

# Busting the cap

Why New York is losing control of its Medicaid spending again

by Bill Hammond

A major initiative of Governor Andrew Cuomo's first term was his attempt to rein in the chronically high costs of New York's Medicaid program.

His reforms, including an inflation-based "global cap" on state Medicaid outlays, showed impressive results in their early years. Overall spending growth slowed considerably, even as enrollment surged with the implementation of the Obama administration's Affordable Care Act. Per-recipient spending – a key indicator of efficiency – declined by \$1,200, or 11 percent, from 2011 to 2016. New York's program remained far costlier than those of most other states, but it was moving closer to the U.S. average.

After 2016, however, much of that progress was lost. Enrollment leveled off at about 6.2 million, but expenditures accelerated. Per-recipient costs jumped 20 percent – almost three times the rate of medical inflation – more than erasing the efficiency gains of the previous five years.

The upward trend came to a head in the spring of 2019, when the Cuomo administration quietly postponed \$1.7 billion in Medicaid payments from the 2018-19 fiscal year to the 2019-20 fiscal year – a step it said was necessary to avoid breaking the spending cap.

This was not a near-miss. State-funded Medicaid expenses, which were budgeted to grow by 4 percent, had actually grown by 12 percent.

Clearly, the state's Medicaid cost-control regime has broken down.

While many of Cuomo's original reforms succeeded, others have faltered or backfired. Meanwhile, the spending cap has been undermined by changing circumstances, growing loopholes, creative accounting and a lack of enforcement – to the point that it now arguably encourages rather than constrains excessive spending.

Still, the effort's early years proved a point – that it's possible to improve the efficiency of New York's Medicaid program while preserving or improving service for patients.

The potential benefits of a reinvigorated reform effort are enormous. Had New York merely maintained per-recipient spending at its 2016 level – which was still about one-quarter higher than the national average – the cumulative savings to state government over the past four years would have approached \$20 billion.

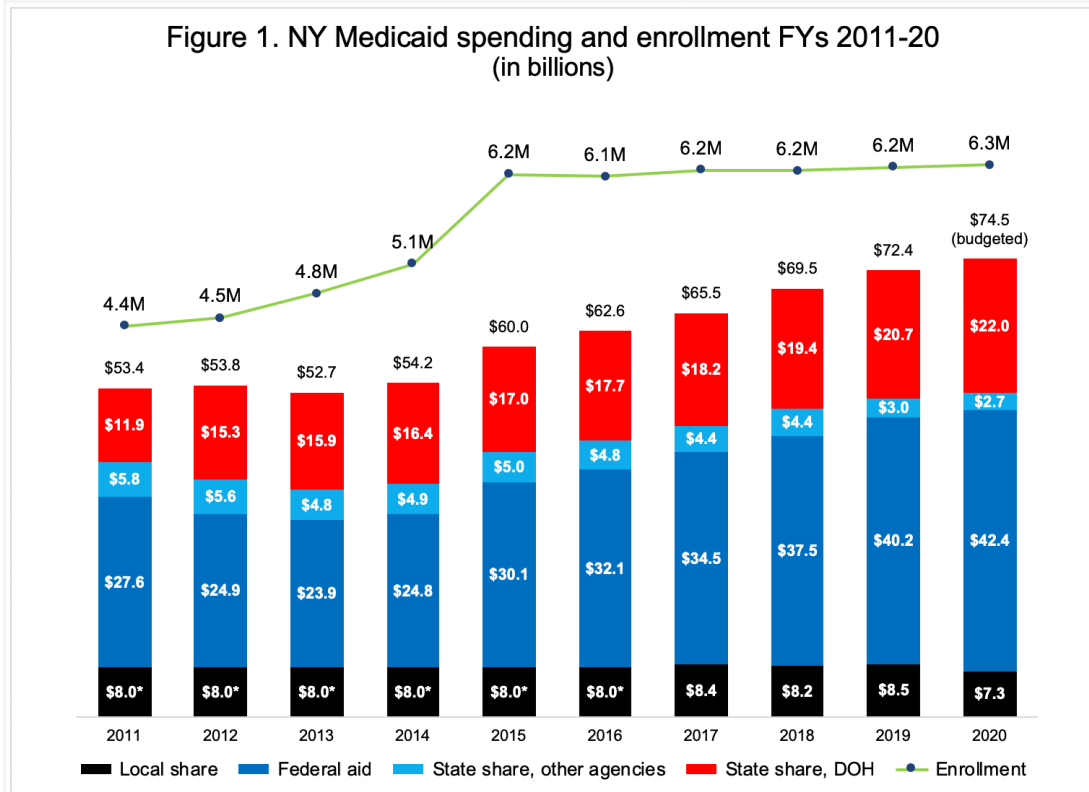
That's enough to finance three years' worth of the Metropolitan Transportation Authority's capital plan – or to cut a \$1,000 check to every resident of the state.

This report traces the progress of Cuomo's Medicaid policies – what they were meant to do, how they controlled spending at first, and why they lost effectiveness over time – and outlines a strategy for renewed reform.

## A History of Extremes

Medicaid, established in 1965, is a nationwide government-funded health plan for the poor and disabled. It is jointly financed by the federal government and the states, and states have discretion, within guidelines, to determine who is eligible and what benefits they receive.

