



# Medicaid Global Spending Cap Report

## April through September 2021 Quarterly Report



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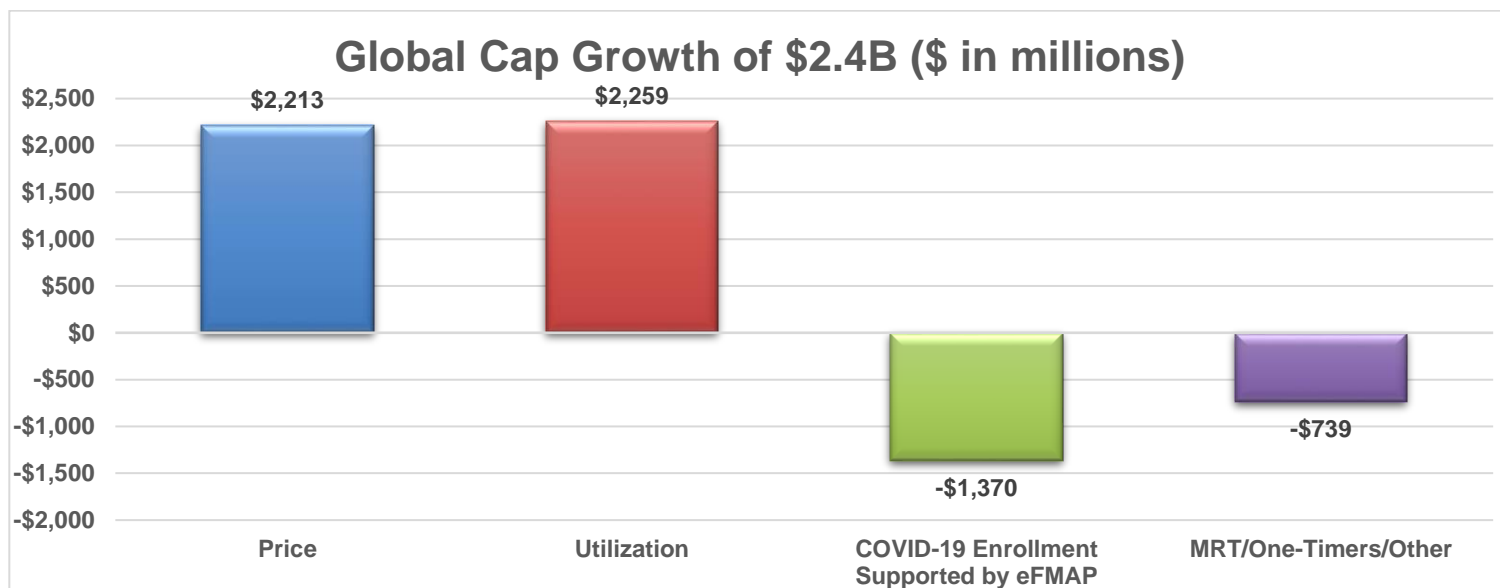
## Overview

The Medicaid Global Spending Cap increased from \$19.9 billion in Fiscal Year (FY) 2021 to \$22.3 billion in FY 2022, a net increase of \$2.4 billion.

This net increase primarily includes the Global Cap index growth of \$580 million (based on the 2.9 percent trend of the ten-year rolling average of the Medical Care Consumer Price Index [CPI]), increased costs for minimum wage rate adjustments of \$369 million, and the year-to-year decline of COVID-19 enhanced Federal Medical Assistance Percentage (eFMAP) support of \$1.2 billion.

Major changes to Medicaid spending, as reflected in the Mid-Year Financial Plan Update, include the extension of the COVID-19 public health emergency (PHE) eFMAP benefit, the resulting costs associated with persistently elevated enrollment and delayed MRT II savings, attributable to the Federal Center of Medicare and Medicaid Services (CMS) Maintenance of Effort (MOE) guidelines restricting program restructuring efforts, and increased support to financially distressed hospital providers. These impacts are accounted for separately in the Financial Plan and do not result in an adjustment to the Global Cap.

The chart below breaks out the major components of the annual increase, including higher costs associated with both price and utilization increases. These costs are primarily offset by COVID-19 eFMAP support as well as MRT budget initiatives.



