

Proposals from Bill Hammond
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Presented to the Governor's Medicaid Redesign Team
February 21, 2020

Proposal 1: Strengthen the 'global cap'
(Potential savings: contingent on other actions)

The Medicaid "global cap," first imposed in 2012, was meant to limit the growth of state spending on so-called Department of Health Medicaid to the 10-year rolling average of the medical component of the Consumer Product Index.

Although this policy can be faulted on some grounds – including its lack of adjustment for changes in enrollment – those shortcomings are not to blame for the fiscal imbalance in the Medicaid program. To the contrary, it was a gradual weakening of the cap, and a failure to enforce its key provisions, that led to the current crisis.

The cap never applied to federal aid, which has increased faster than state spending as a result of the Affordable Care Act. Lawmakers also chose to exempt certain expenses, including, most critically, costs associated with the minimum wage hike of 2016.

As a result of this and other exemptions, the fiscal year 2019 budget called for DOH Medicaid spending to increase by more than 6 percent, which was double the "global cap" rate of about 3 percent.

In the end, actual spending for that year spiked by 15 percent – leading to a deficit of \$1.7 billion that was deferred into fiscal year 2020.

That overspending would have been caught earlier had the state consistently produced the monthly reports mandated by the cap legislation, which were meant to provide early warning of excess costs. The cap also authorizes the executive to unilaterally cut spending as necessary to stay on budget. Those "super powers" were never invoked even as the spending imbalance mushroomed.

In its early years, when it was being followed more scrupulously, the cap kept overall spending in check during an enrollment surge – helping bring New York's high per-recipient costs more in line with national norms.ⁱ

This useful tool should be strengthened, not abandoned. It should be expanded to cover all Medicaid spending, including labor costs associated with the minimum wage. It should be set at a level tight enough to promote efficiency – and leave more tax dollars available for other

state priorities. And officials should recommit to abiding by its reporting requirements and using its enforcement mechanisms when necessary.

The law should also specify that payment delays are not an acceptable strategy for complying with the cap's spending limit.

The cap itself does not cut costs – which is why no savings are attributed to this proposal. Rather, if properly abided by, it creates a framework for managing Medicaid in a sustainable fashion, holding stakeholders accountable and keeping the program on-budget.

Proposal 2: Improve screening for ineligible recipients
(Potential savings: \$500 million)

Multiple state and federal audits have shown that New York's Medicaid rolls include significant numbers of recipients who are ineligible for the program on financial grounds.

In a July 2019 audit, the U.S. Department of Health and Human Services' Office of the Inspector General reviewed a random sample of 130 enrollees and found that the state had incorrectly determined eligibility for six and lacked proper documentation for another 14.ⁱⁱ

Extrapolating from those results, the audit estimated that New York had spent \$520 million in federal funds on ineligible enrollees and \$1.3 billion on potentially ineligible enrollees in the six-month period audited – which equates to \$3.6 billion on an annualized basis.

Most Medicaid recipients currently enroll through the New York State of Health, an insurance exchange operated by the Department of Health. Others sign up through the social service agencies operated by New York City and county governments.

New York could improve eligibility screening by centralizing all enrollment through the state Health Department. This would make it easier to catch double enrollments, avoid conflicts between computer systems and eliminate the risk of perverse incentives at the local level.

Assuming the state could reduce by the number of clearly ineligible enrollees identified in the federal audit, it would save approximately \$500 million.

Proposal 3: Tighten enrollment standards for community-based long-term care
(Potential savings: unknown)

When New Yorkers seek Medicaid coverage for nursing-home care, the state reviews five years' worth of financial records to make sure they have not improperly transferred or shielded assets that would otherwise be available to finance their expenses.

For those seeking community-based long-term care, however, there is no similar “look back” period – making it relatively easy for people of means to make themselves appear impoverished.

Given the soaring demand for community-based services – which can be just as costly as institutional care in many cases – the state should extend the five-year look back to all applicants for long-term care.

Proposal 4: Reduce the overuse of personal assistance
(Potential savings: \$1.4 billion)

It's hard to overstate the disparity, in both cost and scale, between New York's personal assistance program and those of the 32 other states that offer this optional Medicaid benefit.

As of 2016 – the last year for which complete data are available – New York accounted for 40 percent of nationwide Medicaid spending on personal care. Its per capita costs were 6.5 times higher than the national average and 65 percent higher than the No. 2 state, Massachusetts.ⁱⁱⁱ

Since that time, the state's spending has more than doubled to \$5.7 billion (or more than \$11 billion with federal aid included) – making it one of the major causes of Medicaid's recent spending surge.

The bulk of the growth has occurred in the Consumer-Directed Personal Assistance Program, in which recipients choose, train and supervise their own caregivers, who can be friends or family members. This program has advantages when properly used, but is also inherently vulnerable to abuse and fraud.

