

**Redesigning**  
THE MEDICAID PROGRAM



**Medicaid Global Spending Cap**  
*March 2012 Report*



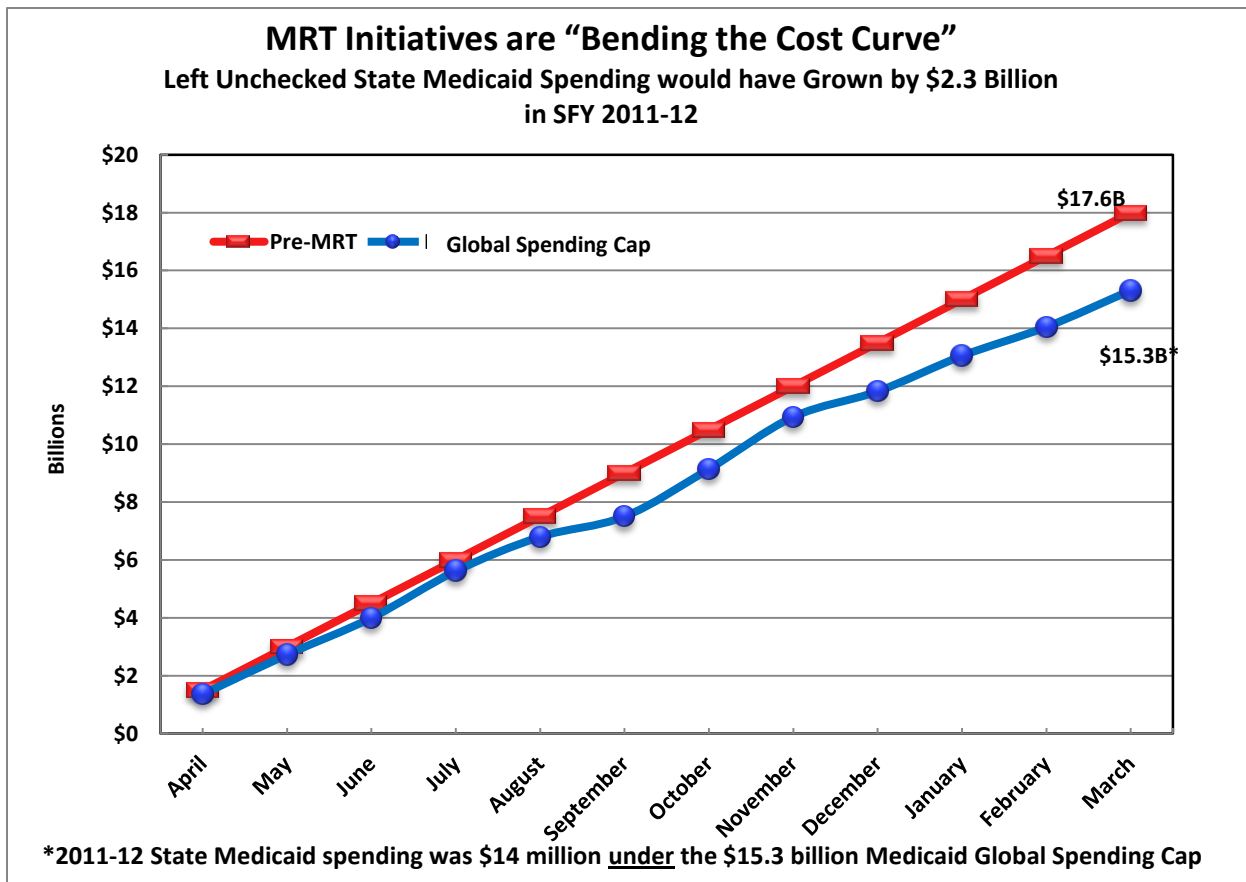
# Redesigning THE MEDICAID PROGRAM



## Global Cap – A Year in Review

The Department of Health and Division of the Budget are very pleased to report that spending under the 2011-12 Global Cap was \$14 million below the \$15.3 billion target. This is a remarkable achievement that involved fiscal discipline, creativity and innovation from all sectors within the Medicaid program.

