

**MEDICAID  
INSTITUTE**  
AT UNITED HOSPITAL FUND

# Medicaid in New York A Primer

Revised and Updated 2008

## **About the Medicaid Institute at United Hospital Fund**

Established in 2005, the Medicaid Institute at United Hospital Fund provides information and analysis explaining the Medicaid program of New York State. The Medicaid Institute also develops and tests innovative ideas for improving Medicaid's program administration and service delivery. While contributing to the national discussion, the Medicaid Institute aims primarily to help New York's legislators, policymakers, health care providers, researchers, and other stakeholders make informed decisions to redesign, restructure, and rebuild the state program.

## **About United Hospital Fund**

United Hospital Fund is a health services research and philanthropic organization whose mission is to shape positive change in health care for the people of New York. We advance policies and support programs that promote high-quality, patient-centered health care services that are accessible to all. We undertake research and policy analysis to improve the financing and delivery of care in hospitals, clinics, nursing homes, and other care settings. We raise funds and give grants to examine emerging issues and stimulate innovative programs. And we work collaboratively with civic, professional, and volunteer leaders to identify and realize opportunities for change.

## **Medicaid Institute at United Hospital Fund**

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ISBN 1-88127-7836

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# Medicaid in New York: A Primer

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## Foreword

This revised and expanded edition of *Medicaid in New York: A Primer*, the inaugural publication, in 2005, of the Medicaid Institute at United Hospital Fund, continues the Institute's mission of providing the information essential to shaping sound health policy and practice so that Medicaid can meet its most important challenges: covering more low-income New Yorkers, better managing patient care, reforming payment systems, providing effective long-term care, and improving program administration.

With New York's Medicaid program as complex and important as it is, a common set of facts and base assumptions is critical to productive policy discussions. This updated *Primer* serves, once again, as a foundation document, a framework for understanding the operations and challenges of the program and introducing it to new generations of policymakers and stakeholders in the health care community. This new report provides the latest information on eligibility rules, beneficiaries, covered services, and costs, and includes a new analysis of recent trends in Medicaid spending and the role of long-term care.

United Hospital Fund has a distinguished history of conducting groundbreaking research, producing incisive policy analysis, and creating innovative programs leading to better health care for all New Yorkers. The Medicaid Institute at the Fund continues this tradition, by helping shape positive change in New York's Medicaid program. This new version of *Medicaid in New York: A Primer* is a significant addition to that process.

James R. Tallon, Jr.  
President  
United Hospital Fund

## What is Medicaid?

This report provides an overview of New York's Medicaid program. It updates content on eligibility rules, enrollment, and costs from *Medicaid in New York: A Primer* (Medicaid Institute 2005), and offers new analyses of Medicaid spending growth and issues related to long-term care, as well as a discussion of Medicaid's key roles and major challenges.

Medicaid is a means-tested health care entitlement program. It provides health insurance for low-income children and adults, acute and long-term care services and supports for disabled individuals without access to other coverage, and secondary coverage for Medicare beneficiaries who need long-term care or help with cost sharing. Medicaid also directly subsidizes safety net providers serving large numbers of low-income and uninsured patients.

Established through the 1965 amendments to the federal Social Security Act, Medicaid is jointly funded by the federal government and states. Within federal guidelines, states administer Medicaid and set the rules governing eligibility, covered benefits, and provider reimbursement. States receive federal financial support and determine what share of Medicaid costs are borne by local governments.

Medicaid serves more than four million New Yorkers. It is one of the largest items in New York's state and local budgets, and accounts for more than half of all federal funding that flows to New York. Medicaid payments to health care providers and insurance plans—now approaching \$50 billion annually in total—fuel about 30 percent of New York's health care economy.

## Who is eligible?

Medicaid eligibility is mainly determined by family income, with children and adults facing different income limits. These limits are defined in relation to the federal poverty level (FPL), which in 2008 was \$10,400 for an individual and \$17,600 for a family or household of three. In general, individuals above these income limits can “spend down” to Medicaid eligibility, with certain medical expenses counting toward a downward adjustment of their household incomes. To receive covered long-term care services, elderly and disabled beneficiaries must also meet Medicaid’s functional eligibility criteria, as well as additional financial requirements. In New York, Medicaid eligibility is extended to adult immigrants lawfully residing in the state, and to children regardless of their immigration status, provided these individuals meet all other eligibility criteria.

