

Health Policy for Low-Income People in New York

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State Reports



Assessing
the New
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*An Urban Institute
Program to Assess
Changing Social Policies*



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This report is part of The Urban Institute's *Assessing the New Federalism* project, a multi-year effort to monitor and assess the devolution of social programs from the federal to the state and local levels. Project codirectors are Anna Kondratas and Alan Weil.

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About the Series

A *ssessing the New Federalism* is a multi-year Urban Institute project designed to analyze the devolution of responsibility from the federal government to the states for health care, income security, employment and training programs, and social services. Researchers monitor program changes and fiscal developments, along with changes in family well-being. The project aims to provide timely nonpartisan information to inform public debate and to help state and local decisionmakers carry out their new responsibilities more effectively.

Key components of the project include a household survey, studies of policies in 13 states, and a database with information on all states and the District of Columbia, available at the Urban Institute's Web site. This paper is one in a series of reports on the case studies conducted in the 13 states, home to half of the nation's population. The 13 states are Alabama, California, Colorado, Florida, Massachusetts, Michigan, Minnesota, Mississippi, New Jersey, New York, Texas, Washington, and Wisconsin. Two case studies were conducted in each state, one focusing on income support and social services, including employment and training programs, and the other on health programs. These 26 reports describe the policies and programs in place in the base year of this project, 1996. A second set of case studies to be prepared in 1998 or 1999 will describe how states reshape programs and policies in response to increased freedom to design social welfare and health programs to fit the needs of their low-income populations.

The income support and social services studies look at three broad areas. Basic income support for low-income families, which includes cash and near-cash programs such as Aid to Families with Dependent Children and Food Stamps, is one. The second area includes programs designed to lessen the

dependence of families on government-funded income support, such as education and training programs, child care, and child support enforcement. Finally, the reports describe what might be called the last-resort safety net, which includes child welfare, homeless programs, and other emergency services.

The health reports describe the entire context of health care provision for the low-income population. They cover Medicaid and similar programs, state policies regarding insurance, and the role of public hospitals and public health programs.

In a study of the effects of shifting responsibilities from the federal to state governments, one must start with an understanding of where states stand. States have made highly varied decisions about how to structure their programs. In addition, each state is working within its own context of private-sector choices and political attitudes toward the role of government. Future components of *Assessing the New Federalism* will include studies of the variation in policy choices made by different states.

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Highlights of the Report

The state of New York has made a large commitment to public support of health and social welfare services. The state has by far the largest Medicaid program in the country, with total expenditures of more than \$24 billion (1995), more than 40 percent greater than the next-highest-spending state. More than 3.3 million New Yorkers were enrolled in the Medicaid program in 1995. The state Medicaid eligibility criteria are far more generous than those of the average state, with the result that 15.6 percent of the state's population is enrolled (versus 13.0 percent for the nation). An additional 447,000 are eligible for Medicaid-equivalent benefits through the Home Relief program. In addition, the state has established a children's health insurance program that currently covers 124,000 children, and the program is being expanded to cover up to 251,000 children. Finally, the state also has had for many years a bad-debt and charity-care pool, a system of cross-subsidies to hospitals with high uncompensated care burdens from those with fewer non-paying patients.

Despite the state's commitment to covering Medicaid and Home Relief recipients, 16.8 percent of the nonelderly population, or about 3.1 million New Yorkers, is uninsured. There is also evidence that the uninsured population is growing. In 1993 the state implemented major reform of its individual and small-group insurance markets in response to rapidly rising premiums facing high-risk individuals in the Empire Blue Cross pool. Despite these efforts, there has been a consistent erosion of small-group and individual coverage in New York in the past few years; for example, 160,000 fewer New Yorkers had coverage in the individual and small-group insurance markets in 1995 than in 1992. These reforms may have made insurance more available to those with serious health problems, though no data are available to document this.

The Medicaid program is the largest single item in the state budget and grew faster from 1990 to 1995 than all other expenditure areas in the budget. The state spends more per Medicaid beneficiary than any other state, generally reflecting a broad benefit package, full-cost reimbursement of hospitals, high nursing home payment rates, and extensive coverage of personal care services. The state's high expenditures also reflect its efforts to shift services previously funded solely by the state into Medicaid to obtain federal matching payments. New York has been one of the most successful states at Medicaid maximization, that is, structuring services to meet Medicaid standards and obtain federal funds. Because of the size of the program, many powerful interest groups have developed that aggressively argue to support their constituencies. Moreover, there is strong Republican control of the state Senate and Democratic control of the Assembly. Under both Democratic and Republican gubernatorial leadership, divided legislature control has ensured compromise. As a result, it is unlikely that there will be any serious reductions in the scope of the Medicaid program.

On January 1, 1997, New York ended its all-payer rate-setting system, permitting insurers and managed care plans to negotiate directly with hospitals. The expectation was that market forces would lower health care costs and reduce the excess capacity in the hospital system. While moving to a system of negotiated rates, the state nonetheless retained previous levels of financial commitment to safety net hospitals through the bad-debt and charity-care pools. The general expectation is that the financially stable academic medical centers will do well in a competitive market, in part because they will continue to receive some subsidies for graduate medical education. On the other hand, many community hospitals without a substantial private paying base could be in serious trouble. There is some concern that many of these community hospitals will have difficulty in continuing to provide care to the growing uninsured population, despite the resources they receive from the bad-debt and charity-care pools.

Managed care has been relatively slow to enter New York State, in part because of the state's regulatory environment (for example, its rate-setting system and certificate-of-need laws). Managed care is now growing rapidly, and growth is expected to accelerate with the end of rate setting. New York has considerable excess capacity in its hospital system and a large supply of physicians, especially specialists, offering managed care plans the opportunity to negotiate aggressively. On the other hand, the state has moved to increase regulation in the health maintenance organization (HMO) market. In the past year, legislation restricting managed care practices was enacted as the result of efforts by consumer groups and the Medical Society of the State of New York.

The health system in New York City is confronted with a variety of changes in state policy and market forces. These include the deregulation of the hospital rate-setting system, reduced support from New York City for the public hospital system, and rapid expansion of Medicaid managed care and Medicare payment reforms, particularly those affecting graduate medical education. On the basis of visits to 11 hospitals and six community health centers, it is clear that hospitals and community health centers are seriously affected by the financial pressures they face. Providers generally face lower managed care rates and, at

the same time, a growing need to lower costs and remain attractive to clients. The larger academic medical centers are actively engaging in mergers and network development, both to increase efficiencies and physician referrals and to increase their market power when negotiating with managed care plans. Community hospitals, on the other hand, see their ability to affiliate with the larger teaching hospitals as essential to their survival. Safety net providers are actively seeking affiliations with physicians and with ambulatory care centers. At this point, few hospitals are closing, but almost all are experiencing reduced utilization. Hospitals are concerned over New York City's reduction in support for its public hospitals yet are still serving the uninsured; they are, however, concerned about their ability to continue serving uninsured people, particularly if several public hospitals close.

In an effort to control expenditures and better coordinate services, the state has made a major effort to expand its use of managed care. On July 15, 1997, the state received approval of a Section 1115 waiver from the Health Care Financing Administration that will allow the state to expand its use of mandatory managed care. It is envisioned that the state will expand managed care enrollment from 645,000 to more than 2.4 million Medicaid beneficiaries. The state not only will enroll beneficiaries of Aid to Families with Dependent Children, it will go further than virtually any other state in enrolling populations with disabilities. The waiver will also result in federal Medicaid funds for the Home Relief population and for hospitals requiring assistance with the transition to managed care.

The state faces a number of major issues in expanding managed care. In the past, there have been problems with enrolling individuals in plans and obtaining enough primary care capacity to serve these enrollees. The state also has multiple and somewhat conflicting objectives. It would like to contract with mainstream or commercial HMOs as well as Medicaid-only plans, provide support to safety net institutions, and regulate managed care organizations aggressively to maintain quality, while at the same time implementing lower capitation rates to achieve savings. Needless to say, the state faces serious challenges meeting these somewhat conflicting objectives.

Finally, the state has a large long-term care industry. Expenditures for nursing home care (\$4.6 billion in 1995) and home care (\$2.7 billion in 1995) together account for about one-third of total Medicaid expenditures. Personal care is an optional home care program under Medicaid that provides assistance for dependencies in activities of daily living rather than medical home health care. New York's use of the personal care benefit is by far the largest in the country. Despite the widespread concerns in the state over asset divestment and the scope of the personal care benefit, current efforts by the state to constrain Medicaid long-term care expenditures have focused on freezing payment rates for nursing homes and increasing efforts to maximize Medicare revenues for both nursing homes and home care.



Thumbnail Sketch of the State

Sociodemographic

New York is the third most populous state in the nation, with a population of 18.2 million (table 1). It has the third-largest elderly population (2.3 million), ranking behind only Florida and California. It has the third-largest population under age 18 (4.7 million), ranking behind only California and Texas. A somewhat higher than average percentage of its population is elderly, and a somewhat lower than average percentage is under age 18 compared with the nation. The state's population is barely growing, increasing by less than 1 percent between 1990 and 1995 (versus 5.6 percent for the nation). New York is heavily urban, with only 9.7 percent of its population living in nonmetropolitan areas (as compared with 21.8 percent for the entire nation). There are larger than average nonwhite, Hispanic, and immigrant populations.

Economic Status

The state is well above average in terms of per capita income. In 1995, the average income of New Yorkers was \$27,678, versus \$23,208 for the nation. However, the state has a fairly skewed distribution of income. Despite the high per capita income, an above average percentage of the population is in poverty—15.9 percent versus 14.3 percent nationally—and a higher than average percentage of children are below poverty. The state also has a lower than average employment rate (as of 1995) and a higher than average unemploy-

Table 1 *State Characteristics*

	New York	United States
Sociodemographic		
Population (1994–95) ^a (in thousands)	18,173	260,202
Percent under 18 (1994–95) ^a	26.0%	26.8%
Percent 65+ (1994–95) ^a	12.8%	12.1%
Percent Hispanic (1994–95) ^a	13.3%	10.7%
Percent Non-Hispanic Black (1994–95) ^a	15.2%	12.5%
Percent Non-Hispanic White (1994–95) ^a	66.7%	72.6%
Percent Non-Hispanic Other (1994–95) ^a	4.9%	4.2%
Percent Noncitizen Immigrant (1996) *	11.9%	6.4%
Percent Nonmetropolitan (1994–95) ^a	9.7%	21.8%
Population Growth (1990–95) ^b	0.8%	5.6%
Economic		
Per Capita Income (1995) ^c	\$27,678	\$23,208
Percent Change in Per Capita Personal Income (1990–95) ^{c, d}	19.7%	21.2%
Percent Change in Personal Income (1990–95) ^{c, e}	20.5%	27.7%
Employment Rate (1996) ^{f, g}	57.8%	63.2%
Unemployment Rate (1996) ^f	6.2%	5.4%
Percent below Poverty (1994) ^h	15.9%	14.3%
Percent Children below Poverty (1994) ^h	24.6%	21.7%
Health		
Percent Uninsured—Nonelderly (1994–95) ^a	16.8%	15.5%
Percent Medicaid—Nonelderly (1994–95) ^a	14.7%	12.2%
Percent Employer Sponsored—Nonelderly (1994–95) ^a	63.3%	66.1%
Percent Other Health Insurance—Nonelderly (1994–95) ^{a, i}	5.2%	6.2%
Smokers among Adult Population (1993) ^j	23.5%	22.5%
Low Birth-Weight Births (<2,500 g) (1994) ^k	7.6%	7.3%
Infant Mortality Rate (Deaths per 1,000 Live Births) (1995) ^l	7.8	7.6
Premature Death Rate (Years Lost per 1,000) (1993) ^{m, n}	60.3	54.4
Violent Crimes per 100,000 (1995) ^o	841.9	684.6
AIDS Cases Reported per 100,000 (1995) ^j	68.4	27.8
Political		
Governor's Affiliation (1996) ^p	R	
Party Control of Senate (Upper) (1996) ^p	26D-35R	
Party Control of House (Lower) (1996) ^p	96D-54R	

a. Two-year concatenated March Current Population Survey (CPS) files, 1995 and 1996. These files are edited by the Urban Institute's TRIM2 microsimulation model. Excludes those in families with active military members.

b. U.S. Bureau of the Census, *Statistical Abstract of the United States: 1996* (116th edition). Washington, D.C., 1996. 1995 population as of July 1. 1990 population as of April 1.

c. *State Personal Income, 1969-1995*. CD-ROM. Washington, D.C.: Regional Economic Measurement Division (BE-55), Bureau of Economic Analysis, Economics and Statistics Administration, U.S. Department of Commerce, October 1996.

d. Computed using mid-year population estimates of the Bureau of the Census.

e. Personal contributions for social insurance are not included in personal income.

f. U.S. Department of Labor. *State and Regional Unemployment, 1996 Annual Averages*. USDL 97-88. Washington, D.C., March 18, 1997.

g. Employment rate is calculated using the civilian noninstitutional population 16 years of age and over.

h. CPS three-year average (March 1994–March 1996 where 1994 is the center year) edited using the Urban Institute's TRIM2 microsimulation model.

i. "Other" includes persons covered under CHAMPUS, VA, Medicare, military health programs, and privately purchased coverage.

j. Normandy Brangen, Danielle Holahan, Amanda H. McCloskey, and Evelyn Yee. *Reforming the Health Care System: State Profiles 1996*. Washington, D.C.: American Association of Retired Persons, 1996.

k. S.J. Ventura, J.A. Martin, T.J. Mathews, and S.C. Clarke. "Advance Report of Final Natality Statistics, 1994." *Monthly Vital Statistics Report*; vol. 44, no. 11, supp. Hyattsville, MD: National Center for Health Statistics, 1996.

l. National Center for Health Statistics. "Births, Marriages, Divorces, and Deaths for 1995." *Monthly Vital Statistics Report*; vol. 44, no. 12. Hyattsville, MD: Public Health Service, 1996.

m. ReliaStar Financial Corporation. *The ReliaStar State Health Rankings: An Analysis of the Relative Healthiness of the Populations in All 50 States*, 1996 edition, Minneapolis, MN: ReliaStar, 1996.

n. Race-adjusted data, National Center for Health Statistics, 1993 data.

o. U.S. Department of Justice, FBI. *Crime in the United States, 1995*. October 13, 1996.

p. National Conference of State Legislatures. *1997 Partisan Composition, May 7 Update*. D indicates Democrat and R indicates Republican.

ment rate (as of 1996). And although the state's per capita income is above average, the growth in per capita income is less than the national average. Finally, growth in personal income, which combines population growth and per capita income, is substantially below the national average. The implication is that resources available to the state are growing more slowly than in the nation as a whole.

Political

New York is a historically liberal and progressive state. This has not dramatically changed with the election of George Pataki, a Republican, as governor. Pataki defeated former Governor Mario Cuomo with proposals for streamlining government; constraining government spending, including reductions in welfare and health care; and enacting a three-year, phased-in tax cut (although not as large as that enacted in New Jersey). In office, Governor Pataki signed the three-year tax cut into law, and slowed year-to-year budget growth. Some of his proposals to reduce health spending have not been adopted, in part because of the power and composition of the New York State Legislature.

The Senate tends to represent upstate rural and suburban New Yorkers and is heavily Republican (35 Republicans to 26 Democrats). The Assembly is more representative of low-income populations and of urban areas, particularly New York City, and is heavily Democratic (96 Democrats to 54 Republicans). The governor, Senate, and Assembly must all agree in order to enact each year's budget. The parties come to agreement over the state budget after protracted negotiations that often go three months beyond the beginning of the budget year.

The distribution of political power in New York affects the nature of state budget agreements. It is unlikely that any major expansion of social legislation could take place. Similarly, it is unlikely that any major contractions could occur. As described below, the legislature sharply reduced the health care cuts proposed by Governor Pataki in the past two years. Similarly, most of the governor's proposals for welfare reform that would dramatically affect the population receiving Aid to Families with Dependent Children (AFDC) beyond federal requirements were not enacted. However, the legislature did agree to significant changes in the Home Relief program.

County governments have a strong role in the administration of New York's health and welfare programs. Counties pay 25 percent of the cost of the AFDC program and Medicaid acute care services and 10 percent of the cost of Medicaid long-term care services. The counties pay a much larger share of these programs than do counties in any other state and are given substantial administrative flexibility in running them. Counties make many important decisions in implementing these programs, for example, enforcing participation in workfare programs. Counties also have an important voice in state legislation. For



example, a 1996 proposal to convert Home Relief payments to a block grant to counties was defeated because of county opposition.