Prior to the Medicaid Redesign Team (MRT), the State was facing a fiscal crisis and the State share of Medicaid spending was projected to grow substantially. The MRT was created by Governor Cuomo to lower growth to the ten year average of the Medical CPI (set at 4%) or \$15.3 billion. To remain within the Global Cap, the MRT adopted 78 discrete saving initiatives that in aggregate saved \$2.3 billion (and the federal government a comparable amount) in 2011-12.



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Also within this period, we've seen the health care community working collectively together across provider silos to develop care delivery models and networks in our effort to create an efficient and sustainable health care system, including:

- Shifting less severe patients from the hospital and emergency room to more appropriate ambulatory/primary care settings;
- Controlling home care and personal care spending that was previously climbing at double-digit growth rates prior to the MRT;
- Shifting Medicaid recipients from costly fee-for-service into Medicaid Managed Care where services are better coordinated and financial incentives are more rational; and
- Voluntary repayment of over \$50 million to the State for outstanding liabilities owed by providers.

It is important to note the fact that the health care system remained within the cap, while providing health care coverage to an additional 152,000 fragile and low income New Yorkers.

Looking forward, the Department of Health and the Division of the Budget are currently working to develop the Global Cap forecast for 2012-13. The current Financial Plan assumes an increase in the State funds Medicaid cap to \$15.9 billion. While the forecast is still under development, 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.

## Results through March 2012 - Summary

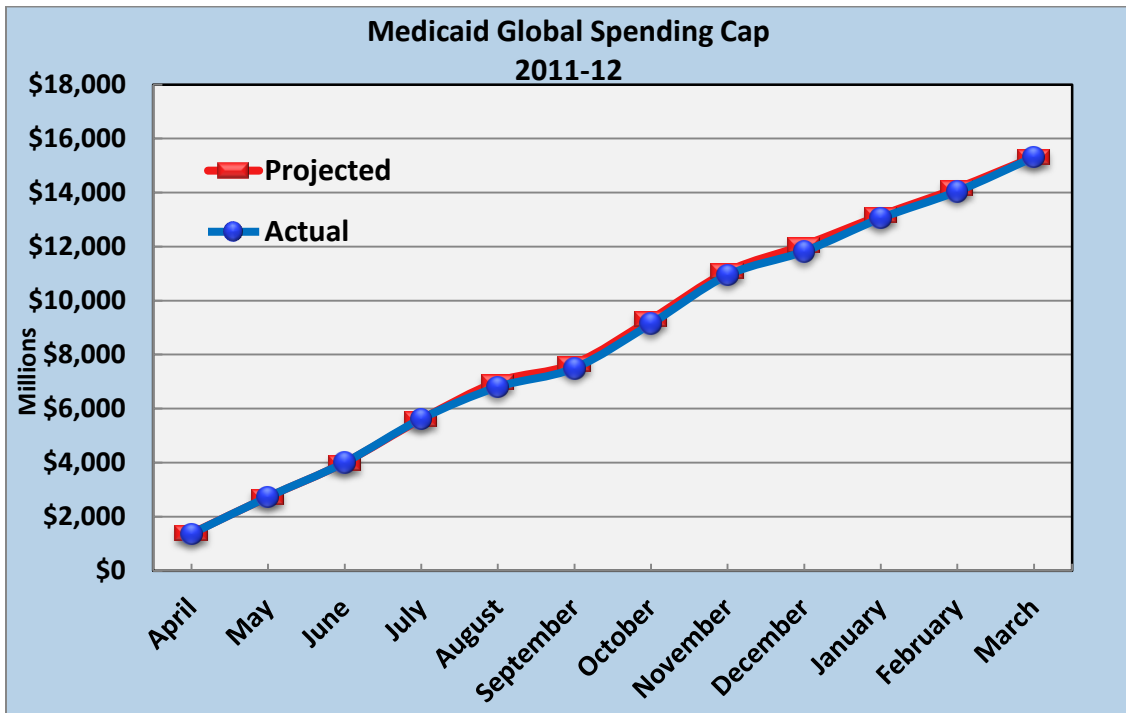
Total State Medicaid expenditures under the Medicaid Global Spending Cap for SFY 2011-12 are \$14 billion or less than 0.1% **below** projections. Cumulative spending for the months April through March resulted in total expenditures of \$15.31 billion compared to the projection of \$15.32 billion. Since April 2011, enrollment in the Medicaid program has grown by more than 152,000 enrollees (or 3.1%), 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,