### **Children**

In New York, children less than a year old are eligible for coverage if family income is below 200 percent FPL. Children aged 1–5 in families with income up to 133 percent FPL, and children 6–18 in families with income up to 100 percent FPL, are also eligible. Infants and children aged 1–18 who do not qualify for Medicaid currently are eligible for New York’s State Children’s Health Insurance Program (SCHIP) if family income does not exceed 250 percent FPL. New York’s Medicaid program for

children is called Child Health Plus A (CHP A) and SCHIP is called Child Health Plus B (CHP B).

Because SCHIP covers children in families with higher incomes than Medicaid does, efforts to make public coverage available to more children require an expansion of SCHIP eligibility. In 2007, New York proposed increasing the family income limit for SCHIP from 250 percent to 400 percent FPL—a policy designed to make SCHIP available to about 60,000 additional uninsured children, nearly all of those not currently eligible for public coverage. The federal government denied financial support for the proposal. While New York is contesting this decision in the courts, the Governor has proposed pursuing the expansion exclusively with state funds if necessary.

### **Adults**

Adults in New York face varying eligibility limits, depending on whether they are parents of a child under 21 living in their household. Parents are eligible for Family Health Plus (FHP), a Medicaid expansion enacted in 1999 and implemented in 2001, with family income of up to 150 percent FPL; childless adults are eligible with family income of up to 100 percent FPL, provided family assets do not exceed limits that vary by enrollment category and family size. In addition, pregnant women with family income of up to 200

percent FPL are eligible for coverage of prenatal care. New York's income limits for adults are generally higher than those of other states; not all low-income New Yorkers are eligible for Medicaid, however. For example, a married couple with no children in the household, earning a combined \$15,000 annually, or a single parent of two children who earns \$27,000 annually, would be ineligible for Medicaid because family income is too high.

#### **Elderly and disabled beneficiaries requiring long-term care**

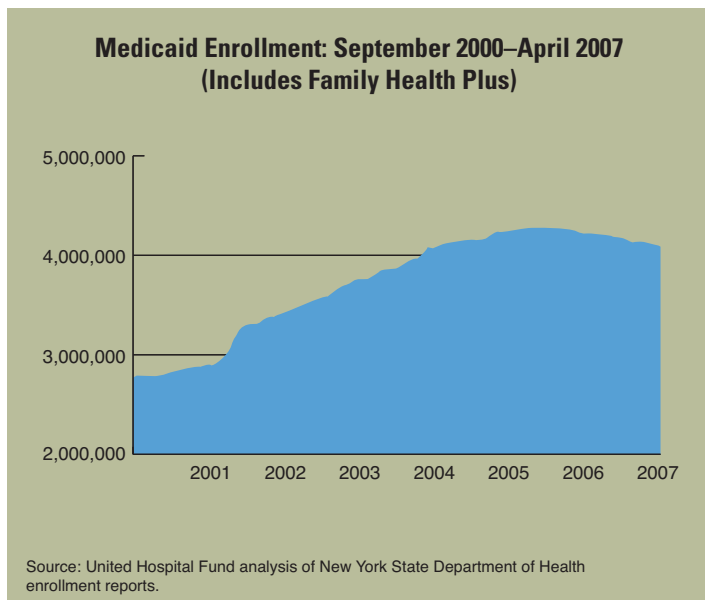
Elderly and disabled beneficiaries who do not require long-term care are subject to the regular Medicaid eligibility criteria described above. Medicaid also provides long-term care services in a variety of settings for elderly or disabled beneficiaries who meet functional criteria as well as financial requirements. These individuals must have limitations in performing activities of daily living, such as eating, bathing, and dressing. They also must have incomes below about 80 percent FPL, and assets of no more than \$4,350 for an individual or \$6,400 for a couple. The federal Deficit Reduction Act of 2005 mandated several changes in how states determine eligibility for nursing home care. Medicaid beneficiaries with more than \$750,000 in home equity are ineligible, unless the home is the primary residence of a spouse or child.

States must look back five years for any asset transfers, and impose as a penalty a waiting period related to the amount of any transfers. In addition, applicants must disclose annuities, which are no longer counted as exempt assets, and name the state as a beneficiary. New York imposed some of these eligibility restrictions prior to the Deficit Reduction Act but must now comply with these more stringent guidelines.

