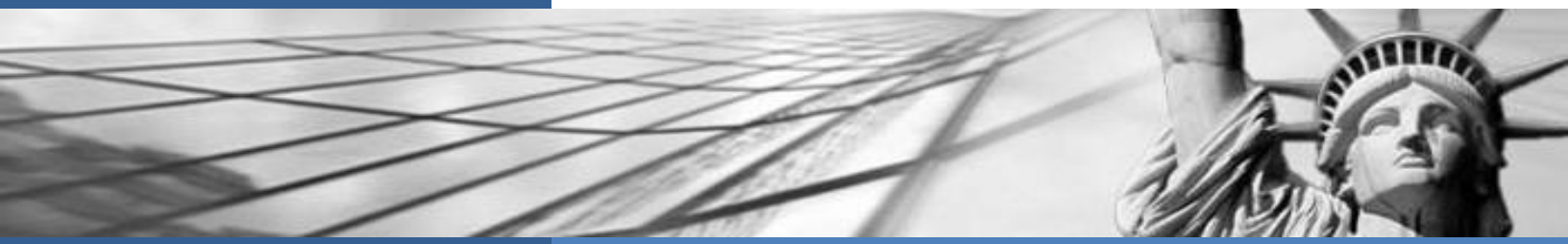

Medicaid Global Spending Cap Report

Redesigning the Medicaid Program

MARCH 2014

NEW YORK
state department of
HEALTH

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Global Cap – A Year in Review

The Department of Health and Division of Budget are very pleased to report that spending under FY 2014 Medicaid Global Spending Cap was $39 million below the $16.421 billion target. Limiting spending to the 3.2 percent spending growth afforded under the Global Cap is truly a remarkable accomplishment that required fiscal discipline, creativity, and innovation from all sectors within the Medicaid program, including:

- Continuing the *Care Management for All initiative* which transitioned a number of populations and benefits into the Managed Care setting as described in the *Beneficiary Transition Schedule to Managed Care* section (page 7);
- Implementing *the 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;
- Allocating resources to fund various *Supportive Housing* initiatives. The plan increased funding for capital to further construct new supportive housing units and continued 2012-13 rental and service subsidies;
- Issuing a Request for Applications for the *Balancing Incentive Program (BIP)*. The BIP Innovation Fund is designed to engage New York's broad network of providers, advocates, and community leaders in developing systemic improvements that address barriers encountered when providing community-based long term supports and services (LTSS) across all populations of Medicaid beneficiaries in the State;
- Establishing the *New York State of Health Insurance Exchange* to comply with the Affordable Care Act. The Exchange provides a comparative marketplace intended to lower cost of health insurance; and
- Expanding Medicaid eligibility requirements to 133 percent of the Federal Poverty Level (FPL).

While the Medicaid program finished the year $39 million under target, it is important to note that included within the final expenditure amount there were $75 million in expenses that would have otherwise occurred in FY 2015, bringing adjusted under spending to $114 million for the year. The $75 million was applied to the Financial Plan Relief as part of the FY 2015 Enacted Budget. The under spending can be explained by:

- ***Lower utilization of services ($108 million).*** The Department is seeing that due to various MRT initiatives the cost to serve each Medicaid recipient has been declining;
- ***Lower State operations costs ($50 million).*** This is primarily due to slower than anticipated spending in various Non-Personal Services spending as described in the *Office of Health Insurance Programs (OHIP) Budget* section (page 6) ;
- ***Higher local administration savings ($11 million).*** A significant MRT initiative impacting State and local governments involves the takeover of the administration of the program by the State by March 2018. This effort and the efficiency from centralization of this function from the counties is returning real dividends for the Medicaid program generating ongoing savings; offset by,
- ***Lower Affordable Care Act enhanced FFP savings ($55 million).*** The lower FFP savings were attributed to an assumption that the savings would be generated on a date of payment basis effective January 1, 2014. Enhanced FFP can only be claimed using dates of service.

In summary, this is the third consecutive year that the health care community has remained below the Global Cap target while expanding health coverage to the State's neediest populations. Total enrollment in the program has increased by more than 446,000 recipients during FY 2014.

Results for FY 2014 - Summary

Total State Medicaid expenditures under the Medicaid Global Spending Cap for FY 2014 through March are $39 million or 0.2 percent **under** projections. Spending for FY 2014 resulted in total expenditures of $16,382 billion compared to the projection of $16,421 billion.

