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Prologue: Medicaid is a major culprit in rising health care costs. The program’s expenditures increased by 13 percent in 1989, 18 percent in 1990, 27 percent in 1991, and 30 percent in 1992 to reach $120 billion. Medicaid has often crowded out other items in states’ budgets; New York, for example, has decreased its public education spending by 5 percent in the past two years. The Kaiser Commission on the Future of Medicaid has attributed Medicaid’s rising costs to increased enrollment in the program (the costliest portion being additional elderly and disabled beneficiaries), increased medical costs in general, and a higher outlay per beneficiary, reflecting both a sicker population and efforts to keep up with private payers’ reimbursement rates. Any health care reform proposal will clearly need to address this cost crisis. Yet author James Fossett argues in this paper that “the largest and most rapidly growing parts of Medicaid are outside the jurisdiction of most currently discussed health reform plans.” Using New York as a case study, he shows that the practice of shifting various state programs onto Medicaid to receive matching federal dollars has resulted in a category of “Medicaided” programs beyond the scope of health care reform. Also, approximately 30 percent of Medicaid spending goes to elderly beneficiaries’ long-term care, which is not included in most health care reform proposals. Yet these are costly aspects of the Medicaid program. “The forces that have caused rapid Medicaid growth in New York and similar states are not the same as those that have produced rapid growth in total health expenditures,” warns Fossett. Medicaid requires a separate reform effort. Fossett is an associate professor at the State University of New York’s Graduate School of Public Affairs and School of Public Health in Albany. He holds a doctorate in political science from the University of Michigan.
Abstract: New York State has the largest, most expensive state Medicaid program in the country. Thus, an examination of its Medicaid program can offer valuable lessons for other states that are considering reform of their health systems, as well as for reform at a nationwide level. Much recent growth in Medicaid in New York stems from shifting state-funded human service programs onto Medicaid and shifting the state's share of Medicaid onto nontraditional revenue sources. In contrast to other states, in which Medicaid is an unpopular program, New York's Medicaid provider constituency is large and diverse, and its clientele is relatively white and middle class. These two constituencies have made Medicaid harder to cut than in other states, in which Medicaid recipients lack political and economic clout. Current versions of national health reform will have little effect on Medicaid spending in New York, since they address neither spending on the elderly nor the “Medicaiding” of programs and revenue sources.

Dramatic increases in Medicaid spending form an important element of the case for national health reform. Medicaid spending increased from $41.8 billion in 1985 to over $100 billion in 1991, and Congressional Budget Office (CBO) projections envision expenditures of over $300 billion in 2000. These figures have engendered considerable concern in both Washington and state capitals because of their adverse consequences for federal deficit reduction and the “crowding out” of spending on other state government functions. There has, however, been little consensus on the causes of Medicaid growth and little attention to the ability of current health reform models—managed competition and global expenditure regulation—to address these causes. Since the magnitude and causes of Medicaid growth differ widely in different states and since states are major actors in most versions of national health reform, these are important questions in the context of particular states’ Medicaid activity.

This paper examines these questions in New York State, which has the largest, most expensive Medicaid program in the country. It documents recent trends in Medicaid spending in New York; identifies the major structural and political reasons for the size and growth of New York’s Medicaid program; and suggests some of the likely consequences of national health reform for Medicaid spending in New York and other states where Medicaid has grown for similar reasons.

My conclusions are pessimistic. Much recent growth in Medicaid in New York stems from shifting state-funded human service programs onto Medicaid and shifting the state’s share of Medicaid onto nontraditional revenue sources. Rather than representing a drain on state resources, much of Medicaid’s recent growth has made New York’s financial situation better, not worse. National health reform is thus unlikely to reduce the cost of Medicaid for either New York or the federal government, since the largest and most rapidly growing parts of Medicaid are outside the jurisdiction of most currently discussed health reform plans. To the contrary, Medicaid expenditures are likely to increase, at least in the short run, as “traditional”
Aid to Families with Dependent Children (AFDC) clients are integrated into managed competition. Achieving appreciable reductions in Medicaid growth in New York and similar states will require a different model of health reform than those currently under discussion.

