NEW YORK STATE | Department of Health

Medicaid Global Spending Cap Report

April 2022 through December 2022 Quarterly Report

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Overview

The Medicaid Global Spending Cap increased from $22.3 billion in Fiscal Year (FY) 2022 to $26.1 billion in FY 2023, a net increase of $3.9 billion. The FY 2023 Enacted Budget included the modification of the Global Cap metric moving from the 10-year rolling average of the medical component of the Consumer Price Index (CPI) to the 5-year rolling average of the Medicaid annual growth rate within the National Health Expenditure Accounts produced by the Office of the Actuary in the Centers for Medicare and Medicaid Services (CMS).[1]

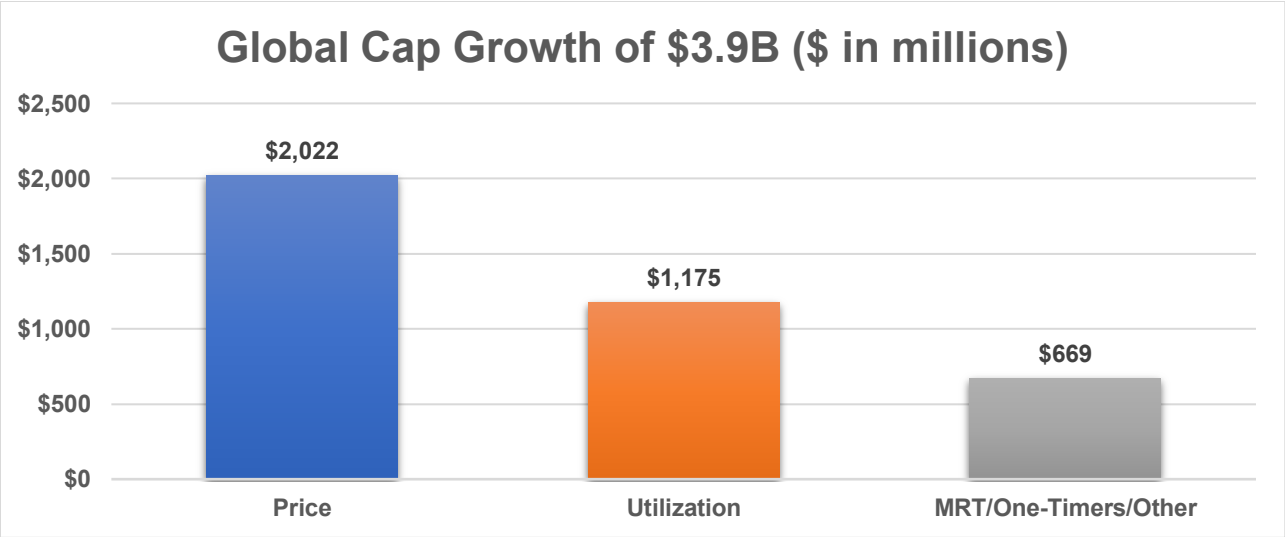
The FY 2023 Global Cap target was updated as a part of the FY 2024 Executive Budget Financial Plan to reflect an update to the Medicaid Global Cap index allowable growth metric, from 4.7 percent to 5.8 percent. This net increase primarily includes the updated Global Cap index growth of $1.2 billion ($224M additional growth above Enacted), increased costs for minimum wage rate adjustments ($262M), including the FY 2023 Enacted Budget Home Care minimum wage increases ($363M), which is offset by Home and Community Based Services (HCBS) eFMAP (-$363M), and the annual change in COVID-19 enhanced Federal Medical Assistance Percentage (eFMAP) ($2.5 billion).

Anticipated DOH Medicaid Spending Outside the Medicaid Global Cap Index:

($ millions)	FY22	FY23	$ Change
Medicaid Global Cap Index	**$20,572**	**$21,762**	**$1,190**
Medicaid Local Growth Takeover	$1,465	$1,648	$183
Minimum Wage	$1,961	$2,223	$262
Home Care Minimum Wage	$0	$363	$363
Use of HCBS eFMAP	$0	($363)	($363)
Medicaid Administration/Other	$643	$387	($256)
Health Conversion For-Profit Tax	$261	$261	$0
Federal Health Care Reform	($120)	($120)	$0
COVID eFMAP*	($2,487)	$0	$2,487
DOH Medicaid w/ Essential Plan	**$22,295**	**$26,161**	**$3,866**

**Additional COVID eFMAP passing through the Mental Hygiene Stabilization Fund. COVID eFMAP results in a cost shift from State to Federal funds, and does not result in a Medicaid program reduction.*

The chart below breaks out the major components of the annual increase including higher costs associated with both price and utilization increases.



[1] https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and Reports/NationalHealthExpendData/NationalHealthAccountsProjected

Price ($2.0B): Components of price growth include:

- Trend increases for Mainstream Managed Care rates ($687M);
- Trend decreases for Long Term Managed Care rates (-$88M);
- Directed Payment Template (DPT) payments to provide funding increases to financially distressed providers ($654M);
- Home Care Minimum Wage ($363M); and
- Various increases for Fee-for-Service (FFS) rates ($354M).

Utilization ($1.2B): The Medicaid Global Cap currently assumes that Medicaid enrollment is projected to increase by 214,000 New Yorkers or 2.8 percent, increasing from 7.6 million enrollees as of March 2022 to 7.8 million enrollees by March 2023. This increase is in large part due to the extension of the COVID-19 pandemic public health emergency (PHE).[2] Due to the maintenance of effort requirements under the Families First Coronavirus Response Act (FFCRA), which has precluded most forms of involuntary disenrollment from Medicaid (e.g., eligibility redeterminations), and attendant loss of employer-sponsored coverage or changes in income, there will be continued growth in Medicaid enrollment through the end of the fiscal year. Components of utilization growth include:

- Mainstream Managed Care enrollment including HIV Special Needs Plans (SNPs) & Health and Recovery Plans (HARPs) are projected to increase by approximately 157,000 individuals from March 2022 through the end of March 2023.
- Long Term Managed Care enrollment is projected to increase 29,000 individuals (10.1 percent); and
- Utilization of services is expected to partially, but slowly, return to pre-COVID-19 levels in acute care, nursing homes, and transportation fee-for-service categories of spending. However due to the extension of the PHE, the total number of FFS recipients are expected to increase by 28,000.

Medicaid Redesign Team (MRT) II/One-Timers/Other ($669M): MRT budget actions, one-time costs/savings, or other payments that do not fall into price or utilization primarily include:

- Additional investments allocated to several groups of hospitals to support operating needs while providers implement pandemic transformation plans ($800M);
- Health Care and Direct Care Workers Bonuses ($1.1B)
- Increases to Medicaid operating rates across-the-board (ATB) by an additional 1 percent to respond to market needs and compete in the labor market to attract qualified workers ($318M);
- Restorations of the 1.5 percent ATB payment reduction that was originally effectuated on April 2, 2020 ($141M);
- Allocated pools for distressed hospitals and nursing homes ($200M);
- Home Care Minimum Wage HCBS eFMAP Offset (-$363M);
- Timing of recoupments of VAPAP State-only advances related to DPT payment delays ($712M);
- Supplemental Federal Revenue (i.e., 6% eFMAP) for Community First Choice Option (CFCO) services to expand home and community-based services and supports to individuals in need of long term care for

[2] *As of the date of this report, the PHE has been extended through the end of the current fiscal year (FY2023) through April 11th.*

help with everyday activities and health-related tasks that can be performed by an aide or direct care worker (-$1.2B); and

- Health Care and Direct Care Workers Bonuses Offset with Financial Plan General Fund resources (-$1.1B).

