Redesigning
THE MEDICAID PROGRAM

Medicaid Global Spending Cap

October 2011 Report

NEW YORK
state department of
HEALTH

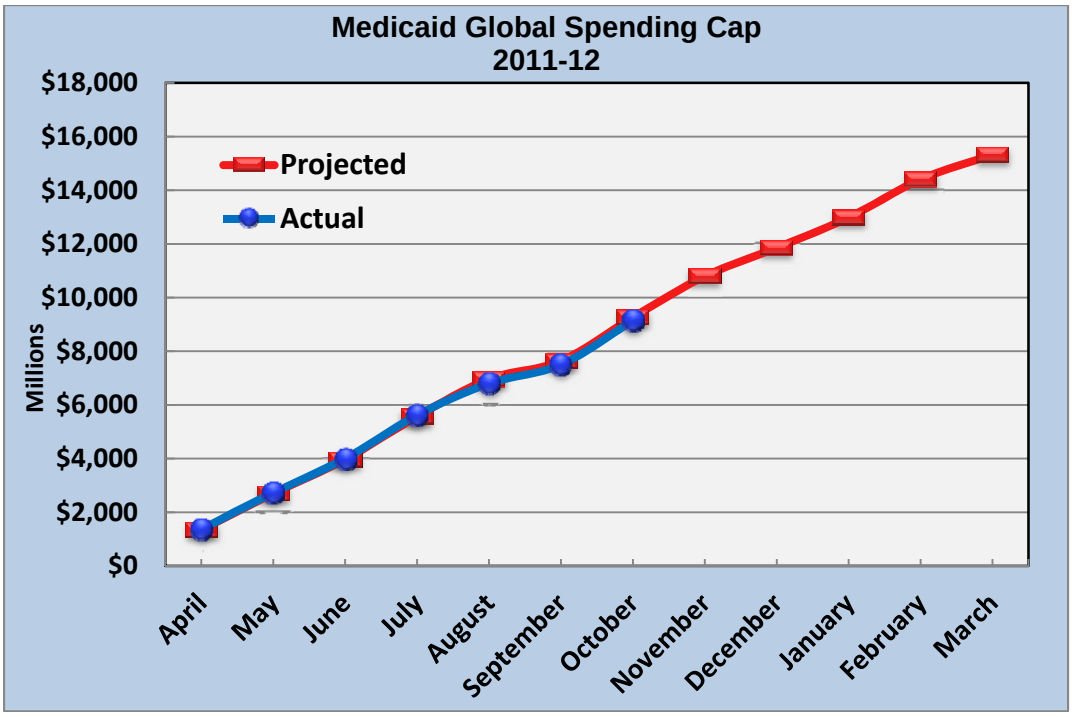
Overview

The Department of Health and Division of Budget are required to report on a monthly basis, under Chapter 59 of the Laws of 2011, actual State Medicaid spending compared to projected expenditures. The Medicaid Global Spending Cap is projected to total $15.3 billion in SFY 2011-12. The charts on page three of this report depict actual spending through October and projected monthly spending for the remainder of the state fiscal year.

Results through October 2011 - Summary

Total State Medicaid expenditures under the Medicaid Global Spending Cap through October of SFY 2011-12 are $125 million or 1.3% **below** projections. Cumulative spending for the months April through October resulted in total expenditures of $9.14 billion compared to the projection of $9.27 billion. Since April 2011, enrollment in the Medicaid program has grown by nearly 101,500 enrollees (or 2.0%), with a majority of these individuals enrolling in either the Family Health Plus or Medicaid Managed Care programs. This enrollment growth will drive additional spending which, if unabated, could place more pressure on the global cap.

It should be noted that Medicaid spending on a month-to-month basis is subject to significant variation due to enrollment swings, provider billing patterns, rate adjustments, and the number of billing cycles within a month. The Department of Health does not expect Medicaid program volatility to decline in the near term due to factors such as, the enrollment trend mentioned above, as well as processing of significant retroactive rate packages (i.e., 2009 hospital rates, managed care premiums, 2009 Outpatient Ambulatory Patient Groups). In addition, there are new Medicaid Redesign Team measures which are on track to be implemented prior to the conclusion of the third quarter of SFY 2011-12. Accordingly, stakeholders and other interested parties should be *cautious* in making judgments and/or reaching conclusions based on results to date. The State will continue to monitor spending and enrollment trends very closely throughout the remainder of the fiscal year.



