



Analysis of the New York State Medicaid Program and Identification of Potential Cost-Containment Opportunities

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Submitted by: The Lewin Group

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Introduction

The New York State (NYS) Medicaid program has long been recognized as among the nation's most expensive programs, both in terms of total expenditures and the unit cost of services provided. With New York's Medicaid program being a major component of its budget, the rising cost of the program has been a significant concern for the State. Also, like many other states, New York faces significant budget shortfalls, increased demand for public services, and significant responsibilities for implementing provisions of the Patient Protection and Affordable Care Act (ACA). The Citizens Budget Commission has, therefore, retained the Lewin Group (Lewin) to identify recent trends in expenditures and enrollment in New York's Medicaid program.

Program Background

Description of the NYS Medicaid Program

Enacted in 1965, the Medicaid program is a federal/state partnership which provides medical and related health care services to low-income individuals and families. The program is authorized under Title XIX of the federal Social Security Act and, in New York, under Title XI of Article V of the Social Services Law. The federal government provides approximately 50 percent of the financial support for New York's program. The balance of the program is funded with a combination of State and local funds.

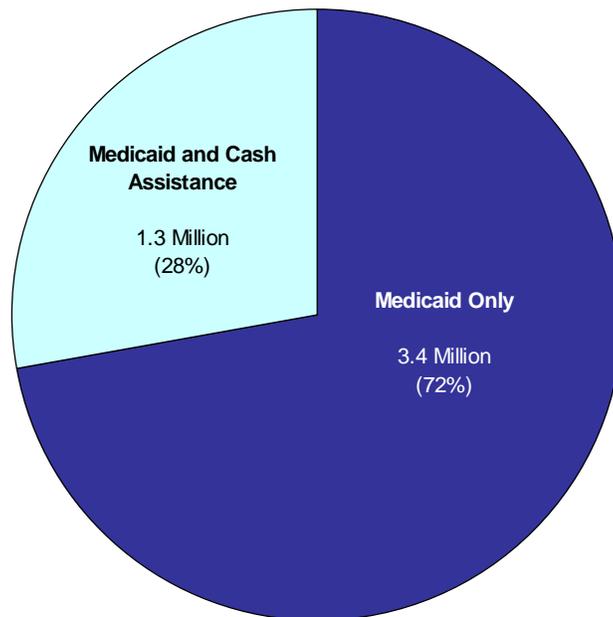
Under the program, states have significant leeway concerning the individuals they cover and the services they provide. To participate in the program, states must provide coverage to certain groups of individuals (termed "mandatory" coverage groups) but are also allowed to provide coverage to individuals and families in other "optional" groups. Similarly, certain "mandatory" services must be included in a state's Medicaid program, while states are also permitted to include "optional" services in their benefit packages. New York provides coverage to individuals in both mandatory and optional coverage groups, as well as providing mandatory and many optional services.

As of March 2010, the NYS Medicaid program had almost 4.7 million enrollees in the program throughout the State, approximately 65 percent of whom reside in New York City.^{1,2} As shown in Figure 1 below, over 70 percent of individuals enrolled in the program receive health insurance provided through the Medicaid program but do not receive cash assistance (e.g., Temporary Assistance for Needy Families (TANF) or Supplemental Security Income (SSI)).

¹ For the purposes of this report, references to "enrollees" include all individuals that are enrolled in the Medicaid program. References to "recipients" include individuals that have received a particular service. "Beneficiaries" are those individuals that are enrolled in a Medicaid managed care organization.

² NYS Medicaid Statistics (http://www.health.state.ny.us/health_care/medicaid/statistics/index.htm)

Figure 1: Distribution of NYS Medicaid Enrollees by Cash Assistance Status (as of March 2010)



Source: NYS Medicaid Statistics, accessed at:
http://www.health.state.ny.us/health_care/medicaid/statistics/index.htm

New York's Medicaid program provides coverage for preventive health and dental care, inpatient and outpatient hospital services, nursing home, home health, personal care, mental health services, and prescription drugs, as well as numerous other health care services. Some services require a small co-payment. NYS also offers an array of Medicaid managed care programs, with nearly three million beneficiaries receiving care through such programs. (Medicaid managed care programs are described in greater detail later in this report.)

Currently, total Medicaid spending in NYS is approximately \$50 billion, projected to grow to \$53 billion in State Fiscal Year (SFY) 2010-11, which is the highest in the nation.³ In Federal Fiscal Year (FFY) 2007, NYS Medicaid spending per capita was the nation's highest at \$2,283, more than twice the national average (\$1,026).⁴ Also in FFY 2007, New York spent approximately \$8,450 per enrollee, the second highest nationally, behind Rhode Island.⁵

NYS has been a national leader in providing coverage to the uninsured for many years. Beginning with the inception of the program, New York was one of the few states that covered low-income adults without children. In the early 1990's, New York expanded coverage for children with its Child Health Plus program, a health insurance program that provides a benefit package similar to employer-based health insurance.⁶ Today, New York continues to provide

³ "Continuing Medicaid Reform: FY2010/11 Executive Budget" from NYS Department of Health