**Price (\$2.2 billion):** The annual growth in the Medicaid Global Spending Cap is limited to the 10-year rolling average of the Medical CPI, which has declined over time from the initial 4 percent to the current rate of 2.9 percent. This allowable growth rate is significantly less than national health spending projections prepared by CMS, which are expected to grow at an average annual rate of 5.4 percent for 2019-28 and reach \$6.2 trillion by 2028<sup>1</sup>. Components of price growth include:

- Trend increases for Mainstream Managed Care rates (\$1.2B);
- Trend increases for Long Term Managed Care rates (\$769M); and
- Various increases for fee-for-service (FFS) rates (\$267M).

**Utilization (\$2.3 billion):** Medicaid enrollment is projected to increase by 633,000 New Yorkers or 9.1 percent, increasing from 7.0 million enrollees as of March 2021 to 7.6 million enrollees by March 2022. This growth is in

<sup>1</sup> <https://www.cms.gov/files/document/nhe-projections-2019-2028-forecast-summary.pdf>

large part due to the COVID-19 pandemic, including pandemic related Federal requirements that have precluded most forms of involuntary disenrollment from Medicaid (e.g., eligibility redeterminations), and attendant loss of employer-sponsored coverage or changes in income. 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 401,000 individuals by March 2022;
- Long Term Managed Care enrollment is projected to increase 13,000 individuals (5 percent); and
- Utilization is expected to partially return to pre-COVID-19 levels in acute care, nursing homes, and transportation fee-for-service categories of spending, resulting in an increase of 219,000 individuals in fee-for-service (FFS).

**COVID-19 Enrollment Supported by eFMAP (-\$1.4 billion):** The Global Cap is utilizing available COVID-19 eFMAP funding to offset the increased enrollment due to impacts of the COVID-19 pandemic.

**MRT II/One-Timers/Other (-\$739 million):** MRT budget actions, one-time costs/savings, or other payments that do not fall into price or utilization include:

- Savings from budget actions such as New York City Health and Hospitals (H+H) Budget Actions, Public Emergency Certified Public Expenditure, and Returning Non-Distressed Providers to the Payment Lag (-\$603M); and
- Returning to the normal pattern of 52 weekly Medicaid fee-for-service payment cycles in FY 2022 as opposed to having an extra 53<sup>rd</sup> weekly cycle, as was the case in FY 2021 (-\$132M).

## 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 has continued into Fiscal Year 2022<sup>2</sup>. 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<sup>3</sup>.

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 decline of eFMAP due to the claiming of 14 months in FY 2021 (for the period of January 2020 to February 2021) and 12 months projected to be claimed in FY 2022 (for the period of March 2021 to February 2022). Due to the timing of reconciliations, March 2022 COVID-19 eFMAP will be realized in April 2022, which is the first month of FY 2023 (\$302 million combined State and Local shares).

COVID 19 eFMAP FY 2021 to FY 2022			
\$ in millions			
	FY 2021	FY 2022	Annual Change
State Share	\$3,420	\$2,983	(\$437)
Local Share	\$754	\$646	(\$108)
<b>Total 6.2% eFMAP</b>	<b>\$4,174</b>	<b>\$3,629</b>	<b>(\$545)</b>

### **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 June 2021, the end of this reporting period, Medicaid enrollment increased by 1.1 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.

Declines in inpatient services were observed as elective procedures were cancelled or postponed. However, the associated spending decreases were partially offset by increased costs associated with higher intensity COVID-19 related inpatient care (e.g., ventilation, intubation) and emergency related services.

Long-term care services that comprise a significant portion of Medicaid spending were also impacted as utilization of

<sup>2</sup> As of the date of this Report, the Federal government has extended the public health emergency through January 2022 which allows for COVID-19 eFMAP through at least March 31, 2022. Notwithstanding the Secretary's ability to revoke the emergency prior to the start of a new calendar quarter (i.e. prior to January 2022), the State's financial plan assumes COVID-19 eFMAP will continue through the end of FY 2022.

<sup>3</sup> 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.

nursing home services decreased; as did personal care services as enrollees deferred services due to the risk of exposure to COVID-19, and as enrollees sought additional informal supports. Certain other services in congregate settings were also closed resulting in lower overall long-term care utilization.

Increased flexibility for telehealth services, including the expansion of telehealth options for clinics, optometrists, and dentists, and the ability of enrollees to seek certain telehealth services through alternate modalities, resulted in increased utilization for certain types of services. Much of the telehealth spend during the COVID-19 period tied directly to behavioral health services.

## Mid-Year Update Model Changes

DOH, in collaboration with the Division of the Budget, updated the Enacted Budget Medicaid Global Cap Model for price and utilization trends based on spending through July 2021, as well as other known factors. This Mid-Year Update Model projects spending to be aligned with the Global Cap spending target of \$22.3 billion. The following table outlines the changes from the Enacted Budget Model of the 1<sup>st</sup> Quarter Global Cap Report to the Mid-Year Update Model of the 2<sup>nd</sup> Quarter Global Cap Report.

