



**Department
of Health**

Medicaid Global Spending Cap Report

March 2019

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Global Cap – A Year in Review

The Department of Health and the Division of Budget report that spending under the FY 2019 Medicaid Global Spending Cap was \$4 million below the \$20.8 billion target, while also continuing:

- *Care Management for All initiative* which has transitioned a number of populations and benefits into the Managed Care setting.
- *Vital Access Provider/Safety Net* program to improve community care, including expanding access to ambulatory services, opening urgent care centers, expanding services in rural areas, and providing more effective services that meet community needs;
- *Value Based Payment Reform (VBP)* designed to transform the Medicaid payment structure from volume driven to value-based;
- *Essential Plan (EP)*. The EP provides New York the opportunity to offer many consumers who qualify for a lower-cost health insurance option than otherwise available through the New York State of Health;

However, FY 2019 had its challenges. Higher spending trends and other pressures resulted in a significant Global Cap deficit. The deficit was driven by higher than anticipated spending over and above the Enacted Budget estimates, unachieved savings initiatives, and other factors described below.

The largest component of the deficit was attributable to higher than anticipated spending over and above the Enacted Budget estimates in various categories, as follows:

- *Long Term Care Services* – Accounts for 46 percent of the total category of service deficit. MLTC enrollment increased by 12 percent annually or 28,124 individuals, more than double the projected enrollment.
- *Acute Care Services* – Higher utilization and the statutorily required Inpatient rebasing rate adjustment. Rebasing is budget neutral for the base year that is used to develop the rates, however when those rates are applied to the utilization of the rate year it resulted in higher spending.
- *Managed Care Services* – 25 percent year-to-year increase in the number of Stop Loss claims processed.
- *Medicare Services* – Higher cost sharing payments for both the Medicare Part A & B and Part D clawback programs.

The second factor contributing to the deficit was unachieved Medicaid savings initiatives:

- The VBP-QIP transition to the EP was delayed until FY 2020, rolling Medicaid Cap relief into the next year.
- Delayed implementation of the 1115 waiver designed to limit MLTC eligibility to less than 3 months in Nursing Homes due to outstanding Federal approval.
- Lower than expected MRT savings related to ‘Require Medicare as a condition of Medicaid eligibility’.

Other factors include:

- A Single State Audit finding identified that individuals were inappropriately enrolled in the Essential Plan. A system correction was implemented to correct this issue.
- Lower accounts receivable collections mainly due to the State's effort to reduce the Accounts Receivable balances over the past several years has diminished the amount available to collect prospectively.

The State has, at times, taken actions to manage the timing of Medicaid payments to ensure compliance with the Global Cap. Between FY 2015 and FY 2018, DOH managed the timing of payments across State fiscal years that ranged from \$50 million to roughly \$435 million. In FY 2019, DOH deferred, for three business days the final cycle payment to Medicaid Managed Care Organizations, as well as other payments. The FY 2019 deferral had a State-share value of \$1.7 billion and was paid utilizing cash on hand in April 2019, consistent with contractual obligations and had no impact on provider services. Absent the deferral, Medicaid spending under the Global Cap would have exceeded the statutorily indexed rate for FY 2019. The Division of Budget and Department of Health will continue to develop options to reduce spending within the Global Cap and/or continue to manage the timing of payments, which may include a deferral to FY 2021 if spending is not reduced to levels that adhere to the Global Cap.

Monthly Results - Summary

Total State Medicaid expenditures under the Medicaid Global Spending Cap for FY 2019 were \$4 million below projections. Spending for FY 2019 resulted in total expenditures of \$20.814 billion compared to the projection of \$20.818 billion.

