Redesigning
THE MEDICAID PROGRAM

Medicaid Global Spending Cap

August 2012 Report

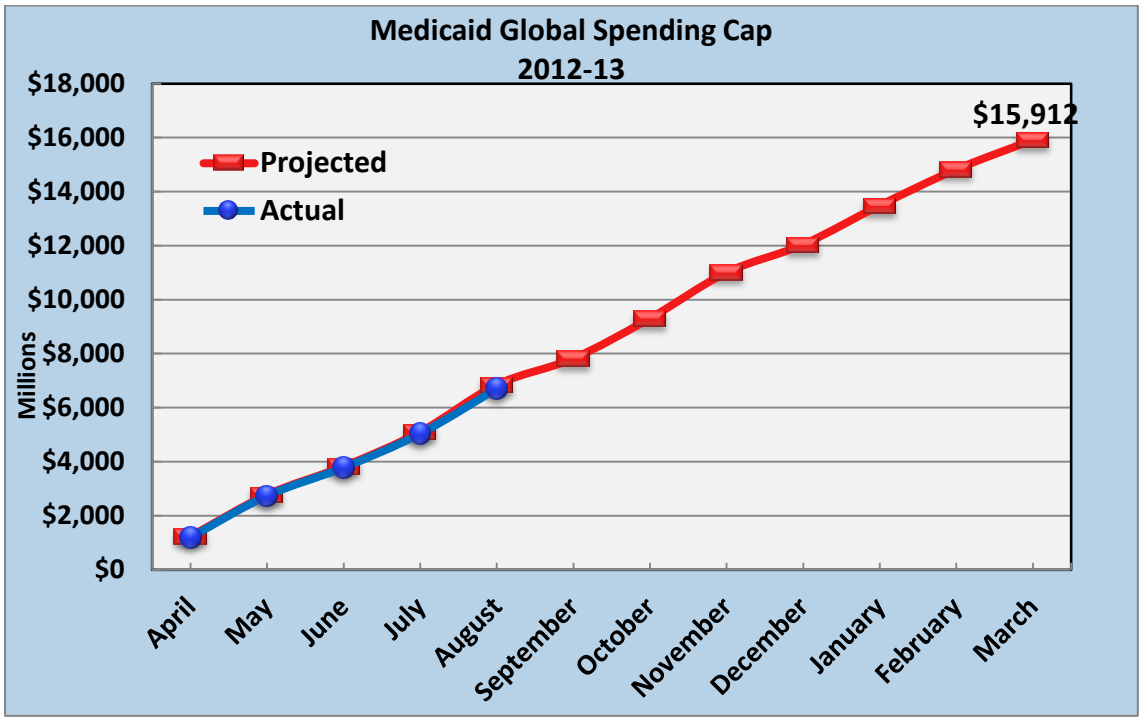
NEW YORK
state department of
HEALTH

Total State Medicaid expenditures under the Medicaid Global Spending Cap for SFY 2012-13 through August are $28 million or 0.4% **below** projections. Spending through August resulted in total expenditures of $6.71 billion compared to the projection of $6.73 billion. 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, as well as the implementation of new Medicaid Redesign Team measures. The State will continue to monitor spending and enrollment trends very closely each month.

In the April Report, DOH and DOB provided an explanation of the $600 million forecasted growth in the program. The components of the growth are:

- Price increases primarily driven by fee-for-service rate increases (some still awaiting CMS approval) and Medicaid Managed Care/Family Health Plus premium increases which will be implemented throughout the year (+$363 million);
- Enrollment growth will increase between 90,000 to 120,000 recipients over last year (+$433 million);
- One-time actions from the prior fiscal year that impact year-to-year growth (i.e., loss of enhanced FMAP and 53rd Medicaid weekly cycle) (+$192 million); offset by,
- Accounts receivable balance (amount owed from providers for rate reductions implemented last year) will be reduced nearly in half (-$259 million); and lastly,
- MRT Phase I savings will annualize and new MRT Phase II initiatives will be implemented (-$129 million).

