MEDICAID INSTITUTE
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Understanding the New State/County Paradigm: The 2005 New York State Medicaid Cap Legislation

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Understanding the New State/County Paradigm: The 2005 New York State Medicaid Cap Legislation

PREPARED FOR THE MEDICAID INSTITUTE
AT UNITED HOSPITAL FUND BY

Deborah Bachrach, Esq.
Mira S. Burghardt, Esq.

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Introduction

Since the inception of the Medicaid program in New York State in 1966, State law has required counties and New York City (collectively referred to hereafter as counties, local districts, or local governments) to underwrite half of the non-federal share of most Medicaid costs for their respective residents. The State, in turn, funded the other half of the non-federal share. (The federal government is responsible for 50% of most Medicaid expenses for the New York State program.) Over time, counties' funding obligations for certain services, most notably long-term care, have been reduced, with the State taking on a larger share of costs for these services.

Initially, the local share had the support of the counties, but by the 1980s counties found that rising Medicaid costs were straining local budgets and putting increasing pressure on local taxes. Implementation of Family Health Plus (a Medicaid expansion program) and Medicaid rate add-ons for worker recruitment and retention in 2001 and 2002 exacerbated these circumstances. By 2003, Medicaid accounted for 73% of local property taxes, and several counties were approaching the State's constitutional limit on these taxes.[1] In addition to raising property taxes, counties responded to rising Medicaid costs by increasing local sales taxes and cutting local jobs and programs.[2]

Counties turned to Albany for relief from their local share obligations, and in 2004 legislation requiring a State takeover of the local share of Family Health Plus was enacted. More comprehensive assistance was provided in 2005, when the State Legislature passed sweeping new legislation (Part C of Chapter 58 of the Laws of 2005) reallocating financial responsibility for the State's Medicaid program.

While the 2005 legislation does not eliminate local funding of Medicaid, it does cap the local share of Medicaid effective January 2006. The cap is based on each county's calendar year 2005 Medicaid expenditures, increased annually thereafter by a statutory trend factor: 3.5% in 2006, 3.25% in 2007, and 3% every year thereafter. The trend factor is not compounded. In 2008 and beyond, counties will have the option of contributing a fixed percentage of their local sales taxes rather than paying the cap amount. The percentage is established by a statutory formula that considers the relationship between a county's 2006 sales tax revenue and its 2006 Medicaid cap amount.

Costs above the cap—including counties' costs for administering the Medicaid program—are now the responsibility of the State. In the past, counties paid 25% of the cost of administering the Medicaid program at the local level. As of January 1, 2006, all local administrative costs are the responsibility of the State (shared by the federal government). The Medicaid cap legislation does not, however, alter the county role in administering various aspects of the Medicaid program, including processing applications and renewals. In fact, the legislation requires the State to issue guidelines to ensure that local districts exercise due diligence with respect to operation of the Medicaid program in their locality, and requires local districts to monitor enrollment, utilization, and patterns suggestive of fraud and abuse.

County officials enthusiastically endorsed the Medicaid cap legislation. Although it does not entirely remove Medicaid costs from local budgets, it substantially reduces the growth of local Medicaid costs, assuming the continuation of historical growth patterns. Indeed, the Medicaid cap legislation is projected to save counties $6.4 billion over the next five State

[1] State Comptroller Alan G. Hevesi, Continued Growth in Medicaid Could Drive One-Third Jump in County Property Taxes by 2010, Press Release, January 13, 2005.

[2] Jeff Murray, Residents Rally for Medicaid Limits, *Star-Gazette*, February 18, 2005; Anthony Farmer, Steinhaus Requests Senators' Help with Medicaid, *Poughkeepsie Journal*, April 2, 2004; Patrick Lakamp, Legislators Call for Cap on Medicaid Expenses, *Buffalo News*, October 4, 2002.

fiscal years, with an additional savings of $2.5 billion due to the State takeover of Family Health Plus.[3] The New York State Comptroller reports that local property tax increases already appear to be leveling off.[4] Equally important, the cap has added much needed stability and predictability to counties' budgeting processes.

Of course, savings for the counties means added costs for the State. The State now bears sole financial responsibility for fluctuations in costs due to State or federal changes in Medicaid policy. The State pays the entire non-federal share of any program expansion. The State also receives 100% of the savings that result from program reform or program cuts, except in the limited case of savings generated by a State-approved demonstration project conducted by a county. Counties would also benefit in the unlikely event that a county would have paid less under the old Medicaid cost-sharing formula.

The cap legislation is the single biggest change in Medicaid financing in New York State since the program's inception 40 years ago. Its most immediate impact will be seen in the declining fiscal obligations of the counties, and increasing fiscal obligations of the State. It remains to be seen how the changes in financing will ultimately affect the scope, operation, and oversight of the Medicaid program.

This report describes the Medicaid cap legislation and, where available, the implementing rules and fiscal analyses prepared by State agencies. The authors' understanding of the legislation and its implications was informed by interviews with State and local officials and staff of the New York State Association of Counties, all of whom gave generously of their time.

Underwriting the Costs of the New York State Medicaid Program

The Federal Contribution to New York State Medicaid Costs

Enacted by the federal government in 1965 and implemented in New York State in 1966, the Medicaid program provides health insurance for low-income children and adults and certain categories of disabled individuals and Medicare beneficiaries. Approximately 4.2 million New Yorkers rely on Medicaid (including the Medicaid expansion program Family Health Plus) for access to health care services.[5] Another 1.2 million individuals are eligible but not enrolled in the State's program.[6]

The federal and state governments share fiscal responsibility for Medicaid, with the federal government providing matching funds for state expenditures under a formula established by the federal Social Security Act (SSA). That formula is based on each state's Federal Medical Assistance Percentage (FMAP), which is in turn based on a comparison of a state's per capita income to the national average per capita income. The FMAP ranges from a statutory minimum of 50% to a statutory maximum of 83%.[7] For New York State, the FMAP is the statutory minimum of 50%, meaning that the federal government pays for half of the State program's costs.[8]

Medicaid is an entitlement program and, as such, there is no ceiling on the amount of money the federal government must match, as long as the individuals and services in question

[3] *2006-2007 New York State Executive Budget*, Overview, pp. 68, 70.
[4] County Medicaid Update, January 13, 2006.
[5] Medicaid Institute at United Hospital Fund, *Medicaid in New York: A Primer*, p.3.
[6] Id. at p.5.
[7] SSA § 1905(b); 42 CFR § 433.10(b).
[8] Kaiser Commission on Medicaid and the Uninsured, *State Medicaid Fact Sheet, New York & US*, available at http://www.kff.org/mfs/medicaid.jsp?r1=NY&r2=US (viewed on August 2, 2006). Based on the formula for computing states' FMAP, the federal government requires lower-income states, such as Mississippi and Alabama, to pay for less of their Medicaid costs. Several of these states have FMAPs that exceed 70%, requiring the states to pay for less than 30% of Medicaid costs.

are eligible for coverage. The same is true of the states' share; states are obligated to cover the amounts that are not paid through the federal match. In most states, this responsibility extends only to the state government and is not shared by local governments. New York State, however, has historically taken a different approach.

1966: Local Share Included as Part of Initial Enactment of State Medicaid Program

Since the Medicaid program's inception in 1966, New York State required counties to pay 50% of Medicaid costs not covered by federal payments—i.e., 25% of the total costs of the State program.[9] This "cost-sharing" rule was established with the support of the counties. Indeed, the County Officers Association stated that its Legislative Committee "unanimously supported" the bill.[10]

Prior to the enactment of the Medicaid program, local governments were responsible for a significant portion of State medical assistance costs. When the federal government took on a larger share of those costs with the implementation of Medicaid, local obligations were in turn diminished. Discussing the 1966 implementation of Medicaid, then-Governor Rockefeller observed that local costs would drop from $198 million in 1965 to $144 million in 1966-67, even as the total cost of medical assistance in the State would increase by approximately $80 million in that same period.[11] The Governor noted that "[i]n 1966-67, New York City will save $54 million under this program because it has heretofore provided more medical assistance at its own expense."[12]

Several interviewees have noted that upstate counties initially supported the local share requirement because it was seen as a hedge against New York City disproportionately benefiting from the Medicaid program at the expense of the upstate counties. Today, New York City recipients constitute approximately 65% of total statewide enrollment.[13] If the State were responsible for the entire non-federal share, the City's disproportionately large program would be funded by taxpayers across the State. With the institution of the local share, the City became directly responsible for a significant portion of its own costs. As a result, the local share was a way to ensure that each locality covered Medicaid costs in proportion to its own expenses.

