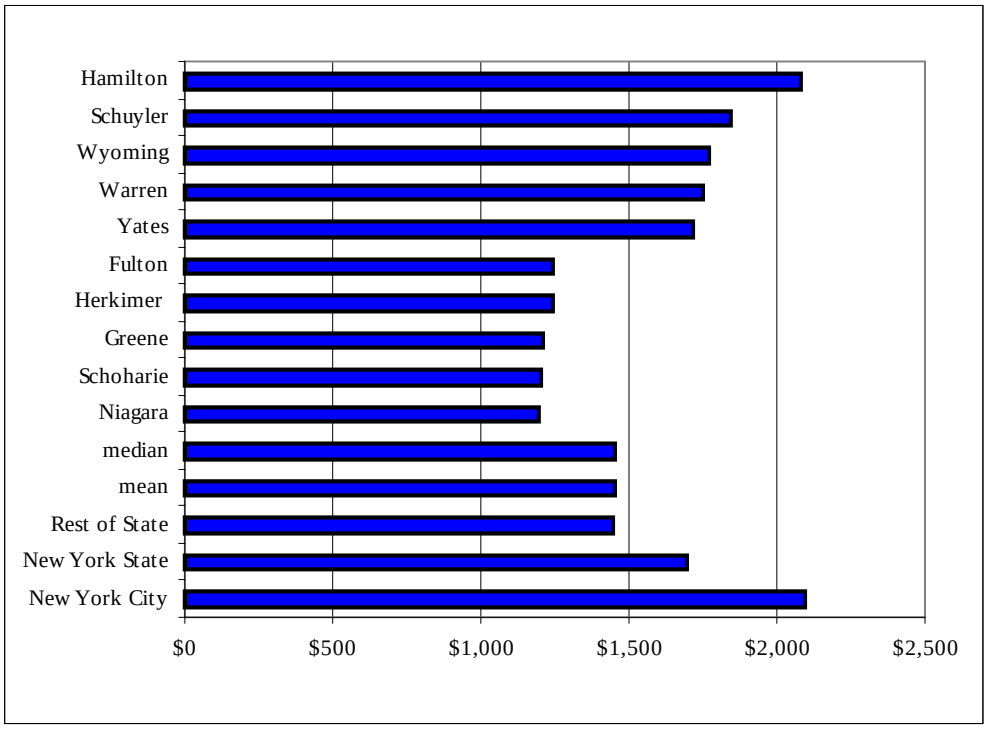
The median percent of Medicaid eligibles receiving community and rehabilitation services in Upstate counties is 2.7%. This ranges from a low of 1.2% in Oswego county to a high of 7.1% in Putnam county as illustrated in Figure 68.Wide variation exists in the average number of units of service. The median for Upstate counties is 161, but ranges from a low of 93 in Broome county to a high of 298 in Essex county.

Case Management

In an effort to control costs, a number of counties have shifted to a case management approach for clients with high needs. The expectation is that coordinating the care provided across systems and providers will reduce the chance of duplicative services and limit the overall costs per recipient. Across Upstate counties, the percentage of Medicaid eligibles who receive case management services is relatively low. The median value for Upstate counties is 4.4%. In Westchester county, 2.3% of Medicaid eligibles receive case management services, while in Seneca county, 7.7% do. Costs per beneficiary vary considerably, from $1,194 in Niagara

county to almost twice that amount, $2,079 in Hamilton County, as illustrated in Figure 69.

Figure 69: Dollars per User for Case Management Services, fiscal year 2000



CHILD HEALTH PLUS

Congress authorized the State Child Health Insurance Program (SCHIP) as part of the Balanced Budget Act of 1997. All fifty states and the District of Columbia have SCHIP programs, most of which began in the late 1990's, and which offer publicly funded health insurance to children in low-income families through programs with broader income and asset limits than traditional Medicaid. Nineteen states have created a separate state child health plan, (including North Carolina, Pennsylvania and Texas of our comparison states). Twenty states have expanded their existing Medicaid program to cover children in slightly higher income brackets (Minnesota, Ohio, Tennessee, and Wisconsin of our comparison states). Seventeen states, including California, Illinois, Maryland, Michigan and New York, have combination plans.

The Child Health Plus program in New York State provides health care coverage for low-income, uninsured children. Children who qualify for Medicaid are enrolled in Child Health Plus A, which has a 25% local share. Eligibles, beneficiary and expenditure data for Child Health Plus A (Medicaid) are included in the regular Medicaid data provided by the New York State Department of Health.

Children in families with slightly higher incomes (100%-159% of poverty) qualify for Child Health Plus B, which has no local share. Families with incomes between 160% and 250% of poverty pay monthly premiums of $9-15 per child, with a total cost capped at between $27 and $45. Families with incomes above 250% of poverty pay the full premium. The coverage has no co-pays and no deductibles. Child Health Plus is a managed care plan administered through Blue Choice. Table 5 provides the income eligibility guidelines for Child Health Plus B.

Table 5: Income Eligibility Criteria for Child Health Plus B in New York

Category	Income
Pregnant woman	=< 200% FPL
Child under 1 year of age	=<200% FPL
Children between 1 and 18	=< 133% FPL

Across the state, over half a million children are enrolled in Child Health Plus B as of March 2003.

Outreach to encourage families to apply for expanded publicly funded health insurance programs such as Family Health Plus and Child Health Plus has resulted in an increased number of Medicaid-eligible families being identified. These families are then enrolled in the Medicaid program that has a 25% local share. By identifying additional families eligible for the Medicaid program, the Child Health Plus program has increased the financial costs to counties, even though counties do not have a financial obligation to the Child Health Plus program itself.

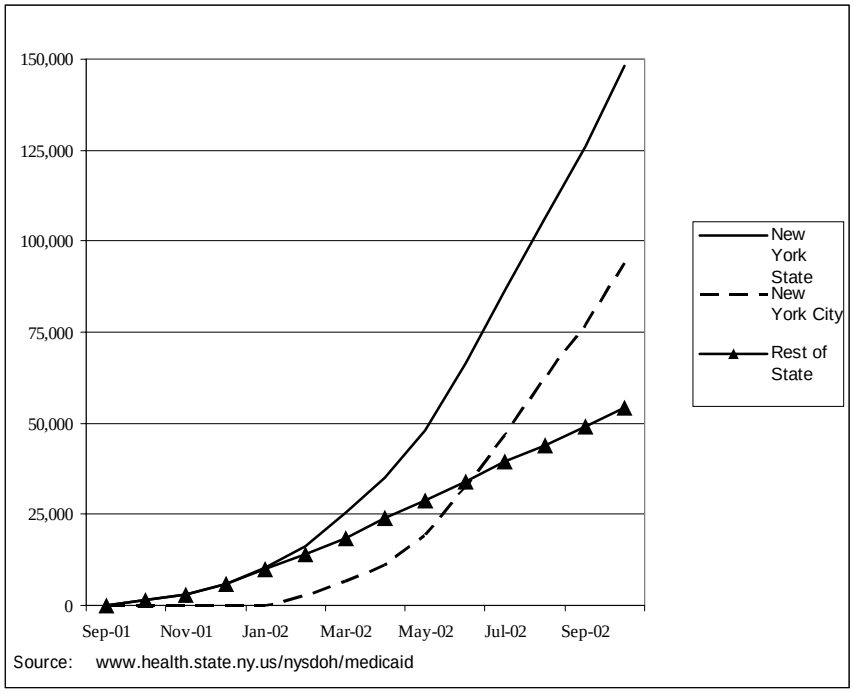
FAMILY HEALTH PLUS

After the failure of national health care reform in 1994, and in the context of strong economic performance and increased revenues, states across the nation looked to reduce their number of uninsured residents through state and federal partnerships. New York joined this national initiative through several policy innovations.