Medicaid Spending Trends In New York

By any standard, New York’s Medicaid program is and has been the largest in the country. New York spends about one in every five Medicaid dollars spent nationally and spends roughly twice as much per resident, per Medicaid recipient, and per $1,000 of personal income as the average state. Service expenditures in New York almost doubled over the period 1987-1991, increasing from $9.2 billion to $17.4 billion, a compound growth rate of 17.3 percent (Exhibit 1). Nonfederal expenditures, which are split between state and county governments, increased from $4.7 billion in 1987 to $8.6 billion in 1991. More recent budget data indicate that total Medicaid appropriations in New York for 1993 are more than $20 billion—more than one-third of the state’s all-funds budget of approximately $54 billion.

Service expenditures in New York increased at approximately the national rate, but the number of recipients has increased less in New York than elsewhere (Exhibit 2). As a result, expenditures per recipient in New York have grown faster than the national rate. Medicaid expenditures in New York have grown primarily not because there are more recipients, but because recipients are receiving more costly, more intensive, or higher-quality services than they once did, or else because Medicaid is paying more for the same package of services.

Medicaid growth in many states can be traced to recent events, such as the recession, mandated eligibility expansions, and court decisions governing hospital and nursing home rates. By contrast, Medicaid growth in New York is much more the result of policies and practices that have been in place for some time. These factors can best be elucidated by describing those program features that historically have distinguished New York’s

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</thead>
<tbody>
<tr>
<td>Total service expenditures</td>
<td>$9,212</td>
<td>$9,745</td>
<td>$10,792</td>
<td>$12,185</td>
<td>$17,427</td>
<td>$8,215</td>
</tr>
<tr>
<td>Nonfederal service expenditures</td>
<td>4,712</td>
<td>4,877</td>
<td>5,440</td>
<td>6,095</td>
<td>8,689</td>
<td>3,977</td>
</tr>
</tbody>
</table>

Source: Health Care Financing Administration, Medicaid Financial Management Report (HCFA 64).
Medicaid program from those of other states, then examining in more detail the political, structural, and management features that have grown up around the program.

Programmatic Features

Most of the features that have made New York’s Medicaid program historically expensive have been described elsewhere and need only restate-
ment. New York has long had liberal AFDC eligibility standards and medically needy criteria, so that New York’s Medicaid clientele has been one-third larger relative to the state’s population than the national average, with a larger share of “expensive” medically needy patients. Even controlling for differences in recipients, however, New York has nearly the highest Medicaid spending rate per recipient in the country. Medicaid recipients in New York receive more intensive and expensive services than those in other states receive.6

This higher spending level is the result of several factors. One is the state’s extensive Medicaid service package. The state provides almost all optional services available under Medicaid and does so on a much larger scale than other states.7 A second major factor is reimbursement. New York pays among the highest rates in the country for care in nursing homes, developmental centers, hospitals, and other institutional settings.8 The cost of providing health care is higher in New York than in most other states.9 This makes the provision of a given package of Medicaid services more expensive than it would be elsewhere.

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**Exhibit 2**

Medicaid Service Expenditures Per Recipient In Selected States, Federal Fiscal Years 1987-1991

<table>
<thead>
<tr>
<th></th>
<th>Percent change in service expenditures</th>
<th>Percent change in number of recipients</th>
<th>Percent change in expenditures per recipient</th>
</tr>
</thead>
<tbody>
<tr>
<td>U.S. total</td>
<td>89.99%</td>
<td>22.37%</td>
<td>55.26%</td>
</tr>
<tr>
<td>New York</td>
<td>89.19</td>
<td>6.64</td>
<td>77.40</td>
</tr>
<tr>
<td>Massachusetts</td>
<td>142.67</td>
<td>20.24</td>
<td>101.82</td>
</tr>
<tr>
<td>Michigan</td>
<td>74.45</td>
<td>-1.11</td>
<td>76.41</td>
</tr>
<tr>
<td>Illinois</td>
<td>37.01</td>
<td>9.79</td>
<td>24.79</td>
</tr>
<tr>
<td>Ohio</td>
<td>31.39</td>
<td>14.80</td>
<td>14.45</td>
</tr>
<tr>
<td>Maryland</td>
<td>78.40</td>
<td>16.33</td>
<td>53.35</td>
</tr>
<tr>
<td>New Jersey</td>
<td>100.23</td>
<td>12.49</td>
<td>77.99</td>
</tr>
<tr>
<td>Pennsylvania</td>
<td>86.50</td>
<td>15.95</td>
<td>60.85</td>
</tr>
<tr>
<td>California</td>
<td>64.27</td>
<td>8.94</td>
<td>50.79</td>
</tr>
</tbody>
</table>