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the implementation of new Medicaid Redesign Team measures enacted as part of the 2012-13 Budget will impact monthly Medicaid spending.



<b>Medicaid Spending April 2011 - March 2012 (dollars in thousands)</b>			
Category of Service	Estimated	Actual	Variance
Inpatient	\$2,066,934	\$2,106,420	\$39,486
Outpatient/Emergency Room	\$347,099	\$304,219	(\$42,880)
Clinic	\$296,273	\$279,067	(\$17,206)
Nursing Homes	\$3,039,749	\$3,044,443	\$4,694
Other Long Term Care	\$1,868,863	\$1,671,936	(\$196,927)
Medicaid Managed Care	\$3,861,172	\$4,051,469	\$190,297
Family Health Plus	\$765,145	\$829,204	\$64,059
Non-Institutional / Other	\$3,384,840	\$3,343,178	(\$41,662)
Cash Audits	(\$303,500)	(\$317,688)	(\$14,188)
<b>TOTAL</b>	<b>\$15,326,576</b>	<b>\$15,312,249</b>	<b>(\$14,327)</b>



## Results through March - Variance Highlights

- ▶ **Lower Fee-for-Service Spending:** Through March, Medicaid spending in major fee-for-service categories is \$444 million below projections as follows:
  - *Inpatient* hospital spending is \$39 million above the estimate. This variance is primarily due to higher than projected utilization associated with fewer recipients shifting from fee-for-service to Medicaid Managed Care.
  - *Outpatient/Emergency Room* spending is \$43 million below projection, a result of lower than expected utilization trends. The Outpatient Emergency Room sector has experienced a decrease in the number of recipients served and a decrease in the number of claims billed. The utilization drops reflect the migration of recipients to Medicaid Managed Care.
  - *Clinic* spending is \$17 million below the target projections.
  - *Nursing Home* spending is \$5 million above the global cap estimate.
  - *Other Long Term Care* services spending, which includes Personal Care, Home Health, Home Nursing, and the Assisted Living programs, is \$197 million below projections. The variance is primarily attributable to lower than projected spending in Personal Care (\$24 million), Home Health (\$147 million), and Home Nursing (\$25 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 Health and Home Nursing variances reflect a significant reduction in per recipient spending based on both claims payment adjustments and agency effort to control and reduce home health service utilization as a result of the implementation of MRT #5 (provider specific spending limits).
  - *Non-Institutional* fee-for-service spending (includes Pharmacy, Transportation, Supplemental Medical Insurance, etc.) is \$231 million below estimates. This variance is primarily due to lower Supplemental Medical Insurance (\$115 million) and Pharmacy spending (\$80 million). Lower than forecasted Medicare rates and the timing of payments drove the under spending for SMI, and higher than projected drug rebates resulted in lower Pharmacy spending.
- ▶ **Higher Medicaid Managed Care Spending:** Total spending through March is \$190 million above projections due to higher than anticipated enrollment. During SFY 2011-12 Managed Care enrollment (not including FHP, CHP, HIVSNP, or MLTC) increased more than 186,000 (6.4%) from 2.9 million to 3.1 million.
- ▶ **Higher Family Health Plus Spending:** Through March, Family Health Plus spending is \$64 million above estimates and continues to reflect higher than projected enrollment. During SFY 2011-12 Family Health Plus enrollment increased over 23,000 (5.8%) from slightly more than 400,500 to over 423,500.
- ▶ **Lower Federal Medical Assistance Payments (FMAP):** Enhanced Federal share payment benefits are \$56 million below projections through March. A portion of this variance may be attributed to the receipt of the anticipated benefits through lower payments in other service categories.