#### **Targeted eligibility groups**

New York extends Medicaid eligibility to smaller targeted groups of beneficiaries. For example, women with incomes up to 200 percent FPL are eligible to receive family planning services through Medicaid. In addition, uninsured women who are diagnosed with breast or cervical cancer through New York's Healthy Women Partnerships screening program (which has an income limit of 250 percent FPL) are eligible for Medicaid. Some targeted expansions are Medicaid "buy-ins." Disabled workers aged 16–64 with net income below 250 percent FPL and resources below \$10,000 are eligible for the Medicaid Buy-In for Working People with Disabilities. In 2007, the state enacted an option allowing employers and certain unions to buy into Family Health Plus for their employees or members; in most cases, employers or unions are expected to pay at least 70 percent of the average premium, with the individual paying the balance.

## Who is enrolled?



As of April 2007, Medicaid provided coverage to about 4.1 million New Yorkers. This total includes 1.6 million beneficiaries aged 18 or under, and 1.5 million (including those in Family Health Plus), aged 19 to 64, without disabilities—groups referred to, respectively, as “children” and “adults”—as well as more than 1.0 million elderly and disabled individuals. An additional 400,000 children receive coverage through SCHIP. The number of beneficiaries covered by Medicaid at any point during a full year typically exceeds the number enrolled in a single month by a significant margin, because each month some beneficiaries gain or lose coverage.

Medicaid enrollment increased dramatically from 2.8 million in September 2000 to 4.3 million in September 2005, due to a combination of policy reforms and economic conditions. In the wake of the September 11 attacks, New York State and New York City jointly implemented Disaster Relief Medicaid, which temporarily simplified eligibility determinations in the city and allowed successful applicants to enroll immediately. The state simultaneously implemented the Family Health Plus eligibility expansion. Additionally, the Medicaid application process newly reflected a New York Court of Appeals decision, in *Aliessa v. Novello*, clarifying that certain non-citizens were eligible. Even after new enrollment under Disaster Relief Medicaid ended, Medicaid enrollment continued its steady increase, as the economy continued to decline, fewer low-wage jobs offered employer-based health insurance,

and more New Yorkers became eligible. At the same time, the state's facilitated enrollment policy enabled participating managed care plans and community-based organizations to help eligible individuals navigate the application process and gain coverage.

This historic rise in Medicaid enrollment of 1.5 million New Yorkers represents a notable increase of 55 percent over five years.

Enrollment among adults, which accounted for 61 percent of the overall increase, grew from about 600,000 in 2000 to 1.5 million in 2005. Children accounted for 32 percent of the enrollment increase, while elderly and disabled beneficiaries made up just 7 percent.

Medicaid enrollment declined by 190,000 between September 2005 and April 2007. The bulk of that decline—120,000—was among children. Although this was partially offset by an increase in SCHIP enrollment of 60,000, it is likely that a new policy shifting some children from Medicaid to SCHIP resulted in some enrollees losing coverage in the transition. The rest of the decline, some 70,000, was among adult beneficiaries; enrollment among the elderly and disabled did not change significantly. It is unclear whether this decline is the result of the Deficit Reduction Act's new requirement that citizenship be documented, or whether it reflects increases in family income that make fewer individuals eligible. It

is also unclear whether enrollees moving off Medicaid are gaining private coverage or becoming uninsured.

### **Beneficiaries requiring long-term care**

One of Medicaid's biggest responsibilities is providing long-term care services to elderly and disabled beneficiaries who require care over a period of months or years. While many of these long-term care patients also have significant acute care needs, their dependence on long-term care services is related to conditions that are generally ongoing and often deteriorate over time. This central truth holds for a diverse group of Medicaid beneficiaries that includes, for example, seniors with dementia, adults with paralysis, and children with developmental disabilities.

An estimated 390,000 Medicaid beneficiaries—not including those relying on post-acute care or short-term rehabilitation services—used long-term care services during federal fiscal year (FFY) 2004. About 40 percent (160,000) of them required residential long-term care, nearly all of them in nursing homes. The remaining 60 percent (230,000) had no institutional care, relying on services provided at home or in community-based settings. Together, these recipients of long-term care services represented 8 percent of the 4.9 million people covered by Medicaid during FFY 2004.

## Who is not enrolled?

Out of an estimated 2.2 million New York State residents under age 65 without health insurance, 840,000—nearly 40 percent—were eligible for Medicaid (with another 60,000 eligible for SCHIP) in 2005, making Medicaid a key building block in any major expansion of health insurance coverage. With an estimated participation rate among eligible children (without private coverage) of about 90 percent, Medicaid and SCHIP have done well, for a means-tested program, in enrolling children within their target populations. Medicaid's participation rate for eligible adults, however, was only about 70 percent in 2005, despite increases in enrollment over the prior five years.

