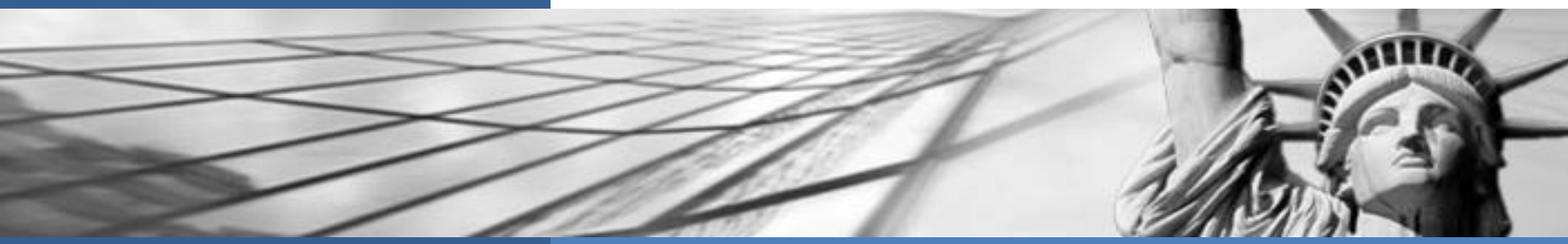

Medicaid Global Spending Cap Report

Redesigning the Medicaid Program

APRIL 2013

NEW YORK
state department of
HEALTH

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Overview

The FY 2014 Enacted Budget extended the Medicaid Global Spending Cap through March 2015. Pursuant to legislation, the Medicaid Global Spending Cap will increase from $15.9 billion to $16.4 billion in FY 2014, roughly 3.2 percent. The CPI used on Medicaid services subject to the trend was 3.9 percent (ten year average of the Medical Care Consumer Price Index), however there were several adjustments made to the Global Cap target that are not subject to the trend, the most significant were the return of Monroe County in local county contributions and the inclusion of OHIP State Operations cost previously budgeted outside of the Medicaid Global Spending Cap. The annual growth in the Global Cap of $510 million over last year includes 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 (+$490 million)	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 A for more detail.*
Utilization (+$140 million)	Utilization reflects the annualization of FY 2013 net enrollment growth (108,300 recipients) as well as assumed new enrollment for FY 2014 (127,000 recipients).
MRT/One-Timers/Other (-$120 million)	MRT/Other primarily includes an increase of $190 million in local county contributions reflecting the return of Monroe County to the program offset by lower expected rebates due to a trend of drugs shifting from brand to generic.

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

- Advances *Care Management for All*, the transition of Medicaid enrollees to care management. There are a number of populations and benefits scheduled to transition into the managed care setting this fiscal year, which are all described in further detail later in this report.
- Implements the *Balance Incentive Program (BIP)*. BIP is a provision of the Affordable Care Act (ACA) to provide additional federal funding to implement structural changes that are believed to best facilitate rebalancing the percentage of individuals in need of long term supports and services in home and community based settings as opposed to institutional settings. For additional information regarding BIP please visit: http://www.health.ny.gov/health_care/medicaid/redesign/balancing_incentive_program.htm
- Allows Family Health Plus enrollees to move to the New York Health Benefit Exchange or to a Qualified Health Plan. This provides enrollees with benefits currently not received under Family Health Plus.

Lastly, as part of the Enacted Budget, the State partnered with the entire health care community to develop a comprehensive solution to solve the loss of $1.1 billion of annual federal Medicaid revenue for developmental disability services. The solution was in large part driven by the success of the MRT. A significant portion, $200 million, was achieved by underspending in FY 2013 which allowed the State to fund expenses that would have otherwise occurred in FY 2014. In addition, roughly $124 million is expected as a result of accelerating MRT initiatives (i.e., Patient Centered Medical Homes, stricter utilization management, MLTC enrollment acceleration, etc.) and implementing other reform measures (i.e., Medicaid managed care efficiencies, increasing the manual review of fee for service claims, and Accounts Receivable recoveries, etc.). In total, the solution consists of State actions ($500 million) as well as additional federal revenue initiatives and other sources ($600 million). Of this amount, $730 million in resources are required to be transferred from the Medicaid Global Spending Cap to stabilize Mental Hygiene funding.