In order to expand health care coverage to low-income adults who do not qualify for Medicaid, New York instituted Family Health Plus in the fall of 2001. Family Health Plus has a 25% local share. The program was initiated Upstate that fall, but its implementation was delayed in New York City as a result of the 9/11 terrorist attack. Family Health Plus was inaugurated in New York City in January 2002.

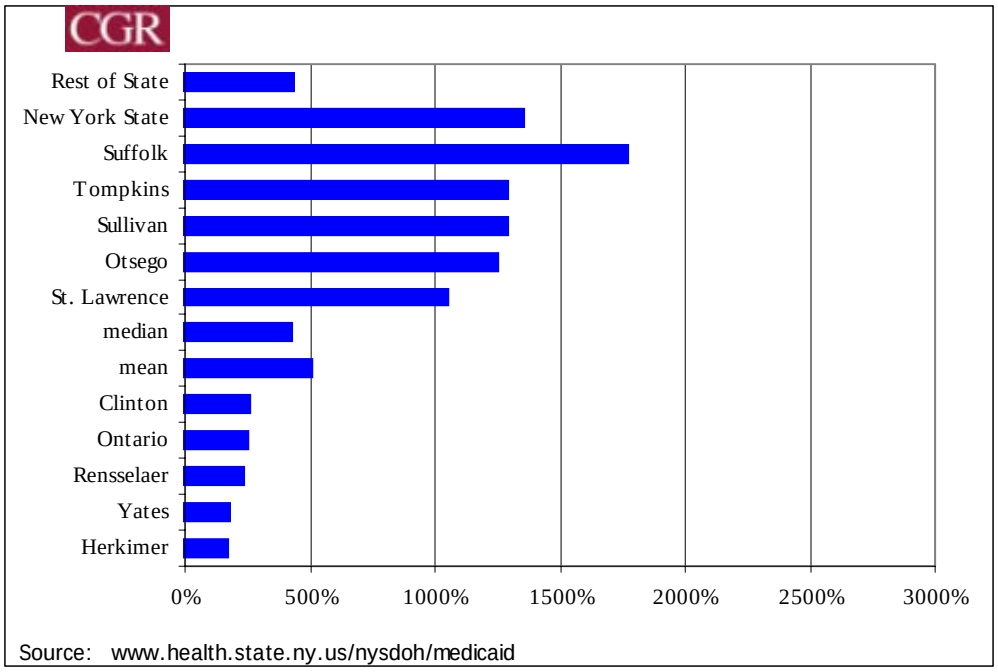
As illustrated in Figure 70, the combination of aggressive advertising, de-stigmatization and no asset limit resulted in an exponential increase in the Family Health Plus caseload, in addition to increases in the Medicaid caseload. These rising enrollments have been a major factor in the recent overall growth of Medicaid costs. By October 2002, one year after the program started, 148,019 adults were enrolled in Family Health Plus across the state. By July 2003 (the latest figures available), 267,289 adults were enrolled in the program.

Figure 70: Total Number of Family Health Plus Eligibles, January-October 2002



As illustrated by Figure 71, the increase in Family Health Plus caseloads has not been uniform across the state. Figure 71 represents the percentage change in enrollments from January 2002 when most counties had at least some people enrolled in the program to October 2002, the most recent month for which data from the state are available. For New York State as a whole, the Family Health Plus caseload increased 1,355%. In Suffolk County, the increase was 1,765% over the ten month period. Half of Upstate counties experienced caseloads greater than 420% during this period of time. However, Herkimer and Yates counties had increases less than half that amount. Both those counties had Family Health Plus caseload increases of under 200%.

Figure 71: Counties with Highest and Lowest Percentage Change in the number of Family Health Plus Eligibles (January –October 2002)

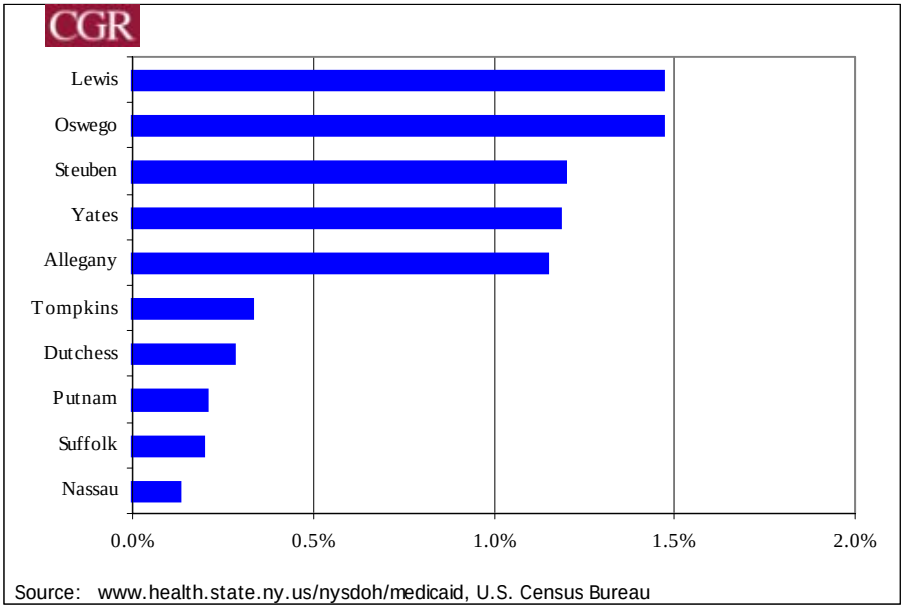


Note: Hamilton County had no one enrolled in FHP in Jan 2002.
NYC only began enrolling a substantial number of participants in February 2002. NYC had an increase of 360,123% from Jan-Oct 2002.

Figure 72 illustrates what proportion of a county's population was enrolled in Family Health Plus as of October 2002. Enrollments in Family Health Plus are a function of the number of people who are income-eligible who actually apply for benefits. Nationwide, it is estimated that somewhere between 70-80% of people eligible for Medicaid benefits apply and receive them[xiv]. There is no similar study for Family Health Plus.

As illustrated below in Figure 72, the percent of the population receiving Family Health Plus benefits ranges from lows in Nassau (.13%), Suffolk (.19%) and Putnam (.2%) counties to highs in Lewis (1.5%), and Oswego (1.5%) counties.

Figure 72: Counties with Highest and Lowest Percentage of Population enrolled in Family Health Plus, as of October 2002



Adults with children under 21 living in the home or 19-20 year old adults living with their parents are eligible for Family Health Plus if the household income is below 150% of poverty. Adults with no children under 21 in the home or 19-20 year olds living independently qualify for benefits if their income is below 100% of poverty. Family Health Plus is a managed care package very similar to that offered to Medicaid recipients. Also, similar to the Medicaid program, the federal government contributes 50% of the cost, while state and local governments each contribute 25% of total expenditures.