Sources: Health Care Financing Administration. HCFA 2082 data tables and Medicaid Financial Management Report (HCFA 64).
More impressionistic evidence suggests that the state supports higher service levels and relies more heavily on expensive institutional settings than other states do. Recent reports from the state comptroller’s office, for example, indicate that the state has appreciably higher rates of institutionalization in psychiatric or developmental centers and larger populations in several other types of residential facilities for the mentally ill or developmentally disabled than other states have. New York Medicaid clients with developmental or psychiatric difficulties appear to be more likely to receive treatment, and to receive it in expensive institutional settings, than comparable patients elsewhere.

Finally, New York has been more aggressive than other states in using Medicaid as “revenue sharing” to support ongoing state activities. Although such cost shifting has become common in the past several years, few other states appear to have made such efforts historically.

**Ideology And Structure**

These generous and expensive program features have been associated with a distinctive set of policy goals among New York policymakers—governors, department commissioners and senior civil servants, budget directors, and legislative leaders—that have remained consistent over the past twenty-five years. Two “standing decisions” about the use of outside funds to support state activities and the level of service that should be available to low-income groups have led to structural and political conditions in which decisions about Medicaid spending are closely intertwined with larger decisions about state finances and health policy. Together with the unusually strong and diverse constituency of providers and clients who are dependent on Medicaid, these policies and practices have taken most of Medicaid “off the table” as a potential source of budget savings and have made it inordinately difficult to cut the rest.

**Maximize use of outside revenue.** New York has long attempted to maximize outside support, particularly federal grant revenue, for all of its activities and to shift programs among revenue sources rather than to cut them. This practice has been pursued aggressively in the use of Medicaid. As growth in state general fund revenue declined over the late 1980s and 1990s the use of Medicaid to support ongoing state activities has intensified and broadened to include a wide range of human service programs, particularly in the Office of Mental Health (OMH), the Office of Mental Retardation and Developmental Disabilities (OMRDD), and the Division of Alcoholism and Alcohol Abuse (DAAA), collectively known in local parlance as the “mental hygiene” agencies.

As a result of these efforts, the amount of Medicaid used to support...
departmental activities has increased sharply. Exhibit 3 displays the amount of federal Medicaid revenue received by the portion of the three mental hygiene agencies’ budgets that finances state-operated programs.\textsuperscript{11} Net Medicaid revenue for these three departments increased by almost 80 percent between 1987 and 1993, from $785 million to approximately $1.4 billion. By contrast, general fund appropriations for state operations in these three departments declined by one-third over the period, indicating appreciable shifting of program support from general funds to Medicaid.\textsuperscript{12}

These figures underestimate the total volume of program shifting. Both the OMH and the OMRDD have been implementing large-scale, long-term realignments, which rely heavily on Medicaid financing, to shift clients from state developmental and psychiatric centers into cheaper and less structured residential settings and home and community-based programs. The precise amount of such shifting cannot be determined from budget documents.\textsuperscript{13} However, a rough estimate of the overall impact of recent Medicaid growth on state finances can be provided by examining

\begin{table}[h]
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\begin{tabular}{|l|c|c|c|c|c|c|c|}
\hline
\hline
\hline
General fund & $1,168.7 & $1,313.3 & $1,242.1 & $1,237.7 & $851.5 & $780.3 & -$388.4 \\
Percent change from previous year & - & 12.37\% & -5.42\% & -0.35\% & -31.20\% & -8.36\% & -33.23\%

Medicaid funds & $785.0 & $873.8 & $978.3 & $1,181.6 & $1,369.8 & $1,385.5 & $600.5 \\
Percent change from previous year & - & 11.31\% & 11.96\% & 20.78\% & 15.93\% & 1.15\% & 76.50\%