Projected Medicaid Spending (Medicaid Claims, Supplemental Programs & Offsets)

The $26.2 billion projected Medicaid State Funds Spending can be organized into three major components:

(1) **Medicaid Claims:** Health care provider claim spending reflects the cost of FFS care and Managed Care capitation payments based on the price and utilization of services by sector (i.e., categories of spending) of the Medicaid program (e.g., hospitals, nursing homes, managed care, long-term care, pharmacy, transportation, etc.). These payments occur weekly **within** the Medicaid claiming system (eMedNY).

Projections for most categories of spending begin with the number of eligible recipients reported at the end of the previous fiscal year and the average spending per recipient for that period. Adjustments to spending projections are then made for anticipated rate (i.e., price) changes, transitions of populations/benefits to managed care (if any), fluctuations in the amount and type of service units (i.e., utilization), and any non-recurring or one-time payments/credits.

(2) **Supplemental Programs:** Payments through administrative or intergovernmental financial mechanisms occur **outside** the eMedNY billing system, such as Disproportionate Share Hospital (DSH), Upper Payment Limit (UPL), Medicare Clawback Part D, Medicare Supplemental Medical Insurance (SMI) Part A/B, Medicaid Local District Social Services Administration and State Operations. These supplemental programs are projected on an individual basis according to their historical spending trends and/or latest programmatic information.

(3) **Offsets:** Additional financial resources are used to offset State Medicaid, such as additional Federal funding, audit collections, drug manufacturer rebates, and Local County contributions, all of which also occur **outside** the eMedNY billing system. These offsets are projected on an individual basis according to their historical spending trends and/or latest programmatic information.

Forecasting Methodology/Data:

- State Medicaid disbursements are forecasted on a cash basis and updated on a quarterly basis, consistent with the schedule for revising the State's Financial Plan.
- The Medicaid forecast involves an evaluation of all major spending categories using a specific approach, depending on whether expenditures are based on monthly plan premiums for Managed Care or weekly fee-for-service payments.
- The forecast uses spending category specific data. This includes detail on total paid claims and premiums, retroactive spending adjustments, caseload, and service utilization.
- This data is incorporated into a forecast modeling application that uses historical expenditure patterns, as well as price and utilization trends to provide time-series analyses that are used to project future expenditures.
- The models also consider non-claims data (e.g., managed care enrollment, Federal Medicare premiums, and trends in the pharmaceutical industry) in certain areas to generate program specific expenditure projections.

Factors Impacting the Medicaid Forecast:

- Medicaid spending is determined by:
    - Price of services provided through the program (e.g., nursing homes, hospitals, prescription drugs);
    - Utilization of services (reflects both the number of individuals enrolled in Medicaid and the utilization of services); and
    - MRT budget actions, one-time costs/savings, or other payments that do not fall into price or utilization.
- Medicaid price and utilization are influenced by a multitude of factors, including:
    - Economic conditions;
    - Total enrollment and population mix in Medicaid;
    - Changes in the health care marketplace;
    - Prescription drug pricing and product development by manufacturers;
    - Complex reimbursement formulas which themselves are affected by another set of factors (e.g., length of hospital stays);
    - Behavior and composition of recipients accessing services; and
    - Litigation.
- The State share of Medicaid spending is also dependent on two factors:
    - Local government contributions toward Medicaid costs; and
    - Federal funding, which can be affected by both statutory and administrative changes at the Federal level.

The following table outlines the FY 2023 Medicaid projections by major health care sector (i.e., category of spending) for Medicaid claims, supplemental programs, and offsets.

Projected FY 2023 Medicaid Spending ($ in millions)				
Category of Spending	**Medicaid Claims**	**Supplemental Programs**	**Offsets**	**Total**
Medicaid Managed Care	**$22,398**	**$1,193**	**($1,892)**	**$21,698**
Mainstream Managed Care	$14,456	$667	($431)	$14,692
Long Term Managed Care	$7,942	$526	($1,462)	$7,006
Total Fee-For-Service	**$8,126**	**$1,214**	**($1,517)**	**$7,823**
Inpatient	$1,800	$842	($13)	$2,628
Outpatient/Emergency Room	$338	$0	($3)	$336
Clinic	$516	$4	($65)	$455
Nursing Homes	$3,052	$286	$0	$3,337
Personal Care	$730	$23	($48)	$706
Home Health	$145	$0	($13)	$132
Other Long Term Care	$177	$8	$0	$185
Pharmacy	$376	$3	($1,301)	($922)
Transportation	$328	$46	($1)	$373
Non-Institutional	$665	$2	($73)	$593
Other State Agencies (OSA)	**$4,243**	**$0**	**($3,097)**	**$1,146**
Mental Hygiene Stabilization Fund (MHSF)	**$0**	**$0**	**$382**	**$382**
Medicare Part A/B & D	**$0**	**$2,782**	**$0**	**$2,782**
VAPAP	**$0**	**$1,284**	**$0**	**$1,284**
All Other	**$16**	**$2,471**	**($920)**	**$1,567**
Medicaid Administration	**$0**	**$540**	**$0**	**$540**
State Operations	**$0**	**$377**	**$0**	**$377**
Local Cap Contribution	**$0**	**$0**	**($6,566)**	**($6,566)**
COVID-19 eFMAP	**$0**	**$0**	**($4,441)**	**($4,441)**
Audit Collections	**$0**	**$0**	**($433)**	**($433)**
TOTAL	**$34,784**	**$9,861**	**($18,484)**	**$26,161**

Major Supplemental Programs:

Medicaid Managed Care ($1.2 billion)

- Mainstream Managed Care: 2 Percent Encounter Withhold Repayments and HIV Special Needs Plans (SNP) Quality Pool.
- Managed Long Term Care: 1.5 Percent Encounter Withhold Repayments, 3 Percent Enrollment Withhold Repayments, and Quality Pools.

Fee-For-Service ($1.2 billion)

- Inpatient: Disproportionate Share Hospital (DSH) and Voluntary Upper Payment Limit (UPL).
- Nursing Homes: Advance Training Initiatives, 2 Percent Supplemental Payments, Reform Initiative, and Young Adult Demonstration.
- Other Long Term Care: Assisted Living Demonstration Vouchers, and Traumatic Brain Injury (TBI) and Nursing Home Transition and Diversion (NHTD) payments.

- Transportation: Supplemental Ambulance and Rural Transportation Investments.

Medicare SMI Part A/B & Clawback Part D ($2.8 billion)

- Supplemental Medical Insurance (SMI) Part A/B: This voluntary Social Security insurance pays a substantial part of Medicare dual enrollees' expenses for hospital, physician, home health, and other medical health services. States must contribute to the Federal Government a portion of the total expenses.