It was initially the State's goal to restore the 2 percent Across the Board (ATB) reductions in the Enacted Budget; however this was not possible given the budgetary constraints on resources under the Medicaid Global Spending Cap. The Department will continue to look for opportunities to mitigate the 2 percent ATB reduction to the extent resources become available.

New Monthly Reporting Requirements

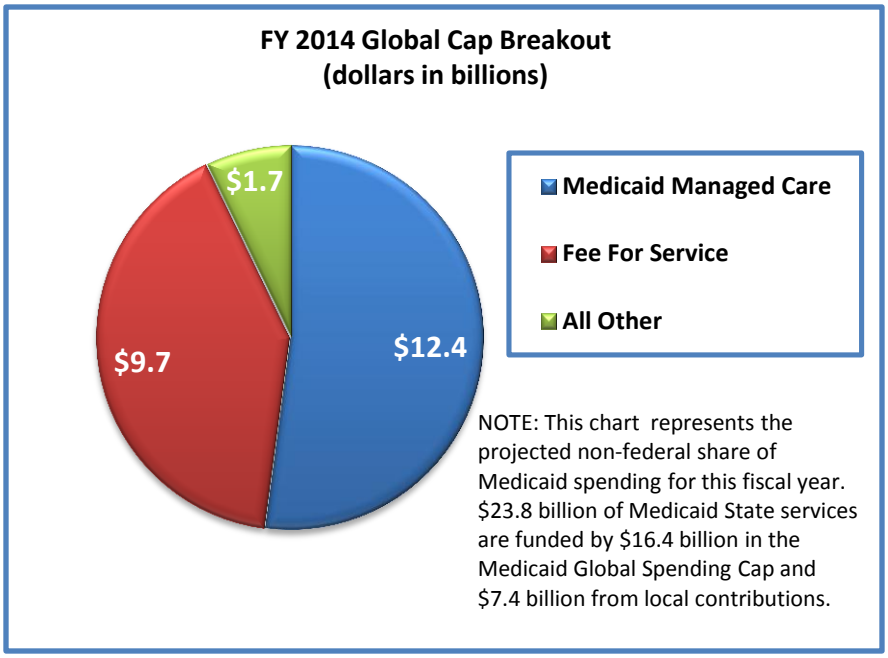
The Department of Health and the Division of the Budget will continue to issue monthly reports on comparing actual State Medicaid spending to projected expenditures, as well as enrollment and regional spending data. In addition, the final FY 2014 Budget requires the Department to provide more information 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.

Importantly, through the first two years of the Global Spending Cap the Medicaid savings allocation plan has not been necessary, in fact, 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. Such initiatives include, 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. The chart in Appendix B illustrates the success the MRT has had on the State's Medicaid program thus far.

Components of the Medicaid Global Spending Cap

The Global Cap is comprised of spending for fee-for-service categories (hospitals, nursing homes, clinics, other long term care providers, and non-institutional related costs), managed care plans (mainstream and long term), Family Health Plus payments and all other (Medicaid administration, OHIP budget, transfers from other State agencies). This spending is offset by local government funding as well as Medicaid audit recoveries, accounts receivable recoupments, and the two percent across-the-board reductions. See Appendix C for the annual budget by category of service.



Relief to the Local Departments of Social Services

The State mandated several structural reforms to relieve local governments of rising health care spending as part of the FY 2013 Enacted Budget, including the three-year phase-in of the elimination of local Medicaid growth and the State takeover of local Medicaid administration functions. The FY 2014 Enacted Budget further provides relief to localities by advancing approximately $86 million in additional Federal funding associated with the implementation of the Affordable Care Act. Additionally, the State is undertaking a major effort to develop and implement an automated eligibility and enrollment system allowing individuals and families to obtain health care coverage through the New York Health Benefit Exchange concurrent the implementation of the Affordable Care Act in January 2014.

