NEW YORK STATE | Department of Health

Medicaid Global Spending Cap Report

March 2020 Report

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Global Cap – A Year in Review

The Department of Health and the Division of Budget report that spending under the FY 2020 Medicaid Global Spending Cap was $6 million below the $22.4 billion target, while also continuing:

- *Care Management for All* initiative which has transitioned a number of populations and benefits into the Managed Care setting;
- *Vital Access Provider / Vital Access Provider Assurance Program* 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;
- *Value Based Payment Reform (VBP)* designed to transform the Medicaid payment structure from volume driven to value-based; and
- *Essential Plan (EP)* which provides New York the opportunity to offer many consumers who qualify for a lower-cost health insurance option than otherwise available through the New York State of Health.

However, this was achieved through reductions in spending growth that followed a review of price and utilization trends, FY 2019 results, and other factors, and the State's conclusion that a structural imbalance existed within the Medicaid Global Cap. A structural imbalance in this case meant that estimated expense growth in State-share Medicaid subject to the Global Cap, absent measures to control costs, was growing faster than allowed under the Global Cap spending growth index (currently 3 percent).

DOB and DOH estimated 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 placed upward pressure on State-share Medicaid spending (which includes spending under and outside the Global Cap) included, 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.

The $4 billion imbalance in the Medicaid Global Cap 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 projected 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. The Enacted MRT II initiatives are detailed in Appendix F.

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

State-share Medicaid spending subject to the Global Cap exceeded the indexed growth amount by $4 billion, inclusive of the FY 2019 deferral of $1.7 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 estimates 6.0 percent annual growth on average between 2020 and 2027.

- Utilization: As of March 2020, Medicaid enrollment has increased by 1.4 million or 30 percent, growing from 4.7 million enrollees in 2012 to 6.1 million enrollees. 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 the significant increase in enrollment of populations with higher service and utilization costs (i.e., long term care) through the MLTC programs. 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 percent 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. 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, Medicaid spent $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. This policy has cumulatively saved local governments over $20 billion since FY 2015. 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 have to cover increased costs.

The $4 billion imbalance in the Medicaid Global Cap 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. As a result, total actual State Medicaid spending finished $6 million below the Medicaid Global Spending Cap for FY 2020. FY 2020 annual spending resulted in total expenditures of $22.358 billion compared to the allowable spending target of $22.364 billion.

April to March -- Medicaid Global Cap Target vs. Actual Spending ($ in millions)			
Category of Service	**Global Cap Target**	**Actual**	**Variance Over / (Under)**
Medicaid Managed Care	**$17,115**	**$17,838**	**$723**
Mainstream Managed Care	$9,860	$10,073	$213
Long Term Managed Care	$7,255	$7,765	$510
Total Fee For Service	**$8,568**	**$9,122**	**$554**
Inpatient	$2,550	$2,775	$225
Outpatient/Emergency Room	$332	$339	$7
Clinic	$405	$426	$21
Nursing Homes	$2,571	$2,619	$48
Other Long Term Care	$787	$803	$16
Non-Institutional	$1,923	$2,160	$237
Medicaid Administration Costs	**$462**	**$530**	**$68**
OHIP Budget / State Operations	**$323**	**$282**	**($41)**
Medicaid Audits	**($362)**	**($411)**	**($49)**
All Other	**$3,352**	**$2,091**	**($1,261)***
Local Funding Offset	**($7,094)**	**($7,094)**	**$0**
TOTAL	**$22,364**	**$22,358**	**($6)**

*Includes the Mental Hygiene Stabilization Fund, which as part of the MRT II, provided $1.7 billion in Financial Plan support in FY 2020.

