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NEW YORK STATE'S INSTITUTION-CENTERED SYSTEM FOR THE PROVISION OF HEALTH CARE

Courtney Burke

Introduction

In his first major health care policy speech as governor of New York, Eliot Spitzer said, *"…we will shift the money away from the institution-centered health care system of our past, towards a more effective patient-centered system for our future. In the process, this paradigm shift will save taxpayers billions of dollars in efficiencies."*[1] As this policy brief demonstrates, New York differs from other states in terms of where people receive health care and how much it costs. Compared to other states, New Yorkers, and particularly those enrolled in publicly funded health insurance programs like Medicaid, Child Health Plus, and Family Health Plus receive more care more often in institutional settings.[2]

What difference in total costs does it make where a person gets care? In New York it makes a large difference because the state pays vastly different rates for the same procedure depending on the setting. A recent United Hospital Fund report outlined how much reimbursements rates for services can vary by setting between physician offices, hospital outpatient clinics, and diagnostic and treatment centers (D&TCs). Office-based physician fees remain far lower than fees for care in institutionally based settings.[3] New York has a long history of providing health care in institutional settings. The state is home to some of the nation's first large-scale hospitals and nursing homes. Medicaid subsidizes care for a large number of highly needy populations, costing as much as $100,000 per person per year.[4] In other areas of the country, health care systems developed differ-

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1 Nelson A. Rockefeller Institute of Government, January 26, 2007.

2 The claim that New York's health care programs are "institution-centered" may also involve how health care providers are paid. Rather than paying providers only for services to specific individuals, "institution-centered" programs may support providers through grants, contracts, memoranda of understanding, or other instruments that provide financial support in exchange for the provider's agreement to perform certain general functions. This aspect of institution centeredness is not treated in this brief.

3 Deborah Bachrach, et al. "Administration of Medicaid in New York State: Key Players and Their Roles," Medicaid Institute at the United Hospital Fund, November 2006.

4 Richard Perez-Pena, "Revolving Door for Addicts Adds to Medicaid Costs," *The New York Times*, April 17, 2007.

ently, tend to be less reliant on institutional settings, and may have more community-based options for care delivery.

So how expansive is New York's institutionally centered system, and how different are costs for care in this system compared to a state that has long been known for its orientation toward community-based care? One such "community-care oriented" state is Oregon, which was the first state to receive a home and community-based waiver in 1981 and to which advocates of community-care have long pointed to as a model.[5] This paper uses publicly available quantitative data to illustrate what New York's "institutionally centered system of care" looks like compared to the U.S. average and to Oregon's "community-oriented" system of care.

Acute Care

Table 1 shows the number of hospital beds per 1,000 of the population in New York, the United States, and Oregon. New York has a much higher number of hospital beds per 1,000 of the population compared to the U.S. average and especially compared to Oregon. Not only does New York have a larger supply of acute care hospital beds, but the population of New York also consumes a much larger amount of acute care services per 1,000 of the population than the national average and especially compared to Oregon. It contrasts with Oregon most notably if inpatient days per 1,000 of the population are compared. In fact, New York has more the twice the number of inpatient days per 1,000 of the population when compared to Oregon. It also has more hospital admissions, more outpatient visits per 1,000, and slightly more emergency room visits when compared to the national average.

One reason for the disparity in hospital service use between New York and other states may be that New York does not pay office-based physicians as well as other states do. Consequently, many physicians in New York do not participate in the Medicaid program and thus Medicaid eligible individuals must receive their care in a hospital setting. In fact, data show that New York pays physicians less than any other state.[6]

Institutional Long-Term Care

In terms of the use of institutionally centered long-term care, New York has well over twice as many nursing facility residents per 100 of the population over age 65 when compared to Oregon and many more nursing facility beds per 1,000 of the population over age 65 (although New York does not have significantly more nursing facility beds than the national average). When compared to the national average, the anomaly in this instance is in fact Oregon — where the number of nursing facility residents is considerably lower compared to New York and the national average. There are also more persons in New York where Medicaid is the primary payer of nursing facility care when compared to Oregon and the U.S. average. New York also pays more per person served in a nursing facility.

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5 In their 1998 article in the *Journal of Health Policy, Politics and Law* called "Variation in State Spending for Long-Term Care: Factors associated with more balanced systems," (and in their book *The Heart of Long-Term Care*, Rosalie A. Kane, Robert L. Kane, and Richard C. Ladd describe how Oregon's long-term care system, and to a lesser degree Washington's and Wisconsin's, are community-care oriented.

6 Data from the Physician Fee Index, available from the Kaiser Commission on Medicaid and the Uninsured, show that New York pays .70 of the national average, while Oregon pays 1.18 of the national average, for all physician fees. The Medicaid fee index measures each state's physician fees relative to national average Medicaid fees.

