NEW YORK STATE | Department of Health

Medicaid Global Spending Cap Report

January 2017

Table of Contents

Overview

The FY 2017 Enacted Budget extended the Medicaid Global Spending Cap through March 2018. Pursuant to legislation, the Medicaid Global Spending Cap has increased from $17.7 billion in FY 2016 to $18.6 billion (including the Essential Program) in FY 2017, an increase of 5.1 percent. The CPI used on Medicaid services subject to the trend was 3.5 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 $814 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 (+$692 million)	• Trend increases for mainstream managed care rates ($374 million) and long term managed care rates ($187 million); • Various FFS rate packages ($87 million); and • Minimum Wage Adjustment ($44 million).
Utilization (+$200 million)	• Annualization of FY 2016 new enrollment (194,000); and • New enrollment for FY 2017 (73,089).
MRT/One-Timers/Other (-$78 million)	• Removal of the 53rd cycle (-$207 million); • Annualization of CFCO enhanced FMAP (-$130 million); • Additional Accounts Receivable collections (-$108 million); • Recoveries of provider cash advances (-$70 million); offset by • State Contribution for the Essential Plan ($464 million).

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

- Pharmacy savings initiatives, including accelerating rebate collections and implementing a Generic CPI Penalty to help mitigate extreme generic price increases by requiring generic manufactures to pay the State additional rebates for drugs with outlier price increases; and

- Additional resources for 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 Delivery System Reform Incentive Payment (DSRIP) Program.

- Minimum Wage – funds have been provided to supplement the Global Cap to implement new minimum wage requirements. Funds will be used to support direct salary costs and related fringe benefits.

Since the inception of the Global Spending Cap in FY 2012, 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.

Medicaid Global Spending Cap Annual Budget (Online and Offline)

The $18.6 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 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 2016 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 ($ in millions)			
Category of Service	**Online**	**Offline**	**Total**
Medicaid Managed Care	**$14,003**	**($278)**	**$13,725**
Mainstream Managed Care	$9,270	($91)	$9,179
Long Term Managed Care	$4,733	($187)	$4,546
Fee For Service	**$7,657**	**$849**	**$8,506**
Acute Care	$2,733	$663	$3,396
Long Term Care	$3,584	$45	$3,629
Non-Institutional	$1,340	$141	$1,481
Medicaid Administration Costs	**$0**	**$480**	**$480**
OHIP Budget / State Operations	**$0**	**$383**	**$383**
Medicaid Audits	**$0**	**($318)**	**($318)**
Other State Agency	**$3,159**	**($981)**	**$2,178**
All Other	**$0**	**$758**	**$758**
Local Cap Contribution	**$0**	**($7,157)**	**($7,157)**
TOTAL	**$24,819**	**($6,264)**	**$18,555**

The State has updated the Global Medicaid Spending Cap estimates based on experience through December 2016. 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 December) was 24,892. The original estimates have been revised to reflect projected growth of 30,712 recipients.
- Higher than expected fee-for-service personal care and CHHA utilizers.

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

- Primary Care Rate Increases (PCRI) – There were additional claims eligible for the enhanced federal funding.
- Reduction to Mainstream Managed Care enrollment growth assumptions. Through December program growth has remained flat.

Major Offline Components

Medicaid Managed Care (-$278 million)

- *Medicaid Managed Care* offline budget includes additional Federal Revenue for Community First Choice Option (CFCO) services, recoveries of provider cash advances made in FY 2016, and a reconciliation of the ACA HMO tax.

Fee For Service (+$849 million)

- *Acute Care* includes payments for Disproportionate Share Hospital, Upper Payment Limit, SUNY IGT, and the Major Academic Pool.
- *Long Term Care* includes additional Federal Revenue for CFCO.
- *Non-Institutional* includes payments for Medicare Part D Clawback and Supplemental Medical Insurance, and offset by rebate collections.

OHIP Budget / State Operations (+$383 million)

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).

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 2017:

OHIP Budget ($ in millions)	
Service Costs	**Budget**
Personal Services	$40
Non-Personal Services	$295
Essential Plan Administration	$48
TOTAL	**$383**

All Other (+$758 million)

The All Other Category includes a variety of payments but is primarily comprised of program spending for the Essential Plan, VAPAP, VAP and Supportive Housing.