- Medicaid Managed Care (MC):
  - *Mainstream Managed Care* spending was $213 million, or 2.2 percent, above estimates through March. Overspending for the program would have been much greater if the State didn't implement various rate reductions.
  - *Long Term Managed Care* was $510 million above estimates through March primarily due to continued enrollment growth in the partial capitation program. Member month enrollment for FY 2020 grew by over 13 percent. Overspending for the program would have been much greater if the State didn't implement various rate reductions.
- Fee-For-Service (FFS): Medicaid spending in major fee-for-service categories was $554 million, or 6.5 percent, over target.
  - *Inpatient* spending was $225 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 March 2020. Additionally, support for distressed hospitals has continued to grow in both FFS and MC, increasing by 27 percent 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 $237 million above the target. This is the result of the State catching up on invoices related to 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 totals $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 $41 million below projections through March primarily due to a delay in receiving appropriate vendor invoices and finalizing contracts.

OHIP Budget – FY 2020 ($ in millions)		
Service Costs	**Annual Budget**	**Actual**
Personal Services	**$38**	**$35**
Non-Personal Services	**$206**	**$172**
Enrollment Center	$69	$54
eMedNY/MMIS	$38	$32
All Payer Database	$9	$1
Data Warehouse	$12	$10
OHIP Actuarial and Consulting Services	$19	$3
All Others	$80	$72
Essential Plan All Others	**$79**	**$74**
TOTAL	**$323**	**$281**

All Other

The All Other category includes a variety of Medicaid payments and offsets, such as spending for Vital Access Provider Assurance Program (VAPAP), Vital Access Provider (VAP) program and Supportive Housing offset by Accounts Receivable collections. The variance of $1.3 billion in this category is mainly attributed to the one time shift of $1.7 billion in FY 2020 costs to the General Fund to assist in closing the $4 billion imbalance within the Global Cap.

Accounts Receivable

The Accounts Receivable (A/R) ending balance for FY 2019 was $224 million. Through the end of March 2020, the A/R balance increased by $67 million to $291 million primarily due to the timing of recoveries associated with retroactive rate packages.

Enrollment

Medicaid Enrollment

Medicaid total enrollment reached 6,082,983 enrollees at the end of March 2020. This reflects a *net* decrease of 60,680 enrollees since March 2019, which is comprised of decreases in mainstream managed care offset by 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 approximately 10 times more than the coverage for individuals enrolled in mainstream managed care.

Medicaid Enrollment Summary				
	March 2019	**March 2020**	**Net Increase / (Decrease)**	**% change**
Managed Care	4,475,671	4,324,511	(151,160)	-3.4%
Long Term Managed Care	257,792	285,605	27,813	10.8%
Fee-For-Service	1,410,200	1,472,867	62,667	4.4%
TOTAL	**6,143,663**	**6,082,983**	**(60,680)**	**-1.0%**

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 March.

Appendix A
Inventory of Rate Packages

Below is the majority of rate packages 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
Long Term Managed Care	April 2019 Partial Capitation Rates	4/1/2019	November 2019
	July 2019 Partial Capitation Rates	7/1/2019	February 2020
	QIVAPP	4/1/2019	January 2020
Assisted Living	2019 Initial Rates	1/1/2019	November 2019
Home Health	2019 CHHA Pediatric Initial Rates	1/1/2019	October 2019
Hospice	2019 Residence Initial Rates	1/1/2019	October 2019
	2019 Non-Residence Initial Rates	1/1/2019	October 2019
Inpatient	2019 Initial Rates	1/1/2019	October 2019
Personal Care	2019 NYC Initial Rates	1/1/2019	August 2019
	2019 Non-NYC Initial Rates	1/1/2019	August 2019
Nursing Home	2019 Initial Rates	1/1/2019	July 2019
	July 2019 Case Mix	7/1/2019	November 2019, January 2020, March 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 March 2020 for each region.

Medicaid Regional Spending ($ in millions)	
Economic Region	**Non-Federal Total Paid**
New York City	$17,550
Long Island	$2,695
Mid-Hudson	$2,633
Western	$1,383
Finger Lakes	$1,171
Capital District	$930
Central	$694
Mohawk Valley	$595
Southern Tier	$519
North Country	$379
Out of State	$109
TOTAL	**$28,658**