Three elements of the Family Health Plus program in particular have had an impact on the cost of this program for local governments:

- ***The program is heavily advertised in New York State***. This publicity makes a concerted effort to emphasize that the program is not Medicaid or "welfare" in an attempt to reduce the stigma of applying for assistance. To that end, non-governmental organizations have been hired as "facilitated enrollers" to accept applications at sites other than local DSS offices. This combination of advertising and efforts to de-stigmatize enrollment has resulted in a

high volume of applications. As a result, Family Health Plus advertising has increased both the FHP enrollment rolls and traditional Medicaid rolls.

- ***The program was inaugurated just as the recession began to hit full force.*** Unlike Medicaid, Family Health Plus has no asset limit. In applying for assistance, people only need to demonstrate they are income-eligible. As workers lost their jobs due to the recession, their families became income-eligible for Family Health Plus and Child Health Plus, resulting in higher than anticipated caseloads. When the program began, the state provided each county with an estimated maximum Family Health Plus caseload for planning purposes. As the program continued to grow and counties surpassed their anticipated maximum enrollments, the state periodically updated these estimates. Most recently, the state has stopped making projections for Family Health Plus enrollment because the actual enrollment keeps exceeding the estimate.

- ***There is some evidence that efforts to provide health care coverage to uninsured or underinsured people through an expansion of Medicaid has shifted costs from the private sector to the public sector.*** The Heritage Foundation makes a compelling argument that offering government-financed health insurance to low-wage workers provides an incentive for companies, also facing large health care cost inflation, to eliminate health insurance coverage for their employees, knowing that the government will pick up the tab[xv]. In addition, employees may choose to forgo employer-provided health insurance that is expensive or less comprehensive in favor of a government-sponsored plan. These "crowd out" effects result in New York State and counties paying for the health insurance of people who would otherwise be covered by the private sector, although it is difficult to assess the extent of the "crowd out" effect.

RECOMMENDATIONS AND CONCLUSIONS

Clearly, New York's Medicaid spending is far outside the norm compared to the rest of the country. The New York Medicaid program has relatively generous eligibility criteria, provides an extensive array of optional medical services and, in many cases, reimburses providers at a level higher than in other states. The cost of these services strains federal, state and local budgets.

This report does not address "why" New York State's Medicaid program has evolved to this point. But the report does address the "what is", i.e. the current state of Medicaid. The picture that evolves is that clearly, Medicaid in New York is an incredibly complex fabric of interwoven threads that represent years of give and take among client advocates, service providers, public officials and legislators in local, state and federal governments. The whole system has evolved in much the same way as a major computer operating system. What starts out as a basic integrated system, over time gets upgrades grafted onto the initial system, with patches on patches to repair upgrades. Medicaid is of course much more complex, but the general analogy holds, in that Medicaid is a "system of systems," all somewhat integrated, but with each mini-system optimized for its own particular requirements. Optimization of mini-systems may, but in many cases does not, result in an optimal solution for the whole, and there are many instances of this conflict in Medicaid within New York.

The big picture question that policymakers need to address is whether or not to try to repair pieces of the fabric through the patchwork approach, or to truly reinvent the system to ultimately create new fabric using those threads which are worth re-using and adding new threads where appropriate. If the decision were made to pursue a true re-invention of the system, the state would need to carefully manage this process. It would need to develop a model of the new system, test the model, develop crosswalks and then transition from the current to the new model. Clearly, this will be a complex, costly and time-consuming project that will take several years. However, this is the path that will have the highest

probability of making truly significant changes to Medicaid in New York.

Recommendations for New York State

Based on the descriptions of "what is" outlined in this report, as well as our own experience in working with individual counties to manage Medicaid, CGR recommends that the state undertake a combination of fundamental, "system wide" changes for the longer term, complemented by several changes that could immediately begin to help control the growth of Medicaid costs. All of these changes could be initiated immediately, but the designations "long term" or "short term" are used to indicate when it is likely that the changes will start to reduce costs. Additional detailed analysis will be required to develop specific cost/benefit estimates for these recommendations, however, enough is now known in each area to convince us that each recommendation will produce significant improvements over the "current state."

Recommendations for New York State – Long Term Changes

Re-Align Full Fiscal and Administrative Responsibility With the State

Of all the states, New York requires by far the largest contribution toward Medicaid costs from local governments (counties). The state sets policy and controls most aspects of the Medicaid program in New York. However, Upstate counties pay for approximately one-third of the total local share. In 2002, for the total Medicaid spending in the state, federal funds paid 51%, state funds paid 33%, and local county funds paid 16%. Thus, state policy makers are in a position where they have full authority without having to accept full fiscal responsibility for their policy directives. For these reasons, the state should assume control of the entire Medicaid program, relieving counties of both the financial and administrative responsibilities.

Although a reasonable argument can be made against creating a new statewide bureaucracy, doing so would solve many problems with the system as it exists today, and would have a high probability for significantly reducing overall costs. Many advantages to such a change exist. As some examples, it would:

- Relieve counties of the costs of "unfunded mandates,"

- Place responsibility for paying for Medicaid benefits on the state government,

- Reduce the size of county budgets by 20% or more and provide significant property tax relief, thereby improving the financial stability of counties across the state,

- Permit counties to reduce their payroll. Shifting full responsibility to the state will result in a realignment of Medicaid workers from counties to the state, and CGR believes that a statewide administration of Medicaid will create opportunities for regional or statewide economies of scale that should result in a net workforce reduction,

- Standardize provision of benefits across the state. CGR believes that managing provision of Medicaid services (along with other related supportive services) with a statewide perspective will reduce the regional differences that have clearly occurred in the current system in areas such as allocation and use of facilities, client assessment (certification) processes and approaches to providing services. An integrated statewide management approach will create opportunities to standardize provision of services and achieve significant economies of scale.

- Provide a more equitable distribution of Medicaid costs. Currently, poorer counties are forced to tax themselves at a higher rate due to the higher percentage of the population receiving Medicaid benefits. State administration of the program will allow these costs to be distributed across the state rather than concentrated in particular counties.

Clearly, three major conceptual challenges to achieving this shift need to be addressed. Opponents to change will question the financial impact (on the state and the counties), the organizational impact (on the state and the counties) and the service impact (on both Medicaid recipients and service providers). As noted above, a substantial amount of planning will be required, and the transition is likely to take years. However, the outline of the

desired end state can be defined, and transition steps identified to achieve that objective.

Previous Transition Strategies

There are numerous options which should be evaluated in developing a comprehensive plan to transition full administrative and financial responsibility for Medicaid to the state. Within the state, a number of transition alternatives have been proposed, with primary objectives being to minimize any financial burden caused by the shift of local costs to the state government and to allow a smooth transition of costs over a multi-year period.

One of the first major transition plans was proposed by then Governor Cuomo in the early 1990's, which would have incorporated a swap of a penny sales tax from the counties to the state in exchange for the state accepting responsibility for Medicaid costs. This strategy has been periodically revisited, although at this point in time a penny sales tax would not offset the increased cost to the state. Another recent strategy proposed by the counties would be to cap the county contribution at a set amount, and have the state absorb future increases. A third strategy proposed by Governor Pataki would be to shift responsibility for certain program costs between the counties and the state to gradually transition counties out of high cost services.

A recent study by the North Carolina Association of County Commissioners found that since the inception of Medicaid, five states have eliminated county funding for either administrative or actual service (program) costs. These states may also provide useful templates for developing transition strategies for New York.

A New Transition Paradigm

CGR believes that a new transition strategy should be considered, based upon focusing attention on populations being served rather than programs being delivered. As discussed previously, different populations have vastly different service needs, different service use patterns and different cost profiles. Cost management strategies should be developed to identify the most cost effective

ways to provide the specific service needs of specific population groups.