There are long-standing, major tensions between New York City and the rest of the state. These existed when the governor and mayor of New York City were both Democrats, and they persist today when the governor and mayor are both Republicans. The city generally feels that the state treats it poorly in most resource allocation decisions and that it contributes much more to the state treasury than it receives from the state. This perception applies to the distribution of aid to schools, Home Relief, public health, and other areas. The view from upstate New York is that the city is a major beneficiary of the distribution of state resources because of its large number of low-income people.

Roadmap to the Rest of the Report

In the remainder of this report we describe the major objectives of health policy in New York. We present some basic data on health insurance, health care indicators, and health care expenditures and then describe the major programs that the state finances and operates. We then examine how the state has developed its Medicaid program and its likely responses to budget crises and possible reductions in federal funding. We describe the array of policies that the state has developed to provide coverage to its low-income population, as well as the deregulation of the hospital system, the growth of managed care, and the increase in hospital mergers and consolidations. We describe Medicaid provider payment and disproportionate share hospital policies and the issues that the state faces in initiating managed care on a broad scale. We summarize the results of our New York City site visits that focused on the impact of government policies and market changes on the safety net institutions in the city. We conclude with a discussion of issues that the state faces in providing long-term care for the elderly and persons with disabilities.

Setting the Policy Context

Overview of the State's Health Agenda

New York spends significantly more on Medicaid than any other state. The prominent role of Medicaid in the state budget ensures that health care will be high on the agenda of the governor and the state legislature. In January 1997, the state deregulated its hospital system with the intent of increasing competition while at the same time retaining cross-subsidies to support safety net hospitals and teaching hospitals. The state hopes to expand Medicaid managed care and in the process expand access and rein in the growth in health care costs. The Senate has rejected legislative efforts in the last decade to enact proposals that would provide universal health insurance coverage; however, these proposals were passed by the Assembly. The state has expanded coverage for children and continues to support one of the more generous state-funded programs in the nation for covering the Home Relief, or general assistance, population. In 1993, the state enacted substantial reforms of the individual and small-group insurance markets. As discussed below, these reforms have not been wholly successful. Finally, the state has hotly debated its commitment to support graduate medical education (GME), with many observers believing that the state is financing the education of far more than its share of the nation's physicians.

Health Care Indicators

New York has a relatively high number of uninsured residents by national standards and also has a broad array of health problems. The state has a higher nonelderly uninsured rate (16.8 percent) than the average state and a higher

percentage of uninsured than any state in the New England or mid-Atlantic regions.¹ New York has a relatively high level of Medicaid coverage, provides Medicaid benefits to its Home Relief population, and has an insurance program for children in low-income households. At the same time, however, New York faces a number of health care problems. Its infant mortality rate is about equal to the national average, but its premature death rate is well above the national average. Among the states, it has one of the highest rates of violent crimes per 100,000 people, although these rates appear to have declined dramatically in recent years. Finally, New York has a much higher than average number of AIDS cases per capita (table 1).

Health Care Spending and Coverage

New York has by far the largest Medicaid program in the country. Medicaid spending in New York was \$24 billion in 1995. Half of this cost is borne by the federal government and the remainder by the state and by local governments. The second-largest Medicaid program in the United States is in California, which spent \$17 billion in 1995, about 30 percent less than New York in 1995. New York spends more than twice the national average on both a per capita and per low-income person basis. Its coverage of its low-income populations (defined as those below 150 percent of the federal poverty level) is among the most extensive in the country. Only four states cover a higher percentage of people with incomes below 150 percent of poverty. New York is second in terms of spending per beneficiary only to New Hampshire, which has very large disproportionate share hospital (DSH) payments. Excluding DSH payments, New York spends more per beneficiary than any other state, reflecting a broad benefit package, full-cost reimbursement of hospitals, high nursing home payment rates, and a high AIDS caseload. Finally, New York has the highest aggregate amount of DSH payments in the nation.

State Health Programs

In New York, the Department of Health oversees Medicaid acute and long-term care, operates public health programs, regulates health care quality, and finances “public goods” (graduate medical education, indigent care). Its broader Medicaid responsibilities are the result of a reorganization in 1996 that restructured the Department of Social Services, which previously had overseen Medicaid eligibility and long-term care policy. The Department of Mental Hygiene, which includes the Office of Mental Health, the Office of Mental Retardation and Developmental Disabilities, and the Office of Substance Abuse, is administratively separate from the Department of Health, although it oversees considerable amounts of Medicaid-related spending.

New York devolves considerable financial and administrative responsibilities to the counties and the City of New York. As noted above, counties contribute a significant portion of Medicaid funding, with the county contribution depending on the type of service. Counties also have a major administrative role in eligibility determination, managed care, mental health, and home care. In public health, counties receive a base grant; beyond the base grant, the state and counties share the cost of expenditures. Although the share depends on the type of services, the state typically pays one-third and the counties, two-thirds. The funding formula for public health was changed in 1995 to favor rural areas over large cities.

Medicaid

Medicaid is by far the largest program in the Department of Health as well as the largest single component of the state budget. This reflects both the scope

Table 2 *New York Spending by Category, 1990 and 1995 (\$ in Millions)*

Program	State General-Fund Expenditures ^a			Expenditures ^b		
	1990	1995	Annual Growth	1990	1995	Annual Growth
Total	\$29,628	\$32,075	1.6%	\$45,293	\$64,855	7.4%
Medicaid ^{c, d}	3,517	5,969	11.2	8,362	22,101	21.5
% of Total	(11.9)	(18.6)	—	(18.5)	(34.1)	—
Corrections	1,926	2,411	4.6	2,112	2,549	3.8
% of Total	(6.5)	(7.5)	—	(4.7)	(3.9)	—
K-12 Education ^e	9,734	10,423	1.4	10,791	12,059	2.2
% of Total	(32.9)	(32.5)	—	(23.8)	(18.6)	—
AFDC	511	720	7.1	1,838	2,160	3.3
% of Total	(1.7)	(2.2)	—	(4.1)	(3.3)	—
Higher Education	2,917	2,898	(0.1)	4,242	4,870	2.8
% of Total	(9.8)	(9.0)	—	(9.4)	(7.5)	—
Miscellaneous ^f	11,023	9,654	(2.6)	17,948	21,116	3.3
% of Total	(37.2)	(30.1)	—	(39.6)	(32.6)	—

Source: National Association of State Budget Officers, 1992 State Expenditure Report (April 1993) and 1996 State Expenditure Report (April 1997).

a. State spending refers to general-fund expenditures plus other state fund spending for K–12 education.

b. Total spending for each category includes the general fund, other state funds, and federal aid.

c. States are requested by the National Association of State Budget Officers (NASBO) to exclude provider taxes, donations, fees, and assessments from state spending. NASBO asks states to report these separately as “other state funds.” In some cases, however, a portion of these taxes, fees, etc., is included in state spending because states cannot separate them. New York reported other state funds of \$0 in 1990 and \$4.282 billion in 1995.

d. Total Medicaid spending will differ from data reported on the HCFA 64 for three reasons: first, NASBO reports on the state fiscal year and the HCFA 64 on the federal fiscal year; second, states often report some expenditures (e.g., mental health or mental retardation) as other health rather than Medicaid; third, local contributions to Medicaid are not included but would be part of Medicaid spending on the HCFA 64.

e. Since approximately 1990, the state has refinanced education, shifting more of the costs to localities.

f. This category includes all remaining state expenditures (e.g., environmental projects, transportation, housing, and other cash assistance programs) not captured in the five listed categories.

of the program and the fact that the state has successfully obtained Medicaid funds for a wide range of health and social services. Medicaid has arguably squeezed out expenditures in other areas, although it is hard to determine how much because Medicaid now pays for many services that used to appear elsewhere in the budget. Table 2 presents spending on Medicaid and other state services from the state’s general-fund, and total state spending, which includes general funds, federal funds, and other state funds. The table shows that Medicaid spending from state general-fund revenues increased by 11.2 percent per year between 1990 and 1995, increasing from 11.9 percent of state general-fund expenditures in 1990 to 18.6 percent in 1995. Total Medicaid spending (federal and state) grew faster than any other expenditure category—by 21.5 percent annually during this period. It increased from 18.5 percent of

total expenditures in 1990 to 34.1 percent in 1995. All other categories declined as a share of total state expenditures.

Table 3 shows that although New York expenditures are high, spending has been growing somewhat more slowly than in the rest of the nation. Between 1990 and 1992, Medicaid spending in New York increased annually by 21 percent, versus 27 percent for the nation as a whole. Between 1992 and 1995, spending grew by 9 percent per year, versus 10 percent for the nation. Table 3 shows that New York's slower spending growth is largely attributable to slower growth for long-term care services. Long-term care spending in New York increased by 7 percent annually between 1992 and 1995, versus 8 percent in the nation over the same period. Acute care expenditures have actually grown somewhat faster in New York than in the rest of the nation, increasing each year between 1992 and 1995 by 17 percent, versus 13 percent nationally. Consistent with the slower growth of long-term care, expenditures for the elderly grew more slowly in New York than in the nation. Spending on the disabled and adults and children grew faster in New York than in the rest of the country because of the significance of acute care spending to these populations.

Table 3 also indirectly shows that the composition of spending in New York is different from the nation's as a whole. Long-term care accounts for 49 percent of New York's expenditures on services, versus 40 percent for the nation. In contrast, acute care accounts for 51 percent of expenditures on services in New York, versus 60 percent in the rest of the country. Similarly, the composition of spending across eligibility groups is different from that of the rest of the country. New York spends 34 percent of Medicaid expenditures for services on the elderly, versus 30 percent nationally, and 41 percent for the disabled, versus 39 percent nationally. As a result, only 25 percent of New York's expenditures for services is for adults and children, compared with 31 percent for the rest of the country.

Table 4 illustrates the high level of spending in New York's Medicaid program. Expenditures per enrollee for the elderly and disabled are approximately twice the levels seen in the rest of the nation. In 1995, New York spent \$18,252 per elderly enrollee, versus \$9,738 in the country overall, and \$15,062 per blind or disabled enrollee, versus \$8,022 in the country overall. Expenditures on adults and children are also substantially higher than in the rest of the nation. These expenditure differences reflect New York's higher health care costs, more generous reimbursement rates for both hospitals and nursing homes, broader benefit package, and greater reliance on institutional services than elsewhere.

Medicaid benefits are also provided to recipients of the state's general assistance program, the Home Relief program. Total spending on medical services for the Home Relief population was \$1.6 billion in 1995, covering approximately 338,000 persons.² There also are insurance subsidy programs—for example, Child Health Plus, which provides subsidized health insurance coverage for children from low-income working families who are not eligible for



Table 3 *Medicaid Expenditures by Eligibility Group and Type of Service, New York and United States (\$ in Millions)*

	New York					United States				
	Expenditures			Average Annual Growth		Expenditures			Average Annual Growth	
	1990	1992	1995	1990-92	1992-95	1990	1992	1995	1990-92	1992-95
Total	\$12,611.1	\$18,486.3	\$24,027.4	21.1%	9.1%	\$73,662.2	\$118,926.0	\$157,872.5	27.1%	9.9%
Benefits										
Benefits by Service	\$11,770.7	\$14,935.6	\$20,608.3	12.6%	11.3%	\$69,168.7	\$97,602.4	\$133,434.6	18.8%	11.0%
Acute Care	4,895.6	6,619.0	10,467.4	16.3%	16.5%	36,904.5	55,059.9	79,438.5	22.1%	13.0%
Long-Term Care	6,875.1	8,316.6	10,140.9	10.0%	6.8%	32,264.2	42,542.5	53,996.1	14.8%	8.3%
Benefits by Group	\$11,770.7	\$14,935.6	\$20,608.3	12.6%	11.3%	\$69,168.7	\$97,602.4	\$133,434.6	18.8%	11.0%
Elderly	\$4,988.8	\$6,116.7	\$6,962.0	10.7%	4.4%	\$23,334.3	\$31,757.9	\$40,087.4	16.7%	8.1%
Acute Care	618.9	837.4	1,259.6	16.3%	14.6%	4,925.4	6,911.5	9,673.7	18.5%	11.9%
Long-Term Care	4,369.9	5,279.2	5,702.4	9.9%	2.6%	18,408.9	24,846.4	30,413.7	16.2%	7.0%
Blind and Disabled	\$4,389.1	\$5,638.3	\$8,478.2	13.3%	14.6%	\$25,771.6	\$35,684.6	\$51,379.4	17.7%	12.9%
Acute Care	1,993.5	2,740.4	4,366.3	17.2%	16.8%	12,929.2	19,483.6	29,760.7	22.8%	15.2%
Long-Term Care	2,395.6	2,897.9	4,112.0	10.0%	12.4%	12,842.4	16,201.0	21,618.7	12.3%	10.1%
Adults	\$934.3	\$1,173.1	\$1,760.8	12.1%	14.5%	\$8,765.0	\$12,710.1	\$16,556.9	20.4%	9.2%
Children	\$1,458.5	\$2,007.5	\$3,407.2	17.3%	19.3%	\$11,297.8	\$17,449.8	\$25,410.9	24.3%	13.3%
DSH	\$416.3	\$3,119.4	\$2,916.6	173.7%	-2.2%	\$1,340.9	\$17,525.6	\$18,988.4	261.5%	2.7%
Administration	\$424.1	\$431.4	\$502.5	0.9%	5.2%	\$3,152.6	\$3,797.9	\$5,449.4	9.8%	12.8%

Source: The Urban Institute, 1997. Based on HCFA 2082 and HCFA 64 data.

**Table 4** *Medicaid Expenditures per Enrollee by Eligibility Group, New York and United States*

	New York					United States				
	Spending per Enrollee			Average Annual Growth		Spending per Enrollee			Average Annual Growth	
	1990	1992	1995	1990-92	1992-95	1990	1992	1995	1990-92	1992-95
Total	\$4,502	\$5,102	\$6,194	6.4%	6.7%	\$2,397	\$2,729	\$3,202	6.7%	5.5%
By Group										
Elderly	\$14,122	\$16,865	\$18,252	9.3%	2.7%	\$6,839	\$8,422	\$9,738	11.0%	5.0%
Cash	8,686	10,032	10,712	7.5%	2.2%	3,329	4,017	4,818	9.8%	6.2%
Noncash	19,084	23,273	25,444	10.4%	3.0%	10,377	12,192	13,521	8.4%	3.5%
Blind and Disabled	\$11,774	\$13,003	\$15,062	5.1%	5.0%	\$6,378	\$7,320	\$8,022	7.1%	3.1%
Cash	8,542	9,604	11,657	6.0%	6.7%	4,969	5,927	6,686	9.2%	4.1%
Noncash	22,088	24,792	28,722	5.9%	5.0%	12,047	12,574	12,660	2.2%	0.2%
Adults	\$1,902	\$2,089	\$2,705	4.8%	9.0%	\$1,301	\$1,518	\$1,728	8.0%	4.4%
Children	\$1,044	\$1,279	\$1,967	10.7%	15.4%	\$770	\$931	\$1,178	9.9%	8.2%

Source: The Urban Institute, 1997. Based on HCFA 2082 and HCFA 64 data.

Medicaid—and several other smaller insurance subsidy programs. Spending for subsidized insurance programs was significantly expanded to \$130 million when the state reconfigured its hospital payment and charity care subsidy system in January 1997. In addition, hospitals and clinics continue to receive funds to help cover the cost of caring for the uninsured. In total, the state distributes \$1.2 billion to health insurance subsidy initiatives and to providers for uncompensated care.

Public Health

In New York, the Office of Public Health has four major activities or divisions: environmental health; AIDS prevention and education; disease monitoring, laboratory oversight, and research; and community health. The state provides few services directly, leaving this to the counties. In counties where the local health department is not full-service, the state will provide environmental services. The state funds, but does not provide, personal health services (e.g., immunizations and health screens); these services are solely the function of local health departments and other local providers. Instead, the state plays a central coordinating role. As a condition of receiving state funds, counties must submit municipal public health service plans in which they articulate their needs and how they will be met. Municipalities are required to provide certain services or arrange for them to be provided. These include, for example, environmental health, family health, and disease control. Other services are optional, for example, dental services and inspection of radiation-producing equipment.

Mental Health and Mental Retardation

New York has separate offices of mental health and mental retardation/developmental disabilities (MR/DD) housed in the Department of Mental Hygiene. Administratively, many activities are coordinated with the Department of Health, particularly since the mental health and mental retardation offices rely to a considerable extent on Medicaid funding.

