VIII. Healthcare

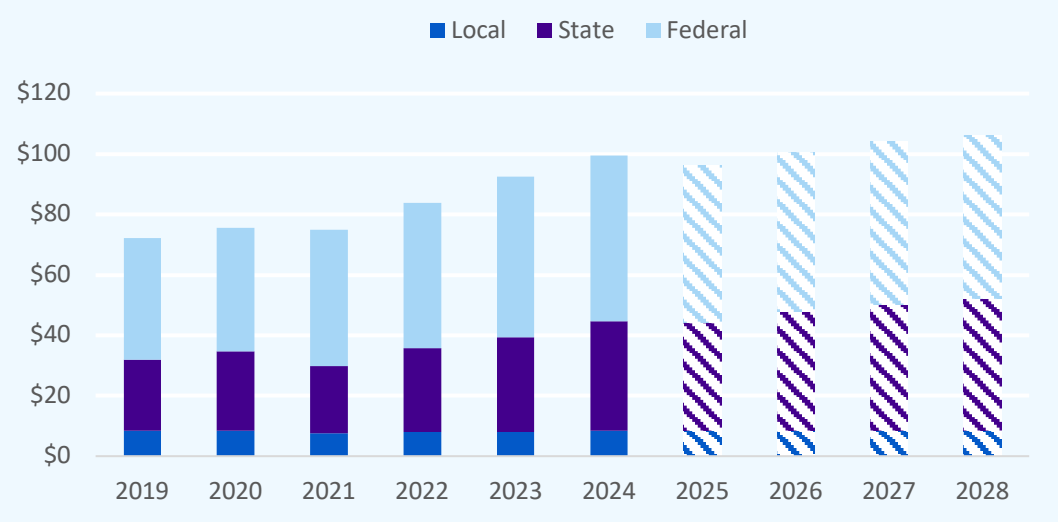
Medicaid Spending

State-Share Medicaid spending to decline 1.9 percent in fiscal year 2025

The executive budget includes meaningful expansions to healthcare access, including continuous coverage for children under the age of six, new initiatives to address medical debt, and a cap on out-of-pocket insulin costs. These initiatives, however, are matched by significant cuts to Medicaid spending, including cuts to home care worker wages, hospital payments and managed care plans, as well as $400 million in unspecified further cuts. The State claims that these Medicaid cuts are necessary given the high rate of spending growth in the program; according to the Executive Budget Financial Plan, the Medicaid budget will grow by 10.9 percent or $3 billion in fiscal year 2025, even with $1.2 billion in proposed spending cuts.

These figures are somewhat misleading. The executive budget financial plan shows that while spending accounted for in the Department of Health (DOH) budget line is increasing, total state-share Medicaid spending – including spending accounted for as mental hygiene, a significant portion of which appears to fund the DOH Medicaid program – is set to decline by $700 million, or 1.9 percent, between fiscal year 2024 and fiscal year 2025. A broader spending measure that includes federal and local shares, in addition to State spending, shows a similar trend: overall Medicaid spending (including state, local and federal funding) is projected to decline by 3.5 percent in fiscal year 2025, from $99.6 billion to $96.1 billion.