Medicaid Spending (\$ in millions)			
Category of Service	Estimated	Actual	Variance Over / (Under)
Medicaid Managed Care	\$16,820	\$16,130	(\$690)
Mainstream Managed Care	\$10,083	\$9,845	(\$238)
Long Term Managed Care	\$6,737	\$6,285	(\$452)
Total Fee For Service	\$7,859	\$8,275	\$416
Inpatient	\$2,548	\$2,556	\$8
Outpatient/Emergency Room	\$311	\$322	\$11
Clinic	\$407	\$455	\$48
Nursing Homes	\$2,509	\$2,682	\$173
Other Long Term Care	\$660	\$703	\$43
Non-Institutional	\$1,424	\$1,557	\$133
Medicaid Administration Costs	\$570	\$503	(\$67)
OHIP Budget / State Operations	\$458	\$338	(\$120)
Medicaid Audits	(\$351)	(\$335)	\$16
All Other	\$2,556	\$2,997	\$441
Local Funding Offset	(\$7,094)	(\$7,094)	\$0
TOTAL	\$20,818	\$20,814	(\$4)

Results through March - Variance Highlights

Medicaid Managed Care

Spending in Managed Care categories was \$690 million below projections.

- Mainstream Managed Care spending was \$238 million below estimates because payments were delayed into the next fiscal year. Spending for the program would have exceeded projections primarily due to an increase in stop loss claims. The State processed 25 percent more stop loss claims this fiscal year over the prior year driving higher than projected spending.
- Long Term Managed Care was \$452 million below estimates through March because payments were delayed into the next fiscal year. Spending for the program would have exceeded projections primarily due to higher than expected enrollment. Enrollment for the year grew by 12% compared to budgeted growth of 5%. Through March 2019, there were 10,000 more enrollees than anticipated.

Fee-For-Service

Medicaid spending in major fee-for-service categories was \$416 million, or 5.3 percent, over projections.

- *Clinic* spending was \$48 million above projections. Total claims billed were 6.4 percent higher than anticipated through March.
- *Nursing Homes* spending was \$173 million above projections. Total claims billed were 7.0 percent higher than anticipated through March. Nursing Homes are one of the most expensive programs covered under Medicaid.
- *Non-Institutional* spending (includes Pharmacy, Medical Supplies, Physicians, Supplemental Medical Insurance, etc.) was \$133 million above projections. This is primarily the result of higher than expected utilization for Transportation services.

OHIP Budget / State Operations

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). FY 2019 spending was \$458 million which also includes Essential Plan administration costs.

Contracts for the Enrollment Center, NYSOH Benefit Exchange, eMedNY/ MMIS, and various MRT initiatives comprise over 80 percent of the total non-personal service budget.

OHIP State Operations was \$120 million below projections through March primarily due to a delay in receiving appropriate vendor invoices and finalizing contracts.

OHIP Budget FY 2019 (\$ in millions)		
Service Costs	Annual Budget	Actual
Personal Services	\$51	\$38
Non-Personal Services	\$313	\$223
Enrollment Center	\$114	\$62
NYSOH Benefit Exchange	\$93	\$60
eMedNY/MMIS	\$31	\$37
All Payer Database	\$15	\$0
Data Warehouse	\$10	\$14
OHIP Actuarial and Consulting Services	\$12	\$3
All Others	\$38	\$47
Essential Plan	\$94	\$77
TOTAL	\$458	\$338

All Other

All Other spending was above projections by \$441 million. The All Other category includes a variety of Medicaid payments and offsets. The overspending is primarily attributed to lower Accounts Receivable collections and unachieved savings from several MRT initiatives.

Accounts Receivable

The Accounts Receivable (A/R) ending balance for FY 2018 was \$224 million. The State is expected to recoup \$174 million by the end of FY 2019, resulting in a projected A/R balance of \$50 million by March 2019. Through the end of March, retroactive rates owed to the State were \$131 million. This reflects net recoveries of \$93 million since March 2018.

The Department of Health is engaged in an initiative to eliminate all currently outstanding retroactive rate Medicaid liabilities owed to the State. These liabilities pose a potential risk to the Medicaid Global Spending Cap. It is therefore important that the Department take these necessary steps to ensure the solvency of the Global Cap and protect the integrity of the Medicaid program. All retroactive rate liabilities processed on August 1, 2015, and forward, which cannot be fully paid within twelve months using the standard fifteen percent Medicaid recoupment percentage, will be adjusted to a higher recoupment rate to ensure that these liabilities will be paid within twelve months from the date of the first recoupment.

