NEW YORK STATE | Department of Health

Medicaid Global Spending Cap Report

February 2016

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Overview

The FY 2016 Enacted Budget extended the Medicaid Global Spending Cap through March 2017. Pursuant to legislation, the Medicaid Global Spending Cap has increased from $17.0 billion in FY 2015 to $17.7 billion (including the Essential Plan) in FY 2016, an increase of 4.6 percent. The CPI used on Medicaid services subject to the trend was 3.6 percent (ten year average of the Medical Care Consumer Price Index); however, there were several adjustments made to the Global Cap target that were not subject to the trend, the most significant of which was the inclusion of OHIP State Operations cost. The annual growth in the Global Cap of $779 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 (+$426 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 B for more detail.*
Utilization (+$709 million)	Utilization reflects the annualization of FY 2015 net enrollment growth (516,000 recipients) as well as assumed new enrollment for FY 2016, including the additional enrollment under the NY State of Health (NYSoH) / Healthcare Exchange.
MRT/One-Timers/Other (-$356 million)	MRT/Other primarily includes Essential Plan savings ($1 billion) and Federal Revenue as a result of the Affordable Care Act ($294 million) *offset by* new investments ($778 million), Financial Plan Relief ($200 million) and loss of one-time Federal revenue ($227 million).

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

- The *Essential Plan (EP),* which will be implemented in a two-phase approach. Phase I, effective April 1, 2015, transitioned certain Medicaid immigrants into the EP while remaining in their respective plans. Phase II, effective November 1, 2015, transitions eligible enrollees from the Marketplace into EP for coverage effective January 1, 2016;

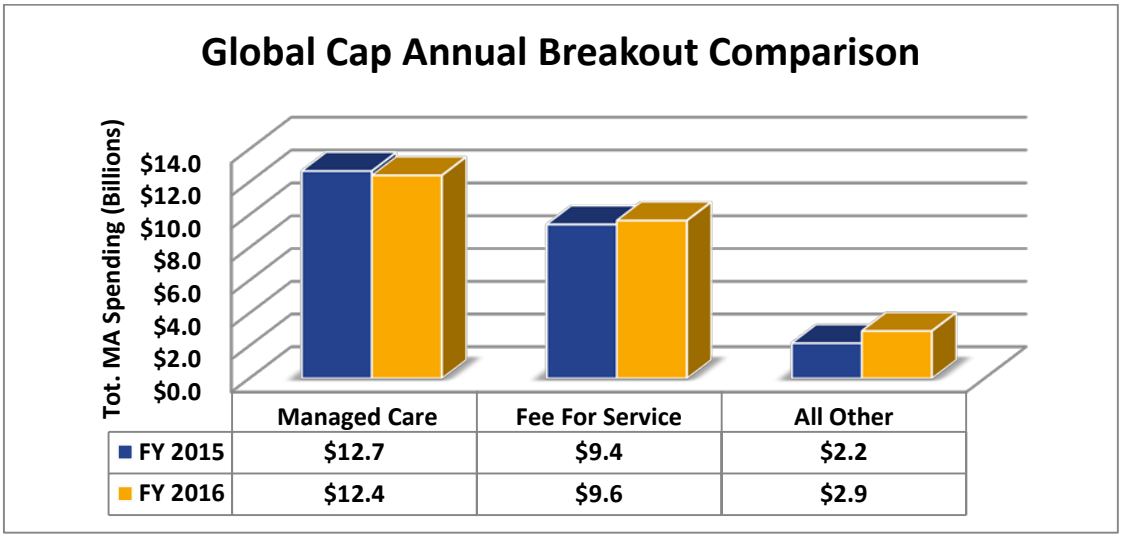
- Additional resources for the *Vital Access Provider/Safety Net Program,* including single public Performing Provider Systems (PPS); and

- $85 million for Hospital Quality and Essential/Rural Community Provider investments, $20 million in Alzheimer's caregiver support, and $5 million for the Governor's End of AIDS initiative.

Through the first four years of the Global Spending Cap, Medicaid spending has remained within the Global Cap while expanding health coverage to the State's neediest populations. 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.

