NEW YORK STATE | Department of Health

Medicaid Global Spending Cap Report

February 2018

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Overview

Pursuant to legislation, the Medicaid Global Spending Cap has increased from $18.6 billion in FY 2017 to $19.5 billion (including the Essential Plan) in FY 2018, an increase of 5.2 percent. The CPI used on Medicaid services subject to the trend was 3.2 percent (ten-year average of the Medical Care Consumer Price Index). The annual growth in the Global Cap of $972 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. It also includes $211 million for minimum wage rate adjustments. Components of the annual growth are as follows:

Price (+$911 million)	• Trend increases for mainstream managed care rates ($411 million) and long term managed care rates ($128 million); • Various FFS rate packages ($161 million); and • Minimum Wage Adjustment ($211 million).
Utilization (+$501 million)	• Annualization of FY 2017 new enrollment; and • New enrollment for FY 2018 (8,100 NH eligibles; 18,800 community-based).
MRT/One Timers/Other ($440 million)	• Lower Essential Plan Contribution (-$268 million); • Recovery of Cash Advances (-$127 million); and • ACA enhanced FMAP (-$106 million); • Higher Accounts Receivable Target (-$46 million); offset by • Restoration of the 2% ATB ($60 million); and • Acceleration of the ACA repayment ($59 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 an enhanced 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, an enhanced integrity program for opioids/controlled substances, and a pharmacy spending growth cap to control exorbitant prescription drug costs.

- Investments for Enhanced Safety Net Hospitals, Critical Access Hospitals, and Women's Health and Prenatal Care.

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 $19.5 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 2017 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	**$16,106**	**($282)**	**$15,824**
Mainstream Managed Care	$10,218	($70)	$10,148
Long Term Managed Care	$5,888	($212)	$5,676
Fee For Service	**$7,288**	**$985**	**$8,273**
Acute Care	$2,692	$688	$3,380
Long Term Care	$3,262	$51	$3,313
Non-Institutional	$1,334	$246	$1,580
Medicaid Administration Costs	**$0**	**$424**	**$424**
OHIP Budget / State Operations	**$0**	**$442**	**$442**
Medicaid Audits	**$0**	**($368)**	**($368)**
Other State Agency	**$3,329**	**($985)**	**$2,344**
All Other	**$0**	**($260)**	**($260)**
Local Cap Contribution	**$0**	**($7,151)**	**($7,151)**
TOTAL	**$26,723**	**($7,195)**	**$19,528**

Major Offline Components

Medicaid Managed Care (-$282 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 2017, and Quality Pool payments.

Fee For Service (+985 million)

- *Acute Care* includes payments for Disproportionate Share Hospital, Upper Payment Limit, SUNY IGT, and the Major Academic Pool.
- *Long Term Care* includes the 3rd installment of Universal Settlement offset by additional Federal Revenue for CFCO.

- *Non-Institutional* includes payments for Medicare Part D Clawback and Supplemental Medical Insurance, offset by rebate collections.

OHIP Budget / State Operations (+$442 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, New York State of Health (NYSOH) Benefit Exchange, eMedNY/Medicaid Management Information Systems (MMIS) and various MRT initiatives comprise 75 percent of the total non-personal service budget. The chart below shows the annual budget for FY 2018 State Operations:

OHIP Budget ($ in millions)	
Service Costs	**Budget**
Personal Services	$40
Non-Personal Services	$306
Essential Plan Administration	$96
TOTAL	**$442**

All Other (-$260 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)			
Provider Type	**Total Amount Awarded**	**LTD Disbursements (through March 2017)**	**FY 2018 Budget**
Hospitals/CAHs	$184	$138	$17
Nursing Homes	$147	$108	$33
Diagnostic & Treatment Centers	$18	$18	-
Certified Health Home Agencies	$3	$2	-
Licensed Health Care Service Agencies	$1	$1	-
Behavioral Health	$55	$24	$37
Sub-Total	**$408**	**$291**	**$87**
Pending VAP Requests	-	-	$24
TOTAL			**$111**

