NEW YORK STATE | Department of Health

Medicaid Global Spending Cap Report

April through February 2020

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Overview[1]

Pursuant to legislation, the Medicaid Global Spending Cap will increase from $20.8 billion in FY 2019 to $22.4 billion (including the Essential Plan) in FY 2020, an increase of 7.4 percent. The CPI used on Medicaid services subject to the trend was 3.0 percent (ten-year average of the Medical Care Consumer Price Index). Based on a review of price and utilization trends, FY 2019 results, and other factors, the State has concluded that a structural imbalance exists within the Medicaid Global Cap. A structural imbalance in this case means that estimated expense growth in State-share Medicaid subject to the Global Cap, absent measures to control costs, is growing faster than allowed under the Global Cap spending growth index (currently 3 percent).

The State estimates that, absent the actions described below, State-share Medicaid spending subject to the Global Cap would exceed the indexed growth amount by $4.0 billion in FY 2020 (including the FY 2019 deferral of $1.7 billion) and $3.1 billion in FY 2021. Factors that are placing upward pressure on State-share Medicaid spending (which includes spending under and outside the Global Cap) include, but are not limited to: reimbursement to providers for the cost of the increase in the minimum wage; the phase-out of enhanced Federal funding; increased enrollment and costs in managed long-term care; and payments to financially distressed hospitals.

Components of the projected $5.5 billion annual growth are as follows:

Price (+$1.29 billion)	• Trend increases for mainstream managed care rates ($357 million); • Long term managed care rates reduction (-$41 million); • Various FFS rate packages ($180 million); and • Minimum Wage Adjustment ($750 million).
Utilization (+$1.07 billion)	• Annualization of FY 2019 enrollment; and • New enrollment for FY 2020 (33,607 individuals).
MRT/One Timers/Other (+$3.14 billion)	• FY 2019 Payment Restructuring ($1.7 billion); • Loss of One-time credits i.e., Essential Plan Medical Loss Ratio rebates ($107 million); • Federal payment increases for Medicare Part B and Part D ($75 million); • Additional Vital Access Provider Assurance Program Payments ($77 million); • Outstanding Federal Obligations ($375 million); and • Local Cap Reconciliation ($110 million).

The State has, at times, taken actions to manage the timing of Medicaid payments to ensure compliance with the Global Cap. Between FY 2015 and FY 2018, the State managed the timing of payments across State fiscal years. In FY 2019, the State deferred, for three business days, the final cycle payment to Medicaid Managed Care Organizations, as well as other payments. The FY 2019 deferral had a State-share value of $1.7 billion and was paid utilizing cash on hand in April 2019, consistent with contractual obligations and had no impact on provider services. Absent the deferral, Medicaid spending under the Global Cap would have exceeded the statutorily indexed rate for FY 2019. This higher spending in FY 2019 appears to reflect growth in managed care enrollment and costs above projections, as well as certain savings actions and offsets that were not processed by year-end.

[1] Please note, the report includes dicussions related to future actions in order to provide additional known details

Following the need to defer FY 2019 Medicaid payments, the Division of the Budget (DOB) and the Department of Health (DOH) recognized that a structural imbalance existed within the Global Cap based on a review of price and utilization trends, and other factors. A structural imbalance in this case meant that estimated expense growth in Stateshare Medicaid subject to the Global Cap, absent measures to control costs, was growing faster than allowed under the Global Cap spending growth index.

DOB and DOH estimates that, absent actions to control costs, State-share Medicaid spending subject to the Global Cap would have exceeded the indexed growth amount by upwards of $3 to $4 billion annually, inclusive of the FY 2019 deferral of $1.7 billion.

The projected $4 billion imbalance in the Medicaid Global Cap, which excludes minimum wage costs, was offset through a combination of the continued deferral of the March payment to Medicaid Managed Care Organizations ($1.0 billion), a FY 2020 savings plan ($599 million), which included a one percent across-the-board reduction in rates paid to providers and health plans, and reductions in discretionary payments. Remaining costs of $1.7 billion were shifted to the General Fund via an adjustment to the amount of mental hygiene spending funded under the Global Cap and a shift of non-Medicaid health care costs under the Child Health Plus program to the Public Health budget.

Medicaid Redesign Team II (MRT II) Overview (May 2020)

In response to the estimated deficit, the Governor formed the MRT II as part of the FY 2021 Executive budget with the objective of restoring financial sustainability to the Medicaid program while connecting other programmatic initiatives that would advance the core healthcare strategies he has pursued since taking office in 2011. The Enacted Budget includes $2.2 billion in recommendations put forward by the MRT to create efficiencies within the Medicaid program and address the Medicaid imbalance, including discovering efficiencies in Managed Care and Managed Long-Term Care, as well as eligibility and administrative reforms.