In contrast to public health, the state takes a more active role in delivering MR/DD services, not just financing. Its delivery role is mostly limited to running large institutions for persons with mental retardation. Because the state has made significant efforts to downsize or close these institutions in favor of community-based care and smaller, more residential-like facilities, more control has shifted to the community. Depending on the type of service, counties pay from 10 percent to 25 percent of expenditures for the MR/DD population. Many services are eligible for federal contributions through the Medicaid program. For example, most of the state's \$1 billion spent on MR/DD services is funded through Medicaid. Of the additional \$800 million that the state for-

wards to local areas and community providers, approximately 70 percent is funded through Medicaid and consequently includes federal support as well.

The state also is an active provider of mental health services. The state operates several adult and child psychiatric hospitals, and provides community-based services such as residential facilities and supportive employment programs. In addition, the state plays an oversight role by licensing and regulating mental health programs operated by local governments and private agencies. In 1996, Governor Pataki proposed removing the state from program operation, instead forwarding funds directly to counties as more flexible block grants. This proposal was not implemented because of resistance from counties that feared greater flexibility would also bring smaller budgets. Mental health funding is somewhat less dependent than MR/DD on Medicaid. Approximately 60 percent of the \$4 billion spent on mental health services is supported by Medicaid.



Assessing the New Federalism: Potential State Responses to Additional Flexibility and Reduced Funding

New York has made a huge commitment to building a social welfare system over the last 30 years, if not throughout this century. The state has generally been supportive of both cash welfare and health care programs. The state has generous AFDC and Home Relief benefits by national standards. The monthly benefit of \$577 for a family of three in New York City in July 1995 was the sixth-highest benefit payment for a family of this size in the nation. The state's Home Relief program is also one of the more generous in the country, with benefit levels virtually identical to AFDC benefits. The state has also made a consistent effort to expand Medicaid coverage and improve access to health care services. The commitment encompasses both acute care for low-income people and a wide range of long-term care services.

As described earlier, Medicaid spending in New York is extremely high by comparison with other states. New York spending is among the highest for each eligibility group and is also near the top for all service categories. The high level of spending is the result of its broad coverage and the high level of provider payments, particularly to hospitals and nursing homes. Another major reason that Medicaid spending growth in New York is higher than elsewhere is "Medicaid maximization," that is, bringing spending on state health and social service programs into Medicaid in order to obtain federal matching funds. The state has systemically brought both institutional and noninstitutional services for the developmentally disabled and the mentally ill populations into the

Medicaid program. This has usually involved upgrading these programs to meet Medicaid standards and then obtaining federal matching funds. The expenditures on these services increase but the state's share of the expenditures declines, at least initially. New York has also made a huge commitment to providing personal care services for the disabled and elderly, spending far more than any other state on this optional Medicaid benefit.

One of the main reasons often given for the development of such a large Medicaid program in New York is that the state share of expenditures is low—25 percent for acute care and 40 percent for long-term care. When Medicaid began in New York, the state required local governments to pay a 25 percent share. The original reasoning was that New York City had a very large social welfare system, dating back to the 1920s and 1930s. Because so many of these services would be brought into the Medicaid program, the state wanted to be sure that New York City paid its “fair” share. The result was that the state paid 25 percent of the costs of all Medicaid services, essentially giving it the same financial incentives of a poor Southern state. In other words, the 25 percent state share gave the state a strong incentive to expand because each dollar of state funds yielded a four-dollar impact once federal and county funds were matched. The result was a large and expensive program.

One consequence of high expenditures is that future spending growth is hard to restrain. Because of its scope, the Medicaid program has spawned many powerful interest groups. In most states the interest groups involved with Medicaid include advocates for the poor and the disabled, public hospitals, and nursing homes. In New York the interest groups also include the nonprofit hospitals and providers of services to persons with mental illness and developmental disabilities. State agencies, particularly the Department of Mental Hygiene, have found that the Medicaid program allows them to serve their clients while the state pays only 25 percent of the costs. Labor unions are also strong advocates for Medicaid because they represent hospital workers and those who provide personal care services.

In the political arena, although affiliations can vary with the issue, the Republican Senate has tended to support the interest of providers, particularly upstate nursing homes, psychiatric centers, and facilities for persons with developmental disabilities. The Democratic Assembly has been strongly supportive of beneficiaries and public hospitals. Both houses have been supportive of voluntary (nonprofit) hospitals. Any budget bill requires a compromise between the Senate and the Assembly; this has made it very hard to cut the program in a budget crisis and would make it very difficult if federal funds were ever cut back.

The 1996–97 budget debate illustrates the complexity of Medicaid politics in New York. The Pataki administration's original 1996–97 budget envisioned cuts of \$1 billion in state spending, which translates into almost \$3 billion in total cuts when the federal and county shares are included. The major ways by which the Pataki administration proposed to save money were rate reductions for hospital and nursing home care, and block grants to counties for noninsti-

tutional long-term care services (for example, personal care and home health care), Home Relief, and mental health care.

The Medicaid block grant—Medigrant—enacted by Congress but vetoed by President Clinton would have reduced the state matching requirement and given the states more flexibility in the ways they could cut spending. When the block grant policy did not materialize, New York had to scale back its proposals; the Pataki administration submitted a contingency budget in March 1996 that called for \$842 million in cuts (state share). Without the added flexibility the block grant would have provided, and given the opposition to the state block grants to counties, the contingency budget focused more intensively on rate reductions and lower inflation adjustments.

The final bill passed by the legislature resulted in cuts of \$623 million in the state share, almost all from hospital and nursing home rate reductions or increases in assessments on nursing homes and hospitals. The block grants to counties for long-term care services, Home Relief, and mental health were dropped. The counties opposed the block grants not only because of the loss of state money but also because of fear of intercounty migration if they continued to provide the same level of services while neighboring counties did not. The state enacted legislation accelerating the implementation of Medicaid managed care, a policy decision that had been debated for several years. It was viewed as the least onerous way of controlling the cost of acute care in Medicaid. Reductions in coverage of the traditional Medicaid populations were never proposed, and it is unlikely they would have been seriously considered. (The 1997–98 budget also proposed large cuts in hospital and nursing home rates, and again these were vigorously opposed by provider organizations and were not enacted.)

After speaking with a wide range of respondents, we concluded that few had any idea how the state would respond to a federal block grant that contained cuts in federal payments, either immediately or over time. It was clear from the interviews that block grants to counties were not a popular idea, nor an idea likely to be introduced again. The state was not likely to cut enrollment, because this would be strongly opposed by Democrats in the Assembly. Deep provider cuts were also unlikely, because of both Republican and Democratic opposition in the Senate.

Some observers thought that long-term care would be protected more than acute care, that the elderly and the disabled would be protected more than families and children, and that upstate interests would fare better than downstate interests. Others simply said that because acute care had been “solved” through the implementation of Medicaid managed care, long-term care was the only area remaining for saving substantial amounts of money, although the powerful lobbies for nursing homes and personal care providers would probably resist such program cuts.



Providing Third-Party Health Coverage for the Low-Income Population

Compared with most other states, New York provides generous health care coverage for its low-income population. The state has high levels of coverage of its AFDC and Supplemental Security Income (SSI) populations and extends coverage to its Home Relief, or general assistance, population. It has also initiated Child Health Plus, an insurance program for children in low-income families that extends coverage up to 222 percent of the federal poverty level. Despite these efforts, 3.1 million New Yorkers, or 16.8 percent of the nonelderly population, were uninsured in 1994–95.³ This reflects an increase from 2.3 million, or 14.6 percent, estimated for the 1990–92 period.^{4,5}

Medicaid

Income eligibility standards for AFDC (and therefore Medicaid) are higher than the national average. The maximum annual income for an AFDC family of three was \$6,924 in 1994, versus \$5,231 for the nation. The maximum income as a percent of poverty was 56.2 percent, versus 41.9 percent for the nation. Coverage of pregnant women and infants extends above the federally mandated 133 percent of poverty to 185 percent of poverty. The medically needy income limit per three-person family was \$767 per month, versus \$534 per month for the nation. The result is that 20.9 percent of the state's population is eligible for Medicaid (versus 17.7 percent nationwide), and 15.6 percent of the population is actually enrolled (versus 13.0 percent nationwide).

Although New York covers a higher percentage of its population than does the nation on average, the growth of enrollment has been slower in recent years: 5.8 percent between 1990 and 1992 in New York versus 11.3 percent for the United States (table 5). Enrollment grew by 4.4 percent between 1992 and 1995, versus 5.2 percent for the nation. New York has had somewhat faster growth for the AFDC population than did the nation as a whole, but slower growth for the noncash groups, for example, pregnant women, children, and the medically needy. The growth among the elderly and the blind and disabled was slightly slower than for the nation as a whole.

The growth in the number of Medicaid enrollees in New York slowed significantly in 1995. As has occurred nationally, the rate of growth in enrollment fell in 1995, increasing by only 1.0 percent from 1994 in all ages and all aid categories (including Home Relief) combined (table 6). In 1995, there were actually declines in the AFDC population. According to eligibility officials, this decline in AFDC caseloads has primarily been the result of increased efforts since 1992 by social service districts to detect fraudulent welfare applications. The improvement in the state's economy is another obvious contributor.

Growth in the state's SSI population continued but at declining rates. This is in line with patterns seen throughout the country. Enrollment growth for all SSI recipients increased by 6.5 percent between 1993 and 1994, and by 5.1 percent between 1994 and 1995. The fastest growth in the SSI population in both New York and the nation has been among children. Enrollment in this group grew by 20.0 percent between 1993 and 1994, but by only 10.8 percent between 1994 and 1995. Enrollment growth among SSI adults is relatively stable, increasing by 5.6 percent and 5.4 percent in 1994 and 1995, respectively. The growth rate of the SSI aged population declined slightly; but growth, unlike the national trend, remained positive, at 2.6 percent in 1995.

The medical-assistance-only program, covering all Medicaid recipients in New York not receiving cash payments, continued to grow, increasing by 5.7 percent in 1994 and 7.0 percent in 1995; this group includes the medically needy as well as pregnant women and children. The high growth rate in 1995 may reflect the fact that those losing cash benefits continue to receive Medicaid, but as Medicaid-only recipients. The absolute number receiving Medicaid as medical assistance only is greater than the decline of AFDC recipients. This is true for children and adults. The number of children receiving benefits as medical assistance only grew by 10.2 percent in 1995; the number of adults ages 21–64, by 6.1 percent. Some of the growth in medical assistance coverage reflects the added coverage of children from the poverty-related expansions in Medicaid eligibility.

Home Relief

New York's Home Relief program provides cash assistance and medical care to poor people who do not qualify for Medicaid (primarily because they have no

**Table 5** Medicaid Enrollment by Eligibility Group, New York and United States (Enrollment in Thousands)

	New York					United States				
	Enrollment			Average Annual Growth		Enrollment			Average Annual Growth	
	1990	1992	1995	1990-92	1992-95	1990	1992	1995	1990-92	1992-95
Total	2,614.3	2,927.6	3,327.4	5.8%	4.4%	28,856.7	35,765.1	41,672.0	11.3%	5.2%
By Group										
Elderly	353.3	362.7	381.4	1.3%	1.7%	3,412.2	3,771.0	4,116.6	5.1%	3.0%
Cash	168.6	175.5	186.2	2.0%	2.0%	1,713.1	1,739.2	1,789.2	0.8%	1.0%
Noncash	184.7	187.2	195.2	0.7%	1.4%	1,699.1	2,031.8	2,327.3	9.4%	4.6%
Blind and Disabled	372.8	433.6	562.9	7.8%	9.1%	4,040.9	4,875.1	6,405.2	9.8%	9.5%
Cash	283.9	336.6	450.6	8.9%	10.2%	3,236.8	3,853.4	4,973.5	9.1%	8.9%
Noncash	88.9	97.1	112.3	4.5%	5.0%	804.1	1,021.7	1,431.7	12.7%	11.9%
Adults	491.2	561.6	651.0	6.9%	5.1%	6,738.7	8,373.3	9,584.2	11.5%	4.6%
Cash	365.6	404.2	464.1	5.2%	4.7%	4,651.6	5,342.5	5,441.4	7.2%	0.6%
Noncash	125.6	157.3	187.0	11.9%	5.9%	2,087.2	3,030.9	4,142.8	20.5%	11.0%
Children	1,397.1	1,569.7	1,732.0	6.0%	3.3%	14,664.9	18,745.7	21,566.0	13.1%	4.8%
Cash	921.2	1,000.4	1,087.5	4.2%	2.8%	9,946.2	11,281.8	11,314.6	6.5%	0.1%
Noncash	475.9	569.4	644.5	9.4%	4.2%	4,718.7	7,463.9	10,251.4	25.8%	11.2%

Source: The Urban Institute, 1997. Based on HCFA 2082 data.

Table 6 *New York State Medicaid Enrollees by Eligibility Group and Age, FFY 1993–95 (Eligibles in thousands)*

	1993	1994	% Change 1993–94	1995	% Change 1994–95
All Eligibles	3,657.4	3,820.1	4.4	3,858.6	1.0
AFDC-All	1,499.3	1,559.1	4.0	1,533.1	(1.7)
0–20	1,056.0	1,083.8	2.6	1,066.5	(1.6)
21–64	443.1	469.0	5.8	461.4	(1.6)
65+	0.2	6.3	2,609.5	5.3	(15.9)
SSI-All	580.0	617.7	6.5	649.1	5.1
0–20	70.6	84.8	20.0	93.9	10.8
21–64	286.7	302.9	5.6	319.1	5.4
65+	222.6	230.1	3.3	236.0	2.6
Medical Assistance-All	1,084.9	1,147.2	5.7	1,228.1	7.0
0–20	499.3	524.0	4.9	577.5	10.2
21–64	381.0	404.1	6.1	428.9	6.1
65+	204.5	219.1	7.1	221.6	1.1
Home Relief-All	492.0	494.7	0.5	447.0	(9.6)
0–20	91.0	82.7	(9.1)	68.8	(16.8)
21–64	399.1	408.7	2.4	374.8	(8.3)
65+	1.9	3.3	73.2	3.5	5.7

Source: New York State Department of Social Services, Division of Health and Long Term Care: Medicaid Reference Statistics, Federal Fiscal Years 1993–1995, July 1996.

Note: Columns may not add due to rounding.

children). In 1995, the program spent \$1 billion for cash benefits for 338,000 recipients. Medical expenditures in 1995 were approximately an additional \$1.6 billion, with most (\$1.4 billion) funded through DSH.⁶ Home Relief recipients receive the full Medicaid benefit package; the state receives federal matching contributions only through DSH payments for inpatient hospital care. Under the Section 1115 waiver, federal Medicaid financial participation will be extended to all services used by Home Relief recipients.⁷

In 1995, the number of Home Relief enrollees receiving Medicaid benefits declined sharply. As shown in table 6, the state covered 494,700 individuals on Home Relief in 1994; this figure dropped to 447,000 in 1995, a 9.6 percent drop. The coverage decline was particularly sharp among children (16.8 percent). Coverage also fell for adults (8.3 percent). The decline is generally attributed to increased fraud detection efforts and the toughening of work requirements for the Home Relief population.

Children's Health Insurance

The state has a major insurance subsidy program for children—Child Health Plus—financed entirely with state funds. Begun in 1991, the program

originally provided \$20 million annually in subsidies, for outpatient coverage only, to low-income children up to age 13 (later expanded to include children ages 13 through 15) and in Medicaid-ineligible families with incomes up to 222 percent of the federal poverty level. Under the original program, children in families with incomes under 160 percent of poverty were fully subsidized. Children in families with incomes between 160 and 222 percent of poverty were required to pay a premium share of \$25 annually per child, up to \$100 per family. Children in higher-income families were permitted to participate but did not receive any subsidy. Services available included outpatient preventive care, well-child exams, immunizations, diagnosis of illness or injury, X-rays, lab testing, treatment for alcohol and substance abuse, outpatient/ambulatory surgery, emergency care (a \$35 fee was charged for inappropriate use), prescription drugs (including a \$3 co-payment), and therapy services, including physical and occupational therapy, chemotherapy, and dialysis. Fifteen insurers provided statewide coverage.