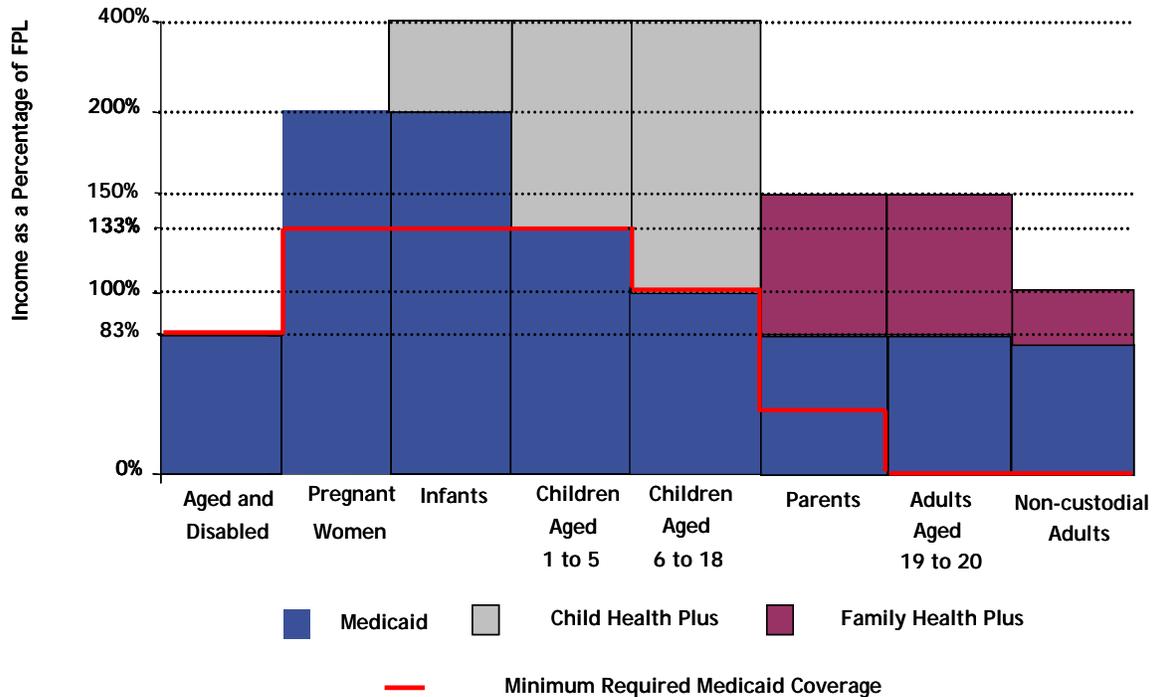
⁴ *ibid*

⁵ Kaiser Family Foundation State Medicaid Health Facts (<http://www.statehealthfacts.org/>).

⁶ Federal support for the Child Health Plus program (65 percent of allowable program costs up to a maximum allotment) is provided under Title XXI of the Social Security Act.

coverage well above national minimum income levels through its Medicaid, Child Health Plus, and Family Health Plus programs.⁷ Figure 2 demonstrates the current levels of eligibility for these programs.

Figure 2: Current Levels of Eligibility for NYS Public Health Coverage



Source: Based upon program data from the NY Department of Health.

As Figure 2 demonstrates, New York State exceeds the minimum levels of Medicaid coverage for pregnant women and infants, as well as for parents and non-custodial adults. Pregnant women with incomes over 100 percent of the Federal Poverty Level (FPL) receive a reduced benefit package, and all but the lowest income adults are enrolled in Family Health Plus. These high eligibility levels result in a larger proportion of New York’s population being enrolled in the Medicaid program than in most other states: in 2007, for example, 26 percent of New Yorkers were enrolled in Medicaid, the fourth highest percentage nationally.^{8,9}

⁷ The Family Health Plus program operates under a Medicaid 1115 waiver, which allows the State to provide a benefit package that is less comprehensive than the standard Medicaid benefit package. This benefit package is similar to the package provided under the Child Health Plus program.

⁸ Kaiser Family Foundation State Medicaid Health Facts (<http://www.statehealthfacts.org/>). The three states with the highest Medicaid enrollment as a percent of population are California, the District of Columbia, and Maine.

⁹ This report does not focus on potential cost savings opportunities related to reducing Medicaid eligibility levels for several reasons, including the fact that national health reform and enhanced federal financial participation provisions require states to maintain eligibility levels or risk the loss of federal financial participation.

Trends in Growth

Enrollment

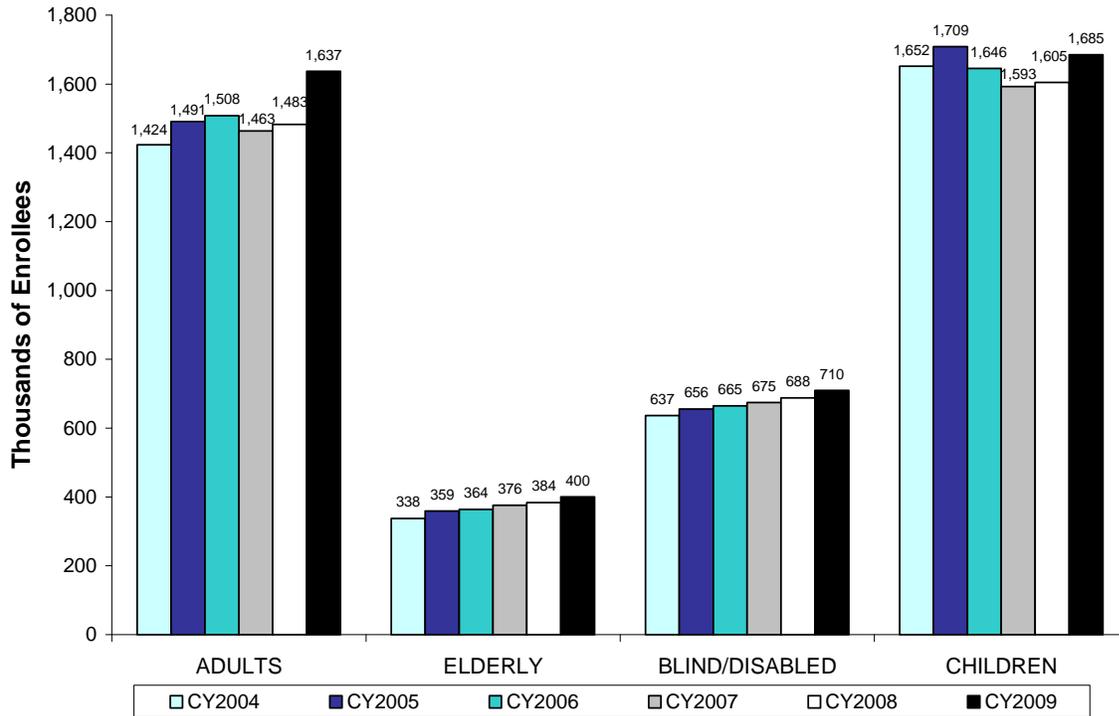
Overall, from calendar year (CY) 2004 to CY 2009, enrollment in the NYS Medicaid program has grown by nine percent, or an additional 382,000 enrollees. This increase includes a 6.6 percent increase from CY 2008 to CY 2009.¹⁰ Much of this latest enrollment increase has been the result of the recent nationwide economic decline. As shown in Figure 3 below, enrollment in the Elderly and Blind/Disabled categories has increased steadily over time, consistent with national demographic trends. Both of these trends are in concert with those seen nationwide in Medicaid programs.