In New York, the program currently covers 6.3 million people, or about one out of three state residents and half of all births.<sup>1,2</sup> Recipients include low-income adults and children



Sources: NYS Division of the Budget, NYS Department of Health. \*Estimated.

as well as people in long-term care because of advanced age or mental or physical disabilities.

In state fiscal year 2019-20, the program is expected to expend \$74.5 billion – 57 percent of which is to be paid by the federal government, 33 percent by the state, and 10 percent by New York City and the 57 counties (see Figure 1).<sup>3</sup>

For most of Medicaid’s history, New York’s program had the highest spending total in the country, outstripping even California, which had almost twice the population. As recently as 1998, New York’s spending was higher than the combined amounts of California and Texas.

More recently, New York’s spending has become less of an outlier as other states expanded their Medicaid programs, a trend encouraged by incentives in the Affordable Care Act. California’s Medicaid budget alone surpassed New York’s for the first time in 2011, the year Governor Cuomo took office.<sup>4</sup>

New York’s high rate of spending has partly derived from its expansive eligibility rules, broad enrollment and generous benefits. But perhaps the most important driving factor was how much it spent on each enrollee. At one point in the early 1990s, New York’s per-recipient spending was more than double the national average. Although that gap has gradually shrunk, New York’s per-recipient cost was still the highest nationally as recently as 2007.<sup>5</sup>

As of 2016 (the most recent year for which nationwide data were available), New York’s overall per-enrollee spending rate, at just under \$10,000, was 10th highest among the states

and 27 percent above the national average.<sup>6</sup> The share of New York’s population enrolled in Medicaid, at 33 percent, was second behind New Mexico at 37 percent.<sup>7</sup>

New York’s per-recipient spending is especially high for recipients in the aged and disabled enrollment groups, who primarily receive long-term care in nursing facilities, group homes or private residences (see Table 1).

One benchmark on which New York still claims the highest rank among states is per-capita spending. In 2016 New York’s per-capita spending was \$3,236 or 79 percent higher than the national average (see Figure 2).<sup>8</sup>

### Cuomo’s ‘Redesign’

When he took office in January 2011 – facing a \$10 billion projected gap in his first budget – Governor Cuomo targeted burgeoning Medicaid costs as a major cause of the state’s chronic financial ills.

His administration was projecting that overall Medicaid expenditures would jump 8 percent in the 2011-12 fiscal year. At the same time, an injection of extra Medicaid funding that Washington had temporarily provided to states after the Great Recession was phasing out. With outlays increasing and federal aid shrinking, Albany’s portion of the Medicaid tab was on track to spike by \$6 billion in a single year.<sup>9</sup>

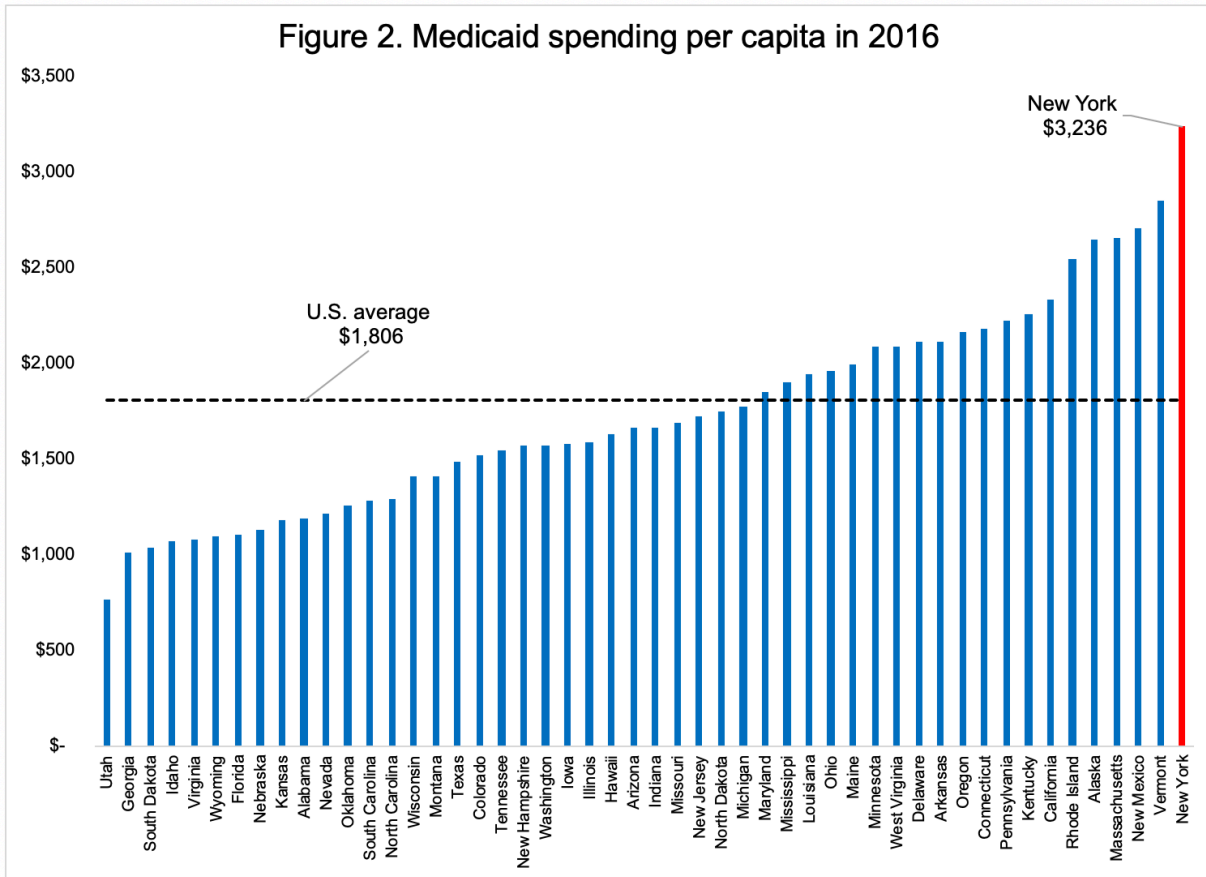
Cuomo and the Legislature responded with a mix of immediate spending cuts – such as eliminating automatic “trend factors” that otherwise boosted provider fees every year – and longer-term management changes.

