NEW YORK STATE | Department of Health

Medicaid Global Spending Cap Report

April through December 2020

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Overview

The Medicaid Global Spending Cap will decrease from $22.364 billion in FY 2020 to $19.936 billion in FY 2021, a net decrease of $2.428 billion. This net decrease is comprised of lower non-Federal share spending as a result of $3.481 billion of COVID-19 Enhanced Federal Medical Assistance Percentage (eFMAP) of 6.2 percent, offset by the annual growth in the Global Cap of $1.053 billion over last year, which includes the Global Cap index growth of $559 million (based on the2.9 percent trend of the ten-year average of the Medical Care Consumer Price Index) and increased costs for minimum wage rate adjustments of $139 million. Based on a review of price and utilization trends and other factors, the State is projecting State-share Medicaid spending subject to the Global Cap to be $123 million higher than allowed under the Global Cap spending growth index.

The chart below breaks out the major components of the annual decrease including lower state spending due to the COVID-19 eFMAP as well as the continuation of Medicaid Redesign Team (MRTII) initiatives, offset by higher costs associated with both price and enrollment increases:

Price (+$710 million)	• Trend increases for mainstream managed care rates ($406 million); • Long term managed care rates reduction (-$91 million); • Various FFS rate packages ($256 million); and • Minimum Wage Adjustment ($139 million).
Utilization (+$787 million)	• Annualization of FY 2020 MLTC enrollment; and • New Managed Care enrollment for FY 2021 (1,060,475 individuals associated with the COVID-19 pandemic).
MRT/One Timers/Other ($3.98 billion)	• COVID-19 Enhanced FMAP, net of local share (-$3.5 billion State share); • MRT 2.0 Savings (-$2.2 billion); • In FY 2020 the Global Cap received non-recurring Financial Plan Relief ($1.7 billion); • Phase down of ACA Enhanced FMAP on Single and Childless Adults going from 93% down to 90% effective January 1, 2020 ($450 million); • Federal payment increases for Medicare Part B and Part D ($170 million); and • 53rd Cycle ($132 million).

The Enacted Budget included $2.2 billion in recommendations put forward by the MRT II to create efficiencies within the Medicaid program and address the Medicaid imbalance, including identifying efficiencies in long term care services, as well as administrative reforms. Additionally, policy initiatives such as the transition of the pharmacy benefit from Managed Care to Medicaid fee-for-service and the implementation of a transportation broker, will increase transparency and identify efficiencies within these areas. The MRT II recommendations also focuses on greater program integrity within the Medicaid program and includes reforms to modernize regulations to eliminate fraud, waste and abuse.

Impact of COVID-19 Pandemic on Medicaid Spending / Enrollment

In response to the COVID-19 pandemic, the Federal government increased its share of Medicaid funding (eFMAP) by 6.2 percent for each calendar quarter occurring during the Federal public health emergency declared by the President of the United States. The enhanced funding began January 1, 2020 and is currently extended through June 30, 2021 (may extended further with an extension of the public health emergency), providing a total of $5.4 billion in additional Federal resources that reduce State and Local

government costs, including an increase of over 1 million individuals receiving Medicaid coverage in FY 2021 as individuals lost their employment or had lower income because of COVID-19 pandemic. A portion of the of the Federal resources will reduce Local costs and, as a result, the State savings totals $3.5 billion and $995 million in FY 2021 and FY 2022, respectively.

To qualify for increased FMAP under the Federal Families First Coronavirus Response Act (FFCRA), States were not permitted to reduce benefits for Medicaid members under a Maintenance of Effort (MOE) requirement. In order to ensure eligibility for the eFMAP, all annual Medicaid eligibility recertifications were eliminated andeligible individuals could only be terminated if they moved out of state, died or asked for their coverage to end.

Moreover, since there are benefit and coverage differences between Medicaid fee-for-service and Medicaid Managed Care, certain routine plan disenrollments were suspended with limited exceptions for member choice. Increased Medicaid eligibility as a result of the COVID pandemic, coupled with MOE requirements that did not permit disenrollment of consumers from their Medicaid managed care plans, resulted in higher Medicaid Managed Care enrollment.