Additionally, policy initiatives, including the carve out of services from Managed Care within Pharmacy and the centralization of a Transportation broker will lead to better transparency and greater efficiencies within these areas. The MRT also focused on greater Program Integrity within Medicaid and included reforms to modernize regulations to eliminate fraud, waste and abuse.

Through a combination of MRT II actions, continued payment restructuring, and use of General Fund resources, the Medicaid program is expected to stay within statutorily allowable levels in FY 2021 and beyond. The Enacted MRT II initiatives are detailed in Appendix F.

Projected Medicaid Spending (Online and Offline)

The $26.4 billion projected Medicaid State Funds Spending can be organized into two major components: (1) health care provider reimbursement and (2) other administrative, intergovernmental or revenue lines, also referred to as “offline” that occurs outside the MMIS billing system. Health care provider spending reflects the cost of care that is attributable to certain service sectors of the program (i.e., hospital, nursing home, managed care, etc.). These payments occur within the Medicaid claiming system (eMedNY). Projections for most service sectors begin with the number of eligible recipients as of the end of FY 2019 and the average spending per recipient. Adjustments to spending projections are then made for anticipated rate packages, transitions of populations/benefits to managed care , and any non-recurring or one-time payments. Monitoring the movement of recipients between fee-for-service reimbursement and monthly managed care rates of payment is critical to evaluating various health service budgets.

The second component of spending, spending that is processed outside the eMedNY billing system, reflects spending on intergovernmental transfer payments, State and Local District Social Service administrative claims, etc., as well as receipts that offset the State’s cost for Medicaid, i.e., drug

manufacturer rebates and accounts receivable collections. The following table outlines the annual Medicaid projections by major health care sector for both provider claims and other payments/revenues.

Projected Medicaid Spending ($ in millions)			
Category of Service	**Online**	**Offline**	**Total**
Medicaid Managed Care	**$19,540**	**($203)**	**$19,337**
Mainstream Managed Care	$10,905	($75)	$10,830
Long Term Managed Care	$8,635	($128)	$8,507
Fee For Service	**$7,559**	**$1,847**	**$9,406**
Acute Care	$2,733	$830	$3,563
Long Term Care	$3,510	$132	$3,642
Non-Institutional	$1,316	$885	$2,201
Medicaid Administration Costs	**$0**	**$606**	**$606**
OHIP Budget / State Operations	**$0**	**$323**	**$323**
Medicaid Audits	**$0**	**($362)**	**($362)**
Other State Agency	**$3,713**	**($476)**	**$3,237**
All Other	**$12**	**$925**	**$937**
Local Cap Contribution	**$0**	**($7,094)**	**($7,094)**
TOTAL	**$30,824**	**($4,434)**	**$26,390**

Major Offline Components

Medicaid Managed Care (-$203 million)

- *Medicaid Managed Care* offline budget includes Quality Pool payments offset by additional Federal Revenue for Community First Choice Option (CFCO) services.

Fee For Service (+$1,847 million)

- *Acute Care* includes payments for Disproportionate Share Hospital, Upper Payment Limit, SUNY IGT, and the Major Academic Pool.
- *Long Term Care* includes the 5th installment of Universal Settlement and the 1% Supplemental Pool payments offset by additional Federal Revenue for CFCO.
- *Non-Institutional* includes payments for Medicare Part D Clawback and Supplemental Medical Insurance, offset by rebate collections.

OHIP Budget / State Operations (+$323 million)

The OHIP State Operations budget reflects the Non-Federal share only of personal services (i.e., salaries of OHIP staff that work on the Medicaid budget) and non-personal services costs (i.e., contractual services).

Contracts for the Enrollment Center, the NY State of Health (NYSOH) Customer Service Center, eMedNY/Medicaid Management Information Systems (MMIS) and various MRT initiatives comprise over 80 percent of the total non-personal service budget. The chart below shows the annual budget for FY 2020 State Operations:

OHIP Budget ($ in millions)	
Service Costs	**Budget**
Personal Services	$38
Non-Personal Services	$206
Essential Plan Administration	$79
TOTAL	**$323**

All Other (+$925 million)

The All Other Category includes a variety of payments but is primarily comprised of spending for the following major programs:

- **Vital Access / Safety Net Provider Program ($365 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 will be used primarily to improve community care including expand access to ambulatory services, open urgent care centers, expand services in rural areas, and provide more effective services that meet community needs.