DOH and DOB are collaborating on making refinements to the enrollment projection model to better gauge the accuracy of the enrollment forecasts, currently estimated at an additional 90,000 to 120,000 recipients (excludes the additional Child Health Plus enrollees estimated at 95,000).



Medicaid Spending August 2012 (dollars in millions)			
Category of Service	**Estimated**	**Actual**	**Variance**
Total Fee For Service	**$4,913**	**$4,845**	**($69)**
Inpatient	$1,341	$1,328	($13)
Outpatient/Emergency Room	$243	$226	($17)
Clinic	$291	$313	$22
Nursing Homes	$1,447	$1,430	($16)
Other Long Term Care	$803	$795	($8)
Non-Institutional	$788	$752	($36)
Medicaid Managed Care	**$3,773**	**$3,765**	**($8)**
Family Health Plus	**$392**	**$393**	**$1**
Medicaid Administration Costs	**$204**	**$204**	**($0)**
Medicaid Audits	**($109)**	**($76)**	**$33**
All Other	**$638**	**$653**	**$14**
Local Funding Offset	**($3,078)**	**($3,078)**	**$0**
TOTAL	**$6,733**	**$6,705**	**($28)**

Results through August - Variance Highlights

- **Lower Fee-for-Service Spending:** Through August, Medicaid spending in major fee-for-service categories is $69 million below projections as follows:

  - *Inpatient* hospital spending is $13 million below projections, a result of lower than projected payment rates. Although utilization is on target with projections, billing for Inpatient services that, in general, have higher payment rates are down, whereas Graduate Medical Education (GME) claims related to Medicaid Managed Care recipients are up. GME rates of payment tend to be lower than case payment rates.

  - *Outpatient/Emergency Room* spending is $17 million below estimates which reflects a lower average payment per claim than anticipated. The largest payment per claim variances are on Ambulatory Surgery claims and Outpatient episode payment claims.

  - *Clinic* spending is $22 million above estimates. The overspending is associated with higher than expected claims billed and a higher average payment per claim than anticipated.

  - *Nursing Home* spending is $16 million below projections due to lower than projected utilization. The difference in utilization is believed to be due to a shift in the population from fee-for-service to Managed Long Term Care with billing occurring under the capitation payments. This shift is difficult to measure due to the nature of the billing differences; however the Department will continue to explore ways to measure the value of the shift.

  - *Other Long Term Care* services spending, which includes Personal Care, Home Health, Home Nursing, and the Assisted Living programs, is $8 million below projections. The variance is primarily attributable to lower than projected spending in Home Health ($62 million), Home Nursing ($15 million) and Assisted Living ($1 million) offset by higher than projected spending in Personal Care ($70 million).

    New York City HRA has informed the Department that a new claims auditing procedure was instituted in 2011-12. This new procedure resulted in some claims being rolled from 2011-12 into the current year which is driving the spending above target within the Personal Care program. The Department and HRA are working on completing a closeout audit of previous year rates dating back to 2008 (required under the reimbursement rules of this program) which is expected to generate recoveries that will offset the deficit within this category.

For Home Health and Home Nursing, the spending below target ($77 million) is primarily the result of a delay in billing as a result of the implementation of the episodic payment system. Episodic pricing commenced May 1, 2012. Spending has been significantly lower than projected in June, July and August as the initial billing period for episodic payments began. The change from weekly billing of hourly and per visit claims versus the episodic system of an interim and final claim submission over a 60 day period creates differences in provider billing patterns. A preliminary analysis of the paid claims data for one cycle in August shows that only 60 of approximately 105 Certified Home Health Agencies submitted episodic claims and over 80% of the claims submitted were interim (50% payment).

- *Non-Institutional* fee-for-service spending (includes pharmacy, transportation, supplemental medical insurance, etc.) is $36 million below estimates. The variance is primarily due to lower than projected spending in pharmacy ($28 million). Lower pharmacy spending is attributed to a 3.3% shift from brand to generic drugs for fee-for-service enrollees, as well as a 4.8% decrease in fee-for-service utilization.