Mid Year Update Model Changes (\$ in millions)			
Category of Spending	Enacted Budget Model	Mid-Year Update Model	\$ Change Higher / (Lower)
<b>Medicaid Managed Care</b>	<b>\$20,748</b>	<b>\$20,909</b>	<b>\$161</b>
Mainstream Managed Care	\$12,737	\$12,896	\$158
Long Term Managed Care	\$8,011	\$8,014	\$2
<b>Total Fee For Service</b>	<b>\$7,068</b>	<b>\$7,249</b>	<b>\$181</b>
Inpatient	\$2,556	\$2,529	(\$27)
Outpatient/Emergency Room	\$349	\$345	(\$5)
Clinic	\$407	\$406	(\$1)
Nursing Homes	\$3,119	\$3,189	\$70
Other Long Term Care	\$867	\$900	\$33
Pharmacy	(\$1,011)	(\$934)	\$77
Transportation	\$239	\$267	\$28
Non-Institutional	\$542	\$547	\$5
<b>Other State Agencies</b>	<b>\$1,517</b>	<b>\$1,186</b>	<b>(\$331)</b>
<b>Medicare Part A/B &amp; D</b>	<b>\$2,416</b>	<b>\$2,672</b>	<b>\$256</b>
<b>All Other</b>	<b>(\$47)</b>	<b>\$48</b>	<b>\$95</b>
<b>Medicaid Administration</b>	<b>\$452</b>	<b>\$452</b>	<b>(\$0)</b>
<b>State Operations</b>	<b>\$302</b>	<b>\$301</b>	<b>(\$1)</b>
<b>Local Cap Contribution</b>	<b>(\$6,727)</b>	<b>(\$6,482)</b>	<b>\$245</b>
<b>COVID-19 eFMAP</b>	<b>(\$3,024)</b>	<b>(\$3,629)</b>	<b>(\$605)</b>
<b>Audit Collections</b>	<b>(\$412)</b>	<b>(\$412)</b>	<b>\$0</b>
<b>TOTAL</b>	<b>\$22,295</b>	<b>\$22,295</b>	<b>(\$0)</b>

**Medicaid Managed Care (\$161 million):** The extension of the PHE is accompanied by cost increases for enrollees whose coverage has been extended due to MOE provisions in FFCRA, as well as the State's 12-month continuous coverage mandate.

**Nursing Home (\$70 million):** The case mix methodology was updated per the FY 2022 Enacted Budget initiative; however, savings did not materialize to the levels previously projected.

**Pharmacy (\$77 million):** Anticipated rebates were reduced to align with recent drug utilization and invoicing trends. Such trends include significant growth in the 340B program (which utilizes 340B drugs not eligible for rebates), and increased utilization of generic drugs (which have lower upfront costs, but also lower rebates).

**Other State Agencies (-\$331 million):** Reflects additional Financial Plan resources to support Office for People with Developmental Disabilities (OPWDD) related Medicaid local share expenses.

**Medicare Part A/B & D (\$256 million):** Includes all FY 2022 regularly scheduled Medicare payments for Part A&B and Part D Clawback Part D (\$201M) to bring the State current on invoices. Trends for utilization and rates were also updated to reflect more recent spending patterns.

**All Other (\$95 million):** Includes the Distressed Provider Assistance Account Payment which supports hospitals and nursing homes that are critical safety-net providers; funded by an equal offset from the



local distressed tax intercept fund.

**Local Cap Contribution (\$245 million):** Decreased the contribution from localities as a means to provide counties with their projected share of the COVID-19 eFMAP for the October 2021 to December 2021 quarter.

**COVID-19 eFMAP (-\$605 million):** Increased the anticipated COVID-19 eFMAP due to the PHE extension for two additional months in FY 2022 (3<sup>rd</sup> month eFMAP will be realized in FY 2023).

## 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 through 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 approval of Maintenance-of-Effort (MOE) requirements associated with the Families First Coronavirus Response Act (FFCRA) eFMAP of 6.2 percent on Medicaid payment 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 2022.

