NEW YORK STATE | Department of Health

Medicaid Global Spending Cap Report

March 2016

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Global Cap – A Year in Review

The Department of Health and the Division of Budget are very pleased to report that spending under FY 2016 Medicaid Global Spending Cap was $3 million below the $17.7 billion target. Limiting spending to the growth afforded under the Global Cap was 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. Both the Nursing Home and Health and Recovery Plan (HARP) recipients transition this fiscal year as described in the *Beneficiary Transition Schedule to Managed Care* section;

- Continuing 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;

- Continuing 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;

- Providing additional funding under the *Vital Access Provider Assurance Program (VAPAP)* for facilities in need of essential and immediate cash assistance, with the ultimate requirement of sustainability and fulfillment of the goals of DRSIP;

- Implementing *Value Based Payment Reform (VBP)* designed to transform the Medicaid payment structure from volume driven to value-based; and

- Implementing the *Essential Plan (EP)*. The EP provides New York the opportunity to offer many consumers a lower-cost health insurance option than is available through New York State of Health (NY State of Health).

In summary, this is the fifth consecutive year that the Medicaid health care community has remained below the Global Cap target while expanding health coverage to the State's neediest populations. In addition, there were several significant pressures on the Global Cap this year and additional resources were identified to mitigate the impact of these unanticipated costs (see Appendix A for more detail).

Results for March 2016 - Summary

Total State Medicaid expenditures under the Medicaid Global Spending Cap for FY 2016 were $3 million under projections. Spending for FY 2016 resulted in total expenditures of $17.738 billion compared to the projection of $17.741 billion.

Medicaid Spending – FY 2016 (dollars in millions)			
Category of Service	**Estimated**	**Actual**	**Variance Over / (Under)**
Medicaid Managed Care	**$12,400**	**$12,466**	**$66**
Mainstream Managed Care	$8,760	$8,673	($87)
Long Term Managed Care	$3,640	$3,793	$153
Total Fee For Service	**$9,658**	**$9,689**	**$31**
Inpatient	$2,923	$3,014	$91
Outpatient/Emergency Room	$458	$491	$33
Clinic	$551	$570	$19
Nursing Homes	$3,469	$3,379	($90)
Other Long Term Care	$653	$676	$23
Non-Institutional	$1,604	$1,559	($45)
Medicaid Administration Costs	**$498**	**$504**	**$6**
OHIP Budget / State Operations	**$257**	**$271**	**$14**
Medicaid Audits	**($358)**	**($261)**	**$97**
All Other	**$2,502**	**$2,285**	**($217)**
Local Funding Offset	**($7,216)**	**($7,216)**	**$0**
TOTAL	**$17,741**	**$17,738**	**($3)**

Results through March - Variance Highlights

Medicaid Managed Care

Medicaid spending in major Managed Care categories was $66 million over projections.

- *Mainstream Managed Care* was $87 million under projections due to slower than expected transition of services to a Managed Care setting for BHO/HARP eligible individuals.
- *Long Term Managed Care* was $153 million above projections due to higher than expected enrollment. Through March there were about 5,400, 3.3 percent, more recipients than anticipated. Also, in order to maximize Federal revenue, the claiming of Federal receipts was delayed; however, these receipts will be claimed next fiscal year.

Fee-For-Service

Medicaid spending in major fee-for-service categories was $31 million, or 0.3 percent, over projections.

- *Inpatient* spending was $91 million, 3.1 percent, over projections primarily due to slower than expected transition of services to a Managed Care setting for FIDA and BHO/HARP eligible individuals. Additionally, the State made cash advances to several safety net providers that are expected to be fully recouped by the end of the next fiscal year. And lastly, there were higher Inpatient expenditures due to GME wrap costs for Essential Plan enrollees that will be transferred to the EP trust fund.