Many eligible but uninsured individuals face difficulties in accessing and retaining Medicaid coverage. A complex application process with multiple documentation requirements, a long wait for coverage after applying, and an annual renewal process that requires enrollees to certify their ongoing eligibility all contribute to the problem. Others may not know they are eligible or may choose not to apply. If all 900,000 eligible but uninsured New Yorkers were covered, the number of uninsured would drop to about 1.3 million, reducing New York's uninsured rate for the non-elderly from 14 to 8 percent. Achieving universal coverage for children in New York State would depend heavily on Medicaid, with most uninsured children (about 180,000 of 320,000) already eligible, and an additional 20 percent eligible for SCHIP.

## What services are covered?

The federal government requires states to cover certain services under Medicaid, including hospital care, physician services, nursing home care, and home health care. States can also choose to cover more than thirty additional categories, including prescription drugs, clinic services, physical and occupational therapy, prosthetics, optometry, personal care for the elderly and disabled, and intermediate care facilities for beneficiaries with mental retardation or developmental disabilities.

Because federal law has not required states to provide such additional services under Medicaid since the program's enactment more than forty years ago, these are technically optional. But nearly all states, New York included, cover most optional services, many of which are central to the effective treatment of acute illness and chronic conditions for low-income individuals. All states cover prescription drugs, for example, which are by any measure an essential component of 21st century health care.

## Who pays for Medicaid?

Medicaid coverage in New York is distinct from private insurance primarily in the breadth of its benefits package. It includes some acute care services that commercial insurers generally do not, and covers long-term care, which neither private insurance nor Medicare generally covers. In addition, Medicaid's coverage of acute care services differs in two important ways. First, Medicaid does not apply waiting periods or exclusions for pre-existing conditions, and, in New York, imposes few benefit limits on medically necessary services that are covered. Second, Medicaid imposes much lower levels of cost sharing than private coverage does. New York generally requires most adult beneficiaries to contribute relatively small co-payments for a range of services and prescription drugs; it has not increased cost sharing to the new levels allowed under the Deficit Reduction Act. For the low-income individuals Medicaid serves, even small financial contributions can be barriers to accessing necessary services.

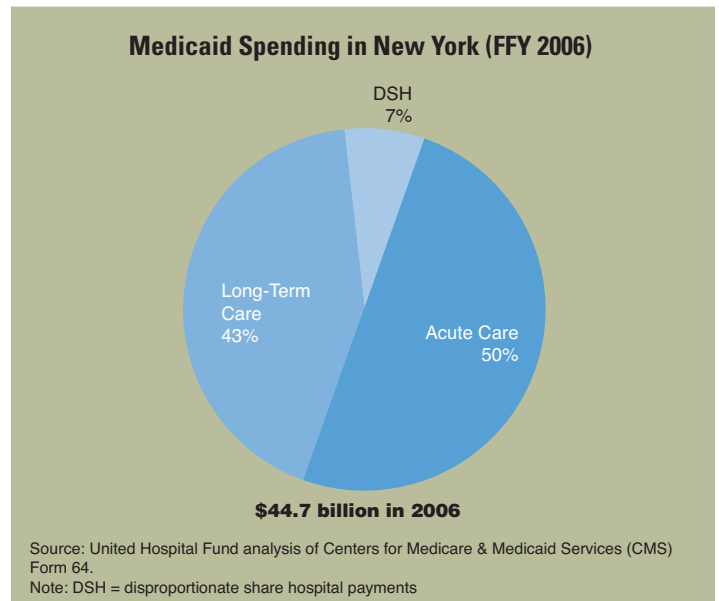
The federal government generally pays for half of New York's Medicaid costs, although it provides more support for certain services and enrollees, and for administrative costs. The federal funding formula for Medicaid, or the federal matching rate, is based on state per capita income relative to the nation. Since New York's per capita income is relatively high, the state's federal Medicaid matching rate is the lowest allowable under federal law: 50 percent. Federal matching rates have a profound impact on state budgets. While New York receives \$1 in federal funds for each state (and local) dollar spent on Medicaid, other states have matching rates as high as 76 percent—a rate that provides more than \$3 in federal support for every \$1 of state (and local) funds. If the Medicaid matching rate reflected the share of state residents living in poverty, rather than per capita income, New York's matching rate would be higher, and the state would receive more federal support for Medicaid.