Components of the Medicaid Global Spending Cap

The Global Cap is comprised of spending for Managed Care plans (mainstream and long term), fee-for-service categories (hospitals, nursing homes, clinics, other long term care providers, and non-institutional related costs), and other areas of spending (i.e., Medicaid administration, OHIP budget, VAP payments, transfers from other State agencies, etc.). This spending is offset by local government funding as well as Medicaid audit recoveries and accounts receivable recoupments. See Appendix A for the annual budget by category of service.



	Managed Care	Fee For Service	All Other
FY 2015	$12.7	$9.4	$2.2
FY 2016	$12.4	$9.6	$2.9

NOTE: The chart represents the actual non-federal share of Medicaid spending for FY 2015 and the projected share for FY 2016. The Local contributions are $7.2 billion in FY 2016, which is used to offset the amounts reflected above.

Mid-Year Update

The State has updated the Global Medicaid Spending Cap estimates based on experience through September 2015. There were several significant emerging pressures on the Global Cap that are now incorporated into the budget.

- Significant enrollment growth in the Long Term Managed Care program. Year-to-date growth (through September) was 11,000 individuals, primarily in NYC (68 percent). The original estimates only assumed an annual growth of 10,000 and have been revised to reflect projected growth of 16,375 recipients.

- Recent court ruling on the Fair Labor Standards Act (FLSA) requiring overtime to be paid at time and one half of wage; travel time is compensable hours; and changes to live-in rules.

- Medicare changes for Medicare Part B dual eligible recipients (monthly premium from $104.90 to $121.80) and per-beneficiary monthly Medicare Part D Clawback charges (annual increase of 11.6%).

The following additional resources were identified to mitigate the impact of these unanticipated costs.

- Community First Choice Option (CFCO) – The Department is pursuing methodology to claim the additional 6 percent FMAP on CFCO services under the Long Term Managed Care program.
- Uncommitted Vital Access Provider program funds were reduced.

Results for February 2016 - Summary

Total State Medicaid expenditures under the Medicaid Global Spending Cap for FY 2016 through January were $56 million, or 0.3 percent, over projections. Spending for FY 2016 resulted in total expenditures of $16.661 billion compared to the projection of $16.605 billion.

Medicaid Spending – FY 2016 (dollars in millions)			
Category of Service	**Estimated**	**Actual**	**Variance Over / (Under)**
Medicaid Managed Care	**$11,859**	**$11,878**	**$19**
Mainstream Managed Care	$8,330	$8,312	($18)
Long Term Managed Care	$3,529	$3,566	$37
Total Fee For Service	**$8,669**	**$8,723**	**$54**
Inpatient	$2,687	$2,713	$26
Outpatient/Emergency Room	$398	$414	$16
Clinic	$519	$530	$11
Nursing Homes	$2,951	$2,979	$28
Other Long Term Care	$611	$622	$11
Non-Institutional	$1,503	$1,465	($38)
Medicaid Administration Costs	**$423**	**$427**	**$4**
OHIP Budget / State Operations	**$204**	**$235**	**$31**
Medicaid Audits	**($260)**	**($192)**	**$68**
All Other	**$2,245**	**$2,125**	**($120)**
Local Funding Offset	**($6,535)**	**($6,535)**	**$0**
TOTAL	**$16,605**	**$16,661**	**$56**

Results through February - Variance Highlights

Medicaid Managed Care

Medicaid spending in major Managed Care categories was $19 million over projections.

- Long Term Managed Care was $37 million above projections due to higher than expected enrollment. Through February there were about 4,150, 2.5 percent, more recipients than anticipated.

Fee-For-Service

Medicaid spending in major fee-for-service categories was $54 million, or 0.6 percent, over projections.

- Inpatient spending was $26 million, 1.0 percent, over projections primarily due to slower than expected transition of services to a Managed Care setting for FIDA and BHO/HARP eligible individuals.
- Outpatient/Emergency Room spending was $16 million, 4.0 percent, over projections. During May, the State received CMS approval to implement the Ambulatory Patient Groups (APG) reimbursement methodology for OASAS Certified Hospital Operated Part 822 Outpatient Clinic and Opioid Treatment Programs (OTP). Due to the significant number of claims to be reprocessed, the implementation of the approved APG rates needed to be scheduled over multiple billing cycles. The variance appears to be related to the timing of these transactions.
- Non-Institutional spending (includes Pharmacy, Medical Supplies, Physicians, Supplemental Medical Insurance, etc.) was $38 million under projections. Total rebates collected through

February exceeded projections by 5.7 percent. The variance appears to be related to the timing of collections.

