Medicaid Global Spending Cap Report

Redesigning the Medicaid Program

JUNE 2014

NEW YORK
state department of
HEALTH

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Overview

The FY 2015 Enacted Budget extended the Medicaid Global Spending Cap through March 2016. Pursuant to legislation, the Medicaid Global Spending Cap has increased from $16.4 billion in FY 2014 to $17.0 billion in FY 2015, an increase of roughly 3.3 percent. The CPI used on Medicaid services subject to the trend was 3.8 percent (ten year average of the Medical Care Consumer Price Index); however, there were several adjustments made to the Global Cap target that were not subject to the trend, the most significant was the inclusion of OHIP State Operations cost. The annual growth in the Global Cap of $540 million over last year included costs associated with both price and enrollment increases, offset by a net change in one time revenue and spending actions as well as the continuation of Medicaid Redesign Team (MRT) initiatives. Components of the annual growth are as follows:

Price (+$1.1 billion)	Price includes an increase in managed care premiums for cost trends and newly covered benefits, as well as fee-for-service rate adjustments. *See Appendix B for more detail.*
Utilization (+$343 million)	Utilization reflects the annualization of FY 2014 net enrollment growth (446,451 recipients) as well as assumed new enrollment for FY 2015, including the additional enrollment under the NY State of Health(NYSoH)/Healthcare Exchange.
MRT/One-Timers/Other (-$863 million)	MRT/Other primarily includes additional Federal Revenue as a result of the Affordable Care Act ($1.1 billion) and a decrease to the Mental Hygiene Stabilization Fund ($285 million) offset by Financial Plan Relief ($300 million) and the restoration of the 2% Across the Board payment reduction ($302 million).

Additionally, as part of the legislation passed with the Enacted Budget, the following major initiatives were included in the Medicaid program:

- *Care Management for All* - This initiative transitions Medicaid enrollees to care management. There are several populations and benefits scheduled to transition into the Managed Care setting this fiscal year; these are described in further detail in the 'Beneficiary Transition Schedule to Managed Care' section.
- *Behavioral Health System* - Dedicates $110 million to successfully transform the Behavioral Health System as the State transitions into Managed Care. The investments include funding for the following: transition Behavioral Health services for children into Managed Care; integration of Behavioral Health and Physical Health; targeted Behavioral Health Inpatient rate increases; OASAS Residential Restructuring; Health Home Plus for Assisted Outpatient Treatment and; new 1915(i) like services.
- *Balance Incentive Program (BIP)* - BIP is a provision of the Affordable Care Act (ACA) which provides additional Federal funding towards implementing structural changes. These improvements are believed to be the best method for rebalancing the delivery of LTSS towards community-based care and away from institutional care settings.

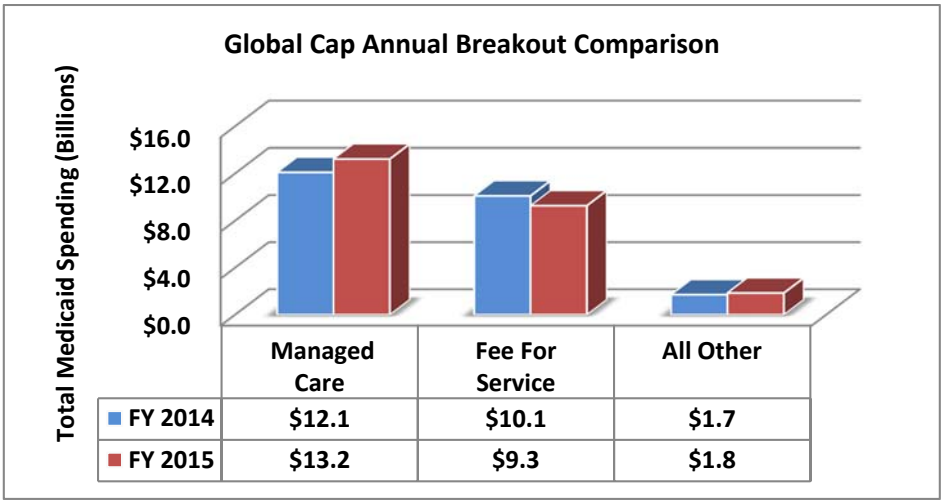
- *Basic Health Plan (BHP)* - The BHP is an option for states under the ACA which offers quality, low cost health insurance to New York State residents not eligible for Medicaid or Child Health Plus. It is funded by 95% of the value of the tax credits available to individuals who would have otherwise enrolled in the Marketplace and will be established in FY 2016.
- *Across the Board (ATB) two percent payment reduction* - The State is in the process of obtaining Federal approval to eliminate the ATB reductions effective April 1, 2014.

