Redesigning
THE MEDICAID PROGRAM

Medicaid Global Spending Cap

March 2013 Report

NEW YORK
state department of
HEALTH

Global Cap – A Year in Review

The Department of Health and Division of Budget are very pleased to report that spending under SFY 2012-13 Global Cap was $2 million below the $15.9 billion target. Limiting spending to the 4 percent spending growth afforded under the Global Cap is truly a remarkable accomplishment that required fiscal discipline, creativity, and innovation from all sectors within the Medicaid program, including:

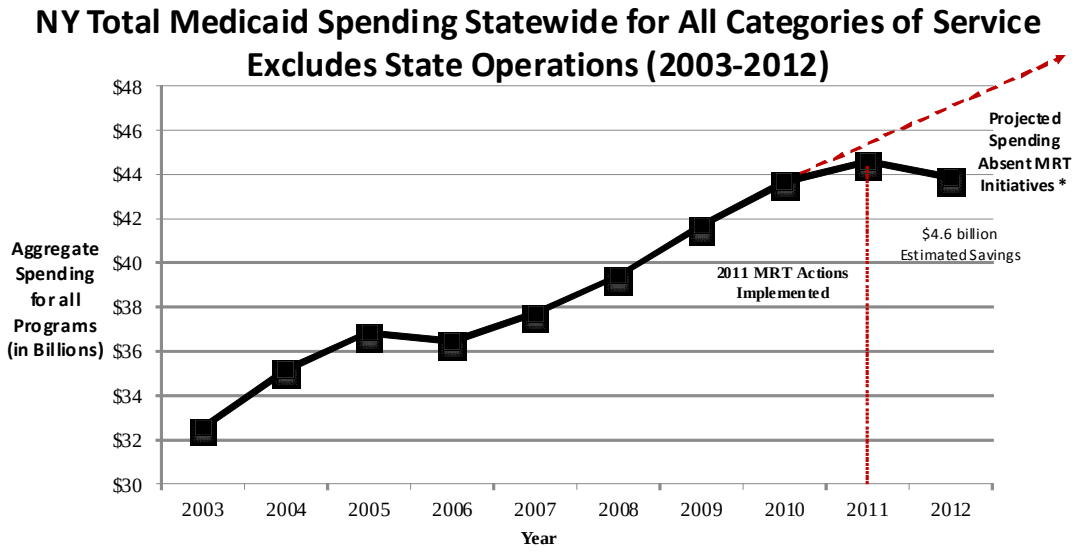
- Shifting less severe patients from the hospital and emergency room to more appropriate ambulatory/primary care settings;
- Controlling home care and personal care costs that were previously climbing at double-digit growth rates prior to the MRT; and
- Continuing the movement of Medicaid recipients from fee-for-service into Medicaid managed care.

While the Medicaid program finished the year $2 million under target, it is important to note that included within the final expenditure amount there was $200 million in expenses that would have otherwise occurred in SFY 2013-14, bringing adjusted under spending to $200 million for the year. This under spending for the year can be explained by:

- Lower utilization of services ($130 million). The Department is seeing that due to various MRT initiatives the cost to serve each Medicaid recipient has actually declined from a high of $8,493 in 2009 to $7,864 in 2012 (see chart below). The MRT is actually bending the cost curve.
- Higher local administration savings ($40 million). A significant MRT initiative impacting State and local governments involves the takeover of the administration of the program by the State by March 2016. This effort and the efficiency from centralization of this function from the counties is starting to return real dividends for the Medicaid program generating ongoing savings.
- Lower State operations costs ($30 million). The budget included funds to support the implementation of MRT initiatives. This savings is due to lower-than-projected implementation costs.

This under spending was applied with other savings measures and Federal resources to solve the $1.1 billion revenue shortfall stemming from changes to the long-standing financing system for developmental disability services.

In summary, this is the second consecutive year that the health care community has remained below the Global Cap target while expanding health care coverage to the State's neediest populations. Since April 2011, total enrollment in the program has increased by over 390,000.