Enrollment

Medicaid Enrollment

Medicaid total enrollment reached 6,154,030 enrollees at the end of March 2019. This reflects a net increase of 5,996 enrollees since March 2018.:

Medicaid Enrollment Summary			
	March 2018	March 2019	Net Increase / (Decrease)
Managed Care	4,768,062	4,730,293	(37,769)
New York City	2,832,697	2,785,678	(47,019)
Rest of State	1,935,365	1,944,615	9,250
Fee-For-Service	1,379,972	1,423,737	43,765
New York City	698,493	743,531	45,038
Rest of State	681,479	680,206	(1,273)
TOTAL	6,148,034	6,154,030	5,996
New York City	3,531,190	3,529,209	(1,981)
Rest of State	2,616,844	2,624,821	7,977

Appendix A Inventory of Rate Packages

Below is the majority of rate packages processed in FY 2019:

Category of Service	Rate Package Description	Effective Date	Date Released
Managed Care	April 2018 Mainstream Rates	4/1/2018	September 2018
	July 2018 Mainstream Rates	7/1/2018	February 2019
	April 2018 HARP Rates	4/1/2018	September 2018
	July 2018 HARP Rates	7/1/2018	February 2019
Long Term Managed Care	April 2018 Partial Capitation Rates	4/1/2018	August 2018
	QIVAPP	4/1/2018	November 2018
	Quality Pools	Various	June 2018
	April 2018 FIDA Rates	4/1/2018	March 2019
Inpatient	Acute & Exempt Unit Actual Capital Updates	Various	May 2018
	Acute & Exempt Unit Inpatient Rates	1/1/2018	May 2018
	July 2018 Statewide Inpatient Rates	7/1/2018	November 2018
Outpatient / Emergency room	FQHC Hold Harmless	1/1/2017	September 2018
	APG Capital Update	Various	November 2018
	2018 Minimum Wage Add-on	1/1/2018	August 2018
Nursing Home	2018 Initial Rates for Nursing Facilities and ADHC	1/1/2018	May 2018
	July Case Mix Rates	7/1/2018	July 2018

Appendix B

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 (BHO/HARP’s), as well as fully integrated plans for Medicare/Medicaid “dual eligibles”. The chart below outlines the list of populations scheduled to transition into the care management setting during FY 2019:

Medicaid Fee for Service Transition to Managed Care (Populations)				
Populations	From (COS)	To (COS)	# of FY 2019 Targeted Enrollees	FY 2019 Enrolled
Nursing Homes	Nursing Homes	MMC/MLTC	7,254	2,607
BHO/HARPs	Various	MMC	23,389	29,018

Appendix C

Phase VIII MRT Initiatives (http://www.health.ny.gov/health_care/medicaid/redesign/mrt_budget.htm)