The table below provides the fiscal impacts attributed to the pandemic related to the additional eFMAP and the State's anticipated impact on enrollment:

FY 2021 COVID 19 Impacts $ in millions	
Total 6.2% eFMAP	($4,235)
Local Share of eFMAP	$754
TOTAL	**($3,481)**

COVID-19 has caused significant unemployment and/or reduction in income, which has driven increased eligibility and enrollment in the Medicaid program. These newly eligible populations have different risk profiles or spending patterns than existing enrollees. For example, shutdowns of elective procedures during the height of the pandemic lead to reduced spending and utilization for these deferred types of care. Further, utilization in nursing homes has declined (after adjusting to exclude impact of the shift from MLTC to FFS that took place September 2020). Additionally, lower than expected enrollment growth in Medicaid Managed Long-Term Care (MLTC) has provided savings as well, while such underspending was offset by increased cost associated with the COVID-related care in the acute care space (e.g. ventilation, intubation, and other emergency services) and increases in FFS personal care.

Projected Medicaid Spending (Online and Offline)

The $20.1 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 2020 and the average spending per recipient. Adjustments to spending projections are then made for anticipated rate (price) changes, transitions of populations/benefits to managed care, if any, 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, 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	**$19,332**	**($654)**	**$18,678**
Mainstream Managed Care	$11,207	($47)	$11,160
Long Term Managed Care	$8,125	($606)	$7,518
Fee For Service	**$7,640**	**$1,155**	**$8,796**
Acute Care	$2,693	$772	$3,465
Long Term Care	$3,703	($121)	$3,582
Non-Institutional	$1,244	$504	$1,748
Medicaid Administration Costs	**$0**	**$467**	**$467**
OHIP Budget / State Operations	**$0**	**$268**	**$268**
Medicaid Audits	**$0**	**($372)**	**($372)**
Other State Agency	**$3,846**	**($1,462)**	**$2,385**
COVID-19 eFMAP	**$0**	**($4,235)**	**($4,235)**
All Other	**$0**	**$565**	**$565**
Local Cap Contribution	**$0**	**($6,491)**	**($6,491)**
Total	**$30,818**	**($10,759)**	**$20,059**
Medicaid Global Cap			**$19,936**
Medicaid Deficit			**($123)**

Major Offline Components

Medicaid Managed Care (-$654 million)

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

Fee For Service (+$1,155 million)

- *Acute Care* includes payments for Disproportionate Share Hospital, Upper Payment Limit, and SUNY IGT.
- *Long Term Care* includes the 2% 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.

Medicaid Administration Costs (+$467 million)

The annual county Medicaid caps for Local Administration will remain at their historic / current levels during SFY 2020-21, 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.

OHIP Budget / State Operations (+$268 million)

The OHIP State Operations budget reflects the Non-Federal share only of personal services (i.e., salaries of OHIP staff that work on Medicaid) 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 2021 State Operations:

OHIP Budget ($ in millions)	
Service Costs	**Budget**
Personal Services	$36
Non-Personal Services	$168
Essential Plan Administration	$64
TOTAL	**$268**

Other State Agency (+$2.385 billion)

Other State Agency consists of Medicaid expenditures for the Office for People With Developmental Disabilities (OPWDD), Office of Mental Health (OMH), Office of Children and Family Services (OCFS), State Education Department (SED) and Office of Addiction Services And Supports (OASAS) services offset by transfers from those agencies to support State share spending.

All Other (+$565 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 ($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.

- **Vital Access Provider Assurance Program (VAPAP) ($286 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 fulfillment of the goals of the Delivery System Reform Incentive Payment (DSRIP) program.

- **Patient Centered Medical Homes ($150 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.

Local Cap Contribution (-$6.491 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 have been capped since FY 2016. However, Local Districts still share in the benefit of the COVID-19 eFMAP and contributions were reduced in FY 2021.

Annual Enrollment Estimates

Medicaid enrollment is expected to reach 7,141,716 individuals by March 2021 an increase of 1,060,475 enrollees since March 2020.

The spike in unemployment caused by the COVID-19 pandemic is expected to drive increased enrollment in public health insurance programs. Approximately 1.1 million individuals were expected to enroll due to COVID at a cost of $912 million. This increase is partially attributable to the MOE requirements that prevents the State from disenrolling individuals from Medicaid. Savings starting in FY 2023 reflect an expected decline in unemployment and downward trend in enrollment compared to the prior update. Enrollment costs have been covered through the use of available enhanced FMAP funding.