For additional information on these initiatives please visit: http://www.health.ny.gov/health_care/medicaid/redesign/.

Through the first three years of the Global Spending Cap, the health care community has remained below the Global Cap while expanding health coverage to the State's neediest populations. Through the collaboration of the MRT and the health care network, major steps towards redesigning the State's Medicaid program and reducing its costs have been made. As a result of this success, the FY 2015 Budget established a Global Cap dividend payment which is designed to reward healthcare providers through a shared savings program if Medicaid spending continues to remain below the Global Cap.

Components of the Medicaid Global Spending Cap

The Global Cap is comprised of spending for Managed Care plans (mainstream and long term), Family Health Plus payments, fee-for-service categories (hospitals, nursing homes, clinics, other long term care providers, and non-institutional related costs), and other areas of spending (i.e., Medicaid administration, OHIP budget, VAP payments, transfers from other State agencies, etc.). This spending is offset by local government funding as well as Medicaid audit recoveries and accounts receivable recoupments. See Appendix A for the annual budget by category of service.



NOTE: The chart represents the actual non-federal share of Medicaid spending for FY 2014 and the projected share for FY 2015. The Local contributions are $7.4 billion in FY 2015, which is used to offset the amounts reflected above.

Results for June 2014 - Summary

Total State Medicaid expenditures under the Medicaid Global Spending Cap for FY 2015 through June are $10 million, or 0.2 percent, **under** projections. Spending for FY 2015 resulted in total expenditures of $4.16 billion compared to the projection of $4.17 billion.

Medicaid Spending – FY 2015 (dollars in millions)			
Category of Service	**Estimated**	**Actual**	**Variance Over / (Under)**
Medicaid Managed Care	**$2,858**	**$2,861**	**$3**
Mainstream Managed Care	$2,119	$2,130	$11
Long Term Managed Care	$739	$731	($8)
Family Health Plus	**$148**	**$165**	**$17**
Total Fee For Service	**$2,360**	**$2,337**	**($23)**
Inpatient	$758	$762	$4
Outpatient/Emergency Room	$104	$107	$3
Clinic	$150	$147	($3)
Nursing Homes	$820	$815	($5)
Other Long Term Care	$183	$178	($5)
Non-Institutional	$345	$328	($17)
Medicaid Administration Costs	**$113**	**$117**	**$4**
OHIP Budget / State Operations	**$38**	**$28**	**($10)**
Medicaid Audits	**($72)**	**($63)**	**$9**
All Other	**$572**	**$562**	**($10)**
Local Funding Offset	**($1,844)**	**($1,844)**	**$0**
TOTAL	**$4,173**	**$4,163**	**($10)**

Results through June - Variance Highlights

- **Medicaid Managed Care Spending:** Medicaid spending in major Managed Care categories was $3 million, or 0.1 percent, over projections.
  - Mainstream Managed Care was $11 million, or 0.5 percent, above projections. The variance is primarily driven by slightly higher than projected members, less than 1 percent.
  - Long Term Managed Care was $8 million, or 1.1 percent, below projections which is due to slightly lower than expected recipients enrolled in the program, approximately 2,000 individuals.

- **Family Health Plus Spending:** Medicaid spending in Family Health Plus was $17 million over projections. Through June the phase-down of the program was occurring at a much slower rate than expected. The State will continue to monitor the transition of Family Health Plus recipients to determine if an adjustment to current assumptions is necessary.

- **Fee-for-Service Spending:** Medicaid spending in major fee-for-service categories was $23 million, or 1.0 percent, under projections.

- *Non-Institutional* spending (includes Pharmacy, Medical Supplies, Physicians, Supplemental Medical Insurance, etc.) was $17 million under target which is attributed to higher than expected rebates. Total rebates collected exceeded projections by 14 percent through June which appears to be related to the timing of collections.

- **Medicaid Audits:** Through June, the spending offsets from Medicaid audit recoveries were below projected levels by $9 million. The majority of this spending variance is associated with the timing of deposits and, as such, should not be considered a factor contributing to overspending the annual global cap amount.

- **All Other:** The All Other category (includes Accounts Receivable, Vital Access Provider payments, Supportive Housing, etc.) was $10 million below projections. The variance is primarily a result of the two percent across the board (ATB) payment reductions. The ATB reductions are continuing to be applied to impacted providers pending federal approval to eliminate. Upon federal approval, providers will be reimbursed the amounts that have been withheld going back to April 2014.