- *Outpatient/Emergency Room* spending was $33 million, 7.2 percent, over projections. The variance was primarily related to processing seven years of APG capital rate packages. All of the rate packages were budgeted; however, the actual impacts exceeded projections by $20 million.
- *Nursing Home* spending was $90 million, 2.6 percent, below estimates. The budget anticipated restoring the two percent ATB however the State Plan Amendment is still pending CMS approval.
- *Non-Institutional* spending (includes Pharmacy, Medical Supplies, Physicians, Supplemental Medical Insurance, etc.) was $45 million under projections. Total rebates collected through March exceeded projections by $80 million, or 6 percent.

OHIP Budget / State Operations

OHIP State Operations was over budget by $14 million. The variance was driven by higher than expected contractual spending, as reflected in the *OHIP State Operations Budget* section.

Medicaid Audits

Spending offsets from Medicaid audit recoveries were below projected levels by $97 million. As benefits transition to Managed Care providers collections are increasingly reflected in premium rates and fewer recoveries are fee-for-service. Additionally, the spending variance was associated with the timing of deposits and repayment of Federal shares for newly established accounts receivables.

All Other

All Other spending was below projected levels by $217 million. The All Other category includes a wide variety of Medicaid payments and offsets. The underspending in this category is attributed to the delay in restoring the 2% Across the Board Reduction due to a pending State Plan Amendment, a lower than anticipated contribution to the Essential Plan due to enrollment mix, and underspending in VAP and VAPAP programs.

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 expenditures were $14 million higher than projected.

Contracts for the Enrollment Center, Medicaid Management Information Systems (MMIS), NYSOH Exchange, transportation management, and various MRT initiatives comprise two thirds of the total non-personal service budget. The chart below compares State Operations spending against the annual budget for FY 2016:

OHIP Budget – FY 2016 (dollars in millions)		
Service Costs	**Annual Budget**	**Actual**
Personal Services	**$35**	**$32**
Non-Personal Services	**$222**	**$239**
NYS Of Health Healthcare Exchange	$53	$55
eMedNY (MMIS)	$35	$39
Enrollment Center	$28	$21
Medicaid Transportation Management	$23	$24
OHIP Actuarial and Consulting Services	$7	$10
All Others	$76	$90
TOTAL	**$257**	**$271**

Accounts Receivable

The Accounts Receivable (A/R) ending balance for FY 2016 was $193 million resulting in a reduction of $87 million to the FY 2015 beginning balance of $280 million.

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 6,195,976 enrollees at the end of March 2016. This reflects a *net* increase of 19,909 enrollees, or 0.3 percent, since March 2015, which is comprised of:

- Effective January 2016, Aliessa individuals previously counted as Medicaid members (174,520) were converted to the Essential Plan; and
- New enrollment of 194,429

Medicaid Enrollment Summary					
	March 2015	**Converted to EP**	**New Enrollees**	**March 2016**	**Net Increase / (Decrease)**
Managed Care	**4,673,939**	**(174,520)**	**144,882**	**4,644,301**	**(29,638)**
New York City	2,878,176	(149,155)	73,994	2,803,015	(75,161)
Rest of State	1,795,763	(25,365)	70,888	1,841,286	45,523
Fee-For-Service	**1,502,128**	**0**	**49,547**	**1,551,675**	**49,547**
New York City	737,195	0	41,229	778,424	41,229
Rest of State	764,933	0	8,318	773,251	8,318
TOTAL	**6,176,067**	**(174,520)**	**194,429**	**6,195,976**	**19,909**
New York City	3,615,371	(149,155)	115,223	3,581,439	(33,932)
Rest of State	2,560,696	(25,365)	79,206	2,614,537	53,841

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	4,143
October 2015	BHO / HARPs	Various	MMC	56,121	35,349