Medicaid Spending FY 2014
(dollars in millions)

Category of Service	Estimated	Actual	Variance Over / (Under)
Total Fee For Service	**$10,238**	**$9,999**	**($239)**
Inpatient	$2,887	$2,834	($53)
Outpatient/Emergency Room	$515	$428	($87)
Clinic	$587	$627	$40
Nursing Homes	$3,344	$3,371	$27
Other Long Term Care	$1,140	$1,030	($110)
Non-Institutional	$1,765	$1,709	($56)
Medicaid Managed Care	**$11,198**	**$11,217**	**$19**
Family Health Plus	**$902**	**$917**	**$15**
Medicaid Administration Costs	**$518**	**$507**	**($11)**
Medicaid Audits	**($463)**	**($550)**	**($87)**
OHIP Budget / State Operations	**$191**	**$141**	**($50)**
All Other	**$1,328**	**$1,567**	**$239**
Local Funding Offset	**($7,491)**	**($7,491)**	**$0**
SUBTOTAL	**$16,421**	**$16,307**	**($114)**
Prepayments of 2014-15 Expenses	**$0**	**$75**	**$75**
TOTAL	**$16,421**	**$16,382**	**($39)**

Note: The $108 million in utilization savings is primarily comprised of lower spending in FFS ($239 million) offset by higher spending in MMC ($19 million) and FHP ($15 million), as well as an increase in accounts receivable balances ($64 million).

Results through March - Variance Highlights

- **Fee-for-Service Spending:** Medicaid spending in major fee-for-service categories was $239 million under projections, 2.3 percent.

  - *Outpatient/Emergency Room* spending was close to 17 percent under projections through March. The variance is primarily the result of lower than expected claim volume, roughly 4 percent, consistent with the migration of benefits to Managed Care. The underspending is also attributed to delays in the implementation of several rate packages totaling approximately $29 million. These rate packages include APG capital updates and Hurricane Sandy providers which the State is expecting to release in FY 2015.

  - *Clinic* spending through March was about 7 percent over projections. This is largely attributable to increases in the volume and price of mental hygiene services, which were 10 percent higher than anticipated through March. A portion of this overspending may be attributed to claims reprocessing related to the transition to the APG methodology.

  - *Other Long Term Care* spending through March was about 10 percent lower than projections. The variance is primarily driven by the personal care and home health care programs and is related to the transition of the targeted fee-for-service populations into the Managed Long Term Care (MLTC) program. The movement of New York City and downstate community based long term care recipients out of the fee-for-service programs has significantly reduced overall spending. The DOH/DOB will continue to monitor the movement of fee-for-service populations into a Managed Care setting and evaluate its effect on expenditures.

  - *Non-Institutional* fee-for-service spending (includes Pharmacy, Medical Supplies, Physicians, Supplemental Medical Insurance, etc.) was $56 million below estimates. The variance is primarily due to lower Pharmacy spending ($37 million) as a result of lower than anticipated claim volume consistent with the migration of benefits to Managed Care. Other Non-Institutional categories, such as Physicians and Medical Supplies, were below target which reflects ongoing efforts to transition services into a Managed Care environment.

- **Medicaid Managed Care Spending:** Through March, mainstream Managed Care and Managed Long-Term Care (MLTC) spending were $19 million, 0.2 percent, above projections. The variance is primarily driven by the number of recipients enrolled in the MLTC program. There were roughly 3,600 more recipients enrolled through March than anticipated, resulting in a variance of roughly $140 million over initial projections. This is the result of a quicker transition of the targeted fee-for-service populations to MLTC plans. Mainstream Managed Care

spending was $113 million below target, of which a portion is attributed to a delay in implementing the April 2013 rates due to pending federal approvals. The rate package will be processed in early FY 2015.

- **Medicaid Administration Costs:** Local District Social Service Medicaid Administration costs were $11 million below projections through March, reflecting efficiencies achieved through the continued efforts of the State takeover of the administration of the Medicaid program from counties and New York City.