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

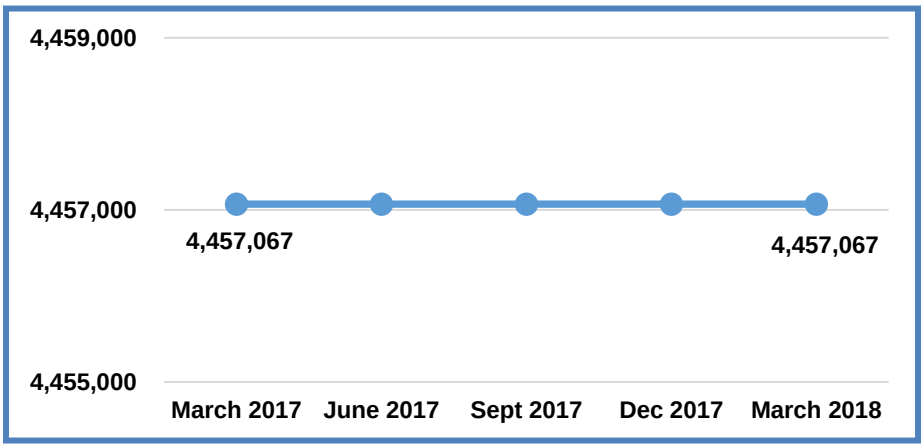
Supportive Housing Allocation Plan ($ in millions)	
	Allocation Plan
Capital Funding	$3
New Supportive Housing Pilot Projects	$21
Rental/Service	$38
Tracking & Evaluation	$1
TOTAL*	**$63**

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

Annual Enrollment Estimates

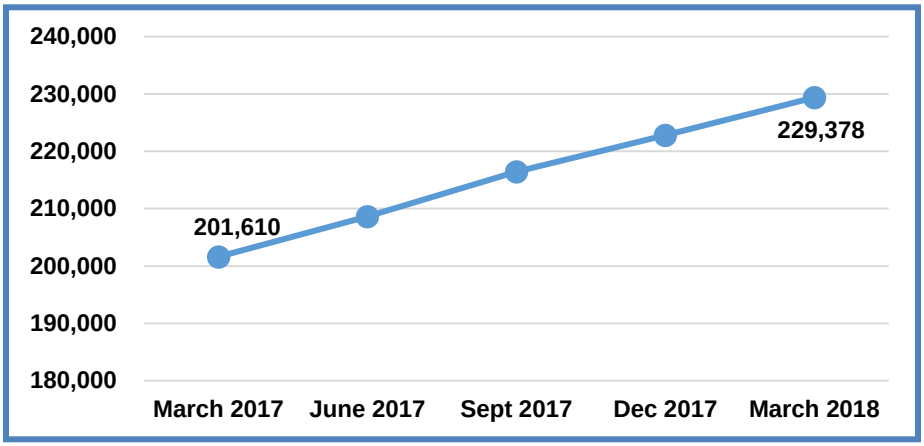
Mainstream Managed Care (includes HIV/SNPs and BHO/HARPs)

Several program changes have affected enrollment in Mainstream Managed Care (MMC). The main factor that contributed to the decline in MMC enrollment last fiscal year was the conversion of enrollees to the Essential Plan (EP) from MMC. Conversion of enrollees from MMC to EP will occur in lower numbers throughout FY 2018. 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.