New York State pays the majority of nonfederal Medicaid costs, but it also requires local governments—counties and New York City—to pay a share. While some other states also require a local share for Medicaid costs, New York's local governments have the largest responsibility in the nation, in both relative and absolute terms. Until recently, the state and local governments generally paid 25 percent each for acute care services (with the federal government paying 50 percent). For long-term care services, the state paid more than 40

## How much does Medicaid cost?

percent, with local governments paying less than 10 percent (and the federal government paying 50 percent). Overall, local governments paid about 17 percent of Medicaid costs in 2005.

Under a state law that took effect in 2006, local governments' overall liability for Medicaid costs is capped. Counties and New York City are now generally responsible for an increase of 3 percent over the previous year's contribution—a level expected to be lower than long-term Medicaid spending growth. The local share already has begun to decline under this cap. This year, the state will contribute about 35 percent of Medicaid spending, with local governments contributing about 15 percent. Barring historically low Medicaid growth over the long term, the state's share will increase and the local share will decline gradually over time.



Medicaid spending in New York totaled \$44.7 billion in services during FFY 2006. This total includes spending on Family Health Plus, but does not include \$1.2 billion for Medicaid administration or about \$0.7 billion in SCHIP costs. Acute care accounted for 50 percent of Medicaid spending, and long-term care 43 percent, with disproportionate share hospital payments making up the balance.

**Aggregate spending patterns**

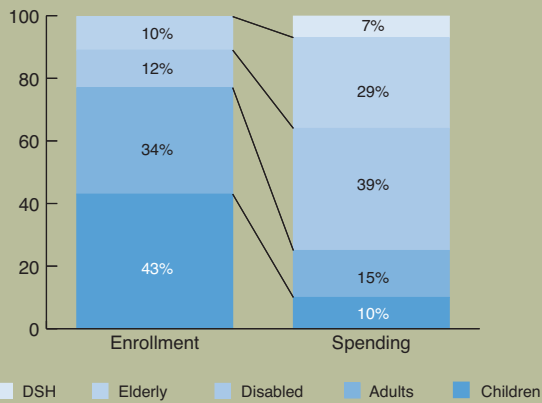
Medicaid spending on a broad range of acute care services totaled \$22.6 billion in 2006. This includes about \$8.2 billion in payments directly to hospitals for general inpatient and outpatient care, not including disproportionate share hospital payments; \$6.4 billion in premiums to Medicaid managed care plans; and \$1.7 billion to clinics, including community health centers. Medicaid's \$2.8 billion in payments for outpatient prescription drugs was significantly lower than in previous years because, starting in 2006, Medicare Part D replaced Medicaid as the source of prescription drug coverage for some 600,000 beneficiaries (known as "duals") enrolled in both Medicare and Medicaid. (While federal law requires states to pay the federal government the vast majority of duals' projected Medicaid costs under prior law, these funds are no longer counted as Medicaid spending.)

Long-term care providers received \$19.1 billion in payments from Medicaid in 2006, including some reimbursement for short-term rehabilitation or post-acute care. Payments to residential long-term care providers totaled \$10.4 billion, 55 percent of long-term care spending: about \$7.0 billion in payments to skilled nursing facilities (or nursing homes), which generally serve beneficiaries with physical disabilities, cognitive impairments, or both; \$3.0 billion to intermediate care facilities for beneficiaries with mental retardation or developmental disabilities; and \$0.5 billion (not including disproportionate share hospital payments) to inpatient mental health facilities.

The other 45 percent of long-term care spending—\$8.7 billion—went to home- and community-based long-term care providers. These payments included about \$1.4 billion for home health services, including skilled nursing care and physical therapy; \$2.5 billion for personal care—assistance with activities of daily living; an estimated \$4.1 billion for a range of home- and community-based services provided under Medicaid waivers, the majority of which are for beneficiaries with developmental disabilities; and about \$0.7 billion in other services and programs. Some programs, such as managed long-term care, coordinate services in an effort to keep beneficiaries in community settings.

Medicaid's responsibility for providing long-term care services is in great part driven by the fact that Medicare—which covers about 85 percent of elderly Medicaid beneficiaries and 30 percent of disabled Medicaid beneficiaries—does not provide a significant long-term care benefit. More than 40 percent of all Medicaid spending is on services for these dual enrollees, and 70 percent of those costs are for long-term care.