Results through April 2013 - Summary

Total State Medicaid expenditures under the Medicaid Global Spending Cap for FY 2014 through April are $2 million or 0.2 percent **under** projections. Spending for the month of April resulted in total expenditures of $1.219 billion compared to the projection of $1.221 billion.

Medicaid Spending FY 2014 - April (dollars in millions)			
Category of Service	**Estimated**	**Actual**	**Variance Over / (Under)**
Total Fee For Service	**$648**	**$656**	**$8**
Inpatient	$228	$231	$3
Outpatient/Emergency Room	$40	$44	$3
Clinic	$51	$57	$6
Nursing Homes	$253	$257	$4
Other Long Term Care	$133	$134	$1
Non-Institutional	($58)	($67)	($9)
Medicaid Managed Care	**$847**	**$848**	**$1**
Family Health Plus	**$75**	**$74**	**($1)**
Medicaid Administration Costs	**$40**	**$37**	**($3)**
Medicaid Audits	**($20)**	**($20)**	**$0**
OHIP Budget / State Operations	**$8**	**$4**	**($4)**
All Other	**$199**	**$196**	**($3)**
Local Funding Offset	**($576)**	**($576)**	**$0**
TOTAL	**$1,221**	**$1,219**	**($2)**

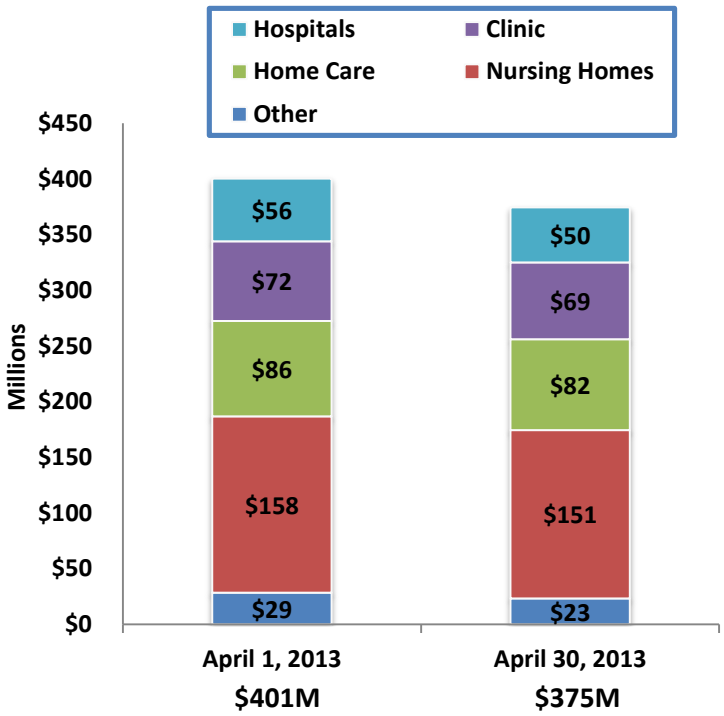
Results through April - Variance Highlights

- **Higher Fee-for-Service Spending:** With the completion of the first month of FY 2014, Medicaid spending in major fee-for-service categories was $8 million above projections, roughly 1 percent.
  - *Clinic* spending for April was 12 percent over projections. This is largely attributable to increases in the volume and price of mental hygiene services, which were 11 percent higher than anticipated in April. Price projections were based on average actual cost per service experience in October of 2012, with volume projections being based on average per cycle claims over the last 6 months of the FY 2013. DOH/DOB will continue to evaluate and monitor price and volume statistics for these services in order to determine if the phenomenon is anomalous or indicative of a continuing trend.
  - *Outpatient/Emergency Room* spending for April was 8 percent over projections. This is largely attributable to increases in the price of mental hygiene services, which were 30 percent higher than anticipated in April. Price projections were based on average actual cost per service experience in October of 2012. DOH/DOB will continue to evaluate and monitor price statistics for these services in order to determine if the phenomenon is anomalous or indicative of a continuing trend.
- **Medicaid Managed Care Spending:** Through April, Medicaid managed care and Family Health Plus spending were on target with projections. The projected number of recipients across the Medicaid managed care and Family Health Plus programs were in line with actual enrollment.