The starting point for this strategy would be to conduct the research needed to stratify Medicaid recipients into groups and subgroups based upon clearly defined service need characteristics, and identify the costs associated with and services provided to each group. Once the groups have been identified, full fiscal responsibility would be allocated to counties or the state on a group by group basis in order to achieve an equitable distribution of costs at the outset, to minimize cost shifting and to mitigate the impact on administrative structures already in place and Medicaid beneficiaries.

Initially, beneficiary groups would be assigned to either the state or counties based upon both an equitable distribution of costs and determination about whether provision of services could be best administered from a local perspective (county responsibility) or regional or state perspective (state responsibility). It is clear that some Medicaid services can best be managed from the local level (for example, specialized fee-based services to children and families or local transportation services), while other Medicaid services would benefit from a regional or statewide management approach that could achieve economies of scale (for example, regional managed care contracts designed to provide coverage in counties currently without such coverage).

The intended long term objective would be to shift complete responsibility for serving all populations to the state. However, experience may dictate that counties can or should be responsible for services to some groups. Or, as other states have found, it may be most efficient for counties to provide some administrative services rather than having a state bureaucracy provide them. Any number of potential variations could develop over time, but the important point would be to start down the path, focusing on provision of cost effective integrated services to client population groups rather than managing Medicaid as a collection of program driven cost centers.

Pursue a Supply Chain Management Strategy

Supply chain management (SCM) is a key cost management strategy used by companies of all sizes in the private sector. Essentially, the strategy is to develop partnership rather than

adversarial relationships with suppliers, and using financial incentives, work with the suppliers to suggest and implement continuous cost reductions. Further, in the long run, SCM attempts to rationalize the supply base, to drive services to the lowest total cost suppliers, where total cost reflects the appropriate balance of price, services and quality. Except for administrative overhead costs, essentially all Medicaid payments are made to suppliers. Thus, the state should determine how to utilize the skills and knowledge of its suppliers to recommend ways to reduce Medicaid costs. In addition,, as the state transitions into becoming fully responsible for Medicaid, it should develop strategies to rationalize the supply base to lower its total cost structure.

This strategy could be employed immediately to begin to identify short term cost reduction opportunities. However, CGR believes that a long-term shift in relationships with service providers should be embedded in the system as it is reinvented in New York.

Recommendations for New York State – Short Term Changes

Promote Managed Care

New York State has been slower than many states to move Medicaid recipients into managed care. In addition, New York State's managed care plan currently only requires able-bodied adults and children to enroll; high-cost users such as disabled and elderly people are exempt or excluded from managed care participation. If counties face difficulties finding a second managed care provider as required by law, they should encourage Medicaid recipients to enroll in a managed care plan voluntarily. The state should restrict access to optional services to only Medicaid recipients enrolled in a managed care plan. The state should review its decision to "carve out" prescription drug coverage and transportation costs from the Medicaid managed care capitation rate.

Change the Formulas that Drive Medicaid Costs

The quickest way for New York to have substantial impact on Medicaid costs is to address one or more of these cost-drivers: the number of people eligible for Medicaid services, the package of services offered through the Medicaid program, and the costs per beneficiary.

What follows are some options that could be considered.

Restrict Eligibility

New York can reduce the number of people eligible for Medicaid by eliminating coverage for optional categories of recipients or by reducing the income threshold for eligibility for benefits. For example, several categories of recipients currently receive Medicaid benefits, but coverage is not required by the federal government. New York could reduce or eliminate Medicaid coverage for Family Health Plus, Child Health Plus B, Safety Net, certain categories of medically-needy people and other optional populations. New York could also create an asset limit for Child Health Plus and Family Health Plus, limiting eligibility to people who have both low incomes and low resources. This approach would save money for the government in the short run, but these cost savings might be offset by delayed utilization of medical care, increased burden on private individual finances, a potential increase in bad debt for hospitals and other health care providers and/or greater use of emergency rooms. In addition, such an approach would raise the number of uninsured people in the state.

Limit the Services Provided

Much has been made of the fact that New York provides a high number of optional Medicaid services, especially compared to other states. Table 4, earlier in the report, identified the categories of services that are by law considered "optional," and how many states provide each optional service compared to New York. The table shows, however, that New York is hardly alone in the provision of optional services, thus, many other states are in the same predicament of needing to identify what services can be reduced or eliminated in order to reduce Medicaid costs.

New York can reduce expenditures on Medicaid by limiting the package of services offered by the Medicaid program. New York could eliminate coverage for a portion or all of the optional medical services the state currently provides. Optional services include certain specialists, dental care, podiatry, and personal care services. For example, if none of the comparison states cover podiatry, then New York State could ask whether it can afford to continue to provide this benefit. Some of the cost-savings from this approach would be offset by substitutions effect. For example, beneficiaries might go to their primary care doctor for podiatry care or might go into a nursing home if no personal care

services are available to help them remain in the community. Health care providers would also likely oppose any attempts to discontinue Medicaid coverage for specialty care.

Re-structure Reimbursement Rates

Third, the state could lower the cost per beneficiary by reducing provider reimbursement rates. New York State could reduce reimbursement rates for health care services provided by Medicaid. Providers would oppose reduced reimbursement rates. Most likely, more providers would refuse to accept Medicaid patients, reducing access to care. It should be noted that this strategy is essentially based on an adversarial relationship between the state and its providers, which is inconsistent with the recommended strategy of supply chain management.

Require Co-Pays

New York State could consider imposing a minimal co-payment for optional services. Co-pays currently cannot be enforced for mandated services if the client claims he or she cannot afford to pay. However, it is generally believed that even minimal co-payment requirements provide an incentive for people to self-police their use of services. For example, The Center for Budget and Policy Priorities reports that healthy people are more likely to forego or postpone care if they have a co-payment[xvi]. Such a policy change would need to take into account that even a nominal co-payment is a much larger share of a poor person's budget than is a co-payment for a non-poor person. The 1999 Medical Expenditure Panel Survey found that non-elderly, non-disabled adults receiving Medicaid spent an average of 2.3% of their income on out-of-pocket medical expenditures. This compares to the .5% of income non-poor, non-elderly, non-disabled adults spent. Perhaps a new state policy could require a sliding scale co-pay based on the type of service provided (to change the incentives for using optional services or types of services to encourage shifting towards more cost-effective providers).

Lobby the Federal Government to Change the FMAP

New York could lobby the federal government to raise the Federal Medical Assistance Percentage (FMAP) for the state. Senator Clinton has made a similar proposal and the federal government has raised the FMAP for all states on a temporary basis for five quarters beginning this past spring. This approach will not address total Medicaid spending, but would shift costs to the federal government. Since the FMAP is based on a decades-old formula

which does not reflect shifts in wealth from the Northeast to other sections of the country, New York can reasonably argue that the formula should be re-visited.

Adopt A Cap Until The State Assumes Full Administrative Control

The most comprehensive approach to reforming Medicaid in New York would clearly be to shift the entire program to the state. However, as that is likely to be a multi-year process, some interim solutions should be pursued in order to achieve some of the improvements desired. In particular, New York State could reduce the county share of Medicaid expenditures, either by reducing the percentage of expenses the county must pay or by adopting a Medicaid cap. Either of these approaches would partially achieve some key objectives, such as providing mandate relief to counties, reducing county costs and shifting cost responsibility to the state government which is where the rules, regulations and benefit levels are promulgated. However, limiting the county share of Medicaid expenditures will not address total Medicaid spending, it will simply shift costs from the counties to the state.