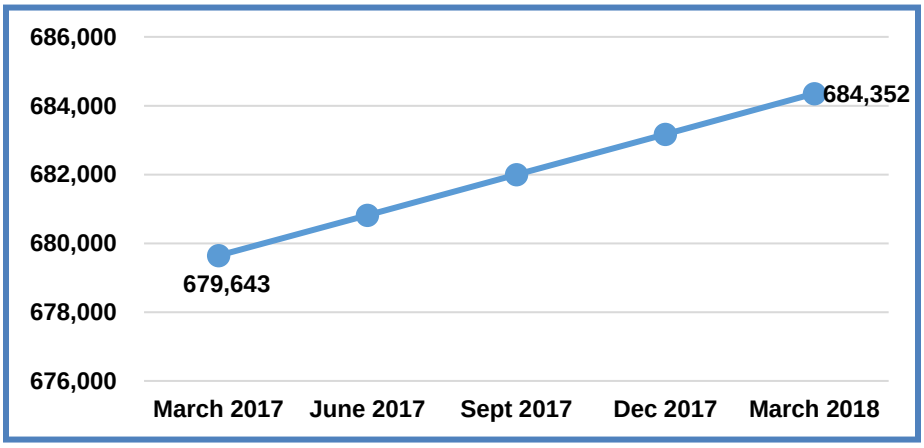
Long Term Managed Care (includes PACE, FIDA, MA and MAP)

The Long Term Managed Care (MLTC) program has been rapidly growing since the mandatory transition of community based long term care individuals was implemented in July 2012. On top of mandatory enrollment, the program is also expanding for Nursing Home recipients. In FY 2017, MLTC grew close to 31,000 individuals, about 9,300 of those were Nursing Home eligibles. The FY 2018 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

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 March 2017, enrollment in the Essential Plan was 679,643. About 43 percent of Essential Plan enrollees were previously eligible for Medicaid while about 57 percent were previously eligible for Qualified Health Plan (QHP) coverage with tax credits. It is expected that enrollment will continue to increase at current levels (0.1% per month) through the end of FY 2018.



Monthly Results - Summary

Total State Medicaid expenditures under the Medicaid Global Spending Cap for FY 2018 through February was $58 million above projections. Spending through February resulted in total expenditures of $19.003 billion compared to the projection of $18.945 billion.

Medicaid Spending ($ in millions)			
Category of Service	**Estimated**	**Actual**	**Variance Over / (Under)**
Medicaid Managed Care	**$14,592**	**$14,684**	**$92**
Mainstream Managed Care	$9,395	$9,401	$6
Long Term Managed Care	$5,197	$5,283	$86
Total Fee For Service	**$8,024**	**$8,106**	**$82**
Inpatient	$2,514	$2,531	$17
Outpatient/Emergency Room	$315	$312	($3)
Clinic	$429	$432	$3
Nursing Homes	$2,554	$2,574	$20
Other Long Term Care	$547	$582	$35
Non-Institutional	$1,665	$1,675	$10
Medicaid Administration Costs	**$289**	**$266**	**($23)**
OHIP Budget / State Operations	**$371**	**$356**	**($15)**
Medicaid Audits	**($368)**	**($436)**	**($68)**
All Other	**$2,638**	**$2,628**	**($10)**
Local Funding Offset	**($6,601)**	**($6,601)**	**$0**
TOTAL	**$18,945**	**$19,003**	**$58**

Results through February - Variance Highlights

Medicaid Managed Care

Medicaid spending in major Managed Care categories was $92 million over projections.

- Long Term Managed Care was $86 million above projections primarily due to higher than expected enrollment. Through February there were 700 more recipients than anticipated.

Fee-For-Service

Medicaid spending in major fee-for-service categories was $82 million, or 1.0 percent, over projections.

- Other Long Term Care spending was $35 million above projections. There were 3,887 more individuals receiving personal care services than anticipated through February.

- Non-Institutional spending (includes Pharmacy, Medical Supplies, Physicians, Supplemental Medical Insurance, etc.) was $10 million above 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 2018 budget is projected to total $442 million which also includes Essential Plan administration costs.

Contracts for the Enrollment Center, NYSOH Benefit Exchange, Essential Plan, eMedNY/ MMIS, and various MRT initiatives comprise 79 percent ($301 million) of the total non-personal service budget.

OHIP State Operations was $15 million under budget through February.