**Extension of the Public Health Emergency:** The Secretary of Human Services has extended the COVID-19 PHE through at least January 17, 2022, which extends COVID-19 eFMAP through March 2022 (the Enacted Global Cap Model assumed COVID-19 eFMAP through December 2021). Due to the timing of monthly reconciliations, March FY 2022 COVID-19 eFMAP will be realized in April 2022 (the first month of FY 2023). The extension of the public health emergency (and COVID-19 eFMAP) is accompanied by cost increases for enrollees whose coverage has been extended due to CMS MOE provisions in the Families First Coronavirus Response Act (FFCRA), as well as the State's 12-month continuous coverage mandate.

**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 public health emergency. Additionally, Section 9817 of the March 2021 ARPA imposed an MOE requirement conditioned on states spending the 10 percent eFMAP related to certain home and community-based services. As a result, several MRT initiatives aimed at modifying eligibility 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.

**Financial Plan Enrollment Projections:** The Mid-Year Financial Plan assumes that enrollment levels will peak at nearly 7.6 million in FY 2022. Total COVID-19 Medicaid enrollment costs amounted to \$912 million in FY 2021 and an estimated \$2.3 billion in FY 2022, which eroded the value of the eFMAP benefit. As the economy recovers and unemployment trends towards pre-pandemic levels, costs associated with individuals temporarily enrolled, are expected to begin declining in FY 2023 due to the Federal requirement that enrollees receive a minimum of twelve-months continuous coverage regardless of changes in eligibility status.

**Distressed Provider Assistance Account Payment:** Established in the FY 2021 Enacted Budget to support financially distressed hospitals and nursing homes that are critical safety-net providers, \$250 million of State-share Medicaid spending was added to the FY 2022 Medicaid Global Cap. In FY 2022, these new Medicaid costs are supported by \$250 million from the local distressed tax intercept fund, thereby resulting in a net zero-impact to the Cap.

**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 9th. CMS partially approved the spending plan on August 25, 2021, and the Department continues to work with CMS on receiving approval for the balance of the spending plan through the second quarter of FY 2022. The Department may modify the spending plan, subject to CMS's approval, on a quarterly basis.

In its quarterly spending plan update from October 18, 2021, 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 has submitted subsequent waiver extension requests to continue its Medicaid Redesign and healthcare delivery system transformation efforts. CMS has approved, through at least March 31, 2022, an 1115 Medicaid waiver extension that preserves the State's Medicaid Managed Care Programs, Children's

HCBS, and self-direction of personal care services. Subsequently, on August 24, 2021, the Department of Health submitted a 1115 waiver amendment concept paper to CMS. This concept paper proposes a framework for substantial new 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 social care and health care in NYS. This comprehensive initiative would also lay the groundwork for reducing long standing racial, disability-related, and socioeconomic health care disparities, increasing health equity through measurable improvement of clinical outcomes, and keeping overall Medicaid program expenditures budget neutral to the Federal government.

The concept paper is non-binding and does not represent an official waiver submission but is a required step of the waiver approval process. CMS is reviewing the concept paper and is in the process of offering the Department of Health (DOH) guidance for modifications prior to the formal waiver amendment submission. This step is necessary to ensure the State's waiver request will align with Federal objectives and requirements.

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

The \$22.3 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 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, 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, occur **outside** of the eMedNY billing system. 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.

The following table outlines the FY 2022 Medicaid projections by major health care sector (i.e., category of spending) for Medicaid claims, supplemental programs, and offsets.

Projected FY 2022 Medicaid Spending (\$ in millions)				
Category of Spending	Medicaid Claims	Supplemental Programs	Offsets	Total
<b>Medicaid Managed Care</b>	<b>\$21,469</b>	<b>\$755</b>	<b>(\$1,314)</b>	<b>\$20,909</b>
Mainstream Managed Care	\$13,472	\$296	(\$872)	\$12,896
Long Term Managed Care	\$7,997	\$459	(\$442)	\$8,014
<b>Total Fee For Service</b>	<b>\$8,103</b>	<b>\$1,127</b>	<b>(\$1,981)</b>	<b>\$7,249</b>
Inpatient	\$2,129	\$762	(\$362)	\$2,529
Outpatient/Emergency Room	\$434	\$0	(\$89)	\$345
Clinic	\$464	\$4	(\$62)	\$406
Nursing Homes	\$2,965	\$279	(\$55)	\$3,189
Other Long Term Care	\$889	\$31	(\$20)	\$900
Pharmacy	\$364	\$2	(\$1,301)	(\$934)
Transportation	\$269	\$36	(\$38)	\$267
Non-Institutional	\$588	\$13	(\$54)	\$547
<b>Other State Agencies</b>	<b>\$4,187</b>	<b>\$0</b>	<b>(\$3,001)</b>	<b>\$1,186</b>
<b>Medicare Part A/B &amp; D</b>	<b>\$0</b>	<b>\$2,672</b>	<b>\$0</b>	<b>\$2,672</b>
<b>All Other</b>	<b>\$0</b>	<b>\$1,223</b>	<b>(\$1,175)</b>	<b>\$48</b>
<b>Medicaid Administration</b>	<b>\$0</b>	<b>\$452</b>	<b>\$0</b>	<b>\$452</b>
<b>State Operations</b>	<b>\$0</b>	<b>\$301</b>	<b>\$0</b>	<b>\$301</b>
<b>Local Cap Contribution</b>	<b>\$0</b>	<b>\$0</b>	<b>(\$6,482)</b>	<b>(\$6,482)</b>
<b>COVID-19 eFMAP</b>	<b>\$0</b>	<b>\$0</b>	<b>(\$3,629)</b>	<b>(\$3,629)</b>
<b>Audit Collections</b>	<b>\$0</b>	<b>\$0</b>	<b>(\$412)</b>	<b>(\$412)</b>
<b>TOTAL</b>	<b>\$33,759</b>	<b>\$6,530</b>	<b>(\$17,994)</b>	<b>\$22,295</b>