- **Medicaid Managed Care Spending:** Through August, Medicaid Managed Care spending is $8 million below projections. Payments anticipated to be incurred in August were not fully realized and are expected to occur in subsequent months.

- **Family Health Plus Spending:** Through August, Family Health Plus spending is on target.

- **Medicaid Administration Costs:** Through August, Medicaid Administration spending is on target with projections.

- **Medicaid Audits:** Through August, the spending offsets anticipated from Medicaid audit recoveries are $33 million below projected levels. This variance may be due to the timing of collections. It is important to note that in July, a national settlement was reached between 43 states (including New York), the District of Columbia and the Federal government regarding GlaxoSmithKline's engagement in various illegal schemes connected to the marketing and pricing of drugs it manufactures. As a result, New York will receive over $146 million in recoveries of which approximately one-half is owed to the Federal Government. The timing of the receipt of these funds is not yet finalized but will be reported on when the funds are realized.

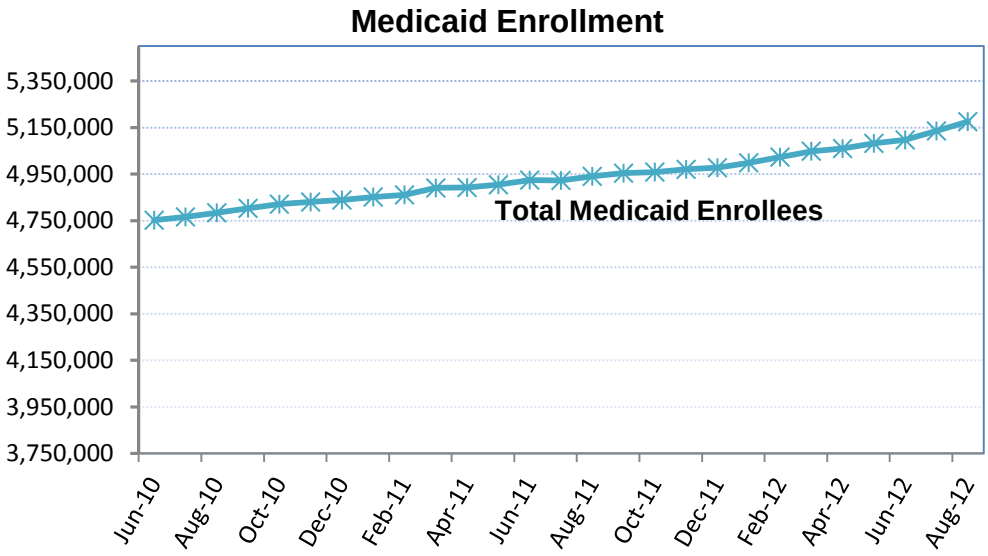
- **Other State Agency (OSA) Spending**: Medicaid spending by Other State Agencies (OSA) is running $40 million below projections through August. The variance is primarily attributable to lower than projected spending in the Office for People with Developmental Disabilities which is associated with the processing of certain retroactive rate packages ($43 million). However, this under spending is offset by an increase in the account receivable balance which will be recouped over subsequent months ($3 million net over spending through August). State share spending is processed by the Department of Health and subsequently transferred from the other agency budgets. The local share of these services is funded principally by counties and NYC and to the extent costs exceed the capped local contribution, funding is through the Department of Health. These services include programs administered through the Office for People with Developmental Disabilities, the Office of Mental Health, the Office of Children and Family Services and the Office of Alcoholism and Substance Abuse Services.

Accounts Receivable

The accounts receivable balance for retroactive rates owed to the State through the end of August is $460 million. This reflects $118 million of recoupments through August. 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 plans to continue to work collectively with the hospitals, nursing homes, and home care providers asking for voluntary payment of outstanding liabilities as a means to avoid interest costs and help mitigate the adverse impact of outstanding receivable balances on the Medicaid Global Spending Cap. The Department will closely monitor the accounts receivable balances each month.