Funding for Child Health Plus was expanded significantly under the New York Health Care Reform Act (NYHCRA) in 1996, from \$106 million in 1997 to \$207 million in 1999, with funding to include children aged 15 to 18 and inpatient services. Under the new program, families at 120 percent or less of poverty pay no premium. Families with incomes between 120 and 159 percent of poverty pay \$9 per covered child per month, up to \$36 per month per family maximum. Families with gross incomes between 160 and 222 percent of poverty pay \$13 per child and a \$52 monthly maximum; as with the old program, people with higher incomes may participate, but they must pay the full premium. In addition, the co-payments of up to \$3 for prescription drugs were retained, and a \$2 co-payment for physician visits was added. Currently, about 124,000 children are enrolled in Child Health Plus. In the next few years, it is expected that an additional 126,000 will be enrolled, for a total of 251,000 children. Some observers question whether the state will achieve these enrollment levels. It is feared that the premium increases resulting from the added coverage of inpatient services will discourage enrollment.

In addition to the expansion of Child Health Plus, NYHCRA included additional funding of \$6 million for the state's small business health insurance partnership program and established \$5 million for an insurance voucher program for the uninsured. The act also provided \$7 million in continued funding for the Catastrophic Health Care Expense Program, \$3 million in grants to support ambulatory surgical services and lab services to the medically indigent, and a continuation of the Secured Hospital Loan Program.⁸

Welfare Reform Legislation

In November 1996, Governor Pataki released his plan for reforming the state's welfare system. Under the bill, benefits to families would be cut by 10 percent after 18 months and 45 percent after four years, and would be completely ended after five years. His plan would allow parents to keep their wel-



fare benefits even if they earn as much as \$1,080 per month (a substantial increase over the current amount of \$667). The bill would abolish the Home Relief program and replace it with a voucher program for food, shelter, and clothing. This program would have been administered as block grants to the counties. People on Home Relief who are unable to work because they are disabled or elderly would continue receiving cash.⁹ (Earlier in 1996, the governor's plans to limit Home Relief to 60 days and to reduce welfare benefits were defeated.) The governor's proposal, to no surprise, met with immediate objections from Assembly Democrats (who hold a comfortable margin and veto power over the governor's plans), as well as skepticism from many Senate Republicans. In response to the plan to transfer authority for the Home Relief program to local governments, the New York City Council said the plan would cause a "race to the bottom" as counties tried to outdo each other in slashing benefits. In the end, the governor and legislature agreed to limit Home Relief cash benefits to two years; after that, recipients would have access only to vouchers for basic needs.

As in other states, New York is required to retain July 1996 AFDC rules for Medicaid eligibility. The state has not yet determined whether it will have a different enrollment process for Medicaid and Temporary Assistance to Needy Families (TANF).

Federal welfare reform legislation (the Personal Responsibility and Work Opportunity Reconciliation Act of 1996—PRWORA) restricted immigrants' eligibility for a wide range of benefits, including Medicaid. Prior to welfare reform, legal noncitizens were eligible for Medicaid on the same basis as citizens. The new law bars immigrants arriving after passage of the law (August 22, 1996) from receiving Medicaid for their first five years in the country. It also gives states the option of providing Medicaid to immigrants already in the United States and to new immigrants following the federal five-year bar.

New York has chosen to continue providing Medicaid benefits to legal immigrants in the United States as of the passage of PRWORA. The state will also extend Medicaid benefits to new immigrants after the federal five-year bar, but the state will not use its own funds to provide Medicaid for legal immigrants during the bar, as some other states have done. New York is also providing prenatal care to undocumented immigrants, who under federal law are only eligible for emergency services under Medicaid, including labor and delivery.

Insurance Reforms

The state enacted substantial reforms of the small-group and individual insurance markets in 1993. These reforms reflected an effort by the state to respond to the common concerns about the commercial insurance industry, namely, that insurance plans seek healthy patients and avoid the sick. The result of this behavior in New York was rapidly increasing Empire Blue Cross premiums because it had become the insurer for high-risk individuals. In April

Table 7 Individual Small-Group Subscribers for New York Licensed Insurers, New York State^a (Units in Thousands)

	Insured Units ^b as of			
	9/30/92	4/1/93	4/1/94	4/1/95
Small Group ^c				
Commercials	325.2	277.9	283.4	192.7
HMOs	163.7	179.1	242.9	406.5
Nonprofits	502.8	480.9	410.8	351.6
Total	991.7	937.9	937.1	950.8
Individual ^c				
Commercials	178.4	150.9	124.5	100.8
HMOs	29.1	32.2	47.3	74.9
Nonprofits	200.5	189.7	153.3	122.4
Total	408.0	372.9	325.1	298.1

Source: Data provided by New York State Department of Insurance as of 9/29/95.

a. Nonprofits are largely Blue Cross/Blue Shield organizations but also include Group Health Incorporated.

b. An insured unit can represent one person or family.

c. Medicare supplemental policies are excluded.

1993, the state implemented legislation requiring open enrollment, guaranteed portability, and community rating. Community rating was basically “pure”: All enrollees would be charged the same price regardless of age or sex, with variations only among geographic areas. The major concern about insurance reform was that it would increase premiums, causing the healthy to leave the market, which would reduce the number with health insurance.

The principal impact of open enrollment and community rating was on the private commercial insurance plans because HMOs and Empire Blue Cross already had open enrollment and community rating by law. The result was that premiums of commercial plans increased sharply at first and have continued to increase at double-digit rates. As shown in table 7, enrollment in commercial plans declined throughout this period. HMOs reduced the scope of their benefit packages in an effort to avoid high-risk enrollees. The HMOs were successful in that their premiums are low and their enrollment expanded; HMO enrollment has expanded throughout the nation, but it seems to have grown much faster in New York than elsewhere. After the 1993 reforms, Empire Blue Cross apparently continued to insure the worst risks and has had substantial increases in premiums and declines in enrollment.

Across all types of plans in the state, there has been a loss of enrollment of about 27 percent in the individual market and 4 percent in the small-group market since September 1992, before the implementation of the legislation. Although the decline in coverage in the small-group market was roughly consistent with changes occurring elsewhere (declines in employer group coverage as premiums grew faster than wages), the decline in the individual market was greater than that shown in national data.

In both the small-group and individual markets, HMOs have expanded enrollment rapidly, outstripping national growth trends. Before 1995, the threat



of adverse selection led many HMOs to reduce the scope of benefits, and thus attract and retain only the “good” insurance risks. By 1995, because of Empire’s rate increases and subsequent decision to discontinue individual comprehensive indemnity health insurance, and because most HMOs and other insurers did not sell individual policies containing prescription drug coverage, many individually insured New Yorkers faced limited choices. To address that issue, in mid-1995 Governor Pataki proposed, and the state enacted, legislation to require HMOs to offer two standardized comprehensive benefits packages, one of which includes a point-of-service option. Other insurers that chose to participate in the comprehensive individual insurance market were also required by the law to sell the point-of-service option.

Taken as a whole, the result of insurance reforms in New York seems to have been less insurance coverage, higher costs, and more limited benefit packages. The 1995 legislation may serve to further stabilize the individual insurance market. The market may well have improved for those with health problems—data are not available to show how much premiums fell and coverage increased for these individuals. But what began as an effort to expand coverage and access clearly seems to have encountered difficulties. These difficulties probably reflect both the rapidity with which reform was implemented and the adoption of “pure” rather than modified community rating.

On balance, New York appears to be carrying out a clear commitment to expand coverage and access. This commitment is seen in the state’s broad Medicaid coverage, its efforts to enroll the Home Relief population in Medicaid, its expansion of Child Health Plus, and its maintenance of the bad-debt and charity-care pool (discussed below). Although the insurance reforms do not seem to have reduced the number of uninsured, they may have increased access for those in poor health.

Financing and Delivery System

Hospital Deregulation

Hospital payment in New York is undergoing a dramatic shift. For the past 13 years, state law has determined hospital payment rates in New York for all payers, including Medicaid, private insurance, and self-insured plans but not Medicare or HMOs. This system imposed a surcharge on all hospital bills. Funds from the surcharge were redistributed to hospitals to cover large portions of their charity care costs. The bad-debt and charity-care pool was later distributed as Medicaid DSH payments, with the state collecting federal matching payments. In addition, assessments on hospital revenue covered other health initiatives, such as child health insurance. Under the rate-setting system, teaching hospitals were also reimbursed for their costs of providing graduate medical education.

This payment system, the New York Prospective Hospital Reimbursement Methodology (NYPHRM), was initially seen to be successful in controlling costs, compared with states without regulation.¹⁰ However, as increased competition in many states among managed care plans reduced hospital costs, New York's hospital system was increasingly seen as being too costly and having considerable excess capacity. Only HMOs were not required to pay the NYPHRM-established rates and could negotiate rates directly with hospitals. The intent was to allow HMOs to take advantage of their shorter length of stay. Over time, expanding HMO penetration has undermined the intent of NYPHRM and its complex system of cross-subsidies. The policy choice was to either regulate HMO rates or deregulate all rates. The consensus among legislators, the governor, insurers, and providers—but not labor unions—supported deregulation.

As a result of the New York Health Care Reform Act (NYHCRA), enacted in 1996, hospitals began to negotiate their own rates in January 1997 with all payers except Medicaid fee for service, automobile no-fault insurance, workers' compensation, and Medicare. In general, it was felt that hospital deregulation would reduce the cost of hospital care and that hospital capacity would shrink. It was expected that even financially strong hospitals would reduce bed capacity and lengths of stay and that the academic medical centers would survive primarily because of mergers and consolidations and because every plan would want the prestige their names would bring. Hospitals in weaker financial condition were expected to downsize and, in some cases, to close.

There was a widespread consensus in the state that subsidies for charity care and graduate medical education (GME) should be retained. Support under NYPHRM was estimated at \$1.2 billion toward charity care and other health initiatives and \$1.8 billion toward GME, not including Medicare. In preparing for deregulation, the policy discussion centered on which public goods to preserve, at what funding levels, and through what financing mechanism. Several considerations came into play: The financing had to comply with federal laws¹¹ and Medicaid disproportionate share hospital rules, and it should not cause regional redistribution. In addition, hospitals preferred to have any payer assessments collected and disbursed through a pool rather than paid directly to hospitals. This pool, it was hoped, would prevent assessments from becoming part of rate negotiations between hospitals and payers.

Ultimately, the legislature chose to reduce direct GME support by \$400 million, less than the governor had proposed. Sharp reductions in GME present a particularly significant challenge because a number of high indigent-care hospitals in New York City depend on medical residents to provide patient care. Support for charity care and other health initiatives was retained at current levels. In 1997, hospitals will continue to receive about \$740 million, plus \$450 million for public hospitals and other hospitals serving large numbers of low-income patients. Health centers will receive \$48 million, double the previous amount, in part to ease the transition to a competitive market. An additional \$400 million is targeted for insurance subsidies and other health initiatives.

Under NYPHRM, financing for uncompensated care came from add-ons to payers' rates for hospital inpatient care as well as assessments on hospital revenue. Under the deregulated system, Medicaid will continue to support uncompensated care as it did under NYPHRM. Under NYHCRA, new assessments were placed on all payments to a broader set of providers and services, including inpatient and outpatient hospital care, diagnostic and treatment centers, and ambulatory surgery centers. Payers have the option of paying assessments to providers directly as a rate add-on rather than to a pool, but the assessment is increased fourfold.¹² Payments to the pool will continue to be paid out as Medicaid DSH payments, with federal matching payments coming to the state.

Under NYPHRM, support for GME was financed through the all-payer rate system. Under the new system, GME is partly funded through an assessment on payers' covered lives and partly through negotiations between providers and payers. The assessment will vary dramatically by region, since GME is heavily concentrated in New York City. In an effort to comply with ERISA, the state will allow payers, including self-insured plans, to elect to pay hospitals for GME expenses directly through a payment add-on—but a dramatically higher one.¹³

The assessment on insured lives will not fund GME at the same level as before. The assessment on Medicaid payments was kept at the same level, but the assessment on insured lives was placed at a level that would guarantee about 55 percent of previous payments for GME. The hospitals must now negotiate rates with insurers sufficient to cover their costs for GME. Some people are concerned that academic medical centers in more competitive markets could have difficulties negotiating sufficiently high rates to support their current programs. Academic medical centers in markets in which there is only one major teaching hospital will probably do quite well.

Managed Care

Managed care was slow to enter New York State. This is attributed by many in the state to the regulatory environment, for example, the rate-setting system and the certificate-of-need requirements. HMOs have typically believed that nonregulated states offered better opportunities, in part because rate-setting states controlled hospital costs more successfully than unregulated fee-for-service markets. But as managed care became increasingly successful in the unregulated markets, the rate-setting states were the ones perceived to have high costs and excess capacity.

HMO growth began in New York in the 1980s and has proceeded rapidly at the expense of traditional indemnity plans. By March 1996, about 29.2 percent of the total insurance market was in managed care, including point-of-service plans.¹⁴ HMOs and other forms of managed care are likely to continue to grow in the state with the end of rate setting. The state offers great opportunities for managed care—preferred provider organizations as well as HMOs—because of the large amount of excess hospital capacity. The supply of physicians is also greater than in most of the rest of the country. This is particularly true for medical and surgical specialists. In 1993, New York State had about 59.6 medical specialists per 100,000 population, versus 39.8 for the nation,¹⁵ and 36.6 surgical specialists per 100,000 population, versus 31.9 for the nation.

However, certain factors could slow the future growth of HMOs. First, the state sets a number of standards for HMOs. To begin with, all HMOs in New York must have open enrollment; they must market to the individual insurance market; they are subject to limits on preexisting condition exclusions;



and they are subject to numerous reporting requirements. A second threat to the growth of HMOs is new provisions in NYHCRA that permit hospitals and physicians to develop integrated delivery systems (IDSs), or provider-organized managed care plans.

Third, the state has enacted legislation restricting managed care practices. The law, termed a “Patient’s Bill of Rights,” was the result of efforts by consumer groups and the Medical Society of the State of New York to control many managed care practices. The provisions of the law apply to both commercial and Medicaid enrollees. Selected provisions of the new law include mandatory disclosure of benefits, enrollee financial obligations, provider panels, referral and prior authorization procedures, and access to specialty services; a prohibition against “gag clauses” for physicians; and provider due process protections for physicians being terminated from networks. In addition, plans must have an adequate network of primary care providers and medical specialists to meet the needs of their enrollees and ensure consumer choice. Consumers must have a choice of at least three primary care providers, subject to time and distance restrictions. Plans must have sufficient specialists of all classes of licensed health professionals.

Hospital Mergers and Consolidations

How the managed care market evolves depends to a great extent on the changes in the hospital market under deregulation. The way the hospital market evolves will determine whether HMOs are able to reduce health care costs in the state. It is widely believed that the state’s system is costly and has a large amount of excess capacity relative to other competitive markets. It is believed that ending the hospital rate-setting system would increase competition among insurers and HMOs and would drive down hospital costs, admissions, lengths of stay, and number of beds. The pace of change, however, is expected to be slowed by the absence of investor-owned for-profit hospitals.

In response to and in anticipation of the impact of deregulation, a substantial amount of hospital merger and consolidation activity has taken place. This includes mergers between New York Hospital and Columbia-Presbyterian Hospital and between St. Luke’s-Roosevelt and Beth Israel, and an affiliation between Mt. Sinai and St. Barnabas. There have also been affiliations among a large number of Catholic hospitals and nursing homes and between the North Shore Health System and a large number of Long Island hospitals. A number of other mergers and consolidations have taken place throughout the state, leaving some small cities with one major hospital or academic medical center.

The general sense we received from our visits was that the merger activity outside New York City could begin to present serious problems for competition in the health care market. First, respondents believed that one hospital could become dominant in a number of small cities. Managed care plans would

have a difficult time competing in the local market without access to this hospital, and this would affect managed care's ability to control its costs. Managed care would make a substantial effort to move care out of hospitals, but there would be a limit to the extent to which this could occur. Second, some markets contained many hospitals but only one large academic medical center. For example, it was argued that access to the Albany Medical Center would be critical for any managed care plan operating in that region.

New York City is a third and more complicated case. Many believe the amount of excess hospital capacity in New York City is so great that merger activity to date is not a threat to competition. Others believe that the mergers and affiliations taking place are led by the largest and most prestigious teaching hospitals, Mt. Sinai and New York Hospital–Presbyterian, and could eventually threaten competition in the New York City market. Some believe that even in New York City, a large HMO could not compete successfully for a middle-class clientele without access to Mt. Sinai or New York Hospital. The prestige of the Mt. Sinai and New York Hospital–Presbyterian networks would seem to give these hospital systems tremendous bargaining power. Some believe the accumulation of market power by the academic medical centers would also mean they would have the ability to negotiate rates sufficient to continue to support the current level of GME. Recent newspaper reports, however, suggest that these hospitals have not yet been successful. The large amount of excess capacity still seems to give insurers the upper hand, and even the strong academic medical centers are reportedly giving large discounts to HMOs.

