



**Department
of Health**

Medicaid Global Spending Cap Report

November 2016

Table of Contents

Overview	2
Medicaid Global Spending Cap Annual Budget	3
Monthly Results - Summary & Variance Highlights	7
Medicaid Enrollment.....	9
Appendices	
A. <i>Inventory of Rate Packages</i>	10
B. <i>Beneficiary Transition Schedule</i>	11
C. <i>Phase VI MRT Initiatives</i>	12
D. <i>Regional Spending Data</i>	13
E. <i>Monthly Variance Detail</i>	14

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)	<ul style="list-style-type: none"> • 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)	<ul style="list-style-type: none"> • Annualization of FY 2016 new enrollment (194,000); and • New enrollment for FY 2017 (73,089).
MRT/One-Timers/Other (-\$78 million)	<ul style="list-style-type: none"> • 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 manufacturers 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 allocated to 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 (dollars in millions)			
Category of Service	Online	Offline	Total
Medicaid Managed Care	\$14,028	(\$331)	\$13,697
Mainstream Managed Care	\$9,436	(\$36)	\$9,400
Long Term Managed Care	\$4,592	(\$295)	\$4,297
Fee For Service	\$7,778	\$688	\$8,466
Acute Care	\$2,788	\$663	\$3,451
Long Term Care	\$3,645	(\$23)	\$3,622
Non-Institutional	\$1,345	\$48	\$1,393
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	\$826	\$826
Local Cap Contribution	\$0	(\$7,157)	(\$7,157)
TOTAL	\$24,965	(\$6,410)	\$18,555

Major Offline Components

Medicaid Managed Care (-\$331 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 (+\$688 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 (dollars in millions)	
Service Costs	Budget
Personal Services	\$40
Non-Personal Services	\$295
Essential Plan Administration	\$48
TOTAL	\$383

All Other (+\$826 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 (dollars 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.

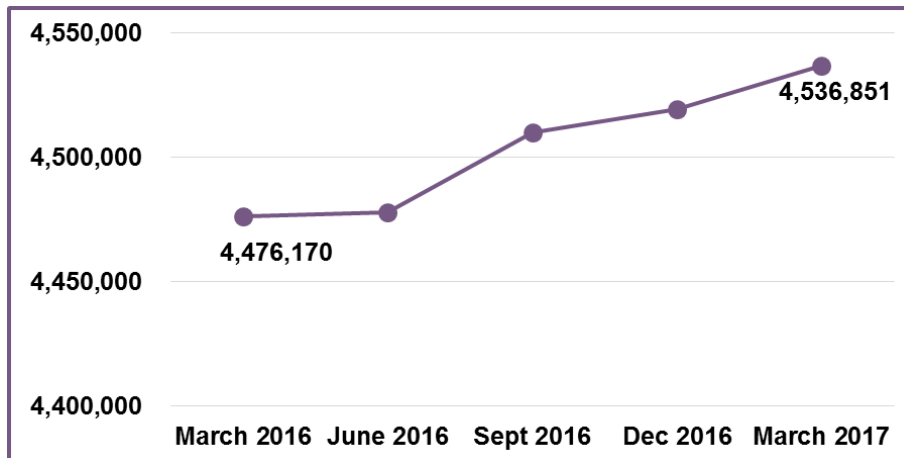
Supportive Housing Allocation Plan (dollars in millions)	
	Allocation Plan
Capital Funding	\$46*
New Supportive Housing Pilot Projects	\$42
Rental/Service	\$38
Tracking & Evaluation	\$1
TOTAL	\$127