Improve Oversight of Specific, High-Cost Services

New York should manage Medicaid beneficiaries, viewing patient care more comprehensively rather than as individual services in isolation. By better identifying high-cost medical service users, and managing their care more comprehensively, the Medicaid program could achieve significant cost savings.

In addition, New York should aggressively utilize a preferred drug list as a means to control pharmacy expenditures and exercise greater oversight of prescriptions.

The state should also impose new thresholds and time limits on the delivery of Medicaid-funded alcohol and drug abuse treatment. Medicaid clients should not be allowed to pursue treatment options indefinitely. Rather, clients should be expected to make regular progress in treatment. If clients are not making progress, they should be switched to other treatment providers.

New York should also continue to encourage elderly and disabled Medicaid recipients to remain in the community as long as home-based services are less expensive than institutional care. These and other improvements should be based on identifying cost and

utilization trends through analysis of the Medicaid recipient database described earlier in the report.

Review Provider Reimbursement Rates to Optimize Use of Lowest Cost Services

New York State should consider increasing primary care physician reimbursement rates which will likely produce a net reduction in total Medicaid costs. Currently, physician reimbursement rates are among the lowest in the nation. As a result, many doctors restrict the number of Medicaid patients they accept or refuse to accept any Medicaid patients at all. This can result in expensive cost-shifting, with Medicaid recipients unable to make an appointment for an office visit with a primary care physician instead turning to more costly ambulatory clinics or emergency rooms for routine care. Raising reimbursement rates may allow primary care physicians to accept more Medicaid patients, thus reducing the use of clinics and emergency rooms by Medicaid patients.

Aggressively Pursue Recoveries

New York State should more aggressively pursue resource recovery from Medicaid recipients. While much of this responsibility currently falls to the counties, the state can assist in those efforts. For example, in the case of car accidents the insurance for the party at fault should pay all medical bills resulting from the accident. The state can provide the counties with information about insurance settlements that the county can then use to pursue recovery. New York State should follow the lead of Washington State and send a letter to all licensed attorneys, reminding them that they must notify the state Health Department when their clients are involved in personal injury cases and have received medical assistance payments for their care.

Recommendations for New York Counties

While counties cannot influence the "big ticket" items, such as eligibility criteria and services offered, it is clear that counties can influence their Medicaid costs, at least "at the margins". CGR is working with several New York counties to evaluate their Medicaid expenditures. Those counties which are being the most aggressive in managing Medicaid costs have focused on employing client utilization data to identify high cost clients and providers and offer opportunities for change. Based on its observations, CGR suggests that all counties should control Medicaid costs through the following strategies.

Tightly Manage Certification

Medicaid eligibility criteria are complex and many applicants have incomes that fluctuate across the eligibility threshold, based on

whether or not an applicant can find work in a given month. Accurately determining eligibility and continuing eligibility is challenging and overworked examiners can make mistakes. Thus, quality control (QC) management can affect the number of eligibles being approved. In addition, some counties have made administrative determinations to strictly follow eligibility certification documentation and process requirements, which effectively slows down approval of new applications. This strategy runs counter to the social policy objective of getting needy recipients coverage as quickly as possible, however, it helps achieve the cost management objective. In the Health Care Reform Act of 2002 (HCRA 2002), the state substantially changed the re-certification process, simplifying the process and allowing clients to mail in their forms in most cases. These changes make it even more difficult for countries to exercise their "gatekeeper" roles effectively. In addition, applicants are who are legitimately eligible eventually enrolled in the program and any medical expenses they incur during the period their application is under review are usually paid by Medicaid retroactively.

Revenue recovery strategies can be considered to fall within the certification management function. Recovery of amounts paid or due from estates, fraudulent applications and other changes reflect a change in status of a beneficiary. County staff need to identify, measure and act upon these changes in a systematic and comprehensive manner.

Pursue Diversion Strategies

Counties can devote management attention to ensure that Medicaid is the payer of last resort. Many examples of these strategies exist. Veterans can be encouraged to make use of VA hospitals. Applicants can be monitored to insure that they utilize private (third party) health insurance rather than using Medicaid. Counties can assist disabled people in gathering the documentation necessary to apply for Supplemental Security Income. Medicaid can pay Medicare Part B premiums for low-income disabled people or senior citizens, which ensures that for dual-eligibles, Medicare is billed before Medicaid. Anecdotal evidence, however, suggests that both the Medicaid and Medicare programs appear to have an administrative quagmire that discourages attempts to collect funds from the appropriate agency. Able-bodied adult applicants can be directed to employers known

to be hiring workers. Counties can actively pursue insurance settlements if a Medicaid recipient is injured through no fault of his or her own.

Promote Lower-Cost Substitutions

County staff in different departments (at least DSS, Health and Mental Health) can pursue strategies to ensure that beneficiaries are using the most cost-effective services to meet their needs. Many different strategies are being tried by counties to identify lower-cost services or lower-cost providers, such as using and promoting in-county versus out-of-county services to reduce transportation costs and using home-based services rather than institutional care where appropriate. Ultimately, identifying the lowest cost solution requires a comprehensive assessment of services available across the entire community and integrating these services into a cost effective unified network.

Engage Suppliers in Cost Reduction Strategies

Just as the state could actively engage suppliers to assist in reducing costs through supply chain management strategies, counties could pursue the same strategies at the local level.

CONCLUSION

Despite all the publicity about ballooning Medicaid spending, rising enrollments and intense pressure on state budgets, research has found that nationwide, Medicaid is holding the line on medical costs, and doing as well, if not better than private health insurance plans.[xvii] Ohio's Medicaid Director is quoted in *Governing Magazine* as saying, "Medicaid as a health plan is not out of control. Our problem is that even a well-managed program like Medicaid is more than state revenue can handle – the program is growing faster than state economies. And that's the dilemma."[xviii]

In order to control its escalating budget and improve its cost structure, New York must make tough decisions if it wants to bring its Medicaid costs in line with comparable states. Some recommendations made in this report, if implemented, would affect the level of services provided by the state. They would reduce the number of people eligible for Medicaid services and limit the types of medical services Medicaid recipients can receive. Other recommendations, however, focus on cost efficiencies by

reducing administrative costs, utilizing opportunities proposed by providers to reduce costs and achieving economies of scale. These could be achieved on a smaller scale by immediately pursuing some of the strategies identified, and on a larger scale by transferring administration of the program to the state.

The state clearly needs to address its Medicaid cost structure, especially in light of the predictable increase in demand from the rising elderly population. However, this report is intended to demonstrate that there are in fact many different opportunities to address the problem of rising Medicaid costs. The task is certainly not hopeless, it is simply daunting because of the complexity of Medicaid. By using data to identify opportunities and incorporating ideas from the many experienced professionals at all levels of government who are trying to ensure that the Medicaid program meets the public policy objectives set forth by the Congress, the State Legislature and the Courts, New York State can improve Medicaid so that it can become more effective and efficient.

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GLOSSARY OF TERMS

ADC (Aid to Dependent Children): Cash assistance to low-income households with children. Prior to national welfare reform, people receiving cash assistance were automatically enrolled in Medicaid.