**Major Supplemental Programs:**

**Medicaid Managed Care (\$755 million)**

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

**Fee For Service (\$1.1 billion)**

- Inpatient: Disproportionate Share Hospital (DSH) and Voluntary Upper Payment Limit (UPL).
- Nursing Homes: Advance Training Initiatives, 2% 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 (\$2.7 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.

### **All Other (\$1.2 billion)**

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

- Distressed Provider Assistance Account Payment (\$250 million): Supports hospitals and nursing homes that are critical safety-net providers; funded by an equal offset from the local distressed tax intercept fund.
- Vital Access Provider Assurance Program (VAPAP) (\$225 million): The VAPAP program provides State-only support for facilities in need of essential and immediate cash assistance with the ultimate requirement of sustainability and access to care.
- Vital Access / Safety Net Provider Program (\$91 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 expand access to ambulatory services, open urgent care centers, expand services in rural areas, and provide more effective services that meet community needs.
- Patient Centered Medical Homes (\$117 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 (\$452 million)**

The annual county Medicaid caps for Local Administration will remain at their historic/current levels during FY 2022, 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 (\$301 million)**

The 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 2022 Budget is projected to total \$301million 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 2022 Budget (\$ in millions)	
Service Costs	Annual Budget
<b>Personal Services</b>	<b>\$45</b>
<i>Medicaid</i>	\$41
<i>Essential Plan</i>	\$4
<b>Non-Personal Services</b>	<b>\$256</b>
<i>Medicaid</i>	\$196
<i>Essential Plan</i>	\$60
<b>TOTAL</b>	<b>\$301</b>

### **Major Offsets:**

#### **Medicaid Managed Care (-\$1.3 billion)**

- Mainstream Managed Care: 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 then reimbursed.
- Long Term Managed Care: 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 (-\$2.0 billion)**

- Inpatient: Similar to CHP, the transfer of Department of Corrections and Community Supervision (DOCCS) medical expenditures for inmates that are coded in eMedNY as DOH Inpatient claims out of the Medicaid Global Cap to the General Fund.
- 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.
- Transportation: Certified Public Expenditures (CPE) supplemental claim for Federal Revenue.

#### **Other State Agencies (-\$3.0 billion)**

Transfers from Other State Agencies to support State-share Medicaid expenditures for services of OPWDD, the 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 (-\$1.2 billion)**

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

- Budget Actions (-\$579 million): Includes New York City H+H Budget Actions (-\$400 million), Return Non-Distressed Medicaid providers back on the State's two-week payment lag schedule (-\$75 million), and the 1.5 percent Across-the-Board payment reduction (-\$104 million).

- Supplemental Federal Revenue (-\$117 million): Includes claiming Federal revenue for Family Planning services, Supportive Housing, and School Supportive Health services.
- Accounts Receivable (-\$55 million): Represents the collection of Medicaid provider liabilities owed to the State resulting from processing retroactive rate adjustments.

### **Local Cap Contribution (-\$6.5 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 2022.

Due to the timing of the release of the counties' share of the COVID-19 eFMAP, county contributions were reduced for the period January 2020 through September 2020 in FY 2021, while the eFMAP received for the period October 2020 through December 2021 is reflected as a reduction to the FY 2022 Local Cap Contribution.

