Citizens Budget Commission

Policy Brief

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The Citizens Budget Commission is a nonprofit, nonpartisan civic organization devoted to influencing constructive change in the finances and services of New York State and City governments.

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A Troubling Prognosis for HHC's Finances

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The New York City Health and Hospitals Corporation (HHC), a vital component of the health care safety net protecting lower income New Yorkers, faces two significant fiscal challenges in the coming years. First, HHC expects about $1.6 billion in annual revenues that have been available through special Medicaid supplementary payments will continue to flow in coming years, but, in fact, they may be in jeopardy.

Second, HHC's expenses, notably for pensions and fringe benefits, have been growing more rapidly than its revenues, obliging its leaders to develop a plan to close projected gaps. The problem is that the current plan does not fully close the gaps and key elements may prove unrealistic. HHC President Alan Aviles recently acknowledged steeper expenditure reductions and layoffs may be necessary should the current plan fail to achieve savings goals. [1]

HHC's Critical Role

HHC is a public benefit corporation that plays a significant role in providing health care services to low-income and uninsured New Yorkers. The HHC's 11 acute care facilities contain nearly 5,000 hospital beds; its more than 200,000 annual inpatient hospital admissions represent a similar share of the citywide total. (See Table 1).

Table 1: New York City Health and Hospitals Corporation, Market Share of Hospital-based Services, 2009

	Total Citywide	HHC Hospitals	Share of Total
Certified Beds -- Total	25,150	4,894	19%
Certified Beds -- Psychiatry	3,272	1,445	44%
Hospital Discharges*	1,144,374	207,160	18%
Medicaid / Uninsured	466,037	140,543	30%
Emergency Visits**	3,872,066	1,077,414	28%
Medicaid / Uninsured	2,402,497	843,650	35%
Psychiatry Discharges	58,232	22,164	38%
Medicaid / Uninsured	35,916	15,547	43%

* Excluding newborn.
** Including admissions.
Source: Analysis of 2009 New York State Hospital Institutional Cost Reports provided by the United Hospital Fund.

HHC provides care to a significant portion of patients citywide who are on Medicaid or uninsured. HHC hospitals care for 30 percent of Medicaid and uninsured patients admitted to acute care facilities. While the city's voluntary hospitals care for the majority of the indigent population needing acute care, their ability to do so depends on the availability of a large public hospital system.

HHC's acute care hospitals play a substantial role in providing emergency care to the city's indigent and uninsured population. Of more than one million emergency room visits to HHC hospitals, 78 percent were made by Medicaid recipients or the uninsured. At other city hospitals, by contrast, Medicaid and uninsured patients account for 56 percent of emergency room visits. HHC cared for 35 percent of emergency department patients citywide who are either Medicaid recipients or uninsured.

HHC is particularly important in providing psychiatric care, treating more than 22,000 psychiatric patients annually. This group includes more than four of every ten such patients who are on Medicaid or uninsured citywide.

HHC operates MetroPlus, a prepaid health plan with 426,000 enrollees. MetroPlus holds contracts to provide services to recipients of Medicaid, Child Health Plus, Family Health Plus,

Medicare and other government health insurance program benefits. MetroPlus enrollees receive primary care services and specialty care from physicians who are affiliated with HHC hospitals and selected voluntary hospitals in the city.[2]

Recent Reliance on City Funding

The City provides funding for the HHC in three general ways. One of these is mandated by the State; the other two involve more policy discretion on the part of municipal leaders.

Medicaid Mandate. The mandated support comes via the required local share of Medicaid payments for managed care premiums and fee-for-service provider payments. At the beginning of New York's Medicaid program in 1967 the State required that the City of New York and the 57 counties pay half of the non-federal portion (equal to 25 percent of the total) of the cost of Medicaid services for their residents. This was unpopular from the start, and Mayor John Lindsay led an unsuccessful effort to oppose the mandate; New York City mayors and numerous county executives have echoed the opposition in years since.[3]

In the 1980s the mandated local share for most long-term care services was reduced from 25 to 10 percent, and in 2005 the growth in the aggregate local share for each county and New York City was capped at 3 percent annually. In 2012 the State tightened that cap, reducing annual growth in the local share from 3 percent to zero growth over three years. Despite the progress in reducing mandated local support, the sum for New York City remains high; however, most of these Medicaid payments go to private providers with only a fraction going to HHC. Because of its mandated nature, this form of Medicaid payment is not considered part of the City's more discretionary support for HHC in the discussion and tables below.