**Shares of Medicaid Enrollment and Spending by Eligibility Category (FFY 2004)**

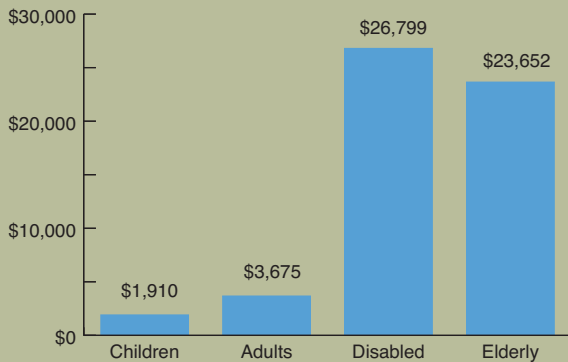


Source: United Hospital Fund and Urban Institute analysis of CMS Form 64 and Medicaid Statistical Information Systems (MSIS) data.  
 Note: Shares may not sum to 100 percent due to rounding.  
 DSH = disproportionate share hospital payments

**Spending per beneficiary**

While children and adults make up about three-quarters of Medicaid beneficiaries, they account for only one-quarter of Medicaid spending. By contrast, the elderly and disabled comprise about a quarter of enrollees but account for two-thirds of Medicaid spending (disproportionate share hospital payments make up the balance). On average, Medicaid spends \$23,652 per elderly beneficiary and \$26,799 per disabled beneficiary—about thirteen times more than spending per child (\$1,910) and seven times more than spending per non-elderly adult (\$3,675).

**Medicaid Spending per Beneficiary (FFY 2004)**



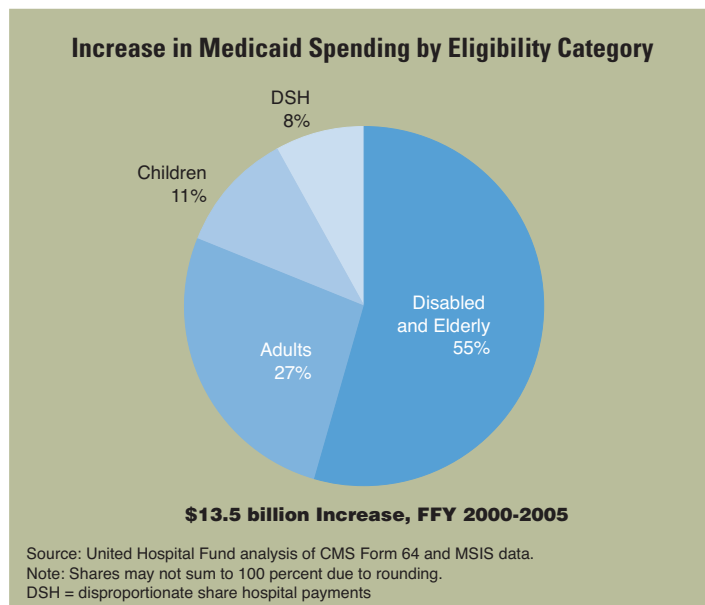
Source: United Hospital Fund and Urban Institute analysis of CMS Form 64 and MSIS data.

While differences in per capita costs among eligibility categories are notable, these averages mask even more dramatic concentrations of spending within these groups—spending in great part driven by the need for long-term care services. The 23 percent of elderly Medicaid beneficiaries who required residential long-term care in FFY 2004, for example, accounted for an average of \$57,645 in spending per person (for all services); the additional 19 percent requiring home- and community-based long-term care accounted for \$38,994 per person. By contrast, the 58 percent of elderly beneficiaries who did not require these services during that year each accounted for \$5,273.

## Recent Medicaid Spending Growth

In the five-year period from FFY 2000 to FFY 2005, Medicaid spending in New York increased 45 percent, from \$29.9 to \$43.4 billion. This represents a significant increase that, to be sure, poses a challenge for the state budget. Yet despite substantial enrollment growth, Medicaid spending in New York grew more slowly during that time, at an average annual compound growth rate of 7.7 percent, than did national health care expenditures, which grew at an average of 8.2 percent.

While adults and children made up 93 percent of the enrollment increase between 2000 and 2005, they accounted for 38 percent of the increase in spending. By contrast, disabled and elderly enrollees, while comprising only 7 percent of enrollment growth, accounted for 55 percent of the spending increase. While per capita spending was roughly flat among adults (-2 percent) and children (+1 percent), it increased substantially among the disabled (+24 percent) and elderly (+20 percent) over this period. The driving force behind increased spending on the disabled and elderly was not new enrollment, which barely changed, but higher per capita costs—reflecting increases in service use, the price of services, or both.