- **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 ($ in millions; State share)			
Provider Type	**Total Amount Awarded**	**LTD Disbursements (through March 2016)**	**FY 2017 Budget**
Hospitals/CAHs	$154	$100	$31
Nursing Homes	$117	$79	$37
Diagnostic & Treatment Centers	$18	$18	--
Certified Health Home Agencies	$3	$2	$1
Essential Community Providers	$8	--	$8
Licensed Health Care Service Agencies	$1	$1	--
Sub-Total	**$301**	**$200**	**$77**
Pending VAP Requests	--	--	$29
Total	**$301**	**$200**	**$106**

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

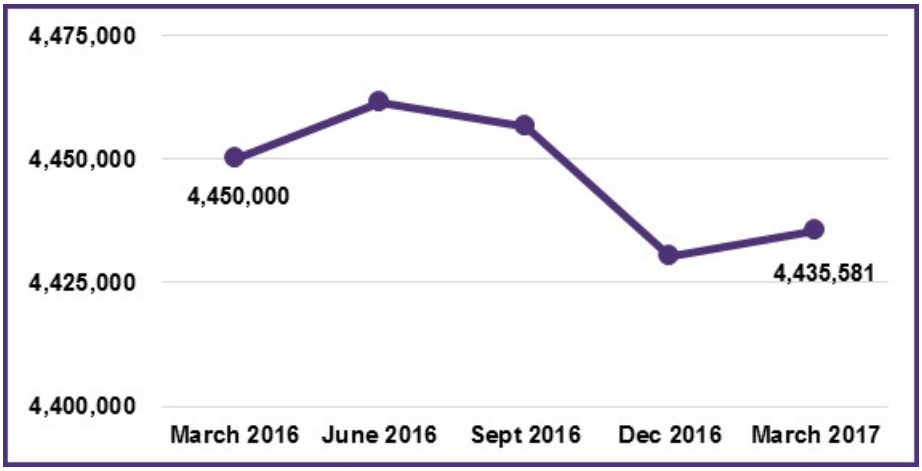
Supportive Housing Allocation Plan ($ in millions)	
	Allocation Plan
Capital Funding	$46*
New Supportive Housing Pilot Projects	$42
Rental/Service	$38
Tracking & Evaluation	$1
TOTAL	**$127**

**$44 million in Bonded Capital; $2 million (Medicaid Access to Homes) from Global Cap.*

Annual Enrollment Estimates

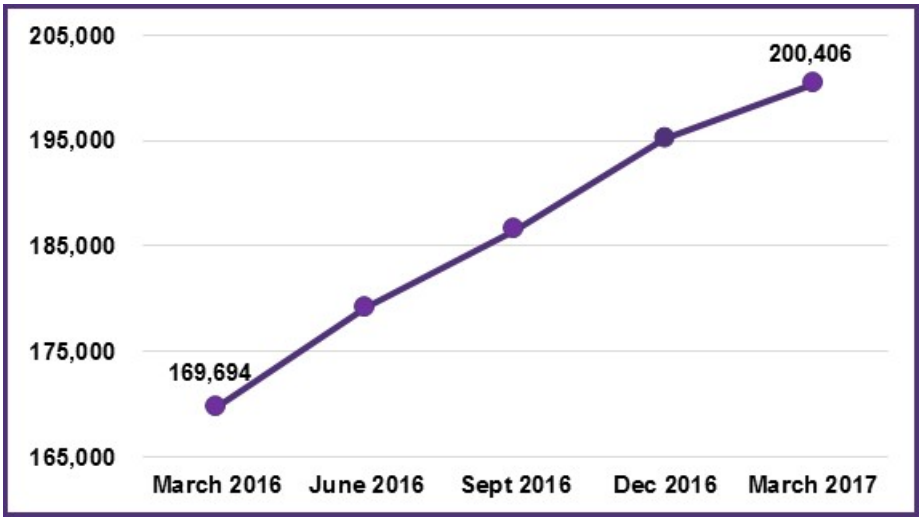
Mainstream Managed Care (includes HIV/SNPs and BHO/HARPs)

Several program changes have affected enrollment in Mainstream Managed Care (MMC). The main factor that contributed to the decline in MMC enrollment from December 2015 to January 2016 was the conversion 210,000 enrollees to the Essential Plan (EP) from MMC. Conversion of enrollees from MMC to EP will occur in lower numbers throughout FY 2017. Additionally, the conversion of eligible MMC enrollees to a Health and Recovery Plan (HARP) outside of New York City began on July 1, 2016. It is expected that MMC enrollment will remain stable through the end of the fiscal year.