- **Medicaid Administration Costs:** Medicaid Administration costs were $3 million below projections in April.
- **OHIP Budget / State Operations**: Through April, OHIP Budget / State Operations costs were slightly below estimates, $4 million. Details on State Operations cost can be found on page 7.

Accounts Receivable

The accounts receivable balance for retroactive rates owed to the State through the end of April was $375 million.

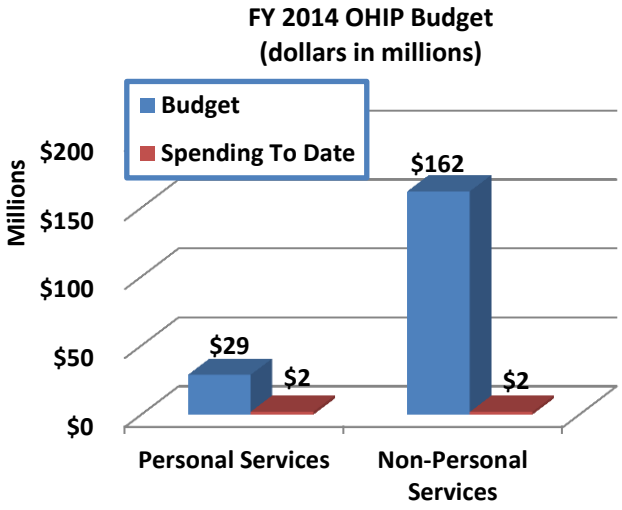


Currently, Medicaid checks issued to providers that are subject to negative retroactive rate adjustments are automatically reduced by a minimum of 15 percent until the liability has been recouped. Should the amount owed not be fully repaid before 10 weekly Medicaid cycles, simple interest at the rate of prime plus two percent (currently 5.25 percent) is assessed on any unpaid balance and accumulates 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 A/R balances becomes more complicated as the State's Medicaid costs will be primarily premium based. As a result, an A/R recovery program was designed. The goal of the program is to recoup all outstanding A/R balances within a two year period. In order to accomplish this, DOH will modify its collection process by offering several repayment options to all providers with outstanding A/R liabilities.

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.

Office of Health Insurance Programs (OHIP) Budget

The FY 2014 Enacted Budget consolidated the Medicaid State Operations budget within the Global Cap. The 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 on non-personal service costs (i.e., contractual services). Contracts for the Enrollment Center, Medicaid Management Information Systems (MMIS), transportation management, and various MRT initiatives comprise 80 percent ($128 million) of the total non-personal service budget. The chart (to the right) provides State Operations cost against the annual budget target.



Enrollment

Medicaid total enrollment reached 5,263,957 enrollees at the end of April 2013. This reflects an increase of roughly 18,300 enrollees, or 0.3 percent, since March 2013. Medicaid managed care enrollment in April 2013 (includes FHP and Managed LTC) reached 3,972,390 enrollees, an increase of around 36,000 enrollees, or 0.9 percent, since March 2013. Below is a detailed breakout by program and region:

NYS Medicaid Enrollment Summary				
FY 2014				
	March 2013	**April 2013**	**Monthly Increase / (Decrease)**	**% Change**
Managed Care	**3,936,431**	**3,972,390**	**35,959**	**0.9%**
New York City	2,574,775	2,589,437	14,662	0.6%
Rest of State	1,361,656	1,382,953	21,297	1.6%
Fee-For-Service	**1,309,197**	**1,291,567**	**(17,630)**	**-1.3%**
New York City	631,374	623,588	(7,786)	-1.2%
Rest of State	677,823	667,979	(9,844)	-1.5%
TOTAL	**5,245,628**	**5,263,957**	**18,329**	**0.3%**
New York City	3,206,149	3,213,025	6,876	0.2%
Rest of State	2,039,479	2,050,932	11,453	0.6%

NOTE: Most current four months counts are adjusted by lag factors (2.92%, 0.94%, 0.43% and 0.15%, respectively to account for retroactive eligibility determinations)

More detailed information on enrollment can be found in the NYS OHIP Medicaid Monthly Enrollment Report on the Department of Health's website at: http://www.health.ny.gov/health_care/managed_care/reports/index.htm