- **Medicaid Audits:** Through March, the spending offsets from Medicaid audit recoveries exceeded projected levels ($463 million) by $87 million. Additional collections were attributable to a State share settlement of $211 million from the Federal government as a result of third party liability (TPL) appeals for additional Medicare funds in dual-eligible home care cases in Federal fiscal years 2007 to 2010. This settlement is not expected to recur as the Federal TPL demonstration expired in FY 2010.

- **All Other:** The majority of the variance in the All Other category is primarily due to the delay in claiming additional Federal revenue for School Supportive Health Services and emergency claiming for legal immigrants who have been in the United States for less than five years. The State continues to work with CMS on these initiatives to secure the necessary approvals for Federal funds in these programs.

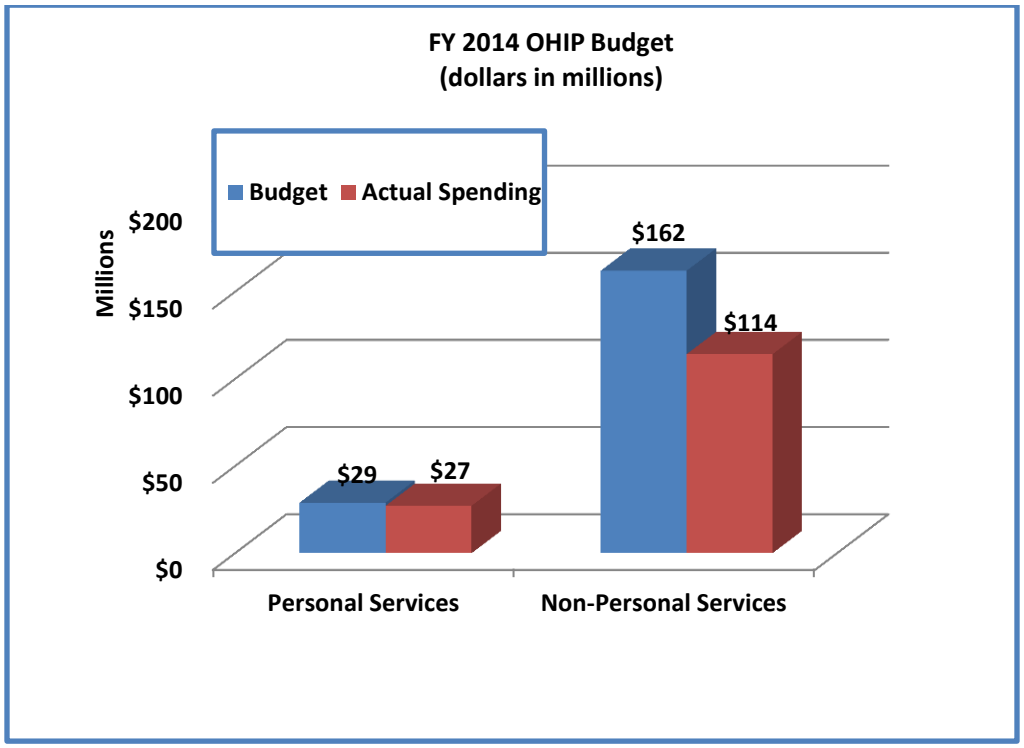
Accounts Receivable

The accounts receivable balance for retroactive rates owed to the State through the end of March was $230 million. This reflects a reduction of $170 million since April 2013, and represents the net impact of recoupments from Medicaid providers offset by retroactive rate adjustments released 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. As a result, an accounts receivable recovery program was designed. The goal of the program is to recoup all outstanding accounts receivable 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 accounts receivable liabilities. As a result of this program, the Department has received roughly $60 million to date from close to 40 providers that have opted to pay off all outstanding accounts receivable liabilities to avoid all interest costs incurred.

Office of Health Insurance Programs (OHIP) Budget

The FY 2014 Enacted Budget consolidated the Medicaid State Operations budget within the Global Cap. This change aligns operational resources with programmatic responsibilities, and provides flexibility in administering and implementing MRT initiatives. 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 as non-personal services 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 compares State Operations spending against the budget for FY 2014. Total OHIP Budget costs were $50 million below estimates primarily due to underspending in the following contractual services: MMIS ($22 million); Enrollment Center ($12 million); and Balance Incentive Program ($10 million).