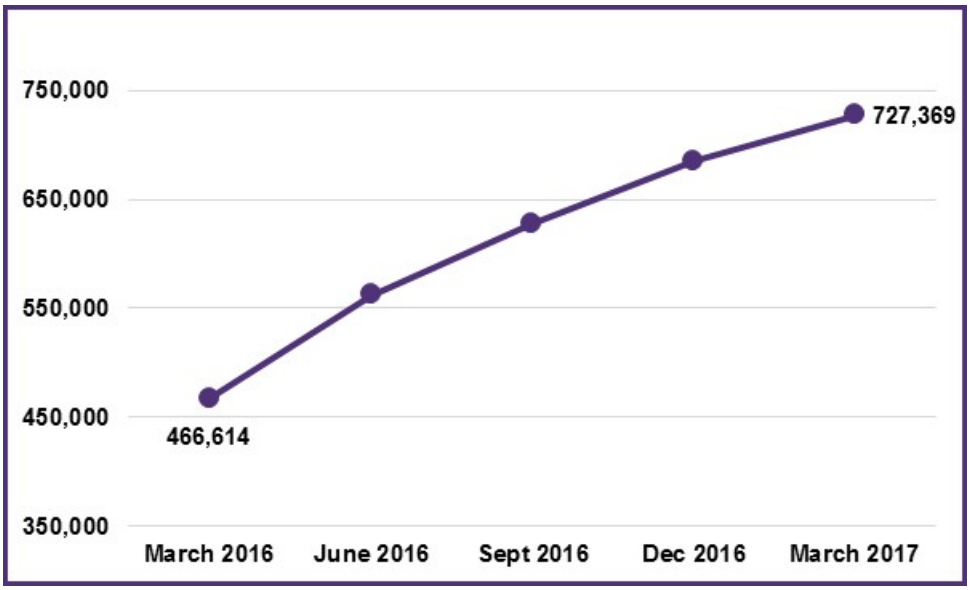
Long Term Managed Care (includes PACE, FIDA, MA and MAP)

The Long Term Managed Care (MLTC) program has been rapidly growing since the mandatory transition of community based long term care individuals was implemented. On top of mandatory enrollment, the program is also expanding for Nursing Home recipients. In FY 2016, MLTC grew close to 22,000 individuals, about 5,500 of those were Nursing Home eligibles. The FY 2017 projections assume continued growth at slightly higher levels than prior years, primarily driven by the Nursing Home transition.



Essential Plan

In its first year of operation, the Essential Plan has been very successful, proving to be an affordable health insurance option for consumers with incomes too high to qualify for Medicaid. As of April 2016, enrollment in Essential Plan was 466,614. About 50 percent of Essential Plan enrollees were previously eligible for Medicaid while about 50 percent were previously eligible for QHP coverage with tax credits. Enrollment has increased by over 200,000 individuals since January 2016, with the group from 150% to 200% of FPL growing the fastest. It is expected that enrollment will continue to increase at current levels (2% per month) through the end of FY 2017.



Monthly Results - Summary

Total State Medicaid expenditures under the Medicaid Global Spending Cap for FY 2017 through January were $45 million over projections. Spending through January resulted in total expenditures of $16.765 billion compared to the projection of $16.720 billion.

Medicaid Spending ($ in millions)			
Category of Service	**Estimated**	**Actual**	**Variance Over / (Under)**
Medicaid Managed Care	**$12,358**	**$12,395**	**$37**
Mainstream Managed Care	$8,419	$8,421	$2
Long Term Managed Care	$3,939	$3,974	$35
Total Fee For Service	**$7,259**	**$7,319**	**$60**
Inpatient	$2,312	$2,319	$7
Outpatient/Emergency Room	$309	$316	$7
Clinic	$389	$386	($3)
Nursing Homes	$2,519	$2,533	$14
Other Long Term Care	$500	$515	$15
Non-Institutional	$1,230	$1,250	$20
Medicaid Administration Costs	**$369**	**$370**	**$1**
OHIP Budget / State Operations	**$271**	**$246**	**($25)**
Medicaid Audits	**($257)**	**($245)**	**$12**
All Other	**$2,646**	**$2,606**	**($40)**
Local Funding Offset	**($5,926)**	**($5,926)**	**$0**
TOTAL	**$16,720**	**$16,765**	**$45**

Results through January - Variance Highlights

Medicaid Managed Care

Medicaid spending in major Managed Care categories was $37 million over projections.