As discussed below, local governments' support for the Medicaid local share would prove short-lived, as they faced the reality of increasing Medicaid costs and a strained tax base.

Repeated Efforts to Repeal or Reduce Local Share

Within 15 years of its initial enactment, counties began calling for reprieve from the costs of the Medicaid program. "Medicaid is the most serious problem—bar none—facing counties in this state," Westchester County Executive Alfred B. DelBello declared in 1981. "If we don't get some relief, the counties will all be bankrupt." [14] Among the proposals developed to provide assistance to counties was a State takeover of counties' financial responsibilities for Medicaid costs. In 1981, for example, then-Governor Carey proposed in his Executive Budget that the State assume the full local share of Medicaid for seven years.[15] Governor Carey "advocated for the takeover by citing the benefits to local property taxpayers, a refrain that would be used repeatedly to support eliminating or reducing county obligations.[16]

[9] L. 1966, ch. 256; see also current New York Social Services Law § 368-a(1)(d).
[10] Letter of Roger Butts to Governor Nelson Rockefeller, April 13, 1966, available in the Governor's Bill Jacket, L. 1966, ch. 256.
[11] Statement of the Governor Before the Joint Legislative Committee on Problems of Public Health and Medicare, Albany, May 24, 1966, available in the Governor's Bill Jacket, L. 1966, ch. 256.
[12] Id.
[13] Medicaid Institute at United Hospital Fund, *Medicaid in New York: A Primer*, p.3.
[14] Tessa Melvin, Rise in Cost of Medicaid Held Threat to Budget, *New York Times*, November 15, 1981.
[15] Robin Herman, Medicaid Takeover at Heart of Carey-Anderson Impasse, *New York Times*, April 23, 1981.
[16] Id.

Similarly, in 1983, Governor Cuomo proposed a partial State assumption of the local share, to be phased in over five years, with the State eventually paying for 90% of non-federal Medicaid costs.[17] For a combination of fiscal and political reasons, none of these efforts ever gained sufficient traction to pass.

Counties were more successful in efforts to chip away at their Medicaid obligations. One significant example occurred in 1983 when the counties' financial responsibility for long-term care was reduced over three years to 20% of the total costs not paid by the federal government.[18] Long-term care costs were targeted because they comprised 46% of Medicaid costs at the time and long-term care was the fastest growing service under the program.[19] The change was estimated to save counties approximately $1.6 billion during the phase-in period alone.[20] In 1994, the local share for long-term care costs was further reduced, to approximately 19% of total costs.[21]

The State already bore full responsibility, under the original State Medicaid statute, for the costs of services to eligible patients in state hospitals for the mentally disabled and to eligible Native Americans and members of their families residing on any Indian reservation in the State.[22] Through legislative changes over the course of several years, the State also assumed full reimbursement responsibility for a range of other specified services or populations, thereby wholly relieving counties of these specific burdens. These other populations included certain long-term mentally disabled beneficiaries who received care from a community-based facility on 45 or more days during a calendar quarter or were discharged from residential care between April 1971 and December 1982, and who required 90 days or more of inpatient treatment (in assistance dubbed "overburden aid"); certain individuals receiving drug abuse treatment; and eligible veterans and their dependents obtaining care at specified facilities.[23]

Thus, some relief was provided to counties over the years, though not the full scope of relief that they sought. Yet even as counties' financial responsibilities for particular services were chipped away, a counter-trend emerged, as the State embarked on a program to "Medicaid" as many wholly State-funded health care programs as the federal government would approve. Medicaiding a program generally relieved the State of 75% of its obligation, transferring 50% to the federal government and 25% to the counties. As a result, counties' local share obligations increased through the Medicaiding of certain programs at the same time that their responsibility for other programs diminished.

Family Health Plus Enactment (HCRA 2000)

Counties' hostility towards the local share receded somewhat in the late 1990s as Medicaid cost growth stabilized. Even though the local share consumed a sizable proportion of county budgets, counties generally found the growth rate manageable and reasonably predictable at 3.25% to 3.5% annually.[24] This would change, however, with the enactment of the Family Health Plus program in 1999 and its implementation in 2001 and 2002.

Family Health Plus, established as part of the Health Care Reform Act of 2000 (HCRA 2000—L.1999, Ch. 1), is a Medicaid expansion program that provides access to coverage to

[17] Josh Barbanel, Cuomo Gives Up Goal on Sharing Medicaid Costs, *New York Times*, May 20, 1983.
[18] L. 1983, Ch. 816.
[19] Senate Lombardi, Letter to Alice Daniel (Counsel to the Governor), July 6, 1983, available in the Governor's Bill Jacket, L. 1983, Ch. 816.
[20] Division of the Budget Report on Bill, L.1983, Ch. 816, available in the Governor's Bill Jacket, L. 1983, Ch. 816.
[21] L.1994, Ch.170, § 475; see also L. 1995, Ch. 81, § 88.
[22] L.1966, Ch. 256.
[23] The various services and populations for which the State took on a larger portion of the Medicaid costs are identified in New York Social Services Law § 368-a(1).
[24] Interview with Ken Crannell, NYSAC, June 13, 2006.

low-income adults ages 19 to 64 who do not have health insurance but have income or resources slightly too high to qualify for Medicaid. Childless adults with incomes up to 100% of the federal poverty limit are eligible for coverage.[25] Parents living with a child under the age of 21 are eligible if the gross family income is up to 150% of the FPL.[26] As of September 2006, statewide enrollment in Family Health Plus totaled 506,344.[27]

Included in HCRA 2000 was an amendment to the Medicaid local share provisions that required counties also to pick up 50% of Family Health Plus costs not paid for by the federal government.[28] The dollar amounts involved proved to be substantial. State and local spending for Family Health Plus reached $193 million in State fiscal year 2002-2003 and jumped to $598 million in 2003-2004.[29] Thus, with the enactment of Family Health Plus, counties faced a significant new financial obligation. In the words of one interviewee, Family Health Plus was the "straw that broke the camel's back."

Funding the Local Share

Counties renewed their efforts to obtain comprehensive relief from their local share responsibilities in the early 2000s. At this point, with the addition of the Family Health Plus program and tens of millions of dollars in Medicaid workforce recruitment and retention rate add-ons in 2002,[30] counties felt the costs of Medicaid more than ever before. Counties' share of the State's Medicaid costs increased from $1.1 billion in 1993 to $2.3 billion in 2003.[31] Medicaid represented the largest budget item in every county.[32] Moreover, the increasing costs to counties showed no sign of slowing. The State Comptroller projected that, if Medicaid costs continued their historical growth, several counties would each experience an increase in Medicaid expenditures of over $100 million between 2005 and 2010.[33]

Counties primarily funded their ever-growing expenses for the local share through increases in local property taxes. The property tax is the largest tax imposed by counties, and constitutes 79% of all local taxes outside of New York City.[34] Under the New York State Constitution, local governments may only raise taxes in a fiscal year by 1.5% to 2.5% (depending on population size) of the average full valuation of local taxable real estate, less certain mitigating factors.[35] For counties outside of New York City, the maximum figure is 1.5%, though the State Legislature is authorized to increase the amount to 2%.[36]

Despite these Constitutional limitations, the impact on local property taxpayers in the early 2000s as a result of Medicaid cost increases was significant. In 2003, Medicaid amounted to 73% of local property taxes.[37] In Chemung County, 97% of property tax revenues were dedicated to underwriting Medicaid costs.[38] Counties complained of closed libraries, elimination of county jobs, and losses of other county services as a result of local Medicaid expenses.[39]

[25] Social Services Law § 369-ee(2)(a)(v).
[26] Id.
[27] See data available at http://www.health.state.ny.us/health_care/managed_care/reports/enrollment/monthly/index.htm.
[28] L.1999, Ch. 1, § 105.
[29] *2006-2007 New York State Executive Budget*, Overview, p. 68. For a copy of the 2006-2007 enacted budget and related documents, visit http://www.budget.state.ny.us/pubs/enacted/enacted.html.
[30] New York State Public Health Law § 2807-v(1)(x), (y), (z), (aa), (bb), (cc), (ee).
[31] State Comptroller Alan G. Hevesi, Continued Growth in Medicaid Could Drive One-Third Jump in County Property Taxes by 2010, Press Release, January 13, 2005.
[32] Thomas J. Prohaska, County's Hope Rise for Medicaid Relief, *Buffalo News*, June 27, 2004.
[33] State Comptroller Alan G. Hevesi, Continued Growth in Medicaid Could Drive One-Third Jump in County Property Taxes by 2010, Press Release, January 13, 2005.
[34] Office of the New York State Comptroller, *Property Taxes in New York State*, April 2006, p. 2.
[35] Article 9, § 10.
[36] Id.
[37] State Comptroller Alan G. Hevesi, Continued Growth in Medicaid Could Drive One-Third Jump in County Property Taxes by 2010, Press Release, January 13, 2005.
[38] Interview with Chemung County Executive Thomas Santulli, June 14, 2006.