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, and fully integrated plans for Medicare/Medicaid "dual eligibles". The charts below outline the list of recipients and benefits scheduled to transition into the care management setting during this fiscal year:

Schedule for Medicaid Fee for Service Transition to Managed Care (Populations) FY 2014

Projected Phase-in	Recipients	Duals / Non Duals	# of Targeted Enrollees*	Enrolled To Date
7/12 to 9/13	NYC Community Based Long Term Care (LTC)	Duals	34,071	22,092
4/13 to 9/13	Local District Social Service Placed Foster Care Children	Non Duals	3,756	306
6/13 to 11/13	Downstate Community Based LTC in Nassau, Suffolk, Westchester counties	Duals	6,400	585
6/13 to 11/13	Individuals in LTHHCP	Both	2,233	427
7/13 to 12/13	Medicaid Buy-In Working Disabled	Non Duals	266	89
9/13 to 2/14	Community Based LTC in Orange and Rockland counties	Duals	685	56
12/13 to 5/14	Nursing Home	Non Duals	7,912	432
1/14 to 6/14	Community Based LTC in Upstate counties	Duals	3,087	80

*NOTE: The targeted enrollees were defined using October 2011 eligibility information.

Schedule for Medicaid Fee for Service Transition to Managed Care (Service Benefits) FY 2014

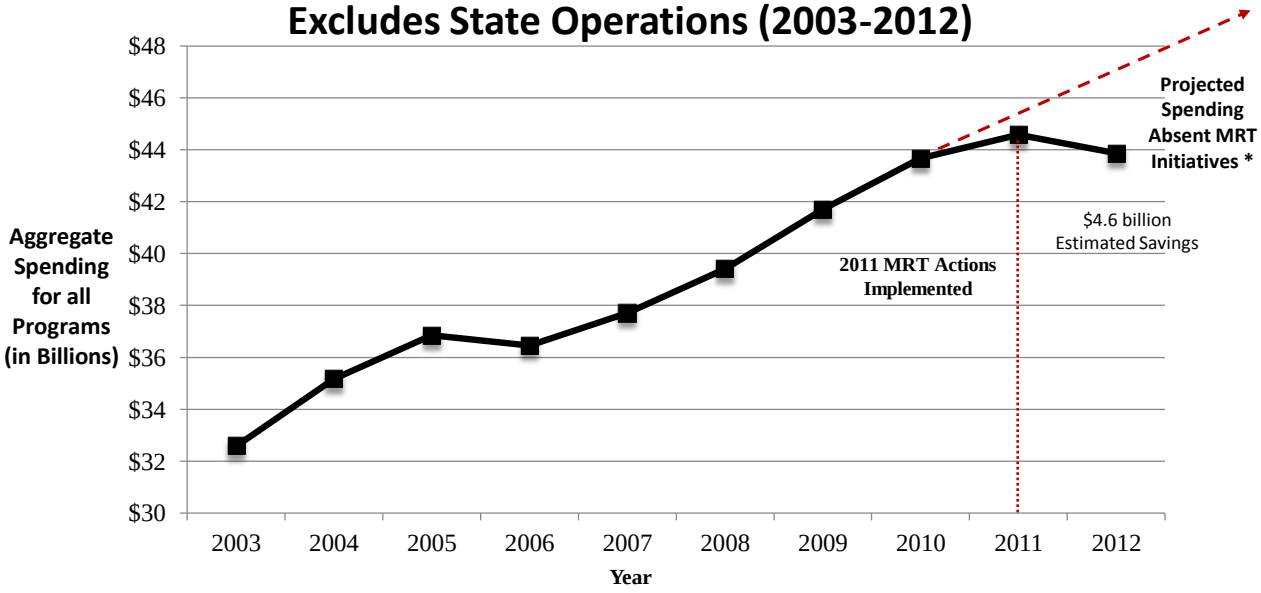
Effective Date	Service Benefits
August 2013	Adult Day Health Care
	AIDS Adult Day Health Care
	Directly Observed Therapy for Tuberculosis
October 2013	Hospice Program
	Nursing Home