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

Annual Enrollment Estimates

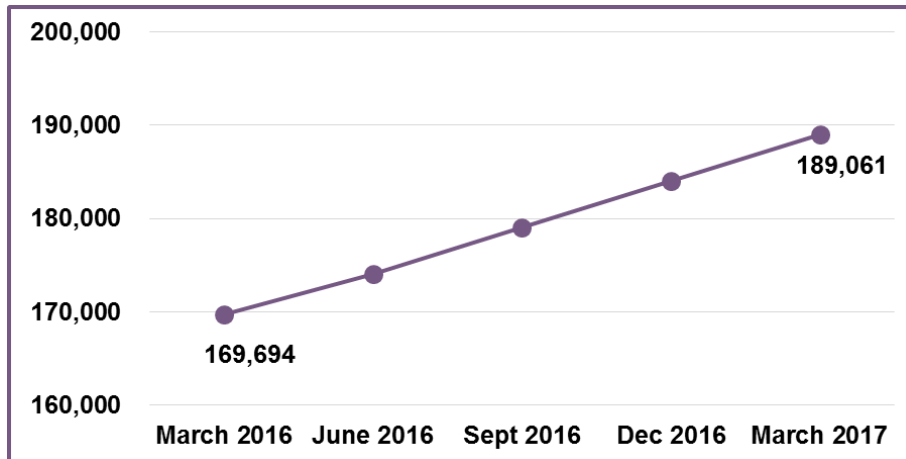
Mainstream Managed Care (includes HIV/SNPs and BHO/HARPs)

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 at current levels going forward with a slight ramp up in the latter half of the year to reflect the transition of HARPs and open enrollment.



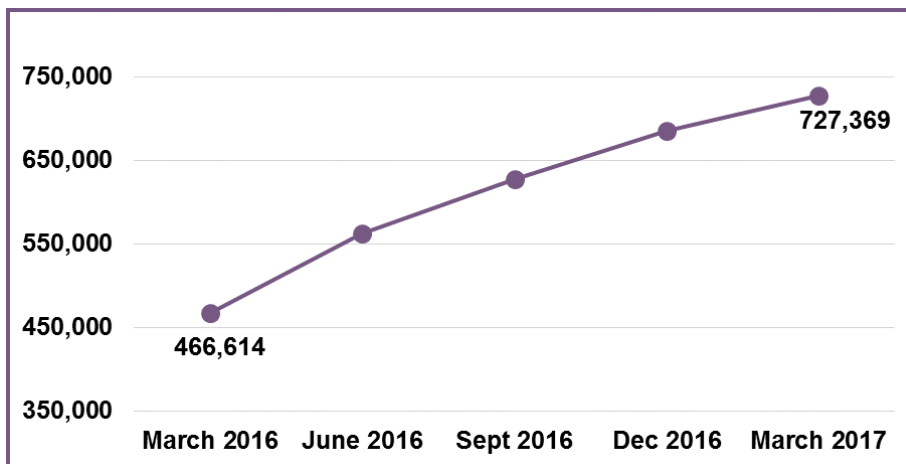
Long Term Managed Care (includes PACE, FIDA, MA and MAP)

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 lower levels than prior years, mostly due to the fact that the mandatory transition process is nearly complete.



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 November were \$26 million above projections. Spending through November resulted in total expenditures of \$13.741 billion compared to the projection of \$13.715 billion.

Medicaid Spending (dollars in millions)			
Category of Service	Estimated	Actual	Variance Over / (Under)
Medicaid Managed Care	\$9,876	\$9,895	\$19
Mainstream Managed Care	\$6,746	\$6,747	\$1
Long Term Managed Care	\$3,130	\$3,148	\$18
Total Fee For Service	\$6,026	\$6,089	\$63
Inpatient	\$1,923	\$1,923	\$0
Outpatient/Emergency Room	\$248	\$257	\$9
Clinic	\$321	\$325	\$4
Nursing Homes	\$2,075	\$2,083	\$8
Other Long Term Care	\$397	\$431	\$34
Non-Institutional	\$1,062	\$1,070	\$8
Medicaid Administration Costs	\$295	\$295	\$0
OHIP Budget / State Operations	\$194	\$188	(\$6)
Medicaid Audits	(\$183)	(\$184)	(\$1)
All Other	\$2,338	\$2,289	(\$49)
Local Funding Offset	(\$4,831)	(\$4,831)	\$0
TOTAL	\$13,715	\$13,741	\$26

Results through November - Variance Highlights

Medicaid Managed Care

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

- Long Term Managed Care was \$18 million above projections due to higher than expected enrollment. Through November there were 4,433, 2.4 percent, more recipients than anticipated.