OHIP Budget FY 2018 ($ in millions)		
Service Costs	**Annual Budget**	**Actual - YTD**
Personal Services	**$40**	**$34**
Non-Personal Services	**$306**	**$240**
Enrollment Center	$113	$99
NYSOH Benefit Exchange	$42	$49
eMedNY/MMIS	$13	$26
Data Warehouse	$10	$12
OHIP Actuarial and Consulting Services	$9	$5
All Payer Database	$9	$2
All Others	$110	$47
Essential Plan	**$96**	**$82**
TOTAL	**$442**	**$385**

All Other

All Other spending was below projections by $10 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 Accounts Receivable collections, and delayed VAP disbursements.

Accounts Receivable

The Accounts Receivable (A/R) ending balance for FY 2017 was $204 million. The State is expected to recoup $135 million by the end of FY 2018, resulting in a projected A/R balance of $69 million by March 2018. Through the end of February, retroactive rates owed to the State were $158 million. This reflects net recoveries of $46 million since March 2017.

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 6,156,115 enrollees at the end of February 2018. This reflects a *net* increase of 40,462 enrollees since March 2017, which is comprised of:

- 8,534 Aliessa individuals previously counted as Medicaid members were converted to the Essential Plan; and
- 48,996 for increased enrollment.

Medicaid Enrollment Summary					
	March 2017	**Converted to EP**	**New Enrollees**	**February 2018**	**Net Increase / (Decrease)**
Managed Care	**4,662,814**	**(8,534)**	**164,282**	**4,818,562**	**155,748**
New York City	2,806,630	(7,366)	108,935	2,908,199	101,569
Rest of State	1,856,184	(1,168)	55,347	1,910,363	54,179
Fee-For-Service	**1,452,839**	**0**	**(115,286)**	**1,337,553**	**(115,286)**
New York City	722,387	0	(91,268)	631,119	(91,268)
Rest of State	730,452	0	(24,018)	706,434	(24,018)
TOTAL	**6,115,653**	**(8,534)**	**48,996**	**6,156,115**	**40,462**
New York City	3,529,017	(7,366)	17,667	3,539,318	10,301
Rest of State	2,586,636	(1,168)	31,329	2,616,797	30,161

Appendix A
Inventory of Rate Packages

Below is the majority of rate packages to be processed in FY 2018:

Category of Service	Rate Package Description	Effective Date	Date Released
Managed Care	January 2016 Mainstream Rates	1/1/2016	May 2017
	July 2016 Mainstream Rates	7/1/2016	May 2017
	April 2017 Mainstream Rates	4/1/2017	September 2017
	July 2016 HARP Rates	7/1/2016	May 2017
	April 2017 HARP Rates	4/1/2017	October 2017
	July 2017 HARP Rates	7/1/2017	
	April 2016 HIV Special Needs Rates	4/1/2016	May 2017
Long Term Managed Care	April 2017 Partial Capitation Rates	4/1/2017	September 2017
	April 2015 HRR Rates	4/1/2015	June 2017
	April 2016 HRR Rates	4/1/2016	
	January 2015 MAP Rates	1/1/2015	July 2017
	January 2016 MAP Rates	1/1/2016	July 2017
	April 2016 PACE Rates	4/1/2016	June 2017
	QIVAPP	4/1/2016	December 2017
	Quality Pools	4/1/2016	October 2017
Inpatient	Acute & Exempt Unit Actual Capital Updates	Various	May 2017
	Acute Rates – Elimination of C-Section Reduction	4/1/2015	
	Acute & Exempt Unit Inpatient Rates	1/1/2017	May 2017
Outpatient / Emergency room	FQHC Hold Harmless	1/1/2016	November 2017
	APG Capital Update	1/1/2017	
Clinic	FQHC Hold Harmless	2/1/2015	June 2017
	EHRS Distribution	Various	October 2017
	UCP Distribution	Various	June 2017
Nursing Home	2018 Initial Rates for Nursing Facilities and ADHC	1/1/2018	
	July 2017 Case Mix Update	7/1/2017	August 2017
	Neurodegenerative	11/1/2016	May 2017