Several counties were projected to approach or even exceed their constitutional maximums by 2010 if Medicaid costs continued to increase as expected.[40]

Counties also increased their sales taxes to cover their increasing local share obligations, but to a lesser extent than property taxes. Local sales tax increases are restricted by State statute, rather than by the State Constitution.[41] Several counties in fact sought or received State legislative approval to increase sales taxes beyond their statutory limits, in part to address rising Medicaid costs.[42] Because of the relatively stable tax base for property taxes, however, increases in local property taxes were seen as a more reliable way to cover the counties' increasing Medicaid costs. The State Comptroller observed:

> Unlike sales taxes and State aid, the property tax is a relatively stable, locally-controlled revenue source....Property taxes are generally used to balance municipal budgets after accounting for all other sources of revenue—this means they tend to increase more quickly if other revenues stagnate or decline.[43]

Several interviewees also noted that beyond the practical expediency of a stable tax base, the emphasis on property tax increases had a political motive, as county executives sought to engage their constituents, local property taxpayers, in the Medicaid battle. Indeed, interviewees reported that officials in some counties would submit local bills to raise property taxes with a notation that they were needed due to Medicaid cost pressures. Thus, although the property and sales tax revenues ultimately go "into the same pot," there was a recognizable, if arguably artificial, linkage between increases in property taxes and increases in Medicaid costs for both economic and political reasons.

It is worth noting that, in contrast to counties, the State did not have to rely on additional tax revenue to fund these new programs. The State's contributions for Family Health Plus and the workforce recruitment and retention rate add-ons came from the HCRA pools, which were built up through various sources other than tax dollars, including the funds resulting from the Empire Blue Cross Blue Shield conversion.[44] Hence, the State did not feel the same pressures vis-à-vis taxpayers that the counties felt.

Family Health Plus Takeover (2004) and Enactment of Medicaid Cap (2005)

Anticipating further Medicaid cost increases and facing already strained property and sales tax bases, in 2004 the counties renewed their efforts to persuade the Governor and the Legislature to cap or take over the county share of the Medicaid program.[45] Cap legislation passed the State Senate that year, but failed in the Assembly.[46] The counties were more successful with respect to their Family Health Plus obligations. The Legislature passed a State takeover of 100% of the counties' share of the Family Health Plus program, to be phased in between January 1, 2005, and January 1, 2006.[47]

[39] Jeff Murray, Residents Rally for Medicaid Limits, *Star-Gazette*, February 18, 2005; Anthony Farmer, Steinhaus Requests Senators' Help with Medicaid, *Poughkeepsie Journa*l, April 2, 2004; Patrick Lakamp, Legislators Call for Cap on Medicaid Expenses, *Buffalo News*, October 4, 2002.

[40] State Comptroller Alan G. Hevesi, Continued Growth in Medicaid Could Drive One-Third Jump in County Property Taxes by 2010, Press Release, January 13, 2005.

[41] See discussion of statutory maximums for county sales taxes at Office of the New York State Comptroller, *Local Government Sales Taxes in New York State*, March 2006, pp. 5, 10, 22.

[42] State Comptroller Alan G. Hevesi, Continued Growth in Medicaid Could Drive One-Third Jump in County Property Taxes by 2010, Press Release, January 13, 2005.

[43] Office of the New York State Comptroller, *Property Taxes in New York State*, April 2006, p. 2.

[44] New York State Public Health Law 2807-v(1)(f), (x), (y), (z), (aa), (bb), (cc), (ee), (mm). For more on the HCRA pools, visit http://www.health.state.ny.us/nysdoh/hcra/hcrahome.htm.

[45] James M. Odato, County Leaders Launch Call for Relief, *The Times Union*, January 6, 2004.

[46] Joel Stashenko, County and Business Executives Complain About Medicaid Costs, Associated Press, January 4, 2005.

[47] L.2004, Ch. 58, Part C, § 2.

In anticipation of the 2005 legislative session, local government officials and the New York State Association of Counties (NYSAC) intensified their campaign to secure cap legislation through a range of advocacy efforts. NYSAC and county executives conducted a concerted lobbying effort in Albany directed at executive leadership and legislators.[48] In Chemung County, for example, County Executive Tom Santulli set up a storefront in a mall to raise his constituents' awareness of the counties' obligations for Medicaid, and to collect signatures for a petition advocating change.[49] Based on these efforts, approximately 14,000 Chemung County residents sent letters to the Governor and key legislators.[50] In Westchester County, County Executive Andrew Spano had a 10-foot billboard, indicating the "running Medicaid tab," placed in front of the county office building in White Plains."[51] These local campaigns were not lost on State legislators as they returned to their hometowns.[52]

Governor Pataki took up the issue of county Medicaid expenditures directly in January 2005, proposing the cap on the local share as part of his 2005-2006 Executive Budget. Unlike in prior sessions, this proposal was passed by the Legislature—going through, as several interviewees attested, smoothly and without any significant opposition. Beyond the political momentum generated by counties' lobbying and grassroots efforts, State officials identified several other rationales for the cap:

- A recognition that, given its larger tax base, the State was better suited to handling the financial burden of Medicaid;
- Making the State fully responsible for new Medicaid costs, and the sole beneficiary of Medicaid savings, would vest responsibility for the program squarely in the entity in control of the program; and
- The State was in a better position to administer the Medicaid program, consistent with overarching policy and fiscal priorities.

Counties received an added benefit under the Medicaid cap legislative package, as the Family Health Plus phase-in period was accelerated for counties outside of New York City. Specifically, the full State takeover of the counties' share of Family Health Plus costs was moved up to October 1, 2005, from January 1, 2006.[53] But the biggest change in 2005 was undoubtedly the historic reallocation of Medicaid funding responsibilities.

Capping Local Government's Share of Medicaid Costs

With the 2004 and 2005 legislative enactments described above, the State took over the local share of Family Health Plus and capped counties' contributions for Medicaid. Counties still have a significant financial obligation for Medicaid costs, though now the respective amounts of their responsibilities are fixed. Because their obligations are fixed, counties have achieved what was identified by numerous interviewees as their most important goal—"stability and predictability" with respect to their financial responsibilities for Medicaid.

Under the Medicaid cap legislation, the local share of Medicaid costs, effective January 1, 2006, is set at each county's calendar year 2005 costs adjusted by an annual trend factor. The cap amount represents each county's "maximum responsibility" for Medicaid expenditures.[54] In 2008, the county may use an alternative option in the form of a tax intercept based on a

[48] Interview with Ken Crannell, NYSAC, June 13, 2006; Interview with Chemung County Executive Thomas Santulli, June 14, 2006; Interview with Nassau County staff, June 14, 2006.
[49] Interview with Chemung County Executive Thomas Santulli, June 14, 2006.
[50] Interview with Chemung County Executive Thomas Santulli, June 14, 2006.
[51] The Medicaid Flap, *The Journal News*, November 29, 2004.
[52] Interview with Chemung County Executive Thomas Santulli, June 14, 2006.
[53] L. 2005, Ch. 58, Part C § 9; see also New York Social Services Law § 368-a(t).
[54] L. 2005, Ch. 58, Part C § 1(f).

fixed percentage of local sales taxes. Whether they decide to continue paying the cap or elect to establish the sales tax intercept, counties' responsibilities will be fixed and known in advance. Counties will never pay more than the cap amount or the alternative sales tax percentage. In addition, counties may reduce their Medicaid obligations by participating in State-approved demonstration projects that result in proven Medicaid savings.