- **ACA Reconciliation ($212 million):** Under the ACA the State receives enhanced Federal funding for single individuals and childless couples in the adult group at or below 100% of the federal poverty level (FPL).

- **Patient Centered Medical Homes ($165 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.

- **Supportive Housing ($63 million):** The Supportive Housing Initiative seeks to ensure that Medicaid members have proper housing that promotes a healthy environment and lifestyle. The FY 2020 Budget included $18 million in State savings for receiving a Federal match on Supportive Housing services. A Federal waiver has been submitted to CMS and is under active negotiation.

Annual Enrollment Estimates

Mainstream Managed Care (includes HIV/SNPs and BHO/HARPs): Mainstream Managed Care (MMC) enrollment is expected to remain relatively flat; however it includes continued transition of eligible recipients to a Health and Recovery Plan (HARP).

Long Term Managed Care (includes PACE, FIDA, MA and MAP): The Long Term Managed Care (MLTC) program has been rapidly growing period after period. In FY 2019, MLTC enrollment reached 258,000, an increase of 28,000 individuals. The FY 2020 projections assume continued growth at the slightly higher levels than prior years, roughly 13% or 33,000 individuals.

Essential Plan: The Essential Plan has been very successful, proving to be an affordable health insurance option for consumers with incomes too high to qualify for Medicaid and a major contributor to the reduction in the number of uninsured New Yorkers. As of March 2019, enrollment in the Essential Plan was 773,584. About 43 percent of enrollees would have been eligible for Medicaid prior to

implementation of the Essential Plan; 57 percent would have been eligible for Qualified Health Plan (QHP) coverage with tax credits.

Results April through February 2020 – Global Cap Target vs. Actual Spending

Through February total actual State Medicaid spending is $3.153 billion above the Medicaid Global Spending Cap for FY 2020. Spending through February resulted in total expenditures of $23.259 billion compared to the allowable spending target of $20.106 billion. The Department in conjunction with the Division of the Budget implemented various Medicaid Savings Plan actions in FY 20 including several Managed Care rate actions in February to alleviate spending trends. Those included the elimination of FY 20 Quality pools and rate reductions.

April to February	Medicaid Global Cap Target vs. Actual Spending ($ in millions)		
Category of Service	**Global Cap Target**	**Actual**	**Variance Over / (Under)**
Medicaid Managed Care	**15,080**	**$17,490**	**$2,410**
Mainstream Managed Care	$8,680	$9,808	$1,128
Long Term Managed Care	6,400	$7,682	$1,282
Total Fee For Service	**$ 7,887**	**$8,566**	**$679**
Inpatient	$2,385	$2,599	$214
Outpatient/Emergency Room	$309	$310	$1
Clinic	$395	$386	($9)
Nursing Homes	$ 2,422	$2,458	$36
Other Long Term Care	$753	$731	($22)
Non-Institutional	$1,623	$2,082	$459
Medicaid Administration Costs	**$499**	**$496**	**($3)**
OHIP Budget / State Operations	**$265**	**$261**	**($4)**
Medicaid Audits	**($203)**	**($322)**	**($119)**
All Other	**$3,126**	**$3,316**	**$190**
Local Funding Offset	**($6,548)**	**($6,548)**	**$0**
TOTAL	**$20,106**	**$23,259**	**$3,153**[1]

1. *Deficit through February should not be trended to arrive at a full year number since two managed care payments were made in April (including the prior year deferral).*

If the overall actual spending trends continue throughout the remainder of the fiscal year, projected Medicaid program spending will reach $26.4 billion. Factors driving this growth are explained below:

- Price: 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 original 4 percent to the current level of 3 percent. This allowable growth rate is significantly less than estimates for health care spending growth by the Federal Centers for Medicare and Medicaid Service Office of the Actuary which estimate growth 5.5 percent annual growth on average between 2018 and 2027.

- Utilization: Medicaid enrollment has increased by 1.4 million New Yorkers or 30%, growing from 4.7 million enrollees in 2012 to 6.1 million enrollees as of February 2020. This increase contributed to the rate of uninsured New Yorkers declining by 58 percent from 11.1 percent to a record low of 4.7 percent in 2018 - a reduction in the number of uninsured of 1.2 million, such that 95 percent of New Yorkers now have health insurance. Also impacting utilization, is that enrollment of populations with higher service and utilization costs (i.e., long term care) through

the MLTC programs has increased significantly. MLTC provides coverage to elderly and disabled and costs approximately 10 times more than coverage for individuals in mainstream managed care plans.