Other hospitals are expected to have even more difficulty in the increasingly competitive environment, although the transition assistance provided in the Section 1115 waiver should help many. Hospitals that are currently financially distressed have never done well in the competition for private patients, and this is unlikely to change. They are also likely to obtain lower rates for Medicaid beneficiaries under managed care and to lose some of their current Medicaid volume. Smaller community hospitals that were absorbed by networks dominated by the larger academic medical centers will probably survive. The key questions were whether the major networks would absorb enough of the hospitals that currently serve the poor, and whether the public and voluntary hospitals would be able to form networks that could successfully compete for Medicaid patients. Advocates in the city clearly will exert political pressure to keep community hospitals open. If some public hospitals and some of the financially distressed voluntary hospitals closed, other hospitals would have to increase the amount of care they provide for the uninsured. The bad-debt and charity-care pools would cover some, but not all, of the costs of serving this population. The question is whether this would cause a downward financial spiral that would make it difficult for many safety net hospitals to remain afloat.

Another issue in New York is the large amount of debt that has been acquired by many hospitals. The possible effect of any hospital defaults on the bond rating for New York State has prompted considerable concern. If several hospitals defaulted on their debt, some observers believed the state might



decide to limit the competitive process and reinstitute some regulation. Some political pressure might also come to bear on the stronger hospitals to absorb the weaker.

Medicaid Provider Payment and Disproportionate Share Hospital Policy

Historically, the Medicaid program in New York has paid physicians rather poorly. They were paid 38 percent of Medicare rates in 1993 based on an index of 28 services.¹⁶ Before Medicaid, New York relied heavily on community health centers and hospital outpatient and emergency rooms, in addition to inpatient care, for uninsured patients, particularly in New York City. Low Medicaid physician rates ensured the continuation of institution- and clinic-based systems of care for the poor. At the same time, the state has paid for hospital care more adequately because of the all-payer rate-setting system. Prospective Payment Assessment Commission (ProPAC) analyses of data from the American Hospital Association indicate that New York Medicaid programs pay 101 percent of hospital costs, compared with the national average of 93 percent.¹⁷

Hospitals in New York with high levels of bad debt and charity care also receive a large amount of DSH payments. The budget of the New York DSH program in 1995 was about \$2.9 billion. The financing and distribution of DSH dollars changed with deregulation, but total DSH spending was projected to stay the same. Subsidies to support uncompensated care account for about half of the DSH program budget (see table 8). Most of the rest of the budget is made up of federal matching payments that the state claims for inpatient hospital care provided to its Home Relief population (explained below). In addition, some DSH payments go to mental hospitals.

In 1990, the state began to pursue aggressively maximizing Medicaid DSH opportunities, converting some of the charity-care subsidies to federally matched Medicaid payments. DSH payments grew from \$219 million in 1988 to \$3.2 billion in 1990, falling to \$2.9 billion in 1995. A primary example of Medicaid maximization is the bad-debt and charity-care pool. Originally, the state claimed the federal match only on the bad-debt and charity-care surcharge that Medicaid paid to the pool for its Medicaid beneficiaries. Later, the state labeled all payments from the bad-debt and charity-care pool to hospitals as Medicaid DSH—because they reimburse hospitals for uncompensated care—so that the entire pool would be federally matched. The amount of the add-on did not change, nor did the amount that hospitals received. The additional federal matching payments were retained by the state.

Under the New York Health Care Reform Act (NYHCRA), the financing and use of charity-care funds changed somewhat. Uncompensated care pool pay-

**Table 8** *Support for Charity Care and Other Special Health Initiatives under NYPHRM*

Name	Financing	Distribution	DSH (Yes/No)	Amount (1995)	Impact of NYHCRA
Bad-debt and charity-care pool	5.48 percent add-on to non-Medicare inpatient rates	All hospitals are eligible. Amount received depends on a hospital's "need" (bad debt and charity care); adjustment increases gradually with need. Major public hospitals receive a lower percentage than all others.	Yes	\$630 million	Replaced: Medicaid pays 5.98 percent add-on to all hospital and clinic rates. Private payers may pay 8.18 percent surcharge to a statewide pool. Those that refuse must pay 8.18 percent plus another 24 percent to providers directly.
Bad-debt and charity-care and capital, statewide pool	1 percent on gross hospital inpatient revenue, "financially distressed" hospitals exempt	Support for financially distressed hospitals (\$91 million plus \$17 million for capital project), Child Health Plus insurance subsidies (\$30 million), and other	In part	\$166 million	"Financially distressed" no longer exempt from revenue assessment. Funds are combined with above and distributed to hospitals (\$739 million) as DSH payments. Other NYHCRA funds are distributed to comprehensive health centers (\$48 million), subsidized insurance programs (\$130 million), and other health initiatives (\$200 million).
Bad-debt and charity-care allowance for financially distressed hospitals	0.325 percent add-on to non-Medicare inpatient rates	Financially distressed hospitals only	Yes	\$37 million	Eliminated
Supplementary bad-debt and charity-care adjustment ("SUP")	Intergovernmental transfers from public hospitals	Major public hospitals only	Yes	\$160 million	No change
Supplementary low income patient adjustment ("SLIPA")	Intergovernmental transfers from public hospitals and state "reserves"	Public or voluntary hospitals not designated as "financially distressed" with at least 25 percent of discharges for Medicaid and uninsured; distribution at increasing rate based on this percentage (\$36 million to voluntary hospitals)	Yes	\$261 million	Public hospitals only
General health services allowance	1.09 percent add-on to non-Medicare hospital rates	To hospitals for primary care education and training, formation of rural networks, and other	No	\$72 million	Eliminated

ments of \$739 million to hospitals were retained and continue to be counted as Medicaid DSH payments. The financing mechanism, however, changed as described earlier in the discussion of pool payments under NYHCRA. The modifications to the charity-care pools mostly affected the largest pool, the bad-debt and charity-care pool (see table 8). Another \$420 million in DSH payments made to hospitals with high percentages of Medicaid and uninsured patients were retained, but only for public hospitals. (These payments are financed with intergovernmental transfers.) Finally, some NYHCRA revenues were distributed to subsidize insurance, community health centers, and other health initiatives.

Beginning in 1992, the state further maximized Medicaid DSH by claiming the federal match for the Home Relief population. Home Relief is a state and locally funded program (50 percent each). Payments to hospitals, inpatient and outpatient, on behalf of Home Relief recipients are treated as DSH payments to hospitals for which the state then claims the federal match. Again, federal funds are retained by the state, which shares them with counties. When this provision was implemented, from the perspective of the hospital there was no change. This DSH amount adds \$1.4 billion on top of the bad-debt/charity-care and other pools, or about half of total DSH payments. These payments continue under the new NYHCRA payment system.

Medicaid Managed Care

Expanding Medicaid managed care has been a major goal of the Pataki administration. An extensive Section 1115 waiver was approved by the federal government on July 15, 1997. The waiver, called the Partnership Plan, will enroll all AFDC and related populations, as well as SSI-eligibles and medically needy beneficiaries, in managed care on a mandatory basis. It also includes provisions to create special mandatory managed care plans for persons with severe mental illness and HIV/AIDS. When this plan is fully implemented, New York will go further than any other state in enrolling severely disabled populations in managed care. Mandatory enrollment of these groups is controversial and will be closely watched by the federal government and by advocates in the state. The waiver's emphasis is on expanding access and quality of care as well as on cost containment, with only a small eligibility expansion to cover Home Relief recipients. This is an expansion only from a federal financing point of view, since this population previously had Medicaid benefits funded by the state.

The governor's waiver proposal was carefully scrutinized by community groups at the local level and regulatory officials at the federal level. In anticipation of the federal waiver, the state passed authorizing legislation in July 1996. When negotiations with the Health Care Financing Administration (HCFA) slowed (over such provisions as rapidity of implementation, devel-

opment of special plans for persons with severe mental illness and HIV/AIDS, primary care capacity in New York City, some commercial plans' practice of making only a portion of their physician panel available to Medicaid enrollees, the availability and distribution of transition funds, and budget neutrality), New York submitted a smaller scale 1915(b) waiver permitting it to enroll some of the AFDC and related groups into managed care. In March 1997, this waiver application was approved. The program will make enrollment mandatory in 31 upstate counties, thereby covering most of the AFDC and related beneficiaries outside New York City. This was an interim measure as the state pursued the larger Section 1115 waiver and the more complex managed care initiative.

Before implementation of the mandatory program, the voluntary managed care program enrolled 645,000 of approximately 2.4 million adults and children who are Medicaid beneficiaries.¹⁸ Thirty-two percent of Medicaid beneficiaries who live in the 57 upstate counties were in managed care, compared with 22 percent in New York City.¹⁹ This mirrors managed care enrollment among the privately insured population. Of the 57 upstate counties, 11 predominantly rural ones have almost no managed care (zero to 1 percent). The Section 1115 waiver would mandate managed care enrollment of most of the remainder—about 2.4 million—including many SSI recipients. Considerable concern remains as to whether the state, particularly New York City, has the primary care capacity to make the conversion to managed care successfully. Because of these concerns, the waiver provides for a two-year geographic phase-in period, with provisions that local districts and managed care plans must demonstrate capacity and readiness at each new implementation phase.

In New York, Medicaid managed care initiatives are county- and New York City-based. Under guidelines set by the state, counties enter into contracts with plans and enroll beneficiaries. Although managed care enrollment has been voluntary for AFDC and related populations, Westchester County and southwest Brooklyn have had mandatory programs under a 1915(b) waiver. A few counties have had programs that do not use HMOs. Instead they link patients with a primary care physician who must approve inpatient care and specialty care use.

Contracting with Health Plans

Commercial HMOs have had a strong incentive to participate in Medicaid, and about 65 percent of Medicaid beneficiaries in managed care are now in fully capitated HMOs.²⁰ Before NYHCRA, the rate-setting law imposed a 9 percent penalty on hospital charges for those HMOs that did not enroll a proportionate share of Medicaid beneficiaries. HMOs were also initially attracted by fairly high capitation rates, but these rates have been significantly reduced recently. In addition, grants were awarded to providers to establish new managed care organizations. Thirty percent of Medicaid beneficiaries in managed care plans are in Prepaid Health Service Plans (PHSPs), Medicaid-only health plans that are predominantly sponsored by clinics and nonprofit hospitals.



With a mandatory program in mind, the state solicited proposals from health plans in November 1995. The state reviewed proposals in conjunction with counties, centralizing what had previously been a very diffuse process. The state identified the counties that wanted to go forward with mandatory managed care—31 of 58 counties plus New York City. The state initially assumed that the voluntary program would convert to mandatory sometime during 1996, once the Section 1115 waiver was approved.²¹ Thus, most HMOs and PHSPs submitted bids expecting much higher volumes of enrollees than had occurred under the voluntary program.

As of August 1996, 53 plans, including PHSPs, were licensed in New York State.²² In response to the state solicitation, 51 plans submitted proposals.²³ Of the 51 plans, 48 met the evaluation criteria. As of September 1996, 46 plans were approved, representing 283 county networks. Some plans have since discontinued participation: As of July 1997, only 35 plans remain.

Enrollment and Capacity Issues

Several issues hampered the Medicaid managed care program, even in its voluntary form: enrollment procedures, rate setting, and capacity. Much of the focus has been on New York City, where fully three-quarters of the state's Medicaid acute care spending occurs. Some plans in New York City were accused of marketing and enrollment abuses. New York City is also the center of concern over capacity problems, particularly primary care shortages. Because of low rates of physician participation in Medicaid, ambulatory care is predominantly health-center- and hospital-based. Direct enrollment of beneficiaries by health plans was halted in New York City from August 1995 to August 1996, after the state discovered that some patients had to wait months for appointments and some plans were allegedly leading beneficiaries to believe that enrollment was required. The state moved quickly to ban such practices and implemented changes in enrollment procedures.

Direct enrollment by plans was subsequently reopened with increased city oversight of marketing and enrollment practices. The state intends to use an enrollment broker in New York City for mandatory and voluntary groups in managed care. The enrollment broker will help educate beneficiaries about their plan options and obligations under managed care.

Under the New York Medicaid managed care law, when enrollment becomes mandatory, beneficiaries will have 60 days to select a plan. After that, the state may automatically assign beneficiaries to a plan, a process called "autoassignment." Not-for-profit PHSPs will receive a minimum of 25 percent of the autoassignees in Year 1; 22.5 percent in Year 2; and 20 percent in Year 3. The remainder of autoassignees will be spread across all participating plans. This was intended to ensure that PHSPs, some of which are connected to financially vulnerable clinics and hospitals, would have the financial benefit of the autoassignees' expected lower levels of service use.

Benefits

Medicaid-contracting plans must cover most Medicaid-covered services except long-term care and a few other services. Plans must offer “enhanced” services (such as general health education, childbirth education, and extended care coordination for pregnant women) and must adhere to specific requirements for children. In addition, plans are required to have contracts with all area school-based health clinics and must reimburse public health agencies for immunizations and tuberculosis services provided to plan members.

Some services are carved out and not included in managed care contracts, for example, long-term care, day treatment and case management for the developmentally disabled, tuberculosis directly observed therapy, and adult day treatment for persons with AIDS, as well as early intervention and special education program services.²⁴ Plans have the option whether to capitate for family planning services; regardless of the plan’s decision, all enrollees may obtain family planning services from any Medicaid provider. Carved-out services will be reimbursed on a fee-for-service basis by the state, not through managed care plans.

Quality Monitoring

Requirements on Medicaid-contracting plans arise from consumer protections that apply to all licensed managed care plans in New York. These are the Patient’s Bill of Rights, a Medicaid-specific managed care bill, the Medicaid request for proposals (RFPs) from health plans, and contracts with plans. Contracts are signed by counties, which may supplement state provisions.

Responding in part to enrollment and capacity problems among plans in New York City, the Patient’s Bill of Rights requires plans to have an adequate network of primary care providers and medical specialists to meet the needs of their enrollees and ensure consumer choice. In addition, the state-issued RFP requires that 60 percent of a contracting plan’s network must be willing to accept Medicaid in the first contract year.²⁵ By the second year, 80 percent of the network must be available to Medicaid beneficiaries, and the state has the option of requiring the entire network to be available.²⁶

The New York Department of Health has a large staff devoted to monitoring quality in managed care. All health plans—PHSPs and HMOs—must report data on membership, utilization, quality of care, access, and membership, as well as general plan management, network information, and financial reports.²⁷ In addition, the Medicaid program requires grievance reports, provider network reports, additional encounter data, appointment availability studies, 24-hour access review, member satisfaction surveys, clinical studies, and more. Health plans in New York believe that the data collection is excessive, particularly since it is not consistent with data commonly required by large employers. Advocates, on the other hand, argue that high standards are required to maintain quality standards for vulnerable populations.



Setting Payments to Health Plans

Before November 1995, New York set payments to HMOs and PHSPs to reflect actual costs and utilization; however, rates were capped at 95 percent of what the state normally spent under fee-for-service. Separate rates were calculated by age, sex, county of residence, and aid category. Based on health plans' financial reports, the state tightened rates over time, bringing them down to about 89 percent of fee-for-service by the end of 1995.

In November 1995, as part of its health plan procurement, New York also instituted a competitive bidding process. The state established an acceptable rate based on fee-for-service expenditures for comparable populations, adjusted downward for expected managed care savings. To facilitate competition, plans were not informed of the rate band. The state accepted all plan bids in the rate range; those that were below the range were brought up to the bottom of the range; and those that bid too high were given the opportunity to contract at the lowest acceptable rate. Through this process the state believes it has achieved savings of approximately 10 percent to 12 percent over previous plan rates.

The process was complicated by the fact that HMOs faced a 9 percent penalty applied to hospital charges if they did not serve Medicaid patients. The HMOs assert that they accepted what they believed to be very low Medicaid rates in order not to be excluded from Medicaid business and face the 9 percent penalty. The 9 percent penalty phased out with NYHCRA and ended when the Section 1115 waiver was approved. Some commercial insurers felt they had been unduly influenced by the potential penalty in setting their rates, and some have subsequently limited their participation in the Medicaid program, which could create further capacity problems for the state. PHSPs believed they were under significant pressure to submit low bids and be selected, since they enroll exclusively Medicaid clients and contract with providers that serve primarily Medicaid clients, and are thus highly dependent on Medicaid contracts. They assert that the rates threaten their viability.