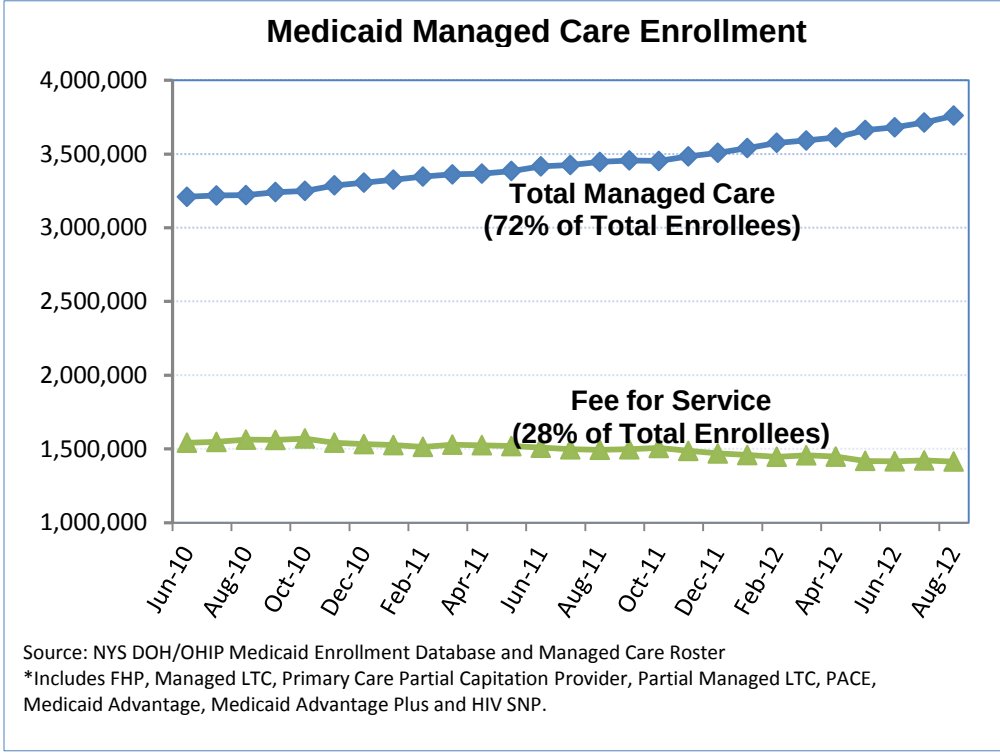
Enrollment

Medicaid total enrollment reached 5,175,173 enrollees at the end of August 2012. This reflects an increase of roughly 127,000 enrollees, or 2.5%, since March 2012. Beginning in November, Medicaid coverage expanded for children under the age of 19 whose family income did not exceed 133 percent of the Federal Poverty Level. This accounts for over 47,000 of the 127,000 new Medicaid enrollees, and 47,000 of the 170,000 new Managed Care enrollees. Importantly, the Federal government ensures that these children who were previously enrolled in the Child Health Plus (CHP) program will continue to be funded through CHP, and as such, will not incur additional costs under the Medicaid Global Spending Cap.



Source: NYS DOH/OHIP Medicaid Enrollment Database
*Most current four months counts are adjusted by lag factors (3.33%, 1.26%, 0.50% and 0.17%, respectively)

Medicaid Managed Care enrollment in August 2012 (includes FHP and Managed LTC and excludes CHP) reached 3,760,496 enrollees, an increase of almost 170,000 enrollees, or 4.7%, since March 2012.



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 link shows provider spending that occurs within the Medicaid claiming system (eMedNY) through August 2012 for each region.

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

Monthly Spending Projections

The monthly spending forecast was developed to reflect:

- Actual spending patterns for State Fiscal Year 2011-12 adjusted for one-time spending that is not expected to recur in SFY 2012-13;
- Anticipated increases in health care prices and estimated changes in service utilization in SFY 2012-13; and
- The achievement of savings generated from the annualization of MRT Phase I actions as well as new Phase II actions over time.