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Federal Medicaid Changes Pose Major Budget Risks to the City's Hospitals

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A SET OF PROPOSED CHANGES to federal Medicaid regulations could sharply reduce revenues to New York's public hospitals. IBO's examination of one of these changes, eliminating Medicaid funding for graduate medical education (GME), finds it would reduce Medicaid payments to New York's public hospitals by $390 million, approximately 7.5 percent of the overall budget of the public hospital system. An additional $790 million in Medicaid GME payments to New York City voluntary hospitals would also be lost. While other states will also be affected by the elimination of Medicaid GME, the effect on New York would be disproportionately great, both because of the concentration of medical residencies here and because of New York's use of GME funds to subsidize "safety net" hospitals.

Between May 2007 and February 2008, the federal government's Centers for Medicare and Medicaid Services issued eight major regulations reducing or eliminating a wide range of Medicaid payments. Three of these regulations—eliminating Medicaid payments for graduate medical education; limiting Medicaid reimbursements to public providers to the cost of providing patient services and limiting the use of intergovernmental transfers and special outlays known as the Upper Payment Limit; and restricting Medicaid payments for hospital outpatient services–would have a direct effect on New York City hospitals, including the city's Health and Hospital Corporation (HHC). These regulations are currently subject to a moratorium enacted by Congress, but unless the moratorium is renewed by May 25, the regulations will go into effect, resulting in major revenue losses to New York hospitals.

Using data from the New York State Department of Health, IBO examined the impact of one of these regulatory changes: the elimination of Medicaid GME funding. IBO finds that this change would reduce federal payments to HHC by $195 million annually, plus an additional $195 million if the state share of Medicaid GME was lost as well. Medicaid GME payments make up approximately 7.5 percent of overall HHC revenues—as much as 15 percent for certain hospitals–so the loss of these payments could create major financial difficulties for HHC. New York City's voluntary (private, nonprofit) hospitals would lose $790 million in combined federal and state Medicaid GME funds. This represents 4.4 percent of their total revenue—a somewhat smaller share but still significant in light of the very narrow operating margins of many hospitals.

Determining Payment Levels. Graduate medical education is clinical training in a hospital residency program, typically lasting three years after graduation from medical school. Residents provide patient care under the supervision of a teaching physician, generally in a specialized teaching hospital. Determining the cost of this training is not straightforward, since teaching occurs in the context of patient care and research. Because of this, Medicare and, in most states, Medicaid compensate hospitals for GME costs in two ways. Direct GME payments are intended to cover costs that are directly attributable to medical education—residents' stipends, payments

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to supervising physicians, and program administration costs. Direct GME uses a formula based on the number of residents and the share of Medicare or Medicaid enrollees among the hospitals' patients. Indirect GME payments, on the other hand, are intended to compensate for the higher patient care costs in teaching hospitals resulting from treating sicker patients, using more diagnostic tests, maintaining more specialized services, and so on. These payments take the form of an increase in the reimbursement rates Medicaid and Medicare pay for care at teaching hospitals.

Direct and indirect GME payments have been part of the Medicaid program from its inception, with the federal government paying its usual share (50 percent in New York). According to a recent Congressional Research Service report, direct and indirect Medicaid GME payments totaled $3.2 billion in 2005, representing 7.0 percent of Medicaid inpatient hospital expenditures nationwide.[1]

Medicaid GME Funding, Public, and Other Hospitals, 2006

Dollars in millions

	Medicaid GME	Medicaid GME Share of Revenue	Residents
Bronx			
Jacobi Medical Center	$47.9	11.5%	287
Lincoln Medical Center	52.1	14.8%	211
North Central Bronx Hospital	14.3	8.5%	46
Bronx voluntary hospitals	166.4	6.9%	1,581
Bronx Total	$280.7	8.4%	2,125
Brooklyn			
Coney Island Hospital	$16.9	6.5%	119
Kings County Hospital	37.8	7.2%	379
Woodhull Medical Center	34.8	10.1%	112
Brooklyn voluntary hospitals	209.5	5.4%	2,150
Brooklyn Total	$299.1	6.0%	2,760
Manhattan			
Bellevue Hospital	$60.8	10.7%	385
Coler-Goldwater Hospitals	14.3	5.5%	8
Harlem Hospital	23.9	8.4%	197
Metropolitan Hospital	34.5	13.9%	171
Manhattan voluntary hospitals	311.9	3.6%	4,653
Manhattan Total	$445.3	4.4%	5,414
Queens			
Elmhurst Hospital	$33.3	7.9%	229
Queens Hospital	19.6	7.6%	82
Queens voluntary hospitals	78.2	3.8%	1,248
Queens Total	$131.2	4.8%	1,559
Staten Island			
Staten Island voluntary hospitals	$24.2	3.0%	370
Staten Island Total	$24.2	3.0%	370
Total New York City	$1,180.5	5.4%	12,229
All hospitals, rest of state	$174.9		4,218
Total, New York State	**$1,355.5**		**16,447**
HHC System*	$390.2	7.4%	2,227

SOURCES: New York State Department of Health; HHC Cash Disbursements and Receipts Report; Greater New York Hospital Association.