In response to these concerns, the state commissioned an independent analysis of the rates. That analysis, by Arthur Andersen, Inc., found that the rates should be increased by 3 to 5 percent.²⁸ In response, the state raised capitation rates by 2 percent in New York City and 7 percent upstate, and debate continues in the legislature on further upward adjustments.

Special Provisions for Some Persons with Disabilities

Under the Section 1115 waiver program, special needs plans (SNPs) would be developed for two populations: (1) adults with serious and persistent mental illness (SPMI) and children with severe emotional disturbances and (2) persons with HIV/AIDS and their minor children. The state estimates there are approximately 70,000 beneficiaries with severe mental illness and 100,000 with HIV/AIDS.²⁹ Enrollment will not be mandatory until at least the second year of implementation; persons with HIV/AIDS or SPMI/SED will not be required to enroll until the SNPs receive federal approval.

Under New York's 1996 Medicaid managed care law, the state may issue licenses for no more than 12 specially licensed comprehensive HIV/AIDS plans.³⁰ Plans must include HIV "centers of excellence" and community-based HIV care providers in their networks. The state has provided funding to consortia of providers to develop these kinds of plans. They also must have contractual arrangements with "community-based social service organizations to ensure access to the full continuum of services needed by HIV-infected persons."³¹ Plans are subject to quality assurance and data reporting requirements tailored to HIV care.

Of the Medicaid eligibles diagnosed with SPMI/SED, some were targeted for the basic managed care plans because they need only moderate mental health services, while others would be enrolled in SNPs with more intensive benefits. The state Medicaid managed care legislation limits the number of SNPs to six for adults and three for children. The impetus for capping the total number of SNPs was legislators' fears that implementing SNPs statewide would be too much change too fast. In addition to limiting the number of SNPs, the legislation mandates that the children's SNPs may not be established until January 1998, although the SNPs for adults may be implemented sooner if ready. When a shift to mandatory enrollment is approved, persons will be given a choice of plans "to the extent feasible."³²

Counties have been given an opportunity to indicate whether they are interested in assuming full financial risk as a mental health SNP, serving as a contractor for a SNP, or doing neither. Counties have been large providers of mental health services in New York, and patient relationships could be disrupted by moving Medicaid beneficiaries to managed care plans that do not include county-sponsored providers in their networks. Groups of counties or individual counties must at this time indicate their interest in becoming an SNP and may not reenter the selection process later.³³ The SNPs may be county-operated or privately operated. Counties individually or in groups may form mental health plans. Commercial behavioral health plans may also apply to become mental health SNPs, as may full-service HMOs.

Hospital Transition Fund and Budget Neutrality

The Section 1115 waiver was approved by HCFA on July 15, 1997, after two years of intense negotiation. Several issues caused delays in the negotiations between state and federal officials. Two issues of particular importance involved attempts to help hospitals make the transition to mandatory managed care, and budget-neutrality issues, issues which became related as negotiations continued. Safety net hospitals and unions representing hospital workers pressed for funding to help safety net providers make the transition to a more competitive environment. Funds would be distributed to hospitals with at least 5,000 admissions, of which 20 percent were Medicaid or uninsured patients. HCFA was sympathetic to the adjustment problems of these hospitals and agreed to a fund of \$250 million per year for five years; HCFA insisted that any hospital transition funds be budget neutral.



Under the original waiver request, the federal government would provide funding for the costs of serving the Home Relief population. The federal contribution toward the Home Relief population would be financed from the savings on the federal matching payments for expenditures on behalf of the elderly, the blind and disabled, adults, and children (both those receiving cash assistance and those receiving medical assistance only). Projected growth over the waiver period for expenditures per enrollee for the elderly, the blind and disabled, adults, and children were 6.3 percent, 5.3 percent, 5.1 percent, and 9.6 percent, respectively. These rates are modest by comparison with recent New York experience in the 1992–95 period but high compared with the nation and with Congressional Budget Office projections over the waiver period. Thus, New York should be able to generate the necessary savings without great difficulty.³⁴

The hospital transition fund (called the Community Health Care Conversion Demonstration Project [CHCCDP]) requires additional state matching funds and possibly additional savings if budget neutrality is to be preserved. The federal government chose to allow the state to count expenditures under Child Health Plus as the state’s contribution and to count federal matching payments as part of the “without waiver” baseline (that is, expected spending in the absence of the waiver). In principle this was similar to other state waiver programs in which HCFA has allowed hypothetical expansions under 1902(r)(2) to increase the state’s “without waiver” baseline. However, in this case, the federal government conditioned approval of the federal match on New York’s providing the additional funds to the CHCCDP. The federal government also allowed several other state-funded health programs to be counted toward the state share of expenditures if necessary. The federal government would match Child Health Plus and other state program expenditures only up to \$250 million, the amount required to fund the CHCCDP. The advantage to New York of using Child Health Plus, as noted above, is that HCFA would allow federal matching funds to be included in the “without waiver” baseline, thus creating the possibility of federal “savings” to finance the CHCCDP. If other state-funded programs were used as the state matching requirement, the baseline would be unchanged and savings would have to come from lower expenditure growth in the traditional program.

Delivering Health Care to the Uninsured and Low-Income Populations

Some programs in New York that fund health care to low-income populations are supported by the Office of Public Health. Within public health, some services are population-based (e.g., education, data collection, and disease surveillance), while others are personal health care services (e.g., immunizations, prenatal care, early intervention, and chronic disease screening). The state does not provide most public health services itself. Rather, funding is passed on to counties that in turn provide services or contract with private entities to do so. As in many other New York health programs, counties share the cost of public health with the state.

Some local health departments also receive funds from Medicaid for providing personal health care services. The dependence of local health departments on Medicaid varies. Rural counties were viewed as heavily dependent on Medicaid and Medicare revenue. These health departments deliver a considerable amount of home health care in their local areas and use revenue collected from these services to cross-subsidize core public health functions. As Medicaid shifts to managed care, managed care plans may contract with private home health agencies or pay public health departments less than they received before. Either way, these local health departments could lose funds. Some local health departments have developed other strategies to increase their revenue support. Five counties have elected to become designated comprehensive “diagnostic and treatment centers” (D&Ts), which makes them eligible for special subsidies in New York.

In New York City, public clinics are operated through the New York Health and Hospitals Corporation; many of these also are D&Ts. These clinics, because they offer comprehensive primary care in underserved areas, were viewed as well positioned relative to managed care. Managed care plans are likely to contract with them (albeit at lower rates of payment than under Medicaid fee-for-service) because there are few other providers in underserved areas. The lower payment rates could threaten their ability to serve the uninsured.

Adapting to Medicaid managed care has become a central concern of community health providers.³⁵ The state reported increased interest among family planning providers, community health centers, local health departments, and school-based health centers in joining managed care networks. Without managed care contracts, these safety net providers lose the potential to subsidize care to the uninsured with Medicaid revenue.³⁶ One way the state has responded has been to require managed care plans to contract with certain providers. In this regard, school health clinics in New York receive special protections. New York has a very large school health program. Hospitals and health centers typically contract with schools to run the school-based clinics. Seventy percent of school health clinics are in New York City; the remainder are in rural areas. Most provide primary care services, and some also provide mental health services. Under the proposed Medicaid waiver program, school clinics may continue to bill Medicaid on a fee-for-service basis for one year after mandatory managed care begins. Thereafter, health plans would be required to contract with school clinics.

Impact of Government Policies and Market Changes on Safety Net Providers in New York City

Background

The effects of policy and market changes on safety net providers are illustrated perhaps more vividly in New York City than in any other American city. Over 40 percent of New York City residents are poor or near poor (below 125 percent of poverty), more than a third are foreign born, and one in four nonelderly New Yorkers is without health insurance coverage. Whereas New York City is home to about 40 percent of the state's population, 60 percent of the state's poverty population lives in the city.

In New York City more than other areas of the state, the poor and uninsured receive ambulatory care services from hospitals and community health centers. At the core of the city's safety net is the largest public hospital system in the nation, consisting of 11 facilities with more than 180,000 discharges annually.³⁷ The public system also provides 5.3 million outpatient and emergency room visits per year (as of 1995) through its hospitals and a network of freestanding ambulatory care centers citywide.³⁸ The public system is complemented by an extensive array of outpatient departments and community health

Table 9 *Percent of Ambulatory Visits by Payer, Institutional Health Care Providers in New York City, 1994*

Facility Type	Medicaid	Self-Pay	Medicare & Private Insurance
Voluntary Hospital Outpatient Departments & Clinics	62.5%	21.8%	15.7%
Public Hospital Outpatient Departments & Clinics	45.0	42.4	12.7
Community Health Centers	55.0	30.0	15.0

Sources: United Hospital Fund, New York University, and Community Health Care Association of New York State.

centers in the nonprofit sector. Taken together, public and voluntary institutions manage general ambulatory care facilities at nearly 300 locations citywide.

The array of public and voluntary facilities provides the great majority of primary care services to the Medicaid and uninsured populations (table 9). This configuration of services is the product of Medicaid reimbursement policies that favor institutional providers over private physicians. Medicaid pays substantially higher rates to institutional providers, enhanced by DSH payments and state-funded indigent-care pool distributions. The ambulatory care institutions are, not coincidentally, heavily dependent on Medicaid to serve uninsured patients. Even accounting for inpatient services, hospitals in New York City are extraordinarily dependent on Medicaid, which covers nearly 70 percent of public hospital discharges and one-third of discharges from voluntary hospitals.³⁹

In this section we describe the status of the New York City safety net and discuss providers' perceptions of the impact of recent public policy and market changes. Findings are based on semistructured interviews of senior executives of 11 hospitals and six health centers conducted between late 1996 and early 1997 by the United Hospital Fund (UHF). The hospitals and health centers were selected systematically from among facilities serving the boroughs of Manhattan and Brooklyn, and interviews followed a protocol developed jointly by UHF and the Urban Institute.⁴⁰ The providers include three hospitals owned by the New York City Health and Hospitals Corporation and eight voluntary hospitals, two of which are academic medical centers and two others designated by the state as "financially distressed."⁴¹ Among the six health centers in the sample, two have close affiliations with hospitals, two are owned by the Health and Hospitals Corporation, and three are Federally Qualified Health Centers.⁴²

Impact of Managed Care on Beneficiaries and Safety Net Facilities

At the time of the interviews, about 400,000 (roughly one in four) Medicaid beneficiaries in New York City were enrolled in managed care through a voluntary program. For many months, institutional providers had been attempting—with some difficulty—to position themselves for a mandatory enrollment



environment. Numerous changes in state policy and program management—including shifting rules governing plan enrollment and marketing practices, declining managed care premiums (and consequently, provider payments), and uncertainty about the status of the Section 1115 waiver—have led to uncertainty among providers.⁴³ One health center executive director stated the problem succinctly:

. . . we planned to move into Medicaid managed care in a big way, then the City banned direct provider enrollment and reduced capitation payments. Then we looked to enroll private and Medicare managed care patients, but the Health Care Reform Act imposed new taxes on private plans and opened indigent care pools to 330 centers. Now self-pay patients are not as much of a financial drag as they were before. [For the future, we are] assuming that Medicaid managed care will become mandatory . . . and fee-for-service rates will decline, and we are planning to sign new Medicaid managed care contracts.

Despite the uncertainty of the policy environment, most of the safety net providers have contracts with one or more managed care plans and, at the time of the interviews, were engaged in negotiations with still other plans. (Only one hospital executive felt that enrollment in managed care may never become mandatory and had not acted aggressively to contract with plans.) Most providers have ownership interest in one or more PHSPs (i.e., Medicaid-only plans), but most also contract with competing plans.

Medicaid managed care has provided incentives for hospitals to reexamine and expand their ambulatory care infrastructure. Most facilities are adding satellite clinics or organizing physician group practices. (These activities represent both new ambulatory care capacity and simple shifting of affiliation arrangements of existing providers.) At least until recently, however, managed care has not had a great deal of influence on the way patients are served. The ability of the safety net providers to improve the management of care—for instance, through improved information systems—is currently mixed. Rather, the providers' initial responses to the incentives of managed care are more basic. For instance, one community health center reported that until recently it had provided free care to Medicaid managed care enrollees from plans with which it had no contract, but now it is turning these patients away. Other providers are responding to the growth of managed care by more aggressively collecting payments from uninsured patients. Virtually all the providers reported that increasing financial pressures, due largely to falling managed care reimbursement rates, would force additional constraints on the way uninsured patients are served.

Impact of Welfare and Immigration Reforms

Many of the institutions we visited serve large numbers of immigrants and welfare beneficiaries. These facilities' executives expressed general concern about the potential effects of pending Medicaid eligibility changes, but the com-

plex mix of refugee, documented, and undocumented immigrants has made the impact of immigration policy less than immediately clear. Moreover, at the time of the interviews, the state had not yet exercised its options under federal laws. As a result, most of the executives had not yet fully analyzed the potential impact of welfare and immigration policies. Some providers are still reaching out to immigrant groups to maintain or expand their patient base. For the present, most of the executives are more concerned about declining rates of reimbursement overall than about the future effects of policies that could increase the burden of caring for the uninsured. One health center director candidly captured the tenor of others' statements when he said that he is dealing with today's fiscal crisis today and will deal with future crises in the future.

Impact of Market Changes and Related Policy Changes

The growth of managed care and of uncertain and shifting hospital network alliances are proceeding rapidly. These market changes are intertwined with new state legislation—the New York Health Care Reform Act (NYHCRA) of 1996—that is only now being implemented. While the market share of managed care is still relatively modest—no more than about 20 percent of utilization in most of the facilities we visited—many of the executives see the future health of their institutions as dependent on a robust response to managed care. Most said they have anticipated a growing and more competitive managed care market for some time and have worked to improve their facility's attractiveness to managed care plans by increasing productivity. Citywide hospital data appear to confirm these assertions. Between 1992 and 1996, the average number of patient days per hospital in New York City fell by 19 percent, driven by a decline in length of stay from 9.7 to 7.7 days. Over the same period, the share of patient days provided by public hospitals, state-designated “financially distressed” hospitals, academic medical centers, and other hospitals has not changed, implying that all segments of the New York hospital market have responded equally to anticipated market changes.⁴⁴

The interviews revealed considerably more variability among institutions in organizational responses to market change. Academic medical centers and other large teaching hospitals are leaders in the network formation and merger process, leaving the smaller hospitals and health centers to respond. Many of the large institutions in the sample are implementing a recent merger or network affiliation. In the face of extreme volatility, each executive saw his merger/network arrangement as superior to that of his major competitors; yet, clearly, it is too early to judge the effect of these organizational changes.

Most of the smaller facilities see mergers and network affiliation agreements as exogenous forces that at present do little more than add to the uncertainty of their operating environment. In one instance, for example, a community hospital struggling to maintain its patient base saw its prospects for affiliation with a major network fade simply because a merger of two academic medical centers had the side effect of bringing this hospital's major competitor into its prospective network. Virtually all the executives see new affiliation arrange-



ments as essential to long-term survival, but in the context of the shifting organizational sands we heard many predictions about the future impact of these arrangements.

Nevertheless, several observations about the likely effects of hospital mergers and network development are possible, even at this early stage. First, each major “deal” is seen as producing some easily achieved economies. The mergers allow managers to “pick the low-hanging fruit,” such as consolidated laboratory or laundry services. Second, mergers allow for expanded physician referral networks. In several cases the new partners in merger/affiliation agreements share in referrals from newly acquired or developed physician capacity. Third, new organizational arrangements position the facilities in a stronger bargaining position with insurers. However, given the excess bed capacity in the New York market, insurers were reported to be affected by the new bargaining leverage only in cases of true mergers. Institutions forging looser affiliation agreements reaped no advantages in negotiations with insurers, but these facilities hoped that these arrangements would position them better in future negotiations. Finally, some executives expressed confidence that over time their new organizational arrangements would position them to achieve greater efficiencies through consolidated services. In these cases, efficiencies would be achieved opportunistically—for example, when department chairpersons retire.

The health care market in New York is changing rapidly. The wave of managed care has come late to New York City, but it has clearly arrived. Recent legislative changes, most notably NYHCRA and the new Medicaid managed care law, are both a response to and a framework for the reshaping of the health care market. Hospital managers are redefining their organizations to improve their competitive position, but at the same time most are working to maintain their traditionally strong commitment to low-income and uninsured patients.

