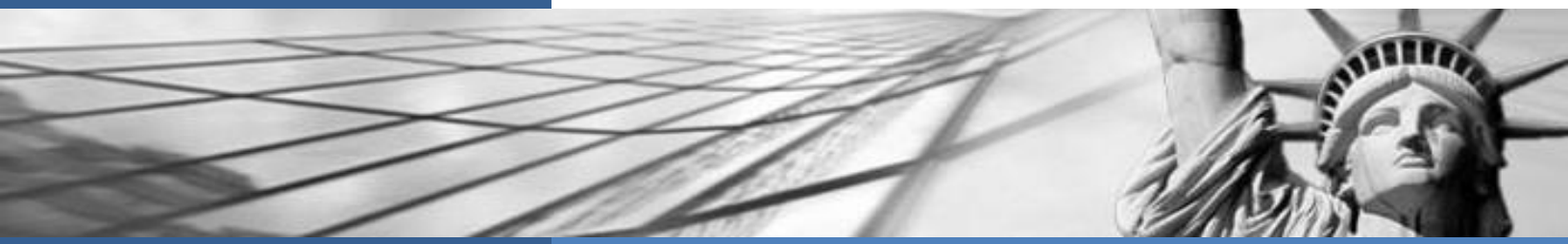

Medicaid Global Spending Cap Report

Redesigning the Medicaid Program

OCTOBER 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 costs 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 (+$436 million)	Price includes managed care premium adjustments for cost trends and newly covered benefits, as well as fee-for-service rate adjustments. *See Appendix A for more detail.*
Utilization (+$130 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 (-$56 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 than expected rebates due to the shift of drugs 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* - This initiative transitions 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. See *Beneficiary Transition Schedule to Managed Care* section (page 7).

- *Balance Incentive Program (BIP)* - BIP is a provision of the Affordable Care Act (ACA) which provides 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.

- *Family Health Plus Wrap* - 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. State funds are provided to cover any additional costs associated with premiums.

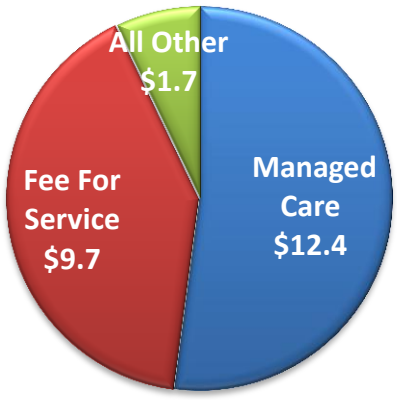
Lastly, as part of the Enacted Budget, the State partnered with the entire health care community to develop a comprehensive solution to solve the loss of $1.1 billion of annual Federal Medicaid revenue for developmental disability services. The solution was in large part driven by the success of the MRT. A significant portion, $200 million, was achieved by underspending in FY 2013 which was used 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 various 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.

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.

FY 2014 Global Cap Breakout
(dollars in billions)



NOTE: This chart represents the projected non-federal share of Medicaid spending for this fiscal year. $23.8 billion of Medicaid State services are funded by $16.4 billion in the Medicaid Global Spending Cap and $7.4 billion from local contributions.

Results through October 2013 - Summary

Total State Medicaid expenditures under the Medicaid Global Spending Cap for FY 2014 through October are $50 million or 0.5 percent **under** projections. Spending for the month of October resulted in total expenditures of $9.602 billion compared to the projection of $9.652 billion.