Calculating the Cap: 2005 Base Year Costs Plus Annual Trend Factor

Each county's Medicaid cap figure is calculated by taking the amount expended on Medicaid by the county in calendar year 2005 and then increasing that figure by a trend factor.[55] Certain Medicaid costs experienced by counties were excluded from the calculation of the 2005 base year figure under the legislation and subsequent amendments,[56] as further detailed in the Appendix, page 20. Interestingly, the legislation passed in the first half of the base year, 2005—which allowed for the possibility of counties "gaming" their expenditures to affect their cap calculations. In theory, this could have been accomplished by depressing administrative costs through the end of 2005 (e.g., by not hiring new staff or by delaying new enrollments until 2006). There is no indication that this occurred, but, regardless, the New York State Department of Health (DOH) was authorized by the legislation to adjust the base year calculation if it identified any "atypical" expenditures in calendar year 2005.[57]

The cap includes amounts that the counties expended for administration of the Medicaid program at the local level. As a result, new administrative costs—such as additional staff salaries and benefits—will be the sole responsibility of the State.

As noted previously, the Medicaid cap trend factor is set in the statute as follows: 3.5% in 2006, an additional 3.25% in 2007, and an additional 3% every year thereafter.[58] The trend factor is not compounded—that is, the total amount each county will owe in 2007, for example, will be the base year figure plus 6.75%. This, combined with the fixed base year calculation based on 2005 costs, gives counties their sought-after predictability for budgeting purposes.

The cap was implemented beginning January 1, 2006, with counties required to pay the appropriate sum in equal weekly amounts to DOH.[59] The actual base year calculation for each county was established by DOH, with approval from the Division of the Budget (DOB), in June 2006, with estimates used for the first six months of 2006.[60] The final amounts are reflected in the following table.

Final Medicaid Cap Payments by County

County	Final Annual Cap 2005-06	Final Weekly Payments 2005-06	Final Annual Cap 2006-07	Final Weekly Payments 2006-07
Albany	$52,399,929	$1,007,691	$54,185,552	$1,042,030
Allegany	$8,233,092	$158,329	$8,513,650	$163,724
Broome	$31,867,836	$612,843	$32,953,790	$633,727
Cattaraugus	$13,970,747	$268,668	$14,446,826	$277,824
Cayuga	$11,850,223	$227,889	$12,254,041	$235,655

[55] 2005, Ch. 58, Part C § 1.
[56] Various exclusions from the calculation of the 2005 base year amount are set forth in Chapter 161 of the Laws of 2005 and Section 60 of Chapter 57 of the Laws of 2006, both of which amended the original version of the Medicaid cap legislation.
[57] L. 2005, Ch. 58, Part C § 3
[58] L. 2005, Ch. 58, Part C § 1(c).
[59] L. 2005, Ch. 58, Part C § 1(f).
[60] L. 2005, Ch. 58, Part C § 1(b), (g)(ii)..

County	Final Annual Cap 2005-06	Final Weekly Payments 2005-06	Final Annual Cap 2006-07	Final Weekly Payments 2006-07
Chautauqua	$26,012,130	$500,233	$26,898,540	$517,280
Chemung	$16,686,965	$320,903	$17,255,604	$331,839
Chenango	$8,218,439	$158,047	$8,498,497	$163,433
Clinton	$14,426,605	$277,435	$14,918,218	$286,889
Columbia	$9,183,970	$176,615	$9,496,931	$182,633
Cortland	$8,328,456	$160,163	$8,612,264	$165,620
Delaware	$7,194,504	$138,356	$7,439,669	$143,071
Dutchess	$35,186,483	$676,663	$36,385,527	$699,722
Erie	$173,524,618	$3,337,012	$179,437,787	$3,450,727
Essex	$5,579,347	$107,295	$5,769,473	$110,951
Franklin	$8,302,945	$159,672	$8,585,883	$165,113
Fulton	$11,415,878	$219,536	$11,804,895	$227,017
Genesee	$7,946,253	$152,813	$8,217,036	$158,020
Greene	$8,093,037	$155,635	$8,368,822	$160,939
Hamilton	$533,829	$10,266	$552,020	$10,616
Herkimer	$11,242,541	$216,203	$11,625,651	$223,570
Jefferson	$16,537,893	$318,036	$17,101,452	$328,874
Lewis	$4,185,134	$80,483	$4,327,750	$83,226
Livingston	$7,671,919	$147,537	$7,933,354	$152,565
Madison	$9,229,585	$177,492	$9,544,100	$183,540
Monroe	$148,655,970	$2,858,769	$153,721,694	$2,956,186
Montgomery	$9,898,007	$190,346	$10,235,299	$196,833
Nassau	$193,675,504	$3,724,529	$200,275,351	$3,851,449
Niagara	$37,697,303	$724,948	$38,981,908	$749,652
Oneida	$46,115,086	$886,829	$47,686,542	$917,049
Onondaga	$84,940,538	$1,633,472	$87,835,042	$1,689,135
Ontario	$13,460,238	$258,851	$13,918,921	$267,672
Orange	$59,319,828	$1,140,766	$61,341,260	$1,179,640
Orleans	$6,870,439	$132,124	$7,104,561	$136,626
Oswego	$20,600,194	$396,158	$21,302,183	$409,657
Otsego	$8,694,890	$167,209	$8,991,184	$172,907
Putnam	$7,966,897	$153,210	$8,238,384	$158,430
Rensselaer	$28,015,614	$538,762	$28,970,298	$557,121
Rockland	$55,104,773	$1,059,707	$56,982,568	$1,095,819
St. Lawrence	$19,743,452	$379,682	$20,416,246	$392,620
Saratoga	$20,425,004	$392,789	$21,121,023	$406,174
Schenectady	$28,131,387	$540,988	$29,090,015	$559,423
Schoharie	$4,748,155	$91,311	$4,909,957	$94,422
Schuyler	$3,108,670	$59,782	$3,214,603	$61,819
Seneca	$4,948,340	$95,160	$5,116,963	$98,403
Steuben	$16,147,276	$310,525	$16,697,524	$321,106
Suffolk	$205,997,054	$3,961,482	$213,016,780	$4,096,477
Sullivan	$16,806,964	$323,211	$17,379,692	$334,225
Tioga	$6,726,243	$129,351	$6,955,452	$133,759
Tompkins	$9,890,641	$190,205	$10,227,683	$196,686
Ulster	$30,051,859	$577,920	$31,075,931	$597,614
Warren	$10,126,782	$194,746	$10,471,870	$201,382
Washington	$9,336,326	$179,545	$9,654,478	$185,663

continued

County	Final Annual Cap 2005-06	Final Weekly Payments 2005-06	Final Annual Cap 2006-07	Final Weekly Payments 2006-07
Wayne	$11,689,670	$224,801	$12,088,017	$232,462
Westchester	$179,376,719	$3,449,552	$185,489,308	$3,567,102
Wyoming	$4,491,431	$86,374	$4,644,485	$89,317
Yates	$3,531,731	$67,918	$3,652,081	$70,232
Upstate	$1,814,115,356	$34,886,834	$1,875,934,653	$36,075,666
New York City	$4,325,294,004	$83,178,731	$4,472,686,303	$86,013,198
Total	**$6,139,409,361**	**$118,065,565**	**$6,348,620,956**	**$122,088,865**

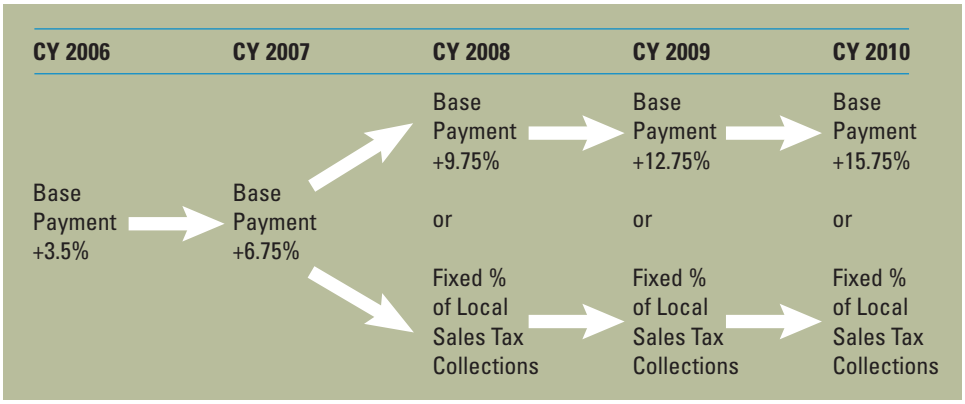
In practice, because the State fiscal year runs from April 1 to March 31, 25% of the cap during a fiscal year will be calculated under the new year's trend amount.[61] For example, in fiscal year 2006-2007, a county's cap amount will be 75% of the 2006 calendar year amount plus 25% of the 2007 calendar year amount. For each fiscal year, DOH must maintain an accounting of the net amounts that a county would have owed under the previous formula for determining the county's local share.[62] If the amount that would be owed by the county under the old local share formula (i.e., generally 25% of total costs) is lower than the amount under the new cap, the county is due the difference from the State.[63] In other words, counties will never owe more than they did under the previous formula for the local share. DOB is authorized, but not required, to lower the cap—i.e., decrease the county's obligations—to account for any increases in the FMAP amount for the State.[64]