Long-Term Care for the Elderly and Persons with Disabilities

Background

Spending

In 1995, New York's Medicaid program spent \$10.1 billion on long-term care services for the elderly and disabled (table 10), accounting for 49 percent of total Medicaid expenditures on services. Of New York's long-term care expenditures, about two-thirds were payments for institutional services in nursing facilities (NFs)—\$4.6 billion—and intermediate care facilities for the mentally retarded (ICF/MRs)—\$2.0 billion. Home care services accounted for \$2.7 billion, while expenditures for mental health services were \$514 million.

Home care services for the blind and disabled have experienced the greatest recent increases in expenditures, with an annual growth rate of 31.3 percent between 1992 and 1995. On the other hand, home care expenditures for the elderly have declined by 3.9 percent annually since 1992. NF expenditures for both the elderly and the blind and disabled grew at an average annual rate of about 9 percent between 1992 and 1995. Growth in expenditures for ICFs/MR between 1992 and 1995 was 8.4 percent for the elderly and 5.7 percent for the blind and disabled. Since 1992, Medicaid expenditures for mental health services have declined at a double-digit rate for both eligibility groups, in part because of a shift from institutions to cost-effective community-based alternatives.

Table 10 Medicaid Long-Term Care Expenditures by Eligibility Group, New York and United States (\$ in Millions)

	New York					United States				
	Long-Term Care Expenditures			Average Annual Growth		Long-Term Care Expenditures			Average Annual Growth	
	1990	1992	1995	1990-92	1992-95	1990	1992	1995	1990-92	1992-95
Total	\$6,875.1	\$8,316.6	\$10,140.9	10.0%	6.8%	\$32,264.2	\$42,542.5	\$53,996.1	14.8%	8.3%
Elderly	\$4,369.9	\$5,279.2	\$5,702.4	9.9%	2.6%	\$18,408.9	\$24,846.4	\$30,413.7	16.2%	7.0%
Nursing Home Care	2,515.7	3,055.5	3,784.6	10.2%	7.4%	15,131.3	20,542.9	25,571.5	16.5%	7.6%
ICFs/MR ^a	118.1	143.6	183.0	10.3%	8.4%	348.9	452.0	615.8	13.8%	10.9%
Mental Health	552.2	600.8	420.1	4.3%	-11.2%	973.0	1,286.0	1,107.3	15.0%	-4.9%
Home Care	1,183.9	1,479.4	1,314.7	11.8%	-3.9%	1,955.7	2,565.6	3,119.1	14.5%	6.7%
Blind and Disabled	\$2,395.6	\$2,897.9	\$4,112.0	10.0%	12.4%	\$12,842.4	\$16,201.0	\$21,618.7	12.3%	10.1%
Nursing Home Care	424.1	576.2	798.2	16.6%	11.5%	3,161.3	3,968.0	4,813.3	12.0%	6.6%
ICFs/MR ^a	1,400.8	1,568.3	1,854.2	5.8%	5.7%	7,241.3	8,380.4	9,321.1	7.6%	3.6%
Mental Health	129.3	150.0	93.5	7.7%	-14.6%	457.9	682.1	881.3	22.1%	8.9%
Home Care	441.5	603.4	1,366.1	16.9%	31.3%	1,982.0	3,170.5	6,603.0	26.5%	27.7%
Adults and Children	\$109.6	\$139.4	\$326.5	12.8%	32.8%	\$1,012.9	\$1,495.1	\$1,963.7	21.5%	9.5%

Source: The Urban Institute, 1997. Based on HCFA 2082 and HCFA 64 data.

a. Intermediate care facilities for the mentally retarded.

Elderly Oriented Services

There are 660 NFs (1997) in New York, which house 114,000 beds. Almost all residents of NFs are elderly, and more than 80 percent are on Medicaid. New York's Medicaid NF reimbursement rates, which averaged \$143 per day for free-standing NFs in 1995, are almost twice the national average. Although some facilities have been very selective about the severity of disability ("case-mix") among Medicaid beneficiaries whom they admit, access by Medicaid beneficiaries to NF care is not thought to be a major problem in light of the high percentage of residents who are covered by Medicaid.

New York uses all three Medicaid program options to provide home care services: home health care, personal care, and home and community-based services waiver. About 180 certified home health agencies (CHHAs) provide Medicare and Medicaid home health services to 100,000 beneficiaries. Personal care services are provided by 475 licensed home care services agencies (LHCSAs), which serve 85,000 beneficiaries with functional or cognitive disabilities. New York's waiver program, known as the Long-Term Home Health Care Program (LTHHCP), involves about 100 providers across the state and serves 20,000 beneficiaries. It is notable that New York accounts for one-third of all Medicaid expenditures for home care in the United States.

A big part of New York's long-term care story is its high spending on the personal care program. New York accounts for 65 percent of national Medicaid personal care expenditures.⁴⁵ In the state, personal care services account for about 70 percent of total state spending on home care, and 80 percent of the expenditures are incurred in New York City alone. The average spending per recipient of \$17,000 per year is high by most standards, but some recipients of personal care services incur costs that exceed \$100,000. Some of our interviewees felt that the personal care program, particularly in New York City, was excessively generous. Others thought that the per-recipient spending levels simply reflected their long-term care needs. Because of the high total expenditures and the variation in per-recipient spending, personal care services will continue to draw attention as the state seeks further savings in Medicaid.

Mental Health/Mental Retardation-Oriented Services

New York's public mental health system includes state-operated, as well as locally funded and operated, programs. Institutions currently house about 6,500 individuals. Community-based services include community residential facilities and care centers, licensed outpatient programs, supportive employment programs, intensive case management, and crisis support programs. By providing funding to localities, the state supports 2,500 programs serving more than 500,000 people with a variety of programs, such as comprehensive psychiatric emergency services and self-help programs.

New York provides long-term care to about 100,000 persons with mental retardation or developmental disabilities (MR/DD) with Medicaid and state-



only funds. Nearly 80,000 people received residential support, ranging from family support to ICFs/MR, and approximately 27,000 people received Medicaid community-based waiver services. Because of a policy focus on community-based care, the number of people in institutions has declined by 75 percent since the mid-1980s and now represents less than 10 percent of the total number of MR/DD beneficiaries.

Long-Term Care for the Elderly

New York has been implementing short-term measures and developing longer range approaches to address problems with Medicaid expenditure growth in long-term care for the elderly. In recent years, Medicare maximization and payment rate cuts have been the major approaches to meeting shortfalls from budget cuts. For the long term, a Task Force Report, “Securing New York’s Future,” recommends that New York increase private cost-sharing for long-term care services by promoting private insurance and modifying Medicaid eligibility rules. The report also recommends making changes in the delivery system by developing cost-effective alternatives, such as continuing-care retirement communities. The state is also moving toward integrated acute and long-term care delivery systems under capitated payments.

Medicare Maximization

In 1995, and again in 1996, the state required nursing homes and home care providers to increase Medicare revenues by 1 percent from the base expenditures of each year. The increase was a target for each industry as a whole, and penalties, in the form of Medicaid payment rate cuts, were not imposed on any particular provider as long as the overall target was met.

Although the nursing home and home care industries were able to meet the specified targets for Medicare maximization, their response to this policy differed. New York is a participant in HCFA’s case-mix and quality demonstration project, which is testing a Medicare prospective payment system for NFs. As a result of the payment methodology developed for the demonstration, state officials believe that NF payments for Medicare patients in New York are about \$40 per day higher than they would have been otherwise. Hence, HCFA has provided strong financial rewards for NFs in New York to maximize Medicare revenues.

Medicare maximization is less appreciated by home care agencies, in part because many such agencies have relied heavily on the generous Medicaid home care programs in the state. In addition, home care providers are worried that some of the cases submitted to Medicare would not meet Medicare coverage criteria, and that billing for “questionable” cases would result in negative financial consequences. Despite the providers’ concerns,

several state- or county-sponsored activities have been initiated to ensure that claims are submitted to Medicare for cases that could conceivably be Medicare-covered.

Conventional Efforts to Control Expenditures

Conventional methods for controlling long-term care expenditures include cutting provider payment rates, constraining the supply of providers, and reducing eligibility. In 1996, cuts in NF payments included the elimination of the “trend factor” in Medicaid payments and cuts from the base rate to “encourage improved productivity and efficiency by providers.” For home care, programmatic efficiencies, such as increased use of electronic response systems to reduce the need for personal care and the assignment of multiple beneficiaries in the same residential area to the same personal care aides, are required by the state to produce savings. Based on the provider payment cuts approved in the 1996–97 budget, which were about 5 percent each for the nursing home and home care industries, it appears that in that fiscal year the state practiced an evenhanded strategy toward the two types of providers.

Certificate-of-need (CON) procedures have constrained nursing home bed growth, yet about 11,000 beds with CON approvals are in the pipeline. One problem is that people who are holding the CONs are not building because of location and zoning issues, as well as the possibility that occupancy rates are softening. Because slots in the Medicaid home and community-based waiver program are tied to nursing home bed need, constraints on nursing home bed supply have automatically constrained the number of LTHHCP enrollees. The number of CHHAs has been constrained by a need methodology, which some of our interviewees thought was antiquated.

Although NFs appear to have been unharmed by the recent cuts in Medicaid payments, in part because of the higher than expected Medicare payments, there is concern that quality of care will be threatened with continuing Medicaid payment cuts and the end of the Medicare demonstration project. The industry is working with the governor’s office on regulatory reform to modify New York’s quality of care standards, which currently exceed federal requirements, but it is not clear that “coming down” to federal standards would result in sufficient savings to compensate for expected reductions in payment.

Delivery System Changes

New York has fostered changes in the delivery system for long-term care. The assisted living program (ALP), for example, was established in 1991 to provide supportive housing and home care to individuals who are medically eligible for placement in nursing homes. There are approximately 1,500 ALP beds now, but 3,000 additional beds have been approved and are in the pipeline.



As in most other states, managed long-term care is mostly experimental in New York and currently involves very few people. New York is home to one of the social/health maintenance organization (S/HMO) sites and two of the Program of All-Inclusive Care for the Elderly (PACE) sites. The two PACE sites serve approximately 700 severely disabled elderly persons. The S/HMO and PACE projects were designed to integrate, to some degree, acute and long-term care services under managed care. The state is also implementing a demonstration project at six sites to study the development of managed long-term care under a capitated Medicaid payment. This project is a precursor to a program that will integrate acute and long-term care services with combined funding from Medicare and Medicaid. In addition, although a proposal was included in the governor's budget in 1996 to create 15 demonstration projects on managed long-term care services, it did not progress because of disagreements in the legislature over whether HMOs could be participants. A proposal by the governor that would allow a limited number of HMOs to participate in a 24-site demonstration project is expected to be implemented in 1997.

Private-Sector Initiatives

Although efforts to increase private initiatives in long-term care have been modest, it is an area that officials in New York indicated would be addressed actively in the future. The main theme of the "Securing New York's Future" report is that private contributions for the costs of long-term care should be increased. The major strategies proposed include (1) promoting purchase of private long-term care insurance by providing incentives through the tax system, (2) tightening Medicaid eligibility rules to increase asset recovery from nursing home and home care users (and families), and (3) increasing the role of continuing-care retirement communities and assisted living facilities.

The focus on increasing private contributions was motivated by a perception, shared by several interviewees, that asset divestment to gain Medicaid eligibility for NF care is a widespread problem in New York. The higher than average proportion of Medicaid residents (83 percent of NF patients are on Medicaid in New York, compared with about 68 percent nationally) was noted as evidence of the asset divestment problem. It could also reflect the combination of higher nursing home costs and higher income eligibility standards in New York. Some interviewees indicated that, to the extent it occurs, asset divestment is only part of a larger problem, which is the lack of an affordable alternative to paying for nursing home care. They noted that private long-term care insurance is not affordable for most elderly New Yorkers.

In the governor's 1997–98 proposed budget, state savings of \$313 million from nursing homes and \$178 million from other continuing care programs—primarily home care services—would be derived almost exclusively from provider payment cuts. In contrast, only \$10 million of savings are to be derived from increasing estate recoveries and tightening eligibility rules. Hence, despite the interest in increasing private contributions reflected by the task force report,

the traditional approaches for deriving savings would again be the focus of the budget debate. The proposed budgetary savings, however, do seem to recognize the prominent role of personal care services as a source of Medicaid long-term care spending, since personal care services are the target for about 50 percent of the proposed savings from home care.

Long-Term Care for Younger Persons with Disabilities

Mental Health

Provision of long-term care for persons with mental health problems has been characterized by a shift in the locus of services from institutions to community-based alternatives. Over the past few decades, the number of people residing in state institutions has declined to fewer than 7,000. Correspondingly, the size of state mental health hospitals has been declining. The largest facility in operation has about 300 beds, in contrast to the closed facilities, which once had thousands of beds. To meet the needs of mental health patients, in this period of deinstitutionalization, community residence beds, subsidized beds in apartments, and psychiatric beds in general hospitals were added.

The type of care provided to mental health patients has also changed. Ten years ago, the focus was on day treatment and hospitals. The focus is now on rehabilitation rather than custodial care. The rehabilitation focus of institutional care is reflected in hospital patients' declining lengths of stay. In addition, mental health services now include use of "social clubs," which are programs that provide job and social assistance but no medical care. Such social day programs are regarded by some as more effective than day treatment programs because they offer services that are more appropriate for the population.

Medicaid maximization has been an important trend in the financing of New York's mental health program. Approximately 60 percent of the mental health program of \$4 billion is financed by Medicaid, including funding through DSH payments. Although growth in the mental health budget has been flat, Medicaid's share continues to increase while the state-only share decreases. Despite the orientation toward deinstitutionalization, the impetus to do so is moderated by the potential loss of Medicaid DSH payments and the fact that some of the community care services (e.g., social clubs) are less "Medicaidable." In fact, one part of the state's motivation to obtain the Section 1115 waiver was to lock in current Medicaid spending and therefore remove the financial penalty of deinstitutionalization.

Mental Retardation/Developmental Disabilities

As with the mental health program, New York's program for persons with mental retardation or developmental disabilities is characterized by a strong emphasis on deinstitutionalizing patients and providing community-based



care. The population of large, state-operated facilities declined 44 percent between 1990 and 1994. Now there are only nine such developmental centers, with the largest housing 423 beds. The state also supports small residential units in the community. Altogether, only about 2,500 persons with MR/DD reside in “institutions.” The designation of such institutions, regardless of their size, as ICFs/MR enables the state to maintain Medicaid matching funds.

The state operates a home and community-based services (HCBS) waiver program that serves about 27,000 people. People admitted to the HCBS waiver program must be ICF/MR eligible and must reside in their own home, a family care home, or an individualized residential alternative. A central feature of this program is that each beneficiary works with a manager to develop an individualized service plan. This approach involves building services and supports around people instead of using program models that bind service packages to certain residential models or day programs. Among the services available are employment, habilitation, prevocational services, respite services, environmental modifications, and adaptive technologies. The approach also includes a significant reliance on a base of informal community supports.

In addition to the HCBS waiver program, the state operates other community-based care programs for persons with MR/DD, including some programs with state-only funding. In 1996, more than 50,000 people were provided community day activities, such as integrated employment, sheltered work, and day treatment. State-only funds are used to maintain a family support program that includes respite and counseling.

New York is very dependent on Medicaid funding for services provided to the MR/DD population. Most (about 70 percent) of the state operations budget of \$1 billion and the \$800 million spent on aid to localities for community services currently come from Medicaid. The state operations budgets are projected to decline in the coming years, with continuing efforts at deinstitutionalization, but expenditures for the HCBS waiver are projected to increase. As a result, the state can be expected to increase its reliance on Medicaid financing of care for the MR/DD population.

Challenges for the Future

New York has a highly sophisticated and expensive health care system, with a large supply of hospitals, nursing homes, and medical and surgical specialists. The state has by far the largest Medicaid program in the country. It has successfully obtained federal Medicaid matching funds for a wide range of state health and social service programs and has one of the largest disproportionate share hospital (DSH) payment programs of any state. It has enacted comprehensive reforms of its small-group and individual insurance markets and deregulated its hospital payment systems while retaining the previous system's support for financing uncompensated care.

Despite these efforts, the state faces many challenges. The percentage of the nonelderly population without health insurance is greater than the national average and growing. In part, this may be due to a decline in coverage in the small-group and individual insurance markets, perhaps in part a result of the state's insurance reforms enacted earlier in the decade. There are no plans to expand Medicaid enrollment, and the Medicaid rolls could fall as a consequence of welfare reform. On the other hand, the state is expanding its health insurance program for children, which should help reduce the number of uninsured New Yorkers. Nonetheless, if the number of uninsured New Yorkers continues to grow, the system could face serious problems. Principally, the revenues from the bad-debt and charity-care pool that support hospitals providing large amounts of uncompensated care could grow increasingly inadequate. This is particularly true if it proves difficult to sustain payments into the pools in future updates of the law.