	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
# of Recipients	4,266,535	4,593,566	4,732,563	4,729,166	4,621,909	4,656,354	4,910,511	5,211,511	5,396,521	5,578,143
Cost per Recipient	$7,635	$7,658	$7,787	$7,710	$8,158	$8,464	$8,493	$8,379	$8,261	$7,864

*Projected Spending Absent MRT Initiatives was derived by using the average annual growth rate between 2003 and 2010 of 4.28%.
**Includes local assistance spending in other State agencies and excludes certain off-line payments, for example supplemental Medicare payments, Local Departments of Social Services administration and disproportionate share payments to hospitals.

Looking Forward –SFY 2013-14

The current Financial Plan assumes an increase in the State funds Medicaid cap to $16.4 billion in SFY 2013-14. However, pursuant to the Budget agreement with the Legislature, up to $730 million in resources will need to be transferred from the Global Cap to resolve the $1.1 billion OPWDD revenue shortfall mentioned above. The Department has conducted a webinar on the elements of the 2013-14 Budget which can be accessed at http://www.health.ny.gov/health_care/medicaid/redesign/mrt_budget.htm. Early indications are that the next State Fiscal Year will be equally as challenging and will require the health care community to continue the progress made this year to advance a more affordable health care system.

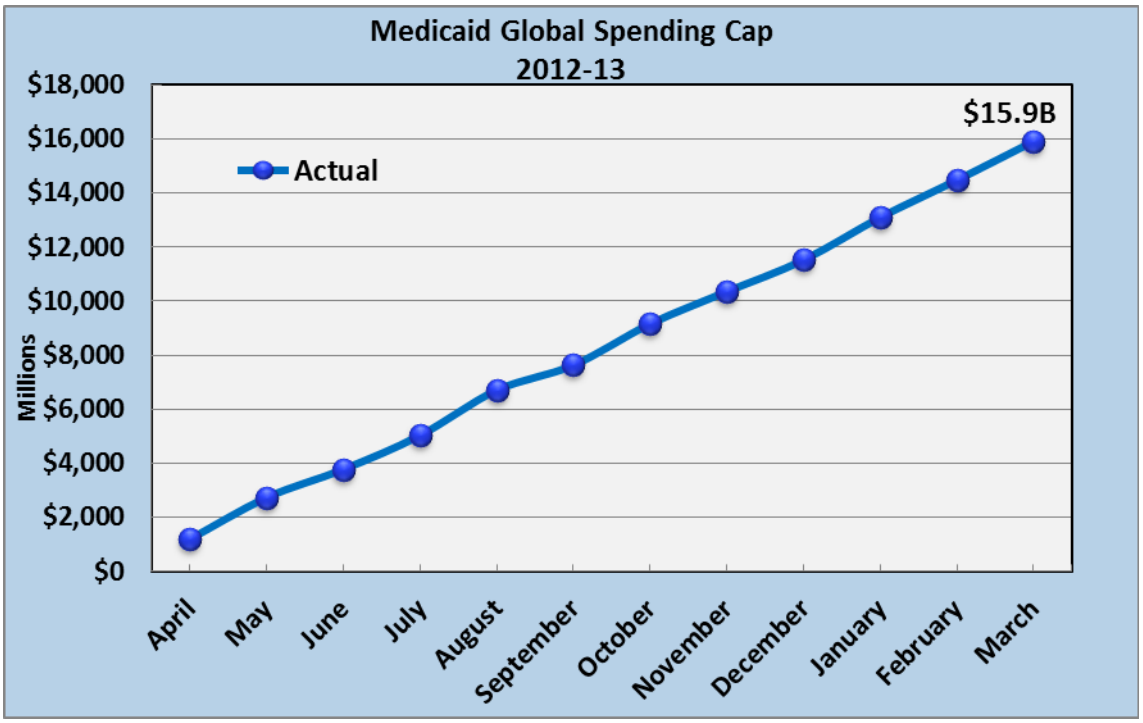
In addition, the final 2013-14 Budget requires the Department to provide more information to the public and stakeholder community, tracking our programs with implementation of MRT initiatives and monthly spending within the Global Cap. Specifically, the statute requires the report to outline factors that could result in Medicaid disbursements to exceed projected spending including:

- Spending increases or decreases due to enrollment fluctuations, rate changes, utilization changes, MRT investments, and the shift of beneficiaries to managed care;
- Variations in offline Medicaid payments; and
- Actions taken to implement any Medicaid savings allocation plan, including information by each category of service and each geographic region.

The Department is working with the Budget Division to develop the required reports and expects to have those available in June.

Results for SFY 2012-13 - Summary

Cumulative spending for the months April through March resulted in total expenditures of $15.91 billion. Since March 2012, enrollment in the Medicaid program has grown by close to 232,500 enrollees (or 4.6%). The total Medicaid growth represents a significant shift of Medicaid recipients from fee-for-service into Medicaid managed care where services are better coordinated and financial incentives are more rational. During this fiscal year Medicaid managed care programs increased by 345,100 individuals while fee-for-service recipients decreased by 112,600. It is important to note that approximately 87,300 of these new enrollees are attributable to the expansion of Medicaid coverage for children under the age of 19 whose family income did not exceed 133 percent of the Federal Poverty Level, which does not incur additional costs under the Medicaid Global Spending Cap.



Medicaid Spending SFY 2013 (dollars in millions)			
Category of Service	**Estimated**	**Actual**	**Variance Over / (Under)**
Total Fee For Service	**$11,601**	**$11,308**	**($293)**
Inpatient	$3,148	$3,075	($73)
Outpatient/Emergency Room	$590	$543	($47)
Clinic	$647	$598	($49)
Nursing Homes	$3,434	$3,417	($17)
Other Long Term Care	$1,794	$1,782	($12)
Non-Institutional	$1,988	$1,893	($95)
Medicaid Managed Care	**$9,751**	**$9,797**	**$46**
Family Health Plus	**$968**	**$957**	**($11)**
Medicaid Administration Costs	**$569**	**$529**	**($40)**
Medicaid Audits	**($323)**	**($303)**	**$20**
All Other	**$648**	**$728**	**$80**
Local Funding Offset	**($7,302)**	**($7,302)**	**$0**
SUBTOTAL	**$15,912**	**$15,714**	**($198)**
Prepayment of 2013-14 Expenses	**$0**	**$196**	**$196**
TOTAL	**$15,912**	**$15,910**	**($2)**

Note: The $130 million in utilization savings is primarily comprised of lower spending in FFS ($293M) and

FHP ($11M) offset by higher spending in MMC ($46 million) and greater accounts receivable balances ($83 million).

Results through March - Variance Highlights

- **Lower Fee-for-Service Spending:** Through March, Medicaid spending in major fee-for-service categories is $293 million below projections as follows:

  - *Inpatient* hospital spending is $73 million below projections, a result of several different payment factors. 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 $47 million below estimates which reflects lower than expected claims billed and a lower average payment per claim than anticipated.

  - *Clinic* spending is $49 million below projections due to a lower than anticipated average payment per claim. There was also an APG capital rate update for the period September 1, 2009 through December 31, 2012, which resulted in $27 million in lower spending.

  - *Nursing Home* spending is $17 million below projections, a result of slightly lower than projected utilization.

  - *Other Long Term Care* services spending, which includes Personal Care, Home Health, Home Nursing, and the Assisted Living programs, is $12 million below projections. The variance is attributable to lower than projected spending in Home Health ($194 million), Home Nursing ($57 million) and Assisted Living ($3 million) offset by higher than projected spending in Personal Care ($242 million).

