Department of Health

Medicaid Global Spending Cap Report

October 2018

Table of Contents

Overview 2

Medicaid Global Spending Cap Annual Budget 3

Monthly Results - Summary & Variance Highlights 7

Medicaid Enrollment..9

Appendices

A. Inventory of Rate Packages 10

B. *Beneficiary Transition Schedule*...12

C. *Phase VI MRT Initiatives*..13

D. *Regional Spending Data* 15

E. *Medicaid Drug Cap*...16

F. State-only Payments 17

Overview

Pursuant to legislation, the Medicaid Global Spending Cap has increased from $19.5 billion in FY 2018 to $20.8 billion (including the Essential Plan) in FY 2019, an increase of 6.7 percent. The CPI used on Medicaid services subject to the trend was 3.2 percent (ten-year rolling average of the Medical Care Consumer Price Index). The annual growth in the Global Cap of $1.3 billion 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 $448 million for minimum wage rate adjustments. Components of the annual growth are as follows:

Component	Details
Price (+$1.03 billion)	• Trend increases for mainstream managed care rates ($362 million) and long term managed care rates ($70 million); • Various FFS rate packages ($154 million); and • Minimum Wage Adjustment ($448 million).
Utilization (+$275 million)	• Annualization of 2017-18 enrollment; and • New enrollment for 2018-19 (7,254 NH eligibles; 11,735 community-based).
MRT/One Timers/Other ($12 million)	• ACA enhanced FMAP (-$224 million) • Accounts Receivable Collections (-$194 million); offset by • Removal of CY 2016 Essential Plan Medical Loss Ratio ($262 million); • ATB Restoration ($58 million); • Removal of one-time audit settlement ($42 million); and • New CFCO services ($25 million).

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 $20.8 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 are based on FY 2018 year-end 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	**$17,146**	**($401)**	**$16,745**
Mainstream Managed Care	$10,353	($345)	$10,008
Long Term Managed Care	$6,793	($56)	$6,737
Fee For Service	**$6,740**	**$1,118**	**$7,858**
Acute Care	$2,506	$759	$3,265
Long Term Care	$3,113	$56	$3,169
Non-Institutional	$1,121	$303	$1,424
Medicaid Administration Costs	**$0**	**$570**	**$570**
OHIP Budget / State Operations	**$0**	**$458**	**$458**
Medicaid Audits	**$0**	**($351)**	**($351)**
Other State Agency	**$3,481**	**($670)**	**$2,811**
All Other	**$0**	**($181)**	**($181)**
Local Cap Contribution	**$0**	**($7,094)**	**($7,094)**
TOTAL	**$27,367**	**($6,551)**	**$20,816**

Major Offline Components

Medicaid Managed Care (-$401 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 2018, and Quality Pool payments.

Fee For Service (+$1,118 million)

- *Acute Care* includes payments for Disproportionate Share Hospital, Upper Payment Limit, SUNY IGT, and the Major Academic Pool.
- *Long Term Care* includes the 4th 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 (+$419 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 over 80 percent of the total non-personal service budget. The chart below shows the annual budget for FY 2019 State Operations:

OHIP Budget ($ in millions)	
Service Costs	**Budget**
Personal Services	$51
Non-Personal Services	$281
Essential Plan Administration	$87
TOTAL	**$419**

All Other (-$181 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 2018)**	**FY 2019 Budget**
Hospitals/CAHs	$225	$144	$52
Nursing Homes	$125	$116	$9
Diagnostic & Treatment Centers	$18	$18	--
Certified Health Home Agencies/LHCSA	$4	$4	--
Behavioral Health	$74	$49	$25
Sub-Total	**$446**	**$331**	**$86**
Pending VAP Requests	--	--	$5
Total			**$91**