NOTE: *Includes MetroPlus and other systemwide functions.

New York Faces Largest Funding Loss. New York hospitals are particularly dependent on Medicaid GME funding, so the effect of its elimination would be most severe here. In 2006, New York State Medicaid GME funding totaled $1.36 billion, over 40 percent of all Medicaid GME funding nationwide (click here for table comparing the states). This was also approximately 40 percent of the $3.4 billion total spent on graduate medical education statewide.

New York's high level of Medicaid GME is in part a result of the same factors that drive high levels of health spending generally in New York. But it is also the result of two factors specific to GME. First, a disproportionate share of the nation's doctors do their residencies in New York. Out of 107,000 medical residents nationwide, 16,500 are in New York–more than 15 percent, even though the state is home to less than 7 percent of the nation's population. Second, New York has historically used GME payments to subsidize hospitals. According to state Health Commissioner Richard Daines, "In New York, a number of inarguably important public goods—from physician supply and distribution, to hospital budget gap closure and indigent care, to research competitiveness—have been linked by decision and default, explicitly and implicitly, to graduate medical education."[2] This use of Medicaid GME is reflected in New York's high rates for direct and indirect GME payments. It is also reflected in the state's formula for direct GME payments, which allows some GME payments to be made to nonteaching hospitals.

GME payments today represent a large share of Medicaid payments to New York's hospitals, including the 11 public hospitals operated by the Health and Hospitals Corporation.

GME payments make up 18.5 percent of Medicaid payments to HHC hospitals, and 7.4 percent of HHC's overall revenue. Within the HHC system, the major teaching hospitals are particularly dependent on Medicaid GME: in 2006 Lincoln Medical Center, in the Bronx, received 14.8 percent of its total revenue—and nearly a third of its Medicaid revenue—through Medicaid GME payments. While Medicaid, including Medicaid GME, is less critical to voluntary hospitals, many of them would also face major losses. Bronx-Lebanon, Brookdale, Montefiore, and Mount Sinai are among the voluntary hospitals most dependent on Medicaid GME funding. So an abrupt termination of Medicaid GME payments could cause severe disruptions to the finances of both public and voluntary hospitals, to patient care, and to the city's economy.

As the table on page 2 shows, while New York State's teaching hospitals are concentrated in New York City, within the city GME funding is widely spread. So the economic effect of any cutoff in Medicaid GME funding would be felt across the city. For HHC, loss of Medicaid GME funding would reverse the improvement in its financial position resulting from increased city subsidies in recent years (see *Larger City Subsidy Saves Public Hospitals, For Now,* March 2008). And beyond the short-term economic effect, the major role played by Medicaid in funding graduate medical education means a loss of this funding could substantially reduce the supply of doctors in future years.

Washington Deadline. The Congressional moratorium on eliminating GME funding (and the other Medicaid changes) expires May 25, 2008. On April 23, the House passed a bill extending the moratorium through April 1, 2009, by a vote of 348 to 62. Legislation extending the moratorium has been introduced in the Senate, but as of May 9, no action had been taken. The Bush Administration has indicated that if the Senate passes the House bill or a similar moratorium extension, a veto is likely.[3]

If Congress fails to extend the moratorium, it is unclear how soon the elimination of the graduate medical education funding (and other regulations) would take effect. But it is clear that the potential end to Medicaid GME represents a serious threat to the finances of New York City hospitals and especially to HHC, and could lead to major reductions in patient care and employment at hospitals throughout the city.

This report prepared by J.W. Mason

ENDNOTES

[1]Elicia J. Herz and Sibyl Tilson, "Medicaid and Graduate Medical Education," March 19, 2008.
[2]Remarks delivered June 18, 2007, quoted in New York State Council on Graduate Medical Education, "Policy Recommendations to the Commissioner of Health," March 2008, p. 62.
[3] "Statement of Administration Policy" at http://www.whitehouse.gov/omb/legislative/sap/110-2/saphr5613-h.pdf