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- ▶ **Higher Local Medicaid Cap Costs:** Local Medicaid Cap expenditures exceeded projected levels by \$170 million. This corresponds to increased State spending in Managed Care and serves to offset under spending in other fee-for-service categories. (Note: Under the 2005 Local Medicaid Cap statute, the State is responsible for covering local costs of Medicaid that exceed the annual cap).
- ▶ **Higher Other State Agency Offset Transfers:** Medicaid spending by other State agencies is \$61 million below annual projections. This spending is processed by the Department of Health and subsequently offset by transfers from the other agency budgets.
- ▶ **Lower Medicaid Administration Costs:** Through March, spending on Medicaid administration finished below projected levels by \$40 million, reflecting lower than anticipated local social service district claiming, and initial efforts by the State to transition administrative functions from counties.
- ▶ **Higher Medicaid Audits:** Through March, spending offsets realized from Medicaid audit recoveries are \$14 million above projections.



## Accounts Receivable

The Department of Health has processed approximately 80 different rate adjustment packages in SFY 2012. Many of these rate packages had retroactive impacts (meaning they adjusted 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.

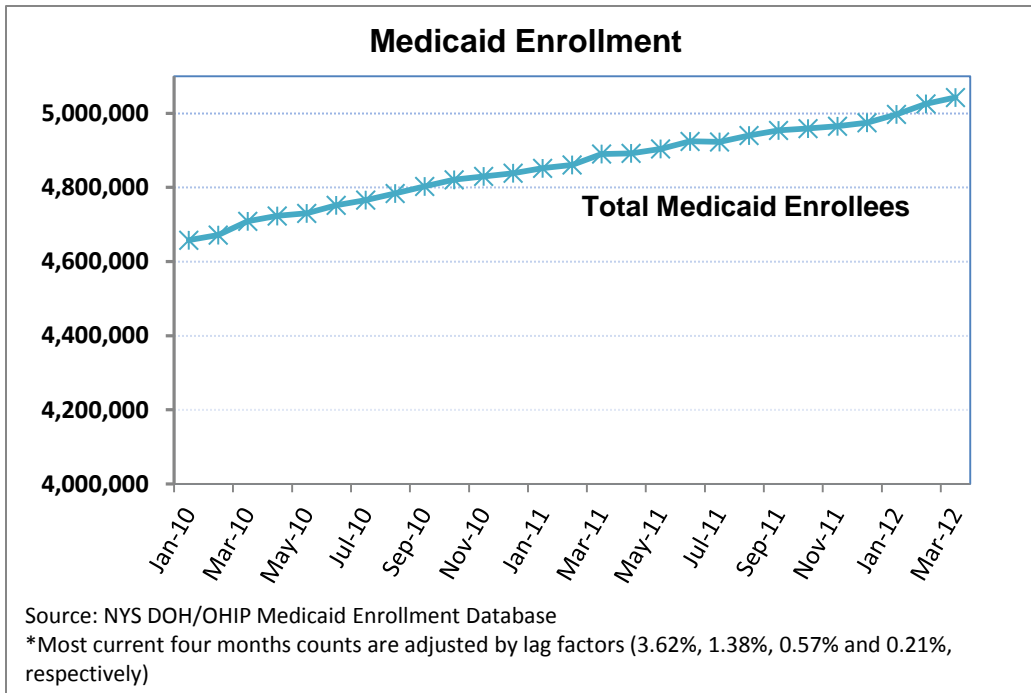
The accounts receivable for retroactive rates owed to the State as of March 2012 is significantly higher than projected. Through March 2012, the accounts receivable balance totaled \$575 million. January was the peak month (at over \$750 million), as most rate adjustment packages were processed, and the balance has begun and is projected to continue to decline in the following months. The Department of Health sent out letters to 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. In response to this letter, the State received \$54 million from providers. The Department will closely monitor the accounts receivable balances each month as it evaluates spending in SFY 2012-13.

