NEW YORK STATE | Department of Health

Medicaid Global Spending Cap Report

March 2018

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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 2018 Medicaid Global Spending Cap was $6 million below the $19.5 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 has transitioned a number of populations and benefits into the Managed Care setting.

- 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;

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

- Continuing 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); and

- Providing additional funding to Critical Access Hospitals.

In summary, this is the seventh 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.

Monthly Results - Summary

Total State Medicaid expenditures under the Medicaid Global Spending Cap for FY 2018 through March was $6 million below projections. Spending through March resulted in total expenditures of $19.522 billion compared to the projection of $19.528 billion.

Medicaid Spending ($ in millions)			
Category of Service	**Estimated**	**Actual**	**Variance Over / (Under)**
Medicaid Managed Care	**$15,825**	**$15,962**	**$137**
Mainstream Managed Care	$10,179	$10,150	($29)
Long Term Managed Care	$5,646	$5,812	$166
Total Fee For Service	**$8,274**	**$8,435**	**$161**
Inpatient	$2,595	$2,646	$51
Outpatient/Emergency Room	$336	$340	$4
Clinic	$449	$468	$19
Nursing Homes	$2,727	$2,760	$33
Other Long Term Care	$587	$633	$46
Non-Institutional	$1,580	$1,588	$8
Medicaid Administration Costs	**$424**	**$286**	**($138)**
OHIP Budget / State Operations	**$442**	**$384**	**($58)**
Medicaid Audits	**($368)**	**($470)**	**($102)**
All Other	**$2,082**	**$2,076**	**($6)**
Local Funding Offset	**($7,151)**	**($7,151)**	**$0**
TOTAL	**$19,528**	**$19,522**	**($6)**

Results through March - Variance Highlights

Medicaid Managed Care

Medicaid spending in major Managed Care categories was $137 million over projections.

- Long Term Managed Care was $166 million above projections primarily due to higher than expected enrollment. Through March there were approximately 400 more recipients in the program than anticipated, resulting in increased costs. Additionally, there were Federal offsets and cash advances to several plans that the State assumed in this fiscal year; however, due to timing these will be collected in the next fiscal year.

Fee-For-Service

Medicaid spending in major fee-for-service categories was $161 million, or 1.9 percent, over projections.

- Inpatient spending was $51 million above projections. The main factor driving higher costs was related to the reimbursement of emergency services only. Medicaid payments for the treatment of emergency medical conditions increased by close to $30 million, or 8 percent, from the prior year.

- Other Long Term Care spending was $46 million above projections. There are 4,430 more individuals receiving personal care services than anticipated through March.

- Nursing Homes spending was $33 million above projections. This is primarily driven by a slower transition into Long Term Managed Care than assumed. The State estimated that 8,100 individuals would transition into Managed Care throughout the fiscal year, but only 6,832 Medicaid recipients actually enrolled in a Managed Care plan.

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 $57 million under budget through March.

OHIP Budget FY 2018 ($ in millions)		
Service Costs	**Annual Budget**	**Actual - YTD**
Personal Services	**$40**	**$37**
Non-Personal Services	**$306**	**260**
Enrollment Center	$113	$101
NYSOH Benefit Exchange	$42	$59
eMedNY/MMIS	$13	$29
Data Warehouse	$10	$13
OHIP Actuarial and Consulting Services	$9	$6
All Payer Database	$9	$2
All Others	$110	$50
Essential Plan	**$96**	**$88**
TOTAL	**$442**	**$385**

All Other

All Other spending was below projections by $4 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 March, retroactive rates owed to the State were $224 million. This reflects net increases of $20 million since March 2017. There were several rate packages implemented in March that resulted in provider rate reductions, which increased the A/R balances. The increase to A/R will be recovered over the course of next fiscal year.

Enrollment

Medicaid Enrollment

Medicaid total enrollment reached 6,164,818 enrollees at the end of March 2018. This reflects a *net* increase of 49,165 enrollees since March 2017, which is comprised of:

- 9,695 Aliessa individuals previously counted as Medicaid members were converted to the Essential Plan; and
- 58,860 for increased enrollment.

Medicaid Enrollment Summary					
	March 2017	**Converted to EP**	**New Enrollees**	**March 2018**	**Net Increase / (Decrease)**
Managed Care	**4,662,814**	**(9,695)**	**112,097**	**4,765,216**	**102,402**
New York City	2,806,630	(8,381)	32,243	2,830,492	23,862
Rest of State	1,856,184	(1,314)	79,854	1,934,724	78,540
Fee-For-Service	**1,452,839**	**0**	**(53,237)**	**1,399,602**	**(53,237)**
New York City	722,387	0	(8,228)	714,159	(8,228)
Rest of State	730,452	0	(45,009)	685,443	(45,009)
TOTAL	**6,115,653**	**(9,695)**	**58,860**	**6,164,818**	**49,165**
New York City	3,529,017	(8,381)	24,015	3,544,651	15,634
Rest of State	2,586,636	(1,314)	34,845	2,620,167	33,531

Appendix A
Inventory of Rate Packages

Below is the majority of rate packages 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	March 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
	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 & Exempt Unit Inpatient Rates	1/1/2017	May 2017
Outpatient / Emergency room	FQHC Hold Harmless	1/1/2016	November 2017
Clinic	FQHC Hold Harmless	2/1/2015	June 2017
	EHRS Distribution	Various	October 2017
	UCP Distribution	Various	June 2017
Nursing Homes	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 that transitioned 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	6,832
BHO/HARPs	Various	MMC	17,430	21,458

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 March 2018 for each region.

Medicaid Regional Spending ($ in millions)	
Economic Region	**Non-Federal Total Paid**
New York City	$16,155
Long Island	$2,538
Mid-Hudson	$2,533
Western	$1,343
Finger Lakes	$1,132
Capital District	$927
Central	$680
Mohawk Valley	$575
Southern Tier	$514
North Country	$373
Out of State	$117
TOTAL	**$26,887**

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.

Appendix F

Material Events

- Delay in implementation of new Children services (from 10/1/17 to 1/1/19)
  - New services place an emphasis on earlier 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
VAPAP	$58,767,172
ACA FFP Correction	$56,000,000
Supportive Housing	$46,989,123
Major Academic Pool	$24,500,000
Alzheimer's Caregiver Support	$24,484,323
End of AIDS	$17,834,464
BH Transformation Non-VAP	$5,449,548
MLTC Ombudsman	$4,616,689
CSEA Buy-in	$1,402,702
Water Fluoridation	$1,292,449
Primary Care Service Corps	$297,743
UFT Buy-in	$52,053
MLTC Technology Demonstration	$42,400
TOTAL	**$241,728,665**