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	$127,486
ACA FFP Correction	$95,000
Supportive Housing	$47,007
Alzheimer's Caregiver Support	$24,785
Major Academic Pool*	$24,500
End of AIDS	$14,142
Assisted Living Voucher Demo	$8,713
MLTC Ombudsman	$5,066
Rural Transportation	$4,000
CSEA Buy-in	$2,722
BH Transformation Non-VAP	$2,110
Water Fluoridation	$1,565
Primary Care Service Corps	$81
MLTC Technology Demonstration	$46
TOTAL	**$357,225**

** 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)	Effective Date	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)	4/1/2020	($142.50)	($114.50)
Managed Care Reforms	N/A	$0.00	$0.00
Tiered VBP Quality Incentive Penalty	1/1/2021	$0.00	($3.50)
Advance VBP Models (Maternity; BH/SUD, Data sharing Global Budget, Member Incentives)	4/1/2021	$0.00	($5.00)
Authorize Electronic Notifications	10/1/2020	($2.40)	($5.26)
VBP Global Budgeting Demonstrations	4/1/2021	$0.00	($4.80)
Standardized Medicaid Managed Care Prior Authorization Data Set	1/1/2021	($0.17)	($0.69)
Hospital Actions		**($297.20)**	**($304.20)**
Reduce Excess Medical Malpractice Liability Coverage Funding	4/1/2020	$0.00	$0.00
Reduce Indigent Care Pool for Voluntary Hospitals	4/1/2020	($87.50)	($87.50)
Discontinue the Public Indigent Care Pool	N/A	$0.00	$0.00
Establish Enhanced Safety Net Transition Collar Pool	4/1/2020	$32.30	$32.30
Reduce Hospital Capital Rate Add-on (5%)	4/1/2020	($17.00)	($17.00)
Reduce Hospital Capital Reconciliation Payment (10%)	4/1/2020	($4.00)	($4.00)
Discontinue Hospital Quality and Sole Community Pools	4/1/2020	($35.00)	($35.00)
Strengthen H+H	4/1/2020	($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)	10/1/2020	($5.05)	($11.75)
Eliminate Spousal Refusal	N/A	$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	10/1/2020 - 4/1/2021	($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	10/1/2020 - 4/1/2021	($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	6/1/2020	($33.00)	($41.00)
Duals Integration, including moratorium on, and phase out of, partial capitation MLTCs	4/1/2020-1/1/2022	($5.30)	($41.80)
Streamline and Enhance Fair Hearing Process	1/1/2021	($0.20)	($0.93)
Delay Community First Choice Option (CFCO) Services	4/1/2020	($46.90)	($46.90)
Cap Statewide MLTC Enrollment Growth at a Target Percentage and Implement a 3% Withhold	10/1/2020	($215.00)	($215.00)
Reduce Workforce Recruitment and Retention Funding by 25%	4/1/2020	($22.50)	($22.50)
Statewide Independent Assessor	10/1/2020	($7.60)	($15.56)
Encounter Data Accountability Penalty/Withhold (1.5% on MLTC Plans)	4/1/2020	($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	10/1/2020	$0.00	$0.00
Community Spouse Resource Amount	N/A	$0.00	$0.00
Issue a Request for Offer for LCHSA's	7/1/2020	$0.00	$0.00
Enhance Wage Parity Enforcement	10/1/2020	$0.00	$0.00
Discontinue Return on Equity for For-Profit Nursing Homes	4/1/2020	($13.90)	($13.90)
Reduce NH Capital (5%)	4/1/2020	($16.00)	($16.00)

