



Medicaid Global Spending Cap Report
Redesigning the Medicaid Program

JULY 2014



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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 (+\$955 million)	Price includes an increase in managed care premiums for cost trends and newly covered benefits, as well as fee-for-service rate adjustments. <i>See Appendix B for more detail.</i>
Utilization (+\$413 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 (-\$828 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.

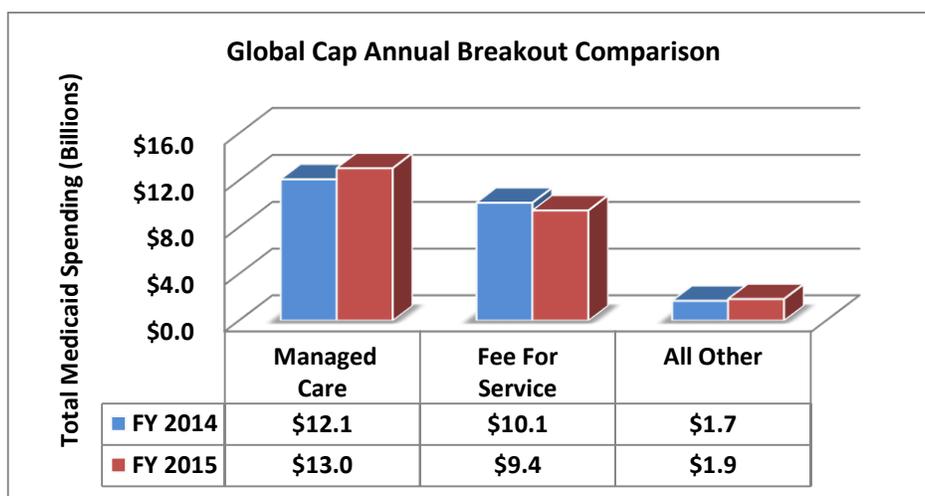
- *Basic Health Plan (BHP)* - The BHP is an option for states under the ACA which offers quality, low cost health insurance to New York State residents not eligible for Medicaid or Child Health Plus. It is funded by 95% of the value of the tax credits available to individuals who would have otherwise 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, Medicaid spending has remained within the Global Cap while expanding health coverage to the State’s neediest populations. Collaboration between the MRT and the health care community has allowed major steps towards redesigning the State’s Medicaid program and reducing cost to be made. As a result of this success, the FY 2015 Budget established a Global Cap dividend payment designed to reward healthcare providers through a shared savings program, if Medicaid spending remains 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 July 2014 - Summary

Total State Medicaid expenditures under the Medicaid Global Spending Cap for FY 2015 through July are \$10 million, or 0.2 percent, **under** projections. Spending through the month of July resulted in total expenditures of \$5.83 billion compared to the projection of \$5.84 billion.

Medicaid Spending – FY 2015 (dollars in millions)			
Category of Service	Estimated	Actual	Variance Over / (Under)
Medicaid Managed Care	\$3,908	\$3,897	(\$11)
Mainstream Managed Care	\$2,876	\$2,866	(\$10)
Long Term Managed Care	\$1,032	\$1,031	(\$1)
Family Health Plus	\$185	\$209	\$24
Total Fee For Service	\$3,069	\$3,057	(\$12)
Inpatient	\$1,016	\$1,010	(\$6)
Outpatient/Emergency Room	\$141	\$147	\$6
Clinic	\$210	\$205	(\$5)
Nursing Homes	\$1,130	\$1,135	\$5
Other Long Term Care	\$245	\$245	\$0
Non-Institutional	\$327	\$315	(\$12)
Medicaid Administration Costs	\$151	\$152	\$1
OHIP Budget / State Operations	\$50	\$45	(\$5)
Medicaid Audits	(\$131)	(\$110)	\$21
All Other	\$1,166	\$1,138	(\$28)
Local Funding Offset	(\$2,554)	(\$2,554)	\$0
TOTAL	\$5,844	\$5,834	(\$10)

Results through July - Variance Highlights

- **Medicaid Managed Care Spending:** Medicaid spending in major Managed Care categories was \$11 million, or 0.3 percent, under projections.
 - ▶ Mainstream Managed Care was \$10 million, or 0.3 percent, under projections. The variance is primarily driven by the migration of Family Health Plus recipients into mainstream managed care plans. The transition appears to be occurring at a slower rate than anticipated.
 - ▶ Long Term Managed Care was on target with projections.
- **Family Health Plus Spending:** Medicaid spending in Family Health Plus was \$24 million over projections. Through July the phase-down of the program occurred at a much slower rate than expected. Under the reforms of the federal Affordable Care Act, the Family Health Plus (FHP) program will be ending by December 31, 2014. FHP recipients already enrolled will continue to receive coverage through their health plan. Beginning January 1, 2014, qualified enrollees will enroll in a health plan through the NYSoH Healthcare Exchange. FHP enrollment has decreased from 341,859 recipients in January 2014 to 228,700 in July 2014.