- Clawback Part D: Under the Medicare Part D drug benefit program, most costs are paid by beneficiary premiums and general tax revenues. States must contribute to the Federal Government for beneficiaries who are eligible for both Medicare and Medicaid who receive drug coverage through Part D.

Vital Access Provider Assurance Program (VAPAP) ($1.3 billion)

The VAPAP program provides State-only support for facilities in severe financial distress to enable these facilities to maintain operations and provision of vital services while they implement longer-term solutions to achieve sustainable health care service delivery.

All Other ($2.5 billion)

The All Other category includes a variety of Medicaid payments and offsets, the largest components of which are described as follows:

- Health Care Worker Bonus ($1.1 billion): front line health care and mental hygiene practitioners, technicians, assistants and aides that provide hands on health or care services to individuals earning less than $125,000 annually will receive a State-funded bonus payment of up to $3,000 in FY 2023. The amount of the bonus will be based on hours worked and length of time in service with qualified employers. State employees in comparable titles will receive bonuses, as well.

- Timing of VAPAP Recoupments related to DPT Payments ($712 million): Global Cap models thus far have assumed that State-only VAPAP advances made to hospitals, as a bridge while awaiting CMS DPT approval, would be recouped within this fiscal year. CMS approved the DPTs in January 2023, which limits the ability to fully recoup VAPAP advances in FY 2023. Therefore, these VAPAP advances have been incorporated into the FY 2023 model as costs with corresponding recoupments assumed next fiscal year.

- Vital Access/Safety Net Provider Program ($186 million): 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 are used primarily 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.

- Affordable Care Act (ACA) Federal Financial Participation (FFP) Correction ($154 million): As part of the ACA, CMS anticipated that states that adopted continuous eligibility for adults would experience a two percent increase in enrollment. Based on this estimate, CMS determined that 97.4 percent of Medicaid enrollee member months for newly eligible individuals in the Adult Group will be matched at the enhanced FMAP rate (90%) and 2.6 percent will be matched at the regular FMAP rate (50%). This liability began accruing on January 1, 2014, and accrues on a quarterly basis going forward. eMedNY is unable to carve out a portion of the Adult Group. As a result, the State claims for the entire group at the eFMAP rate and thus overclaims for 2.6 percent of the Adult Group, resulting in the liability which is then repaid manually to the Federal government.

- Patient Centered Medical Homes ($116 million): The Medicaid Patient Centered Medical Home (PCMH) incentive program gives incentive payments to National Committee for Quality Assurance PCMH-

recognized providers to support their ongoing efforts to deliver high-quality, coordinated care to Medicaid members.

- Affordable Housing ($63 million): The Supportive Housing Initiative seeks to ensure that Medicaid members have proper housing that promotes a healthy environment and lifestyle.

Medicaid Administration ($540 million)

The annual county Medicaid caps for Local Administration will remain at their historic/current levels during FY 2023, although it is anticipated that county Administration costs will continue to decrease over time as the State assumes more administrative functions previously borne by local districts.

The State assumption of Medicaid administrative functions is behind schedule due to challenges with systems upgrades to the State's Welfare Management System (WMS). In addition, extensive attention has been given to refining the MAGI eligibility and enrollment rules for NY State of Health (NYSOH) applicants to ensure Medicaid coverage is correctly provided and continuity of care is maintained.

The Department of Health continues to work collaboratively with local governments and the Division of Budget to facilitate the transition of Medicaid administrative functions and associated costs to the State. The latest annual report detailing the Medicaid Administration Takeover can be found at: Medicaid Administration Annual Report.

State Operations ($376 million)

The Office of Health Insurance Programs (OHIP) State Operations budget reflects the Non-Federal share of personal services (i.e., salaries of OHIP staff) and non-personal services costs (i.e., contractual services). The FY 2023 Budget is projected to total $377 million which also includes Essential Plan administration costs.

Contracts for the Enrollment Center, the NYSOH Customer Service Center, eMedNY/MMIS, and various MRT initiatives comprise a significant portion of the total non-personal service budget.

State Operations FY 2023 Budget ($ in millions)	
Service Costs	**Annual Budget**
Personal Services	**$57.6**
Medicaid	*$53.1*
Essential Plan	*$4.5*
Non-Personal Services	**$318.9**
Medicaid	*$248.4*
Essential Plan	*$70.5*
TOTAL	**$376.5**

Major Offsets:

Medicaid Managed Care (-$1.9 billion)

- Mainstream Managed Care (MMC): Transfer of Child Health Plus (CHP) claims out of the Medicaid Global Cap to the General Fund. Historically, the cost of the CHP program has been paid by the General Fund; however, in the first instance those costs are paid by the Medicaid Global Cap and are then reimbursed.

- Managed Long Term Care (MLTC): Supplemental Federal Revenue (i.e., 6% eFMAP) for Community First Choice Option (CFCO) services to expand home and community-based services and supports to individuals in need of long term care for help with everyday activities and health-related tasks that can be performed by an aide or direct care worker.

Fee-For-Service (-$1.5 billion)

- Inpatient: Similar to CHP, the transfer of Department of Corrections and Community Supervision (DOCCS) medical expenditures for inmates that are funded initially through the Medicaid Global Cap.

- Other Long Term Care: Supplemental Federal Revenue for CFCO services (see above for additional information regarding CFCO).

- Pharmacy: OBRA and Supplemental Rebate collections from drug manufacturers.

Other State Agencies & MHSF (-$2.7 billion)

Transfers from Other State Agencies (OSA) to support State-share Medicaid expenditures for services of the Office for People with Developmental Disabilities (OPWDD), Office of Mental Health (OMH), Office of Children and Family Services (OCFS), State Education Department (SED), Department of Corrections & Community Supervision (DOCCS) and Office of Addiction Services and Supports (OASAS).

All Other (-$920 million)

The All Other category includes a variety of Medicaid offsets, the largest components of which are described as follows:

- The use of ARP FMAP ($553 million) to offset HCBS investments that hit the Medicaid Global Spending Cap in the first instance.

- Supplemental Federal Revenue (-$269 million): Includes claiming Federal revenue for Family Planning Services, Undocumented Pregnant Women, and School Supportive Health Services.

- Accounts Receivable (-$10 million): Represents the collection of Medicaid provider liabilities owed to the State resulting from processing retroactive rate adjustments.

Local Cap Contribution (-$6.6 billion)

The Local Cap Contribution represents the contribution the State receives from Local Districts for their share of the Medicaid program. The Local share of Medicaid expenditures has been capped since FY 2016. However, Local Districts still share in the benefit of the COVID-19 eFMAP and contributions have been reduced in FY 2023.

COVID-19 eFMAP (-$4.4 billion)

Refer to the “Impact of the COVID-19 Pandemic” section for additional details.

Audit Collections (-$433 million)

The Department of Health collaborates with the Office of the Medicaid Inspector General (OMIG) and the Office of the Attorney General (AG) in recovering improperly expended Medicaid funds. OMIG conducts and coordinates the investigation, detection, audit, and review of Medicaid providers and recipients to ensure they are complying with all applicable laws and regulations. OMIG recovers any improper payments through cash collections and voided claim recoveries. Cash collections are recovered through three avenues: direct payments, payment plans, and withholds.