Office of Health Insurance Programs (OHIP) State Operations Budget

The OHIP State Operations budget reflects the non-Federal share only and includes personal services costs (i.e., salaries of OHIP staff that work on the Medicaid budget) as well as non-personal services costs (i.e., contractual services). The budget is projected to total $230 million in FY 2015. The annual increase is offset by reductions in local district administrative claims, consistent with the State takeover, as well as funding certain NYSOH Exchange operations.

Contracts for the Enrollment Center, Medicaid Management Information Systems (MMIS), NYSOH Healthcare Exchange, transportation management, and various MRT initiatives comprise 65 percent ($124 million) of the total non-personal service budget. The chart below compares State Operations spending against the annual budget for FY 2015:

OHIP Budget – FY 2015
(dollars in millions)

Service Costs	Annual Budget	Actual - YTD
Personal Services	**$42**	**$6**
Non-Personal Services	**$188**	**$22**
Medicaid Transportation Management	$33	$3
eMedNY (MMIS)	$29	$5
NYS Of Health Healthcare Exchange	$25	$4
Enrollment Broker	$20	$1
Early Innovator	$17	-
All Others	$64	$9
TOTAL	**$230**	**$28**

Accounts Receivable

The Accounts Receivable (A/R) ending balance for FY 2014 was $230 million. The State is expected to recoup $107 million by the end of FY 2015, resulting in a projected A/R balance of $123 million by March 2015. Through the end of June, retroactive rates owed to the State were $209 million. This reflects a decrease of $21 million since March 2014, and represents the net impact of recoupments from Medicaid providers offset by retroactive rate adjustments effectuated during this fiscal year.

Currently, Medicaid checks issued to providers that are subject to negative retroactive rate adjustments are automatically reduced by a minimum of 15 percent until the liability has been recouped. Should the amount owed not be fully repaid before 10 weekly Medicaid cycles, simple interest at the rate of prime plus two percent (currently 5.25 percent) would be assessed on any unpaid balance and accumulate on a weekly basis. Collection of the interest assessed commences as soon as the principal amount owed has been fully repaid. With the migration to Managed Care, the State's ability to recover outstanding accounts receivable balances becomes more complicated as the State's Medicaid costs will be primarily premium based.

Medicaid Enrollment

Medicaid total enrollment reached 5,796,601 enrollees at the end of June 2014. This reflects an increase of 101,657 enrollees, or 1.8 percent, since March 2014. Below is a detailed breakout by program and region:

Medicaid Enrollment Summary FY 2015

	March 2014	June 2014	Increase / (Decrease)
Managed Care	**4,116,631**	**4,383,461**	**266,830**
New York City	2,589,433	2,730,083	140,650
Rest of State	1,527,198	1,653,378	126,180
Fee-For-Service	**1,578,313**	**1,413,140**	**(165,173)**
New York City	785,320	692,926	(92,394)
Rest of State	792,993	720,214	(72,779)
TOTAL	**5,694,944**	**5,796,601**	**101,657**
New York City	3,374,753	3,423,009	48,256
Rest of State	2,320,191	2,373,592	53,401

NOTE: Most current four months counts are adjusted by lag factors (2.33%, 1.08%, 0.43% and 0.15%, respectively to account for retroactive eligibility determinations)

Beneficiary Transition Schedule to Managed Care

Care Management for All was a key component of the MRT's recommendations intended to improve benefit coordination, quality of care, and patient outcomes over the full range of health care, including mental health, substance abuse, developmental disability, and physical health care services. It will also redirect almost all Medicaid spending in the State from fee-for-service to care management. The care management system currently in place includes comprehensive plans, HIV/AIDS special needs plans, partial capitation long term care plans, and Medicare/Medicaid supplemental plans. As *Care Management for All* progresses, additional plans tailored to meet the needs of the transitioning population will be added, including mental health and substance abuse special needs plans, as well as fully integrated plans for Medicare/Medicaid "dual eligibles". The charts below outline the list of recipients and benefits schedule to transition into the care management setting during FY 2015:

Medicaid Fee for Service Transition to Managed Care (Populations) FY 2015					
Effective Date	**Populations**	**From (COS)**	**To (COS)**	**# of Targeted Enrollees**	**FY 2015 Enrolled**
June 2014	Community Based LTC – Rest of State	OLTC	MLTC	16,503	5,903
October 2014	Nursing Home – Primary FIDA Region	NH	MMC / MLTC	4,556	
January 2015	BHO/HARPS	OMH / Various	MMC	TBD	

