



MEDICAID WATCH '05

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Some key facts to consider:

- Albany imposes some \$800 million in extra Medicaid charges to pay hospitals for graduate medical education; roughly half the doctors we train leave to practice in other states.
- Partly because New York does not do enough to promote preventive care, our rate of inpatient hospitalization is 42 percent above the national average.
- Although hospital lobbyists continually predict devastation from funding “cuts,” the number of hospital jobs in New York is up by 28,000, or 9 percent, since 1990. That’s three times the growth rate in overall private-sector employment.
- If we could simply get New York’s overall Medicaid spending down to **twice** the national average, instead of 2.3 times average, taxpayers would save \$5.3 billion.

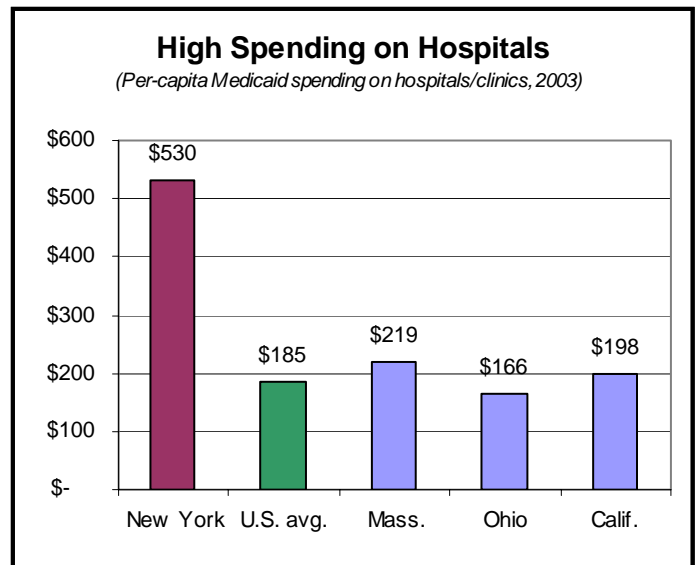
WHAT’S OUR BIGGEST SINGLE DISPARITY WITH OTHER STATES? NEW YORK’S HOSPITALS

If New York is ever going to get serious about controlling Medicaid costs, we need to go where the money is. For starters, that means hospitals.

Hospital spending represents the biggest single disparity between Medicaid spending in New York and in our competitor states. That means it presents the greatest opportunity to reduce costs at both the state and local levels. (It’s also the most important cost center Albany will assume from localities, if the Legislature approves a proposed cap on the local share of Medicaid spending.)

Our Medicaid spending on hospitals and clinics totaled more than \$10 billion in 2003. Adjusted for population, that was almost **three times** the national average. It was well over twice the level in Massachusetts, another liberal state with highly regarded teaching institutions.

Billions in additional spending are driven by the state government’s long and continuing opposition to the market forces that reduce costs and improve quality elsewhere. Analyses by independent experts such as



Standard & Poor’s and Governor Pataki’s Health Care Reform Working Group find that Albany artificially props up hospitals that should close or downsize.

Such taxpayer support “is often politically driven,” rather than based on actual consumer needs, according to S&P. Primarily at the behest of the powerful hospital workers’ union, state officials even refused to approve one hospital

closing that local officials had sought as a means of strengthening their overall health-care system.

The state’s longstanding rejection of consumer-driven forces leaves New York with 21 percent more hospital beds than the national average, adjusting for population. As the Governor’s working group noted, “Excess capacity is expensive to maintain and yields no good result.”

A MAJOR OPPORTUNITY TO IMPROVE CARE, AS WELL

Contrary to what we sometimes hear, making New York’s hospital sector more efficient does not mean “taking away our health care.” It’s more likely to improve quality of care.

When too many hospitals perform a service, such as cardiac surgery, some will attract

too few patients to maintain expertise. Higher volumes in fewer institutions can improve treatment outcomes.

Because New York’s political establishment tends to focus on preserving institutions, the state has paid inadequate attention to measuring results

and taking other steps to improve quality. That’s changing, but more must be done.

For instance, Medicaid should reward hospitals that achieve performance benchmarks, while reducing reimbursements when complications arise from hospital error.