The number of children enrolled in the Medicaid program has varied over the time period, with CY 2009 levels slightly lower than the peak reached in CY 2005. The number of children enrolled in the Medicaid program dropped significantly between CY 2005 and CY 2007, due primarily to implementation of the repeal of the eligibility expansion that allowed children between the ages of 6 and 18 with incomes between 100 and 133 percent FPL to enroll in the Medicaid program. With this repeal, these children became eligible for the Child Health Plus program, leading to a nearly 22 percent increase in Child Health Plus enrollment from July 2005 to July 2007.

Growth in the number of adults eligible for the Medicaid program has varied over this time period although, overall, the number of enrollees increased by over 210,000 individuals, or 15 percent, since CY 2004. There was an approximate 3 percent decline in the number of adult enrollees between CY 2006 and CY 2007, most likely the result of implementation of several changes in eligibility requirements (e.g., establishment of an asset limitation for Family Health Plus enrollees and additional requirements related to proof of citizenship). While the general economic decline was a driver of the 10.4 percent increase in the number of enrollees between CY 2008 and CY 2009, other eligibility changes (e.g., allowing individuals to attest to their income at time of renewal and raising the eligibility levels for childless adults so that there was one statewide level) also are believed to have affected the number of adults enrolled in the program.

¹⁰ NYS Medicaid Statistics (http://www.health.state.ny.us/health_care/medicaid/statistics/index.htm)

Figure 3: Average Monthly Medicaid Enrollment by Eligibility Category (CY 2004 - CY 2009)



Source: NYS Medicaid Statistics (http://www.health.state.ny.us/health_care/medicaid/statistics/index.htm)

Note: 1) Data include all individuals enrolled in the Medicaid program including Family Health Plus. Child Health Plus enrollment is not included.

2) Actual average enrollment levels for CY2004 through CY2009.

Medicaid Managed Care

New York’s Medicaid program offers several managed care options. Most managed care programs provide primary, preventive, and acute care services only (e.g., physician services, outpatient department and clinic services, and hospital care). New York also offers its enrollees a number of managed care options that provide primary, preventive, and acute, as well as long-term care services (e.g., ongoing home health care services and personal care services). Some services, such as those related to behavioral health and pharmacy, are not included in the managed care benefit package but are paid for on a fee-for-service basis.

Most enrollees in New York’s Medicaid program are required to enroll in a managed care program (termed “mandatory enrollment”). Individuals who are not mandated to enroll in a managed care program can voluntarily enroll. For example, non-disabled children and adults in almost all counties in the State are required to enroll in a managed care program; enrollment is voluntary in several smaller counties. All enrollees in the Family Health Plus program receive care through managed care plans. Low-income individuals who are blind or disabled, but not receiving health care coverage under Medicare (i.e., individuals under age 65 that receive or are qualified for federal Supplemental Security Income) are also mandated to enroll in managed

care plans.¹¹ Individuals who receive primary, preventive, and acute care coverage under the Medicare program are never mandated to enroll in a managed care program although they are, as noted below, able to do so voluntarily.

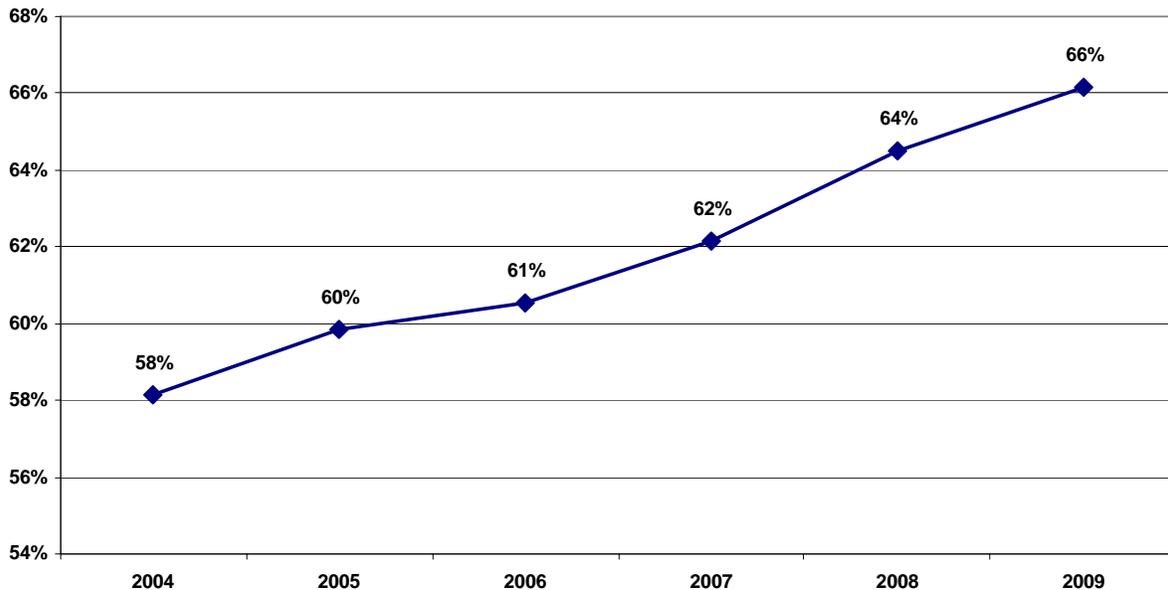
New York also operates several voluntary managed care programs for individuals who are elderly or disabled, including the Medicaid Advantage (primary, preventive, and acute care services only) and Medicaid Advantage Plus (all services provided by Medicaid Advantage programs plus long term care services) programs. These programs allow individuals who are dually-eligible for both Medicaid and Medicare to enroll in a managed care program. Individuals who are eligible for nursing home care can also enroll in a managed long term care program or a Program for All-Inclusive Care for the Elderly (PACE) program.