In addition to the price and utilization drivers noted above, specific categories/items also contributing to spending growth include:

- Long-Term Care: Long-term care is by far the fastest growing category of Medicaid spending. Enrollment in the State's Managed Long-Term Care program has been growing at approximately 13% per year for the last several years. MLTC spending growth overall -- and the Consumer Directed Personal Assistance Program (CDPAP) within it -- have been the biggest drivers of spending growth in New York's Medicaid program. Particularly in FY 2019, much of this spending growth was driven by the increase in use of CDPAP services which is designed to divert members from high-cost nursing homes and institutional settings to less costly in-home care that keeps them in their communities. From FY 2014 to FY 2019, MLTC enrollment grew by 88 percent, well beyond the 23 percent increase in mainstream managed care enrollment. Between 2017 and 2018 alone, spending through CDPAP grew by 85 percent from $1.3 billion gross to $2.4 billion gross.

- Minimum Wage: In the current fiscal year, the State expects that Medicaid will spend $3 billion (Gross, with a Federal share) or $1.5 billion (State share) to support the increased cost providers must pay workers because of the Statewide minimum wage increases. This is an increase of $750 million (State share) from the prior fiscal year. This cost is projected to increase to $1.8 billion in FY 2021 growing to $2.0 billion in FY 2022. Minimum wage has now reached the statutory level of $15 per hour in NYC and the cost per hour will flatten; however, global cap spending will continue to increase with any increases in service utilization.

- Local Contributions: Since FY 2015, the State has taken over 100 percent of Medicaid spending growth from local governments to help them stay within their 2 percent property tax caps. The policy has cumulatively saved local governments over $20 billion. In FY 2020 alone, this takeover cost the State over $4 billion. However, local governments continue to serve in the role of determining eligibility for certain Medicaid programs, though they no longer had to cover and increased costs.
- Medicaid Managed Care (MC): Medicaid spending in major Managed Care categories was $2.4 billion over budgeted spending. This is mainly due to the deferral of a managed care payment by three days into FY 2020, continued enrollment growth in Managed Long Term Care and lower Federal funding on the Affordable Care Act expansion population enrolled in Mainstream Managed Care.

- Fee-For-Service (FFS): Medicaid spending in major fee-for-service categories was $679 million, or 8.6 percent, over target.

    - *Inpatient* spending was $214 million above target. This is a result of approximately $80 million in anticipated prior year payments being processed in April 2019 as well as higher than expected utilization through February 2020. Additionally, support for distressed hospitals has continued to grow in both FFS and MC, increasing by 27% between FY 2019 and FY 2020 to a total of nearly $500 million (state share) in FY 2020.

    - *Non-Institutional* spending (includes Pharmacy, Medical Supplies, Physicians, Supplemental Medical Insurance, etc.) was $459 million above the target. This is the result of being more timely with the Medicare Part B Supplemental Medical Insurance and Medicare Part D Clawback payments and lower than expected rebate collections.

OHIP Budget / State Operations

The OHIP State Operations budget reflects the Non-Federal share only of personal services (i.e., salaries of OHIP staff) and non-personal services costs (i.e., contractual services). The FY 2020 Budget is projected to total $323 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 over 80 percent of the total non-personal service budget.

OHIP State Operations was $4 million below projections through February.

OHIP Budget FY 2020 ($ in millions)		
Service Costs	**Annual Budget**	**Actual - YTD**
Personal Services	**$38**	**$32**
Non-Personal Services	**$206**	**$163**
Enrollment Center	$69	$47
eMedNY/MMIS	$38	$29
All Payer Database	$9	$1
Data Warehouse	$12	$9
OHIP Actuarial and Consulting Services	$19	$3
All Others	$80	$74
Essential Plan All Others	**$79**	**$70**
TOTAL	**$323**	**$261**

All Other

All Other spending was over allowable spending by $190 million. The All Other category includes a variety of Medicaid payments and offsets, such as Accounts Receivable collections, and disbursements for VAPAP, VAP and Supportive Housing.

Accounts Receivable

The Accounts Receivable (A/R) ending balance for FY 2019 was $224 million. The State is expected to recoup $20 million by the end of FY 2020, resulting in a projected A/R balance of $204 million by March 2020. Through the end of February, retroactive rates have increased by $79 million since March 2019. This reflects the timing of recoveries due to the processing of retroactive rate packages.