A second issue is whether the state can sustain its high level of spending on Medicaid. Medicaid expenditures are the largest single item in the state bud-

get, and they have been growing faster than all other state expenditures. Nonetheless, the state legislature has been reluctant to make dramatic reductions in Medicaid spending, although severe cuts are often proposed. Most recent cost-containment efforts are centered on hospital and nursing home rate reductions and the expansion of managed care. Efforts to curtail enrollment and benefits have not been seriously proposed. It is unclear at this point whether the state will be successful in achieving major savings through managed care. Given the historic commitment to low-income populations and the presence of strong interest groups, it is also unclear how the state would respond to a serious recession or a major reduction in federal funding.

Federal approval of the Section 1115 waiver will allow the state to expand mandatory managed care enrollment from 645,000 to more than 3 million beneficiaries. Although the program will be phased in slowly, New York faces a number of challenges. These range from issues of marketing and enrollment abuses to ensuring sufficient primary care capacity, particularly in New York City. The state would also like to (1) expand contracting with “mainstream” or commercial health maintenance organizations (HMOs), (2) continue to provide support for safety net institutions, and (3) aggressively regulate managed care organizations to ensure quality. At the same time, managed care is a major component of the state’s cost-containment strategy. Whether these multiple and probably conflicting objectives can be achieved is a serious question.

The state’s insurance and hospital markets are undergoing major changes. Hospital deregulation is expected to lead to the expansion of commercial HMOs. HMOs are likely to continue to develop and expand market share because of excess capacity in the state. But in anticipation of hospital deregulation and the growing power of HMOs, hospitals are moving rapidly to form various kinds of affiliations, mergers, and joint ventures. The key issue is how these mergers or affiliations affect the market power of these entities. Will they be able to successfully bargain with managed care organizations? What will be the impact of their success or failure on hospital use and system cost?

Other issues revolve around the future of New York’s powerful academic and medical centers. Will they retain enough market power to earn sufficient revenue to finance their graduate medical education programs as well as a certain amount of support for indigent care? As the health care market evolves, the system’s ability to serve low-income people could be threatened. A major issue that the state faces is whether enough funds will remain in place for hospitals to continue serving low-income people, or whether the market will become so competitive that hospitals will come to see uncompensated care as a cost they can no longer afford. Will enough of the public and nonprofit hospitals that have served low-income populations in the past be able to survive in an increasingly competitive system? Will these hospitals be able to charge sufficient rates to generate the surplus that would allow them to shoulder bad debt and charity care? Or will these burdens force closures and downsizing, thus limiting the amount of uncompensated care that can be provided?

Finally, can the state continue to afford its costly commitment to long-term care services? Its cost-containment efforts in recent years have largely centered on cutting rates to nursing homes and home health providers and forcing the industry to rely more on the Medicare program. With the recent repeal of the Boren amendment, New York may become more aggressive in reducing nursing home rates. However, the power of the elderly and nursing home lobbies would limit the state's capabilities in this area. Another major issue is whether personal care benefits, by far the largest in the country, will be a target of cost-containment efforts. A final issue is whether the state will be successful in expanding private-sector financing options to take pressure off the Medicaid program.



Notes

1. Urban Institute estimates from the 1995–96 Current Population Survey as adjusted by the TRIM2 microsimulation model.
2. State of New York, *The Partnership Plan*, Section 1115 waiver application submitted to Secretary of Health and Human Services and the Administrator of the Health Care Financing Administration, March 17, 1995.
3. Urban Institute estimates from the 1995 and 1996 Current Population Survey as adjusted by the TRIM2 microsimulation model.
4. Colin Winterbottom, David W. Liska, and Karen M. Obermaier, *State Level Databook on Health Care Access and Financing*, Washington, D.C.: The Urban Institute, 1995.
5. Some of this apparent growth may be due to changes in population weights in 1993 (replacing weights from the 1980 census to the 1990 census).
6. Section 1115 waiver proposal.
7. “Section 1115” refers to the section of the Social Security Act that permits research and demonstration waivers.
8. New York State Senate Health Committee, “New York State Health Care Reform Act of 1996.”
9. James Dao, “Opposition Looms for Welfare Bill Offered by Pataki,” *New York Times*, November 18, 1996.
10. Stephen Zuckerman, “Rate-Setting and Hospital Cost-Containment: All-Payer vs. Partial-Payer Approaches,” *Health Services Research*, Vol. 22, No. 3 (August 1987). James C. Robinson and Harold S. Luft, “Competition, Regulation, and Hospital Costs, 1982 to 1986,” *Journal of the American Medical Association*, Vol. 260, No. 18 (November 11, 1988).
11. The federal Employee Retirement Income Security Act (ERISA) limits states’ ability to regulate or tax self-insured medical plans. The U.S. Supreme Court twice upheld the NYPHRM provisions. (DeBuono, New York Commissioner on Health, et al. v. NYSA-ILA Medical and Clinical Services Fund, by its trustees, Bowers, et al., No. 95-1594 U.S. Supreme Court, June 1997, and New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., U.S. Supreme Court, 1995.)
12. A rate add-on was upheld previously by the Supreme Court. Although a direct pool payment might violate ERISA, the state hopes that presenting a choice between a pool payment and a rate add-on would comply with ERISA as well as provide an incentive for direct payment.
13. Again, although a covered-lives add-on might potentially violate ERISA, the state believes the add-on to a rate of payment would not.
14. The Interstudy Competitive Edge 6.1 Part II: Industry Report, St. Paul, MN: Interstudy, September 1996.
15. Area Resource File, 1993.
16. Stephen Norton, “Medicaid Fees and the Medicare Fee Schedule,” *Health Care Financing Review*, Vol. 17 (Fall 1995): 167-181.
17. Prospective Payment Assessment Commission, “Medicare and the American Health Care System: Report to Congress,” Washington, D.C.: ProPAC, June 1995.
18. Managed care enrollees as a percentage of full-time equivalent enrollees in Medicaid.
19. New York State Department of Social Services, September 1996.
20. Based on Health Care Financing Administration managed care and 2082 data.
21. New York State Department of Health, Office of Managed Care, *Health Plan Request for Proposals*, November 15, 1995.

22. New York State Department of Health, Office of Managed Care, *Health Maintenance Organizations Currently Certified to Operate in New York State*, Albany, NY: DOH, August 22, 1996.
23. New York State Department of Health, *Status Report—September 10, 1996*, memorandum.
24. State of New York, Assembly Bill 11329, July 12, 1996, and *Health Plan Request for Proposals*.
25. *Health Plan Request for Proposals*.
26. The Section 1115 terms and conditions affirm these requirements for the first and second years of the demonstration.
27. New York State HMO Council and Conference, *The New Two-Class System*, Albany, NY: NYSHMOC, June 1996.
28. “The New York State Bureau of Managed Care Financing Actuarial Review,” Hartford, CT: Arthur Andersen, December 1996.
29. *The Partnership Plan*.
30. State of New York, Assembly Bill 11329, July 12, 1996.
31. Assembly Bill 11329.
32. Assembly Bill 11329.
33. New York State, Office of Mental Health and Department of Health, “Mental Health Special Needs Plans: Request for Information,” Albany, NY: NYS OMH/DOH, January 31, 1997.
34. The per capita caps apply once mandating begins anywhere in the state, so it may be more difficult to achieve budget neutrality during the first years of the waiver.
35. New York State Department of Health, Center for Community Health, *Maternal and Child Health Service Block Grant, Interim Application for FFY 1997*, Albany, NY: NYSDOH, 1996b.
36. *Maternal and Child Health Service Block Grant, Interim Application for FFY 1997*.
37. New York State Department of Health, 1994 Hospital Institutional Cost Reports.
38. New York State Department of Health, 1995 Hospital Institutional Cost Reports and Ambulatory Health Care Facility Reports.
39. New York State Department of Health, 1994 Hospital Institutional Cost Reports.
40. For a detailed description of the methodology and findings of the interviews, see Cantor et al., “Health Care in New York City: Service Providers’ Response to a Changing Market,” Draft Report, New York City: United Hospital Fund, 1997.
41. The sample of hospitals consists of Bellevue Hospital Center, Beth Israel Medical Center, Brooklyn Hospital Center, Columbia-Presbyterian Medical Center, Coney Island Hospital, Harlem Hospital, Maimonides Medical Center, Mt. Sinai Medical Center, North General Hospital, St. Luke’s-Roosevelt Hospital, and St. Mary’s Hospital of Brooklyn.
42. The sample of health centers consists of the Ambulatory Care Network Corp., Bedford-Stuyvesant Family Health Center, Cumberland Diagnostic and Treatment Center, Renaissance Health Network, Settlement Health Center, and William F. Ryan Community Health Center.
43. See above for a full discussion of Medicaid managed care policy.
44. United Hospital Fund, *Hospital Watch*, Vol. 8, No. 1, Exhibit 2 (March 1997); and UHF unpublished tabulations of the *Hospital Watch* quarterly survey.
45. Susan E. Hardwick, P. Jennifer Pack, Elizabeth Ann Donohoe, and Kristen J. Aleksa, *Across the States 1994: Profiles of Long-Term Care Systems*, Washington, D.C.: AARP, 1994.

APPENDIX
List of
People Interviewed

State Government

Governor's Office

Robin Frank

Barbara Howard

Department of Health

Ellen Anderson

Judith Arnold

Nancy Barhydt

Robert Barnett

Neil Benjamin

Frederick Bodner

Norm Bryer

Martin Conroy

Michelle Cravetz

Rosemary DeSanta

Brian Ellsworth

Linda Goudy

Dennis Graziano

John Kaelin

Christopher Kus, MD

Gary Lind

Charles Murphy

Norma Nelson

Patricia Pine

Robert Reed

Gary Riviello

Phyllis Silver

Kenneth C. Spitalny, MD

Linda Stackman

Mark Van Guysling

Carla Williams

Jay Zucker

Others

Dennis Norton

James M. Guteman

Bob Hubbard

Division of the Budget

Health and Life Bureau, Insurance Department

Office of the Attorney General

State Legislator's Staffs

Shay Bergin

James Clyne

Jane Preston

Office of Assemblyman Richard Gottfried

Office of Assembly Majority Leader Sheldon Silver

Senate Health Subcommittee

Provider Associations

Healthcare Association of New York State (HANYS)

Darrell Jeffers

Ray Sweeney

Home Care Association of New York State

Fred Griesbach

Carol Rodat

Medical Society of the State of New York

Laurie Cohen

Gerard Conway

Shauneen McNally

New York State HMO Conference

Arlene Alpert
Kerry S. DeWitt
Amy Nailnovich

Others

Sharon Carlo	New York Association of Homes and Services for the Aging
Ed Stafford	New York State Health Facilities Association
Phyllis Wang	New York State Association of Health Care Providers

Advocacy Groups

Deborah Bachrach	Attorney, Kalkines, Arky, Zall and Bernstein LLP
Marc Brandt	The ARC
Richard Kirsch	Citizen Action

Universities

Columbia University

Michael Sparer
Lawrence Brown

Others

Richard Cody	Consultant
Jim Fossett	Department of Political Sciences, SUNY Albany
Ron Rouse	Consultant
Mildred Shapiro	Consultant
James Tallon	United Hospital Fund

NEW YORK CITY

Hospitals

Ronald C. Ablow, M.D.	St. Luke's-Roosevelt Hospital Center
Al Beco	St. Luke's-Roosevelt Hospital Center
Frederick D. Alley	The Brooklyn Hospital Center
Stanley Brezenoff	Maimonides Medical Center
Howard C. Cohen	Coney Island Hospital
John Glendening	Coney Island Hospital
David Tanneholz	Coney Island Hospital
David Sklar	Coney Island Hospital
John Ballow	Coney Island Hospital
Barry R. Freedman	Mount Sinai Medical Center
Gregory M. Kaladjian	Bellevue Hospital Center
Eugene L. McCabe	North General Hospital
Lisa Alvarenga	North General Hospital
Enid B. McCoy	St. Mary's Hospital of Brooklyn
Robert G. Newman, M.D.	Beth Israel Medical Center
Thomas Hayes	Beth Israel Medical Center
William T. Speck, M.D.	Columbia-Presbyterian Medical Center
Linnette Webb	Harlem Hospital Center

Health Centers

Linda Curtis
Ulysess S. Kilgore
Monica Sweeney, M.D.
Raoul DeOcera
Gayle Lewis

Barbara E. Minch
Ana A. Taras
Cesar Perales

Walid Michelen

Roslyn Weinstein

Ric Plaisance
Roberta Berrien, M.D.

Cumberland Neighborhood Family Health Care Center
Bedford-Stuyvesant Family Health Center
Bedford-Stuyvesant Family Health Center
Bedford-Stuyvesant Family Health Center
Renaissance Health Care Network:
 Sydenham Neighborhood Family
 Health Care Center
William F. Ryan Community Health Center
William F. Ryan Community Health Center
The Washington Heights-Inwood Ambulatory Care
 Network Corporation
The Washington Heights-Inwood Ambulatory Care
 Network Corporation
The Washington Heights-Inwood Ambulatory Care
 Network Corporation
Settlement Health
Settlement Health



About the Authors

John Holahan is the director of the Urban Institute's Health Policy Center. He has authored several publications on the Medicaid program. He has also published research on the effects of expanding Medicaid on the number of uninsured and the cost to federal and state governments. Other research interests include expanding health insurance for children, health system reform, changes in health insurance coverage, physician payment, and hospital cost containment.

Alison Evans is a former research associate in the Urban Institute's Health Policy Center. She participated in several case studies within the Assessing the New Federalism project and analyses of all-payer rate setting systems and Medicare budget issues. She is currently a doctoral student at the University of California at Berkeley.

Korbin Liu is a principal research associate with the Health Policy Center of the Urban Institute. Most recently he has been studying transitions between acute, subacute, and long-term care services of Medicare enrollees. As part of the Institute's analysis of the impact of Medicare and Medicaid reform, he is examining the potential effects of expenditure growth controls of those programs on long-term care services.

Margaret Sulvetta is director of computer services at the Urban Institute. At the time of the research for this report, she was a senior research associate in the Urban Institute's Health Policy Center, where she specialized in research on hospitals, reimbursement systems, and Medicare.

Kathryn Haslanger is director of the United Hospital Fund's Division of Policy Analysis. She is responsible for developing and managing the Fund's policy agenda and identifying, developing, and managing program opportunities in the areas of home care, primary care, and managed care. Before joining the Fund in 1990, Ms. Haslanger served as deputy commissioner for Community Care and Senior Services at the New York City Human Resources Administration.

Joel Cantor is director of the research division of the United Hospital Fund. He also serves as a research associate professor at New York University Robert F. Wagner Graduate School of Public Service. His current work focuses on health care financing and delivery in New York. Prior to joining the staff of the United Hospital Fund, Dr. Cantor was director of Evaluation Research at the Robert Wood Johnson Foundation.

Errata

Several published *State Reports* and *Highlights* include an error in Table 1, “State Characteristics.” Incorrect figures were included for noncitizen immigrants as a percentage of the population. Corrections were made on August 13, 1998 to both the HTML and PDF version of these reports on the *Assessing New Federalism* website.

Correct figures for 1996

	Noncitizens as a Percent of the Population
UNITED STATES	6.4%
Alabama	0.9%
California	18.8%
Colorado	5.1%
Florida	10.0%
Massachusetts	5.4%
Michigan	2.3%
Minnesota	3.0%
Mississippi	0.9%
New Jersey	8.8%
New York	11.9%
Oklahoma	1.5%
Texas	8.6%
Washington	4.3%
Wisconsin	2.1%

Source: Three-year average of the Current Population Survey (CPS) (March 1996-March 1998, where 1996 is the center year) edited by the Urban Institute to correct misreporting of citizenship.

The error appears in the following publications:

State Reports:

Health Policy: Alabama, Colorado, Florida, Massachusetts, Michigan, Minnesota, Mississippi, New Jersey, New York, Texas, Washington

Income Support and Social Services: Alabama, California, Massachusetts, Michigan, Minnesota, Texas, Washington

Highlights:

Health Policy: Alabama, Florida, Massachusetts, Michigan, Minnesota, Mississippi, New Jersey, New York, Oklahoma, Texas, Washington

Income Support and Social Services: Minnesota, Texas



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