Care Management Actions		**($42.73)**	**($69.50)**
Reform Patient Center Medical Homes (PCMH)	4/1/2020	($6.00)	($18.10)
Achieve Health Home Rate Efficiencies (HH Admission/Step Down Criteria Revisions)	7/1/2020	($11.63)	($15.50)
Discontinue Health Home Outreach	7/1/2020	($16.00)	($16.00)
Establish Plan of Care Incentive/Penalty Payments	7/1/2020	($5.00)	($5.00)
Comprehensive Prevention and Management of Chronic Disease	4/1/2020	($16.80)	($37.10)
Children's Preventive Care and Care Transitions	4/1/2020	($0.10)	($0.20)
Managed Care Process Optimization for Higher Risk Behavioral Health Patients (HARP/BH HCBS)	10/1/2020	($0.40)	($0.50)
Children's Behavioral Health Services	4/1/2020	$1.70	$1.70
Invest In Medically Fragile Children	10/1/2020	$12.80	$25.70
Promote Evidence-based Preventative Dentistry	4/1/2020	($1.60)	($3.60)
Emergency Room Avoidance and Cost Reductions	1/1/2021	($0.20)	($1.80)
Addressing Barriers to Opioid Care	7/1/2020	$0.00	$1.60
Promote Maternal Health to Reduce Maternal Mortality	4/1/2020	$0.50	($0.70)
Pharmacy Actions		**($34.60)**	**($130.20)**
Transition Pharmacy Benefit to FFS	4/1/2021	$10.90	($87.20)
Reduce Coverage for Over-the-Counter Drugs (OTCs)	N/A	$0.00	$0.00
Discontinue Prescriber Prevails	N/A	$0.00	$0.00
Reduce Drug Cap Growth by Enhancing Purchasing Power	4/1/2020	($45.50)	($43.00)
Transportation Actions		**($74.72)**	**($216.66)**
Discontinue Supplemental Ambulance Rebate Payments	N/A	$0.00	$0.00
Reduce Taxi/Livery Rates	4/1/2020	($35.10)	($51.37)
Transition to a Medicaid Transportation Broker Program	4/1/2020	$0.00	($35.40)
Carveout Medicaid Transportation from MLTC	4/1/2021	$0.00	($13.67)
Carveout Medicaid Transportation from Adult Day Health Care	N/A	$0.00	$0.00
Maximize Public Transit in NYC	10/1/2020	($1.76)	($26.05)
Public Emergency CPE	10/1/2020	($37.75)	($89.95)
ER Ambulance Diversion/Emergency Triage, Treat and Transport Program	10/1/2020	($0.11)	($0.22)
Community Paramedicine	N/A	$0.00	$0.00
Program Integrity		**($60.40)**	**($73.60)**
Modernize Regulations Relating to Program Integrity	9/1/2020	($60.40)	($67.20)
Modernize Medicaid Third Party Health Insurance	9/1/2020	$0.00	($6.40)
Health Information Technology / Social Determinants of Health		**($8.80)**	**($17.65)**
Medicaid System Information Technology & Data Access Modernization	4/1/2020	($5.00)	($2.50)
Telehealth Network	4/1/2020	($2.60)	($10.20)
Pilot Social Determinants of Health (SDH) Interventions with Proven Return on Investment (ROI)	9/1/2020	($1.20)	($4.95)
General Savings		**($130.00)**	**($55.00)**
Additional ATB Rate Reduction (0.5% Annually; Effective 4/1/20)	4/1/2020	($125.00)	($50.00)
Shift Water Fluoridation funding to Capital	4/1/2020	($5.00)	($5.00)

Appendix G
Notable Events

- 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.

- 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.

- In FY 2020, DOH continued the payment restructuring of the final cycle payment to Medicaid Managed Care Organizations, as well as other payments. The payment restructuring had a State-share value of $1.7 billion and was paid utilizing cash on hand in April 2020, consistent with contractual obligations and had no impact on provider services.

- DOH implemented rate reductions to the managed care product lines in FY 2020. These rate adjustments included bringing rates down to the lower bound of the rate ranges, eliminating the equity pools in Mainstream Managed Care and reducing the annual disbursement of the quality pools in Managed Care.

- The FY 2020 Enacted Budget authorized the State to implement an across the board (ATB) reduction to Medicaid payments up to $190.2 million State share. Pursuant to this authority, such payment reductions were applied for dates of service January 1, 2020, through March 31, 2020, and each State Fiscal Year thereafter.

- The FY 2019 Enacted Budget included an initiative that transitioned the permanent (greater than 3 months) Nursing Home benefit in MLTC to FFS (exclusive of the Medicare benefit). The savings associated with this proposal were not realized in the current fiscal year due to a delay in it's implementation.

- The General Fund provided the Global Cap with $1.7 billion in relief 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.

- As mentioned earlier in the report, 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.

- 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.