Medicaid Audits

Through February, spending offsets from Medicaid audit recoveries were below projected levels by $68 million. The Department will continue to work with the Office of the Medicaid Inspector General (OMIG) to determine if this variance will have any impact on the annual Global Cap amount.

Office of Health Insurance Programs (OHIP) State Operations Budget

The OHIP State Operations budget reflects the Non-Federal share only of personal services (i.e., salaries of OHIP staff that work on the Medicaid budget) and non-personal services costs (i.e., contractual services). The FY 2016 budget is projected to total $225 million. The annual increase includes funding certain New York State of Health (NYSOH) Exchange operations.

Contracts for the Enrollment Center, Medicaid Management Information Systems (MMIS), NYSOH Exchange, transportation management, and various MRT initiatives comprise 63 percent ($119 million) of the total non-personal service budget. The chart below compares State Operations spending against the annual budget for FY 2015:

OHIP Budget – FY 2016 (dollars in millions)		
Service Costs	**Annual Budget**	**Actual - YTD**
Personal Services	**$35**	**$29**
Non-Personal Services	**$190**	**$206**
NYS Of Health Healthcare Exchange	$53	$45
Enrollment Center	$28	$20
Medicaid Transportation Management	$23	$21
eMedNY (MMIS)	$15	$36
OHIP Actuarial and Consulting Services	$7	$9
All Others	$64	$75
TOTAL	**$225**	**$235**

Accounts Receivable

The Accounts Receivable (A/R) ending balance for FY 2015 was $280 million. The State is expected to recoup $170 million by the end of FY 2016, resulting in a projected A/R balance of $110 million by March 2016. Through the end of January, retroactive rates owed to the State were $285 million. This reflects an increase of $5 million since March 2015. During January Intermediate Care Facilities (ICF) rates were updated for rate rationalization effective July 1, 2014, January 1, 2015 and April 1, 2015. This resulted in large retroactive reductions generating significant A/R liabilities. Those balances have been aggregated and spread against all ICF providers operated by the indebted corporate entities in order to expedite recoveries and eliminate receivable balances prior to the end of the State fiscal year.

The Department of Health is engaged in an initiative to eliminate all currently outstanding retroactive rates Medicaid liabilities owed to the State, no later than March 31, 2017. 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.

Medicaid Enrollment

Medicaid total enrollment reached 6,198,505 enrollees at the end of February 2016. This reflects an increase of 22,438 enrollees, or 0.4 percent, since March 2015. Below is a detailed breakout by program and region:

Medicaid Enrollment Summary FY 2016			
	March 2015	**January 2016**	**Increase / (Decrease)**
Managed Care	**4,673,939**	**4,664,775**	**(9,164)**
New York City	2,878,176	2,827,903	(50,273)
Rest of State	1,795,763	1,836,872	41,109
Fee-For-Service	**1,502,128**	**1,533,730**	**31,602**
New York City	737,195	759,753	22,558
Rest of State	764,933	773,977	9,044
TOTAL	**6,176,067**	**6,198,505**	**22,438**
New York City	3,615,371	3,587,656	(27,715)
Rest of State	2,560,696	2,610,849	50,153

During January there was a significant decrease in total Medicaid enrollment due to the Essential Plan. Effective January 2016, Aliessa individuals previously counted as Medicaid members were converted to the Essential Plan. This accounts for approximately 160,000 enrollees to date.