Below is the breakout by major program:

Mainstream Managed Care (includes HIV/SNPs and BHO/HARPs): Due to the economic repercussions of COVID-19, New York has been one of the hardest states in relation jobs with a large number of people either unemployed or expected to become unemployed. As a result, these individuals will now qualify for Medicaid increasing enrollment in Managed Care by 1,060,475 in FY 2021.

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 2020, MLTC enrollment reached 283,786, an increase of 27,694 individuals. The FY 2021 projections assume that MLTC enrollment remains relatively flat for the year. Due primarily to the COVID-19 MOE requirements, and the September 2020 implementation of a prior year budget action that disenrolled individuals in long term stays in the Nursing Home from Managed Long Term Care partial capitation plans to Medicaid fee-for-service, year end enrollment is only expected to slightly increase.

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

Through December total actual State Medicaid spending is $110 million above the Medicaid Global Spending Cap for FY 2021. Spending through December resulted in total expenditures of $16.088 billion compared to the allowable spending target of $15.978 billion.

April to December	Medicaid Global Cap Target vs. Actual Spending ($ in millions)		
Category of Service	**Global Cap Target***	**Actual**	**Variance Over / (Under)**
Medicaid Managed Care	**$15,611**	**$15,766**	**$155**
Mainstream Managed Care	$8,877	$8,976	$99
Long Term Managed Care	$6,734	$6,791	$56
Total Fee For Service	**$6,562**	**$6,526**	**($36)**
Inpatient	$1,984	$1,981	($4)
Outpatient/Emergency Room	$274	$274	($1)
Clinic	$292	$289	($3)
Nursing Homes	$1,832	$1,841	$9
Other Long Term Care	$653	$637	($16)
Non-Institutional	$1,527	$1,505	($22)
Medicaid Administration Costs	**$184**	**$184**	**$0**
OHIP Budget / State Operations	**$217**	**$217**	**$0**
Medicaid Audits	**($326)**	**($326)**	**$0**
All Other	**($1,101)**	**($1,110)**	**($9)**
Local Funding Offset	**($5,169)**	**($5,169)**	**$0**
TOTAL	**$15,978**	**$16,088**	**$110**

*This Global Cap Targets by category of service have been adjusted to account for the impact of COVID and reflects the observed trends such as the impacts of higher acute care spend and lower nursing home spend due to decline in utilization. However, this model does not yet reflect the managed care COVID rate reductions as effectuated with the FY 2022 Executive Budget. (see Subsequent Events Section below)..

If the overall actual spending trends continue throughout the remainder of the fiscal year, projected Medicaid program spending is expected to exceed the annual Global Cap target by $123 million. 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 2.9 percent. This allowable growth rate is significantly less than Federal estimates which project National Health Expenditures to grow at an average annual rate of 5.4 percent for 2019-28 and to reach $6.2 trillion by 2028.

- Utilization: Medicaid enrollment has increased by 734,513 New Yorkers or 12.1 percent, growing from 6.1 million enrollees in March 2020 to 6.8 million enrollees as of December 2020.

Medicaid Managed Care

Medicaid spending in major Managed Care categories was $155 million over anticipated spending, or 1 percent. The Department will continue to analyze these trends with its actuary and evaluate in relation to Federal guidance regarding allowable reimbursement changes to respond to the COVID-19 public health emergency.

Fee-For-Service

Medicaid spending in major fee-for-service categories was $36 million, or 0.5 percent, under target.

- *Non-Institutional* spending (includes Pharmacy, Medical Supplies, Physicians, Supplemental Medical Insurance, etc.) was $22 million under the target. Claims for non-emergency modes of transportation have significantly decreased over prior year levels which is to be expected during the emergency period.

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 2021 Budget is projected to total $268 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 is on target through December.

OHIP Budget FY 2021 ($ in millions)		
Service Costs	**Annual Budget**	**Actual - YTD**
Personal Services	$36	$28
Non-Personal Services	$168	$147
Essential Plan All Others	$64	$51
TOTAL	**$268**	**$226**

All Other

All Other spending was under allowable spending by $7 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 2020 was $206 million. The State is expected to recoup $52 million by the end of FY 2021, resulting in a projected A/R balance of $154 million by March 2021. Through the end of December, retroactive rates have increased by $26 million since March 2020.