In addition to cash collections, OMIG finds inappropriately billed claims within Managed Care capitation payments or provider fee-for-service claims. To correct an error, OMIG and DOH process the current accurate claim, and reduce this claim by the inappropriate claim value to recoup the previous overclaim and decrease state spending. Beginning in FY 2017, void recoveries were included as part of the audit collections to more accurately reflecting accounting for cash collections. These cash audit collection recoveries are used to offset Global Cap spending.

Executive Budget Model Changes

DOH, in collaboration with the Division of the Budget, updated the First Quarter Update Medicaid Global Cap Model for price and utilization trends based on actuals through September 2022, as well as other known factors. This Executive Budget Model projects spending to be aligned with the Global Cap spending target of $26.2 billion. The following table outlines the changes from the First Quarter Update Model outlined in the Second Quarter Global Cap Report to the Executive Budget Model of the Third Quarter Global Cap Report.

Executive Budget Model Changes ($ in millions)			
Category of Spending	**First Quarter Update Model**	**Executive Budget Model**	**$ Change Higher / (Lower)**
Medicaid Managed Care	**$22,540**	**$21,698**	**($842)**
Managed Care	$14,363	$14,692	$329
Long Term Managed Care	$8,177	$7,006	($1,171)
Total Fee For Service	**$7,796**	**$7,823**	**$27**
Inpatient	$2,664	$2,628	($36)
Outpatient/Emergency Room	$340	$336	($4)
Clinic	$436	$455	$19
Nursing Homes	$3,410	$3,337	($73)
Personal Care	$588	$706	$118
Home Health	$126	$132	$6
Other Long Term Care	$175	$185	$10
Pharmacy	($905)	($922)	($17)
Transportation	$354	$373	$19
Non-Institutional	$608	$593	($15)
Other State Agency/Transfer	**$1,188**	**$1,146**	**($42)**
MHSF	**($762)**	**$382**	**$1,144**
Medicare Part A/B & D	**$2,854**	**$2,782**	**($72)**
VAPAP	**$1,284**	**$1,284**	**$0**
All Other	**$766**	**$1,567**	**$801**
Medicaid Administration	**$439**	**$540**	**$101**
State Operations	**$382**	**$377**	**($5)**
Local Cap Contribution	**($6,566)**	**($6,566)**	**$0**
COVID-19 eFMAP	**($3,551)**	**($4,441)**	**($890)**
Cash Audits	**($433)**	**($433)**	**$0**
TOTAL	**$25,937**	**$26,161**	**$224**

Medicaid Managed Care ($329 million): The extension of the PHE is accompanied by cost increases for enrollees whose coverage has been extended due to Maintenance of Effort (MOE) provisions in FFCRA, as well as the State's 12-month continuous coverage mandate.

Long Term Managed Care (-$1.2 billion): The Supplemental Federal Revenue (i.e., 6% eFMAP) for Community First Choice Option (CFCO) services was finalized and resulted in higher than expected eFMAP for the CY 2021 claim. The Executive Budget model also accelerates the submission of the CY 2022 claim; previously the First Quarter Update model assumed the CY 2022 claim would be achieved in FY 2024.

Personal Care ($118 million): Removed the FY 2023 Enacted Budget savings attributed to the Long Term Service and Support Coverage in the Essential Plan initiative due to ongoing discussions with CMS.

Other State Agencies & MHSF ($1.1 billion): Reflects the additional quarter of COVID-19 eFMAP and re-estimates due to increased Medicaid spending as a result of higher enrollment and utilization that provided additional eFMAP above the current target. Revisions to the support for the cost increases for enrollees resulting from the extended MOE provisions in FFCRA, as well as the State's 12-month continuous coverage mandate. These changes were offset by financial plan support for expansion of the Health Care Worker Bonus titles.

All Other ($801 million): Increased funding for the Health Care Worker Bonus payments to health care and direct workers earning less than $125,000 annually. Due to delays in securing CMS approval of several DPTs designed to provide funding increases to financially distressed providers, the Department released State-only VAPAP advances. The Global Cap models thus far have assumed that these State-only advances would be recouped within the same fiscal year; however, CMS approved the DPTs in January 2023, which limits the ability to recoup the VAPAP advances in FY 2023. Therefore, these advances have been incorporated into the FY 2023 model as costs with corresponding recoupments assumed next fiscal year.

Medicaid Administration Costs ($101 million): Reflects an increase in anticipated spending due to delays in State Takeover functions as described earlier in the report.

COVID-19 eFMAP (-$890 million): Increased the anticipated COVID-19 eFMAP by an additional quarter due to the PHE extension as well as recognizing higher eFMAP collections as a result of increased Medicaid spending due to higher enrollment and utilization.

Global Cap Target (-$224 million): Updates the Global Cap Index to reflect the five-year rolling average of the Medicaid annual growth rate from the National Health Expenditure (NHE) Accounts analysis produced by the Office of the Actuary in CMS. The updated growth rate is now 5.8 percent, an increase from the Enacted trend of 4.7 percent.

Results April through December 2022 – Global Cap Target vs. Actual Spending

Through December 2022, total actual State Medicaid spending is $216 million over the Medicaid Global Spending Cap projection. Spending through December resulted in total expenditures of $20.5 billion compared to the projected spending target of $20.3 billion. Due to the complex projected fluctuations in monthly spending, simply trending the variance in a linear fashion would not be an accurate method for gauging year-end results.

April to December 2022 Medicaid Global Cap Target vs. Actual Spending ($ in millions)				
Category of Spending	**Global Cap Target**	**Actual**	**$ Variance Over / (Under)**	**% Variance Over / (Under)**
Medicaid Managed Care	**$17,997**	**$18,185**	**$189**	**1.0%**
Mainstream Managed Care	$11,307	$11,444	$137	1.2%
Long Term Managed Care	$6,690	$6,742	$52	0.8%
Total Fee-For-Service	**$5,738**	**$5,815**	**$77**	**1.3%**
Inpatient	$2,034	$2,064	$31	1.5%
Outpatient/Emergency Room	$244	$245	$1	0.3%
Clinic	$345	$351	$6	1.8%
Nursing Homes	$2,350	$2,355	$5	0.2%
Personal Care	$551	$547	($4)	-0.7%
Home Health	$113	$110	($2)	-2.0%
Other Long Term Care	$140	$139	($1)	-0.7%
Pharmacy	($772)	($734)	$38	-4.9%
Transportation	$275	$274	($1)	-0.4%
Non-Institutional	$458	$463	$5	1.1%
Other State Agencies	**$614**	**$614**	**$0**	**0.0%**
Mental Hygiene Stabilization Fund	**$287**	**$287**	**$0**	**0.0%**
Medicare Part A/B & D	**$2,286**	**$2,270**	**($16)**	**-0.7%**
VAPAP[3]	**$674**	**$674**	**$0**	**0.0%**
All Other	**$819**	**$776**	**($43)**	**-5.3%**
Medicaid Administration	**$343**	**$355**	**$12**	**3.4%**
State Operations	**$242**	**$232**	**($10)**	**-4.2%**
Local Cap Contribution	**($4,948)**	**($4,948)**	**$0**	**0.0%**
COVID-19 eFMAP	**($3,459)**	**($3,459)**	**$0**	**0.0%**
Audit Collections	**($314)**	**($307)**	**$7**	**-2.3%**
TOTAL	**$20,278**	**$20,494**	**$216**	**1.1%**

The following explanations regarding the variances between the Global Cap Target through December and the actual spending are reserved for significant variances with the understanding that small variances do not require an explanation and equate to "being on target."