Enrollment

Medicaid Enrollment

Medicaid total enrollment reached 6,069,411 enrollees at the end of February 2020. This reflects a *net* decrease of 74,252 enrollees since March 2019, which is comprised of decreases in mainstream managed care, but increases in populations associated with higher service utilization and costs (i.e. long term care populations). MLTC provides coverage to the elderly and disabled and costs about 10 times more than the coverage for individuals enrolled in mainstream managed care.

Medicaid Enrollment Summary				
	March 2019	**February 2020**	**Net Increase / (Decrease)**	**% change**
Managed Care	4,475,671	4,322,983	(152,688)	-3.41%
Long Term Managed Care	257,792	283,981	26,189	10.16%
Fee-For-Service	1,410,200	1,457,523	47,323	3.36%
TOTAL	**6,143,663**	**6,064,487**	**(79,176)**	**1.29%**

Note: Enrollment counts come from the Medicaid Data Warehouse (enrollment database) and are adjusted for a lag factor (1.68%). These counts reflect the net impact of new enrollment and disenrollment that occurred from April through February.

Appendix A
Inventory of Rate Packages

Below is the majority of rate packages to be processed in FY 2020:

Category of Service	Rate Package Description	Effective Date	Date Released
Managed Care	April 2019 Mainstream Rates	4/1/2019	November 2019
	July 2019 Mainstream Rates	7/1/2019	February 2020
	October 2019 Mainstream Rates	10/1/2019	February 2020
	April 2019 HARP Rates	4/1/2019	November 2019
	July 2019 HARP Rates	7/1/2019	February 2020
	October 2019 HARP Rates	10/1/2019	February 2020
	April 2019 HIV SNP Rates	4/1/2019	
	January 2020 EP rates	1/1/2020	
Long Term Managed Care	April 2019 Partial Capitation Rates	4/1/2019	November 2019
	July 2019 Partial Capitation Rates	7/1/2019	February 2020
	October 2019 Partial Capitation Rates	10/1/2019	
	QIVAPP	4/1/2019	January 2020
Inpatient	Acute & Exempt Unit Actual Capital Updates	Various	
	January 2020 Statewide Inpatient Rates	1/1/2020	
Outpatient / Emergency room	FQHC Hold Harmless	1/1/2018	
	APG Capital Update	Various	
	Home Health Agency Rates	Various	
Clinic	FQHC Hold Harmless	1/1/2017	
	APG Capital Update	Various	
	2019 Minimum Wage Add-on	1/1/2019	
Nursing Home	2019 Initial Rates	1/1/2019	July 2019
	2020 Initial Rates	1/1/2020	
	July 2019 Case Mix	7/1/2019	November 2019
	Reversal of the July 2019 Case Mix	7/1/2019	January 2020
	Cash Receipts Assessment Rates	Various	October 2019 November 2019

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

Initiative	FY 2020 (in millions)
GC Pressures	
Financial Plan Target	$425.00
Total GC Pressures	**$425.00**
Pharmacy Savings Initiatives	
Establish Fair Drug Pricing Models in Managed Care through improved Pharmacy Benefit Manager (PBM) oversight	($43.30)
Drug Cap Enhancements	($13.70)
Total Pharmacy Savings	**($57.00)**
LTC Savings Initiatives	
Establish per-member per-month payment for Fiscal Intermediary Services	($75.00)
CFCO Readiness	($24.50)
NH Case Mix Adjustment	($122.80)
SOFA EISEP Investment	$15.00
SOFA EISEP DOH MA Offset	($34.00)
MLTC Manage Utilization of Personal Care	($25.00)
Total LTC Savings	**($266.30)**
Managed Care Savings Initiatives	
State takeover of third party health insurance disenrollment	($18.70)
Additional TPHI Recoveries	($3.90)
Transition Flushing Support to Value Based Payment Quality Improvement Program (VBP-QIP)	($29.60)
Office of Medicaid Inspector General Managed Care Recoveries	($4.10)
Total Managed Care Savings	**($56.30)**
Other Savings	
Promote promising DSRIP ideas to reduce unnecessary utilization	($10.00)
Health Home Rate Reduction	($5.00)
Reimburse National Diabetes Prevention Program	($0.90)
Supportive Housing Federal Waiver	($18.30)
Reinvest Supportive Housing	$0.00
Eliminate Major Academic Centers of Excellence Payment	($24.50)
Total Other Savings	**($58.70)**
Other Investments	
Recognize Applied Behavioral Analysts	$6.40
Fund additional year of Ambulance Rate Adequacy Increase	$3.10
SUNY Disproportionate Share Hospital Investment	$60.00
Electronic Visit Verification (EVV) Investment	$10.00
OTB Retiree - Shift to Medicaid	$2.81
Increase the United Hospital Fund (UHF)	$0.30
Nursing Home Transition and Diversion (NHTD) - Shift to Medicaid	$1.84
Traumatic Brain Injury (TBI) - Shift to Medicaid	$11.47
Behavioral Health Parity Staffing Investment	$0.53