**Table 1: Medicaid spending per recipient, 2014**

	<i>All recipients*</i>	<i>Aged</i>	<i>Disabled</i>	<i>Adults</i>	<i>Children</i>
<b>New York</b>	\$7,806	\$20,888	\$24,905	\$4,453	\$2,627
<b>U.S.</b>	\$5,736	\$13,063	\$16,859	\$3,278	\$2,577
<b>% difference</b>	36%	60%	48%	36%	2%

*Source: Kaiser Family Foundation. \*Dollar amounts vary from other figures in this report due to methodological differences.*

Figure 2. Medicaid spending per capita in 2016



Source: Author's calculations using data from the Centers for Medicare & Medicaid Services and the Census Bureau

Those changes included:

- Imposing a “global cap” on the state share of Medicaid, which limited annual growth to the 10-year rolling average of the medical inflation rate.
- Empowering the health commissioner to unilaterally cut provider fees if spending threatened to exceed the cap.
- Appointing a 25-member Medicaid Redesign Team of state officials and industry stakeholders to find the savings necessary to stay on budget.

Taken together, these steps transformed the political dynamics surrounding the program.

The cap brought a measure of restraint to spending growth, especially in the context of rising enrollment. The redesign team provided a calmer, more collaborative venue to hash out

the complexities of Medicaid reform – a contrast to the politicized annual stand-offs in the Legislature, which often led to late budgets while achieving limited progress. The commissioner’s additional budget powers, although never invoked, gave industry officials an incentive to collaborate on finding savings.

The policymakers’ self-declared mission was achieving the “triple aim”: improving care, improving health and reducing cost.

In late February 2011, six weeks after its creation by executive order, the Medicaid Redesign Team reported back with 79 recommendations, nearly all of which were accepted by Health Department officials, the state Legislature or both.<sup>10</sup>

Many of the proposals focused on enrolling more recipients in private health plans. This

program, known as “Medicaid managed care,” had been mandatory for most non-disabled adults and children. The panel recommended expanding it to groups that had been exempted, such as nursing home residents and recipients with lifelong disabilities.

The redesign also required managed care plans to take ownership of Medicaid’s prescription drug benefit, which had previously been carved out of managed care.

Other reforms called for establishing organizations known as “health homes” to coordinate the care of recipients with especially costly needs – such as those with both mental illness and addiction to alcohol or drugs – and centralizing the management of non-emergency transportation for Medicaid recipients to medical appointments.

In 2012, Cuomo and the Legislature also agreed to freeze the Medicaid contributions paid by New York City and county governments, leaving the state to fully fund any increase in the non-federal share. This move became fully effective in 2015.<sup>11</sup>

In a related effort, the Cuomo administration obtained an additional \$8 billion in federal funding over five years to create the Delivery System Reform Incentive Payment program, or DSRIP.<sup>12</sup>

To qualify for this money, hospitals and other health-care providers and social service groups were required to organize themselves into regional “performing provider systems,” with a mandate to improve the coordination of care delivery for Medicaid recipients and cut down on preventable hospital visits. The waiver period runs through March 2020.

## Mixed Results

Over the past eight years, dozens of changes recommended by the Medicaid Redesign Team have been implemented with varying degrees of success.

The push for more managed care has shown progress. As of November 2018, 77 percent of all recipients were enrolled in privately run Medicaid managed care plans, up from 69 percent in 2011.<sup>13</sup> The share of spending through managed care plans has increased more dramatically, from less than half to 68 percent – reflecting the much higher costs associated with managed long-term care for enrollees with disabilities.<sup>14</sup>

The increase in managed care was accompanied by lower spending in certain areas, prescription drugs being a particularly striking example.

Previously, the state directly reimbursed pharmacies for filling the prescriptions of Medicaid recipients – a

system known as “fee for service.” Under the new approach, those pharmacy claims would be paid by managed care plans, along with bills from doctor’s offices, clinics, hospitals, etc.

The expectation was that the plans would do a better job of encouraging patients to replace high-priced brand-name drugs with generic alternatives – as plans routinely do for private-sector customers.

The effect was striking: In the first two years after the “carve in” took effect in 2011, the average gross price per prescription paid by Medicaid dropped 23 percent, far outpacing a national downward trend of less than 2 percent.<sup>15</sup> This was likely due in part to plans’ efforts to switch patients from name-brand drugs to generic alternatives.

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New York's Medicaid drug costs rebounded after 2013, due in large part to heavy spending on newly released hepatitis C treatments that cost tens of thousands of dollars for a course of treatment. However, the state's per-prescription spending rate stayed below the national average through 2017.<sup>16</sup>

Other reforms have fallen short of expectations.