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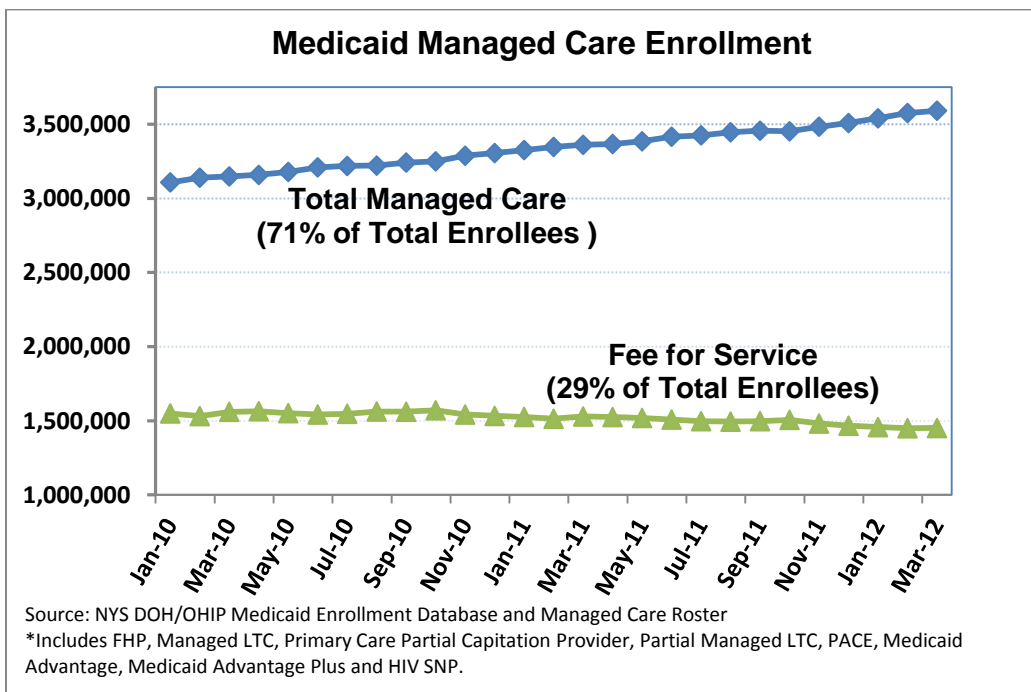


## Enrollment

Medicaid enrollment reached 5,042,707 enrollees at the end of March 2012. This reflects an increase of more than 152,000 enrollees, or 3.1%, since April 2011.



Medicaid Managed Care enrollment in March 2012 (includes FHP and Managed LTC and excludes CHP) reached 3,591,307 enrollees, an increase of almost 230,000 enrollees, or 6.8%, since April 2011.







## 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 actual spending for April 2011 through March 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](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 2010-11 adjusted for one-time spending that is not expected to recur in SFY 2011-12;
- ▶ Anticipated increases in health care prices and estimated changes in service utilization in SFY 2011-12;
- ▶ The achievement of savings generated from 73 MRT actions over time, and
- ▶ Lower costs spread among the categories attributed to the \$640 million in Health Care Industry savings and the \$475 million Medicaid caseload reestimate.

Detailed monthly spending projections can be found on the Department of Health's website at:  
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