Enrollment

Medicaid total enrollment reached 5,697,529 enrollees at the end of March 2014. This reflects an increase of 446,451 enrollees, or 8.5 percent, since March 2013. Since January, nearly 494,000 people have signed up for the Medicaid program through the New York State of Health Marketplace, attributable to the Affordable Care Act. Through March, approximately 360,000 of those recipients are being reflected under the Fee-For-Service program due to delays in Medicaid Managed Care plan assignments and technical issues with enrollment transactions. According to early indications, the State expects that a significant portion of these recipients will enroll in a Medicaid Managed Care plan and therefore Managed Care/Fee-For-Service data is expected to show a significant correction.

Below is a detailed breakout by program and region:

NYS Medicaid Enrollment Summary				
FY 2014				
	March 2013	**March 2014**	**Increase / (Decrease)**	**% Change**
Managed Care	**3,936,431**	**4,116,758**	**180,327**	**4.6%**
New York City	2,574,775	2,589,513	14,738	0.6%
Rest of State	1,361,656	1,527,245	165,589	12.2%
Fee-For-Service	**1,314,647**	**1,580,771**	**266,124**	**20.2%**
New York City	626,980	793,640	166,660	26.6%
Rest of State	687,667	787,131	99,464	14.5%
TOTAL	**5,251,078**	**5,697,529**	**446,451**	**8.5%**
New York City	3,201,755	3,383,153	181,398	5.7%
Rest of State	2,049,323	2,314,376	265,053	12.9%

NOTE: Most current four months counts are adjusted by lag factors (2.92%, 1.08%, 0.43% and 0.15%, respectively to account for retroactive eligibility determinations)

More detailed information on Managed Care 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 transitioned into the care management setting during FY 2014:

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

Start Date	Recipients	Duals / Non Duals	# of Targeted Enrollees*	FY 2014 Enrolled
July 2012	NYC Community Based Long Term Care (LTC)	Duals	34,071	26,106
April 2013	Local District Social Service Placed Foster Care Children	Non Duals	3,756	597
June 2013	Downstate Community Based LTC in Nassau, Suffolk, Westchester counties	Duals	6,400	3,077
June 2013	Individuals in LTHHCP	Both	2,233	1,716
July 2013	Medicaid Buy-In Working Disabled	Non Duals	266	114
September 2013	Community Based LTC in Orange and Rockland counties	Duals	685	342
January 2014	Community Based LTC in Upstate counties	Duals	3,087	402

**NOTE: The targeted enrollees were defined using October 2011 eligibility information. Some of these targeted enrollees may no longer be participating in the program or may have moved to different levels of care and as a result will not be shifting.*

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

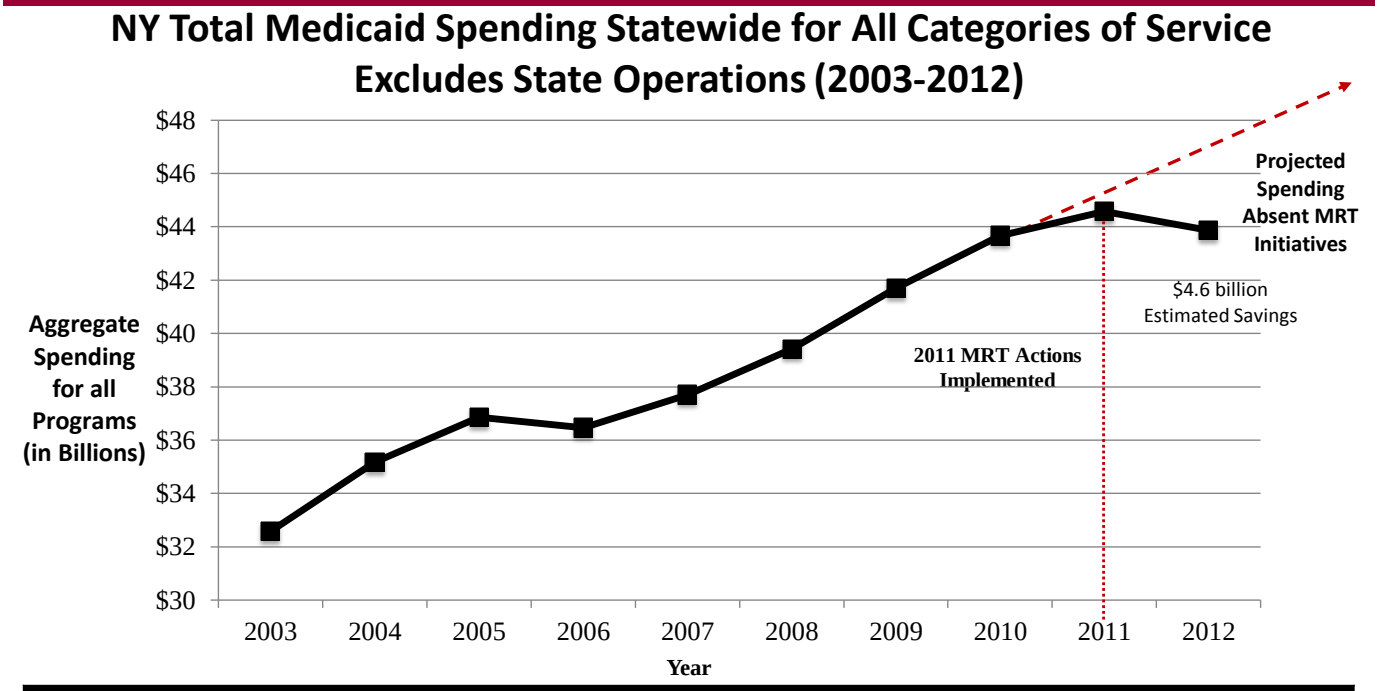
Effective Date	Service Benefits
August 2013	Adult Day Health Care
	AIDS Adult Day Health Care
	Directly Observed Therapy for Tuberculosis
October 2013	Hospice Program