For example, the Fully Integrated Duals Advantage (FIDA) program targeted a particularly costly subset of the so-called dual-eligible population, who qualify for both Medicaid and Medicare.

The goal was to enroll more of them in managed care. However, federal policy does not allow mandatory managed-care enrollment for Medicare recipients, as it does for Medicaid recipients, so participation has been voluntary. As of 2018, fewer than 4,000 people out of a target population of 110,000 were signed up.

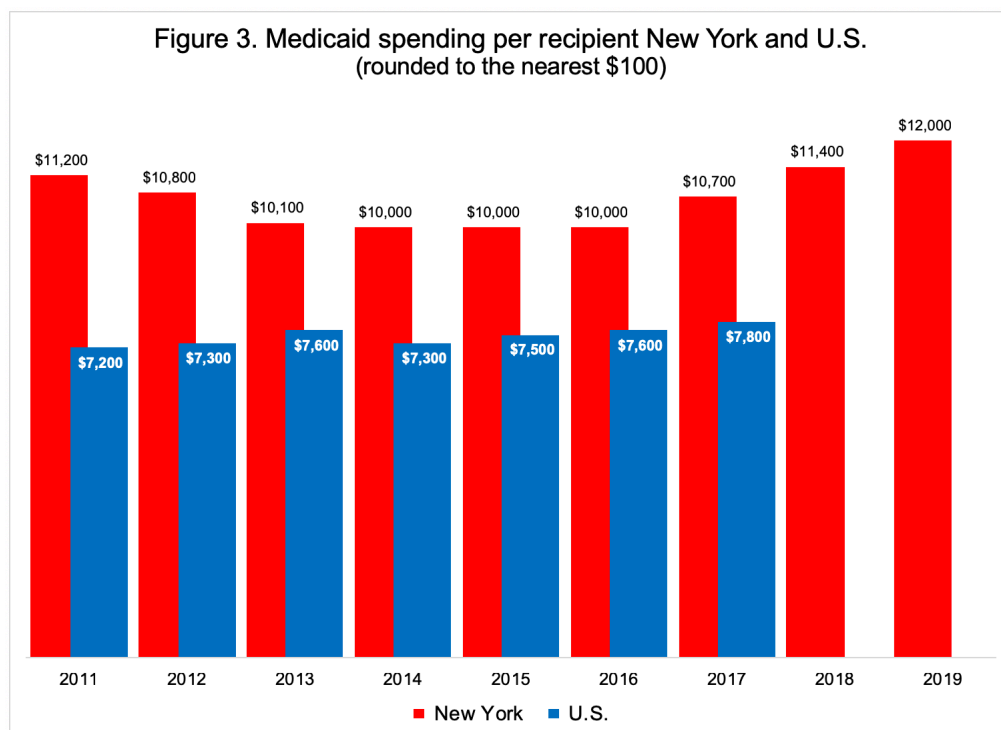
According to a report from the Citizens Budget Commission of New York, "The low participation likely is due to individuals' satisfaction with their current care, their lack of understanding of the nature of the FIDA plans and their potential benefits, and in some cases current providers encouraging them to opt out."<sup>17</sup>

The program is due to expire at the end of 2019.

## Spending Trends

Overall, from 2011 to 2016, the Medicaid Redesign Team's cost-control efforts showed signs of working. Enrollment soared by 31 percent as the Affordable Care Act broadened eligibility and promoted sign-ups, but the global cap held spending growth to 17 percent.<sup>18</sup>

As a result, per-recipient spending dropped 11 percent, and the gap between New York and the U.S. average shrank from \$3,900 to \$2,400.<sup>19</sup>



Sources: Author's calculations using data from the U.S. Centers for Medicare & Medicaid Services, NYS Division of the Budget and NYS Department of Health. National data were not yet available for 2018 and 2019.



## What's Driving Medicaid Costs?

**Enrollment:** One major driver of New York's high Medicaid costs is unusually high enrollment.

Its poverty rate is about average at 13 percent, yet the share of its population covered by Medicaid, at 33 percent, is second only to New Mexico.<sup>29,30</sup> The 20-point disparity between New York's enrollment rate and its poverty rate is the widest of any state's – and suggests that a majority of recipients are living above the poverty line.

Some fraction of that latter group is likely the result of error or fraud, as audits have found.<sup>31</sup> But much of it is legitimate: The eligibility threshold is 138 percent of the federal poverty level for most recipients, 154 percent for children from 1 to 19, and 224 percent for pregnant women and infants.<sup>32</sup>

New Yorkers with higher incomes can also qualify for Medicaid if they have uninsured medical expenses that would consume all or most of their earnings, or by using legal maneuvers to transfer or shield assets before entering a nursing home.

Many of these enrollees would not need Medicaid if they had access to affordable alternatives. The state could therefore reduce Medicaid spending by making private coverage more affordable for employers and individuals.

First steps would include repealing the heavy insurance taxes imposed under the state's Health Care Reform Act, which counterproductively add \$5 billion to premiums, and rolling back coverage mandates that go beyond expert guidelines and promote waste.<sup>33</sup>

**Personal Care:** An especially stark example of high Medicaid spending in New York is the program known as "personal care," which provides non-medical services – such as cooking, house-cleaning and help with bathing – for disabled people living at home.