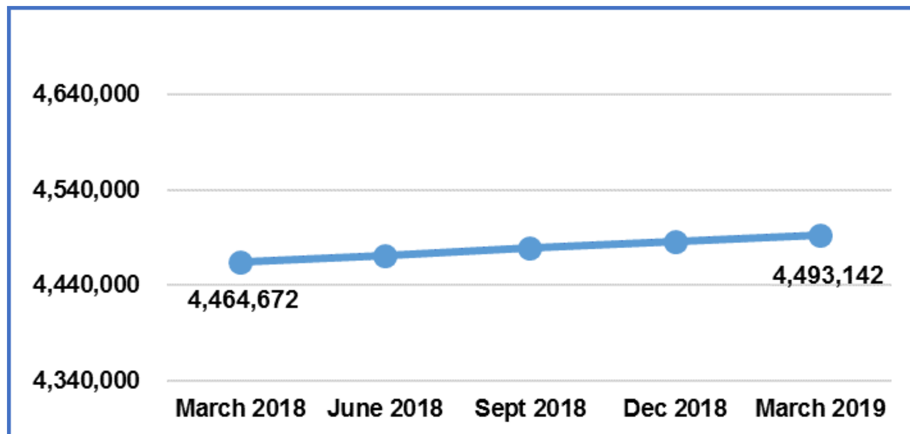
- **Supportive Housing:** The Supportive Housing Initiative seeks to ensure that Medicaid members have proper housing that promotes a healthy environment and lifestyle, and leads to improved health outcomes.

Supportive Housing Allocation Plan ($ in millions)	
	Allocation Plan
Capital Funding	$2
New Supportive Housing Pilot Projects	$21
Rental/Service	$39
Tracking & Evaluation	$1
TOTAL	**$63**

Annual Enrollment Estimates

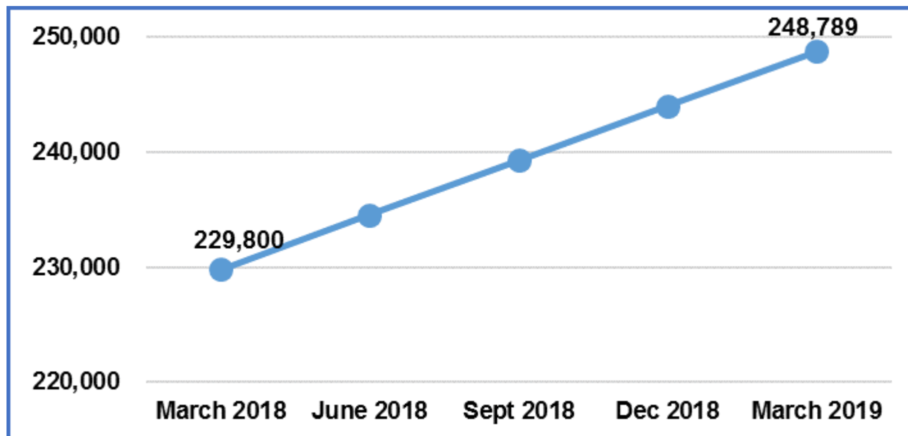
Mainstream Managed Care (includes HIV/SNPs and BHO/HARPs)

Mainstream Managed Care (MMC) enrollment is expected to remain relatively flat, increasing by slightly less than 30,000 enrollees (0.6%) throughout the year. This includes continued transition of eligible recipients to a Health and Recovery Plan (HARP).



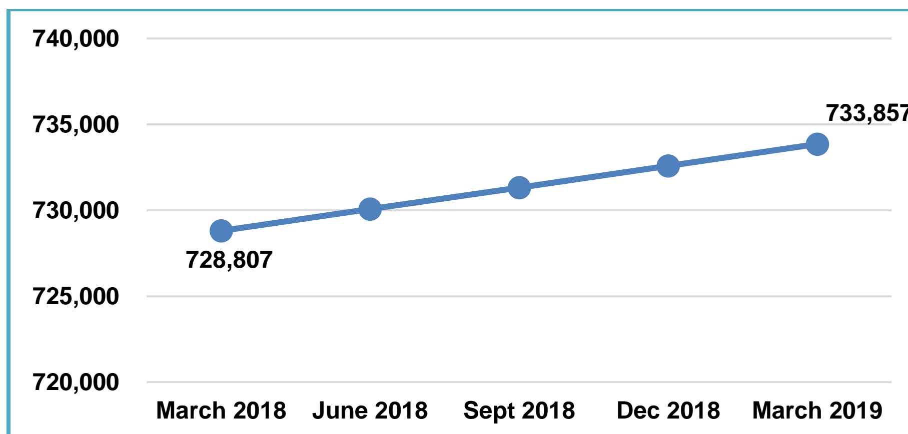
Long Term Managed Care (includes PACE, FIDA, MA and MAP)

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 2018, MLTC enrollment reached 229,800, an increase of 28,190 individuals. Of those individuals, about 6,800 were Nursing Home eligibles. The FY 2019 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 2018, enrollment in the Essential Plan was 728,807. 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 remain stable through the end of FY 2019, increasing by 0.7%.