Appendix A
Inventory of Rate Packages

The State implemented the following Medicaid rate adjustments in FY 2014:

Category of Service	Rate Package Description	Effective Date
Clinic	APG Capital rates	2009-2012
Nursing Homes	Case Mix Adjustments	July 2012 January 2013
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

Appendix B
Bending the Cost Curve



	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Total Medicaid Spending	**$32.6B**	**$35.2B**	**$36.9B**	**$36.5B**	**$37.7B**	**$39.4B**	**$41.7B**	**$43.7B**	**$44.6B**	**$43.9B**
# 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**

NOTE: The number of recipients equals the sum of all unique recipients that received a Medicaid service within the fiscal year.

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, 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 2014
(dollars in millions)

Category of Service	Online	Offline	Total
Total Fee For Service	**$9,185**	**$1,053**	**$10,238**
Inpatient	$2,309	$578	$2,887
Outpatient/Emergency Room	$545	($30)	$515
Clinic	$664	($77)	$587
Nursing Homes	$3,344	$0	$3,344
Other Long Term Care	$1,110	$30	$1,140
Non-Institutional	$1,213	$552	$1,765
Managed Care	**$11,274**	**($76)**	**$11,198**
Family Health Plus	**$902**	**$0**	**$902**
Medicaid Administration Costs	**$0**	**$518**	**$518**
Medicaid Audits	**$0**	**($463)**	**($463)**
OHIP Budget / State Operations	**$0**	**$191**	**$191**
All Other	**$3,019**	**($1,691)**	**$1,328**
Local Funding Offset	**$0**	**($7,491)**	**($7,491)**
TOTAL	**$24,380**	**($7,959)**	**$16,421**

Appendix D
FY 2014 Savings Initiatives

As part of the partnership solution the following initiatives were implemented in fiscal year 2013-14:

FY 2014 MRT Initiatives (dollars in millions)		
Initiative	**Projected Effective Date**	**State Dollars**
Accelerate MRT:		
PCMH Savings	April 2013	$7
Accelerate MLTC Enrollment	April 2013	$3
Implement Appropriateness Edits on emergency Medicaid Pharmacy Claims	April 2013	$2
Total		**$12**
Other Reforms/Savings:		
Reduce Accounts Receivable Balances	April 2013	$60
Gold STAMP Program to Reduce Pressure Ulcers	April 2013	$6
Managed Care Efficiency Adjustments	July 2013	$25
Increase manual review of claims	July 2013	$8
Eliminate e-Prescribing Incentive	July 2013	$1
Basic Benefit Enhancements	October 2013	$5
Activating Ordering/Prescribing/ Referring/Attending edits	October 2013	$4
Total		**$109**

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 March 2014 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.