Medicaid Spending FY 2014 - October (dollars in millions)			
Category of Service	**Estimated**	**Actual**	**Variance Over / (Under)**
Total Fee For Service	**$6,040**	**$5,940**	**($100)**
Inpatient	$1,714	$1,715	$1
Outpatient/Emergency Room	$297	$268	($29)
Clinic	$365	$409	$43
Nursing Homes	$2,004	$2,005	$1
Other Long Term Care	$745	$701	($44)
Non-Institutional	$915	$842	($73)
Medicaid Managed Care	**$6,528**	**$6,573**	**$45**
Family Health Plus	**$568**	**$564**	**($4)**
Medicaid Administration Costs	**$309**	**$272**	**($37)**
Medicaid Audits	**($376)**	**($388)**	**($12)**
OHIP Budget / State Operations	**$63**	**$62**	**($1)**
All Other	**$986**	**$1,045**	**$59**
Local Funding Offset	**($4,466)**	**($4,466)**	**$0**
TOTAL	**$9,652**	**$9,602**	**($50)**

Results through October - Variance Highlights

- **Lower Fee-for-Service Spending:** Medicaid spending in major fee-for-service categories was $100 million under projections, 1.7 percent.
  - *Outpatient/Emergency Room* spending was close to 10 percent under projections through October. The average payment per claim through October was significantly lower than projections, roughly 8 percent. The price projections were based on average actual cost per service experience in October 2012. The price discrepancy may be the result of seasonal changes in services.
  - *Clinic* spending through October was 12 percent over projections. This is largely attributable to increases in the volume and price of mental hygiene services, which were 19 percent higher than anticipated through October. Starting in May, the State began reprocessing OMH claims with dates of service between October 1, 2010 and August 31, 2013 to reflect revised APG rate codes. This process is anticipated to take 33 weeks to complete, upon which the original claims will be reversed. Therefore, the higher spending related to the reprocessing is expected to be recovered during the remainder of the year.

- Other Long Term Care spending through October was 6 percent lower than projections. The variance is primarily driven by the personal care and home health care programs. The difference appears to be 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 the average rates. The DOH/DOB will continue to monitor the movement of fee-for-service populations into a managed care setting and evaluate its effect on payment rates.

- Non-Institutional fee for service spending (includes Pharmacy, Medical Supplies, Physicians, Supplemental Medical Insurance, etc.) was $73 million below estimates. The variance is primarily due to lower Pharmacy spending ($28 million) as a result of lower than anticipated claim volume. The number of scripts filled to date was roughly 5 percent lower than estimates. Other Non-Institutional categories, such as Physicians and Medical Supplies, are continuing to trend below estimates which reflects ongoing efforts to transition both services and benefits into a managed care environment.

- **Medicaid Managed Care Spending:** Through October, mainstream Managed Care and MLTC spending were $45 million, 0.7 percent, above projections. The variance is primarily driven by the number of recipients enrolled in the MLTC program. Enrollment through October was greater (roughly 3,000) than anticipated resulting in a variance of roughly $42 million over projections. This is likely the result of a quicker transition of the targeted fee-for-service populations to MLTC plans.

- **Medicaid Administration Costs:** Medicaid Administration costs were $37 million below projections through October, reflecting efficiencies achieved through the continued efforts of the State takeover of the administration of the Medicaid program.

Accounts Receivable

The accounts receivable balance for retroactive rates owed to the State through the end of October was $239 million. This reflects a reduction of $161 million since April 2013, and represents the net impact of recoupments from Medicaid providers offset by retroactive rate adjustments released during this fiscal year.

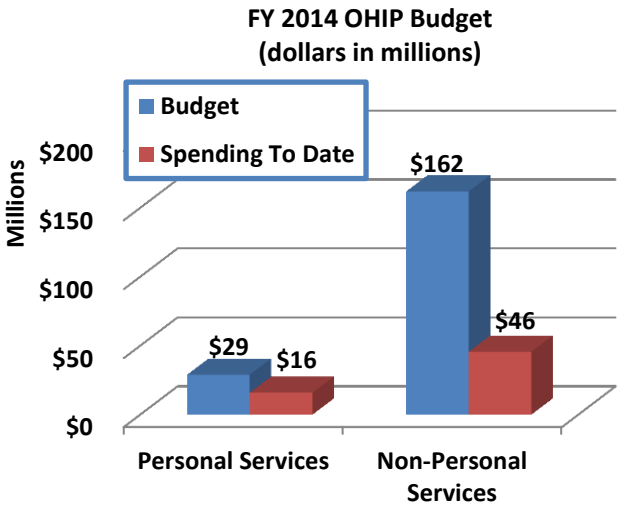
Currently, Medicaid checks issued to providers that are subject to negative retroactive rate adjustments are automatically reduced by a minimum of 15 percent until the liability has been recouped. Should the amount owed not be fully repaid before 10 weekly Medicaid cycles, simple interest at the rate 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 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. As a result of this program, the Department has received roughly $50 million to date from close to 40 providers that have opted to pay off all outstanding A/R liabilities to avoid all interest costs incurred.