Medicaid spending on all services except prescription drugs increased by 6 percent between 2005 and 2006. Measuring Medicaid spending during this period is complicated because Medicare Part D went into effect, shifting direct spending on prescription drugs for duals from Medicaid to Medicare. Without this adjustment, Medicaid growth would appear artificially low. It is not yet clear what impact the declines in enrollment since September 2005 have had on Medicaid spending because detailed data that tie spending to beneficiaries are not yet available.

## How does Medicaid pay for services?

The state reimburses providers participating in Medicaid in a variety of ways. Under fee-for-service Medicaid, hospitals receive fixed payments for inpatients that reflect each admission's historical costs, adjusted for diagnosis, regional wages, and facilities' graduate medical education costs. For outpatient visits, Medicaid makes fixed payments based on the type of care and the setting in which it is provided—hospital outpatient department, clinic, or physician's office. Nursing homes receive per diem rates that reflect each facility's mix of patients. Home health services are typically reimbursed per visit, and personal care is generally reimbursed per hour. Many other services and products, such as prescription drugs and medical equipment, carry fixed unit prices. Medicaid disproportionate share hospital payments—direct subsidies to hospitals serving high concentrations of Medicaid patients and the uninsured—are grants that are not linked directly to care for individual patients.

Under Medicaid managed care, the state pays health plans monthly premiums, and the plans negotiate reimbursement rates with providers. In recent years, health plan premiums have been negotiated between the state and each participating plan. While based in part on enrollees' age and gender, and the region in which they live, these rates have contained significant variation in premiums for similar groups of enrollees. As of 2008, the state is beginning to move to a new system, which calculates average costs in nine regions for five broad groups of enrollees, and then risk-adjusts

each plan's premium based on the health status of its members. Within the managed care setting, most plans pay their participating providers on a fee-for-service basis; however, some plans negotiate capitation agreements under which providers agree to deliver certain services to groups of enrollees for a set fee. These capitation agreements pass along to providers the plans' financial incentive to deliver less costly services.

The state embraced managed care in the 1990s as a strategy to provide Medicaid enrollees with greater continuity and coordination of care, increase use of primary and preventive care, and reduce unnecessary emergency room visits and avoidable hospitalizations. Currently, about 60 percent of New Yorkers receiving Medicaid are enrolled in managed care. Medicaid managed care is mandatory for most adults and children, and about 75 percent of them are enrolled. The state recently required certain disabled and elderly beneficiaries to join a managed care plan as well, but only about 15 percent are enrolled. Because such a small share of Medicaid's more costly beneficiaries are enrolled, Medicaid managed care still accounts for less than 15 percent of all Medicaid spending (and less than 30 percent of acute care spending). Under the terms of New York's Federal-State Health Reform Partnership (F-SHRP) Medicaid waiver—an agreement that covers many aspects of Medicaid policy and can bring the state substantial new federal funding over the next few years—the state is requiring more disabled and elderly beneficiaries to join a managed care plan.

## Program integrity

Protecting Medicaid's integrity is both vital, because the program represents substantial public resources, and challenging, because thousands of participating providers deliver complex and varied combinations of services to millions of beneficiaries throughout the state. Both beneficiaries and providers can compromise the program's integrity by triggering improper Medicaid payments. Beneficiaries can falsify documents in order to gain Medicaid coverage, and individuals who are not enrolled can use a beneficiary's card to receive services. While there is anecdotal evidence of such beneficiary fraud, there is no indication that it is widespread or accounts for significant Medicaid spending.

Improper provider activities are a bigger threat to the integrity of Medicaid. The most serious category—fraud and abuse—entails providers intentionally submitting false claims for reimbursement to which they are not entitled. This occurs when providers deliberately bill for services that were never delivered, willfully provide unnecessary services, or knowingly falsify the volume or complexity of services provided.

In 2006 the state created the Office of the Medicaid Inspector General (OMIG) to consolidate staff and functions designated to detect and prevent Medicaid fraud and abuse. OMIG works closely with the executive branch agencies responsible for Medicaid, the Attorney General's office, and federal and local agencies. In 2007, New York enacted the False Claims Act, which allows the state to keep an additional 10 percent of recoveries and impose civil penalties that, in certain cases, would be \$12,000 plus triple the amount of any false claims. New York's F-SHRP Medicaid waiver increases pressure on the state to make financial recoveries through the detection of Medicaid fraud. To avoid losing federal funding, the state must recover more than \$200 million in FFY 2008, a target that increases each year to more than \$600 million in FFY 2011.