Maternal Mortality	$4.00
Early Intervention Rate Increase	$3.60
Total Other Investments	**$104.05**
Adds/Avails	
CFCO Revenue	($49.00)
Audit Recoveries	($21.75)
Reduce Managed Care Quality Bonus	($10.00)
Reduce Managed Long Term Care Quality Bonus	($5.00)
Federal Maximization/IMD	($5.00)
Additional Health Home Savings	($20.00)
Enhanced Safety Net Hospitals	$16.00
ICS/VNS Investment	$4.00
Medicaid Re-estimate	$0.00
Total Adds/Avails	**($90.75)**
Total MRT	**$0.00**

Appendix C
Regional Data

The Global Cap legislation requires the Department to publish actual State Medicaid spending by region. The regions selected are based on the Governor's eleven economic development areas. The chart below represents total provider spending that occurs within the Medicaid claiming system (eMedNY) through February 2020 for each region.

Medicaid Regional Spending ($ in millions)	
Economic Region	**Non-Federal Total Paid**
New York City	$16,394
Long Island	$2,492
Mid-Hudson	$2,424
Western	$1,268
Finger Lakes	$1,073
Capital District	$857
Central	$638
Mohawk Valley	$546
Southern Tier	$477
North Country	$348
Out of State	$116
TOTAL	**$26,633**

*This is claims data by region and does not include offline cash adjustments

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
Medicaid Drug Cap

- The State Fiscal Year 2018 Enacted Budget establishes a Medicaid Drug Cap that will limit pharmacy spending growth in the Medicaid program to the 10-year rolling average of the medical component of the consumer price index plus four percent (7.2% in the current year), less $85 million in state share savings in FY 2020.

- If the Budget Director determines that expenditures will exceed the annual growth limitation imposed by the Medicaid Drug Cap, the Commissioner of Health may refer drugs to the State's Drug Utilization Review Board (DURB) for a recommendation as to whether a supplemental rebate should be paid by the manufacturer.

- If the Department intends to refer drugs to the DURB, it will notify affected manufacturers and will attempt to reach agreement on rebate amounts prior to DURB referral.

- In determining whether to recommend a target supplemental rebate for a drug the DURB must consider the cost of the drug to the NYS Medicaid program and may consider, among other things: the drug's impact on the Medicaid drug spending, significant and unjustified increases in the price of the drug, and whether the drug may be priced disproportionally to its therapeutic benefits.

- In formulating a recommendation, the DURB may consider, among other things: publicly available and DOH supplied pricing information, the seriousness and prevalence of the disease or condition being treated, Medicaid utilization, the drug's effectiveness or impact on improving health, quality of life or overall health outcomes, the likelihood that the drug will reduce the need for other medical care (including hospitalization), the average wholesale price, wholesale acquisition cost, and retail price of the drug, and the cost of the drug to Medicaid minus rebates.

- If after the DURB recommends a target rebate amount, DOH and the manufacturer are unable to reach agreement regarding supplemental rebate amounts, the manufacturer will be required to provide DOH with certain information including but not limited to marketing, research, and development costs for the drug.

Appendix E
State-only Payments (YTD)

Payments ($ in thousands)	Non Federal Total Paid
VAPAP	$111,620
Supportive Housing	$37,620
Major Academic Pool*	$24,500
Alzheimer's Caregiver Support	$22,640
End of AIDS	$13,065
Assisted Living Voucher Demo	$8,487
MLTC Ombudsman	$4,889
Rural Transportation	$4,000
CSEA Buy-in	$2,558
Water Fluoridation	$1,521
Primary Care Service Corps	$81
MLTC Technology Demonstration	$46
TOTAL	**$231,028**