Medicaid Fee for Service Transition to Managed Care (Service Benefits) FY 2015	
Effective Date	**Service Benefits**
April 2014	LT Chemical Abuse
October 2014	Nursing Homes
January 2015	Hemophilia Blood Factors Risperdol, Invega, Zyprexa Clotting

Appendix A
Medicaid Global Spending Cap Annual Budget (Online and Offline)

The $17.0 billion Medicaid State Funds Spending Cap can be organized into two major components: (1) health care provider reimbursement and (2) other administrative, intergovernmental or revenue lines, also referred to as "offline" or occurring outside the MMIS billing system. Health care provider spending reflects the cost of care that is attributable to certain service sectors of the program (i.e., hospital, nursing home, managed care, etc.). These payments occur within the Medicaid claiming system (eMedNY). Projections for most service sectors begin with FY 2014 ending recipients and average rates per recipient. Adjustments to spending projections are then made for anticipated rate packages, transitions of populations/benefits to the Managed Care setting, and any non-recurring or one-time payments. Monitoring the movement of recipients between fee-for-service reimbursement and monthly Managed Care rates of payment is critical to evaluating various health service budgets.

The second component of spending, spending outside the eMedNY billing system, reflects spending on intergovernmental transfer payments, State and Local District Social Service administrative claims, etc., as well as receipts which offset the State's cost for Medicaid, i.e. drug manufacturer rebates and accounts receivable collections. The following table outlines the annual Medicaid projections by major health care sector for both provider claims and other payments/revenues.

Medicaid Global Spending Cap Annual Budget – FY 2015
(dollars in millions)

Category of Service	Online	Offline	Total
Medicaid Managed Care	**$12,920**	**($157)**	**$12,763**
Mainstream Managed Care	$9,323	($157)	$9,166
Long Term Managed Care	$3,597	$0	$3,597
Family Health Plus	**$277**	**$0**	**$277**
Total Fee For Service	**$8,260**	**$1,184**	**$9,444**
Inpatient	$2,079	$757	$2,836
Outpatient/Emergency Room	$424	($12)	$412
Clinic	$608	($47)	$561
Nursing Homes	$3,381	$0	$3,381
Other Long Term Care	$574	$0	$574
Pharmacy	$299	($103)	$196
Dental	$36	$0	$36
Transportation	$205	$0	$205
Non-Institutional Other	$654	$589	$1,243
VAP	**$0**	**$165**	**$165**
Supportive Housing	**$0**	**$115**	**$115**
Medicaid Administration Costs	**$0**	**$453**	**$453**
OHIP Budget / State Operations	**$0**	**$232**	**$232**
Medicaid Audits	**$0**	**($424)**	**($424)**
All Other	**$3,009**	**($9,072)**	**($6,063)**
Local Cap Contribution	$0	($7,377)	($7,377)
Accounts Receivable	$0	($107)	($107)
Other State Agency / Transfer	$3,009	($1,388)	$1,621
Other	$0	($200)	($200)
TOTAL	**$24,466**	**($7,504)**	**$16,962**

Appendix B
Inventory of Rate Packages

The State is anticipating Medicaid rate adjustments resulting in price increases of up to $1.1 billion this fiscal year. Below is a list of the majority of anticipated rate packages to be implemented:

Inventory of Rate Packages – FY 2015 (dollars in millions)					
			Projected Impact		
Category of Service	**Rate Package Description**	**Effective Date**	**Gross**	**Non-Federal**	**Date Released**
Mainstream Managed Care	April 2014 Premiums	4/1/2014	$864	$432	
Long Term Managed Care	2014 Mandatory Rates; 2014 Risk Rates (incl. wage parity)	4/1/2014	$506	$253	
Nursing Homes	Nursing Home Appeals / Litigation	Various	$175	$88	
	July 2013 Case Mix Adjustment	7/1/2013	$68	$34	July 2014
	January 2014 Case Mix Adjustment	1/1/2014	$68	$34	
	Cash Receipts Assessment Reconciliations	2011-2012	$29	$15	
	Minimum Data Set Audits	2012-2013	$10	$5	
Inpatient	Transition II Update	2010 - 2014	$26	$13	
	Acute & Exempt Unit Actual Capital Rates	Various	$19	$9	
	Psychiatric Rates (Pre-Reform)	1/1/2010	$10	$5	
	Language Assistance MRT HD	6/1/2013	$5	$3	
	Hurricane Sandy Providers (Psychiatric; GME; 4/1/2012 Inpatient)	2009 - 2012	($32)	($16)	
Outpatient/ Emergency Room	APG capital updates for 2009 - 2012 rates	Various	$40	$20	
	Hurricane Sandy Providers (APG and HHA)	2009 - 2012	$15	$8	
Clinic	Electronic Health Records	2008-2009	$7	$4	
	Uninsured Care Programs	2011-2013	$2	$1	
Personal Care	NYC Wage Parity	3/1/2014	$14	$7	
Home Health	NYC Wage Parity	3/1/2014	$38	$19	