## Challenges facing Medicaid

Medicaid faces many difficult and complex challenges. Perhaps no two are more important—or at first glance more at odds—than increasing Medicaid enrollment to about five million, by enrolling eligible but uninsured New Yorkers, while also containing Medicaid spending growth. To be sure, increased enrollment carries additional costs to the program. But the recent historic rise in adult and child enrollment occurred in a period of moderate overall spending increases, and was not the primary driver of Medicaid cost growth during that period. Moreover, realizing efficiencies within the program can help offset the cost of increases in coverage.

While setting ambitious goals for Medicaid, it is important to note that New York State does not have the statutory authority or the budgetary resources to resolve all the challenges facing the program, many of which stem from flaws and limitations in how the nation finances health care as a whole. Comprehensive Medicaid reform requires a broad policy debate at the federal level that addresses the underlying cost of health care services, the erosion of employer-based coverage, the concentration of financial stress among safety net providers, and the long-term care needs of elderly and disabled persons, many of whom have Medicare. It is possible that a renewed national focus on health care issues will lead to major health policy reform at the federal level, which in turn could provide some relief for New York's Medicaid program as soon as 2009. But it is also possible that the federal government, faced with its own fiscal pressures and competing priorities, will reduce its level of support for Medicaid in the future.

Whatever happens at the federal level, New York State can make far-reaching Medicaid policy decisions. Setting eligibility levels, designing the application and enrollment process, changing provider reimbursement rates, and negotiating health plan premiums are important tools that can have important impacts on beneficiaries, providers, health plans, and the state budget. But these levers in themselves do not hold the potential for transformative change.

The state's power for genuine reform lies more in its ability to change how Medicaid purchases, organizes, and delivers services, particularly for its most complex and costly beneficiaries. This level of change, for example, means redefining a unit of care, rather than simply re-pricing an existing unit. A strategy geared toward increasing the continuity, coordination, and quality of care holds the potential to change how providers interact with patients, and with each other, and may foster opportunities to better deploy the resources of the Medicaid program. This approach requires policies that are complex to design and challenging to implement. In some cases, models for managing care may need to be invented from scratch. But tailoring and targeting new approaches to service delivery that focus on high concentrations of Medicaid spending is a path worth pursuing. An ambitious approach to Medicaid policy, characterized by rigorous analysis and bold innovation, aspires to strengthen New York's program by making it both more inclusive and more efficient.

## Data Sources

This report relies on the analysis of several data sets for estimates of Medicaid enrollment and spending.

### Enrollment

- Monthly enrollment by category is based on United Hospital Fund analysis of New York State Department of Health enrollment reports.
- Enrollment over the course of a year is based on Urban Institute and United Hospital Fund analysis of Centers for Medicare & Medicaid Services (CMS) Medicaid Statistical Information System (MSIS) data.
- Estimates of the uninsured non-elderly, including the eligible but uninsured, are based on Urban Institute and United Hospital Fund analysis of the U.S. Current Population Survey data.

### Spending

- Total Medicaid costs and spending by service are based on United Hospital Fund analysis of CMS Financial Management Reports (Form 64).
- Medicaid spending by enrollment category and by users of services are based on Urban Institute and United Hospital Fund analysis of CMS MSIS data.

### Notes

- Urban Institute analysis of MSIS data assigns all beneficiaries who are both elderly and disabled to the elderly category.
- Medicare premiums are allocated to disabled and elderly enrollees, according to the share of duals in each group, to allocate all Medicaid spending into an eligibility category (or disproportionate share hospital). Medicare premiums are not included in estimates of spending per beneficiary.
- To distinguish between beneficiaries receiving long-term care and those receiving post-acute care delivered by long-term care providers, the Urban Institute counted beneficiaries in the bottom 10 percent of spending on each institutional long-term care service, or on home- and community-based services collectively, as using post-acute rather than long-term care. Beneficiaries requiring both institutional and community-based long-term care are counted as users of institutional long-term care, making the three groups of beneficiaries—those receiving institutional, community-based, or no long-term care—mutually exclusive and collectively exhaustive.

In all cases, this analysis uses the most recent month or year of data available. The age of the data sets used varies; for example, release of the CMS MSIS data set typically trails release of CMS Form 64 by one to two years.

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