Medicaid Supplementary Payments. Since the 1980s the federal government has authorized federal matching funds for supplemental payments as part of a state's Medicaid program.[4] These supplemental payments differ from other Medicaid payments in that they are not directly paid in exchange for provision of a specific service such as a hospital stay or a doctor visit; instead, they are paid as a lump sum to providers (typically hospitals and nursing homes) who met certain qualifications related to the extent to which they serve Medicaid and other low-income patients. They also differ from other Medicaid payments in that the non-federal portion of the funding relies predominantly on payments from local governments (in the case of HHC and other public facilities) or on State taxes on the providers themselves (in the case of voluntary hospitals and other private providers) rather than on broader based State general fund revenues. The City's contribution toward supplemental payments to the HHC is authorized by the state and flows through the State Department of Health, but there is local discretion in the scale of these payments to HHC.

The federal Medicaid program allows supplemental payments of two types. Disproportionate Share Hospital (DSH) payments are given to hospitals whose patients are drawn disproportionately from the Medicaid and uninsured population. The federal government sets a limit on the amount of federal funds each state will receive each year for DSH payments, but states have considerable discretion in determining how to distribute that money among eligible providers in the state.[5] Upper Payment Limit (UPL) payments are given to eligible institutions whose Medicaid payment rate for inpatient and/or outpatient services are less than what they would receive for the same service under the federal Medicare program. Payments can be made to these hospitals to supplement their Medicaid rates, but a facility cannot receive more in combined Medicaid rates and UPL payments than it would have earned under the Medicare program for the services.

Direct City Appropriations. The third, and highly discretionary, form of City support for HHC is the transfer of funds directly from the City to HHC and payments by the City on behalf of HHC. In the latter category are payments by the City for malpractice settlements against HHC and debt service payments on bonds issued by the City for HHC capital projects. In most recent years the City requests and receives full or partial reimbursement from HHC for these payments. Other direct transfers to HHC are typically linked to the value of services HHC provides for uniformed personnel, prisoners and other items for which the City assumes responsibility.

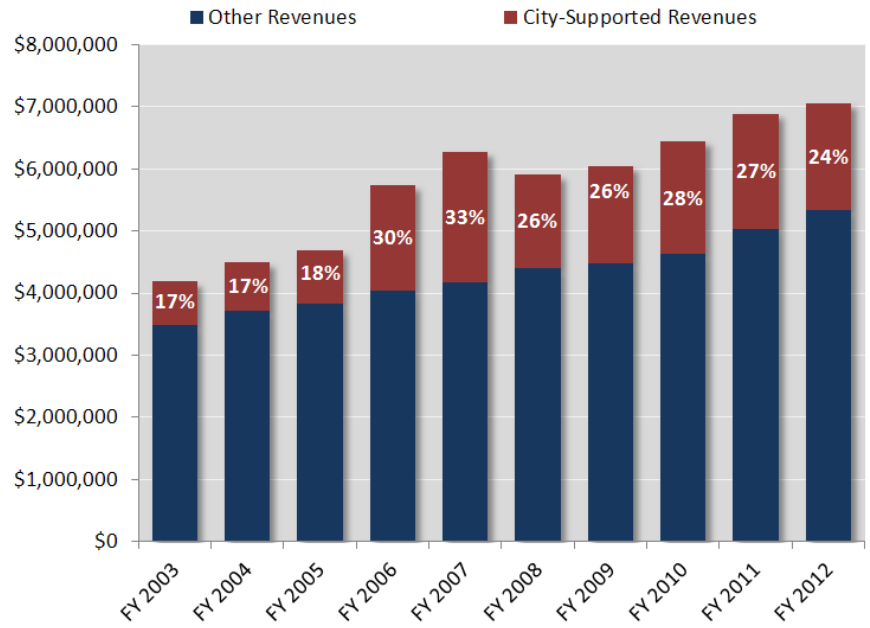
Recent Trends. During the administration of Mayor Michael Bloomberg the City's support for HHC has changed in two important ways. First, it has grown significantly. Early in the Administration, the combined support through the City appropriation and Medicaid supplemental payments (identified together as "City supported revenues" in Figure 1 and the Appendix) rose from $698 million in fiscal year 2003 to $852 million in fiscal year 2005, or from 17 to 18 percent of total revenues. Then this support jumped to $1.7 billion in fiscal year 2006 and $2.1 billion in fiscal year 2007, reaching one-third to total revenues in fiscal year 2007. The support dropped in the two subsequent years, but was still well above fiscal year 2005 levels. In fiscal years 2010 and 2011 the support exceeded $1.8 billion annually equaling at least 27 percent of total revenues. Much of the variability in the later years is related to delays in federal approval of requested supplemental payments.