Medicaid Spending April through October 2011 (dollars in thousands)			
Category of Service	**Estimated**	**Actual**	**Variance**
Inpatient	$1,225,075	$1,216,997	($8,078)
Outpatient/Emergency Room	$205,642	$181,398	($24,244)
Clinic	$180,963	$184,660	$3,697
Nursing Homes	$1,899,661	$1,864,284	($35,377)
Other Long Term Care	$1,097,521	$1,054,679	($42,841)
Medicaid Managed Care	$2,032,365	$2,030,542	($1,824)
Family Health Plus	$395,475	$429,944	$34,469
Non-Institutional / Other	$2,427,927	$2,334,197	($93,730)
Cash Audits	($199,071)	($155,857)	$43,214
TOTAL	**$9,265,558**	**$9,140,844**	**($124,714)**

Results through October - Variance Highlights

- **Lower Fee-for-Service Spending:** Through October, Medicaid spending in major fee-for-service categories is $109 million below projections as follows:
  - *Inpatient* hospital spending is $8 million under the estimate. The Inpatient sector has experienced a 1% decrease in the number of claims projected to the actual claims billed, consistent with providing services in more appropriate settings, and the migration of recipients to Medicaid Managed Care.
  - *Outpatient/Emergency Room* spending is $24 million below projection and reflects a 9% decrease in the number of recipients served as services continue to migrate to Medicaid Managed Care.
  - *Clinics* are $4 million above estimates primarily driven by the increase of 1% in individuals served.
  - *Nursing Home* spending is $35 million below projections due to a decline in the number of individuals served.
  - *Other Long Term Care* services spending, which includes Personal Care, Home Health, Home Nursing, and the Assisted Living programs, is $43 million lower than projections. The variance is primarily attributable to lower than projected spending in Personal Care ($21 million) and Home Nursing ($13 million). The Personal Care variance continues to reflect efforts to reduce utilization as well as a reduction in fee-for-service spending due to the inclusion of personal care services in the benefit package for Managed Care enrollees (effective August 1, 2011). The Home Nursing variance reflects a continued reduction in spending due to the migration of recipients to Medicaid Managed Care.
  - *Non-Institutional* fee-for-service spending (includes Pharmacy, Transportation, Supplemental Medical Insurance, etc.) is $3 million below estimates. This variance is primarily due to lower Supplemental Medical Insurance ($58 million) and Early Intervention ($11 million) spending offset by higher Pharmacy spending ($68 million). Lower than forecasted Medicare rates drove the under spending for SMI. Higher than projected utilization resulted in higher Pharmacy spending through October.
- **Lower Medicaid Managed Care Spending:** Total spending through October is $2 million below projections due to lower than expected claim volume. However, there appears to be a difference between actual enrollment as recorded on the plan roster and billed claims.
- **Higher Family Health Plus Spending:** Through October, Family Health Plus spending is $34 million above estimates and continues to reflect higher than projected enrollment.
- **Lower Federal Medical Assistance Payments (FMAP):** Enhanced Federal share benefits are $56 million below projections through October. A portion of this variance may be attributed to the receipt of the anticipated benefits through lower payments in other service categories. The enhanced FMAP period ended June 30, 2011. It is not anticipated there will be significant additional earnings for the remainder of the fiscal year.
- **Local Medicaid Cap Costs:** To date, Local Medicaid Cap expenditures are below projected levels by $95 million. This is related to both fee-for-service and Managed Care spending variances (Note: Under the 2005 Local Medicaid Cap statute, the State is responsible for covering local costs of Medicaid that exceed the annual cap).

- **Lower Other State Agency Offset Transfers**: Medicaid spending by other State agencies is running $127 million above projections through October. This spending is processed by the Department of Health and subsequently offset by transfers from the other agency budgets.

- **Medicaid Administration Costs**: Spending through October is below projected levels by $36 million.

- **Lower Medicaid Audits:** Through October, spending offsets realized from Medicaid audit recoveries are $43 million below projected levels, which results in higher spending.