Phase VIII MRT Initiatives (\$ in millions)	
Initiative	FY 2019
Global Cap Target	\$425.0
Global Cap Base Deficit	\$0.0
Nursing Home 1% ATB (4 year payback)	\$35.0
Enrollment Reconciliation	\$10.0
Additional Funding for VAPAP/VBPQIP	\$45.4
Outstanding Federal Obligations	\$133.0
Total Federal Actions/Pressures on GC	\$648.4
Convert VBP-QIP / Other Supplemental programs to Essential Plan	(\$281.5)
Total Essential Plan Initiatives	(\$281.5)
Update Professional Dispensing Fee	\$0.4
Reduce Opioid Dispensing by 20% by 2020	(\$1.1)
Medication Adherence	(\$5.0)
Rebate Risk Assessment	(\$15.0)
Total Pharmacy Savings	(\$20.7)
Implement a penalty on poor performing Nursing Homes	(\$7.7)
Rationalize Nursing Homes Case Mix Index Increases	(\$7.5)
Admin Rate Reduction/Regulation Relief	(\$18.9)
Expand Access to Assisted Living Program Services (ALPs)	\$4.4
Require a Continuous 120 days of Community Based Long Term Care (CBLTC) for Continuing Plan eligibility	(\$4.8)
Prohibit Fiscal Intermediary (FI) Bad Actors that Advertise False or Misleading Information.	(\$4.9)
Licensed Home Care Services Agencies (LHCSA) Contract Limits w/ MLTC Plans, Review, Registration, & Moratorium	(\$13.7)
Social Adult Day Health Benefit Efficiency Savings	(\$28.1)
Restrict MLTC Members from Transitioning from Plan to Plan for 12 Months After Initial Enrollment	(\$5.2)
Authorization vs. Utilization Adjustment for MLTC	(\$1.2)
Limit MLTC Eligibility to < 3 Months in NHs	(\$79.0)
Traumatic Brain Injury (TBI) Clinic Rate Adjustment	\$0.4
Additional Hospice Funding	\$0.9
Rural County Provider funding	\$1.5
Total LTC Initiatives	(\$163.9)
Increase Current Penalties for Managed Care Plans that Fail to Meet Value Based Payments (VBP) targets	(\$10.0)
Reduce FFS/MCO Rate for Providers Without VBP Contracts	(\$7.5)
Reduce Overutilization of Laboratory Services	(\$7.5)

Total Managed Care Savings	(\$25.0)
Criminal Background Checks	\$1.1
Penalty for Failure to Enroll High Risk Plan Members in Health Homes	(\$15.0)
Health Home Healthy Rewards Program	(\$15.0)
Redirect Outreach Resources to Increase HH Enrollment of High Risk Members	(\$4.4)
Total Health Home Initiatives	(\$33.3)
Reduce Accounts Receivable Balances	(\$12.6)
MC Pilot to Improve Access to Clozapine	(\$2.0)
Best Practices in ER Diversion & Inpatient Discharge	(\$4.5)
Reducing Unnecessary Utilization - Physical Therapy Cap	\$2.3
Correct Ambulatory Patient Group (APG) Weights for IV Infusion/Hydration Bags	(\$5.0)
Remove Originating Site Requirement from Telehealth Program	(\$5.0)
OMIG Savings Initiatives	(\$25.0)
First One Thousand Days	\$1.5
Ambulance Fee Increase	\$6.3
Total Other	(\$44.1)
Increased MRT/Safety Net Inter-Governmental Transfer (IGT)	(\$46.3)
MCO Tax Repeal	(\$3.9)
Telehealth Expansion	(\$10.0)
Health Homes - Quality Improvements	(\$10.0)
Maximus Contract - 3-year Extension	(\$15.0)
Claims Editing Enhancements	(\$17.0)
Proportionally Reduce Managed Care Quality Pools	(\$13.0)
Total Legislative Avails	(\$115.2)
Reimbursement rates for Crouse Community Center	\$0.4
Hepatitis C Investment	\$5.0
Safety Net (50% Safety Net 50% CHA & SCH)	\$30.0
Total Legislative Adds	\$35.4
TOTAL	\$0.0

Appendix D

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 March 2019 for each region.

Medicaid Regional Spending (\$ in millions)	
Economic Region	Non-Federal Total Paid
New York City	\$17,287
Long Island	\$2,652
Mid-Hudson	\$2,623
Western	\$1,399
Finger Lakes	\$1,175
Capital District	\$956
Central	\$714
Mohawk Valley	\$597
Southern Tier	\$529
North Country	\$384
Out of State	\$110
TOTAL	\$28,425