Fee-For-Service

Medicaid spending in major fee-for-service categories was \$63 million, or 1 percent, over projections.

- *Outpatient/Emergency Room* spending was \$9 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 \$34 million above estimates. This is a result of higher than expected utilization through November. There were 2,909 more individuals receiving personal care services than anticipated.
- *Non-Institutional* spending is on target with projections.

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 \$6 million. The variance was driven by lower than expected contractual spending.

OHIP Budget – FY 2017 (dollars in millions)		
Service Costs	Annual Budget	Actual - YTD
Personal Services	\$40	\$23
Non-Personal Services	\$295	\$136
Enrollment Center	\$86	\$49
eMedNY/MMIS	\$43	\$31
Medicaid Transportation Management	\$28	\$16
NYS Of Health Healthcare Exchange	\$26	(\$8)
OHIP Actuarial and Consulting Services	\$9	\$7
All Others	\$103	\$41
Essential Plan	\$48	\$28
TOTAL	\$383	\$188

All Other

All Other spending was below projected levels by \$49 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 collections of Accounts Receivable.

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 November, retroactive rates owed to the State were \$201 million. This reflects net recoveries of \$124 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, 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.

Enrollment

Medicaid Enrollment

Medicaid total enrollment reached 6,113,035 enrollees at the end of November 2016. This reflects a *net* decrease of 54,255 enrollees, or 0.9 percent, since March 2016, which is comprised of:

- Aliessa individuals previously counted as Medicaid members (50,899) were converted to the Essential Plan; and
- Decreased enrollment of 3,356

Medicaid Enrollment Summary FY 2017					
	March 2016	Converted to EP	New Enrollees	November 2016	Net Increase / (Decrease)
Managed Care	4,645,864	(50,899)	60,136	4,655,101	9,237
New York City	2,804,033	(39,027)	38,641	2,803,647	(386)
Rest of State	1,841,831	(11,872)	21,495	1,851,454	9,623
Fee-For-Service	1,521,426	0	(63,492)	1,457,934	(63,492)
New York City	755,513	0	(27,201)	728,312	(27,201)
Rest of State	765,913	0	(36,291)	729,622	(36,291)
TOTAL	6,167,290	(50,899)	(3,356)	6,113,035	(54,255)
New York City	3,559,546	(39,027)	11,440	3,531,959	(27,587)
Rest of State	2,607,744	(11,872)	(14,796)	2,581,076	(26,668)

Essential Plan Enrollment

Essential Plan enrollment reached 620,834 enrollees at the end of November 2016. This reflects an increase of 154,220 enrollees since March 2016.

Essential Plan Enrollment Summary FY 2017			
	March 2016	November 2016	Increase / (Decrease)
Statewide	466,614	620,834	154,220

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	
	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	
	Partial Capitation Rates-October 2016	10/1/2016	
	FIDA Rates-October 2016	10/1/2016	
	FIDA Rates Phase V-January 2016	1/1/2016	
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 November
Nursing Homes	Nursing Homes	MMC/MLTC	7,105	5,472
BHO/HARPs	Various	MMC	52,671	43,279

Appendix C

Phase VI MRT Initiatives

Phase VI MRT Initiatives (dollars 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	2,484,117	425,548	2,058,569

NYSOH Healthcare Exchange – FY 2017 Medicaid Eligibility Determinations		
	Total	% of Total
Childless adults income < 100% (75% FMAP)	725,362	29.2%
Childless adults income 100-138% (100% FMAP)	228,539	9.2%
All Other (50% FMAP)	1,530,216	61.6%
Total	2,484,117	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 November 2016 for each region.

Medicaid Regional Spending (dollars in millions)	
Economic Region	Non-Federal Total Paid
New York City	\$10,188
Long Island	\$1,628
Mid-Hudson	\$1,586
Western	\$821
Finger Lakes	\$717
Capital District	\$591
Central	\$422
Mohawk Valley	\$349
Southern Tier	\$320
North Country	\$232
Out of State	\$86
TOTAL	\$16,940

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/