Comments on Medicaid Global Spending Cap Calculations and Partnership

The Medicaid global spending cap is a centerpiece of Medicaid redesign, and is significantly changing the relationships between the state and providers, between risk contractors and providers, and among providers. Over several years, Medicaid has emerged as the *de facto* insurance program for long term care (LTC), leading to a high degree of reliance on Medicaid funding for these services. Accordingly, the global cap and "partnership" between the state and providers is a particularly compelling issue for the future of LTC services and supports.

Global Spending Cap Calculations

1. ***The formula for annual adjustments to the global cap should be reviewed.*** Year-to-year adjustments to the cap are based on the 10-year average growth rate in the medical component of the consumer price index (CPI), which is a measure of price inflation in health care. However, changes in the cap are not being used to adjust payments to risk contractors and providers to reflect changes in input costs. Rather, the cap limits total state share Medicaid health spending which is, in turn, affected by a complex array of variables including changes in: (1) Medicaid enrollment; (2) patient acuity; (3) composition of services; and (4) payment arrangement (i.e., fee for service vs. managed care).

   A 10-year moving average of the CPI-medical services offers advantages and disadvantages. It will tend to provide greater stability year-to-year, but be less reactive to year-to-year changes in the economy and Medicaid expenditures. It is relevant to health care price inflation, but is not a relevant proxy for macroeconomic factors such as enrollment growth or changes in economic capacity to pay. Adding to the complexity is that Medicaid is a counter-cyclical program, with demands on the program greatest when the economic capacity to support the program is diminished. The proxy currently in use and the manner in which it is applied (i.e., 10-year moving average) should be systematically evaluated, with an eye towards balancing these realities.

2. ***Forecast changes in Medicaid enrollment should be built into, or alternatively excluded from, the cap.*** Enrollment growth (e.g., expansions due to federal mandates or economic downturns, etc.) is largely if not entirely outside of the control of the provider community, and yet providers would likely have to bear the brunt of dealing with the issue if the cap were breached. The state's forecast change in enrollment and associated costs should be built into the annual global cap amounts on top of the change to the CPI-medical services or, alternatively, excluded from the cap calculations.

3. ***Other items should be excluded from the cap calculations.*** As discussed in the workgroup, the state should consider excluding the following expenditures from the cap: (1) retroactive

payments; (2) state matching funds related to the proposed MRT waiver; and (3) payments specifically associated with natural disasters/declared emergencies.

4. ***Any universal appeals/litigation settlement should specifically be excluded from the cap.*** With further regard to retroactive payments, we recommend that any payments associated with the proposed universal settlement of nursing home rate appeals and litigation be excluded from the cap. This settlement – if executed – relates to amounts owed to facilities from time periods that pre-date the global cap by several years in many cases.

5. ***Further information should be provided on the annual category of service estimates.*** How the state develops its spending projections for each category of service may have a bearing on whether a certain type of provider could face a non-uniform cut if the global cap is exceeded. Further information on the bases for these estimates – including material assumptions such as estimated service units, unit costs of services and transitions from fee-for-service to Medicaid managed care – would foster a better understanding of projected spending by category and likely enhance confidence in the estimates.

6. ***The state should confirm that other spending offsets are included in the cap calculations.*** These offsets include recoveries related to: (1) audit activities by entities other than the OMIG, such as the Medicaid Fraud Control Unit of the Attorney General's office and federal recovery audit contractors; and (2) local social services district recoveries (e.g., estates, etc.).

The Global Cap Partnership

The cap is intended to represent a partnership among providers, insurers and the state. However, the recently proposed amendments to the Executive Budget raise potential concerns about the future of the partnership. At the same time, a partnership offers opportunities for shared savings and strategic investments in health care and collateral infrastructure.

1. ***Health care providers should not effectively bear the burden of lost federal funding.*** We appreciate the budgetary challenge of the loss of federal funding for developmental disabilities services, and that the solution proffered by the Executive would not result in direct Medicaid cuts to health care providers. However, health care providers would: (1) relinquish $200 million of under-spending in SFY 2012-13 that arguably should have been shared with them; (2) go without or have delayed various sources of federal/other funding and added MRT investments that would have otherwise benefited them in SFY 2013-14; and (3) be more exposed to a potential breach of the global cap in SFY 2013-14. Inasmuch as this has created a general fund shortfall, we believe that the burden should be shared more widely across the state budget.

2. ***If there is a full or partial restoration of the trend factor cut to developmental disability services, a proportionate restoration should be made to Medicaid health care funding.*** This restoration could be used to accelerate restoration of the 2% across-the-board cut and/or to reverse one or more elements of the proposed savings plan.

3. ***An inflationary adjustment to provider and plan rates is long overdue.*** Most Medicaid providers have not received such an adjustment to their payments since 2009, despite continuing increases in labor and other input costs. Whether such adjustments are conferred

entirely through inflationary proxies or partially through performance-based measures, this should be considered a priority among potential shared savings initiatives.

4. ***Quality pools should be funded with shared savings or waiver dollars and not out of Medicaid base rates.*** Quality enhancements require strategic investments. Basic Medicaid payments for most LTC services are less than the actual costs of providing those services. Removing further funding from the base (e.g., the $50 million nursing home quality pool) may actually detract from quality among the providers that stand to lose funding. Quality payments should be funded from shared MRT savings, the MRT waiver and/or other sources.

5. ***Federal funds from rebalancing should be reinvested in LTC services.*** An Executive Budget proposal would implement a "balancing incentive program" which, if approved, would provide an estimated $600 million of enhanced federal funding. These funds should be earmarked for reinvestment in the state's home and community-based services infrastructure, which has been decimated by cuts and program changes in recent years.

LeadingAge NY looks forward to continuing to work with the Executive, the Department of Health and state lawmakers to realize the full potential of a partnership on Medicaid spending.

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