Medicaid Managed Care

Medicaid spending in major Managed Care categories was $189 million, or 1.0 percent, over anticipated spending through December. This is mainly due to the timing of reprocessing retroactive claims for MMC plans related to FY 2022 DPT payments that were recently approved by CMS. The Executive Budget Model did not anticipate this rate adjustment to be processed until the fourth quarter.

3 VAPAP Advances related to DPT were previously mapped to the VAPAP spending line in prior quarter reports, but have now been reclassified to the All Other spending line to keep them separate from the traditional VAPAP spending and budget allocation.

Fee-For-Service

Medicaid spending in major fee-for-service categories was $77 million, or 1.3 percent, over target.

- Inpatient was $31 million, or 1.5 percent, over projected spending. This variance is attributed to higher than expected claims paid during the third quarter. Graduate Medical Education (GME)/worker incentive discharges were slightly higher than previous quarters, likely due to continued growth in total Medicaid enrollment, as these discharges represent claims for both FFS and MMC individuals.

- Pharmacy was $38 million, or 4.9 percent, under anticipated projections. This variance is largely attributed to lower than expected rebate collections.

Medicare Part A/B & D

Medicare Part A/B & D was $16 million, or 0.7 percent under budget through December. This variance is largely attributed to lower than expected Part D expenditures.

All Other

All Other underspent by $43 million, or 5.3 percent, which is largely due to the timing of accounts receivable payments and collections. Variances from the projected budget throughout the year are commonly due to the timing of approvals/disbursements, but with an expectation that the annual targets will be achieved by fiscal year's end.

Medicaid Administration Costs

Medicaid Administration was $12 million over the budget through December as a result of delays in the State assumption of Medicaid administrative functions.

State Operations

OHIP State Operations underspent by $10 million, or 4.2 percent through December, which is due to the timing in processing contractual payments.

Enrollment

Medicaid enrollment is expected to increase to 7,789,300 individuals by March 2023, which is an increase of approximately 214,000 individuals from March 2022. This increase is in large part due to the extension of the COVID-19 PHE.

Mainstream Managed Care (includes HIV/SNPs and BHO/HARPs): Mainstream Managed Care (MMC) enrollment including HIV Special Needs Plans (SNPs) & Health and Recovery Plans (HARPs) are projected to increase by approximately 157,000 individuals from March 2022 through the end of March 2023.

Managed Long Term Care (includes Partial Capitation, PACE, FIDA IDD and MAP): Managed Long Term Care (MLTC) enrollment reached 281,500 by the end of FY 2022, a net increase of 1,500 individuals. Two factors contributed to the modest growth: a slower return to pre-pandemic growth rate levels, and the Nursing Home carveout initiative (implemented September 2020) that disenrolled long term stay individuals from MLTC plans and placed them into Medicaid fee-for-service. The FY 2023 projections assume that enrollment will grow by ten percent, approximately 29,000 individuals, over March 2022 levels.[4] This growth rate is higher than last year's trends however it is still slightly lower than pre-pandemic growth rates.

Medicaid Enrollment to Date

Medicaid Enrollment Summary Medicaid Managed Care vs Fee-for-Service				
	March 2022	**December 2022***	**Net Increase / (Decrease)**	**% Change**
Mainstream Managed Care	5,521,680	5,666,437	144,757	2.6%
Long Term Managed Care	281,538	302,408	20,870	7.4%
Fee-For-Service	1,771,992	1,792,910	20,918	1.2%
TOTAL	**7,575,210**	**7,761,755**	**186,545**	**2.5%**

Medicaid Enrollment Summary by NYC vs Rest of State				
	March 2022	**December 2022***	**Net Increase / (Decrease)**	**% Change**
NYC	4,301,457	4,341,833	40,376	0.9%
Rest of State	3,273,753	3,419,922	146,169	4.5%
TOTAL	**7,575,210**	**7,761,755**	**186,545**	**2.5%**

**Note: Enrollment counts are from the Medicaid Data Warehouse (enrollment database) and are reported on DOH's website: NYS Medicaid Enrollment Databook. Data is pulled monthly to account for any retroactive updates. These counts reflect the net impact of new enrollment and disenrollment that occurred from March through December based on data pulled 1/17/2023.*

[4] *These enrollment assumptions will be adjusted, as necessary, through approved rate packages.*

Impact of the COVID-19 Pandemic

In response to the COVID-19 pandemic, the Federal government increased its share of Medicaid funding (i.e. eFMAP) by 6.2 percent for each calendar quarter occurring during the Federal public health emergency declared by the Secretary of Health and Human Services (HHS). The enhanced funding began January 1, 2020, and will continue through Fiscal Year 2023.[5] Certain expenditures, including expenditures for the Medicaid expansion population already eligible for enhanced federal match under the Affordable Care Act (ACA) and certain medical services already eligible for an enhanced Federal match did not qualify for the 6.2 percent eFMAP.[6]

The additional Federal resources reduced State and Local government costs and helped support the significant increase in Medicaid enrollment resulting, in large part, from individuals losing income and/or job-related insurance coverage because of the COVID-19 pandemic. Due to Federal MOE requirements under the FFCRA, states are precluded from terminating an individual's Medicaid enrollment, except in very limited circumstances (e.g., death, moving out of state, voluntary termination, etc.) and, for a period, making any changes in the amount, duration, and scope of Medicaid benefits, as a condition of receiving eFMAP.

The following table provides the projected and actual fiscal impacts attributed to the pandemic related to the additional COVID-19 eFMAP that is claimed on a one-month lag. There is a year-to-year increase of eFMAP due to the claiming of 11.5 months in FY 2022 (for the period of March 2021 to February 2022) and 12.5 months projected to be claimed in FY 2023 (for the period of February 2022 to February 2023) as well as higher eFMAP collections as a result of increased Medicaid spending due to higher enrollment and utilization. The eFMAP collections are projections and subject to reconciliation.

COVID-19 eFMAP $ in millions			
	FY 2022	**FY 2023**	**Annual Change**
State Share	$2,983	$3,651	$688
Local Share	$646	$790	$144
Total 6.2% eFMAP	**$3,629**	**$4,441**	**$812**

Increased Enrollment:

As stated previously, the COVID-19 pandemic resulted in the most significant one-year increase in Medicaid enrollment since the inception of the program. Increased enrollment resulted as individuals lost income and/or job-related insurance coverage and as the State was required to suspend termination of eligibility under federal law as a condition of receiving eFMAP.

Between March 2020, when the Federal public emergency was declared by the Secretary of HHS, and December 2022, the end of this reporting period, Medicaid enrollment increased by 1.7 million. A month-by-month summary of Medicaid enrollment can be found at: NYS Medicaid Enrollment Databook.