Appendix C
Savings Initiatives

As part of the FY 2015 Enacted Budget the following initiatives are scheduled to be implemented in this fiscal year:

Savings Initiatives – FY 2015 (dollars in millions)	
Initiative	**Non-Federal**
MRT:	
Prior Authorization for Non-Medically Acceptable Indicators for Prescription Drugs	$10
Basic Benefit Initiatives	$3
Reduce Inappropriate Prescribing and Align Point of Sale Editing Across FFS and MMC	$3
Eliminate e-Prescribing Incentive Payment	$2
Total	**$18**
Other Reforms/Savings:	
OMIG Fraud and Abuse Integrity Initiative	$31
Additional Settlement Revenues	$30
Community First Choice Option	$28
Reduce/Eliminate A/R Balances (within 2 to 3 years)	$27
CHIPRA Performance Bonus Award	$13
Program Integrity Initiatives	$2
Total	**$131**

Appendix D
Grant Award Programs

Vital Access/Safety Net Provider Program

The Vital Access/Safety Net Provider Program (VAP) supports projects for facilities that were selected due to their serious financial condition and critical role in providing services to New York State's fragile, elderly, and low-income population. These awards support multi-year projects submitted by hospitals, nursing homes, free standing clinics, and home health providers. The VAP funds will be used primarily to improve community care including expand access to ambulatory services, open urgent care centers, expand services in rural areas, and provide more effective services that meet community needs.

VAP Program Awards (dollars in millions)				
Provider Type	**# of Providers**	**Total Amount Awarded**	**FY 2014 Disbursed**	**FY 2015 Actual - YTD**
Hospitals	25	$148	$64	**$9**
Diagnostic & Treatment Centers	18	$36	$3	-
Nursing Homes	8	$33	$17	**$3**
Critical Access Hospitals	23	$16	$5	-
Certified Health Home Agencies	2	$5	$2	-
TOTAL	**76**	**$238**	**$91**	**$12**

Supportive Housing

The Supportive Housing Initiative seeks to ensure that Medicaid members have proper housing that promotes a healthy environment and lifestyle.

Supportive Housing Allocation Plan – FY 2015 (dollars in millions)	
	Allocation Plan
Capital Funding	$38
Rental/Service Subsidies	$34
New Supportive Housing Pilot Projects	$22
Tracking & Evaluation	$1
Other – To be Allocated	$20
TOTAL	**$115**
YTD Actuals	**$7**

Additional Information on Grant Award programs:

http://www.health.ny.gov/health_care/medicaid/redesign/2013-2014_support_housing_initiatives

https://www.governor.ny.gov/press/01272014-vap-funding

http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/

http://www.health.ny.gov/health_care/medicaid/redesign/iaaf/

Appendix E
Enrollment through the NYSOH Healthcare Exchange

The charts below represent the monthly breakout of Medicaid recipients enrolling through the NYSOH Healthcare Exchange as well as the Medicaid eligibility determinations:

Profile of Medicaid Enrollees through NYSOH Healthcare Exchange			
	Total	**Fee For Service**	**Managed Care**
January	177,056	142,457	34,599
February	316,562	250,472	66,090
March	540,240	405,933	134,307
April	646,032	373,251	272,781
May	729,576	293,396	436,180
June	805,923	264,642	541,281

NYSOH Healthcare Exchange – FY 2015 Medicaid Eligibility Determinations		
	Total	**% of Total**
Childless adults income < 100% (75% FMAP)	290,132	36.0%
Childless adults income 100-138% (100% FMAP)	89,458	11.1%
All Other (50% FMAP)	426,333	52.9%
Total	**805,923**	**100.0%**

Appendix F
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 chart below represents total provider spending that occurs within the Medicaid claiming system (eMedNY) through June 2014 for each region.

Medicaid Regional Spending – FY 2015 (dollars in millions)	
Economic Region	**Non-Federal Total Paid**
New York City	$3,491
Long Island	$583
Mid-Hudson	$558
Western	$282
Finger Lakes	$244
Capital District	$205
Central	$145
Mohawk Valley	$121
Southern Tier	$109
North Country	$83
Out of State	$31
TOTAL	**$5,852**

More 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/