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 2018:

Medicaid Fee for Service Transition to Managed Care (Populations)				
Populations	**From (COS)**	**To (COS)**	**# of FY 2018 Targeted Enrollees**	**FY 2018 Enrolled YTD**
Nursing Homes	Nursing Homes	MMC/MLTC	8,100	6,613
BHO/HARPs	Various	MMC	17,430	20,407

Appendix C

Phase VII MRT Initiatives (http://www.health.ny.gov/health_care/medicaid/redesign/mrt_budget.htm)

Phase VII MRT Initiatives ($ in millions)	
Initiative	**SFY 18 Impact**
Medicare Part B and Part D Increases	175.4
ACA Over Claim Repayment	59.0
Compliance with Covered Outpatient Drug Rule and Copay Provisions	5.5
Mental Hygiene Stabilization Fund	(267.0)
Total Federal Actions/Pressures on GC	**(27.1)**
Enhanced Program Integrity for Opioids / Controlled Substances	(1.4)
Control Exorbitant Prescription Drug Costs	(55.0)
Conduct Comprehensive Clinical Editing	(0.4)
Generic CPI Penalty Adjustment - 75%	(8.8)
Total Pharmacy Savings	**(65.6)**
Ban MLTC Marketing	(3.0)
Adjustment of End-of-Life Services for Medicare	(4.4)
Implementation of a Plan Fining Mechanism for DLTC	(2.0)
Balancing Incentive Program to support FLSA	(35.0)
Eliminate Bed Hold Payment	(10.3)
Reduce MLTCP Quality Bonus	(15.0)
Total LTC Savings	**(69.7)**
Require Medicare Coverage as a Condition of Medicaid Eligibility	(25.5)
Reduction in Mainstream Managed Care Quality Bonus	(20.0)
Reduction in Number of VBP Pilots	(5.0)
Reduce Payments to Plans for Facilitated Enrollment	(10.0)
Total Managed Care Savings	**(60.5)**
Reduce 911 "Frequent Flier" calls	(4.2)
Transportation Manager savings	(8.0)
Total Transportation Care Savings	**(12.2)**
Reduction of BIP Funds (No Wrong Door/NY Connects)	(4.0)
Increase Penalty for Early Elective Deliveries	(1.5)
Continued Medicaid Coverage Review	(5.0)
Enhanced Claim Editing for Emergency Services Only	(2.5)
Reduce VAPAP/VBP-QIP	(15.0)
Realign Children's SPA and MC implementation	(10.0)
NYC Administrative Efficiencies	(55.0)
DOH Global Cap Admin	(8.0)
PCMH Enhanced Funding Reduction	(10.0)
Reduce Hospital Quality Pool	(15.0)
Reduce Supportive Housing	(20.0)
Total Other	**(146.0)**
Medicaid Reestimate / DSRIP Savings	(25.0)
Additional Accounts Receivable	(10.1)
Health Homes Reduction	(10.0)
Total Legislative Avails	**(45.1)**
Enhanced Safety Net Hospital Program	10.0
Women's Health Prenatal Care	5.0
SUNY DSH	9.3
Critical Access Hospitals	10.0
Monroe County NH	0.9
Wage Parity for CDPAP Assistants	9.0
Total Legislative Adds	**44.2**
TOTAL	**(382.0)**

Appendix D
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 2018 for each region.