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/

Appendix E

Medicaid Drug Cap

- The State Fiscal Year 2018 Enacted Budget established a Medicaid Drug Cap that will limit pharmacy spending growth in the Medicaid program to the 10-year rolling average of the medical component of the Consumer Price Index plus four percent (7.2% in the current year), less \$85 million in state share savings in FY 2019.
- If the Budget Director determines that expenditures will exceed the annual growth limitation imposed by the Medicaid Drug Cap, the Commissioner of Health may refer drugs to the State's Drug Utilization Review Board (DURB) for a recommendation as to whether a supplemental rebate should be paid by the manufacturer.
- If the Department intends to refer drugs to the DURB, it will notify affected manufacturers and will attempt to reach agreement on rebate amounts prior to DURB referral.
- In determining whether to recommend a target supplemental rebate for a drug the DURB must consider the cost of the drug to the NYS Medicaid program and may consider, among other things: the drug's impact on the Medicaid drug spending, significant and unjustified increases in the price of the drug, and whether the drug may be priced disproportionately to its therapeutic benefits.
- In formulating a recommendation, the DURB may consider, among other things: publicly available and DOH supplied pricing information, the seriousness and prevalence of the disease or condition being treated, Medicaid utilization, the drug's effectiveness or impact on improving health, quality of life or overall health outcomes, the likelihood that the drug will reduce the need for other medical care (including hospitalization), the average wholesale price, wholesale acquisition cost, and retail price of the drug, and the cost of the drug to Medicaid minus rebates.
- If after the DURB recommends a target rebate amount, DOH and the manufacturer are unable to reach agreement regarding supplemental rebate amounts, the manufacturer will be required to provide DOH with certain information including but not limited to marketing, research, and development costs for the drug.
- In the first year of implementation, the Medicaid Drug Cap successfully achieved the \$55 million state share statutory savings target. The Department was able to establish processes for evaluating on-going drug spend and determining the budget impact of high cost drugs. The NYS Medicaid Drug Cap has achieved national recognition for its unique approach to addressing growth in Medicaid drug spending.

Appendix F

Notable Events

- Delay in implementation of new Children services (from 10/1/17 to 1/1/19)
 - New services place an emphasis on earlier intervention for children experiencing behavioral health challenges before they rise to the level of needing high intensity clinical services.
 - Includes Community Psychiatric Support and Treatment, Psychosocial Rehabilitation Services, Crisis Intervention, Family Peer Support Services, Youth Peer Training and Support Services, and Other Licensed Practitioners.
- Delay of new Community First Choice Option services (from 7/1/17 to 1/1/19) which was further delayed as part of the FY 2020 enacted budget (to 1/1/20)
 - Requires MLTC plans to expand and/or enhance the current benefit package to include all services and supports within the CFCO for adults age 21 and over.
- Bed Hold Reimbursement
 - The Enacted Budget included language to eliminate the payment for bed hold days for nursing homes effective April 1, 2017. The Department has not implemented the elimination of bed hold reimbursement at this time.
- OIG released an audit report indicating that NYS improperly made payments to MLTC plans that failed to comply with contract rules.
 - DOH has issued several new policies and procedures to monitor MLTC plans for compliance to address deficiencies cited in the audit report.
 - DOH is currently working with OMIG to review the records that were subject to the audit.
- VBP Stimulus for MLTC program
 - Provides stimulus funding to support all MLTC plans with VBP contracting in place.
- The Global Cap was increased to reflect an update to the ten-year average of the Medical Care Consumer Price Index, which went from 3.2 percent to 3.3 percent, resulting in an increase of \$2 million.
- In FY 2019, DOH deferred, for three business days the final cycle payment to Medicaid Managed Care Organizations, as well as other payments.
 - The deferral had a State-share value of \$1.7 billion and was paid utilizing cash on hand in April 2019, consistent with contractual obligations and had no impact on provider services. Absent the deferral, Medicaid spending under the Global Cap would have exceeded the statutorily indexed rate for FY 2019.
 - The higher spending in FY 2019 appears to reflect growth in managed care enrollment and costs above projections, as well as certain savings actions and offsets that were not processed by year-end.
- The Division of Budget and Department of Health will continue to develop options to reduce spending within the Global Cap and/or continue to manage the timing of payments, which may include a deferral to FY 2021 if spending is not reduced to levels that adhere to the Global Cap.