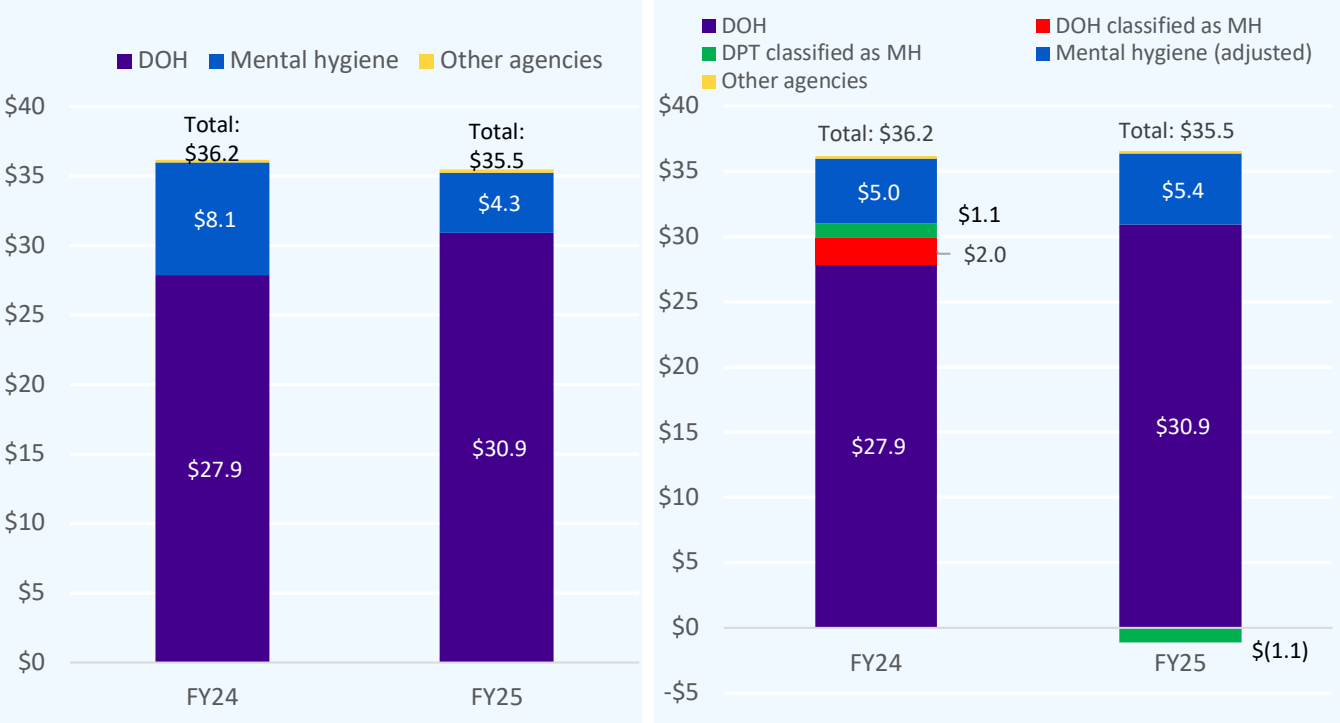
Figure 8.1. Medicaid funding by source, fiscal years 2019 to 2028



Declines in Medicaid spending are driven by several factors: (i) enrollment declines, (ii) the governor's proposed cuts, and (iii) the State's method of accounting for a one-time loan to financially distressed hospitals. The governor's budget address appears to show rapid spending growth due to the State's takeover of $1.7 billion that was previously paid for by federal pandemic funding. This amounts to an increase in State spending but not because of a parallel increase in services. Another reason for the

reported growth appears to be due to some creative accounting: the budget misclassifies over $2 billion in fiscal year 2024 DOH Medicaid spending as mental hygiene spending, likely in order to keep the State (technically) under the Medicaid Global Cap for fiscal year 2024. This maneuver has the effect of artificially depressing fiscal year 2024 DOH Medicaid spending, resulting in an artificially high reported rate of growth into 2025.

Figure 8.2. State-share Medicaid spending by classification, fiscal year 2024 to 2025



Factors that affect Medicaid spending

The opacity of the executive budget's Medicaid accounting makes it difficult to determine exactly how fast state-share Medicaid costs are increasing and to what degree this growth is sustainable. That said, it is clear that increased utilization and demographic trends will continue to cause program growth.

- **Enrollment decline:** Medicaid enrollment has declined substantially, to 7.6 million, from its pandemic-era peak of 8 million in June 2023. Prior to the pandemic, 6.1 million New Yorkers were enrolled in Medicaid. During the pandemic Public Health Emergency, many New Yorkers became eligible for Medicaid and the federal government prevented states from disenrolling Medicaid recipients, leading to a sharp increase in Medicaid enrollment. This federal requirement ended in mid-2023, and the State has begun to disenroll participants. The State now expects enrollment to stabilize at around 6.8 million people — somewhat above previous projections of 6.6 million — costing the state an extra $402 million in fiscal year 2025. Enrollment estimates for Child Health Plus and the Essential Plan were also revised upward.

- **Managed Long-Term Care Growth:** The state's Managed Long-Term Care (MLTC) program, which provides home care to older adults and disabled individuals through private insurance companies, represents a small share of total Medicaid enrollment but a much larger share of costs. Just 335,000 individuals were enrolled in New York's MLTC programs in 2023, less than 5 percent of total enrollment, but those programs accounted for 27 percent of total state-share Medicaid costs. MLTC enrollment and usage continue to climb as New York's population ages. MLTC enrollment rose by 11 percent between December 2022 and December 2023. Home care advocates have recently criticized these MLTC programs as wasteful, arguing that they waste billions of dollars in profits and high administrative costs while providing little of value to beneficiaries. The state has not released data on projected enrollment in Managed Long-Term Care, but they are likely to be a key driver of growth in future years given the state's aging population.