Spending on Services:

The COVID-19 pandemic has impacted both the utilization of services and the intensity of services beneficiaries sought as compared to prior years, and as compared to expected spending during the reporting period. This was particularly the case for certain types of services discussed briefly below.

At the height of the pandemic, spending on Acute Care (Inpatient/Outpatient/Clinic) services increased significantly due to higher intensity COVID-19 related inpatient care (e.g., ventilation, intubation) and emergency related services. Spending has subsequently trended downwards as costs have declined with a decrease in COVID-19 hospitalizations, and utilization remains below pre-pandemic levels.

[5] *As of the date of this report, HHS has extended the PHE through April 11, 2023, which provides an additional quarter of eFMAP in the current year from the FY 2023 Quarter 2 Report update.*

[6] *The ACA's Medicaid provisions allows New York to utilize Federal funding (90% Federal Share) to expand Medicaid to single and childless adults with incomes up to 138 percent of the Federal Poverty Limit.*

Long Term Care services that comprise a significant portion of Medicaid spending have risen significantly from pre-pandemic levels, which is primarily attributable to increased costs for Nursing Homes, Personal Care, and Home Health services, partially offset by continued lower utilization compared to pre-pandemic usage.

Non-Institutional Fee-for-Service spending remains relatively flat compared to pre-pandemic levels. Transportation utilization continues to trend below pre-pandemic levels with the increased flexibility for telehealth services, including the expansion of telehealth options for clinics, optometrists, and dentists. The ability of enrollees to seek certain telehealth services through alternate modalities resulted in increases in utilization for certain types of services, with much of the telehealth spend during the COVID-19 period tied directly to behavioral health services.

Notable Events

MRT II: The FY 2021 Enacted Budget included $2.2 billion in recommendations put forward by the MRT II to create efficiencies within the Medicaid program and address the Medicaid imbalance, including identifying efficiencies in long term care services, as well as administrative reforms. Over two-thirds of the $2.2 billion in savings actions have been implemented, with the remaining savings pending due to ongoing litigation, and Federal government Maintenance-of-Effort (MOE) requirements associated with the Families First Coronavirus Response Act (FFCRA) enhanced Federal Medical Assistance Percentage (eFMAP) of 6.2 percent on Medicaid payment (see next paragraph for additional information) and the American Rescue Plan Act (ARPA) eFMAP of 10 percent for certain home and community-based services.

The Financial Plan assumes the remaining savings actions will be implemented in FY 2023, aside from those actions limited to the MOE requirements associated with the recent Federal public health emergency extension, which will be implemented through FY 2025.

FFCRA & ARPA MOE Requirements: Section 6008 of the March 2020 FFCRA imposed an MOE requirement conditioned on states receiving the 6.2 percent eFMAP during the Federal PHE. Additionally, Section 9817 of the March 2021 ARPA imposed an MOE requirement for the duration of the period over which states are able to spend the 10 percent eFMAP related to certain home and community-based services. As a result, several MRT II initiatives aimed at modifying eligibility (i.e., the 30-month lookback) and other Personal Care Services/Consumer Directed Personal Assistance Program requirements have been delayed. The MOEs additionally preclude states from utilizing most forms of involuntary disenrollment from Medicaid, which has also resulted in the suspension of eligibility redeterminations as was done previously.

Financial Plan Enrollment Projections: The Executive Budget Update to the Financial Plan reflects the extension of the PHE as outlined in the HHS guidelines[7]. This assumes that enrollment levels will continue to grow to 7.8 million by March 2023, and start to return to near pre-pandemic levels in FY 2024. As the economy recovers and unemployment trends towards pre-pandemic levels, costs associated with individuals temporarily enrolled, but entitled to twelve months of continuous coverage, are anticipated to persist through the end of FY 2023, and decline in FY 2024.

Extension of the Public Health Emergency (PHE): The Secretary of Human Services has extended the COVID-19 PHE through April 11, 2023, which extended COVID-19 eFMAP through at least June 30, 2023. The extension of the PHE (and COVID-19 eFMAP) is accompanied by cost increases for enrollees whose coverage has been extended due to CMS MOE provisions in the FFCRA, as well as the State's 12-month continuous coverage mandate.

However, on December 29, 2022, the Consolidated Appropriations Act was signed into law. This legislation made the expiration of the continuous enrollment requirement separate from the end of the COVID-19 PHE. The continuous enrollment condition will end on March 31, 2023. States will have up to 12 months to initiate, and 14 months to complete, a renewal for all individuals enrolled in Medicaid, Child Health Insurance Program (CHIP), and the Basic Health Program (BHP) following the end of the continuous enrollment condition.

The FFCRA's temporary FMAP increase will be gradually reduced beginning April 1, 2023, and will end on December 31, 2023. The Department of Health is currently evaluating guidance provided by CMS in determining the impacts of the PHE unwind and resuming redeterminations.

Home & Community-Based Services (HCBS) eFMAP: In addition to the 6.2 percent COVID-19 eFMAP increase, the Federal ARPA bill provided a temporary 10 percentage point increase to the FMAP for certain Medicaid HCBS claimed through March 31, 2022. Such additional funding must supplement, not supplant, current Medicaid funding.

After a collaborative, multi-agency effort with the Department's partner agencies that touch on the categories of HCBS for which the eFMAP is being provided, the Department submitted New York's initial spending plan to CMS on July 9, 2021. CMS has approved all but two spending plan initiatives. The Department is working with CMS to achieve approval for these final two proposals. The Department may modify the spending plan, subject to CMS's approval, on a quarterly basis.

[7] CMS published guidance for the unwind of the Public Health Emergency and eFMAP on January 31st 2023. https://www.medicaid.gov/federal-policy-guidance/downloads/sho23002.pdf

In its spending plan update from February 7, 2023, New York continued to recommend investments that will support the needs of our most vulnerable populations, including children, individuals with intellectual and developmental disabilities (I/DD), those suffering from addiction, those with behavioral health needs, and older adults. New York's approach prioritizes investments with long term sustainable benefits, including building workforce capacity and digital infrastructure to streamline service delivery, improving the quality and efficiency of services in the more immediate term, and helping HCBS providers overcome pandemic-related expenses and service disruptions.

1115 Medicaid Waiver: The State submitted an 1115 waiver extension request to CMS that preserves current Medicaid Managed Care Programs, Children's HCBS, and self-direction of Personal Care services. This waiver renewal was approved on March 31, 2022, and is effective for five years.

Separately, DOH has developed a new programmatic amendment to the now-renewed 1115 waiver, titled *New York Health Equity Reform (NYHER): Making Targeted, Evidence-Based Investments to Address the Health Disparities Exacerbated by the COVID-19 Pandemic*. This amendment focuses on addressing health disparities that have been highlighted and exacerbated by the COVID-19 pandemic and achieving health equity in the State through the greater integration of physical health, behavioral health, and health-related social needs (HRSNs). This request seeks approximately $13.5 billion in Federal funding over five years to invest in an array of multi-faceted and related initiatives that would change the way the Medicaid program integrates and pays for physical health, behavioral health, and HRSNs in NYS.