Over the past several years, to both improve the quality of care provided to individuals enrolled in the program and to contain costs, the Medicaid program has worked to increase the proportion of Medicaid enrollees that are enrolled in comprehensive managed care plans. Since 2004, the overall percentage of individuals enrolled in managed care plans has increased from 58 percent to 66 percent (Figure 4). This expansion has occurred in a number of ways, including expanding mandatory managed care for non-disabled individuals in certain counties which do not have a choice of plans and phasing in the mandatory program for individuals receiving SSI. Nationally, the percentage of Medicaid enrollees that were enrolled in comprehensive managed care in 2009 was 46.5 percent.¹²

¹¹ New York operates its mandatory managed care programs under Section 1115 waivers: the Partnership Plan and the Federal-State Health Reform Partnership.

¹² Medicaid Managed Care Penetration Rates by State as of June 30, 2009, Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services, special data request, July 2010 from Kaiser Family Foundation State Medicaid Health Facts (<http://www.statehealthfacts.org/>).

Figure 4: Percent of New York Medicaid Enrollees That Were Enrolled in Managed Care (2004 - 2009)



Source: NYS Medicaid Statistics, based on average monthly enrollment statistics for each calendar year period accessed at: http://www.health.state.ny.us/health_care/medicaid/statistics/index.htm.

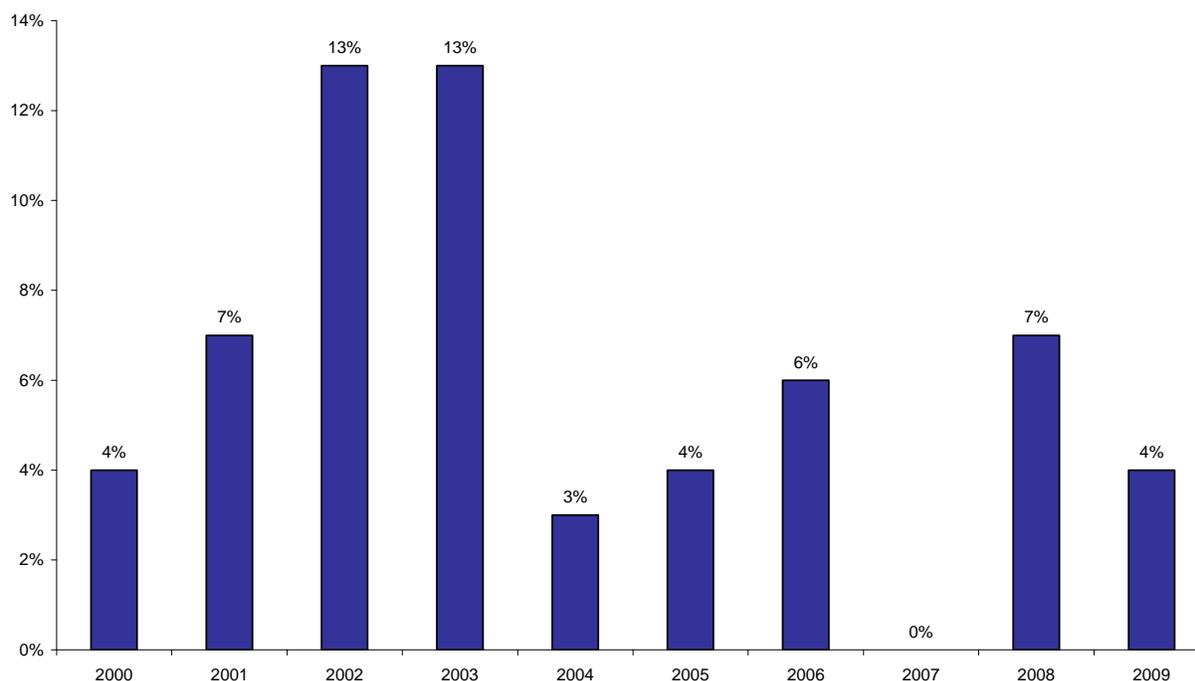
Note: Reflects enrollment in Medicaid managed care and Family Health Plus programs. Data on managed long term care, and Medicare and Medicaid Advantage programs are not included.

Expenditures

Although annual growth in spending varied significantly from FFY 2004 to FFY 2009 as shown in Figure 5, total NYS Medicaid spending increased by an average of approximately four percent per year. This is in line with growth in the Medical Care category of the Consumer Price Index (CPI), which also increased at approximately four percent per year from 2004 to 2009, despite the fact that enrollment grew by eight percent during this period.¹³ The most likely reason that enrollment increased at a greater rate than spending in recent years is that the economic downturn spurred enrollment increases among the adult and children eligibility categories, which cost significantly less per enrollee than the aged and disabled populations.

¹³ U.S. Department of Labor, Bureau of Labor Statistics (http://www.bls.gov/cpi/cpi_dr.htm#2004)

Figure 5: Annual Medicaid Spending Growth in NY



Source: United Hospital Fund analysis of CMS 64 data.

Note: Spending is for FFYs and includes all funds; administration is not included. For 2006 and 2007, annual growth rates are adjusted to exclude declines in Rx drug spending triggered by implementation of Medicare Part D.

Overall spending growth, however, masks significant variation among spending trends for specific categories of service. Based on our experience and discussions with State officials, we conducted a more in depth review of spending trends for several categories of service including the following:

- Long Term Care
- Community Rehabilitation
- Prescription Drugs
- Inpatient Hospital
- Clinic/Physician/Outpatient
- Medicaid Managed Care

Long Term Care (LTC) spending has substantially increased over the past several years, but the number of recipients for these services has decreased. As shown in Figure 6, there is an increase in spending combined with a decrease in the number of recipients for nursing homes, certified home health agencies (CHHAs), personal care, long term home health care, and other non-institutional long term care services. While the rate of growth for nursing home services has been modest, that is not the case for non-institutional long term care services. Medicaid spending for personal care services has increased by 28.0 percent, while the number of

recipients decreased by 8.2 percent, resulting in a *per-recipient* spending increase of nearly 40 percent. Long term home health care and other non-institutional long term care services experienced 35.5 percent and 56.9 percent increases in Medicaid spending, respectively, with 1.2 percent and 9.2 percent decreases in the number of recipients. This resulted in 37.2 percent and 72.9 percent increases in *per-recipient* spending in long term home health care and other non-institutional long term care services. The most dramatic *per-recipient* spending growth, 76 percent, has been for CHHAs, which have experienced an 11.4 percent decrease in the number of recipients and yet a 55.9 percent increase in spending.