Monthly Results - Summary

Through October, total State Medicaid expenditures under the Medicaid Global Spending Cap for FY 2019 were $49 million above projections. Spending through October resulted in total expenditures of $13.857 billion compared to the projection of $13.808 billion.

Medicaid Spending ($ in millions)			
Category of Service	**Estimated**	**Actual**	**Variance Over / (Under)**
Medicaid Managed Care	**$10,451**	**$10,500**	**$49**
Mainstream Managed Care	$6,341	$6,351	$10
Long Term Managed Care	$4,110	$4,149	$39
Total Fee For Service	**$5,125**	**$5,212**	**$87**
Inpatient	$1,652	$1,652	$0
Outpatient/Emergency Room	$198	$195	($3)
Clinic	$278	$291	$13
Nursing Homes	$1,566	$1,593	$27
Other Long Term Care	$406	$412	$6
Non-Institutional	$1,025	$1,069	$44
Medicaid Administration Costs	**$358**	**$365**	**$7**
OHIP Budget / State Operations	**$235**	**$218**	**($17)**
Medicaid Audits	**($219)**	**($220)**	**($1)**
All Other	**$2,087**	**$2,011**	**($76)**
Local Funding Offset	**($4,229)**	**($4,229)**	**$0**
TOTAL	$13,808	$13,857	$49

Results through October - Variance Highlights

Medicaid Managed Care

Medicaid spending in major Managed Care categories was $49 million over projections.

- Long Term Managed Care was $39 million above estimates through October primarily due to higher than expected enrollment. There were roughly 7,000 more individuals enrolled in the MLTC partial capitation plan than budgeted.

Fee-For-Service

Medicaid spending in major fee-for-service categories was $87 million, or 1.7 percent, over projections.

- *Clinic* spending was $13 million above projections. Total claims billed were 10.8 percent higher than anticipated through October.
- *Non-Institutional* spending (includes Pharmacy, Medical Supplies, Physicians, Supplemental Medical Insurance, etc.) was $44 million above projections. This is the result of higher than expected utilization for Transportation services.

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 2019 budget is projected to total $419 million which also includes Essential Plan administration costs.

Contracts for the Enrollment Center, NYSOH Benefit Exchange, eMedNY/ MMIS, and various MRT initiatives comprise over 80 percent of the total non-personal service budget.

OHIP State Operations was $17 million below projections through October.

OHIP Budget FY 2019 ($ in millions)		
Service Costs	**Annual Budget**	**Actual - YTD**
Personal Services	**$51**	**$23**
Non-Personal Services	**$281**	**$153**
Enrollment Center	$106	$57
NYSOH Benefit Exchange	$71	$30
eMedNY/MMIS	$31	$23
All Payer Database	$15	$0
Data Warehouse	$10	$8
OHIP Actuarial and Consulting Services	$12	$2
All Others	$36	$33
Essential Plan	$87	$42
TOTAL	**$419**	**$218**

All Other

All Other spending was below projections by $76 million. The All Other category includes a variety of Medicaid payments and offsets. The underspending is primarily attributed to the timing of Accounts Receivable collections, and Affordable Housing disbursements.

Accounts Receivable

The Accounts Receivable (A/R) ending balance for FY 2018 was $224 million. The State is expected to recoup $174 million by the end of FY 2019, resulting in a projected A/R balance of $50 million by March 2019. Through the end of October, retroactive rates owed to the State were $137 million. This reflects net recoveries of $90 million since March 2018.