Beneficiary: A person who uses a medical service paid for by Medicaid

Categorically eligible: A person who is eligible for Medicaid coverage because they fall into a covered category. For example, the person is a child or adult who meets the low-income standards to be eligible for Medicaid. The federal government requires all states to provide Medicaid benefits to people who fit these criteria. Some states expand Medicaid coverage to include people who are not categorically eligible for benefits.

Dual eligibles: Elderly and disabled individuals who qualify for both Medicare and Medicaid health insurance benefits.

Eligible: A person who meets the eligibility criteria for the Medicaid program, has applied and is enrolled in the program.

Enrolled: A person who meets the eligibility criteria for the Medicaid program, has applied and is enrolled in the program.

Federal Medical Assistance Percentage (FMAP): The federal government matches state and local Medicaid expenditures. The federal government provides at least $1 for each $1 spent by the state and local governments. In some states, the federal share is 80% or more.

Home Relief: New York State-funded public assistance to low-income individuals and families who do not qualify for federal cash assistance programs.

Home and Community-based Services: Health care services provided to allow elderly and disabled people to remain in their

neighborhoods and avoid institutional care. Many states have received waivers to provide these services. Under the waiver, services not normally covered by Medicaid are provided using Medicaid dollars with the understanding that the services provided allow the client to avoid institutional care that would be more expensive than their current care.

Institutional Long-Term Care: Health care provided to elderly or disabled recipients in a nursing home or other facility where the recipient resides with other people in similar circumstances. Recipients require ongoing care, often on a daily basis, for an extended period of time. In most cases, the recipient is not expected to recover a sufficient level of functioning to be discharged from the facility.

Long-Term Care: Health care provided primarily for the elderly, but also including some disabled people. Includes both institutional care provided in a nursing home or assisted living facility as well as personal care services and other health care provided in the home. Recipients require ongoing care, often daily, for an extended period of time.

Medicaid: A federal-state program that provides health insurance for low-income adults and children.

Medical Assistance: Category of beneficiaries who receive health insurance coverage through Medicaid, but are not eligible for cash assistance programs.

Medically eligible: A person whose income is above the threshold for Medicaid eligibility, but whose medical condition results in medical expenses sufficient to reduce the person's income to a level that meets the Medicaid eligibility threshold. People who meet these standards are in an optional Medicaid category and states are not required to provide coverage.

Medicare: A federal program that provides health insurance coverage for senior citizens, regardless of income.

Potentially eligible: The sum total of all people who qualify for Medicaid benefits, regardless of whether or not they have enrolled in the program. Studies (Rockefeller take-up study) show that

70% of people who are income eligible for Medicaid actually enroll in the program. The remaining 30% are eligible for the program, but choose not to apply for various reasons.

Recipient: A person who has used medical services paid for by the Medicaid program.

Safety Net: New York State-funded public assistance to individuals and families who do not qualify for federal cash assistance programs. Safety Net is New York State's general assistance program.

SSI: Supplemental Security Income. Cash assistance to low-income elderly people or low-income people under 65 years of age who are blind or disabled.

TANF (Temporary Assistance to Needy Families): Cash assistance to low-income families with children, formerly known as Aid to Families with Dependent Children (AFDC). Prior to welfare reform, low-income families receiving cash assistance were automatically enrolled in Medicaid.

User: A person who has received a specific medical service paid for by Medicaid.

APPENDIX A: A NOTE ABOUT DATA AND METHODOLOGY

Data for this report are drawn from three main sources: the Center for Medicare and Medicaid Services, the New York State Department of Health and the Kaiser Commission on Medicaid and the Uninsured. Data across these three sources are not comparable due to variations in the methods of collection. While data from CMS and NYSDoH are internally comparable, the Kaiser Commission data are comparable within states, but not across states. As a result, each data source may have different results for the same variable due to variations in data collection methods. While this fact may lead to some confusion, no single data source provides all the information we would like to include in the report, making it necessary to shift among sources. We believe the advantage of examining Medicaid from a variety of perspectives overcomes the disadvantages of using multiple data sources. To the extent possible, this report makes comparisons and draws conclusions by comparing data points using data from the same source. In some cases, results will be different depending on the data source used. In such cases, we have made an effort to identify the data source to help clarify variations.

This report relies most extensively on data from fiscal years 2000 and 2001. National 2001 data were released by CMS after the report was prepared. The 2001 data are not included in this report. For the most part, data available on the NYSDoH website are for State Fiscal Year 2000, although in certain cases, namely Medicaid enrollments and Medicaid managed care statistics, more current data are available. While the lack of current data poses limitations, we believe that the available data do lend themselves to meaningful interpretation.

One further complicating factor to obtaining data that are comparable across states is the variation in the way states implement their Medicaid programs. As a federal-state

partnership, Medicaid allows for considerable variation in program implementation among the states. Especially after the passage of welfare reform in 1996, many states sought and received waivers from the federal government to undertake reforms in their Medicaid program. As a result, interstate comparisons become more challenging as states are less likely to report data in comparable form. This is especially true when making comparisons between states that have their entire Medicaid population in managed care, such as Tennessee and Michigan, and states that still rely heavily on fee-for-service care, such as Illinois, New York and Ohio. Managed care capitation rates often encompass services that are detailed separately in fee-for-service plans. The practical result is to skew these comparisons, making states that use managed care extensively look like low spenders on specialty services and high spenders on managed care while the inverse impression is given about states that still rely primarily on fee-for-service. To the extent possible, this report makes comparisons across states, but the reader should bear in mind that variations in Medicaid program administration may be in part responsible for these differences.

APPENDIX B: SELECTED DATA TABLES

Selected Comparison Data, 1993 and 2000

Note: 1993 data are from the 1995 CGR report "Medicaid Cost Containment: Options for New York". Interstate data are from the Health Care Financing administration and Intrastate data are from the New York State Department of Health. In 2000, interstate data are from the Center for Medicare and Medicaid Services and intrastate data are from the New York State Department of Health.

Table 6: Total Medicaid Expenditures Lowest to Highest for 12 selected states

Medicaid Expenditures	
1993	**2000**
Maryland	Wisconsin
Wisconsin	Minnesota
Minnesota	Tennessee
Tennessee	Maryland
North Carolina	North Carolina
Michigan	Michigan
Pennsylvania	Pennsylvania
Illinois	Ohio
Ohio	Illinois
Texas	Texas
California	California
New York	***New York***

Table 7: Medicaid Costs per Recipient, Lowest to Highest for 12 selected states

Medicaid Costs Per Recipient	
1993	**2000**
California	California
Tennessee	Tennessee
Texas	Texas
North Carolina	Michigan
Michigan	North Carolina
Ohio	Pennsylvania
Pennsylvania	Wisconsin
Illinois	Illinois
Wisconsin	Maryland
Maryland	Ohio
Minnesota	Minnesota
New York	***New York***

Table 8: Medicaid Spending per Capita, Lowest to Highest for 12 selected states

Medicaid Spending per Capita	
1993	**2000**
Texas	Texas
California	Michigan
Pennsylvania	California
Michigan	Pennsylvania
Maryland	Wisconsin
North Carolina	North Carolina
Wisconsin	Tennessee
Tennessee	Ohio
Illinois	Illinois
Ohio	Minnesota
Minnesota	Maryland
New York	***New York***

Table 9: Medicaid Spending as a Percentage of Gross State Product, Lowest to Highest for 12 selected states