- **Financially Distressed Hospitals:** While many of New York's hospitals have recovered from the pandemic and operate at a profit, a growing number — particularly those that serve low-income Medicaid or uninsured populations — are operating at a loss. The Executive Budget briefing acknowledges this, pointing out that nearly 30 percent of New York's hospitals are financially distressed, but does not provide the financial resources to support these hospitals. In fact, the Executive Budget Briefing contains a graph showing that the sector will face nearly $1.5 billion in unmet need for nearly 30 hospitals around the state under the Governor's proposal. The state will face difficult choices about how — or whether — to keep these hospitals open.

- **Directed Payment Template (DPT) Recoupment:** The State reports a $1.1 billion expense in fiscal year 2024 and a corresponding $1.1 billion credit in fiscal year 2025 related to a previously undisclosed loan that the State provided to hospitals in fiscal year 2023. The Directed Payment Template program is a Medicaid program jointly funded by the State and the federal government to provide support to financially distressed hospitals. After federal approval of the program was delayed in 2023, the State loaned hospitals the entire cost of the program — $1.7 billion — agreeing that hospitals would pay back the $1.1 billion federal share when federal approvals came through. Although hospitals have received the federal funding, they have not reimbursed the State, for reasons that are unclear.

Executive Budget Proposals

The executive budget proposes $1.2 billion in cuts to Medicaid spending in fiscal year 2025.

Cuts to home care wages

The State offers home care to Medicaid beneficiaries through two programs: the agency model, in which a home care agency employs direct care workers who care for Medicaid beneficiaries, and the Consumer Directed Personal Assistance Program (CDPAP), in which Medicaid beneficiaries direct their own care, and caregivers are paid through a fiscal intermediary. CDPAP provides benefits to hundreds of thousands of Medicaid recipients and employs hundreds of thousands of aides, including many family caregivers.

Both programs have received wage increases in recent years. However, the executive budget proposes to reverse these wage gains for downstate CDPAP (but not agency) workers, reducing their wages by $2.54, or 12 percent. This cut is projected to save the state $200 million in fiscal year 2024 and $400 million annually in later years.

Cuts to mainstream Medicaid and long-term care

In addition to a number of specific cuts, the Executive Budget proposes $400 million in unspecified cuts. It is unclear what these cuts might be or what process will be used to arrive at them; the financial plan states only that "[t]he State will work with industry leaders and stakeholders in the coming months to develop actions that will provide recurring savings."

Cuts to hospital and nursing home funding

The State would reduce the capital component of Medicaid rates for both hospitals and nursing homes, reduce the Vital Access Provider Assurance Program (VAPAP) for financially distressed hospitals by $75 million, and appears to cut State support for VAPAP funding for hospitals by $275 million. These moves come as healthcare unions and hospital industry groups call for a major increase to provider Medicaid rates, which they argue fail to cover the cost of care.[29] The Governor appeared to push back against that demand in her executive budget presentation, arguing that the administration had already provided rate increases last year. However, providers argue that these rate increases were counterbalanced by cuts in other areas.

Cuts and reforms to managed care

The vast majority of New York Medicaid is operated by private insurance companies under managed care. These companies are paid a flat rate per member per month by the State, and are expected to fund some or all of a Medicaid beneficiary's healthcare costs out of this payment. Critics have argued that many of these companies, particularly those in the Managed Long-Term Care (MLTC) program, are wasteful, and are pushing to completely eliminate the role of these insurance companies in the State's long-term care program. The governor's budget rejects such wholesale reform, but it does impose a number of cuts on managed care, including:

- Eliminating Quality Pool Payments, intended to incentivize better performance, for both mainstream and long-term managed care plans, saving $112 million.

- Reversing a 1 percent across-the-board rate increase that MLTC plans received last budget, saving $204 million.

- Competitive procurement of MLTC plans, which would not achieve savings in fiscal year 2024 but is projected to save $300 million annually by fiscal year 2027. (Currently, the state does not select plans through procurement, and any qualifying plan is allowed to participate in the program, which has led to an excessive number of plans together with fragmentation and inefficiency.)

- Liquidated damages for contract violations, which would make it easier for the state to impose fines on managed care organizations that violate the terms of their contract, estimated to save $5 million per year beginning in fiscal year 2026.