### **COVID-19 eFMAP (-\$3.6 billion)**

Refer to the previous, "Impact of the COVID-19 Pandemic," section for additional details.

### **Audit Collections (-\$412 million)**

The Department of Health collaborates with the Office of the Medical 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 regulation. 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.



## Results April through September 2021 – Global Cap Target vs. Actual Spending

Through September 2021, total actual State Medicaid spending is \$59 million below the Medicaid Global Spending Cap projection. Spending through September resulted in total expenditures of \$11.566 billion compared to the allowable spending target of \$11.625 billion. However, 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 September 2021 Medicaid Global Cap Target vs. Actual Spending (\$ in millions)				
Category of Spending	Global Cap Target	Actual	\$ Variance Over / (Under)	% Variance Over / (Under)
<b>Medicaid Managed Care</b>	<b>\$11,197</b>	<b>\$11,184</b>	<b>(\$12)</b>	<b>-0.1%</b>
Mainstream Managed Care	\$6,649	\$6,628	(\$21)	-0.3%
Long Term Managed Care	\$4,547	\$4,556	\$9	0.2%
<b>Total Fee For Service</b>	<b>\$3,482</b>	<b>\$3,430</b>	<b>(\$52)</b>	<b>-1.5%</b>
Inpatient	\$1,296	\$1,279	(\$17)	-1.3%
Outpatient/Emergency Room	\$172	\$163	(\$9)	-5.1%
Clinic	\$204	\$195	(\$9)	-4.3%
Nursing Homes	\$1,394	\$1,397	\$3	0.2%
Other Long Term Care	\$452	\$443	(\$8)	-1.9%
Pharmacy	(\$451)	(\$460)	(\$8)	1.9%
Transportation	\$151	\$154	\$3	1.8%
Non-Institutional	\$264	\$259	(\$6)	-2.1%
<b>Other State Agencies</b>	<b>\$608</b>	<b>\$608</b>	<b>\$0</b>	<b>0.1%</b>
<b>Medicare Part A/B &amp; D</b>	<b>\$1,320</b>	<b>\$1,323</b>	<b>\$3</b>	<b>0.2%</b>
<b>All Other</b>	<b>(\$13)</b>	<b>(\$37)</b>	<b>(\$24)</b>	<b>-190.5%</b>
<b>Medicaid Administration</b>	<b>\$256</b>	<b>\$256</b>	<b>\$0</b>	<b>0.0%</b>
<b>State Operations</b>	<b>\$135</b>	<b>\$140</b>	<b>\$5</b>	<b>3.8%</b>
<b>Local Cap Contribution</b>	<b>(\$3,296)</b>	<b>(\$3,296)</b>	<b>\$0</b>	<b>0.0%</b>
<b>COVID-19 eFMAP</b>	<b>(\$1,836)</b>	<b>(\$1,845)</b>	<b>(\$9)</b>	<b>-0.5%</b>
<b>Audit Collections</b>	<b>(\$227)</b>	<b>(\$198)</b>	<b>\$30</b>	<b>13.0%</b>
<b>TOTAL</b>	<b>\$11,625</b>	<b>\$11,566</b>	<b>(\$59)</b>	<b>0.5%</b>

The following explanations regarding the variances between the Global Cap Target through September 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 \$12 million under anticipated spending, or 0.1 percent.

- Mainstream Managed Care was \$21 million under anticipated spending, or 0.3 percent. This variance is largely attributed to higher-than-expected ACA eFMAP received on the enrolled population (i.e., total enrollment is actualizing as projected; however, a larger share of the newly enrolled population is drawing down more eFMAP than expected by being a part of the Medicaid expansion population<sup>4</sup>).

<sup>4</sup> 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.

## **Fee-For-Service**

Medicaid spending in major fee-for-service categories was \$52 million, or 1.5 percent, under target.

- Inpatient was \$17 million under anticipated spending, or 1.3 percent. This variance is largely attributed to lower-than-expected cost per claim.

## **All Other**

All Other spending underspent by \$24 million or 191 percent. 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.

## **Audit Collections**

Audit collections received were \$30 million, or 13 percent, below projections through September, which is due to the timing in processing of audits and resulting recoveries.

## Medicaid Enrollment

Due to enrollment of individuals who lost their employment or had lower income because of the COVID-19 pandemic Medicaid enrollment is expected to grow to 7,594,000 individuals by March 2022, an increase of 633,000 individuals from March 2021.