Beneficiary Transition Schedule to Managed Care

Care Management for All was a key component of the MRT's recommendations intended to improve benefit coordination, quality of care, and patient outcomes over the full range of health care, including mental health, substance abuse, developmental disability, and physical health care services. It will also redirect almost all Medicaid spending in the State from fee-for-service to care management. The care management system currently in place includes comprehensive plans, HIV/AIDS special needs plans, partial capitation long term care plans, and Medicare/Medicaid supplemental plans. As Care Management for All progresses, additional plans tailored to meet the needs of the transitioning population will be added, including mental health and substance abuse special needs plans, as well as fully integrated plans for Medicare/Medicaid "dual eligibles". The chart below outlines the list of recipients schedule to transition into the care management setting during FY 2016:

Medicaid Fee for Service Transition to Managed Care (Populations) FY 2016					
Effective Date	**Populations**	**From (COS)**	**To (COS)**	**# of Targeted Enrollees**	**FY 2016 Enrolled**
February 2015	Nursing Home	NH	MMC / MLTC	6,641	3,416
October 2015	BHO / HARPs	Various	MMC	56,121	35,803

Appendix A
Medicaid Global Spending Cap Annual Budget (Online and Offline)

The $17.7 billion Medicaid State Funds Spending Cap can be organized into two major components: (1) health care provider reimbursement and (2) other administrative, intergovernmental or revenue transactions, also referred to as "offline" or occurring outside the Medicaid claiming system (eMedNY). 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 eMedNY. Projections for most service sectors begin with FY 2015 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 that 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 2016 (dollars in millions)			
Category of Service	**Online**	**Offline**	**Total**
Medicaid Managed Care	**$13,132**	**($732)**	**$12,400**
Mainstream Managed Care	$9,356	($596)	$8,761
Long Term Managed Care	$3,776	($136)	$3,640
Total Fee For Service	**$8,609**	**$1,040**	**$9,649**
Inpatient	$2,023	$886	$2,909
Outpatient/Emergency Room	$458	$0	$458
Clinic	$593	($42)	$551
Nursing Homes	$3,467	$2	$3,469
Other Long Term Care	$670	($17)	$653
Pharmacy	$351	($401)	($50)
Dental	$32	$0	$32
Transportation	$255	$0	$255
Non-Institutional Other	$760	$612	$1,372
VAP	**$0**	**$106**	**$106**
Supportive Housing	**$0**	**$123**	**$123**
Medicaid Administration Costs	**$0**	**$498**	**$498**
OHIP Budget / State Operations	**$0**	**$225**	**$225**
Medicaid Audits	**$0**	**($358)**	**($358)**
Local Cap Contribution	**$0**	**($7,216)**	**($7,216)**
All Other	**$3,073**	**($759)**	**$2,314**
Accounts Receivable	$0	($170)	($170)
Other State Agency / Transfer	$3,073	($1,247)	$1,826
Other	$0	$658	$658
TOTAL	**$24,814**	**($7,073)**	**$17,741**

Note: The amounts above have been updated to reflect the changes described in the mid-year update section of this report.

Appendix B
Inventory of Rate Packages

The State is anticipating Medicaid rate adjustments resulting in price increases of up to $426 million this fiscal year. Below is a list of the majority of anticipated rate packages to be implemented:

Inventory of Rate Packages – FY 2016 (dollars in millions)				
Category of Service	**Rate Package Description**	**Effective Date**	**Non-Federal Impact**	**Date Released**
Inpatient	Acute & EU Capital	Various	$40	June 2015 September 2015
Outpatient / Emergency Room	APG capital updates for 2009 - 2012 rates	Various	$20	
	Hospital-based OASAS clinic APG	10/1/10 - 12/31/14	$19	May 2015
	Methadone Maintenance Treatment Program	01/03/11 - 12/31/14	$19	September 2015
	Collaborative Care	04/01/15	$4	May 2015
Clinic	Electronic Health Records distribution	Various	$7	
	Uninsured Care Programs distribution	Various	$3	
Nursing Homes	2015 Initial Rates (9 Months)	01/01/15	$9	April 2015
	2016 Initial Rates (3 Months)	01/01/16	$3	
	Cash Receipts Assessment Reconciliation	Various	$8	April 2015
	Case Mix	01/01/15, 07/01/15, 01/01/16	$72	September 2015
	Minimum Data Set Audits Reconciliation	07/01/12, 01/01/13, 07/01/13, 01/01/14	$19	December 2015
	Advanced Training Initiative	04/01/15	$23	
Home Health	LTHHCP Annual Rates	01/01/15	$15	May 2015
	CHHA Episodic Payment System EPS Rebasing	04/01/15	($25)	July 2015
Personal Care	TBI Rate Increase	04/01/15	$11	August 2015
	NHTD Rate Increase	04/01/15	$4	August 2015
Managed Care	April 2015 Premiums	04/01/15	$283	January 2016
Long Term Managed Care	April 2015 Premiums	04/01/15	$67	January 2016
	April 2014 Premiums	04/01/14	($119)	May 2015