Lack of support for safety net hospitals

The governor's budget reduces overall operating support for safety net hospitals. For some downstate hospitals, this lack of support will be partially compensated through new federal resources available in the state's 1115 waiver, but the future of safety-net hospitals statewide remains in doubt. The budget reallocates some $500 million in capital funding to fund a "Safety Net Transformation Program," but the goals of this program are unclear and may include service reductions; indeed, it appears that some of this funding will support a "transformation" of SUNY Downstate Hospital that advocates and labor have described as a closure.[30]

Savings on Medicaid pharmacy benefits

The budget proposes several reforms to Medicaid drug procurement, projected to collectively save the state $87 million by fiscal year 2026.

Increased Audit Target

The State hopes to save $100 million per year beginning in fiscal year 2025 by more effectively identifying and recouping inappropriate Medicaid payments. The budget does not detail how this will be achieved.

Expanded Coverage, Access, and Affordability

While the Executive Budget proposes deep cuts to the Medicaid program, the budget includes several initiatives which, while less fiscally significant, would expand healthcare access. These include:

- **Continuous Eligibility for Kids in Medicaid and CHIP:** In Medicaid, "continuous eligibility" means that once individuals demonstrate initial eligibility, they will not be disenrolled even if they fail to demonstrate eligibility in subsequent years. Continuous eligibility for specific populations can significantly expand insurance coverage. In this budget, the Governor proposes to offer continuous eligibility to children under 6, which would cost just $30 million a year but would significantly improve health coverage for this population.

- **Expanded Premium Subsidies for the Exchange Population:** Due to a recent expansion of the Essential Plan, the State will receive more flexible funding from the federal government. The Executive Budget proposes to use some of this funding to subsidize premiums for individuals making up to 350 percent of the federal poverty line who purchase insurance on the Affordable Care Act exchange. The budget does not detail how extensive these subsidies will be or what they will cost.

- **Further Measures to Combat Medical Debt:** Medical debt is a rising concern for New Yorkers, and the sharply declining quality of employer-sponsored insurance means that even

individuals with insurance are exposed to debt. The first line of defense against medical debt is hospital "charity care" provisions, which require hospitals to provide care below cost for patients who need it. The executive budget includes a number of regulations aimed at requiring hospitals to better protect patients from medical debt, including expanding charity care protections to families up to 400 percent of the federal poverty line, forbidding hospitals from initiating legal action to collect debt from those earning less than this, and including underinsured (as well as uninsured) patients in charity care coverage.

- **Limits on Out-of-Pocket Insulin Costs:** The Governor's budget proposes to require some employer-sponsored insurance plans to cover the full cost of insulin. This proposal would not cap the price of insulin but would protect patients from this price by requiring their insurers to pay it.

Other Healthcare Initiatives

Federal funding for social determinants of health (1115 waiver)

In early January, the state received approval of its new 1115 waiver from the federal government. This approval makes federal funding available for a significant investment in health equity. The State plans to spend nearly $3.8 billion over four years to build "Social Care Networks" which will allow Medicaid funds to pay for "social determinants of health" such as housing and food for Medicaid beneficiaries.

Workforce investment

The 1115 waiver also makes available nearly $700 million in largely federal Medicaid funds for training and loan forgiveness for healthcare workers. In addition, the budget proposes a number of "scope of practice" reforms, typically to allow less highly credentialed healthcare workers to perform tasks previously performed by more highly credentialed workers.

Risks and Missed Opportunities

- **The DPT Loan:** As discussed above, the executive budget assumes that the State will recoup loans of over $1 billion provided to financially distressed hospitals in 2023. These loans were due to be repaid last year, and the fact that they weren't — combined with the precarious state of many of New York's safety net hospitals — strongly suggests that the hospitals are not in a financial position to repay these loans. If the loans are not repaid in FY25, the State's Medicaid budget will need to fill a $1 billion hole.

- **Implausible Medicaid savings:** The budget depends on the Governor finding another $400 million in unspecified Medicaid cuts. It is unlikely that these cuts will be achievable.

- **Unclear and implausible enrollment projections:** The executive budget financial plan includes only limited information on projected Medicaid enrollment. Enrollment is projected to stabilize at 6,766,673 individuals in fiscal year 2025 and remain virtually flat at that level: the

fiscal year 2028 figure is just 0.03 percent lower. These estimates seem quite implausible, given that an aging population will increase long-term care enrollment, and they fail to provide any insight on how the State is incorporating this aging population into its models. Indeed, it appears possible that fiscal projections do not take growing MLTC enrollment into account at all; if so, real costs will likely be sharply higher by 2028 than the budget's projections.