Finally, counties received a one-time benefit with the implementation of the cap through the conversion of accounting methodologies from an accrual accounting system to a cash-based accounting system in 2005.[65] Under the accrual accounting system, Medicaid expenses were budgeted to the year of service, not the year of payment for the services. As a result, counties set up reserve funds to account for Medicaid services that were expected to be provided in a given year but not paid until the next year. Under the cash-based system, Medicaid expenses are accounted for in the year of payment, regardless of the year of service. With the conversion to a cash-based accounting system, counties received a one-time savings in the amount of their reserves for 2005, which are no longer needed for their Medicaid budgeting purposes. In New York City, for example, this resulted in an additional savings of $450 million.[66]

Sales Tax Intercept Option

Beginning on January 1, 2008, the Medicaid cap legislation provides an alternative means for counties to fulfill their financial obligations for Medicaid. They may elect to pay their Medicaid contribution through an intercept of a fixed percentage of local sales tax revenue.[67] The State, which collects all sales tax receipts and then remits the applicable local portion to a county, will keep the applicable intercept amount instead of remitting it to the county.[68] If a county elects the sales tax intercept option, the county will no longer have to make any cap payments to the State.

[61] L. 2005, Ch. 58, Part C § 1(d).
[62] L. 2005, Ch. 58, Part C § 1(g)(iii). Under an amendment to this section enacted in 2006 (in Section 59, Chapter 57 of the Laws of 2006), 50% of the State "clawback" payment to the federal government for Medicare Part D (i.e., the prescription drug benefit) will be considered to be the local share for that payment and will be included in the annual cap reconciliation.
[63] L. 2005, Ch. 58, Part C § 1(g)(iii).
[64] L. 2005, Ch. 58, Part C § 4.
[65] For more details, see New York City Independent Budget Office, *Analysis of Mayor's Preliminary Budget for 2007,* March 2006, p. 98.
[66] New York City Independent Budget Office, *Analysis of Mayor's Preliminary Budget for 2007,* March 2006, p. 98.
[67] L. 2005, Ch. 58, Part C §§ 2, 7, 8.
[68] New York State Tax Law § 1261(f).



CY = Calendar Year
Source: New York State Association of Counties

While there are some nuances in the formula for calculating the sales tax intercept, essentially the amount of the intercept for each county will be set by dividing the county's cap payment amount for State fiscal year 2006-2007 by the county sales tax receipts for the same period.[69] The resulting percentage will be applied on a fixed basis to county sales tax revenues
collected by the State beginning in 2008. The amount of tax remittances due each month to each county from the State will be reduced by the intercept amount, which will be turned over to the State Treasury.[70] If the intercept obligation is larger than the State Comptroller's net payment to the county for any given month, the county will be billed for the difference.[71]

According to several interviewees, the sales tax intercept option was added to assist a small number of what were frequently referred to as "anemic" counties with slow-growing tax rates. These counties can expect that the growth of their tax rates will consistently be lower than the trend factor. Therefore, they achieve more savings by committing a fixed percentage of their sales taxes than by paying the cap amount with the applicable trend factor. Because sales tax is compounded and the trend factor is not, sales tax growth must be less than 2.7% for it to be at a lower rate than that of the trend factor of 3.0%.[72]

One interviewee suggested that the sales tax intercept offers an advantage over the Medicaid cap that should inform any numerical analysis. The tax intercept option is, in effect, a hedge against a downturn in the economy—i.e., the plummeting of local tax revenues. If that were to occur, the intercept would decrease in proportion to tax revenues, while the cap would remain fixed, without a relationship to tax revenues.[73]

The Medicaid cap legislation puts in place a specific process for electing the sales tax intercept option.[74] If county officials determine that they would like to go forward with the tax intercept, the county's local legislative body must adopt a resolution that expressly agrees to

[69] New York State Tax Law § 1261(f).
[70] New York State Tax Law § 1261(f)(2)(D)(3).
[71] New York State Tax Law § 1261(f)(5).
[72] Tarren Bragdon, From Headache to Migraine? Medicaid Cap Strengthens Need for Remedies in NY, *NYHealthMatters*, February 2006, p. 3. (According to this article, the 2.7% figure is valid through 2016.)
[73] Interview with Monroe County Budget Director Bill Carpenter, July 6, 2006.
[74] Monroe County has been exploring the possibility of utilizing the tax intercept option, a controversial issue as part of this discussion has arisen because Monroe County shares sales tax revenue among its cities, towns, villages, and school districts (the "municipalities") at a much more generous rate than any other county. Various officials raised concerns about whether the county would have to hold the municipalities harmless if it elected to use the sales tax intercept – i.e., cover the municipalities' portion of the sales tax that would be taken by the State under the intercept option. A recent court decision ruled that the county did not need to do so. As a result, if the county elects to use the sales tax intercept, the municipalities' portion of the sales tax revenue will also be reduced by the relevant percentage of the intercept. To help defray the costs of the sales tax intercept option, county officials are discussing whether to increase sales taxes by .75%.

implement the tax revenue intercept.[75] A mandatory form for the resolution is provided in the law itself.[76] The resolution must be mailed to the Department of Health by September 30, 2007.[77] If the county adopts the tax intercept option, it may not later rescind this decision.[78] And, likewise, a county that fails to select the sales tax option may not later adopt it.

The cap legislation includes special rules for New York City, which also may choose to participate in the tax intercept if it passes a resolution complying with the requirements described above.[79] The methodology for the New York City tax intercept is generally similar to the county tax intercept. One key difference is that personal income tax revenues, in addition to sales and use taxes, are to be a source of the intercept. Nonetheless, New York City officials have confirmed that the tax intercept option is unlikely to be attractive to them.[80]

Demonstration Authority

The 2005 legislation fixes and limits counties' Medicaid payments. It also provides a vehicle through which counties lower their Medicaid obligations below the cap amount: demonstration projects. The legislation authorizes counties to develop programs "demonstrating innovative methods of improving the delivery of quality health care services in a cost effective manner."[81] If a demonstration program receives State approval, any savings achieved will be shared equally with the county.[82] DOH guidance indicates, however, that a project's net savings, recoveries, and/or costs will be offset by any State costs incurred to implement or operate the demonstration.[83]

Several demonstration projects are already underway, including:

Medicaid Fraud, Waste, and Abuse Demonstration Project. Twelve counties (Albany, Broome, Chautauqua, Dutchess, Erie, Monroe, Nassau, Orange, Rensselaer, Rockland, Suffolk, and Westchester) are participating in a fraud and abuse demonstration project under the oversight of the State of New York Office of the Medicaid Inspector General (OMIG). Designated as agents of OMIG under the project, the counties are authorized to conduct audits and investigations for the purpose of identifying provider fraud.

OMIG has issued a lengthy directive detailing the counties' obligations, the process for targeting and investigating potential fraud and abuse, and the circumstances in which counties can share in any recoveries.[84] When a county identifies an instance of potential provider fraud or waste, it must refer the matter to OMIG, which then reviews it and determines whether possible fraud is involved. OMIG refers instances of potential provider fraud to the Medicaid Fraud Control Unit of the Attorney General's Office. If that unit pursues the case, the county may not share in any recoveries.