Other funds & $307.5 & $195.6 & $239.6 & $154.5 & $185.8 & $83.2 & -$224.3 \\
Percent change from previous year & - & -36.39\% & 22.49\% & -35.52\% & 20.26\% & -55.22\% & -72.94\%

Total funds & $2,261.2 & $2,382.7 & $2,460.0 & $2,573.8 & $2,407.1 & $2,249.0 & -$12.2 \\
Percent change from previous year & - & 5.37\% & 3.24\% & 4.63\% & 4.48\% & 6.57\% & -0.54\%

Share of appropriations & & & & & & & \\
General fund & 51.68\% & 55.12\% & 50.49\% & 48.09\% & 35.37\% & 34.70\% & -16.99\%

Medicaid funds & 34.72\% & 36.67\% & 39.77\% & 45.91\% & 56.91\% & 61.61\% & 26.89\%

Other funds & 13.60\% & 8.21\% & 9.74\% & 6.00\% & 7.72\% & 3.70\% & -9.90\%

\hline
\end{tabular}
\caption{New York Medicaid Appropriations For State Operations, Mental Hygiene Agencies, Millions Of Dollars, State Fiscal Years 1988-1993}
\end{table}

\textbf{Source:} Annual New York State budget.

\textbf{Note:} Includes Office of Mental Health, Office of Mental Retardation and Developmental Disabilities, and Division of Alcoholism and Alcohol Abuse.
trends in the combined appropriations for the departments that account for the overwhelming bulk of Medicaid spending. Exhibit 4 displays total combined appropriations for 1987-1993 for the mental hygiene agencies and the Medicaid portions of the Department of Social Services (DSS), the state’s Medicaid agency.\textsuperscript{14}

These figures suggest that the “true” total cost of Medicaid to the state has grown only modestly in recent years. Total general fund appropriations for this complex of programs have grown by only 27 percent during this six-year period, compared with a 106 percent increase in other funds, including Medicaid, and a 67 percent increase in total appropriations. General funds supported less than 38 percent of total spending in these agencies in 1993, compared with almost half in 1988. The figures in Exhibits 3 and 4 are not conclusive but are consistent with the notion that increasing amounts of general fund appropriations to these agencies are being used as state matching funds to attract federal support.

The state also has increased Medicaid reimbursement by almost $800 million per year by using revenues from preexisting provider taxes as state match and relabeling funds in the bad debt and charity care pools attached to the state’s hospital rate-setting machinery as payments to so-called disproportionate-share hospitals. Funds in the bad debt and charity care pools, which are collected from assessments on insurance payers, previously had been used to pay hospitals for uncompensated care. This increased use of non-general fund revenue for state match enables the state to continue or expand expenditures at no additional budget cost.

Maximizing the use of Medicaid to support agency operations and shifting the source of state matching funds tend to take the departments and programs these funds support “off the table” in budget negotiations. Cutting

\begin{tabular}{|l|c|c|c|c|c|c|c|}
\hline
\hline
General fund & $5,072.3 & $6,123.6 & $5,922.8 & $6,405.1 & $6,533.2 & $6,456.0 & $1,383.7 \\
Other funds & 5,288.7 & 5,713.6 & 6,434.7 & 7,153.0 & 9,361.0 & 10,888.4 & 5,599.7 \\
Total funds & 10,361.0 & 11,837.3 & 12,357.5 & 13,558.0 & 15,894.3 & 17,344.4 & 6,983.4 \\
\hline
\hline
Share of appropriations & & & & & & & \\
General fund & 48.96% & 51.73% & 47.93% & 47.24% & 41.10% & 37.22% & -11.73% \\
Other funds & 51.04% & 48.27% & 52.07% & 52.76% & 58.90% & 62.78% & 11.73% \\
\hline
\end{tabular}