Enrollment

Medicaid Enrollment

Medicaid enrollment has increased significantly (almost 800,000 enrollees) between March 2020 and December 2020, largely as a result of the COVID-19 public health emergency. An estimated 2 million workers in vulnerable industries lost their jobs and/or income as a result of the COVID-19 crisis and more than 800,000 people have or are expected to lose their health insurance coverage. Many of these individuals have enrolled in Medicaid since March 2020. In addition, because of the FFCRA MOE requirements, existing Medicaid enrollees' coverage was maintained during the period of the emergency. In total, Medicaid enrollment is estimated to increase by over 1 million through the end of FY 2021.

Medicaid total enrollment reached 6,815,754 enrollees at the end of December 2020. This reflects a *net* increase of 734,513 enrollees since March 2020. Components of enrollment are as follows:

Medicaid Enrollment Summary				
	March 2020	**December 2020**	**Net Increase / (Decrease)**	**% change**
Managed Care	4,334,899	5,122,214	787,315	18.2%
Long Term Managed Care	280,067	272,713	(7,354)	-2.6%
Fee-For-Service	1,466,275	1,420,827	(45,448)	-3.1%
TOTAL	**6,081,241**	**6,815,754**	**734,513**	**12.1%**

Subsequent Events

The Financial Plan Executive Budget for FY 2022 was released on January 19, 2021.

The General Fund is the primary funding source for the Medicaid Global Spending Cap. The Executive Budget is projecting a two-year deficit in the General Fund of $12.7 billion for FYs 2021 and 2022. The Medicaid program achieved savings of roughly $1.2 billion in FY 2021 mainly driven by a downward revision to managed care rates based on lower health care utilization due to the pandemic, use of available fund balances and unspent VAPAP funds to offset costs and other revisions.

Prior to revisions and savings, the updated forecast of Medicaid costs are expected to exceed the Global Cap attributable to increased enrollment and utilization. The savings include a comprehensive package of telehealth reforms, achieving programmatic efficiency savings in the home and community-based care sector with the implementation of the new Electronic Visit Verification system, enhancing pharmacy oversight by eliminating "prescriber prevails" and coverage for certain over-the-counter products, reducing supplemental pools for certain health care plans and providers, and other continued cost-containment measures that are expected to control the level of spending permitted under the Global Cap index.

These savings initiatives are not reflected in the Global Cap model presented in this report. The January and February Global Cap reports will be updated to reflect the Executive Budget and Executive Budget Amendment events.

The Financial Plan Executive Budget Amendment for FY 2022 was released on February 22, 2021.

The estimates for Medicaid enrollment attributable to COVID-19 have been increased based on experience to date and updated economic and unemployment data. Total COVID Medicaid enrollment costs amount to $912 million in FY 2021 and $1.7 billion in FY 2022.

The updated enrollment estimates reflect Federal MOE rules governing individual enrollments during Federal public health emergency period, which currently extends through June 2021. The State must comply with the Federal MOE rules to retain the enhanced FMAP benefit provided through the Families First Coronavirus Relief Act (FFCRA), which has been programmed in the Financial Plan to offset increased State-share Medicaid costs attributable to COVID-related enrollment.

Appendix A
Inventory of Rate Packages

Below is the majority of rate packages to be processed in FY 2021:

Category of Service	Rate Package Description	Effective Date	Date Released
Managed Care	April 2020 Mainstream Rates	4/1/2020	December
	April 2020 HARP Rates	4/1/2020	December
	April 2020 HIV Special Needs Plans (HIV SNP) Rates	4/1/2020	
	2019 HIV SNP Incentive Pool Payment	1/1/2019	
Long Term Managed Care	April 2020 Partial Capitation Rates	4/1/2020	October
	April 2020 Medicaid Advantage Plan (MAP) Rates	4/1/2020	
	April 2020 Program of All-Inclusive Care for the Elderly (PACE) Rates	4/1/2020	
	January 2020 Medicaid Advantage (MA) Rates	1/1/2020	July
	January 2021 Medicaid Advantage (MA) Rates	1/1/2021	
	QIVAPP	4/1/2020	
	Quality Pools	Various	December
Inpatient	Acute & Exempt Unit Actual Capital Updates	Various	
	January 2020	1/1/2020	November
	January 2021 Statewide Inpatient Rates	1/1/2021	
	Inpatient Psychiatric Rates	10/1/2018	December
Outpatient / Emergency room	FQHC Hold Harmless	1/1/2019	October
	APG Capital Update	Various	
	FQHC MEI Increase	1/1/2020	
Clinic	FQHC Hold Harmless	1/1/2019	October
	APG Capital Update	Various	
	2020 Minimum Wage Add-on	1/1/2020	
	2021 Minimum Wage Add-on	1/1/2021	
Nursing Homes	MRT Capital Reduction Package	4/1/2020	September
	2020 NH Initial Rates	1/1/2020	September
	2021 NH Initial Rates	1/1/2021	
	NH Rate Corrections	Various	November
	Quality Pool and 1% Supplemental	4/1/2020	
	MDS Audits	Various	
	Cash Receipts Assessment Rates	Various	
Assisted Living	2020 ALPs Initial Rates	1/1/2020	August
	2021 ALPs Initial Rates	1/1/2021	

Hospice	2020 Non-Residence Rates	1/1/2020	
	2021 Non-Residence Rates	1/1/2021	
	2020 Residence Rates	1/1/2020	
	2021 Residence Rates	1/1/2021	
Home Health	2020 CHHA Pediatric Rates	1/1/2020	September
	2021 CHHA Pediatric Rates	1/1/2021	
	2020 CHHA Episodic Rates	1/1/2020	
	2021 CHHA Episodic Rates	1/1/2021	

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

Proposals (State Share $ millions)	FY 2021
Total Spending Reductions	**($2,201)**
Continuation of FY 20 Medicaid Savings Plan Reductions	**($739)**
Reduce Mainstream Managed Care (MMC) Quality Pool Payments by 50%	($60.00)
MMC Rate Range Reduction	($96.07)
Discontinue Value Based Payment (VBP) Stimulus	($42.50)
Discontinue the Hospital Enhanced Safety Net Program	($66.00)
Discontinue Delivery System Reform Incentive Program (DSRIP) Equity Pools	($190.00)
Additional Hospital Actions	$63.40
Reduce Managed Long-Term Care (MLTC) Quality Pool Payments by 25%	($17.25)
MLTC Rate Range Reduction (MLTC)	($20.93)
Discontinue Future Supportive Housing Resources Associated with Federal Waiver	($18.00)
Discontinue Future Social Determinants of Health Investments	($44.00)
ATB Rate Reduction (1.0% Annually; Effective 1/1/20)	($248.00)
Budget Year Spending Reductions	**($1,462)**
Mainstream Managed Care Actions	**($145.07)**
Encounter Data Accountability Penalty/Withhold (2.0% on MMC Plans)	($142.50)
Authorize Electronic Notifications	($2.40)
Standardized Medicaid Managed Care Prior Authorization Data Set	($0.17)
Hospital Actions	**($297.20)**
Reduce Indigent Care Pool for Voluntary Hospitals	($87.50)
Establish Enhanced Safety Net Transition Collar Pool	$32.30
Reduce Hospital Capital Rate Add-on (5%)	($17.00)
Reduce Hospital Capital Reconciliation Payment (10%)	($4.00)
Discontinue Hospital Quality and Sole Community Pools	($35.00)
Strengthen H+H	($186.00)
Long Term Care Actions	**($668.60)**
Institute an Eligibility Lookback Period of 30 Months for Home and Community-Based Services (HCBS)	($5.05)
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)