If OMIG determines that a referred matter does not involve potential fraud, however, it may authorize the county to pursue the investigation or audit the provider at issue. OMIG has encouraged counties "to audit cost-based rate providers such as hospitals, nursing homes, diagnostic and treatment centers, personal care, consumer directed personal care, certified home health agencies and long term home health care programs in areas such as whether or

[75] L. 2005, Ch. 58, Part C § 2.
[76] L. 2005, Ch. 58, Part C § 2(b)(ii).
[77] L. 2005, Ch. 58, Part C § 2(b)(i).
[78] L. 2005, Ch. 58, Part C § 2(b)(i).
[79] New York State Tax Law § 1261(g).
[80] Interview with PV Anantharam, Bob Melican, and Alyssa Cohen, June 2, 2006.
[81] L. 2005, Ch. 58, Part C § 5.
[82] L. 2005, Ch. 58, Part C § 5.
[83] Letter from Brian J. Wing to Commissioners of Local Districts, May 19, 2006.
[84] OMIG, Administrative Directive, Transmittal: 06 OMIG/ADM-1, June 2, 2006. For more on OMIG, see Governor George Pataki, Executive Order 140.1.

not services were properly ordered, medically necessary, appropriately documented or provided by a qualified individual."[85] Counties may share in any recoveries by non-fraud audits/investigations after a reconciliation of gross expenditures and gross recoveries.

Chemung County Demonstration Project. Chemung County is designing a demonstration project that combines data mining efforts and care coordination efforts.[86] The county has been using a tool from Salient Corporation to evaluate Medicaid claims data from the State's data warehouse. This tool allows the county to track utilization for each beneficiary on a visit/service/provider basis. The information from the data warehouse is updated weekly, so the county is able to evaluate the data in almost real time.

By employing this data mining tool, the county intends to implement a care coordination model that will mandate full recipient participation. Because only a partial capitation managed care plan operates in Chemung County, Chemung officials believe there is an opportunity for significant benefits from the demonstration project. Specific initiatives are targeting the utilization of high-cost services (emergency room, inpatient medical/surgical), implementing specific disease management programs (asthma, diabetes), and encouraging the use of preventive health services. The county has contracted with Excellus BlueCross BlueShield (in conjunction with the Monroe Plan for Medical Care) to manage the program, with the county maintaining an oversight role.

In addition to care management, the Salient tool is able to identify outliers and track potential fraud by providers and beneficiaries. Chemung County Executive Tom Santulli observed that the mere capability of tracking fraud in this way appears to have acted as a deterrent for potential abusers of the system.[87]

The State Legislature passed a bill authorizing the project in 2006[88] and the State and county will pursue a federal waiver if they determine it necessary for the project to proceed. County officials have estimated $12-18 million in savings once the project is implemented, with administrative costs of $4-5 million.[89]

Pharmacy Litigation. Approximately 30 counties, as well as other states, have been pursuing a lawsuit against pharmaceutical companies regarding overcharges of drug costs. In order to ensure that counties would maintain the suit after the passage of the Medicaid cap, DOH agreed to convert it into a demonstration project.

Transportation Project. Allegany County is operating a demonstration project in which the county serves as a coordinator of patient transportation to and from health care services.[90] The county intends to achieve savings through ensuring the efficient and appropriate use of transport services.

The State has established a process for counties to secure demonstration authority, including use of a DOH application (the "Local District Demonstration Project Concept Paper Request" form) for projects other than those related to Medicaid fraud and abuse.[91] A preliminary response from DOH is to be issued within 45 days, but projects may not proceed until any necessary federal approvals are obtained.[92]

[85] OMIG, Administrative Directive, Transmittal: 06 OMIG/ADM-1, June 2, 2006, p. 6.
[86] New York Social Services Law § 364-j (22); *Excellus BlueCross BlueShield Chemung County Medicaid Reform Proposal*, March 13, 2006 (provided to authors by Chemung County Executive Tom Santulli); Interview with Chemung County Executive Tom Santulli, June 14, 2006.
[87] Interview with Chemung County Executive Tom Santulli, June 14, 2006.
[88] This legislation is codified at New York Social Services Law § 364-j (22).
[89] *Chemung County 2006 Budget*, November 10, 2005, p. 2; Interview with Chemung County Executive Tom Santulli, June 14, 2006.
[90] Interview with Brian J. Wing, June 19, 2006.
[91] Letter from Brian J. Wing to Commissioners of Local Districts, May 19, 2006.
[92] Letter from Brian J. Wing to Commissioners of Local Districts, May 19, 2006.

Once all of the approvals are obtained for a demonstration project, a county must execute a Memorandum of Understanding with the State on (a) the scope of the demonstration; (b) an implementation date; (c) the length of the demonstration, including estimated beginning and ending dates; (d) a provision for State monitoring of demonstration activity; (e) the fiscal evaluation and methodology for determining savings; and (f) termination clauses that would allow either DOH or the local district to end the project prior to the planned end date.[93]

Finally, the savings achieved by demonstration projects may or may not reach levels where the financial rewards significantly exceed the administrative costs. Anecdotally, one official observed that the Medicaid Fraud, Waste, and Abuse Demonstration project appeared to be "more work than it was worth."

Monitoring and Oversight of Program

While counties' financial responsibilities are contained under the Medicaid cap legislation, they continue to have certain oversight responsibilities. As noted above, when county officials believe they have identified any patterns of fraud or abuse that may require further investigation, they must report the incidents to State authorities.[94] The cap legislation also requires DOH to establish "requirements and guidelines" to ensure that the counties are exercising "due diligence with respect to their statutory and regulatory functions in the administration, supervision and operation" of Medicaid in their locality.[95] DOH's guidance must address the obligation of counties, in conjunction with the State, to regularly monitor enrollment, utilization, provider service, and expenditure patterns, including patterns suggestive of fraud and abuse.[96]

In addition, the law mandates that DOH officials notify a county if it appears that the county is not complying with its own obligations.[97] Upon such notification, the county must review its activities and report its findings back to the Commissioner. After this report is submitted, the Commissioner may impose penalties and sanctions on the county if DOH finds that the county has "substantially failed" or "continues to fail" to comply with its obligations.[98] These penalties and sanctions are not specified by the law, which instead refers to "sanctions and penalties as are permitted under the public health law and social services law."[99] The Commissioner may also choose to take more modest steps to remedy any problems, including the provision of technical assistance to help the county achieve compliance, and/or requiring a plan of action by the county to achieve compliance.[100]

To assist in its monitoring of counties, DOH is developing a tool tentatively named the Local District Performance Indicator Report. The draft tool proposes to track caseload information (e.g., the number of total cases and average days overdue for Medicaid and Family Health Plus recertification), case processing (e.g., total applications processed and total days to disposition), long-term home health care program expenditures (e.g., per claim and per recipient), and administrative information (e.g., recoveries, total administrative costs, total Medicaid staff assigned to function). According to DOH staff, the agency will focus on outliers identified through the tool when assessing whether audits of particular counties' activities are needed.

Counties are well aware of the State's oversight role. Almost every county official interviewed stated, without prompting, that they were concerned that the State would scrutinize

[93] Letter from Brian J. Wing to Commissioners of Local Districts, May 19, 2006.
[94] L. 2005, Ch. 58, Part C § 6(2)(a).
[95] L. 2005, Ch. 58, Part C § 6(1).
[96] L. 2005, Ch. 58, Part C § 6(2).
[97] L. 2005, Ch. 58, Part C § 6(2)(b).
[98] L. 2005, Ch. 58, Part C § 6(3), (4).
[99] L. 2005, Ch. 58, Part C § 6(4).
[100] L. 2005, Ch. 58, Part C § 6(3)(a), (b).

more closely and/or take a hard line on cost increases due to county action or inaction. In at least one local district, this resulted in a request from DOH for prior approval of staffing changes. In the past, such decisions were almost always made by counties without involvement by the State. Other interviewees mentioned that they would not even consider hiring more staff because of concerns about the State's view of these changes.