Appendix G

State-only Payments (YTD)

Payments	Non Federal Total Paid
Supportive Housing	\$53,257,491
VAPAP	\$45,434,298
Major Academic Pool	\$24,500,000
Alzheimer's Caregiver Support	\$22,452,035
End of AIDS	\$14,012,518
MLTC Ombudsman	\$6,506,696
Rural Transportation	\$4,000,000
ACA FFP Correction	\$4,000,000
CSEA Buy-in	\$1,757,436
Water Fluoridation	\$1,741,362
UFT Buy-in	\$1,181,434
BH Transformation Non-VAP	\$922,500
Primary Care Service Corps	\$702,957
MLTC Technology Demonstration	\$702,957
TOTAL	\$181,171,684

Appendix H Monthly Results (December-February)

December

Medicaid Spending (\$ in millions)			
Category of Service	Estimated	Actual	Variance Over / (Under)
Medicaid Managed Care	\$13,104	\$13,200	\$96
Mainstream Managed Care	\$8,001	\$8,028	\$27
Long Term Managed Care	\$5,103	\$5,172	\$69
Total Fee For Service	\$6,546	\$6,713	\$167
Inpatient	\$2,016	\$2,022	\$6
Outpatient/Emergency Room	\$246	\$244	(\$2)
Clinic	\$348	\$365	\$17
Nursing Homes	\$2,025	\$2,098	\$73
Other Long Term Care	\$514	\$526	\$12
Non-Institutional	\$1,397	\$1,458	\$61
Medicaid Administration Costs	\$473	\$480	\$7
OHIP Budget / State Operations	\$270	\$252	(\$18)
Medicaid Audits	(\$245)	(\$257)	(\$12)
All Other	\$2,613	\$2,602	(\$11)
Local Funding Offset	(\$5,320)	(\$5,320)	\$0
TOTAL	\$17,441	\$17,670	\$229

January

Medicaid Spending (\$ in millions)			
Category of Service	Estimated	Actual	Variance Over / (Under)
Medicaid Managed Care	\$14,421	\$14,639	\$218
Mainstream Managed Care	\$8,747	\$8,837	\$90
Long Term Managed Care	\$5,674	\$5,802	\$128
Total Fee For Service	\$7,071	\$7,233	\$162
Inpatient	\$2,213	\$2,203	(\$10)
Outpatient/Emergency Room	\$274	\$272	(\$2)
Clinic	\$389	\$406	\$17
Nursing Homes	\$2,238	\$2,296	\$58
Other Long Term Care	\$577	\$599	\$22
Non-Institutional	\$1,380	\$1,457	\$77
Medicaid Administration Costs	\$488	\$495	\$7
OHIP Budget / State Operations	\$298	\$280	(\$18)
Medicaid Audits	(\$331)	(\$290)	\$41
All Other	\$2,949	\$2,936	(\$13)
Local Funding Offset	(\$6,002)	(\$6,002)	\$0
TOTAL	\$18,894	\$19,291	\$397

February

Medicaid Spending (\$ in millions)			
Category of Service	Estimated	Actual	Variance Over / (Under)
Medicaid Managed Care	\$15,607	\$15,997	\$390
Mainstream Managed Care	\$9,536	\$9,771	\$235
Long Term Managed Care	\$6,071	\$6,226	\$155
Total Fee For Service	\$7,678	\$7,956	\$278
Inpatient	\$2,365	\$2,383	\$18
Outpatient/Emergency Room	\$293	\$294	\$1
Clinic	\$405	\$428	\$23
Nursing Homes	\$2,406	\$2,497	\$91
Other Long Term Care	\$628	\$657	\$29
Non-Institutional	\$1,581	\$1,697	\$116
Medicaid Administration Costs	\$520	\$500	(\$20)
OHIP Budget / State Operations	\$335	\$355	\$20
Medicaid Audits	(\$353)	(\$316)	\$37
All Other	\$2,896	\$3,093	\$197
Local Funding Offset	(\$6,548)	(\$6,548)	\$0
TOTAL	\$20,135	\$21,037	\$902