**Mainstream Managed Care (includes HIV/SNPs and HARPs):** Due to the economic repercussions of COVID-19, New York has been one of the hardest hit states in relation to jobs with a large number of people either unemployed or expected to become unemployed. As a result, these individuals would qualify for Medicaid, thereby increasing enrollment in Mainstream Managed Care by close to 401,000 in FY 2022.

**Long Term Managed Care (includes PACE, FIDA IDD, MA and MAP):** Long Term Managed Care (MLTC) enrollment reached 280,000 by the end of FY 2021. This was a net increase of 5,000 individuals consisting of an increase of 22,000 individuals, offset by the Nursing Home carveout initiative (implemented September 2020) that disenrolled approximately 17,000 long term stay individuals from MLTC partial capitation plans and placed into Medicaid fee-for-service. The FY 2022 projections assume that enrollment will grow by five percent, approximately 13,000 individuals, over March 2021 levels<sup>5</sup>.

### Medicaid Enrollment to Date

Medicaid Enrollment Summary Medicaid Managed Care vs Fee for Service				
	March 2021	September 2021	Net Increase / (Decrease)	% Change
Mainstream Managed Care	5,185,045	5,362,786	177,741	3.4%
Long Term Managed Care	280,250	285,415	5,165	1.8%
Fee-For-Service	1,496,429	1,558,164	61,735	4.1%
<b>TOTAL</b>	<b>6,961,724</b>	<b>7,206,365</b>	<b>244,641</b>	<b>3.5%</b>

Medicaid Enrollment Summary by NYC vs Rest of State				
	March 2021	September 2021	Net Increase / (Decrease)	% Change
NYC	3,966,428	4,102,503	136,075	3.4%
Rest of State	2,995,296	3,103,862	108,566	3.6%
<b>TOTAL</b>	<b>6,961,724</b>	<b>7,206,365</b>	<b>244,641</b>	<b>3.5%</b>

*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 April through September based on data pulled October 5, 2021.*

<sup>5</sup> These enrollment assumptions will be adjusted, as necessary, through approved rate packages.

## Appendix A – Inventory of Rate Packages

Below are the largest of the anticipated rate packages to be processed in FY 2022:

Category of Service	Rate Package Description	Month Paid
Managed Care	April 2021 Mainstream Rates*	October 2021
	April 2021 HARP Rates*	October 2021
	April 2021 HIV Special Needs Plans (HIV SNP) Rates	
	January 2020 HIV SNP Rates	December 2021
	FY 2021 Encounter Withhold	June 2021
	CY 2020 HIV SNP Incentive Pool Payment	
Long Term Managed Care	April 2021 Partial Capitation Rates*	October 2021
	April 2021 Medicaid Advantage Plan (MAP) Rates*	October 2021
	April 2021 Program of All-Inclusive Care for the Elderly (PACE) Rates	
	FY 2021 Encounter Withhold	June 2021
	FY 2021 QIVAPP	
	CY 2020 Quality Pools	November 2021
Inpatient	2016 & 2017 Acute & Exempt Actual Capital Updates	
	January 2021 Acute & Exempt Unit Inpatient Rates	June 2021
Outpatient / Emergency Room	CY 2016 APG Capital Update	
	CY 2017 APG Capital Update	
	CY 2018 APG Capital Update	
	January 2020 Hold Harmless	
Clinic	October 2021 FQHC MEI Increase	October 2021
	CY 2020 APG Capital Update	
	CY 2021 APG Capital Update	
Nursing Homes	January 2021 NH Initial Rates	September 2021
	July 2021 NH Rate Updates	October 2021
	January 2021 NH Rate Corrections	October 2021
	January 2021 Cash Receipts Assessment Rates	
	CY 2020 Cash Receipts Assessment Reconciliation	December 2021
	FY 2022 Advanced Training Initiative	
	FY 2022 Quality Incentive Pool and 2% Supplemental	
	FY 2022 Nursing Home Reforms	
	CY 2017 MDS Audits	
Personal Care	January 2021 Initial Rates	
	January 2021 Private Duty Nursing Rates	
Assisted Living	January 2021 ALPs Initial Rates	
Hospice	January 2021 Non-Residence Rates	
	January 2021 Residence Rates	
Home Health	January 2021 CHHA Pediatric Rates	
	January 2021 CHHA Episodic Rates	
Other	July 2020 Patient Centered Medical Homes	
	January 2021 Patient Centered Medical Homes	

\*The final impacts of the April 2021 Managed Care and MLTC rates to the Global Cap Model are currently being assessed.