** Major Academic Pool was eliminated in the FY 2020 Budget. Payment reflects funding for FY 2019.*

Appendix F
MRT II Initiatives - FY 2021 Enacted Budget

FY 2021 MRT II Scorecard

(State Share $ millions)	FY 2021 Enacted	FY 2022 Enacted
Total Spending Reductions	**($2,201)**	**($2,737)**
Continuation of FY 20 Medicaid Savings Plan Reductions	**($739)**	**($682)**
Reduce Mainstream Managed Care (MMC) Quality Pool Payments by 50%	($60.00)	($60.00)
MMC Rate Range Reduction	($96.07)	($96.07)
Discontinue Value Based Payment (VBP) Stimulus	($42.50)	($42.50)
Discontinue the Hospital Enhanced Safety Net Program	($66.00)	($66.00)
Discontinue Delivery System Reform Incentive Program (DSRIP) Equity Pools	($190.00)	($190.00)
Additional Hospital Actions	$63.40	$121.00
Reduce Managed Long-Term Care (MLTC) Quality Pool Payments by 25%	($17.25)	($17.25)
MLTC Rate Range Reduction (MLTC)	($20.93)	($20.93)
Discontinue Future Supportive Housing Resources Associated with Federal Waiver	($18.00)	($18.00)
Discontinue Future Social Determinants of Health Investments	($44.00)	($44.00)
ATB Rate Reduction (1.0% Annually; Effective 1/1/20)	($248.00)	($248.00)
Budget Year Spending Reductions	**($1,462)**	**($2,056)**
Mainstream Managed Care Actions	**($145.07)**	**($133.75)**
Encounter Data Accountability Penalty/Withhold (2.0% on MMC Plans)	($142.50)	($114.50)
Managed Care Reforms	$0.00	$0.00
Tiered VBP Quality Incentive Penalty	$0.00	($3.50)
Advance VBP Models (Maternity; BH/SUD, Data sharing Global Budget, Member Incentives)	$0.00	($5.00)
Authorize Electronic Notifications	($2.40)	($5.26)
VBP Global Budgeting Demonstrations	$0.00	($4.80)
Standardized Medicaid Managed Care Prior Authorization Data Set	($0.17)	($0.69)
Hospital Actions	**($297.20)**	**($304.20)**
Reduce Excess Medical Malpractice Liability Coverage Funding	$0.00	$0.00
Reduce Indigent Care Pool for Voluntary Hospitals	($87.50)	($87.50)
Discontinue the Public Indigent Care Pool	$0.00	$0.00
Establish Enhanced Safety Net Transition Collar Pool	$32.30	$32.30
Reduce Hospital Capital Rate Add-on (5%)	($17.00)	($17.00)
Reduce Hospital Capital Reconciliation Payment (10%)	($4.00)	($4.00)
Discontinue Hospital Quality and Sole Community Pools	($35.00)	($35.00)
Strengthen H+H	($186.00)	($193.00)
Long Term Care Actions	**($668.60)**	**($1055.11)**
Institute an Eligibility Lookback Period of 30 Months for Home and Community-Based Services (HCBS)	($5.05)	($11.75)
Eliminate Spousal Refusal	$0.00	$0.00