In 2016, New York spent \$5.5 billion on personal care services, which was the most of any state by a factor of almost three.<sup>34</sup> That cost has increased 71 percent since Cuomo's first year, more than four times faster than the overall Medicaid budget.

New York's per-capita spending on personal care, at \$279 in 2016, was the highest in the country and more than six times the average of the 33 states that offer the benefit (Figure 6).<sup>35</sup>

With 6 percent of the population, New York accounted for 40 percent of nationwide personal care spending in 2016, up from 23 percent in 2011.

In spite of extremely high spending, personal care receives comparatively little oversight from the state's Medicaid Fraud Control Unit, a branch of the state attorney general's office. From 2012 to 2015, the unit conducted just 21 investigations of personal care fraud. That was 0.3 percent of all such probes conducted during the period.<sup>36</sup>

The state could reduce personal care spending by setting stricter limits on eligibility and utilization and beefing up anti-fraud efforts.

**Provider Subsidies:** Another cost driver is the substantial amount that Medicaid spends on subsidies for hospitals, often with little connection to patient care.

One such program is the Indigent Care Pool, which distributes \$1 billion per year. Its declared purpose is to partially reimburse hospitals for providing free care to the uninsured and to supplement the relatively low fees paid by Medicaid. However, the formula used to allocate funding is arcane and dysfunctional, which sometimes results in overly generous grants to wealthy hospitals that treat few poor patients, and overly stingy grants for the true safety-net institutions.<sup>37</sup>

Two other subsidy programs, the Vital Access Provider Assurance Program and the Value-Based Payment Quality Improvement Program, effectively function as general assistance for financially struggling hospitals.

In fiscal year 2018-19, more than half of the \$539 million distributed by those two programs went to four hospitals in Brooklyn: Brookdale, Interfaith, Kingsbrook and Wyckoff Heights.<sup>38</sup> For each of them, the grants amounted to more than one-fifth of their annual revenue – and all had received similarly generous grants for the previous four years. What should be short-term help for institutions in crisis has become a major source of ongoing support.

Medicaid money should be reserved for providing care to those who need it, not needlessly subsidizing wealthy hospitals or propping open institutions that are no longer financially viable.

After 2016, however, the picture changed significantly. First, enrollment stopped its rapid growth and held steady around 6.2 million, where it stands today. Meanwhile, spending growth accelerated.<sup>20</sup>

From 2011 to 2016, when enrollment was rising, New York’s Medicaid budget grew by an average of 3 percent per year. From 2015 to 2019, with enrollment flat, the average annual increase was almost 6 percent.<sup>21</sup>

As a result, per-recipient spending increased more over the past three years than it had declined over the previous five, rising to \$12,015 for 2019 (see Figure 3, page 6).<sup>22</sup>

### A Leaky Cap

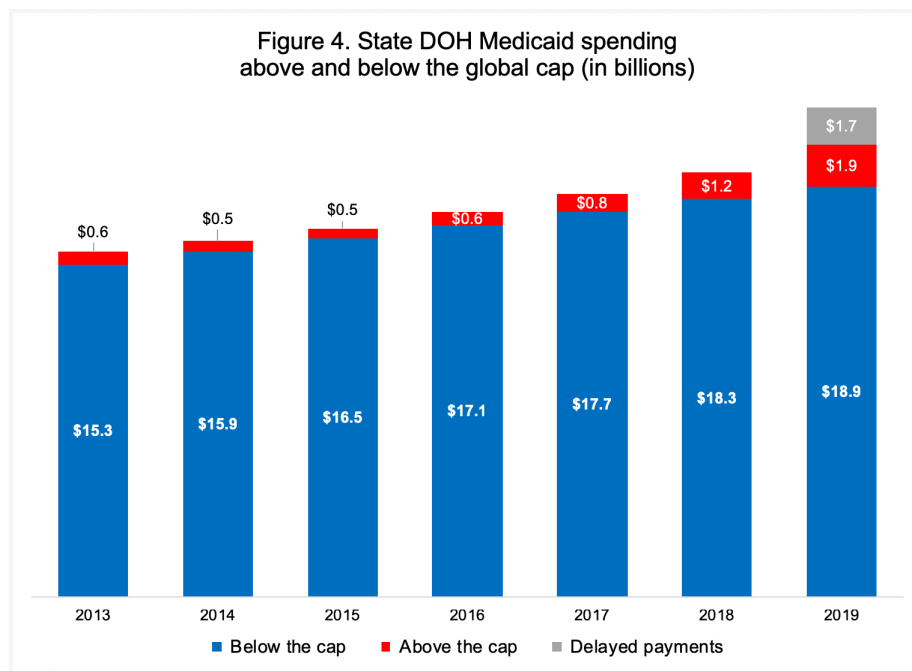
The recent trends have highlighted structural weaknesses in the Medicaid spending cap, some of which were built in from the beginning and others added later.