Medicaid payments to the caregivers in the consumer-directed program flow through organizations called “fiscal intermediaries,” who withhold taxes and handle other payroll-processing functions. These minimally-regulated enterprises are paid a percentage of each caregivers’ earnings, giving them a financial incentive to maximize enrollment and utilization.

The double-digit growth rate of personal assistance (and managed long-term care generally) is out of line with demographic trends and has shown no sign of slowing. The phenomenon strongly suggests that a program originally intended for people with severe disabilities is being tapped into by a wider population.

To control the spiraling cost of this program, the state should:

- Redefine personal assistance as a discretionary benefit, which is the norm in other states, rather than an entitlement. This would give officials more control over who receives how much of a costly benefit.
- Tighten medical eligibility standards, setting a higher minimum degree of disability.
- Tighten financial eligibility standards, including instituting the five-year asset “look back” currently applied to those seeking nursing home coverage (see Proposal 3).
- Reduce the number of contractors, known as “fiscal intermediaries,” who handle payroll-processing for consumer-directed personal assistance. Switch their reimbursement from percentage commissions to fixed per-consumer fees.

- Adjust laws and procedural rules that inhibit reasonable management of personal assistance utilization by local officials and managed-care plans.
- Investigate policies and industry practices that may incentivize excessive enrollment in managed long-term care and personal assistance.
- Consider a short-term moratorium on new enrollments, with exceptions for hardship cases, while the state studies permanent reforms.

Over the past four years, spending on this program has grown by an average of more than \$1 billion annually. Simply holding spending steady at its current level – without year-to-year cuts -- would save approximately \$1.4 billion in fiscal year 2021.

Proposal 5: Reform the Indigent Care Pool
(Potential savings, \$138 million to \$330 million)

Each year, the state allocates \$1.1 billion in Medicaid funds to the Indigent Care Pool, with the stated purpose of compensating hospitals for providing free or discounted care to low-income, uninsured patients.

The bulk of that funding, or just under \$1 billion, flows to not-for-profit hospitals – and that portion is the focus of this proposal.

Under the program's current funding formula, the amount an institution receives often has little to do with need. Some wealthy hospitals receive grants far in excess of their actual charity-care expenses, while money-losing safety-net providers are shortchanged.^{iv}

The bulk of the ICP funds (just under \$1 billion) flows to not-for-profit hospitals which, as a group, dedicate only 1.2 percent of their revenue to free care for the uninsured – far less than the national average of 2.1 percent.

Last year, the governor floated a proposal that would have set a \$10,000 cap on ICP grants to certain large, financially strong downstate hospitals, saving the state an estimated \$138 million a year.

Farther-reaching reforms could achieve larger savings – while also resulting in a more rational system for funding charity care.

The state could, for example, set an expectation that not-for-profit hospitals dedicate at least 1.5 percent of their revenues to free care for the uninsured – then fully reimburse hospitals for all charity-care expenses above that amount. Under that scenario, the state-share savings would be about \$330 million a year.

If the minimum charity-care threshold were set at 2 percent of revenues, the savings would increase to \$370 million.

Proposal 6: Rescind across-the-board rate increases for hospitals and nursing homes
(Potential savings, \$278 million)

Effective Nov. 1, 2018, the Health Department issued across-the-board Medicaid rate increases of 2 percent for hospitals and 1.5 percent for nursing homes.

The change was made without public discussion or authorization by the Legislature, and subsequent events have raised further questions about the advisability of this expenditure.

As described at the time, the rate increase was to be financed with proceeds of the Fidelis Care sale, which had been deposited in the Health Care Transformation Fund – an inherently questionable use of a one-time source of revenue to pay an ongoing expense. Federal officials have since notified the state that they are reviewing whether using Fidelis proceeds in this way is legally permissible, raising the possibility that the state could lose federal matching aid for this expenditure.

The rate hike was apparently intended to defray increased labor expenses, including the costs of a July 2018 collective bargaining agreement between the League of Voluntary Hospitals and 1199 SEIU. One provision of that agreement described a “surplus” in the National Benefit Fund and called for diverting the money to other purposes, including an organization that lobbies in Albany.

The amount of surplus to be diverted, \$145 million, was \$5 million more than the estimated annual cost of the rate increase as provided by the governor's office to the New York Times – which creates doubt as to whether the extra funding was strictly necessary.

Rescinding the rate increase would save an estimated \$278 million, which was the cost for fiscal year 2021 as projected by the Budget Division in a November 2018 financial plan update.

Proposal 7: Limit subsidies for distressed hospitals
(Potential savings: \$143 million)

Targeted Medicaid funding for financially distressed hospitals is projected to cost the state almost \$500 million in the coming year. As discussed at the Medicaid Redesign Team's first meeting, this amount has grown 160 percent since 2016.

Some of the hospitals receiving these funds have experienced a long-term decline in demand for their services – a byproduct of industry-wide trends – and have come to depend on the grants for as much as 25 percent of their revenue.

Open-ended, long-term subsidies of this kind are an inappropriate use of health-care resources. Medicaid dollars are meant for the benefit of people, not institutions, and should follow patients to the providers of their choice.