Source: Annual New York State budget.
Note: Includes Office of Mental Health, Office of Mental Retardation and Developmental Disabilities, Division of Alcoholism and Alcohol Abuse, and Medicaid portions of the Department of Social Services.
\* $270 million excluded from general fund appropriation in 1992-1993 resulting from provider donations.
a general fund dollar that is used for state Medicaid match loses the state between two and three dollars in federal and local match, so that the state loses between three and four dollars in total revenue to realize a dollar of general fund savings. This makes Medicaid hard to cut relative to programs whose general fund support does not attract matching funds, since the state only loses a dollar for each dollar of general fund savings. This larger “bang for the buck” creates a strong incentive for the state to view Medicaid as a revenue source rather than an expenditure and to maximize the volume of expenditures that are shifted from state to federal funds. Budget officials and legislators searching for general fund revenue to support initiatives in other areas have no incentive to disturb these arrangements.

Maximize access to services. A second state policy has removed an even larger portion of Medicaid from short-run budget control. The state has had a strong, longstanding commitment to equal access to care for low-income groups, which has led it to set Medicaid’s hospital and nursing home rates through the same machinery that governs the rates paid by all insurance carriers. Rather than having a separate set of Medicaid rates responsive to the state’s short-run budget conditions, Medicaid pays approximately the same rates for hospital and nursing home care as other insurance carriers except Medicare. The logic of this approach has been stated by a former state health commissioner: “In contrast with most other states, New York has attempted to control the rate of growth of total hospital costs—not just Medicaid costs—with Medicaid benefitting through saving its ‘fair share’ of cost limitations. The principle of equal access/single class of care is important. . . . We would be opposed to . . . approaches that would result in the development or channeling of Medicaid beneficiaries to ‘second class’ services.”

Setting Medicaid hospital and nursing home rates through the health regulatory process, which is managed by the state Department of Health rather than the Department of Social Services, has the practical effect of removing payments to these providers—which account for over half of the state’s Medicaid expenditures—from budgetary control. Realizing general fund savings from reduced Medicaid hospital or nursing home rates in the context of the rate setting process would require that rates paid by all payers be reduced. Such an action would cause the state to lose matching revenue from Medicaid; hospitals and nursing homes would lose revenue from other payers.

A more complex version of the same process is likely at work in rate setting for community services to the mentally ill and developmentally disabled. This process is heavily, if not decisively, influenced by officials at the OMH, the OMRDD, and the Division of the Budget. Department officials have incentives to set rates liberally to ensure adequate placements.
for patients to be transferred from state facilities. The state also has been facing considerable investment of its own funds to keep institutions eligible to receive Medicaid funds and stands to realize considerable savings from treating adult psychiatric patients in community settings. These factors may lead the Division of the Budget to view liberal rates for community providers as acceptable costs. The effect, again, has been to subordinate Medicaid cost control to the maintenance of access, as defined by department and budgetary officials with professional and financial incentives to define access liberally.

Long-standing policies and practices to maximize outside revenue and maintain adequate access to services, in brief, have reduced the state's ability and incentives to control Medicaid growth. Department officials, the Division of the Budget, and legislative finance committees have strong incentives to maximize Medicaid's use as a source of revenue to support ongoing programs, and health department regulation of Medicaid hospital and nursing home rates limits budgetary control of these expenditures.

**Political Constituency: A Medicaid-Industrial Complex?**

A third factor that limits the state's ability to regulate Medicaid spending is the distinctive provider and clientele constituency that has grown up around the program. New York's Medicaid constituency is large, geographically and politically diverse, and integrated by both income and race. This unusually broad base of support makes New York's Medicaid program more difficult to cut than Medicaid programs elsewhere.