Figure 6: Long Term Care Spending and Service Recipients (CY 2003 to CY 2008)

	Spending (in millions)				Number of Recipients				Spending per Recipient		
	CY 2003	CY 2008	Change		CY 2003	CY 2008	Change		CY 2008	Change	
			\$	%			#	%		\$	%
Institutional LTC	\$6,264.6	\$7,119.2	\$854.7	13.6%	154,487	148,600	-5,887	-3.8%	\$47,909	\$7,358	18.1%
Nursing Homes	\$5,930.5	\$6,705.6	\$775.1	13.1%	139,081	132,620	-6,461	-4.6%	\$50,563	\$7,922	18.6%
Other Inst. LTC ¹⁾	\$334.0	\$413.6	\$79.6	23.8%	17,222	18,869	1,647	9.6%	\$21,919	\$2,524	13.0%
Non-Institutional LTC*	\$3,150.7	\$4,299.9	\$1,149.2	36.5%	187,581	170,662	-16,919	-9.0%	\$25,195	\$8,399	50.0%
Personal Care	\$1,824.7	\$2,336.1	\$511.4	28.0%	84,823	77,861	-6,962	-8.2%	\$30,004	\$8,492	39.5%
Certified Home Health Agencies	\$760.4	\$1,185.5	\$425.2	55.9%	92,553	82,007	-10,546	-11.4%	\$14,456	\$6,241	76.0%
Long Term HHC	\$510.2	\$691.5	\$181.2	35.5%	26,804	26,470	-334	-1.2%	\$26,122	\$7,086	37.2%
Other Non Inst. LTC ²⁾	\$55.3	\$86.8	\$31.5	56.9%	29,503	26,774	-2,729	-9.2%	\$3,241	\$1,367	72.9%
Managed LTC	\$444.3	\$1,078.9	\$634.6	142.8%	12,293	29,979	17,686	143.9%	\$35,988	-\$158	-0.4%

Recipient counts do not add up to subtotals or totals because a recipient may have received more than one service during a calendar year.

Source: Data received from NYS Bureau of Medicaid Statistics & Program Analysis based on DOH/OHIP AFPP DataMart (Claims paid through August 2010)

Notes: 1) Includes Residential Treatment Facilities and Adult Day Care; 2) Includes Assisted Living program services and Personal Emergency Response Services (PERS)

* Descriptions of non-institutional LTC programs are provided in Appendix B

These substantial rates of increase should be examined more closely to isolate their causes (for example, increases in rates of payment or utilization) and to determine whether cost containment and program management actions are warranted. Also, while the change in spending for nursing home services is modest compared to the change in non-institutional long term care services, we do note that New York Medicaid's nursing home rates are among the

highest in the nation and that there have been numerous cost containment initiatives proposed in this area.¹⁴

Spending on community rehabilitation services, primarily for the mental health and mental retardation and developmental disability population, has increased dramatically over recent years, as shown in Figure 7. While there has been a significant 33 percent increase in the number of recipients of these services, spending *per-recipient* increased by 31 percent, resulting in an overall spending increase of 74 percent. This was mainly caused by the dramatic increase in spending (73 percent) and recipients (29 percent) for OMR Waiver Services. The reason for this increase is unclear, and may be related to both rates of payment and utilization levels.

Figure 7: Community Rehabilitation Spending and Recipients (CY 2003 to CY 2008)

	Spending (in millions)				Number of Recipients				Spending per Recipient		
	CY 2003	CY 2008	Change		CY 2003	CY 2008	Change		CY 2008	Change	
			\$	%			#	%		\$	%
Community Rehabilitation Services*	\$3,010.6	\$5,221.9	\$2,211.3	73.5%	61,990	82,277	20,287	32.7%	\$63,467	\$14,902	30.7%
Care at Home	\$4.3	\$6.1	\$1.8	41.6%	1,146	1,119	-27	-2.4%	\$5,425	\$1,685	45.0%
OMH Waivers	\$194.5	\$362.5	\$168.0	86.4%	12,436	17,774	5,338	42.9%	\$20,394	\$4,757	30.4%
OMR Waivers	\$2,751.9	\$4,748.2	\$1,996.3	72.5%	47,041	60,585	13,544	28.8%	\$78,372	\$19,872	34.0%
Bridge to Health	N/A	\$2.4	N/A	N/A	0	285	285	N/A	\$8,545	\$8,545	N/A
Traumatic Brain Injury	\$59.9	\$102.7	\$42.8	71.4%	1,420	2,639	1,219	85.8%	\$38,922	-\$3,283	-7.8%

Recipient counts do not add up to subtotals or totals because a recipient may have received more than one service during a calendar year.

Source: Data received from NYS Bureau of Medicaid Statistics & Program Analysis based on DOH/OHIP AFPP DataMart (Claims paid through August 2010)

* Descriptions of community rehabilitation services are provided in Appendix B

As depicted in Figure 8, total prescription drug spending decreased by 27 percent from federal fiscal years 2004 to 2008. This decline in spending is primarily due to the fact that the vast majority of prescription drug spending for dual eligibles was shifted to the federal government under Medicare Part D, which became effective in 2006. Prescription drug spending for non-duals increased about 24 percent, with only a slight increase in recipients between federal fiscal years 2004 to 2008.

¹⁴ Eljay, LLC for the American Health Care Association, "A Report on Shortfalls in Medicaid Funding for Nursing Home Care." November 2009.