As enacted in 2011 and periodically renewed since, the cap limits the growth of state Med-

icaid spending to the 10-year rolling average of the Consumer Price Index’s medical component.<sup>23</sup>

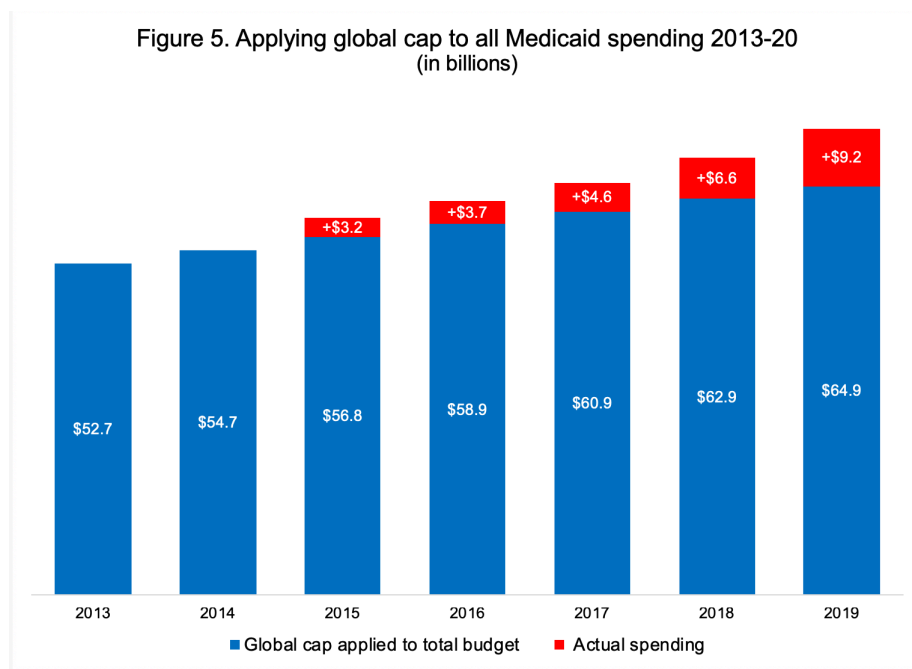
The cap has applied primarily to Medicaid spending that flows through the state Department of Health, commonly labeled in budget documents as “DOH Medicaid.” This category omits the “mental hygiene” populations served through the Office of Mental Health, the Office for People with Developmental Disabilities and the Office of Alcoholism and Substance Abuse Services. Over the years, the Cuomo administration has included varying portions of mental hygiene Medicaid spending under the cap.

The cap has also covered only the state’s share of Medicaid spending. At first, this made little difference, because federal aid is provided on a matching basis and normally rises and falls at the same rate as state spending. After 2014, however, the Affordable Care Act boosted federal matching rates for certain categories of Medicaid recipients. This means that total spending has grown faster than the state’s contribution.



Source: NYS Division of the Budget. Figures do not include mental hygiene spending, federal aid or local contributions.





Source: NYS Division of the Budget, NYS Department of Health, author's calculations

A significant shortcoming of the cap is its lack of an adjustment for enrollment, which makes it more stringent when the covered population is growing and less stringent when enrollment is flat or shrinking.

As discussed above, when enrollment surged 31 percent from 2011 to 2016, the cap held total spending growth to the much lower rate of 17 percent, and per-recipient spending dropped accordingly. When enrollment leveled off after 2016, the cap allowed spending to keep going up and per-recipient costs quickly climbed.

The effectiveness of the cap has been further weakened by exemptions for certain categories of spending, which have grown over time.

For example, when lawmakers approved Governor Cuomo's proposal to freeze the local share of Medicaid costs (paid by counties and New York City), they excluded the additional expense to the state from the cap.<sup>24</sup> That amount started small but has risen to \$1.1 billion per year as of fiscal year 2020.<sup>25</sup>

After enacting a multi-stage minimum wage hike in 2016, the Legislature approved Cuomo's

plan to boost Medicaid payments to reflect providers' higher labor costs while excluding the additional expense from the cap.<sup>26</sup> That amount has burgeoned to \$1.1 billion for 2020. Including federal aid, the total minimum-wage impact on Medicaid spending will be \$2.2 billion or more.<sup>27</sup>

The cap's integrity suffered perhaps its biggest blow during the 2018-19 fiscal year, when the Cuomo administration quietly postponed a month's worth of Medicaid payments from the end of March to early April, effectively shifting a month's worth of expenditures from one fiscal year to the next.<sup>28</sup>

It turned out that spending for the year had been on track to exceed the capped amount by \$1.7 billion, or 8 percent. In those circumstances, state law requires the health commissioner and budget director to institute spending cuts as necessary to stay on budget. By resorting to a bookkeeping maneuver instead, they signaled an unwillingness to enforce the cap, even as previously loosened.

If the \$1.7 billion had been paid on schedule, above-the-cap expenditures would have to-

taled \$3.6 billion in fiscal year 2019, or 16 percent of DOH Medicaid spending. That's up from \$450 million or 3 percent in 2015 (see Figure 4, page 8).

If, beginning in 2013, the global cap had been applied without exception to all Medicaid spending – including mental hygiene and federal aid – the program's budget for 2019 would be \$9 billion less, and per-recipient spending would be \$1,500 lower (see Figure 5, page 9).