Medicaid Spending as Percentage of Gross State Product	
1993	**2000**
California	Texas
Texas	California
Maryland	Michigan
Pennsylvania	Pennsylvania
Michigan	Illinois
Illinois	Wisconsin
North Carolina	North Carolina
Wisconsin	Minnesota
Minnesota	Ohio
Ohio	Maryland
Tennessee	Tennessee
New York	***New York***

Table 10: Medicaid Expenditures as a Share of Total State Spending, Lowest to Highest for 12 selected states

Medicaid Expenditures as Share of Total State Spending	
1993	**2000**
California	Wisconsin
Wisconsin	California
Pennsylvania	Michigan
Maryland	Pennsylvania
Michigan	Minnesota
Minnesota	Ohio
Texas	Texas
North Carolina	North Carolina
Ohio	Maryland
Illinois	Tennessee
Tennessee	Illinois
New York	***New York***

Table 11: Inpatient Hospital Costs per Recipient, Lowest to Highest for 12 selected states

Medicaid Inpatient Hospital	
1993	**2000**
Tennessee	Tennessee
North Carolina	Texas
Texas	North Carolina
Ohio	Pennsylvania
Wisconsin	California
Michigan	Wisconsin
Pennsylvania	Ohio
Minnesota	Michigan
California	Minnesota
Maryland	Maryland
Illinois	***New York***
New York	Illinois

Table 12: Outpatient Hospital Costs per Recipient, Lowest to Highest for 12 selected states

Medicaid Outpatient Hospital	
1993	**2000**
Pennsylvania	Tennessee
California	California
Illinois	Pennsylvania
Ohio	Minnesota
Minnesota	Ohio
North Carolina	Wisconsin
Wisconsin	Michigan
Texas	Texas
Michigan	North Carolina
Tennessee	Illinois
New York	Maryland
Maryland	***New York***

Table 13: Intermediary Care Facilities, Lowest to Highest for 12 selected states

Medicaid ICF MR Care	
1993	**2000**
Texas	Illinois
Illinois	Minnesota
Wisconsin	California
Tennessee	Texas
Minnesota	Ohio
California	Wisconsin
Ohio	North Carolina
Michigan	Pennsylvania
Maryland	Michigan
North Carolina	Maryland
Pennsylvania	Tennessee
New York	***New York***

Table 14: Other Practitioners' Services per Recipient, Lowest to Highest for 12 selected states

Other Practitioners' Services	
1993	**2000**
North Carolina	Illinois
Michigan	Michigan
Pennsylvania	Maryland
Tennessee	***New York***
Maryland	Ohio
Texas	California
California	Tennessee
Wisconsin	Pennsylvania
Ohio	Texas
Illinois	Minnesota
Minnesota	North Carolina
New York	Wisconsin

Table 15: Dental Services Costs per Recipient, Lowest to Highest for 12 selected states

Dental Services	
1993	**2000**
Illinois	Tennessee
Maryland	Michigan
Michigan	Pennsylvania
Pennsylvania	Wisconsin
Ohio	Maryland
Wisconsin	Minnesota
Tennessee	Ohio
Minnesota	California
North Carolina	Texas
New York	***New York***
Texas	North Carolina
California	Illinois

Table 16: Physician Services per Recipient, Lowest to Highest for 12 selected states

Physician Services	
1993	**2000**
New York	Pennsylvania
Pennsylvania	***New York***
Wisconsin	Wisconsin
Illinois	California
Ohio	Michigan
California	Illinois
Michigan	Ohio
Maryland	Maryland
Texas	Texas
North Carolina	North Carolina
Minnesota	Minnesota
Tennessee	Tennessee

Table 17: Clinic Services per Recipient, Lowest to Highest for 12 selected states

Clinic Services	
1993	**2000**
Texas	Texas
Wisconsin	Tennessee
North Carolina	Maryland
Illinois	North Carolina
Minnesota	Wisconsin
Tennessee	Minnesota
California	Illinois
Ohio	California
Pennsylvania	Ohio
Maryland	Pennsylvania
Michigan	***New York***
New York	Michigan

Table 18: Hospital Inpatient per Recipient, Lowest to Highest 10 New York Counties

Hospital Inpatient	
1993	**2000**
Franklin	Tioga
Jefferson	Herkimer
Fulton	Cattaraugus
Chenango	Schuyler
Clinton	Madison
Chautauqua	Montgomery
Schuyler	Chautauqua
Greene	St. Lawrence
Herkimer	Cortland
St. Lawrence	Chemung
Orange	Dutchess
Ulster	Monroe
Monroe	Sullivan
Rockland	Suffolk
Sullivan	Rockland
Suffolk	Greene
Putnam	Westchester
Westchester	Putnam
Nassau	Nassau

Table 19: Percent of Managed Care Eligibles enrolled in Managed Care, Lowest to Highest 10 New York Counties

Percent of Medicaid Eligibles Enrolled in Managed Care	
1993	**2000**
North Carolina	Illinois
New York	***New York***
Illinois	Ohio
California	Wisconsin
Wisconsin	California
Ohio	Minnesota
Pennsylvania	Maryland
Michigan	North Carolina
Maryland	Pennsylvania
Minnesota	Michigan

Table 20: Medicaid SNF Costs, Lowest to Highest for 12 selected states

Medicaid SNF Costs	
1993	**2000**
Texas	Texas
Illinois	North Carolina
Michigan	Wisconsin
North Carolina	Pennsylvania
Wisconsin	California
Maryland	Michigan
California	Maryland
Ohio	Minnesota
Pennsylvania	Ohio
Minnesota	Illinois
New York	***New York***

Table 21: Medicaid Home Health Care Costs per Recipient, Lowest to Highest For 12 selected states

Medicaid Home Health Care Costs	
1993	**2000**
Tennessee	Ohio
California	Minnesota
Pennsylvania	Texas
Texas	Illinois
Michigan	North Carolina
Illinois	Michigan
Ohio	California
Maryland	***New York***
North Carolina	Pennsylvania
Minnesota	Wisconsin
Wisconsin	Tennessee
New York	Maryland

Table 22: Skilled Nursing Facility Costs per Recipient, Lowest to Highest 10 New York Counties

County SNF Costs	
1993	**2000**
Genesee	Allegheny
St. Lawrence	St. Lawrence
Allegheny	Cattaraugus
Cortland	Niagara
Orleans	Genesee
Chautauqua	Broome
Broome	Tompkins
Warren	Warren
Niagara	Oswego
Cattaraugus	Orleans
Schuyler	Wayne
Fulton	Ulster
Sullivan	Putnam
Montgomery	Orange
Westchester	Dutchess
Seneca	Westchester
Rockland	Rockland
Nassau	Suffolk
Suffolk	Nassau

Table 23: Home Health Care Costs per Recipient, Lowest to Highest 10 New York Counties

County Home Health Care Costs	
1993	**2000**
Broome	Allegheny
Yates	Steuben
Madison	Herkimer
Herkimer	Yates
Wyoming	Madison
Schuyler	Oneida
Washington	Livingston
Oneida	Tompkins
Otsego	Cayuga
Cayuga	Seneca
Dutchess	Fulton
Erie	Dutchess
Rockland	Ulster
Suffolk	Suffolk
Ulster	Orange
Monroe	Rockland
Nassau	Westchester
Westchester	Putnam
Putnam	Nassau