    The variances for the subcategories within the Other Long Term Care services are attributable to the assumptions used for the movement of long term care recipients to a managed care setting. The Department's preliminary estimates assumed that the majority of long term care recipients and costs transitioning into the Managed Long Term Care program would come from the Personal Care sector. The latest findings have demonstrated the opposite; close to 90 percent of the long term care fee-for-service Medicaid costs that have transitioned into managed care were previously from Home Health and Home Nursing.

  - *Non-Institutional* fee-for-service spending (includes pharmacy, transportation, supplemental medical insurance, etc.) is $95 million below projections. The variance is primarily due to lower than projected spending in pharmacy, a result of lower than expected utilization caused by drug utilization shifting into

managed care plans. Spending for Case Management services is also under projections. Total claims billed to date are approximately 25% below projected claims. Early Intervention spending was also below projections, a result of releasing revised reimbursement rates in March 2013.

- **Medicaid Managed Care Spending:** Through March, Medicaid managed care spending is $46 million above projections. The variance is primarily a result of making stop loss payments of $50 million that were not assumed in the projections.

- **Family Health Plus Spending:** Through March, Family Health Plus spending is $11 million below projections. To date, enrollment for Family Health Plus is slightly lower than expected, 1.0%.

- **Medicaid Administration Costs:** Through March, local district Medicaid Administration spending is $40 million below projections. This surplus is consistent with efforts undertaken by the State to take over the Medicaid Administration program from localities. The 2012-13 Enacted Budget capped local administrative costs at the 2011-12 levels and initiated a State phased-in take-over of administrative functions, such as processing of Family Planning Benefit Program applications, transportation management, and other tasks that were previously executed by local districts and counties. The State recently expanded State disability reviews to one additional county, fully implemented the transportation management in New York City, and centralized resolution of reported deaths in selected counties in January. Preliminary results indicate that all county claims are anticipated to be paid for in the current Fiscal Year.

- **Medicaid Audits:** Through March, the spending offsets from Medicaid audit recoveries are $20 million below projected levels ($323 million). This variance is timing related and should be recovered over the next State Fiscal Year.

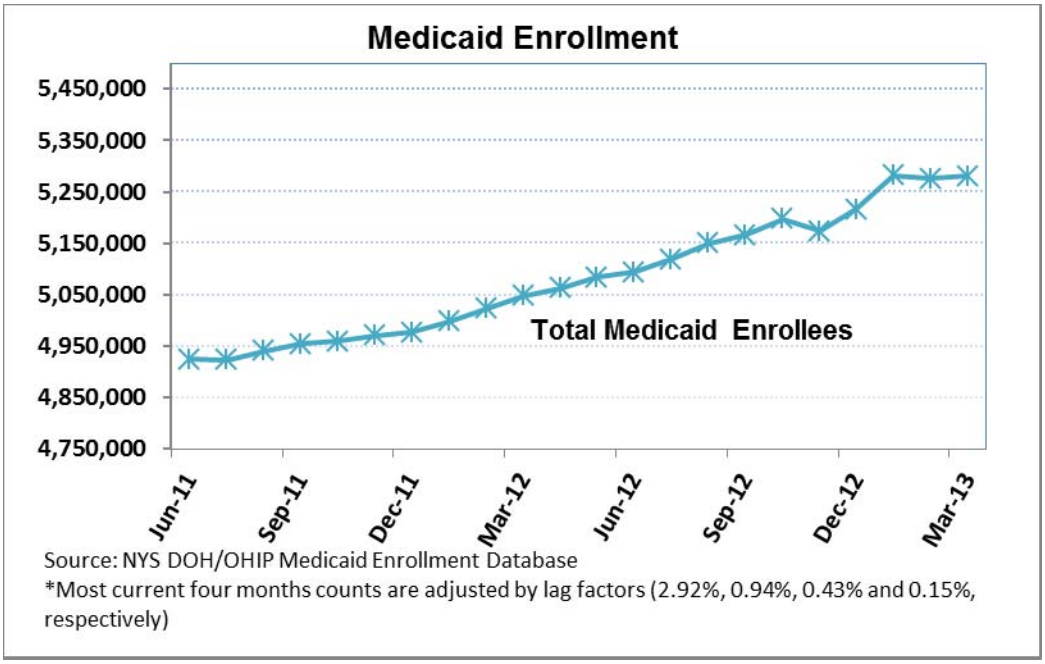
- **Other State Agency (OSA) Spending**: Medicaid spending by Other State Agencies (OSA) closed $36 million below projections through March. The local share of these services is funded principally by counties and NYC and to the extent costs exceed the capped local contribution, funding is through the 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