Medicaid in most states is an unpopular program with a narrow base of political and constituency support. Even in other large industrialized states, Medicaid eligibility is relatively restricted, creating a frequently inaccurate public image that the program serves a poor, minority, inner-city clientele. Because Medicaid reimbursement is generally low relative to prevailing charges, providers have financial incentives to discriminate in favor of non-Medicaid patients. Medicaid patients thus tend to be concentrated among a small number of providers who are primarily located in inner cities and have little professional prestige. Provider organizations such as medical societies and hospital and nursing home associations are lukewarm supporters of Medicaid at best, because most of their members have few Medicaid clients and no strong financial stake in program decisions. The program's major provider support thus comes from public hospitals, community health centers, and other providers, which primarily serve a poor, minority, inner-city clientele. These providers generally lack prestige, numbers, and other political resources and frequently have been unable to attract legislative support from outside of central cities.
By contrast, Medicaid’s provider constituency in New York is large and diverse. Health care is the largest nongovernmental industry in New York, and Medicaid’s expansive eligibility and broad service coverage have created a geographically and politically diverse “Medicaid-industrial complex” dependent on the program for continued employment, salary growth, and revenue. The state’s large investment in a wide range of services from institutional providers and its willingness to pay high rates for services from these providers have created statewide networks—particularly in Republican suburban areas—of agencies in home health, personal care, developmental disability, and mental health that have no other purpose but to provide care to Medicaid patients. The state’s high reimbursement rates for nursing home and hospital care also have given a larger subset of these providers a larger stake in Medicaid decisions than is the case in other states. Finally, the extensive use of Medicaid to support state developmental and psychiatric centers has created strong de facto support for this use of these funds in the rural, upstate Republican communities where many institutions are located. This “economic development” aspect of Medicaid has created a considerable bipartisan constituency in favor of high levels of Medicaid expenditures.

A second constituency of unusual importance in New York Medicaid politics is organized labor. Since the cost of providing health and related care is largely wages and salaries, Medicaid services and rates directly affect the employment prospects of large numbers of public and private employees. Unionized employees at state developmental and psychiatric centers, supported by politicians concerned about the impact of closing large local employers and purchasers, have vigorously resisted closure of these institutions without elaborate guarantees of continued employment. Lower-paid workers at public hospitals, nursing homes, and nonprofit agencies have pressed strongly for wage parity with higher-paid state workers, with settlements passed onto Medicaid in the form of higher reimbursement.

In addition to this provider constituency, Medicaid in New York serves a different clientele than is true in other states. In contrast to states with restrictive eligibility requirements, New York’s Medicaid clientele is relatively large, white, and middle class. Eligibility rules for the elderly and developmentally disabled make it relatively easy for nominally middle-class individuals to become Medicaid eligible. While recent federal legislation has lessened the ability of elderly patients to divest assets to become eligible for Medicaid payment for nursing home care, eligibility for home health and personal care services is easier to arrange, so that clients can “dump their money at nine and be eligible for home care by ten.” In similar fashion, mentally retarded and developmentally disabled individuals become legally “free-standing” individuals whose support from family mem-
bers is not counted as income for purposes of Supplemental Security Income (SSI) and Medicaid eligibility as of their twenty-first birthday. This provision allows individuals from middle- and upper-income families to transfer to Medicaid the frequently large costs of the services they receive.

This large, diversified constituency of providers and clients has made Medicaid harder to cut in New York than in many other states. Medicaid’s major political constituency in most states is composed of a small number of public institutions and other providers, concentrated in large urban areas, whose clientele is primarily poor and minority. This makes Medicaid vulnerable to program cuts stemming from adverse budget circumstances. Because Medicaid in New York draws on a broader and more dispersed constituency, it has proved harder to control.

Implications For Nationwide Reform

This analysis suggests several conclusions about the likely consequences of national health reform for Medicaid in New York and in states with similar programs and histories. While almost certainly an outlier, New York is far from the only state to “Medicaid” programs and revenue sources; thus the effects of national health reform in New York are a useful clue to its effects in other states. ¹⁹

The precise relationship between Medicaid and national health reform has not been well defined, but most proposals appear to envision Medicaid retaining financial responsibility for long-term care for elderly and disabled populations and for most “nonmedical” services. Other Medicaid populations, particularly AFDC families, and acute care services will be integrated into the structure of health insurance purchasing cooperatives (HIPCs), with Medicaid charged a community-rated premium for a standard service package determined by the federal government.

The most obvious consequence, or nonconsequence, of national health reform for Medicaid in New York and similar states is that expenditures in either Washington or Albany are unlikely to decline. Health care for the elderly, who are also covered by Medicare, is exempt from most reform schemes, as is nursing home and other long-term care for both elderly and nonelderly patients. There has been little discussion of “Medicaided” human service programs or revenue sources, but reducing cost or revenue shifting seems unlikely to be a central element of national health reform. ²⁰

The most expensive and rapidly growing parts of Medicaid, in short, are largely off the table in most national health reform schemes.