Modify Benefit Eligibility Criteria for Personal Care Services (PCS) and the Consumer Directed Personal Assistance Program (CDPAS) Benefit - For all Medicaid programs, require that individuals are assessed to need more than limited or greater assistance with more than 2 ADLs in order to receive PCS and CDPAS – with an exception for individuals with Alzheimer's or Dementia who would need to require supervision or greater assistance with more than 1 ADL to access PCS and CDPAS - To be eligible for enrollment in an MLTC plan, require that individuals are assessed to need more 120 Days of continuous community based long-term care services and limited or greater assistance with more than 2 ADLs - with an exception for individuals with Alzheimer's or Dementia who would need to require supervision or greater assistance with more than 1 ADL to access PCS and CDPAS	($119.25)		($277.47)
Administrative Reforms to the PCS and CDPAS Benefit - Require the Community Health Assessments (CHAs) annually, rather than semi-annually - Eliminate requirement for monthly care management visits by MLTCs - Require the CHA and Tasking Tool to consider telehealth as a substitute to care hours - Permit CHAs to be conducted via synchronous telehealth modalities - Require a Uniform Tasking Tool that plans/LDSSs use to Determine the Individual's care plan including the number of hours of care that will be approved - Centralize and make independent the physician order authorization process - Require an additional level of utilization review for PCS and CDPAS when the requested hours exceed 12 hours per day to ensure the individual can remain safely in the community	($82.00)		($263.00)
Implement Comprehensive CDPAP Program Reforms and Efficiencies - Complete Request for Offers (RFO) - Impose moratorium on Fiscal Intermediary (FI) Advertising - Implement conflict of interest rules for FIs - Implement protocols, roles and standards for CDPAP consumers and designated representation - Eliminate requirements on plans and LDSSs to notify consumers of CDPAP benefit availability - Require that Consumers may only have one FI - Permit personal assistants to provide non-emergent transportation to consumers during approved care hours	($33.00)		($41.00)
Duals Integration, including moratorium on, and phase out of, partial capitation MLTCs	($5.30)		($41.80)
Streamline and Enhance Fair Hearing Process	($0.20)		($0.93)
Delay Community First Choice Option (CFCO) Services	($46.90)		($46.90)
Cap Statewide MLTC Enrollment Growth at a Target Percentage and Implement a 3% Withhold	($215.00)		($215.00)
Reduce Workforce Recruitment and Retention Funding by 25%	($22.50)		($22.50)
Statewide Independent Assessor	($7.60)		($15.56)
Encounter Data Accountability Penalty/Withhold (1.5% on MLTC Plans)	($101.90)		($89.30)
Offer Non-Medicaid Long-Term Care Programs to Encourage Delayed Enrollment in Medicaid with a private pay option for consumers to purchase on NYSoH	$0.00		$0.00
Community Spouse Resource Amount	$0.00		$0.00
Issue a Request for Offer for LCHSA's	$0.00		$0.00
Enhance Wage Parity Enforcement	$0.00		$0.00
Discontinue Return on Equity for For-Profit Nursing Homes	($13.90)		($13.90)
Reduce NH Capital (5%)	($16.00)		($16.00)
Care Management Actions	**($42.73)**		**($69.50)**
Reform Patient Center Medical Homes (PCMH)	($6.00)		($18.10)
Achieve Health Home Rate Efficiencies (HH Admission/Step Down Criteria Revisions)	($11.63)		($15.50)
Discontinue Health Home Outreach	($16.00)		($16.00)
Establish Plan of Care Incentive/Penalty Payments	($5.00)		($5.00)
Comprehensive Prevention and Management of Chronic Disease	($16.80)		($37.10)
Children's Preventive Care and Care Transitions	($0.10)		($0.20)

Managed Care Process Optimization for Higher Risk Behavioral Health Patients (HARP/BH HCBS)	($0.40)		($0.50)
Children's Behavioral Health Services	$1.70		$1.70
Invest In Medically Fragile Children	$12.80		$25.70
Promote Evidence-based Preventative Dentistry	($1.60)		($3.60)
Emergency Room Avoidance and Cost Reductions	($0.20)		($1.80)
Addressing Barriers to Opioid Care	$0.00		$1.60
Promote Maternal Health to Reduce Maternal Mortality	$0.50		($0.70)
Pharmacy Actions	**($34.60)**		**($130.20)**
Transition Pharmacy Benefit to FFS	$10.90		($87.20)
Reduce Coverage for Over-the-Counter Drugs (OTCs)	$0.00		$0.00
Discontinue Prescriber Prevails	$0.00		$0.00
Reduce Drug Cap Growth by Enhancing Purchasing Power	($45.50)		($43.00)
Transportation Actions	**($74.72)**		**($216.66)**
Discontinue Supplemental Ambulance Rebate Payments	$0.00		$0.00
Reduce Taxi/Livery Rates	($35.10)		($51.37)
Transition to a Medicaid Transportation Broker Program	$0.00		($35.40)
Carveout Medicaid Transportation from MLTC	$0.00		($13.67)
Carveout Medicaid Transportation from Adult Day Health Care	$0.00		$0.00
Maximize Public Transit in NYC	($1.76)		($26.05)
Public Emergency CPE	($37.75)		($89.95)
ER Ambulance Diversion/Emergency Triage, Treat and Transport Program	($0.11)		($0.22)
Community Paramedicine	$0.00		$0.00
Program Integrity	**($60.40)**		**($73.60)**
Modernize Regulations Relating to Program Integrity	($60.40)		($67.20)
Modernize Medicaid Third Party Health Insurance	$0.00		($6.40)
Health Information Technology / Social Determinants of Health	**($8.80)**		**($17.65)**
Medicaid System Information Technology & Data Access Modernization	($5.00)		($2.50)
Telehealth Network	($2.60)		($10.20)
Pilot Social Determinants of Health (SDH) Interventions with Proven Return on Investment (ROI)	($1.20)		($4.95)
General Savings	**($130.00)**		**($55.00)**
Additional ATB Rate Reduction (0.5% Annually; Effective 4/1/20)	($125.00)		($50.00)
Shift Water Fluoridation funding to Capital	($5.00)		($5.00)