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)
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)
Duals Integration, including moratorium on, and phase out of, partial capitation MLTCs	($5.30)
Streamline and Enhance Fair Hearing Process	($0.20)
Delay Community First Choice Option (CFCO) Services	($46.90)
Cap Statewide MLTC Enrollment Growth at a Target Percentage and Implement a 3% Withhold	($215.00)
Reduce Workforce Recruitment and Retention Funding by 25%	($22.50)
Statewide Independent Assessor	($7.60)
Encounter Data Accountability Penalty/Withhold (1.5% on MLTC Plans)	($101.90)
Discontinue Return on Equity for For-Profit Nursing Homes	($13.90)
Reduce NH Capital (5%)	($16.00)
Care Management Actions	**($42.73)**
Reform Patient Center Medical Homes (PCMH)	($6.00)
Achieve Health Home Rate Efficiencies (HH Admission/Step Down Criteria Revisions)	($11.63)
Discontinue Health Home Outreach	($16.00)
Establish Plan of Care Incentive/Penalty Payments	($5.00)
Comprehensive Prevention and Management of Chronic Disease	($16.80)
Children's Preventive Care and Care Transitions	($0.10)
Managed Care Process Optimization for Higher Risk Behavioral Health Patients (HARP/BH HCBS)	($0.40)
Children's Behavioral Health Services	$1.70
Invest In Medically Fragile Children	$12.80
Promote Evidence-based Preventative Dentistry	($1.60)
Emergency Room Avoidance and Cost Reductions	($0.20)
Promote Maternal Health to Reduce Maternal Mortality	$0.50
Pharmacy Actions	**($34.60)**
Transition Pharmacy Benefit to FFS	$10.90
Reduce Drug Cap Growth by Enhancing Purchasing Power	($45.50)

Transportation Actions	**($74.72)**
Reduce Taxi/Livery Rates	($35.10)
Maximize Public Transit in NYC	($1.76)
Public Emergency CPE	($37.75)
ER Ambulance Diversion/Emergency Triage, Treat and Transport Program	($0.11)
Program Integrity	**($60.40)**
Modernize Regulations Relating to Program Integrity	($60.40)
Health Information Technology / Social Determinants of Health	**($8.80)**
Medicaid System Information Technology & Data Access Modernization	($5.00)
Telehealth Network	($2.60)
Pilot Social Determinants of Health (SDH) Interventions with Proven Return on Investment (ROI)	($1.20)
General Savings	**($130.00)**
Additional ATB Rate Reduction (0.5% Annually; Effective 4/1/20)	($125.00)
Shift Water Fluoridation funding to Capital	($5.00)

Appendix C
Regional Spending 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 December 2020 for each region.

Medicaid Regional Spending ($ in millions)	
Economic Region	**Non-Federal Total Paid**
New York City	$13,986
Long Island	$2,164
Mid-Hudson	$2,084
Western	$1,098
Finger Lakes	$932
Capital District	$725
Central	$549
Mohawk Valley	$487
Southern Tier	$406
North Country	$303
Out of State	$77
TOTAL	**$22,812**

More detailed regional information can be found on the Department of Health's website at: http://www.health.ny.gov/health_care/medicaid/regulations/global_cap/

Appendix D
State-only Payments (YTD)

Payments ($ in thousands)	Non Federal Total Paid
VAPAP	$35,239
Supportive Housing	$25,459
Alzheimer's Caregiver Support	$18,943
End of AIDS	$7,060
Assisted Living Voucher Demo	$6,149
MLTC Ombudsman	$3,892
CSEA Buy-in	$1,437
Water Fluoridation	$751
Primary Care Service Corps	$461
TOTAL	**$99,392**

Appendix E
Monthly Results (April-November 2020)

April Medicaid Global Cap Target vs. Actual Spending ($ in millions)			
Category of Service	**Global Cap Target**	**Actual**	**Variance Over / (Under)**
Medicaid Managed Care	**$1,493**	**$1,555**	**$63**
Mainstream Managed Care	$820	$850	$30
Long Term Managed Care	$673	$706	$33
Total Fee For Service	**$849**	**$846**	**($3)**
Inpatient	$244	$241	($3)
Outpatient/Emergency Room	$39	$34	($5)
Clinic	$42	$44	$2
Nursing Homes	$225	$217	($8)
Other Long Term Care	$83	$83	$1
Non-Institutional	$217	$228	$11
Medicaid Administration Costs	**$15**	**$15**	**$0**
OHIP Budget / State Operations	**$5**	**$5**	**$0**
Medicaid Audits	**($63)**	**($63)**	**$0**
All Other	**($585)**	**($586)**	**($1)**
Local Funding Offset	**($657)**	**($657)**	**$0**
TOTAL	**$1,057**	**$1,116**	**$59**