Table 1. Comparisons of Various Health Care Data: New York, U.S., and Oregon			
	New York	***U.S.***	***Oregon***
Acute Care Hospitals			
Hospital beds per 1,000 population, 2005	3.3	2.7	1.8
Hospital admissions per 1,000 population, 2005	131	119	92
Hospital emergency room visits per 1,000 population, 1999-2005	396	387	334
Inpatient days per 1,000 population, 2005	946	665	410
Outpatient visits per 1,000 population, 2005	2,236	1,490	1,902
Physicians			
Physicians per 1,000 of the population, 2006	4.5	3.2	3.3
Primary care physicians as a % of physicians, 2006	38.7	39.4	40.8
Primary care physicians per 1,000 of the population, 2006	1.7	1.3	1.3
Nursing Facilities			
Nursing facility residents per 100 age 65+, 2005	4.4	3.6	1.6
Nursing facility residents with Medicaid as primary per 100 age 65+, 2005	73	65	61
Nursing facility beds per 1,000 age 65+, 2004	49	47	27
Medicaid payment rate per day for nursing facility care, 2002	$172	$118	$111
Noninstitutional long-term care			
Medicaid home health participants per 1,000, 2002	4.8	2.7	0.6
Medicaid personal care participants per 1,000, 2002	4.6	2.4	0.6
Medicaid home & community-based waiver participants per 1,000, 2002	3.8	3.2	11.8[7]
Expenditures			
Medicaid long-term care expenditures per person in state, 2005	$871	$319	$235
Medicaid nursing facility expenditures per person served, 2003	$33,751	$23,882	$18,123
Medicaid home and community-based expenditures per served, 2002	$17,898	$10,531	$11,982
* Data from the Kaiser Commission on Medicaid & the Uninsured & the AARP's Profiles in Long-Term Care. Population data are from 2005. Data on physicians does not include the 2 percent who work for the federal government.			

7 Oregon provides most of its home care and personal care under its HCBS waiver, which allows the state to limit the amount of personal care and home care services it provides.

Noninstitutional Long-Term Care

Given New York's larger percent of nursing facility beds for the population, one might guess that the state provides more long-term care in institutional settings because it does not have an adequate system of home and community-based care. Interestingly, New York also has a greater number of Medicaid home health participants and personal care participants per 1,000 of its population than most states. Thus, just as New York spends more and has more institutionally centered long-term care, so too does it have more home and community-based care. In contrast, Oregon has much higher participation in its waiver and relatively little use of home care and personal care because it provides most home and community-based services through its waiver rather than regular Medicaid.

Expenditures

Given the figures in Table 1, it is not surprising that New York spends more than most states on institutionally related care. However, what is surprising is *how much more*. New York spends nearly twice as much as Oregon per person served in a nursing facility as well as more on persons served in home and community-based settings — although the proportional difference is slightly less. Examined another way, New York comprises 8 percent of all enrollees nationally but constitutes 17 percent of all institutional spending as shown in Table 2.

Table 2. Spending on Institutional Care Compared with Enrollment, FY 2006

Service Category	*All States' Medicaid Spending, FY 2006*	*New York's (NY) Medicaid Spending, FY 2006*	*NY Spending as a Percent of All Spending, FY 2006*
All Hospital*	$63.1b	$10.7b	17%
All Mental Hospitals*	$6.1b	$0.8b	13%
All ICF/MR*	$12.2b	$2.9b	23%
Nursing Facilities	$47.4b	$6.9b	15%
All Institutional Spending	$128.8b	$21.2b	17%
Enrollment	***All Enrollees***	***NY Enrollees***	***Percent of Enrollees from NY***
Medicaid Enrollees, FY 2003	55,071,200	4,583,000	8%

* "All hospital" includes inpatient, outpatient, and disproportionate share (DSH) hospital spending. All Mental Hospitals includes Mental Hospitals and Mental Health DSH. All Intermediate Care Facilities/Mentally Retarded includes public and private facilities. Data are from CMS Form 64, obtained on January 31, 2007, and are point-in-time data and may be subject to change. Enrollment data are from the Kaiser Commission on Medicaid and the Uninsured.

Why Is New York So Different?

As pointed out in this paper's introduction, there are several reasons why New York is more reliant on institutions than other states. The state has a longer history of providing care in institutions and our reimbursement system favors care in institutional settings where higher intensity care is re-

imbursed more favorably. Disparities in cost between New York and other states are exacerbated by other factors such as utilization patterns (i.e., more people travel to New York State rather than out of the state for institutionally based care; more people turn to care in institutions because fewer office-based physicians participate in Medicaid). In addition, there are a greater number of specialty physicians and medical residents in institutional settings relative to other states, which also increases the cost of care.

New York Also Spends More on Home and Community-Based Long-Term Care

One might guess that New York's reliance on institutions means that the state does not spend as much money on community-based care. This may be the case for acute care, where the state does not reimburse physicians as well as other states, but the state still spends a far greater amount per capita than other states on home and community-based waivers and personal care, as well as other long-term care services. Therefore the difference in Medicaid costs between New York and other states is caused not just by the fact that the state relies so heavily on higher-cost institutional settings, but also because the state is more generous in all areas of care provision. How much "the institution centered" nature of the system accounts for the differences in total cost and how much the generosity of benefits and eligibility account for differences is difficult to precisely quantify — but there is little doubt that the current system is expensive.

Does New York's Reliance on Institutions Matter?

Governor Spitzer also asked during his health care policy speech *"is this the best use of money for the patients in the health care system? And do these expenditures help transform the health care system from the one we have into the one we need?"* One consideration for policy makers as they seek an answer to this important question is the relative role that Medicaid plays in the health care delivery system. In New York, Medicaid comprises a much larger portion of the state's health spending: one out of three dollars versus an average of one of out of five in other states.[8] Therefore, shifts in Medicaid spending in New York have greater consequences on the state's health care delivery system than they would in most states. In-depth, detailed examination of how New York's reimbursement system affects how care is provided, for how long, to whom, by whom, and how it differs from other states, is necessary to lay a foundation for the analysis of possible policy change and new directions. Given the amount of Medicaid spending — $46 billion this fiscal year — and the number and range of affected interests, understanding New York's system of health care in this way is essential for policy makers to assess and balance the institutional and patient-centered approaches to health care reform in New York State.

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8 "Trends: Trends in U.S. Health Care Spending, 2001" by Katherine Levit, et al. *Health Affair* 22, 1 (January/February 2003).