The Department 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. This change more appropriately aligns operational resources with programmatic responsibilities, and provides flexibility in administering and implementing MRT initiatives more effectively. 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 to date against the annual OHIP budget target. Non-personal services spending totals $46 million year to date, which corresponds to one million dollars in variance through October, this assumes that the majority of spending in certain contracts, including BIP and the Healthcare Exchange, will spend in the fourth quarter.



Enrollment

Medicaid total enrollment reached 5,361,527 enrollees at the end of October 2013. This reflects an increase of 110,449 enrollees, or 2.1 percent, since March 2013. Medicaid managed care enrollment in October 2013 (includes FHP and Managed LTC) reached 4,056,714 enrollees, an increase of 120,283 enrollees, or 3.1 percent, since March 2013. Below is a detailed breakout by program and region:

NYS Medicaid Enrollment Summary				
FY 2014				
	March 2013	**October 2013**	**Increase / (Decrease)**	**% Change**
Managed Care	**3,936,431**	**4,056,714**	**120,283**	**3.1%**
New York City	2,574,775	2,615,820	41,045	1.6%
Rest of State	1,361,656	1,440,894	79,238	5.8%
Fee-For-Service	**1,314,647**	**1,304,813**	**(9,834)**	**-0.7%**
New York City	626,980	637,534	10,554	1.7%
Rest of State	687,667	667,279	(20,388)	-3.0%
TOTAL	**5,251,078**	**5,361,527**	**110,449**	**2.1%**
New York City	3,201,755	3,253,354	51,599	1.6%
Rest of State	2,049,323	2,108,173	58,850	2.9%

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	23,895
4/13 to 9/13	Local District Social Service Placed Foster Care Children	Non Duals	3,756	475
6/13 to 11/13	Downstate Community Based LTC in Nassau, Suffolk, Westchester counties	Duals	6,400	2,251
6/13 to 11/13	Individuals in LTHHCP	Both	2,233	1,430
7/13 to 12/13	Medicaid Buy-In Working Disabled	Non Duals	266	96
9/13 to 2/14	Community Based LTC in Orange and Rockland counties	Duals	685	74
1/14 to 6/14	Community Based LTC in Upstate counties	Duals	3,087	165