Rather than reducing Medicaid costs, national health reform is likely to produce a sharp increase in Medicaid spending for AFDC families, historically the least expensive Medicaid population. New York’s average Medic-
aid expenditures per dependent child in 1990, for example, were slightly over $1,100, less than 10 percent of comparable expenditures for elderly recipients and only about one-third the widely quoted estimates of the premium cost for the standard service package. Medicaid spending for dependent children, who account for over 40 percent of New York Medicaid recipients, would approximately triple under most versions of national health reform. Spending for AFDC adults also would increase by a smaller but nonnegligible amount.

Merging AFDC women and children into HIPC coverage would present operational problems similar to those encountered in New York and elsewhere in attempts to establish Medicaid managed care programs for this population.21 The inner-city institutions that are the primary source of care for this population are likely to prove difficult to integrate into the provider networks that will bid for HIPC contracts because of high costs and management difficulties. In states such as New York, where local public hospital and clinic networks are large and dependent on Medicaid revenue, the local governments that operate these facilities, the unions that represent their employees, and their bureaucratic patrons in state health departments are likely to be concerned about the potential loss of revenue for these institutions stemming from cost containment pressures and competition from private providers and may resist incorporation.22

The major moral that New York’s Medicaid saga offers for national health reform, however, is that the forces that have caused rapid Medicaid growth in New York and similar states are not the same as those that have produced rapid growth in total health expenditures. Implementation of the most commonly discussed health reform models is unlikely to produce major improvement in either state or federal finances as a result of declines in the growth of Medicaid spending. A different version of health reform, targeted explicitly to long-term care, state cost and revenue shifting, and other more focused concerns, would be necessary to achieve these ends.

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NOTES


4. Counties nominally divide the nonfederal share of Medicaid expenditures equally with the state, but there are increasingly large exceptions to this general rule, so that the local share has been declining over time. The most commonly cited local estimate is that the state pays approximately one-third of total Medicaid costs, while counties pay about 17 percent. A number of proposals have been made for the state to assume the entire nonfederal cost of Medicaid. For a useful description, see Citizens Budget Commission, A Plan for State Assumption of Local Income Maintenance and Medicaid Costs (Albany: CBC, May 1992).


7. In 1991, for example, New York accounted for over one-third of all Medicaid home health spending and two-thirds of personal care spending.

8. Somewhat paradoxically, the state pays among the lowest rates in the country relative to prevailing charges for care from private physicians and other office-based providers. The state also pays much higher rates for physician services provided by community health centers, hospital outpatient clinics, and other institutional providers than it does for care from office-based physicians.


11. Unlike other states, New York enacts agency operating budgets in two separate appropriations bills. The State Operations appropriation, which is reported here, covers only those activities directly performed by agency employees. Grants and other payments to local governments or nonprofit agencies are financed by a separate Aid to Localities appropriation.

12. These figures underestimate the total volume of these activities, since Medicaid and other outside revenues are “passed through” off-budget public authorities, which retain a portion of these revenues for debt service.

13. Under New York’s complicated appropriations structure, the state share of Medicaid payments to local governments or community organizations for mental health, developmental disability, and alcohol and substance abuse services is generally appropriated to the Aid to Localities portion of the appropriate agency’s budget, while the federal share of these payments is appropriated to the Aid to Localities budget of the Depart-
ment of Social Services (DSS), the state’s Medicaid agency. In neither case are these payments distinguished from other payments.

14. Under New York’s appropriations structure, Medicaid revenue that supports the activities of state agencies is appropriated twice—once as federal revenue in the state operations budget of the DSS, and again, net of the deductions for debt service described in the text, through a “patient income account” listed as “special revenue-other” in the state operations budgets of the departments that spend the revenue. We have eliminated this double counting by netting out the departments’ shares from the DSS appropriation. These figures also exclude the recent use of provider taxes and payments from bad debt and charity care as state matching funds for Medicaid and to support additional payments to disproportionate-share hospitals to isolate the effects of Medicaid growth on the general fund.