- Long Term Managed Care was $35 million above projections due to higher than expected enrollment. Through January there were 1,052, 0.6 percent, more recipients than anticipated.

Fee-For-Service

Medicaid spending in major fee-for-service categories was $60 million, or 0.8 percent, over projections.

- *Outpatient/Emergency Room* spending was $7 million over projections. The variance was primarily related to retroactive rates being processed. The impact was slightly higher than expected.
- *Other Long Term Care* spending was $15 million above estimates. This is a result of higher than expected utilization through January. There were 2,143 more individuals receiving personal care services than anticipated.
- *Non-Institutional* spending was $20 million above projections which is primarily driven by the timing of rebate collections.

OHIP Budget / State Operations

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 2017 budget is projected to total $383 million which also includes Essential Plan administration costs.

Contracts for the Enrollment Center, Medicaid Management Information Systems (MMIS), NYSOH Exchange, transportation management, and various MRT initiatives comprise 65 percent ($192 million) of the total non-personal service budget.

OHIP State Operations was under budget by $25 million. The variance was driven by lower than expected contractual spending.

OHIP Budget – FY 2017 ($ in millions)		
Service Costs	**Annual Budget**	**Actual - YTD**
Personal Services	**$40**	**$28**
Non-Personal Services	**$295**	**$180**
Enrollment Center	$86	$60
eMedNY/MMIS	$43	$38
Medicaid Transportation Management	$28	$22
NYS Of Health Healthcare Exchange	$26	($4)
OHIP Actuarial and Consulting Services	$9	$10
All Others	$103	$54
Essential Plan	**$48**	**$38**
TOTAL	**$383**	**$246**

All Other

All Other spending was below projected levels by $40 million. The All Other category includes a variety of Medicaid payments and offsets. The underspending in this category is primarily attributed to the timing of Vital Access Provider and Supportive Housing program spending.

Accounts Receivable

The Accounts Receivable (A/R) ending balance for FY 2016 was $325 million. The State is expected to recoup $194 million by the end of FY 2017, resulting in a projected A/R balance of $131 million by March 2017. Through the end of January, retroactive rates owed to the State were $228 million. This reflects net recoveries of $97 million since March 2016.

The Department of Health is engaged in an initiative to eliminate all currently outstanding retroactive rates Medicaid liabilities owed to the State. 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.

Enrollment

Medicaid Enrollment

Medicaid total enrollment reached 6,133,564 enrollees at the end of January 2017. This reflects a *net* decrease of 33,726 enrollees, or 0.5 percent, since March 2016, which is comprised of:

- Aliessa individuals previously counted as Medicaid members (60,362) were converted to the Essential Plan; and
- New enrollment of 26,636.

Medicaid Enrollment Summary FY 2017					
	March 2016	**Converted to EP**	**New Enrollees**	**January 2017**	**Net Increase / (Decrease)**
Managed Care	**4,645,864**	**(60,362)**	**54,227**	**4,639,729**	**(6,135)**
New York City	2,804,033	(46,250)	45,879	2,803,662	(371)
Rest of State	1,841,831	(14,112)	8,348	1,836,067	(5,764)
Fee-For-Service	**1,521,426**	**0**	**(27,591)**	**1,493,835**	**(27,591)**
New York City	755,513	0	(14,628)	740,885	(14,628)
Rest of State	765,913	0	(12,963)	752,950	(12,963)
TOTAL	**6,167,290**	**(60,362)**	**26,636**	**6,133,564**	**(33,726)**
New York City	3,559,546	(46,250)	31,251	3,544,547	(14,999)
Rest of State	2,607,744	(14,112)	(4,615)	2,589,017	(18,727)

Essential Plan Enrollment

Essential Plan enrollment reached 663,818 enrollees at the end of January 2017. This reflects an increase of 197,204 enrollees since March 2016.