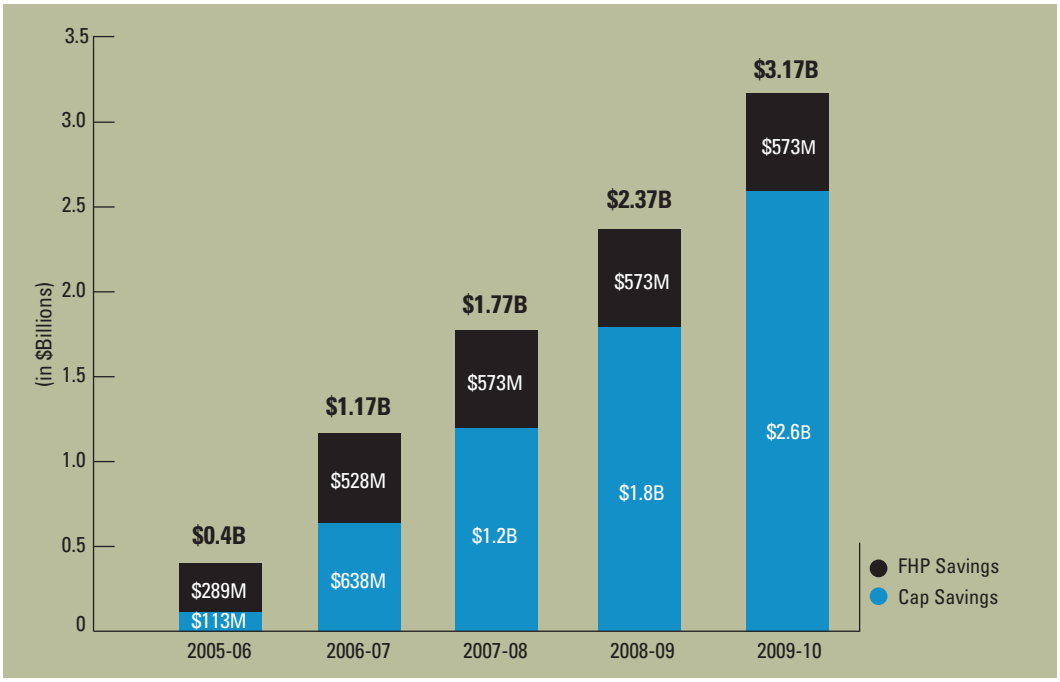
Implications of the Medicaid Cap

Fiscal Implications

The most immediate and obvious impact of the Medicaid cap and Family Health Plus takeover is financial. The capping of counties' Medicaid costs and elimination of their financial obligations for Family Health Plus means savings for the counties, compared with what they would have spent under the prior law, and increased costs for the State. The Governor's 2006-2007 Executive Budget projected that the Medicaid cap would save counties $638 million in the current fiscal year.[101] The Family Health Plus takeover is expected to save counties an additional $528 million during the same period.[102] For the five-year period between FY 2005-2006 and FY 2009-2010, counties are expected to save a total of $6.4 billion as a result of the Medicaid cap and an additional $2.5 billion as a result of the State takeover of Family Health Plus.[103]

To the extent that these numbers hold true, the State can expect to experience a parallel increase in costs over this period. In addition, because Medicaid costs are likely to grow at a faster rate than the statutory trend factor used to calculate the counties' capped costs, the State's proportional level of responsibility for Medicaid costs will increase significantly over time. Indeed, Governor Pataki stated, in January 2006, that he expected Medicaid costs would increase by 10% in FY 2006-2007 alone.[104]

Five-Year Projected Savings for Counties Due to Medicaid Cap and Family Health Plus Takeover[105]



Source: *2006-2007 New York State Executive Budget*

[101] *2006-07 New York State Executive Budget*, Overview, p. 69.
[102] *2006-07 New York State Executive Budget*, Overview, p. 70.
[103] *2006-07 New York State Executive Budget*, Overview, pp. 69-70.
[104] James M. Odato, Medicaid Assistance to Cost State $1.1 Billion, *Albany Times Union*, January 13, 2006.
[105] DOB staff informed the authors that the Executive Budget assumed Family Health Plus savings to be flat for 2007-2008 through 2009-2010 because enrollment appears to have peaked.

Local governments have likewise projected significant savings in their respective budgets because of the Medicaid cap. The New York City Office of Management and Budget has estimated that the City will save over $1 billion by FY 2009 as a result of the Medicaid cap.[106] Nassau County is projecting over $160 million in savings in 2009,[107] having spent over $369 million on Medicaid costs in 2004.[108] Even counties with smaller budgets contemplate significant drops in their Medicaid costs. For instance, the Chemung County budget estimates that the county's Medicaid spending will actually decrease in 2006 to $18.5 million from $24.3 million in 2005. This assumes sizable savings as a result of the Chemung County demonstration project described above.[109]

The Medicaid cap has already translated into tangible benefits for local property taxpayers. The New York State Office of the State Comptroller reported, in January 2006, that county property tax increases for 2006 are "moderating."[110] Among the Comptroller's findings were that:

- Between 2005 and 2006, property taxes for all counties (except New York City) increased by 3.3% statewide, compared with average annual growth of 7.0% between 2001 and 2005;
- Over 75% of counties (48 of 57), and New York City, had 2006 property tax levy increases below their growth trends from the last five years; and
- As a share of their 2006 tax levies, counties received benefits ranging from 12.2% (Rockland) to 0.7% (Hamilton). The report noted that this "is due to variations in county Medicaid costs subject to the cap, its projected Medicaid growth rate and the relative burden that Medicaid costs place on its overall budget and property tax levy."[111]

County-by-County Property Tax Trends—Pre-Cap (2001-2005) vs. Post-Cap (2006)

County	Property Tax Levy 2006	Property Tax Levy Percent Change 2006	Property Tax Levy Average Annual Increase (2001-2005)	2006 % Change Lower Than 5-Year Average Annual Increase?
Albany	$66,670,620	-0.4%	16.6%	Yes
Allegany	$21,721,100	15.3%	8.1%	No
Broome	$53,277,871	3.9%	8.7%	Yes
Cattaraugus	$39,880,000	5.4%	8.4%	Yes
Cayuga	$29,565,821	-1.8%	12.8%	Yes
Chautauqua	$53,850,489	0.0%	10.9%	Yes
Chemung	$25,942,218	4.4%	5.4%	Yes
Chenango	$22,631,987	0.4%	10.0%	Yes
Clinton	$26,099,639	9.9%	12.4%	Yes
Columbia	$34,267,638	4.4%	10.3%	Yes
Cortland	$23,706,994	4.0%	11.5%	Yes
Delaware	$22,902,981	2.8%	8.8%	Yes
Dutchess	$76,024,334	7.2%	8.7%	Yes
Erie	$188,100,000	19.3%	0.8%	No
Essex	$13,548,044	0.0%	11.5%	Yes

[106] Budget Summary, *The City of New York Executive Budget Fiscal Year 2006*, May 2005, p. 51.
[107] *Nassau County Fiscal 2006-2009 Multi-Year Financial Plan*, p. 11, available at http://www.nassaucountyny.gov/agencies/OMB/myfp.html.
[108] *Nassau County Summary of the Fiscal 2006 Adopted Budget*, adopted October 30, 2005, p. 9.
[109] *Chemung County 2006 Budget*, November 10, 2005, p.2
[110] *County Medicaid Update*, January 31, 2006, available at http://www.osc.state.ny.us/localgov/pubs/listresearch. htm.
[111] *County Medicaid Update*, January 31, 2006.