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)	$8,760
Long Term Managed Care	$3,777	($136)	$3,640
Total Fee For Service	**$8,618**	**$1,040**	**$9,657**
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	$769	$612	$1,381
Medicaid Administration Costs	**$0**	**$498**	**$498**
OHIP Budget / State Operations	**$0**	**$257**	**$257**
Medicaid Audits	**$0**	**($358)**	**($358)**
Local Funding Offset	**$0**	**($7,216)**	**($7,216)**
All Other	**$3,073**	**($571)**	**$2,502**
Other State Agency / Transfer	$3,073	($1,247)	$1,826
Accounts Receivable	$0	($170)	($170)
Supportive Housing	$0	$123	$123
VAP	$0	$106	$106
Other	$0	$617	$617
TOTAL	**$24,823**	**($7,082)**	**$17,741**

Appendix A - Continued
Mid-Year Update

The State updated the Global Medicaid Spending Cap estimates based on experience through September 2015. There were several significant pressures on the Global Cap that were 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.

- Additional Federal Resources – The Department is pursuing methodology to claim additional FMAP on services provided in the Long Term Managed Care program.
- Uncommitted Vital Access Provider program funds were reduced.

Appendix B
Inventory of Rate Packages

Below is a list of the majority of rate packages processed in FY 2016:

Category of Service	Rate Package Description	Effective Date	Date Released
Inpatient	Acute & EU Capital	Various	June 2015 September 2015
Outpatient / Emergency Room	APG capital updates	1/1/2009 – 12/31/2015	March 2016
	Hospital-based OASAS clinic APG	10/1/10 - 12/31/14	May 2015
	Methadone Maintenance Treatment Program	01/03/11 - 12/31/14	September 2015
	Collaborative Care	04/01/15	May 2015
Nursing Homes	2015 Initial Rates	01/01/15	April 2015
	Cash Receipts Assessment Reconciliation	Various	April 2015
	Case Mix	01/01/15, 07/01/15, 01/01/16	September 2015 March 2016
	Advanced Training Initiative	04/01/15	March 2016
Home Health	LTHHCP Annual Rates	01/01/15	May 2015
	CHHA Episodic Payment System EPS Rebasing	04/01/15	July 2015
Personal Care	TBI Rate Increase	04/01/15	August 2015
	NHTD Rate Increase	04/01/15	August 2015
Managed Care	April 2015 Premiums	04/01/15	January 2016
Long Term Managed Care	April 2014 Premiums	04/01/14	May 2015
	April 2015 Premiums	04/01/15	January 2016

Appendix C
Savings Initiatives

As part of the FY 2016 Enacted Budget the following major initiatives were 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 Disbursed**
Hospitals	$118	$18	$52	$30
Critical Access Hospitals	$16	$0	$5	$2
Nursing Homes	$121	$7	$34	$32
Diagnostic & Treatment Centers	$18	$0	$11	$6
Certified Health Home Agencies	$3	$0	$2	$1
TOTAL	**$275**	**$25**	**$104**	**$71**

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	**Disbursed**
Capital Funding	$63	$62
Rental/Service Subsidies	$33	$31
New Supportive Housing Pilot Projects	$26	$8
Tracking & Evaluation	$1	$0
TOTAL	**$123**	**$101**

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	2,210,635	465,458	1,745,177

NYSOH Healthcare Exchange – FY 2016 Medicaid Eligibility Determinations		
	Total	**% of Total**
Childless adults income < 100% (75% FMAP)	662,974	30.0%
Childless adults income 100-138% (100% FMAP)	204,794	9.3%
All Other (50% FMAP)	1,342,867	60.7%
Total	**2,210,635**	**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 March 2016 for each region.

Medicaid Regional Spending – FY 2016 (dollars in millions)	
Economic Region	**Non-Federal Total Paid**
New York City	$15,413
Long Island	$2,483
Mid-Hudson	$2,384
Western	$1,248
Finger Lakes	$1,071
Capital District	$891
Central	$637
Mohawk Valley	$525
Southern Tier	$475
North Country	$346
Out of State	$141
TOTAL	**$25,614**

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/