**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.*

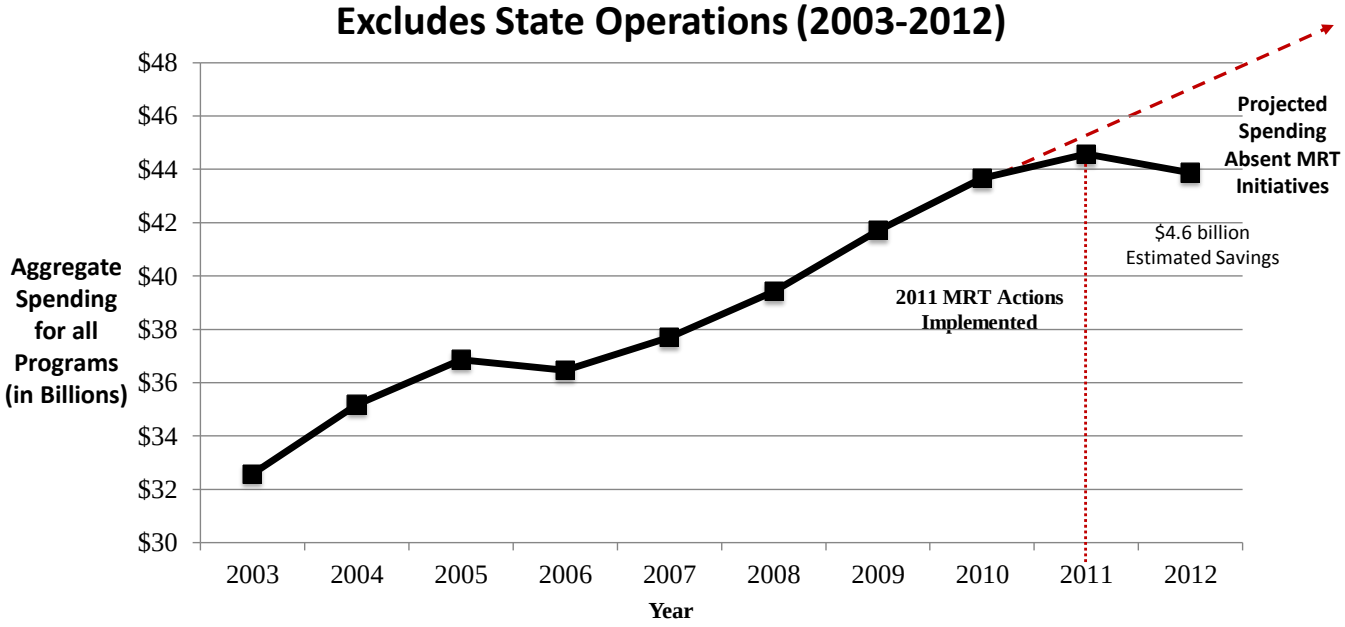
Schedule for Medicaid Fee for Service Transition to Managed Care (Service Benefits) FY 2014	
Effective Date	**Service Benefits**
August 2013	Adult Day Health Care
	AIDS Adult Day Health Care
	Directly Observed Therapy for Tuberculosis
October 2013	Hospice Program
January 2014	Nursing Home

Appendix A
Inventory of Rate Packages

The State is anticipating Medicaid rate adjustments resulting in price increases of up to $436 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
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, 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 (dollars in millions)			
Category of Service	**Online**	**Offline**	**Total**
Total Fee For Service	**$9,309**	**$1,102**	**$10,411**
Inpatient	$2,343	$578	$2,921
Outpatient/Emergency Room	$552	($30)	$522
Clinic	$674	($77)	$597
Nursing Homes	$3,373	$0	$3,373
Other Long Term Care	$1,135	$30	$1,165
Non-Institutional	$1,232	$601	$1,833
Managed Care	**$11,461**	**($76)**	**$11,385**
Family Health Plus	**$915**	**$0**	**$915**
Medicaid Administration Costs	**$0**	**$518**	**$518**
Medicaid Audits	**$0**	**($463)**	**($463)**
OHIP Budget / State Operations	**$0**	**$191**	**$191**
All Other	**$2,696**	**($1,741)**	**$955**
Local Funding Offset	**$0**	**($7,491)**	**($7,491)**
TOTAL	**$24,381**	**($7,960)**	**$16,421**

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:		
Stricter Utilization Management by Transportation Manager	March 2013	$6
PCMH Savings	April 2013	$7
Accelerate MLTC Enrollment	April 2013	$3
Implement Appropriateness Edits on emergency Medicaid Pharmacy Claims	April 2013	$2
Total		**$18**
Other Reforms/Savings:		
Federal Revenue from Additional Emergency Medicaid Claiming	January 2011	$250
Preschool/School Supportive Health Services Program (SSHSP) Cost Study	October 2011	$120
Reduce Accounts Receivable Balances	April 2013	$50
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		**$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 October 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.