Figure 8: Prescription Drug Spending and Recipients (FFY 2004 to FFY 2008)

	Spending (in millions)				Number of Recipients				Spending per Recipient		
	FFY 2004	FFY 2008	Change		FFY 2004	FFY 2008	Change		FFY 2008	Change	
			\$	%			#	%		\$	%
Total	\$4,598.1	\$3,358.4	-\$1,239.7	-27.0%	2,724,003	2,605,203	-118,800	-4.4%	\$1,289	-\$399	-23.6%
Dual Eligibles	\$1,996.2	\$141.0	-\$1,855.1	-92.9%	489,632	364,185	-125,447	-25.6%	\$387	-\$3,690	-90.5%
Non-Dual Eligibles	\$2,601.9	\$3,217.4	\$615.4	23.7%	2,234,371	2,241,018	6,647	0.3%	\$1,289	\$125	10.7%

Source: Lewin analysis of CMS' Medicaid Statistical Information System (MSIS) FY2004-2008.

Note: New York makes payments to the federal government, commonly termed "clawback" payments, which are required by Medicare Part D statute. These payments effectively offset the non-federal portion of the savings identified above for dual eligible individuals.

This increase appears modest, particularly given historical rates of increase in the costs of prescription drugs. However, with the implementation of the Medicare Part D program, which substantially changed the classes of drugs provided under the Medicaid program, as well as the growth in the proportion of generic drugs used, this growth level may warrant further analysis.

For inpatient hospital services, total NYS Medicaid spending increased from CY 2003 to CY 2008 at the same time as the number of recipients of these services also increased. Inpatient hospital *spending per recipient* was stable year-over-year from CY 2003 to CY 2008 (Figure 9).

Figure 9: Inpatient Hospital Spending and Recipients (CY 2003 to CY 2008)

	Spending (in millions)				Number of Recipients				Spending per Recipient		
	CY 2003	CY 2008	Change		CY 2003	CY 2008	Change		CY 2008	Change	
			\$	%			#	%		\$	%
Inpatient Services	\$6,317.6	\$6,430.3	\$112.7	1.8%	638,717	649,029	10,312	1.6%	\$9,907	\$16	0.2%

Source: Data received from NYS Bureau of Medicaid Statistics & Program Analysis based on DOH/OHIP AFPP DataMart (Claims paid through August 2010)

Note: Includes Graduate Medical Education and state-operated facilities.

While *per-recipient* spending for inpatient hospital services has not changed, particularly in light of changes in the medical CPI, NYS has undertaken a number of budget initiatives since 2008 to reduce the cost base for inpatient hospital services.

Figure 10 demonstrates that spending on outpatient services, including outpatient hospital care, clinic, and physician visits, remained essentially flat between CY 2003 and CY 2008 with an 11 percent decrease in the number of recipients during this period. This decrease in fee-for-service utilization may be attributable to increases in managed care enrollment.

Figure 10: Clinic/Physician/Outpatient Spending and Recipients (CY 2003 to CY 2008)

	Spending (in millions)				Number of Recipients				Spending per Recipient		
	CY 2003	CY 2008	Change		CY 2003	CY 2008	Change		CY 2008	Change	
			\$	%			#	%		\$	%
Physician/ D&TC/Clinic	\$2,816.5	\$2,830.4	\$13.9	0.5%	2,132,138	1,900,931	-231,207	-10.8%	\$1,489	\$168	12.7%
Physician	\$383.7	\$301.9	-\$81.9	-21.3%	1,368,555	1,042,250	-326,305	-23.8%	\$290	\$9	3.3%
Diagnostic & Treatment Center	\$1,241.5	\$1,360.0	\$118.5	9.5%	824,147	848,093	23,946	2.9%	\$1,604	\$97	6.5%
Outpatient	\$1,191.3	\$1,168.5	-\$22.8	-1.9%	1,270,288	1,031,308	-238,980	-18.8%	\$1,133	\$195	20.8%

Recipient counts do not add up to subtotals or totals because a recipient may have received more than one service during a calendar year.

Source: Data received from NYS Bureau of Medicaid Statistics & Program Analysis based on DOH/OHIP AFPP DataMart (Claims paid through August 2010)

As shown in Figure 11, spending on Medicaid managed care premiums increased by more than \$2 billion (43 percent) from 2004 to 2008. This increase was partially driven by a 14 percent overall increase in beneficiaries. Much of this increase is due to the implementation of the mandatory managed care program for the SSI and SSI-related populations. In 2004, the SSI population accounted for 3.5 percent of managed care beneficiaries. By 2008, SSI accounted for 8.6 percent of managed care beneficiaries. Since rates for the SSI population are significantly higher than for other adults and children, we would expect that a substantial portion of the overall spending increase is the result of these more expensive individuals being added to the program.

Figure 11: Medicaid Managed Care Spending and Beneficiaries (CY 2004 to CY 2008)

	Spending (in millions)				Number of Beneficiaries				Spending per Beneficiary		
	CY 2004	CY 2008	Change		CY 2004	CY 2008	Change		CY 2008	Change	
			\$	%			#	%		\$	%
Medicaid Managed Care	\$5,140.4	\$7,369.7	\$2,229.3	43.4%	2,355,056	2,682,374	327,319	13.9%	\$2,747	\$565	25.9%

Source: NYS Medicaid Statistics, accessed at:
http://www.health.state.ny.us/health_care/medicaid/statistics/index.htm

Note: Reflects enrollment in the Medicaid managed care and Family Health Plus programs. Managed long term care, and Medicaid Advantage and Medicaid Advantage Plus programs are not included.

Comparisons to Other States and National Averages

New York's Medicaid program is the most expensive in the nation and provides services to the second largest number of enrollees. New York accounts for approximately 8.5 percent of all Medicaid enrollees and approximately 14.1 percent of national Medicaid spending.¹⁵

¹⁵ Kaiser Family Foundation State Medicaid Health Facts (<http://www.statehealthfacts.org/>)

Expenditures by Eligibility Category

The Medicaid program is often considered two health care coverage programs: one for relatively healthy children and families, and another for individuals who are elderly or disabled. Examining expenditures over the totality of the Medicaid program does not allow one to see the substantial variation in spending across eligibility categories. As a result, the following comparisons to other states and the national average are structured to incorporate these differences.