After working directly with CMS and stakeholders on concepts contained in this new programmatic waiver amendment and in accordance with federal transparency requirements, DOH submitted a Federal public notice to the NYS Registry on April 13, 2022, and hosted two public hearings on May 3, 2022, and May 10, 2022. The presentation slides, recordings, and transcripts from both hearings are available on the DOH website.[8] The 30-day public comment period closed on May 20, 2022 and another public hearing was held on September 28, 2022.

During the public comment period, DOH received 358 written comment submissions and heard from 75 speakers at the three public hearings. DOH has worked with partner agencies to review and evaluate the approximately 1,800 unique comments received and incorporated feedback from stakeholders where possible and appropriate. DOH formally submitted the final waiver amendment application to CMS on September 2, 2022. CMS deemed the application submission complete on September 15, 2022; The Federal Public Comment period was open from September 19, 2022, to October 19, 2022, during which 298 unique comments were submitted via the Medicaid.gov portal.

After submission to CMS, the review and approval process can take several months or longer. However, DOH is actively working with CMS to achieve an approval as expeditiously as possible. DOH plans to begin the five-year waiver demonstration period upon approval from CMS. Program implementation will begin once the amendment, or components of the amendment, is approved and special terms and conditions (STCs) are received from CMS.

[8] *https://www.health.ny.gov/health_care/medicaid/redesign/medicaid_waiver_1115.htm*

Appendix A. Inventory of Rate Packages

Below are the largest of the anticipated rate packages to be processed in FY 2023:

Category of Service	Rate Package Description	Month Paid
Managed Care	April 2022 Mainstream Rates	May 2022
	April 2022 HARP Rates	May 2022
	April 2022 HIV Special Needs Plans (HIV SNP) Rates	August 2022
	Encounter Withhold FY 2022	December 2022
	Quality Pools CY 2021	June 2022
	HIV SNP Incentive Pool Payment CY 2021	August 2022
Long Term Managed Care	April 2022 Partial Capitation Rates	May 2022
	April 2022 Medicaid Advantage Plan (MAP) Rates	May 2022
	April 2022 Program of All-Inclusive Care for the Elderly (PACE) Rates	December 2022
	Encounter Withhold FY 2022	October 2022
	QIVAPP FY 2022	June 2022
	Quality Pools CY 2021	June 2022
Inpatient	Acute & Exempt Unit Inpatient Rates CY 2022	May 2022
	Acute & Exempt Unit Inpatient Rates CY 2023	
Outpatient / Emergency Room	APG capital update CY 2017	
	APG capital update CY 2018	
	APG capital update CY 2019	
	APG capital update CY 2020	
	APG capital update CY 2021	
	Hold Harmless CY 2021	
Clinic	APG Capital Rate Update CY 2023	
	Article 28 Minimum Wage CY 2021	
	Article 28 Minimum Wage CY 2022	
	October 2022 FQHC MEI Increase	
	Hold Harmless CY 2021	October 2022
Nursing Homes	NH Operating Initial Rates CY 2022	August 2022
	NH Operating Initial Rates CY 2023	
	July 2022 NH Case Mix Rate Update	November 2022
	NH Capital Initial Rates CY 2022	September 2022
	NH Capital Initial Rates CY 2023	
	NH Case Mix 5% Cap Release	September 2022
Personal Care	PC Initial Rates CY 2021	June 2022
	PC Initial Rates CY 2022	
Assisted Living Providers	ALP Rates CY 2022	
	ALP Rates CY 2023	
Hospice	Hospice Residence Rates CY 2022	September 2022
	Hospice Non-Residence Rates FFY 2023	
Home Health	CHHA Pediatric (includes MW) CY 2021	June 2022
	CHHA Pediatric (includes MW) CY 2022	
Other	July 2021 Patient Centered Medical Homes	
	January 2022 Patient Centered Medical Homes	

Appendix B. FY 2023 Enacted Budget

(http://www.health.ny.gov/health_care/medicaid/redesign/mrt_budget.htm)

Below is a condensed version of the FY 2023 Enacted Scorecard which focuses the list on budget actions anticipated to be implemented in FY 2023. Any lost savings or availed spending will be accommodated within the Medicaid Global Cap.

(State Share -- $ millions)	FY 2023 Enacted	Implemented Y/N	Achieved to Date
Global Cap Forecast with Legislation (Surplus)/Deficit	**($437.036)**		
Global Cap Index Inflation - CMS Office of the Actuary Medicaid Projection (5-Year Rolling Average)	($366.000)	Y	($366.000)
Health Care Bonus - State Total	$922.748	Y	$511.298
Financial Plan Support for Health Care Bonuses	($922.748)	Y	($511.298)
Global Cap (Surplus)/Deficit	**($803.036)**		**($366.000)**
Budget Actions	**$844.246**		**$453.601**
Hospital Actions	**$350.000**		**$350.000**
Distressed Hospital Pool	$100.000	Y	$100.000
Distressed Provider Account Investment (inc. $100M of Financial Plan Resources)	$250.000	Y	$250.000
Long Term Care Actions	**$48.803**		**$8.129**
Nursing Home Reforms	*$161.500*		*$6.762*
Nursing Home Support for Compliance with Staffing Regulations	$61.500	N	$0.000
Increase Nursing Home Vital Access Provider (VAP) Funding	$100.000	Y	$6.762
LTC--Medicaid Diversion	*($110.564)*		*$0.000*
*Long Term Service and Support (LTSS) Coverage in Essential Plan	($110.564)	N	$0.000
LTC Other Reforms	*($2.133)*		*$1.367*
Increasing Private Duty Nursing (PDN) Reimbursement for Nurses Servicing Adult Members	$19.450	Y	$14.588
Use of Federal HCBS funding to support PDN Reimbursement	($19.450)	Y	($14.588)
Alzheimer's Program under Medicaid	$1.367	Y	$1.367
Fully Implement the Duals Integration Roadmap	($3.500)	N	$0.000
Managed Care Actions	**($34.428)**		**$103.288**
Moving Integrated Plans to Middle of the Rate Range	$20.000	Y	$15.000
Restore MMC/MLTC Quality Pools (1-Year Restoration)	$77.250	Y	$77.250
*Utilize Child Health Plus (CHP) to Access Federal Funding for Enhanced Pregnancy Coverage	($183.000)	N	$0.000
Applied Behavior Analysis (ABA) Rates to Incentivize Providers in Managed Care	$36.605	N	$0.000
Adjust HIV SNP Rates to Reflect High Needs Model	$14.717	Y	$11.038
Other Actions	**$462.349**		**$350.684**
Increase Medicaid Trend Factor by 1% to Recognize Provider Cost Increases	$318.310	Y	$238.733
Restoration of 1.5% Across the Board (ATB)	$140.759	Y	$105.569
Investment in Children's Behavioral Health Services	$37.260	Y	$27.945