- **Fee-for-Service Spending:** Medicaid spending in major fee-for-service categories was \$12 million, or 0.4 percent, under projections.
 - ▶ *Non-Institutional* spending (includes Pharmacy, Medical Supplies, Physicians, Supplemental Medical Insurance, etc.) was \$12 million under target which is attributed to higher than expected drug rebates. Total rebates collected exceeded projections by 8 percent through July which appears to be related to the timing of collections.
- **Medicaid Audits:** Through July, the spending offsets from Medicaid audit recoveries were below projected levels by \$21 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 \$28 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 restore the reductions. Upon federal approval, providers will be reimbursed withheld retroactive amounts to April 2014.

Office of Health Insurance Programs (OHIP) State Operations Budget

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

Contracts for the Enrollment Center, Medicaid Management Information Systems (MMIS), NYSOH 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	\$10
Non-Personal Services	\$188	\$35
Medicaid Transportation Management	\$33	\$6
eMedNY (MMIS)	\$29	\$7
NYS Of Health Healthcare Exchange	\$25	\$4
Enrollment Broker	\$20	\$3
Early Innovator	\$17	\$1
All Others	\$64	\$14
TOTAL	\$230	\$45

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 July, retroactive rates owed to the State were \$598 million. This reflects an increase of \$368 million since March 2014, which is associated with rate adjustments implemented for State Operated OPWDD providers. The State expects the increase in A/R related to the State Operated OPWDD providers to be resolved within the next few months.

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 5,828,876 enrollees at the end of July 2014. This reflects an increase of 133,932 enrollees, or 2.4 percent, since March 2014. Below is a detailed breakout by program and region:

Medicaid Enrollment Summary FY 2015			
	March 2014	July 2014	Increase / (Decrease)
Managed Care	4,116,631	4,412,785	296,154
New York City	2,589,433	2,744,157	154,724
Rest of State	1,527,198	1,668,628	141,430
Fee-For-Service	1,578,313	1,416,091	(162,222)
New York City	785,320	695,294	(90,026)
Rest of State	792,993	720,797	(72,196)
TOTAL	5,694,944	5,828,876	133,932
New York City	3,374,753	3,439,451	64,698
Rest of State	2,320,191	2,389,425	69,234

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	6,197
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	\$12,946	(\$157)	\$12,789
Mainstream Managed Care	\$9,344	(\$157)	\$9,187
Long Term Managed Care	\$3,602	\$0	\$3,602
Family Health Plus	\$277	\$0	\$277
Total Fee For Service	\$8,290	\$1,184	\$9,474
Inpatient	\$2,079	\$757	\$2,836
Outpatient/Emergency Room	\$424	(\$12)	\$412
Clinic	\$608	(\$47)	\$561
Nursing Homes	\$3,411	\$0	\$3,411
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	\$110	\$110
Supportive Housing	\$0	\$115	\$115
Medicaid Administration Costs	\$0	\$453	\$453
OHIP Budget / State Operations	\$0	\$230	\$230
Medicaid Audits	\$0	(\$424)	(\$424)
All Other	\$3,009	(\$9,081)	(\$6,072)
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)	(\$209)	(\$209)
TOTAL	\$24,522	(\$7,570)	\$16,952

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)					
Category of Service	Rate Package Description	Effective Date	Projected Impact		Date Released
			Gross	Non-Federal	
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	\$262	
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	\$25
Diagnostic & Treatment Centers	18	\$36	\$3	\$2
Nursing Homes	8	\$33	\$17	\$4
Critical Access Hospitals	23	\$16	\$5	\$3
Certified Health Home Agencies	2	\$5	\$2	-
TOTAL	76	\$238	\$91	\$34

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	\$58
Rental/Service Subsidies	\$34
New Supportive Housing Pilot Projects	\$22
Tracking & Evaluation	\$1
TOTAL	\$115
YTD Actuals	\$9

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	178,119	143,481	34,638
February	318,011	251,848	66,163
March	542,791	408,371	134,420
April	660,492	387,479	273,013
May	745,590	309,019	436,571
June	825,683	283,908	541,775
July	906,979	275,356	631,623

NYSOH Healthcare Exchange – FY 2015 Medicaid Eligibility Determinations		
	Total	% of Total
Childless adults income < 100% (75% FMAP)	321,071	35.4%
Childless adults income 100-138% (100% FMAP)	97,047	10.7%
All Other (50% FMAP)	488,861	53.9%
Total	906,979	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 July 2014 for each region.

Medicaid Regional Spending – FY 2015 (dollars in millions)	
Economic Region	Non-Federal Total Paid
New York City	\$4,784
Long Island	\$795
Mid-Hudson	\$769
Western	\$381
Finger Lakes	\$335
Capital District	\$278
Central	\$196
Mohawk Valley	\$168
Southern Tier	\$150
North Country	\$114
Out of State	\$41
TOTAL	\$8,011

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/