The state should set limits on the scale and duration of such grants, and make them contingent on hospitals taking steps to downsize, close or otherwise return to financial viability.

If spending on subsidy programs for distressed hospitals were capped at its 2018 level, the state would save \$143 million.

Proposal 8: Cap funding for minimum wage costs
(Potential savings, \$300 million)

Since the enactment of a minimum wage hike in 2016, which lifted the hourly rate from \$9 to as much as \$15 an hour over a period of years, the state has reimbursed health-care providers for their associated labor costs.

This expense has risen to \$1.5 billion in the current fiscal year – or more than \$3 billion with federal matching aid included – which is far more than originally forecast.

To date, this funding has been exempted from the “global cap” – with the result that overall DOH Medicaid spending has been allowed to increase at more than double the medical inflation rate.

If the cap is to be effective, it should apply to all Medicaid spending – including labor, which is a core expense. Now that the minimum wage increase is fully effective in New York City, and largely effective elsewhere in the state, the costs associated with the minimum wage should return to being managed under the cap.

Based on current projections, this additional discipline would avoid approximately \$300 million in additional state spending.

Proposal 9: Eliminate subsidized malpractice coverage for physicians
(Estimated savings, \$127 million)

Through the state's Health Care Reform Act, New York spends \$127 million a year to provide doctors with supplemental malpractice liability coverage on top of the private insurance they buy for themselves.

This effectively puts taxpayers in the position of boosting the net incomes of professionals who generally earn far more than the average New Yorker.

New York's malpractice premiums are among the highest in the country, in large part because of its dysfunctional system for handling medical tort cases. The proper solution to that problem is to reform the tort system, not subsidize it. Nor should the state be indemnifying doctors in cases of true negligence.

Eliminating this unwarranted expenditure would save \$127 million.

Proposal 10: Reject new taxes

Through its Health Care Reform Act, New York imposes some of the heaviest health insurance taxes in the nation.^v They currently generate almost \$5 billion a year – making them the state's third largest source of revenue. Although these taxes are levied on insurance companies, they are ultimately paid by average consumers – adding approximately \$1,000 to the cost of a typical family policy.

These taxes are not adjusted for income, hitting low-paid retail workers just as hard as Wall Street executives.

One of the levies, known as the covered lives assessment, also varies widely from region to region for historical reasons that are no longer relevant. The added cost for family coverage ranges from \$29.19 a year in the Utica-Watertown region, to \$572.66 in New York City – an 1800 percent difference.

These taxes are especially counterproductive as a means of raising money for Medicaid. By making private insurance less affordable, they tend to push employers and individuals to drop their coverage – making it more likely that they will need Medicaid if they get seriously ill.

Hiking HCRA taxes – or imposing new taxes on health care – would not only fail to control Medicaid's rising costs, but would likely make the situation worse in the long term. The state should be looking to reduce or eliminate its taxes on health insurance, not increase them.

Proposal 11: Reject additional cost-shifts to local government

The proposed change in the local contribution to Medicaid costs – which would shift expenses to New York City and the counties if they fail to both hold property taxes below 2 percent and Medicaid spending below 3 percent – should be rejected.

New York already shifts a greater share of Medicaid costs to local government – and local taxpayers – than any other state. This has the perverse effect of putting the greatest burden on localities with the highest concentrations of poverty and, in many cases, the least ability to pay.^{vi}

Management of Medicaid is predominantly controlled by the state, subject to federal laws and regulations. State officials determine the benefits offered, set reimbursement rates for providers, write the eligibility guidelines, contract with insurance plans and make other decisions relevant to Medicaid spending, such as hiking the minimum wage.

Local officials exercise some discretion, but they do so under state direction.

If the state is concerned that decisions made at the local level are driving higher costs, it should either tighten its regulations or take full management control.

The state took a step in the right direction when it froze the local share as of 2015. It should work toward building on that progress, not undo it.

ⁱ See the Empire Center’s October 2019 report, “Busting the Cap: Why New York Is Losing Control of its Medicaid Spending Again.”

ⁱⁱ Office of the Inspector General, U.S. Department of Health and Human Services, “New York Did Not Correctly Determine Medicaid Eligibility for Some Non-Newly Eligible Beneficiaries,” July 17, 2019.

ⁱⁱⁱ Steve Eiken, et al., “Medicaid Expenditures for Long-Term Services and Supports in FY 2016,” Medicaid Innovations Accelerator Program, IBM Watson Health, May 2018 (produced on behalf of the Centers for Medicare & Medicaid Services).

^{iv} See the Empire Center’s September 2017 report, “Indigent Carelessness: How Not To Subsidize Hospital Charity Care.”

^v See the Empire Center’s January 2017 report, “Hooked on HCRA: New York’s 20-Year Health Tax Habit.”

^{vi} See the Empire Center’s July 2018 report, “Shifting Shares: The Costly Challenge of a State Medicaid Takeover.”