Use of Federal HCBS funding to support Children's Behavioral Health Services	($37.260)	Y	($27.945)
Increase Top 20 Orthotics and Prosthetics Codes to Medicare Rates	$3.750	Y	$2.813
Establish Unique Identifier for All Unenrolled Provider Types	($5.000)	N	$0.000
Promote Access to Primary Care	$4.930	Y	$3.698
Eliminate Unnecessary Requirements from the Utilization Threshold (UT) Program	($0.230)	N	$0.000
Enhanced Durable Medical Equipment (DME) Management	($0.170)	Y	($0.128)
Maternal Health Actions	**$4.335**		**($8.500)**
Improve and Expand Access to Prenatal and Postnatal Care	$6.335	N	$0.000
Advancing Comprehensive Maternal Care in Managed Care	$15.000	N	$0.000
Maternal Health Investments - Avoided Costs	($17.000)	Y	($12.750)
Other State of the State Actions	**$13.187**		**$0.000**
Create a Center of Medicaid Innovation to Lower Costs and Improve Care	$1.200	N	$0.000
*Promote Health Equity and Continuity of Coverage for Vulnerable Seniors	$5.000	N	$0.000
Patient Access and Developer Portals	$4.06	N	$0.000
Health Care Bonus Enforcement	$2.930	N	$0.000
Adds	**$904.825**		**$38.741**
Additional Hospital Funding	$800.000	Y	$305.420
*Maternal Health for Postpartum Coverage for Undocumented	$2.325	N	$0.000
*Medicaid Coverage for Undocumented Age 65+	$56.454	N	$0.000
Additional QIVAPP Support	$37.400	Y	$38.741
*Medicare Savings Program Expansion	$5.200	N	$0.000
Medicaid Ambulance Billing	$3.446	N	$0.000
Avails	**($946.035)**		**($463.835)**
Other Revisions and Timing of Payments Across Fiscal Years	($342.335)	Y	($342.335)
Mainstream Managed Care Non-Federal Share Assumption	($486.000)	Y	($364.500)
Temporary Support for One-time COVID-related Hospital Expenses	($84.000)	Y	($63.000)
CDPAP Request for Offer (RFO) Re-estimate	($25.000)	N	$0.000
*Elderly Pharmaceutical Insurance Coverage (EPIC) Savings Offset related to MSP Expansion	($8.700)	N	$0.000
Total Global Cap (Surplus)/Deficit	**$0.000**		**($337.493)**
Home Care Minimum Wage Increase	$362.578	Y	$181.289
Use of Federal HCBS funding to support Home Care Minimum Wage Increase	($362.578)	N	$0.000
Home Care Minimum Wage Increase Supported Outside the Global Cap	**$0.000**		**$181.289**

*Includes Budget Actions with an effective date that is beyond the time period of this report.

Appendix C. Regional Spending Data

The chart below represents total provider spending that occurs within the Medicaid claiming system (eMedNY) through December 2022 for each region. These values represent physically where the services were provided, but not necessarily where the recipient of the services reside.

Medicaid Regional Spending ($ in millions)	
Economic Region	**Non-Federal Total Paid**
New York City	$15,254
Long Island	$2,433
Mid-Hudson	$2,500
Western	$1,169
Finger Lakes	$995
Capital District	$775
Central	$558
Mohawk Valley	$501
Southern Tier	$426
North Country	$298
Out of State	$80
TOTAL	**$24,989**

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 D. State-Only Payments (YTD)

State-only Payments ($ in millions)	Non-Federal Total Paid
Net VAPAP advances related to DPT	$927.2
VAPAP	$674.0
Supportive Housing	$38.3
Rural Transportation	$8.0
Alzheimer's Caregiver Support	$19.1
End of AIDS	$7.7
Assisted Living Voucher Demo	$5.7
MLTC Ombudsman	$0.7
CSEA Buy-in	$1.6
Primary Care Services Corp	$0.4
TOTAL	**$1,682.7**

Appendix E. Medicaid Drug Cap

- The FY 2018 Enacted Budget established a Medicaid Drug Cap that limits pharmacy spending growth in the Medicaid program tied to the annual growth rate of the Medicaid Global Cap, which is determined annually according to statute (5.8% in FY 2023).

- Prior to FY 2023, the Global Cap allowable growth was previously calculated using the ten-year rolling average of the medical component of the CPI for all urban consumers. The FY 2023 Enacted Budget modified the metric by which Medicaid Global Cap and Medicaid Drug Cap allowable spending growth is calculated, utilizing the five-year rolling average of health care spending, using projections from the CMS Actuary.

- 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 an 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.

- Over the past five years of implementation (FY 2018-FY 2022), the Medicaid Drug Cap has achieved over $500 million in gross savings through spending reductions and additional supplemental rebate agreements with pharmaceutical manufacturers for over 60 high-cost drugs.

- In FY 2021, the COVID-19 pandemic significantly altered underlying assumptions historically used to project pharmacy specific utilization and spending in the Medicaid program. Specifically, the COVID-19 pandemic and associated Maintenance of Effort (MOE) requirements under Section 6008 of the Families First Coronavirus Response Act (FFCRA) resulted in a rapid (and unpredictable) escalation in Medicaid enrollment with newly eligible populations having different risk profiles or spending patterns than existing Medicaid enrollees. Given the uncertainty of underlying enrollment and spending assumptions it was not possible to accurately project whether Medicaid pharmacy spending would exceed the statutory growth rate. Therefore, the Medicaid Drug Cap was not triggered in FY 2021.

- Consistent with the statutory formula, the Medicaid Drug Cap for FY 2023 is $1.9 billion (State share) and reflects a growth rate of 5.8 percent consistent with the Medicaid Global Spending Cap. The Department is still evaluating the projected net drug spend for FY 2023 which will be reported on in a future update.

Appendix F. Additional Information

- Fee-For-Service Rates for General Hospitals:
  - Inpatient Rates: https://www.health.ny.gov/facilities/hospital/reimbursement/apr-drg/rates/ffs/index.htm
  - Outpatient Rates: https://www.health.ny.gov/health_care/medicaid/rates/apg/rates/hospital/index.htm
- Fee-For-Service Rates of Pharmaceutical Drugs on the Preferred Drug List (PDL): https://newyork.fhsc.com/downloads/providers/NYRx_PDP_PDL.pdf
- Fiscal Intermediaries: Article VII – HMH Part PP: At this time, there are 0 Fiscal Intermediaries contracted with the State, below is the current status:
  - The FY 2023 Enacted Budget revised Social Services Law Section 365-f with a material modification of the approach underlying the fiscal intermediary Request for Offers (RFO) issued in December 2019 and the Survey of Qualified Offerors issued in June 2021.
  - The new legislative provisions now require DOH to offer contracts to the 68 awardees from February 2021 and all other qualified offerors from the initial RFO if such other qualified offerors affirmatively attest that they served at least 200 consumers in NYC, or 50 consumers in other areas of the state, at any point during the first calendar quarter of 2020.
  - DOH developed and issued the attestation documents to the qualified offerors and OMIG is auditing the attestation supporting information. Once completed, awards will be made to additional offerors and the Department will contract with the original 68 awardees and those selected under the attestation process.
  - MLTC Policy 21.01 outlining the transition policies for non-contracted fiscal intermediaries remains in effect. Please note, DOH has not announced a “contract notification date” and therefore all fiscal intermediaries can continue to operate at this time.