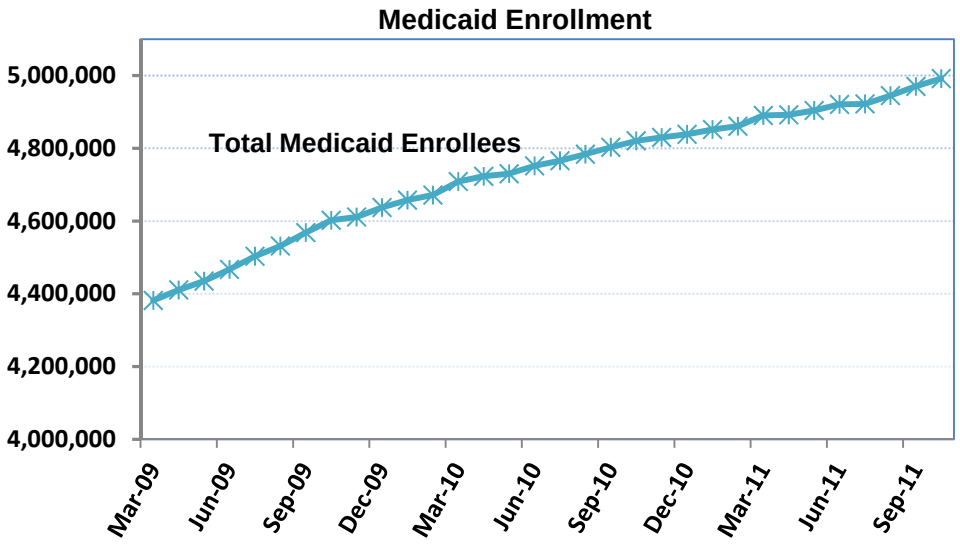
Accounts Receivable

The Department of Health has approximately 80 different rate adjustment packages to process between November 2011 and February 2012. Many of these rate packages have retroactive impacts (meaning they adjust rates for prior periods). With a few exceptions (those pertaining to mental hygiene programs not subject to the Medicaid Global Spending Cap), these rates are all included in the Medicaid Global Spending Cap calculation and the impacts they will have on the State's Financial Plan are important to note. When the State makes payment on these rate packages, all adjustments with a positive impact get paid to providers on the date of the transaction. For those providers with a rate decrease, the State's policy has been to collect these funds back by intercepting a portion of future payments over time. This avoids creating an undue hardship on the provider.

The accounts receivable for retroactive rates owed to the State as of October 2011 is $535 million. The State is expecting the balance to peak at over $600 million in January 2012, with the activation of the 80 different rate adjustment packages to process, and begin to decline in the following months. It should be noted that to the extent recoveries are not made, there will be a direct impact on the Medicaid Global Spending Cap. The Department of Health will closely monitor these balances throughout the remainder of the fiscal year.

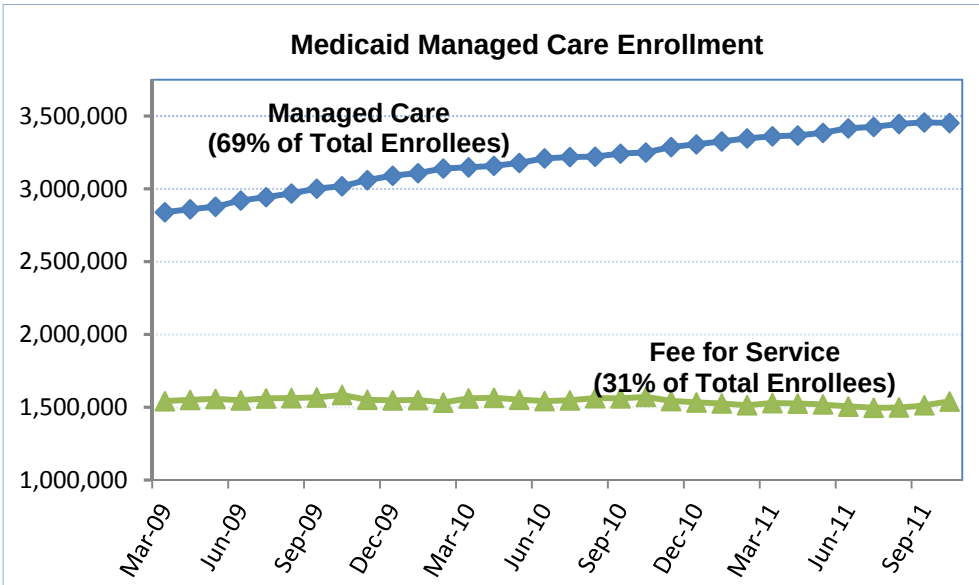
Enrollment

Medicaid enrollment reached 4,991,840 enrollees at the end of October 2011. This reflects an increase of 101,500 enrollees, or 2.0%, since April 2011.



Source: NYS DOH/OHIP Medicaid Enrollment Database
**Most current four month counts are adjusted by lag factors (3.62%, 1.38%, 0.57% and 0.21%, respectively)*

Medicaid Managed Care enrollment in October 2011 (includes FHP and Managed LTC and excludes CHP) reached 3,452,435 enrollees, an increase of 91,000 enrollees or 2.7% since April 2011.



Source: NYS DOH/OHIP Medicaid Enrollment Database and Managed Care Roster
**Includes FHP, Managed LTC, Primary Care Partial Capitation Provider, Partial Managed LTC, PACE, Medicaid Advantage, Medicaid Advantage Plus and HIV SNP.*

Regional Spending Data

The Global Cap legislation requires the Department to publish actual state Medicaid spending by region. The regions selected are based on the Governor's eleven economic development areas. The following chart shows actual spending for April through October 2011 for each region.

Provider Claims:	**$8,888**
New York City	$5,363
Long Island	$900
Mid-Hudson	$807
Western	$398
Finger Lakes	$355
Capital District	$306
Central	$212
Mohawk Valley	$187
Southern Tier	$166
North Country	$121
No Service County & Out of State	$74
Manual / Offline Spending	**$252**
TOTAL	**$9,140**

Detailed regional information can be found on the Department of Health's website at:

http://www.health.ny.gov/health_care/medicaid/regulations/global_cap/regional/index.htm