The increase in City support was accompanied by a shift in the form of the assistance. Less reliance was placed on direct appropriations and more on the Medicaid supplemental payments. In fiscal years 2003 through 2005 the direct appropriation ranged between $195 million and $321 million. In the next six years the appropriation was in this range only in fiscal year 2010; in other years it was far smaller and in two years was negative as the City sought reimbursement from HHC for expenditures on its behalf.

The increase in support has been concentrated in the Medicaid supplemental payments. The City contribution to the supplemental payments was raised from $278 million in fiscal year 2005 to a peak of over $1.0 billion in fiscal year 2007, with the combined federal and City Medicaid supplemental support exceeding $2.0 billion in the later year. City supported

supplemental payments were reduced in subsequent years, but the City' $913 million contribution in 2011 generated over $1.8 billion in combined federal and City support through supplemental payments – a figure more than triple the amount of such support in the earlier years.

Figure 1: New York City Health and Hospitals Corporation Revenues, Fiscal Years 2002 to 2012
(dollars in thousands)



Source: See Appendix.

In addition to increased operating support, the City has also been providing HHC with support in the form of new capital investments. Since 1993, HHC has funded some of its capital program by issuing its own debt. However, New York City continues to play a significant role in paying for key modernization projects undertaken at major hospitals, including Harlem and Bellevue. In fiscal years 2002 through 2011 the City made capital commitments worth nearly $1.7 billion for HHC.[6]

The Troubling Prognosis

HHC's fiscal prognosis is troubling because anticipated continuation of large-scale supplemental Medicaid payments is in jeopardy, and because even with the substantial City and federal support that is assumed in HHC's projections the corporation expects to run operating deficits in the coming years.

Threats to City-Supported Revenues. The current level of City support is in jeopardy as the City's own finances enter a new era of lower revenues. From fiscal years 2003 to 2011, actual tax collections were at least $1 billion above the amount originally budgeted.[7] These unanticipated tax revenues, resulting from conservative forecasting and strong growth on Wall Street and in the real estate market, provided a key cushion to the city's budgeting process.

That streak of good fortune is ending in fiscal year 2012. Profits on Wall Street are currently running $7 billion below what was projected when the budget was adopted in June 2011. Current projections indicate the City will end the fiscal year with tax revenues totaling only $114 million more than originally projected, a surplus of just 0.3 percent above total tax revenues of more than $42 billion.[8]

The surpluses built up in the past decade are gone, leaving City Hall to contemplate significant cuts to all programs. Prospects are dim for a quick turnaround based on new City revenues. Overall tax revenue growth over the next four years is projected to fall well below the average growth rate enjoyed by the city since 1989.

Moreover, it will be more difficult to use whatever City support may be available to leverage federal funds. The national health care reform law calls for federal DSH payments to be cut by 50 percent by 2019, with reductions beginning in 2014.[9] Political and legal obstacles may prevent the law from being fully implemented. However, projections of tight federal budgets in coming years mean DSH payments will remain a target for cuts even if health care reform is halted. The national political climate suggests other federal interventions yielding additional revenue are unlikely.

An Inadequate Gap-Closing Plan. HHC projects supplemental Medicaid payments from the City and federal government to drop modestly in 2014 but remain at nearly $1.6 billion annually through 2016. Even with these uncertain supplemental Medicaid payments, HHC's financial projections show large operating deficits every fiscal year through 2016 when the gap exceeds $1.7 billion. (See Table 2). These deficits are based on Generally Accepted Accounting Principles (GAAP), which require reporting for non-cash items such as the liability for retirees' future health insurance. However, even after adjustment to cash-based accounting, significant deficits remain, as shown in the "Cash Surplus/(Gap)" line in Table 2.