## Appendix B – MRT II Initiatives – FY 2022 Enacted Budget

([http://www.health.ny.gov/health\\_care/medicaid/redesign/mrt\\_budget.htm](http://www.health.ny.gov/health_care/medicaid/redesign/mrt_budget.htm))

Below is a condensed version of the FY 2022 Enacted Scorecard which focuses the list on budget actions anticipated to be implemented in FY 2022.

(State Share \$ millions)	Effective Date	FY22 Enacted
<b>Mainstream Managed Care (MMC) Actions</b>		<b>(\$4.40)</b>
FY18 MMC Medical Loss Ratio (MLR) Recoupment	4/1/21	(\$4.40)
<b>Hospital Actions</b>		<b>(\$16.12)</b>
Reduce Hospital Capital Rate Add-on (from 5% to 10%)	10/1/21	(\$8.50)
Discontinue Value Base Payment (VBP) Readiness Funding	4/1/21	(\$7.62)
<b>Long-Term Care Actions</b>		<b>(\$42.35)</b>
Electronic Visit Verification (EVV) Savings	4/1/21	(\$20.00)
FY18 Managed Long-Term Care MLR Recoupment	4/1/21	(\$22.35)
<b>Other</b>		<b>(\$225.81)</b>
Return Non-Distressed Providers to Lag	4/1/21	(\$75.00)
Pilot Medical Respite	4/1/21	(\$1.31)
Comprehensive Telehealth Reform Package	4/1/21	(\$39.50)
Offset of State-Only Medicaid Costs	4/1/21	(\$110.00)
<b>Adds</b>		<b>\$129.00</b>
Nursing Home Reforms	4/1/21	\$32.00
Young Adult Nursing Home – Pilot	4/1/21	\$8.75
Housing Disregard for Personal Care Services (PCS) and Consumer Directed Personal Assistance Program (CDPAP)	1/1/22	\$0.10
Expands Post-Partum Eligibility Coverage Between 200% and 223% Federal Poverty Level (FPL)	10/1/21	\$0.95
Delay Pharmacy Fee-For-Service (FFS) Transition to FY24	4/1/21	\$87.20
<b>Avails</b>		<b>(\$398.18)</b>
Expanded In-Home Services for the Elderly (EISEP) Investment Savings	4/1/21	(\$11.30)
Updated State Support Associated with the Delay Pharmacy FFS Transition to FY24	4/1/21	(\$15.00)
Updated State Support Associated with Home and Community Based Service (HCBS) Training Programs	4/1/21	(\$5.00)
Health+ Hospitals (H+H) VBP Credit	4/1/21	(\$30.78)
Strengthen H+H Delay to FY22	4/1/21	(\$207.00)
Nursing Home Case Mix	7/1/21	(\$83.33)
COVID-19 Managed Care Rate Reduction Account Receivable	4/1/21	(\$45.77)
<b>Net FY 2022 Enacted Global Cap Savings Actions</b>		<b>(\$557.86)</b>

## Appendix C – Regional Spending Data

The chart below represents total provider spending that occurs within the Medicaid claiming system (eMedNY) through September 2021 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	\$8,978
Long Island	\$1,444
Mid-Hudson	\$1,407
Western	\$738
Finger Lakes	\$619
Capital District	\$475
Central	\$351
Mohawk Valley	\$310
Southern Tier	\$269
North Country	\$195
Out of State	\$54
<b>TOTAL</b>	<b>\$14,840</b>

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/](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
Supportive Housing	\$19.5
Alzheimer's Caregiver Support	\$7.1
End of AIDS	\$6.0
Rural Transportation	\$4.0
Assisted Living Voucher Demo	\$3.3
MLTC Ombudsman	\$2.2
VAPAP	\$1.5
CSEA Buy-in	\$1.0
Primary Care Service Corps	\$0.4
<b>TOTAL</b>	<b>\$45.0</b>

## Appendix E – Medicaid Drug Cap

- The FY 2018 Enacted Budget established a Medicaid Drug Cap that limits pharmacy spending growth in the Medicaid program to an annual growth rate built on the 10-year rolling average of the medical component of the Consumer Price Index, which is determined annually according to statute (3.0% in FY 2022).
- 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 disproportionately 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 first three years of implementation (FY 2018- FY 2020), the Medicaid Drug Cap has stayed under the allowable growth rate and achieved savings through spending reductions and additional supplemental rebate contracts with pharmaceutical manufacturers for over 50 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.
- The Department, in collaboration with the Division of the Budget, is currently evaluating whether pharmacy expenditures will exceed the annual growth limitation imposed by the Medicaid Drug Cap (2.9%) in FY 2022.