Appendix C
Savings Initiatives

As part of the FY 2016 Enacted Budget the following major initiatives are scheduled to be implemented in this fiscal year:

Dollars in Millions (Non-Federal Share)	FY 2016
Accelerate Rebate Collections	($27)
Cost-sharing Limits to Medicare Part B Claims	($25)
Rebase CHHAs	($25)
Implement Managed Care Pharmacy Efficiencies	($13)
Statewide Supplemental Rebates	($13)
Savings Initiatives	**($103)**

Appendix D
Grant Award Programs

Vital Access/Safety Net Provider Program

The Vital Access/Safety Net Provider Program (VAP) supports projects for facilities that were selected due to their serious financial condition and critical role in providing services to New York State's fragile, elderly, and low-income population. These awards support multi-year projects submitted by hospitals, nursing homes, free standing clinics, and home health providers. The VAP funds will be used primarily to improve community care including expand access to ambulatory services, open urgent care centers, expand services in rural areas, and provide more effective services that meet community needs.

VAP Program Awards (dollars in millions; state share)				
Provider Type	**Total Amount Awarded**	**FY 2014 Disbursed**	**FY 2015 Disbursed**	**FY 2016 Actual - YTD**
Hospitals	$118	$18	$52	$20
Diagnostic & Treatment Centers	$18	$0	$11	$4
Nursing Homes	$121	$7	$34	$18
Critical Access Hospitals	$16	$0	$5	$1
Certified Health Home Agencies	$3	$0	$2	$0
TOTAL	**$275**	**$25**	**$104**	**$43**

Supportive Housing

The Supportive Housing Initiative seeks to ensure that Medicaid members have proper housing that promotes a healthy environment and lifestyle.

Supportive Housing Allocation Plan – FY 2016 (dollars in millions)	
	Allocation Plan
Capital Funding	$63
Rental/Service Subsidies	$33
New Supportive Housing Pilot Projects	$26
Tracking & Evaluation	$1
TOTAL	**$123**
YTD Actuals	**$59**

Additional Information on Grant Award programs:

http://www.health.ny.gov/health_care/medicaid/redesign/supportive_housing_initiatives.htm

https://www.governor.ny.gov/press/01272014-vap-funding

http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/

http://www.health.ny.gov/health_care/medicaid/redesign/iaaf/

Appendix E
Enrollment through the NYSOH Healthcare Exchange

The charts below represent the monthly breakout of Medicaid recipients enrolling through the NYSOH Healthcare Exchange as well as the Medicaid eligibility determinations:

Profile of Medicaid Enrollees through NYSOH Healthcare Exchange			
	Total	**Fee For Service**	**Managed Care**
January 2014 - Current	2,194,526	451,996	1,742,530

NYSOH Healthcare Exchange – FY 2016 Medicaid Eligibility Determinations		
	Total	**% of Total**
Childless adults income < 100% (75% FMAP)	658,143	30.0%
Childless adults income 100-138% (100% FMAP)	203,301	9.3%
All Other (50% FMAP)	1,333,082	60.7%
Total	**2,194,526**	**100.0%**

Appendix F
Regional Spending Data

The Global Cap legislation requires the Department to publish actual State Medicaid spending by region. The regions selected are based on the Governor's eleven economic development areas. The chart below represents total provider spending that occurs within the Medicaid claiming system (eMedNY) through February 2016 for each region.

Medicaid Regional Spending – FY 2016 (dollars in millions)	
Economic Region	**Non-Federal Total Paid**
New York City	$14,091
Long Island	$2,260
Mid-Hudson	$2,161
Western	$1,130
Finger Lakes	$968
Capital District	$809
Central	$574
Mohawk Valley	$474
Southern Tier	$431
North Country	$311
Out of State	$130
TOTAL	**$23,339**

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/