HHC's operating deficits also remain after accounting for projected savings from its cost-cutting plan. The corporation is currently implementing a gap-closing plan that was released in May 2010, and begun in fiscal year 2011.[10] The focus of that plan was to reduce costs without reducing medical service levels, primarily by outsourcing some operational and managerial functions. HHC trimmed its full-time employee headcount by roughly 2,500 between 2009 and early 2012, reducing personal service expenditures by $218 million.[11]

Table 2: New York City Health and Hospitals Corporation, Projected Revenues and Expenses, Fiscal Years 2012 to 2016
(dollars in thousands)

			PROJECTED		
	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Total Revenues	**$7,052,800**	**$7,144,300**	**$7,240,000**	**$7,369,900**	**$7,483,500**
Patient Service, Premium and Other Revenue*	5,331,100	5,527,200	5,669,100	5,791,900	5,904,000
City-Supported Revenues	1,721,700	1,617,100	1,570,900	1,578,000	1,579,500
City Share of Supplemental Payments	860,850	823,350	795,750	795,750	795,750
Federal Share of Supplemental Payments	860,850	823,350	795,750	795,750	795,750
Direct Appropriations from New York City	-	(29,600)	(20,600)	(13,500)	(12,000)
Total Expenses**	**$8,026,900**	**$8,407,200**	**$8,707,500**	**$8,971,300**	**$9,224,000**
Surplus/(Gap)	**($974,100)**	**($1,262,900)**	**($1,467,500)**	**($1,601,400)**	**($1,740,500)**
Adjustment to Cash	**$1,007,600**	**$575,200**	**$537,000**	**$522,600**	**$522,800**
Cash Surplus/(Gap)	**$33,500**	**($687,700)**	**($930,500)**	**($1,078,800)**	**($1,217,700)**
Corrective Actions	**$100,400**	**$471,300**	**$747,600**	**$956,700**	**$1,156,700**
Cost Containment	28,100	24,200	21,100	21,100	21,100
Restructuring	72,300	197,100	239,900	239,700	239,700
State/Federal Actions	-	250,000	450,000	650,000	850,000
City Share of DSH Preservation	-	-	36,600	45,900	45,900
Gain/(Loss) After Corrective Actions	**$133,900**	**($216,400)**	**($182,900)**	**($122,100)**	**($61,000)**

* Includes Bad Debt and Charity Care Pool Funds, Other Pool Funds and Self Pay Revenue of $126.4 million in fiscal year 2012, $126.3 million in fiscal year 2013, and $121.5 million in each subsequent fiscal year.

** Includes operating expenses and net non-operating expenses.

Source: New York City Office of Management and Budget, "Financial Plan Modification Letter to the Financial Control Board, Exhibit B-1," February 24, 2012; and data provided by the New York City Office of Management and Budget and the Health and Hospitals Corporation.

Despite these successes, the HHC plan launched in 2010 is insufficient to close HHC's gap in coming years and major elements are uncertain. If the plan were fully implemented, cash deficits ranging from $51 million to $216 million (and GAAP deficits typically exceeding $600 million annually) would remain in coming years.

Yet it is likely that HHC's gap-closing plan will not be fully implemented in its current form. The modest cost-saving initiatives can be realized. However, the remaining programmatic changes HHC identifies as "restructuring" and values at nearly $240 million annually will be much more difficult to implement. For instance, consolidating long-term care services currently offered at the Coler-Goldwater facility on Roosevelt Island (an action projected to save HHC more than $10 million annually) will depend on finding other ways to care for existing patients.[12] Doing so will require, in part, construction of a new facility, work that could extend beyond the 2014 target.

Perhaps even more significant is that HHC's corrective action plan now calls for unspecified gap-closing actions from the State and federal governments that rise from $250 million in fiscal year 2013 to $850 million in fiscal year 2016. Should these unspecified items fail to materialize, HHC's cash-defined operating deficit in fiscal year 2013 increases to $466 million from $216 million. In fiscal year 2016 that deficit increases to $911 million from $61 million. Given the push in Albany and Washington to reduce health care spending, this additional support likely will not come in the form of new revenues. If the HHC and the City cannot identify sources for these funds and to replace any lost supplemental Medicaid payments, then HHC will need to redouble its efforts at delivering services more efficiently or face a dramatic reduction in the services it can provide to New York City's needy residents.