Medicaid Regional Spending ($ in millions)	
Economic Region	**Non-Federal Total Paid**
New York City	$14,807
Long Island	$2,345
Mid-Hudson	$2,333
Western	$1,234
Finger Lakes	$1,036
Capital District	$854
Central	$618
Mohawk Valley	$529
Southern Tier	$469
North Country	$342
Out of State	$108
TOTAL	**$24,676**

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/

Appendix E

Medicaid Drug Cap

- The State Fiscal Year 2018 Enacted Budget establishes a Medicaid Drug Cap that will limit pharmacy spending growth in the Medicaid program to the 10-year rolling average of the medical component of the consumer price index plus five percent (8.2% in the current year), less $55 million in state share savings in SFY 2018.

- If the Budget Director determines that expenditures will exceed the annual growth limitation imposed by the Medicaid Drug Cap, the Commissioner of Health may refer drugs to the State's Drug Utilization Review Board (DURB) for a recommendation as to whether a supplemental rebate should be paid by the manufacturer.

- If the Department intends to refer drugs to the DURB, it will notify affected manufacturers and will attempt to reach agreement on rebate amounts prior to DURB referral.

- In determining whether to recommend a target supplemental rebate for a drug the DURB must consider the cost of the drug to the NYS Medicaid program and may consider, among other things: the drug's impact on the Medicaid drug spending, significant and unjustified increases in the price of the drug, and whether the drug may be priced disproportionally to its therapeutic benefits.

- In formulating a recommendation, the DURB may consider, among other things: publicly available and DOH supplied pricing information, the seriousness and prevalence of the disease or condition being treated, Medicaid utilization, the drug's effectiveness or impact on improving health, quality of life or overall health outcomes, the likelihood that the drug will reduce the need for other medical care (including hospitalization), the average wholesale price, wholesale acquisition cost, and retail price of the drug, and the cost of the drug to Medicaid minus rebates.

- If after the DURB recommends a target rebate amount, DOH and the manufacturer are unable to reach agreement regarding supplemental rebate amounts, the manufacturer will be required to provide DOH with certain information including but not limited to marketing, research, and development costs for the drug.

- The Executive is currently working to implement the Medicaid Drug Cap.

Appendix F

Material Events

- Delay in implementation of new Children services (from 10/1/17 to 7/1/18)
  - New services place an emphasis on early intervention for children experiencing behavioral health challenges before they rise to the level of needing high intensity clinical services.
  - Includes Community Psychiatric Support and Treatment, Psychosocial Rehabilitation Services, Crisis Intervention, Family Peer Support Services, Youth Peer Training and Support Services, and Other Licensed Practitioners.
- Delay of new Community First Choice Option services (from 7/1/17 to 1/1/19)
  - Requires MLTC plans to expand and/or enhance the current benefit package to include all services and supports within the CFCO for adults age 21 and over.
- Bed Hold Reimbursement
  - The Enacted Budget included language to eliminate the payment for bed hold days for nursing homes effective April 1, 2017. The Department has not implemented the elimination of bed hold reimbursement at this time.
- OIG released an audit report indicating that NYS improperly made payments to MLTC plans that failed to comply with contract rules.
  - DOH has issued several new policies and procedures to monitor MLTC plans for compliance to address deficiencies sited in the audit report.
  - DOH is currently working with OMIG to review the records that were subject to the audit.
- VBP Stimulus for MLTC program
  - Provides stimulus funding to support all MLTC plans with VBP contracting in place.
- The Global Cap was increased to reflect an update to the ten-year average of the Medical Care Consumer Price Index, which went from 3.2 percent to 3.3 percent, resulting in an increase of $11 million.

Appendix G

State-only Payments (YTD)

Payments	Non Federal Total Paid
Major Academic Pool	$24,500,000
VAPAP	$49,694,763
Supportive Housing	$35,430,484
Alzheimer's Caregiver Support	$22,823,201
End of AIDS	$16,191,731
MLTC Ombudsman	$4,616,689
BH Transformation Non-VAP	$5,449,548
CSEA Buy-in	$1,093,655
Water Fluoridation	$1,259,783
Primary Care Service Corps	$285,743
UFT Buy-in	$52,053
MLTC Technology Demonstration	$0
TOTAL	**$161,397,648**