County	Property Tax Levy 2006	Property Tax Levy Percent Change 2006	Property Tax Levy Average Annual Increase (2001-2005)	2006 % Change Lower Than 5-Year Average Annual Increase?
Franklin	$15,366,069	4.3%	14.1%	Yes
Fulton	$23,628,893	-16.9%	8.0%	Yes
Genesee	$23,355,375	7.2%	9.3%	Yes
Greene	$17,830,025	-1.5%	9.9%	Yes
Hamilton	$5,108,907	3.5%	12.2%	Yes
Herkimer	$21,280,000	13.3%	9.9%	No
Jefferson	$39,247,520	4.3%	4.6%	Yes
Lewis	$10,038,966	7.1%	8.2%	Yes
Livingston	$20,138,418	4.3%	7.5%	Yes
Madison	$28,300,967	-0.1%	11.7%	Yes
Monroe	$305,171,008	3.4%	5.5%	Yes
Montgomery	$27,051,023	2.3%	11.8%	Yes
Nassau	$738,700,000	0.0%	5.3%	Yes
Niagara	$71,599,011	2.9%	6.9%	Yes
Oneida	$54,960,283	0.5%	4.0%	Yes
Onondaga	$187,453,259	-2.2%	6.6%	Yes
Ontario	$41,176,982	7.4%	8.0%	Yes
Orange	$99,102,312	4.2%	11.2%	Yes
Orleans	$11,393,323	5.5%	6.8%	Yes
Oswego	$38,864,943	2.8%	-1.1%	No
Otsego	$11,424,789	4.9%	3.3%	No
Putnam	$22,732,280	8.7%	1.8%	No
Rensselaer	$41,930,000	6.6%	11.1%	Yes
Rockland	$46,253,000	-1.1%	4.5%	Yes
Saratoga	$37,364,909	4.9%	8.8%	Yes
Schenectady	$57,970,453	-1.0%	8.1%	Yes
Schoharie	$15,437,773	16.9%	6.7%	No
Schuyler	$8,399,708	3.6%	8.6%	Yes
Seneca	$9,228,337	4.5%	7.7%	Yes
St Lawrence	$36,333,134	0.0%	9.0%	Yes
Steuben	$40,475,052	2.7%	10.0%	Yes
Suffolk	$486,572,972	2.3%	5.0%	Yes
Sullivan	$39,097,308	9.1%	4.9%	No
Tioga	$17,829,929	1.7%	9.4%	Yes
Tompkins	$33,102,442	0.0%	13.4%	Yes
Ulster	$64,973,736	39.1%	10.6%	No
Warren	$29,533,105	9.7%	10.3%	Yes
Washington	$24,405,250	-4.7%	14.3%	Yes
Wayne	$36,860,612	-7.4%	10.0%	Yes
Westchester	$500,914,252	4.5%	9.9%	Yes
Wyoming	$10,552,188	5.4%	6.2%	Yes
Yates	$11,793,280	2.8%	6.0%	Yes
Upstate Total	**$4,061,141,529**	**3.3%**	**7.0%**	**Yes= 48**
New York City*	$4,658,981,728	-18.26%	14.8%	Yes

*The New York City data do not include the portion of the property tax levy dedicated to school purposes.
Source: Office of the State Comptroller. January 13, 2006. *County Medicaid Update*.

Every county representative, indeed virtually every official, interviewed spoke of the importance of stability and predictability in county budgeting and budget relief that made it less difficult to balance county budgets. For example, Nassau County officials noted that for the first time in years, their health and human services programs are not threatened, although there is no plan to add extra funds to those programs due to the Medicaid cap.[112] However, some counties continue to struggle with Medicaid costs. The Chemung County executive noted that the county's Medicaid cap payment still accounts for approximately 80% of county property taxes. Chemung County shut down two of its branch libraries because of Medicaid local-share cost pressures, and they remain closed.

Operational Implications

The shift in financial responsibilities for the Medicaid program under the cap legislation alters State and county incentives, and may trigger significant changes in program administration. Areas of potential change identified in our interviews include:

Programmatic Leadership. The State is now solely responsible for financing changes to the benefit package, eligibility categories, enrollment among the already-eligible population, administration, and all other aspects of the program. The increased financial obligations of the State reinforce its responsibility for the scope and operations of the Medicaid program. In addition, the shift should heighten State officials' sensitivity to increases and decreases in Medicaid costs pursuant to State and federal changes in the program. Notably, cuts in programs and services will result in twice as much in savings for the State, while expansions in benefits, coverage, or administration will cost twice as much.

Responsibility for and Oversight of Administration. Medicaid administration has traditionally been the joint responsibility of the State and the counties. State law establishes the overarching eligibility rules for the program (consistent with federal rules), but counties have had a certain level of autonomy in developing and implementing procedures for enrollment and renewal. With changes in administrative expenses now solely affecting the State, and with the inclusion of the monitoring and oversight provisions in the Medicaid cap legislation, the State arguably has cause to take on more responsibility and/or set more specific guidelines for program administration. State officials are aware of this dynamic, but are moving slowly to expand or alter their role. At the same time, county officials are interested in maintaining a local role in program administration, while quite sensitive to the increased fiscal and oversight obligations of the State.

Medicaid Cost Containment Measures. One interviewee noted that, prior to the cap legislation, State cost containment proposals often centered on services—most notably long-term care—for which the State took on a larger share of the costs than did the counties. Cuts in long-term care saved the State almost twice as much as cuts in acute care, for example. Now the State will be financing all Medicaid services in equal proportion, regardless of type of services (inpatient, outpatient, etc.) or location of delivery (hospital, clinic, nursing home, home health, etc.). Thus, to whatever extent matching ratios previously motivated State actions, the cap legislation eliminated that incentive.

Scope of the State Medicaid Program. No longer vulnerable to fluctuating Medicaid costs, counties might be thought to have a greater incentive to support program expansions and easier access to coverage. At a minimum, counties no longer have a financial motive to resist coverage expansions or streamlined enrollment procedures. Interviews with county

[112] Note that Nassau County did use some of the Medicaid cap savings to pay for a transition to a "pay as you go" (or "PAYGO") system under which it will not take on more debt in the future to finance tax refunds or other county expenses. See *Nassau County Fiscal 2006-2009 Multi-Year Financial Plan*, p. 12.

officials have demonstrated, however, that they are not currently interested in advocating for expansions or streamlined procedures, and remain extremely sensitive to Medicaid's prominence in the State budget and the implications of increased Medicaid costs for State taxpayers. Among their reasons were (1) concerns that the cap could be chipped away or even repealed; (2) the implications of the Medicaid cap legislation provisions for monitoring and oversight of counties by the State; and (3) wariness about State audits and other actions if local Medicaid costs increased.

Demonstration Projects. The opportunity to further reduce their annual Medicaid payments through cost-saving demonstration projects is of real interest to county representatives and many appear to be engaged in creative thinking about such projects. While most focus on fraud, a number are interested in innovative clinical and care management demonstration projects that they believe would both improve care and cut costs. Once seen as a debilitating challenge, Medicaid, for many counties, has become an interesting opportunity.

Conclusion

While the Medicaid cap legislation is detailed and complicated, the bottom line is clear: effective January 1, 2006, the local share of Medicaid is capped, and it is the State that will absorb the fiscal impact—new costs or savings—of all future changes to the Medicaid program. As a result, the State can no longer avoid the full fiscal implications of program expansions and reimbursement increases. Additionally, the State stands to reap a greater benefit from cuts in benefits, eligibility, services, and rates. How the State will respond to these incentives remains unknown. But given the size of New York's Medicaid budget and its importance to low-income residents, health care providers, and health care workers, the fiscal and political pressures on the State will no doubt be unprecedented.

Appendix

2005 Costs Included and Excluded in Calculation of Each County's Medicaid Cap Base

		2005 Local Medicaid
MARS 72 + MARS 73 *(MARS 72 and 73 Reports for Jan-Dec 2005)*		
Less Family Health Plus *(The local share of the Family Health Plus Program is excluded.)*	-	
Less Schedule E *(Medicaid payments or recoveries, made or received during Jan-Dec 2005 and claimed through the automated claiming system)*	-	
Less Supplementary Medical Insurance Payments *(Medicare Part A and Part B premiums during Jan-Dec 2005)*	-	
Less Indigent Care Adjustment *(Local share of public hospital indigent care adjustment)*	-	
Less Offline Payments *(Medicaid payments issued by DOH for various claims not accommodated by the MMIS, including disproportionate share, court ordered, and other lump sum payments)*	-	
Less Overburden Aid[113] *(Payments made to counties to reimburse the local share of Medicaid payments for certain mentally disabled recipients)*	-	
Less Prescription Drug Rebates *(Rebates for prescription drugs paid to the county during Jan-Dec 2005)*	-	
Less Other Recoveries *(State recoveries of Medicaid expenditures, such as audits, Attorney General recoveries, and third party health insurance)*	-	
Plus Medicaid Administrative Costs *(Local share of Medicaid administrative costs incurred and claimed during Jan-Dec 2005)*	+	
Total Medicaid Cap Base	=	
Plus Non-federal Share of Intergovernmental Transfers *(Intergovernmental and Upper Payment Limit transfers paid to public nursing facilities and hospitals during Jan-Dec 2005)*	+	

Sources: Part C of Chapter 58 of the Laws of 2005; Chapter 161 of the Laws of 2005; Sections 60 and 61 of Chapter 57 of the Laws of 2006; NYSAC.

[113] Pursuant to Section 61 of Chapter 57 of the Laws of 2006, counties are reimbursed effective June 2, 2006, for overpayments resulting from any miscategorization of Medicaid beneficiaries erroneously miscategorized as eligible under overburden aid without regard to the Medicaid cap. However, to the extent that such overpayments occurred on or before June 2, 2006, and were included as expenditures for calendar year 2005, those amounts are considered as part of the Medicaid cap calculation.