The Department of Health is engaged in an initiative to eliminate all currently outstanding retroactive rate 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 6,179,628 enrollees at the end of October 2018. This reflects a *net* increase of 31,594 enrollees since March 2018, which is comprised of:

Medicaid Enrollment Summary			
	March 2018	**October 2018**	**Net Increase / (Decrease)**
Managed Care	**4,768,062**	**4,713,861**	**(54,201)**
New York City	2,832,697	2,797,474	(35,223)
Rest of State	1,935,365	1,916,387	(18,978)
Fee-For-Service	**1,379,972**	**1,465,767**	**85,795**
New York City	698,493	755,747	57,254
Rest of State	681,479	710,020	28,541
TOTAL	**6,148,034**	**6,179,628**	**31,594**
New York City	3,531,190	3,553,221	22,031
Rest of State	2,616,844	2,626,407	9,563

Appendix A
Inventory of Rate Packages

Below is the majority of rate packages to be processed in FY 2019:

Category of Service	Rate Package Description	Effective Date	Date Released
Managed Care	April 2018 Mainstream Rates	4/1/2018	September 2018
	July 2018 Mainstream Rates	7/1/2018	
	October 2018 Mainstream Rates	10/1/2018	
	April 2018 HARP Rates	4/1/2018	September 2018
	July 2018 HARP Rates	7/1/2018	
	October 2018 HARP Rates	10/1/2018	
	April 2018 HIV SNP Rates	4/1/2018	
	CY 2018 EP Rates	4/1/2018	
	January 2019 EP rates	1/1/2019	
Long Term Managed Care	April 2018 Partial Capitation Rates	4/1/2018	August 2018
	July 2018 Partial Capitation Rates	7/1/2018	
	October 2018 Partial Capitation Rates	10/1/2018	
	January 2019 Partial Capitation Rates	1/1/2019	
	April 2018 MAP Rates	4/1/2018	
	April 2018 PACE Rates	4/1/2018	
	QIVAPP	4/1/2018	
	Quality Pools	Various	June 2018
	April 2018 FIDA Rates	4/1/2018	
Inpatient	Acute & Exempt Unit Actual Capital Updates	Various	May 2018
	Acute Rates – Elimination of C-Section Reduction	4/1/2015	
	Acute & Exempt Unit Inpatient Rates	1/1/2018	
	July 2018 Statewide Inpatient Rates	7/1/2018	
	January 2019 Statewide Inpatient Rates	1/1/2019	
Outpatient / Emergency room	FQHC Hold Harmless	1/1/2017	
	APG Capital Update	Various	
	Home Health Agency Rates	Various	
Clinic	FQHC Hold Harmless	1/1/2017	
	APG Capital Update	Various	
	2018 Minimum Wage Add-on	1/1/2018	August 2018
	2019 Minimum Wage Add-on	1/1/2019	
	FQHC 2018 MEI Appeal	10/1/2018	

Nursing Home	2018 Initial Rates for Nursing Facilities and ADHC	1/1/2018	May 2018
	2019 Initial Rates for Nursing Facilities and ADHC	1/1/2019	
	July Case Mix Rates	7/1/2018	July 2018
	2017 Cash Assessments Reconciliation	1/1/2017	

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 (BHO/HARP's), as well as fully integrated plans for Medicare/Medicaid "dual eligibles". The chart below outlines the list of populations scheduled to transition into the care management setting during FY 2019:

Medicaid Fee for Service Transition to Managed Care (Populations)				
Populations	**From (COS)**	**To (COS)**	**# of FY 2019 Targeted Enrollees**	**FY 2019 Enrolled**
Nursing Homes	Nursing Homes	MMC/MLTC	7,254	2,213
BHO/HARPs	Various	MMC	23,389	24,172

Appendix C

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

Phase VIII MRT Initiatives ($ in millions)	
Initiative	**FY 2019**
Global Cap Target	$425.0
Global Cap Base Deficit	$0.0
Nursing Home 1% ATB (4 year payback)	$35.0
Enrollment Reconciliation	$10.0
Additional Funding for VAPAP/VBPQIP	$45.4
Outstanding Federal Obligations	$133.0
Total Federal Actions/Pressures on GC	**$648.4**
Convert VBP-QIP / Other Supplemental programs to Essential Plan	($281.5)
Total Essential Plan Initiatives	**($281.5)**
Update Professional Dispensing Fee	$0.4
Reduce Opioid Dispensing by 20% by 2020	($1.1)
Medication Adherence	($5.0)
Rebate Risk Assessment	($15.0)
Total Pharmacy Savings	**($20.7)**
Implement a penalty on poor performing Nursing Homes	($7.7)
Rationalize Nursing Homes Case Mix Index Increases	($7.5)
Admin Rate Reduction/Regulation Relief	($18.9)
Expand Access to Assisted Living Program Services (ALPs)	$4.4
Require a Continuous 120 days of Community Based Long Term Care (CBLTC) for Continuing Plan eligibility	($4.8)
Prohibit Fiscal Intermediary (FI) Bad Actors that Advertise False or Misleading Information.	($4.9)
Licensed Home Care Services Agencies (LHCSA) Contract Limits w/ MLTC Plans, Review, Registration, & Moratorium	($13.7)
Social Adult Day Health Benefit Efficiency Savings	($28.1)
Restrict MLTC Members from Transitioning from Plan to Plan for 12 Months After Initial Enrollment	($5.2)
Authorization vs. Utilization Adjustment for MLTC	($1.2)
Limit MLTC Eligibility to < 3 Months in NHs	($79.0)
Traumatic Brain Injury (TBI) Clinic Rate Adjustment	$0.4
Additional Hospice Funding	$0.9
Rural County Provider funding	$1.5
Total LTC Initiatives	**($163.9)**
Increase Current Penalties for Managed Care Plans that Fail to Meet Value Based Payments (VBP) targets	($10.0)
Reduce FFS/MCO Rate for Providers Without VBP Contracts	($7.5)
Reduce Overutilization of Laboratory Services	($7.5)