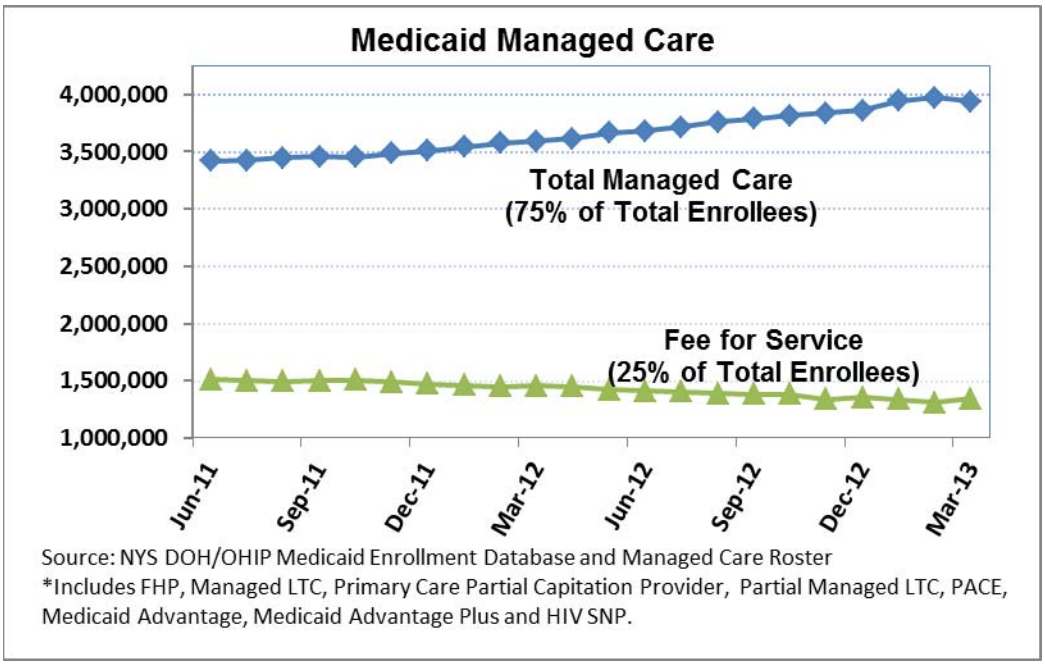
The accounts receivable balance for retroactive rates owed to the State through the end of March is $400 million. This represents a reduction of $177 million from last fiscal year, and reflects the net impact of recoupments from Medicaid providers offset by retroactive rate adjustments released during this fiscal year. The Department of Health will continue to work collectively with the hospitals, nursing homes, and home care providers during the next State Fiscal Year 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 continue to closely monitor the accounts receivable balances each month.

Enrollment

Medicaid total enrollment reached 5,280,777 enrollees at the end of March 2013. This reflects an increase of roughly 232,500 enrollees, or 4.6%, since March 2012.



Medicaid managed care enrollment in March 2013 (includes FHP and Managed LTC) reached 3,936,431 enrollees, an increase of around 345,100 enrollees, or 9.6%, 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.

Beginning in November 2011, 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 87,300 of the new 232,500 Medicaid enrollees and 87,300 of the 345,100 new Medicaid managed care enrollees since March 2012. 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.

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 March 2013 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