Based on FFY 2007 data, when compared to other states, NYS had higher than average Medicaid spending per enrollee across all eligibility categories; adults, elderly, blind/disabled, and children, ranking 5th, 1st, 1st, and 22nd respectively among the 50 states and the District of Columbia. Of particular note is the fact that spending per enrollee for the elderly and blind/disabled populations was almost double the national average (Figure 12).

Figure 12: FFY 2007 Medicaid Spending per Enrollee

State	Adults	Elderly	Blind/Disabled	Children	Total (Overall Rank)
National Average	\$2,541	\$12,499	\$14,481	\$2,135	\$5,163
CA	\$969	\$9,467	\$14,437	\$1,445	\$3,168
CT	\$2,615	\$21,507	\$21,650	\$2,527	\$7,357
FL	\$2,854	\$8,449	\$11,677	\$1,665	\$4,487
MA	\$3,506	\$18,069	\$10,641	\$4,064	\$7,490
MI	\$3,036	\$16,762	\$11,521	\$1,622	\$4,660
NJ	\$4,312	\$16,069	\$20,584	\$2,305	\$7,814
NY	\$3,897	\$22,159	\$28,223	\$2,344	\$8,450
PA	\$3,414	\$20,702	\$12,266	\$2,656	\$7,159
TX	\$3,185	\$8,437	\$13,572	\$2,400	\$4,555
New York Data as Compared to National Average					
National rank	5	1	1	22	2

Source: Lewin analysis of data from Kaiser Family Foundation State Medicaid Health Facts (<http://www.statehealthfacts.org/>)

Even after accounting for the geographic difference in medical practice overhead in NYS, Medicaid spending per enrollee was still on average 35 percent higher than the national average, and much of this is due to spending for the elderly, blind, and disabled (Figure 13). Per recipient spending for non-disabled children is slightly lower than the national average when accounting for New York's higher geographic cost differential.

Figure 13: FY 2007 Medicaid Spending per Enrollee
(Adjusted with Weighted Average NY Practice Expense Geographic Practice Cost Index of 1.215)

State	Adults	Elderly	Blind/Disabled	Children	Total
NY	\$3,206	\$18,231	\$23,220	\$1,928	\$6,952

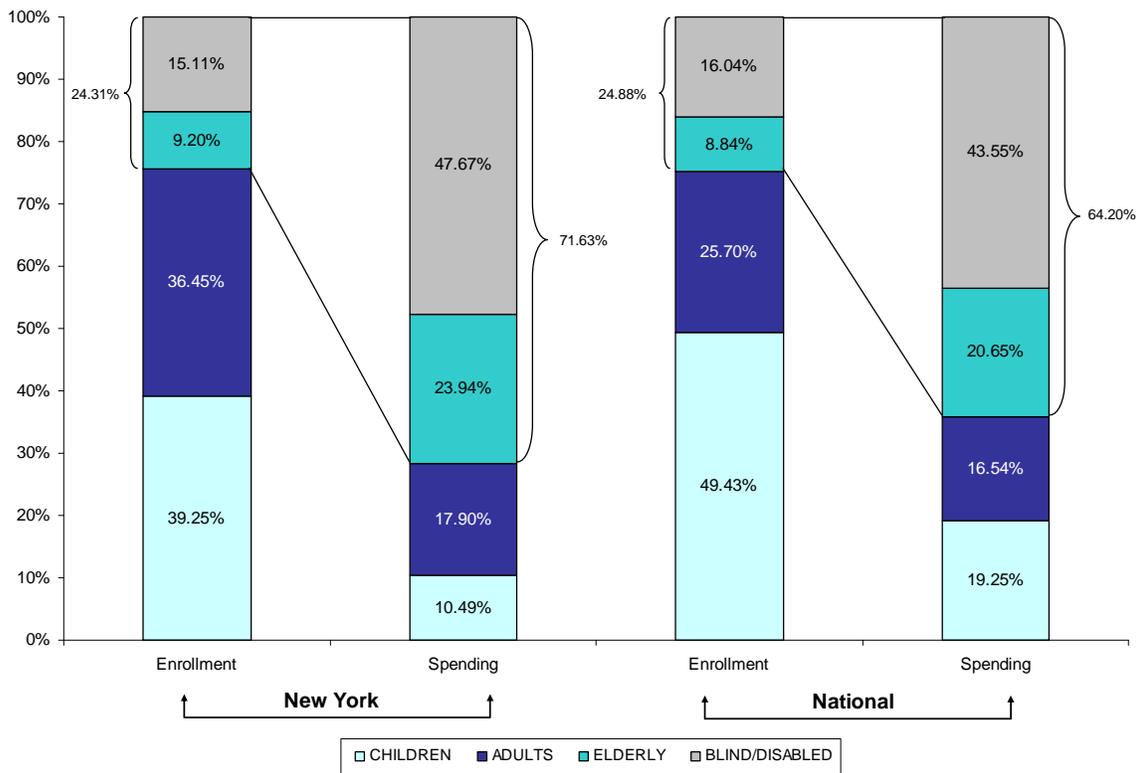
National	\$2,541	\$12,499	\$14,481	\$2,135	\$5,163
% Difference	26%	46%	60%	-10%	35%

Source: Lewin analysis of data from Kaiser Family Foundation State Medicaid Health Facts (<http://www.statehealthfacts.org/>)

New York’s relative proportion of elderly, blind, and disabled enrollees is consistent with the national average (approximately 24 percent). However, New York’s spending on these populations accounted for 72 percent of total Medicaid expenditures in FFY 2008, while the national average total spending for the same group was only 64 percent (Figure 14).

It is also notable that New York has a substantially smaller proportion of children enrolled in its program compared to the national average (39 percent versus 49 percent). This difference is primarily due to the greater proportion of adults covered by New York’s program.