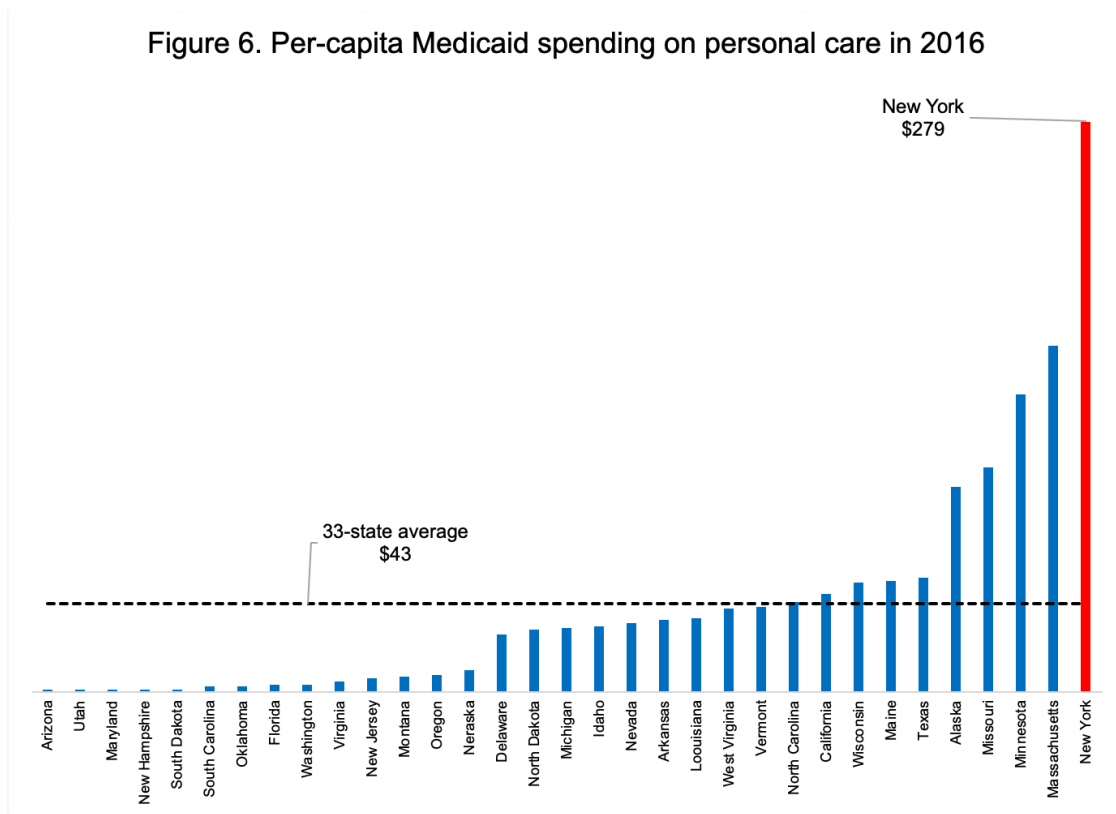
Given the changed circumstances, growing loopholes and lack of enforcement, the global cap is no longer effective as a brake on Medicaid spending or as a tool for improving efficiency. To the contrary, it now permits – and arguably encourages – higher-than-inflation growth in what is already the costliest Medicaid program in the U.S.

## Course Correction

The Cuomo administration's decision to delay \$1.7 billion in fiscal 2019 Medicaid payments into fiscal 2020 should be seen as a red flag. Spending levels that had showed signs of moving closer to national norms are now surging upward again – bypassing statutory limits and claiming an ever-larger share of state resources. These trends could lead to a crisis when the current economic expansion reaches its inevitable end.

As this report's sampling of cost drivers illustrates (see page 7), there are many opportunities to save money through better, more efficient management – which in many cases would enhance rather than harm the overall health-care system. What's needed is not sudden, drastic change, but continuous improvement and steady discipline.

Figure 6. Per-capita Medicaid spending on personal care in 2016



Source: U.S. Centers for Medicare & Medicaid Services

The history of Cuomo's Medicaid reform regime shows that it can function as a framework for positive change, but that its effectiveness depends on the stringency of the global cap. Tightening the cap – and recommitting to its enforcement – would be a start toward regaining control over spiraling costs.

Even incremental improvements could lead to substantial savings. As of 2016, New York's per-recipient spending was 36 percent above the national average. Each point of that gap translates to more than a half-billion dollars in excess spending per year.

To restore spending discipline, the state should:

- Apply the cap to per-recipient costs, not aggregate costs, to avoid overspending when enrollment stays flat or goes down.
- Establish separate capped rates for various categories of patients, to reflect the vast difference in needs and expenses between, say, an elderly nursing home patient and a generally healthy 18-year-old.
- Set the growth rate low enough to drive lower per-recipient spending over time – with a long-term goal of moving New York's rate closer to the national average.

- Close loopholes, such as the exemption for minimum wage costs, so that the cap constrains all spending and not just some of it.
- Broaden the cap to cover total Medicaid spending, not just state funding, to put the focus on achieving efficiency savings rather than maximizing federal aid.
- Forbid a repeat of the delayed-payment maneuver used this spring, which violated the cap in spirit if not in letter.

Once the cap is strengthened, a revived Medicaid Redesign Team should systematically identify examples of over-spending and waste – such as personal care and ill-conceived provider hospital subsidies – and develop plans for reducing or eliminating them altogether.

More than money is at stake. Much of the inefficiency of New York's Medicaid program is a symptom of underlying mismanagement – of programs that deliver fragmented, wasteful care, put the interests of providers ahead of patients and leave the state vulnerable to abuse and fraud.

Medicaid plays a critical role in the lives of millions of New Yorkers, including its most disabled and vulnerable citizens. It's incumbent on state leaders to get it right.