FPI Recommendations

Eliminate Managed Long-Term Care

The Governor has correctly argued that the growth of New York's spending on Medicaid long-term care is unsustainable in the long term. However, the budget's proposal to address long-term spending growth through a roughly 12 percent cut to the wages of the largest group of home care workers is deeply unwise. New Yorkers who need home care already struggle to find home care workers at current wages; the steep cuts proposed in the executive budget would drive the system further into crisis and force some home care recipients into nursing homes, which are far more expensive for the State.[31] A far better path to controlling spending would be to reform the wasteful Managed Long Term Care (MLTC) program, which fundamentally distorts New York's spending on long-term care.

New York's MLTC program was implemented at the behest of the 2011 Medicaid Redesign Team initiative; its goal was to control the rising costs of providing long-term care for New York's aging population. In this regard, the program has been a failure: the State's long-term care costs have continued to rise dramatically, driven not only by a rise in enrollment and utilization, but by the rent-seeking behavior of private MLTC managed care organizations (MCOs). A 2022 audit by the State Comptroller estimated that New York had paid MCOs over $700 million to cover individuals who were not eligible for the program, and another $2.8 billion for individuals who used little or no long-term care.[32] Labor and advocates have recently argued that the State wastes as much as $2.5 billion annually on profit and administrative expenses for MCOs. The Department of Health has proven consistently incapable of policing MCO behavior, and MCOs' drive to expand generates an inherently inflationary dynamic in the system.

The executive budget reflects some awareness of these problems: The Governor proposes replacing the State's current "any willing provider" system in which any qualifying health plan can offer MLTC with a competitive procurement, and estimates that this alone — simply picking better, more efficient MCOs — would save $300 million State share ($600 million total) when fully implemented. However, adjustments around the edges of the system are inadequate to address the scale of the problem. A wholesale reform along the lines proposed in the Home Care Savings and Reinvestment Act, which would replace MCOs with a more efficient and streamlined care coordination system, would save far more money than the Governor's proposed adjustments and wage cuts, without sacrificing workers' wages or participants' safety and autonomy.

Expanding Coverage Using 1332 Waiver Funds

A major absence in the Executive Budget is any discussion of healthcare access for undocumented immigrants, as called for by the Coverage4All campaign. Given New York's history of coverage expansions, undocumented immigrants are the last major group of New Yorkers who lack access to health insurance. An analysis by the Community Service Society has credibly suggested that New York

could expand the Essential Plan to cover 150,000 undocumented immigrants at no cost to the state, using federal funding alone — yet the Executive Budget makes no mention of this proposal.[33]

The opportunity to cover undocumented New Yorkers at no cost to the state comes from the changing structure of the Essential Plan. The Essential Plan offers Medicaid-like coverage to 1.4 million New Yorkers and is administered by the State with subsidy from the federal government. Since the beginning of this program, federal subsidy has exceeded the total cost of the program, creating a surplus of billions of dollars a year. However, historically this surplus has not been available for State use due to federal regulations. That will change this year, as the State has expanded the Essential Plan using a different federal authority, the Section 1332 waiver program, which grants greater flexibility in use of the surplus. As a result, the State will receive surplus funding of over $1 billion a year going forward.

The budget proposes to use some of this funding to subsidize premiums for those who purchase coverage on the ACA exchange. However, significant funding will likely remain in the program — enough to cover 150,000 undocumented New Yorkers. This coverage expansion would be a boon to immigrant communities and to the doctors and hospitals who treat them.

Offering a Long-Term Vision for New York's Safety Net Hospitals

The budget acknowledges that nearly one-third of New York's hospitals are financially distressed, and for the past three years the State has been propping these hospitals up with one-time or temporary money — largely through the VAPAP program. Now the budget proposes reducing that funding stream. The budget also relies on these same hospitals repaying $1.1 billion in loans through the DPT recoupment. These policies will likely result in a chaotic series of hospital closures and mergers that reduce access to services, mitigated by ad hoc bailouts in response to community opposition.

The State's healthcare system should not depend on ad hoc bailouts. If the State believes that some of the state's hospitals need to close or merge, the executive budget should propose a systematic vision for achieving orderly closure. On the other hand, if the State believes that safety net hospitals require more support, the executive budget should propose recurring, stable funding to keep their doors open. One way to do this would be an overall increase to Medicaid rates, as proposed by healthcare unions and hospital industry groups. Another, less expensive, route would be to expand programs targeted specifically at safety-net hospitals, like the Directed Payment Template program and the Global Payment Model 1115 waiver. Either route would be preferable to continued year-to-year discretionary funding, which keeps hospitals on life support without allowing for long-term planning.