Figure 14: FFY 2008 Enrollment and Spending Distribution: New York vs. National



Source: Lewin analysis of CMS’ Medicaid Statistical Information System (MSIS) FFY2008

Recent Cost Control Initiatives

Major initiatives

Over the past several years, New York State officials have taken a number of steps to contain Medicaid costs, particularly for hospital services and prescription drugs. Significant steps have

also been taken to curb fraud and abuse and to recover funds in instances where providers billed the Medicaid program inappropriately.

Inpatient and Outpatient Hospital Services

NYS implemented budget initiatives in 2008 and 2009 to reform hospital reimbursement. In December 2008, outpatient hospital reimbursement was modified to use Ambulatory Patient Groups (APGs) as the basis for reimbursement. This change, which is designed to more appropriately account for outpatient costs, is currently being phased in. According to the Department of Health, implementation of APGs is just one component of a larger, multi-year agenda to transition funds from inpatient to outpatient services to support quality outpatient care and to address the problem of avoidable hospitalizations.

In December 2009, another aspect of this transition effort was enacted. Inpatient hospital reimbursement was modified by, among other things, updating the base year for costs from 1981 to 2005 and adopting an updated case mix system to better account for patient acuity. These changes were expected to result in an annual spending reduction of \$225 million, most of which was reinvested in outpatient and physician services.

Prescription Drugs

In 2006, the Department of Health implemented the Preferred Drug Program (PDP) and Clinical Drug Review Program (CDRP). The PDP encourages providers to prescribe certain drugs through the use of a preferred drug list. The CDRP is aimed at ensuring that specific drugs are utilized in a medically appropriate manner by requiring prior authorization. Both programs have expanded over the past several years. According to a recent annual report, SFY 2008-09 gross savings attributable to the program included approximately \$289 million for the PDP and \$23 million for the CDRP.¹⁶

Waste, Fraud, and Abuse

The Office of the Medicaid Inspector General (OMIG) was established in 2006 to coordinate Medicaid fraud, waste, and abuse control activities for all State agencies. Since that time, according to the Division of the Budget, annual reported cost savings (State share) have tripled from approximately \$300 million in SFY 2006-07 to \$1.02 billion in SFY 2009-10. For the first quarter of CY 2010, the OMIG reports total cost savings equal to approximately \$468 million (State share).¹⁷

¹⁶ NYS Medicaid PDP Annual Report 08/09 (http://www.health.state.ny.us/health_care/medicaid/program/docs/annual_report_preferred_drugs_2008-09.pdf)

¹⁷ NYS Office of the Medicaid Inspector General (<http://omig.ny.gov/data/>)

Conclusion

Despite significant efforts by State policy makers, health care costs in New York State continue to increase at a substantial rate. The programs analyzed in this report account for a significant amount of spending in the Medicaid program and an even more significant proportion of the overall growth in the program. As part of ongoing efforts to more effectively manage the Medicaid program, these areas are likely to be further considered for additional cost containment initiatives.

Appendix A

Methodology

Analyses were conducted using NYS data, obtained from both the NYS Department of Health and the Division of the Budget, whenever possible. Comparisons to other states and national averages relied upon national data compiled by the Centers for Medicare and Medicaid Services (CMS) and the Kaiser Family Foundation. As a result, data used for comparison purposes may at times appear inconsistent with program statistics based on NYS data. Inconsistencies are attributable to differences in when data is compiled as well as variation in what is included in different data sets.

To conduct our analysis of the NYS Medicaid program, we took the following steps:

- We conducted interviews with officials from the NYS Division of Budget and Department of Health to obtain historical and future budget and program expenditure data.
- We obtained CY 2004–2009 Medicaid enrollment and expenditure data from the NYS Department of Health website.¹⁸
- We compared FFY 2004 – FFY 2008 NYS Medicaid expenditure and enrollment data to other large states (California, Florida, Michigan and Texas) and neighboring (Pennsylvania, New Jersey, Massachusetts and Connecticut), as well as national averages using data from the CMS' Medicaid Statistical Information System (MSIS).
- For comparisons to other states, we also used FFY 2007 Medicaid expenditure and beneficiary information from the Kaiser Family Foundation's State Health Facts website.¹⁹

¹⁸ NYS Medicaid Statistics (http://www.health.state.ny.us/health_care/medicaid/statistics/index.htm)

¹⁹ Kaiser Family Foundation State Medicaid Health Facts (<http://www.statehealthfacts.org/>)

Appendix B

Selected Program Descriptions for Non-Institutional Long Term Care and Community Rehabilitation Services

Non-Institutional Long Term Care Program Descriptions:

- **Personal Care:** services such as housekeeping, meal preparation, bathing, toileting, and grooming
- **Certified Home Health Agency:** services such as part-time, intermittent health care and support services, as well as long-term nursing and home health aide services, to individuals who need intermediate and skilled health care
- **Long Term Home Health Care:** a coordinated plan of medical, nursing, and rehabilitative care provided at home to disabled persons who are medically eligible for placement in a nursing home and whose cost of care is less than the cost of nursing home care in the applicable county

Community Rehabilitation Program Descriptions:

Note: All programs described below are provided through “waiver” programs, i.e., programs that provide arrays of services that are not otherwise authorized under the standard Medicaid program but that can be authorized to permit states flexibility in providing services to specific populations. Waiver programs can be authorized to test policy innovations, implement managed care delivery systems, and allow long-term care services to be delivered in community settings.

- **Care At Home:** a program designed to provide certain medical and related services to families who want to bring their physically disabled child home from a hospital or nursing home
- **OMH Waiver:** a program of supports and services that enables individuals who have complex health and mental health needs who would otherwise require an institutional level of care to live at home or in the community
- **OMR Waiver:** a program of supports and services (e.g., habilitation services, respite care, service coordination, and adaptive technologies) that enables adults and children with developmental disabilities to live in the community as an alternative to Intermediate Care Facilities
- **Bridges to Health:** a program of family and community support services for children in the foster care system to supplement the existing foster care and Medicaid State Plan programs
- **Traumatic Brain Injury:** a program of services needed to assist participants with traumatic brain injury to live in community-based settings and achieve maximum independence