Essential Plan Enrollment Summary FY 2017			
	March 2016	**January 2017**	**Increase / (Decrease)**
Statewide	466,614	663,818	**197,204**

Appendix A
Inventory of Rate Packages

Below is a list of the majority of rate packages to be processed in FY 2017:

Category of Service	Rate Package Description	Effective Date	Date Released
Managed Care	Mainstream April 2016	4/1/2016	December 2016
	Mainstream July 2016	7/1/2016	
	Mainstream October 2016	10/1/2016	
	Mainstream January 2017	1/1/2017	
Long Term Managed Care	FIDA Rates Phase IV-October 2015	10/1/2015	July 2016
	FIDA Rates-April 2016	4/1/2016	
	Partial Capitation Rates-April 2016	4/1/2016	December 2016
	Partial Capitation Rates-October 2016	10/1/2016	
	FIDA Rates Phase V-January 2016	1/1/2016	January 2017
Inpatient	Acute Rates - Elimination of PPNO's and Inappropriate Use of Services Reductions - 4/1/2015	4/1/2015	
	Acute & Exempt Unit Actual Capital Updates	Various	
Outpatient / Emergency room	Language Assistance - IP service -uses OPD rate code	9/1/2012 - 03/31/2017	August 2016
	FQHC Rates	Various	October 2016
	APG capital update for 2016	1/1/2016	
	Home Health Agency Rates	Various	
	Hospital-based OASAS rehab clinic APG	01/01/11 – 03/31/2017	November 2016
Clinic	APG Capital Update	Various	
	Elimination of 2% ATB reduction for D&TCs as of 4/1/15	4/1/2015	
	Electronic Health Records distribution	Various	
	Uncompensated Care Program distribution	Various	October 2016
Nursing Home	OMIG Audits	Various	
	CMI Update	Various	August 2016 October 2016 November 2016
	Transportation Adjustment	4/1/2016	
	Advanced Training Initiative	1/1/2017	
	Cash Receipts Assessment	1/1/2015	July 2016

Additional Information on rate packages:

http://www.health.ny.gov/facilities/medicaid_rate_inventory/

Appendix B
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 2017:

Medicaid Fee for Service Transition to Managed Care (Populations) FY 2017				
Populations	**From (COS)**	**To (COS)**	**# of FY 2017 Targeted Enrollees**	**FY 2017 Enrolled through January**
Nursing Homes	Nursing Homes	MMC/MLTC	7,105	6,363
BHO/HARPs	Various	MMC	52,671	42,862

Appendix C
Phase VI MRT Initiatives

Phase VI MRT Initiatives ($ in millions)	
Initiative	**Impact**
Federal Actions	$183
Pharmacy Savings Initiatives	($65)
Long Term Care Savings Initiatives	($17)
Managed Care Savings Initiatives	($146)
Other Savings	($45)
Other Investments	$90
TOTAL	**$0**

Additional Information on Phase VI MRT:
http://www.health.ny.gov/health_care/medicaid/redesign/mrt_budget.htm

Appendix D
Enrollment through the NYSOH Healthcare Exchange

Profile of Medicaid Enrollees through NYSOH Healthcare Exchange			
	Total	**Fee For Service**	**Managed Care**
January 2014 - Current	**2,633,454**	476,691	2,156,763

NYSOH Healthcare Exchange – FY 2017 Medicaid Eligibility Determinations		
	Total	**% of Total**
Childless adults income < 100% (85% FMAP)	768,969	29.2%
Childless adults income 100-138% (100% FMAP)	242,278	9.2%
All Other (50% FMAP)	1,622,207	61.6%
Total	**2,633,454**	**100.0%**

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 chart below represents total provider spending that occurs within the Medicaid claiming system (eMedNY) through January 2017 for each region.

Medicaid Regional Spending ($ in millions)	
Economic Region	**Non-Federal Total Paid**
New York City	$12,763
Long Island	$2,016
Mid-Hudson	$1,946
Western	$1,029
Finger Lakes	$896
Capital District	$734
Central	$534
Mohawk Valley	$436
Southern Tier	$406
North Country	$292
Out of State	$104
TOTAL	**$21,156**

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/