Appendix A
Inventory of Rate Packages

The State is anticipating Medicaid rate adjustments resulting in price increases of up to $490 million this fiscal year. Below is a list of the majority of anticipated rate packages to be implemented:

Category of Service	Rate Package Description	Projected Effective Date
Inpatient	Acute and Exempt Unit Rates	January, April, October 2010 January, April, October 2011 January 2012
	Psychiatric Rates	January 2010
	Hurricane Sandy Providers (Psychiatric rates; Graduate Medical Education rates; April 2012 Inpatient rates)	2009-2012
Outpatient	Ambulatory Patient Group (APG) rates	2009-2012
	Public/Non-Public APG rates	July 2013
	Hurricane Sandy Providers (APG and Home Health Aides)	January 2009 December 2012
Clinic	APG Capital rates	2009-2011
	Electronic Health Records (EHRs) distribution	October 2008 October 2009
Nursing Homes	Case Mix Adjustments	July 2012
Personal Care	Central Insurance Program (CIP) NYC providers	April 2013
Managed Long Term Care	FY 2013 Health Recruitment and Retention (HR&R) awards	July 2012
	NYC community based LTC mandatory transition rates-phase I	July 2012
	FY 2014 HR&R awards	July 2013
Medicaid Managed Care	April 2013 rates	April 2013
	July 2013 rates	July 2013
	October 2013 rates	October 2013
	January 2014 rates	January 2014

Appendix B
Bending the Cost Curve



	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

Appendix C
Annual Online and Offline Budget

The $16.4 billion Medicaid State Funds Spending Cap can be organized into two major components, health care provider reimbursement and 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 2013 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, for example drug manufacturer rebates or 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 2014 - April
(dollars in millions)

Category of Service	Online	Offline	Total
Total Fee For Service	**$9,290**	**$1,095**	**$10,385**
Inpatient	$2,335	$572	$2,907
Outpatient/Emergency Room	$552	($30)	$522
Clinic	$674	($77)	$597
Nursing Homes	$3,322	$0	$3,322
Other Long Term Care	$1,177	$30	$1,207
Non-Institutional	$1,229	$601	$1,830
Medicaid Managed Care	**$11,490**	**($76)**	**$11,414**
Family Health Plus	**$1,001**	**$0**	**$1,001**
Medicaid Administration Costs	**$0**	**$518**	**$518**
Medicaid Audits	**$0**	**($363)**	**($363)**
OHIP Budget / State Operations	**$0**	**$191**	**$191**
All Other	**$2,624**	**($1,858)**	**$766**
Local Funding Offset	**$0**	**($7,491)**	**($7,491)**
TOTAL	**$24,702**	**($8,281)**	**$16,421**

NOTE: The Department is in the process of developing the Medicaid managed care premiums, effective April 2014. As a result, any deviation from current rate assumptions may result in revisions to the Budget provided above.

Appendix D
FY 2014 Savings Initiatives

As part of the partnership solution the following initiatives are scheduled to be implemented in this fiscal year:

FY 2014 MRT Initiatives (dollars in millions)		
Initiative	**Projected Effective Date**	**State dollars**
Accelerate MRT:		
PCMH Savings	April 2013	$7
Stricter Utilization Management by Transportation Manager	March 2013	$6
Accelerate MLTC Enrollment	April 2013	$3
Implement Appropriateness Edits on emergency Medicaid Pharmacy Claims	April 2013	$2
Total		**$18**
Other Reforms/Savings:		
Managed Care Efficiency Adjustments	July 2013	$25
Reduce Accounts Receivable Balances	April 2013	$50
Activating Ordering/Prescribing/ Referring/Attending edits	October 2013	$4
Increase manual review of claims	July 2013	$8
Basic Benefit Enhancements	October 2013	$5
Gold STAMP Program to Reduce Pressure Ulcers	April 2013	$6
Eliminate e-Prescribing Incentive	July 2013	$1
Federal Revenue from Additional Emergency Medicaid Claiming	January 2011	$250
Preschool/School Supportive Health Services Program (SSHSP) Cost Study	October 2011	$120
Total		**$469**

Appendix E
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 April 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