New York State Medicaid: County Profile Summary Tables

Table 24: Dollars Per User, State Fiscal Year 1999-2000

Medicaid County Profile Summary Tables				
Dollars per user				
	min	max	mean	median
Physicians - Psych	$78.00	$398.00	$210.25	$207.35
Physicians - MMTP	$0.00	$2,178.80	$214.39	$0.00
Physicians Primary care	$115.79	$223.80	$163.79	$166.04
Physicians all other	NA	NA	NA	NA
Clinics - emergency room	$145.01	$223.24	$186.18	$184.00
Clinics psych including alcohol	$1,036.19	$4,697.92	$1,863.18	$1,659.13
Clinics, alcohol services	$701.17	$3,345.25	$1,353.00	$1,245.85
Clinics - MMTP	$0.00	$6,394.00	$3,039.00	$3,496.55
Clinics Primary Care	$219.03	$641.69	$345.54	$322.61
Clinics All other	NA	NA	NA	NA
Inpatient	$4,813.10	$12,328.70	$5,410.64	$4,813.11
Pharmacy	$924.20	$1,887.80	$1,133.21	$1,107.75
Lab	$32.00	$60.90	$41.71	$40.86
Dental	$135.10	$351.00	$237.16	$236.44
Transportation	$114.30	$1,081.20	$405.38	$373.59
Institutional LTC	$19,467.10	$41,215.30	$27,382.25	$26,679.63
Noninstitutional LTC	$1,849.70	$19,012.50	$5,325.57	$4,974.73
HMO	$100.10	$1,608.70	$849.75	$889.82
Supp Health Serv Prog	$1,953.10	$4,402.80	$2,963.70	$2,978.10
Case Management	$1,194.50	$2,092.20	$1,455.19	$1,451.92
ICF-DD	$8,709.00	$70,078.80	$33,410.88	$32,098.20
OMR Inpatient	$0.00	$638,277.00	$97,702.90	$12,514.40
Community and Rehab	$16,321.80	$33,996.30	$24,625.49	$24,105.19

Table 25: Units Per User, Fiscal Year 1999-2000

Medicaid County Profile Summary Tables				
Units Per User				
	min	max	mean	median
Physicians - Psych	3.0	14.0	8.1	8.1
Physicians - MMTP	0.0	34.2	3.5	0.0
Physicians Primary care	4.7	7.9	6.0	5.9
Physicians all other	NA	NA	NA	NA
Clinics - emergency room	1.6	2.2	1.8	1.8
Clinics psych including alcohol	11.5	49.2	22.0	20.5
Clinics, alcohol services	12.0	56.3	22.2	20.1
Clinics - MMTP	0.0	53.0	26.6	30.9
Clinics Primary Care	2.8	5.6	4.2	4.1
Clinics All other	NA	NA	NA	NA
Inpatient	4.5	11.1	6.7	5.9
Pharmacy	19.9	28.2	22.7	22.7
Lab	4.6	7.0	5.6	5.5
Dental	3.4	6.5	4.4	4.2
Transportation	2.9	29.1	9.7	8.7
Institutional LTC	226.2	272.4	247.5	247.0
Noninstitutional LTC	N/A	N/A	N/A	N/A
HMO	4.1	9.2	7.3	8.0
Supp Health Serv Prog	5.3	12.1	8.5	8.6
Case Management	8.2	21.4	13.9	13.6
ICF-DD	105.0	370.8	237.5	237.5
OMR Inpatient	0.0	335.0	84.1	6.5
Community and Rehab	97.4	297.5	169.1	161.3

Table 26: Users as a Percentage of Eligibles, Fiscal Year 1999-2000

Medicaid County Profile Summary Tables				
Users as % of eligibles				
	min	**max**	**mean**	**median**
Physicians - Psych	0.2%	7.2%	1.7%	1.1%
Physicians - MMTP	0.0%	0.0%	0.0%	0.0%
Physicians Primary care	18.9%	56.5%	39.2%	39.8%
Physicians all other	NA	NA	NA	NA
Clinics - emergency room	11.0%	36.0%	20.3%	19.5%
Clinics psych including alcohol	4.0%	17.0%	10.4%	10.4%
Clinics, alcohol services	0.8%	4.0%	2.1%	2.1%
Clinics - MMTP	0.0%	1.3%	0.2%	0.1%
Clinics Primary Care	6.2%	54.3%	27.6%	27.7%
Clinics All other	NA	NA	NA	NA
Inpatient	8.8%	19.5%	13.6%	13.6%
Pharmacy	60.0%	70.0%	64.4%	64.3%
Lab	10.0%	30.0%	18.2%	17.7%
Dental	10.0%	30.0%	20.0%	20.3%
Transportation	0.0%	20.0%	8.5%	8.1%
Institutional LTC	3.0%	13.6%	7.0%	7.0%
Noninstitutional LTC	2.5%	11.2%	5.7%	5.3%
HMO	0.2%	57.8%	20.0%	17.1%
Supp Health Serv Prog	1.0%	8.1%	5.3%	5.4%
Case Management	1.4%	7.7%	4.5%	4.4%
ICF-DD	0.0%	2.0%	0.7%	0.6%
OMR Inpatient	0.0%	0.0%	0.0%	0.0%
Community and Rehab	0.5%	7.1%	2.8%	2.7%

ENDNOTES

[i]Lemov, Penelope, *Governing Magazine,* p. 58

[*] Most families and children have episodes of Medicaid eligibility that last less than a year and are often associated with local economic difficulties. In contrast, many disabled adults and elderly adults have episodes of Medicaid eligibility that are longer and often independent of local economic conditions.

[ii] Ku, Leighton and Matthew Broaddus. "Why are States' Medicaid Expenditures Rising?", Center for Budget and Policy Priorities, January 13, 2003. Retrieved from www.cbpp.org on May 15, 2003.

[iii] Lemov, Penelope, *Governing Magazine*, May 2003.

[iv] The "Jobs and Growth Tax Relief Reconciliation Act of 2003" offers temporary assistance to the states by releasing $20 billion in federal funds. Half this money will to be used to increase the federal matching rates for Medicaid and the other half will be evenly divided among states to use on a variety of "essential government" services, such as health care, social services, public safety, education, job training, transportation or infrastructure. According to the New York State Division of the Budget, New York can expect approximately $1.4 billion in increased federal Medicaid funds as a result of this legislation. NYSAC estimates the county share will be $470 million. (New York State Association of Counties, "Summary and Impact of the Jobs and Growth Tax Relief Act of 2003", May 30, 2003. Retrieved from www.nysac.org on June 23, 2003.)

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[xii] Gearan, Anne, "Supreme Court Gives Maine Go-Ahead to Try to Lower Drug Prices: But Justices Warn the Program May Not Survive Further Challenges" www.washingtonpost.com., May 19, 2003.

[xiii] Lemov, Penelope, "Easing the Pain," *Governing Magazine*, May 2003, p. 60.
[xiv] Rockefeller Institute report on take-up rates.
[xv] Owcharenko, Nina, "Why Expanding Medicaid to Cover the Uninsured is Not the Solution", Executive Memorandum #811, The Heritage Foundation. http://www.heritage.org/Research/HealthCare/EM811.cfm, May 15, 2003.
[xvi] Ku, Leighton, "Charging the Poor More for Health Care: Cost-Sharing in Medicaid", Center on Budget and Policy Priorities, www.cbpp.org/5-7-03health.htm, May 15, 2003.
[xvii] Lemov, Penelope, "Easing the Pain", *Governing Magazine*, p. 60.
[xviii] Ibid, p. 60.