Total Managed Care Savings	**($25.0)**
Criminal Background Checks	$1.1
Penalty for Failure to Enroll High Risk Plan Members in Health Homes	($15.0)
Health Home Healthy Rewards Program	($15.0)
Redirect Outreach Resources to Increase HH Enrollment of High Risk Members	($4.4)
Total Health Home Initiatives	**($33.3)**
Reduce Accounts Receivable Balances	($12.6)
MC Pilot to Improve Access to Clozapine	($2.0)
Best Practices in ER Diversion & Inpatient Discharge	($4.5)
Reducing Unnecessary Utilization - Physical Therapy Cap	$2.3
Correct Ambulatory Patient Group (APG) Weights for IV Infusion/Hydration Bags	($5.0)
Remove Originating Site Requirement from Telehealth Program	($5.0)
OMIG Savings Initiatives	($25.0)
First One Thousand Days	$1.5
Ambulance Fee Increase	$6.3
Total Other	**($44.1)**
Increased MRT/Safety Net Inter-Governmental Transfer (IGT)	($46.3)
MCO Tax Repeal	($3.9)
Telehealth Expansion	($10.0)
Health Homes - Quality Improvements	($10.0)
Maximus Contract - 3-year Extension	($15.0)
Claims Editing Enhancements	($17.0)
Proportionally Reduce Managed Care Quality Pools	($13.0)
Total Legislative Avails	**($115.2)**
Reimbursement rates for Crouse Community Center	$0.4
Hepatitis C Investment	$5.0
Safety Net (50% Safety Net 50% CHA & SCH)	$30.0
Total Legislative Adds	**$35.4**
TOTAL	**$0.0**

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 October 2018 for each region.

Medicaid Regional Spending ($ in millions)	
Economic Region	**Non-Federal Total Paid**
New York City	$10,193
Long Island	$1,573
Mid-Hudson	$1,542
Western	$825
Finger Lakes	$693
Capital District	$571
Central	$422
Mohawk Valley	$348
Southern Tier	$313
North Country	$227
Out of State	$66
TOTAL	**$16,773**

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 established 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 four percent (7.2% in the current year), less $85 million in state share savings in FY 2019.

- 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.

- In the first year of implementation, the Medicaid Drug Cap successfully achieved the $55 million state share statutory savings target. The Department was able to establish processes for evaluating on-going drug spend and determining the budget impact of high cost drugs. The NYS Medicaid Drug Cap has achieved national recognition for its unique approach to addressing growth in Medicaid drug spending.

Appendix F
State-only Payments (YTD)

Payments	Non Federal Total Paid
VAPAP	$36,448,860
Supportive Housing	$24,960,629
Major Academic Pool	$24,500,000
Alzheimer's Caregiver Support	$14,459,558
End of AIDS	$7,921,093
MLTC Ombudsman	$4,607,455
Rural Transportation	$4,000,000
CSEA Buy-in	$1,233,520
UFT Buy-in	$1,181,434
BH Transformation Non-VAP	$922,500
Water Fluoridation	$300,152
MLTC Technology Demonstration	$111,017
Primary Care Service Corps	$90,108
Assisted Living Voucher Demo	$60,068
TOTAL	**$120,796,394**