## Endnotes

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<sup>2</sup>51 percent as of 2014. Kaiser Family Foundation, “Births Financed by Medicaid.” <https://www.kff.org/medicaid/state-indicator/births-financed-by-medicaid/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>

<sup>3</sup>New York State Division of the Budget, “FY 2020 Enacted Budget Financial Plan.” <https://www.budget.ny.gov/pubs/archive/fy20/enac/fy20fp-en.pdf>

<sup>4</sup>Centers for Medicare & Medicaid Services, “Health expenditures by state of residence: summary tables, 1991-2014,” Table 25. <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/index.html>

<sup>5</sup>Ibid.

<sup>6</sup>Author’s calculations using spending and enrollment data from CMS.

<sup>7</sup>Author’s calculations using enrollment data from CMS and population figures from the U.S. Census Bureau.

<sup>8</sup>Ibid.

<sup>9</sup>Division of the Budget, “2011-12 Executive Budget Financial Plan,” January 2011. <https://www.budget.ny.gov/pubs/archive/fy1112archive/eBudget1112/financialPlan/FinPlan.pdf>

<sup>10</sup>“Governor Cuomo Accepts Recommendations from the Medicaid Redesign Team,” Executive Chamber press release, February 24, 2011. <https://www.governor.ny.gov/news/governor-cuomo-accepts-recommendations-medicaid-redesign-team>

<sup>11</sup>Chapter 56 of the Laws of 2012, Part F.

<sup>12</sup>Melanie Evans, “New York gets \$8 billion Medicaid waiver,” *Modern Healthcare*, February 13, 2014. <https://www.modernhealthcare.com/article/20140213/NEWS/302139953/new-york-gets-8-billion-medicaid-waiver>

<sup>13</sup>New York State Department of Health, monthly global cap updates. [https://www.health.ny.gov/health\\_care/medicaid/regulations/global\\_cap/](https://www.health.ny.gov/health_care/medicaid/regulations/global_cap/)

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<sup>15</sup>Bill Hammond, “The Cost of Cures: Analyzing the Surge in New York’s Medicaid Drug Spending,” *Empire Center for Public Policy*, April 10, 2018. <https://www.empirecenter.org/publications/the-cost-of-cures/>

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<sup>17</sup>Citizens Budget Commission of New York, “Options to Enhance the Coordination of Care for Dually Eligible Individuals in New York State,” April 25, 2019. <https://cbcny.org/research/options-enhance-coordination-care-dually-eligible-individuals-new-york-state>

<sup>18</sup>Author’s calculations using enrollment figures from the Department of Health and spending data from the Division of the Budget.

<sup>19</sup>Ibid.

<sup>20</sup>Ibid.

<sup>21</sup>Ibid.

<sup>22</sup>Ibid.

<sup>23</sup>Chapter 59 of the Laws of 2011, Part H, Sections 91 and 92.

<sup>24</sup>Chapter 56 of the Laws of 2012, Part F.

<sup>25</sup>Division of the Budget, “FY 2020 Enacted Budget Financial Plan,” May 2019, p. 110. <https://www.budget.ny.gov/pubs/archive/fy20/enac/fy20fp-en.pdf>

<sup>26</sup>Chapter 54 of the Laws of 2016, Part JJ.

<sup>27</sup>Division of the Budget, “FY 2020 Enacted Budget Financial Plan,” May 2019, p. 110.

<sup>28</sup>Ibid., p. 37.

<sup>29</sup>Census Bureau, “Percentage of People in Poverty by State Using 2- and 3-Year Averages: 2013-2014 and 2015-16,” September 12, 2017. <https://www.census.gov/library/publications/2017/demo/p60-259.html>

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<sup>31</sup>See, for example, “Managed Care Premium Payments for Recipients with Comprehensive Third-Party Insurance,” New York State Office of the Comptroller, June 2018 (<https://www.osc.state.ny.us/audits/allaudits/093018/sga-2018-16s60.pdf>), and “New York Did Not Correctly Determine Medicaid Eligibility for Some Newly Enrolled Beneficiaries,” U.S. Department of Health and Human Services Office of the Inspector General, January 2018 (<https://www.osc.state.ny.us/audits/allaudits/093018/sga-2018-16s60.pdf>).

<sup>32</sup>Western New York Law Center, “Income and Resource Limits for New York State Public Health Insurance Programs.” <http://www.wnyc.com/health/entry/15/>

<sup>33</sup>Division of the Budget, “FY 2020 Enacted Budget Financial Plan,” p. 118. See also: Bill Hammond, “Hooked on HCRA: New York’s 20-Year Health Tax Habit,” *Empire Center*, January 10, 2017. <https://www.empirecenter.org/publications/hooked-on-hcra/>

<sup>34</sup>Steve Eiken, et al., “Medicaid Expenditures for Long-Term Services and Supports in FY 2016,” *IBM Watson Health*, May 2018. <https://www.medicaid.gov/medicaid/ltss/downloads/reports-and-evaluations/ltss-expenditures2016.pdf>

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<sup>36</sup>U.S. Department of Health & Human Services Office of Inspector General, “Medicaid Fraud Control Units: Investigation and Prosecution of Fraud and Beneficiary Abuse in Medicaid Personal Care Services,” December 2017 (supplementary tables). <https://oig.hhs.gov/oei/reports/oei-12-16-00500.asp>

<sup>37</sup>Hammond, “Indigent Carelessness: How not to subsidize hospital charity care,” *Empire Center*, September 18, 2017. <https://www.empirecenter.org/publications/invincible-indigence/>

<sup>38</sup>Department of Health figures provided to the Indigent Care Pool Workgroup.