Appendix

Appendix: New York City Health and Hospitals Corporation, Operating Revenues, Fiscal Years 2003 to 2012

(dollars in thousands)

	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	PROJECTED FY 2012
Operating Revenues - Total	**$4,175,122**	**$4,489,672**	**$4,678,288**	**$5,731,620**	**$6,264,529**	**$5,897,276**	**$6,036,928**	**$6,440,565**	**$6,883,088**	**$7,052,800**
Net Patient Service Revenue*	2,801,044	3,000,887	3,017,948	3,204,003	3,217,526	3,291,577	3,248,481	3,241,313	3,488,957	3,288,200
Premium Revenue	274,483	407,087	484,599	541,895	608,511	779,611	946,872	1,107,197	1,279,390	1,755,700
Grants Revenue	364,325	257,695	272,027	258,014	308,840	279,024	240,194	220,152	213,226	244,700
Other Revenue	37,669	43,379	52,133	33,874	36,466	36,961	36,530	47,323	47,519	42,500
City-Supported Revenues	697,601	780,624	851,581	1,693,834	2,093,186	1,510,103	1,564,851	1,824,580	1,853,996	1,721,700
Federal Share of Supplemental Payments**	251,343	229,739	277,923	903,109	1,018,644	792,177	741,196	768,766	913,202	860,850
City Share of Supplemental Payments**	251,343	229,739	277,923	903,109	1,018,644	792,177	741,196	768,766	913,202	860,850
Direct Appropriations from New York City	194,915	321,146	295,735	(112,385)	55,899	(74,251)	82,460	287,048	27,593	-

* Includes Bad Debt and Charity Care Pool Fund, Other Pool Funds and Self Pay Revenues.

** Includes Disproportionate Share (DSH) Payments, Upper Payment Limit (UPL) Payments, and Supplementary Low Income Patient Adjustment (Supp/SLIPA) Payments.

Source: New York City Health and Hospitals Corporation, *Annual Financial Statements*, for fiscal years 2002 to 2011. Fiscal year 2012 from New York City Office of Management and Budget, "Financial Plan Modification Letter to the Financial Control Board, Exhibit B-1," February 24, 2012; additional data provided by the Health and Hospitals Corporation.

Endnotes

[1] New York City Health and Hospitals Corporation, *Testimony of Alan D. Aviles, President, New York City Health and Hospitals Corporation, before The Committee on Health, New York City Council,* Alan Aviles (New York, NY: March 19, 2012), http://www.nyc.gov/html/hhc/html/pressroom/city-council-testimony-20120319.shtml.

[2] Other city hospitals with physicians providing primary care services to MetroPlus enrollees include Beth Israel Medical Center, St. Luke's Roosevelt Hospital, Lutheran Medical Center, Maimonides Medical Center, SUNY Downstate Medical Center, Long Island College Hospital, and Peninsula Hospital. Source: MetroPlus Provider Directory, available at http://www.metroplus.org/provider_directories.php.

[3] See Citizens Budget Commission, *A Poor Way to Pay for Medicaid: Why New York Should Eliminate Local Funding for Medicaid,* (Citizens Budget Commission, December 2011).

[4] For a description of Medicaid supplemental payments see Medicaid and CHIP Payment and Access Commission, *Report to the Congress on Medicaid and CHIP,* March 2012, Chapter 3, pp. 167- 201.

[5] In New York State, one long-standing form of supplementary payment is know as the Supplementary Low Income Payment Adjustment (SLIPA).

[6] Data provided by New York City Office of Management and Budget.

[7] Maria Doulis, "What's Different About Next Year's City Budget," Citizens Budget Commission, February 10, 2012, http://www.cbcny.org/cbc-blogs/blogs/what%E2%80%99s-different-about-next-year%E2%80%99s-city-budget.

[8] *Ibid.*

[9] New York's loss of DSH funding could be made worse if the state's charity care pool allocation rules are not changed. The state's current rules do not conform to guidelines in the health reform law for how DSH funds will be allocated after 2014. See Elisabeth R. Benjamin, Arianne Slagle and Carrie Tracy, "Incentivizing Patient Financial Assistance: How to Fix New York's Hospital Indigent Care Program," Community Service Society of New York, February 2012, http://www.cssny.org/publications/.

[10] New York City Health and Hospitals Corporation, "Restructuring HHC: The Road Ahead," May 2010, http://www.nyc.gov/html/hhc/downloads/pdf/hhc-road-ahead-report.pdf.

[11] New York City Health and Hospitals Corporation, "Minutes of the March 13, 2012 Finance Committee Meeting," p.10.

[12] New York City Health and Hospitals Corporation, "Restructuring HHC: The Road Ahead," May 2010, http://www.nyc.gov/html/hhc/downloads/pdf/hhc-road-ahead-report.pdf.