April to May Medicaid Global Cap Target vs. Actual Spending ($ in millions)			
Category of Service	**Global Cap Target**	**Actual**	**Variance Over / (Under)**
Medicaid Managed Care	**$3,061**	**$3,119**	**$58**
Mainstream Managed Care	$1,684	$1,707	$22
Long Term Managed Care	$1,376	$1,412	$36
Total Fee For Service	**$1,611**	**$1,619**	**$8**
Inpatient	$425	$431	$6
Outpatient/Emergency Room	$71	$104	$33
Clinic	$75	$72	($3)
Nursing Homes	$401	$384	($18)
Other Long Term Care	$147	$141	($6)
Non-Institutional	$492	$488	($4)
Medicaid Administration Costs	**$15**	**$15**	**$0**
OHIP Budget / State Operations	**$11**	**$11**	**$0**
Medicaid Audits	**($98)**	**($98)**	**$0**
All Other	**($592)**	**($594)**	**($2)**
Local Funding Offset	**($1,183)**	**($1,183)**	**$0**
TOTAL	**$2,825**	**$2,889**	**$64**

April to June Medicaid Global Cap Target vs. Actual Spending ($ in millions)			
Category of Service	**Global Cap Target**	**Actual**	**Variance Over / (Under)**
Medicaid Managed Care	**$5,629**	**$5,708**	**$79**
Mainstream Managed Care	$3,079	$3,122	$43
Long Term Managed Care	$2,550	$2,586	$36
Total Fee For Service	**$2,152**	**$2,135**	**($18)**
Inpatient	$621	$626	$5
Outpatient/Emergency Room	$102	$117	$15
Clinic	$102	$98	($4)
Nursing Homes	$567	$552	($15)
Other Long Term Care	$203	$198	($5)
Non-Institutional	$557	$543	($14)
Medicaid Administration Costs	**$15**	**$15**	**$0**
OHIP Budget / State Operations	**$40**	**$40**	**$0**
Medicaid Audits	**($126)**	**($126)**	**$0**
All Other	**($705)**	**($707)**	**($3)**
Local Funding Offset	**($1,708)**	**($1,708)**	**$0**
TOTAL	**$5,299**	**$5,357**	**$58**

April to July Medicaid Global Cap Target vs. Actual Spending ($ in millions)			
Category of Service	**Global Cap Target**	**Actual**	**Variance Over / (Under)**
Medicaid Managed Care	**$7,534**	**$7,642**	**$108**
Mainstream Managed Care	$4,167	$4,230	$63
Long Term Managed Care	$3,367	$3,412	$45
Total Fee For Service	**$2,843**	**$2,790**	**($53)**
Inpatient	$844	$839	($5)
Outpatient/Emergency Room	$141	$145	$3
Clinic	$136	$131	($4)
Nursing Homes	$767	$746	($21)
Other Long Term Care	$284	$281	($2)
Non-Institutional	$672	$648	($24)
Medicaid Administration Costs	**$15**	**$15**	**$0**
OHIP Budget / State Operations	**$65**	**$65**	**$0**
Medicaid Audits	**($159)**	**($159)**	**$0**
All Other	**($608)**	**($612)**	**($4)**
Local Funding Offset	**($2,349)**	**($2,349)**	**$0**
TOTAL	**$7,342**	**$7,393**	**$51**

April to August Medicaid Global Cap Target vs. Actual Spending ($ in millions)			
Category of Service	**Estimated**	**Actual**	**Variance Over / (Under)**
Medicaid Managed Care	**$9,074**	**$9,188**	**$113**
Mainstream Managed Care	$5,006	$5,080	$74
Long Term Managed Care	$4,068	$4,107	$39
Total Fee For Service	**$3,622**	**$3,579**	**($43)**
Inpatient	$1,052	$1,051	($2)
Outpatient/Emergency Room	$173	$167	($6)
Clinic	$169	$163	($6)
Nursing Homes	$928	$917	($11)
Other Long Term Care	$350	$353	$4
Non-Institutional	$950	$928	($22)
Medicaid Administration Costs	**$22**	**$22**	**$0**
OHIP Budget / State Operations	**$95**	**$95**	**$0**
Medicaid Audits	**($193)**	**($193)**	**$0**
All Other	**($540)**	**($544)**	**($5)**
Local Funding Offset	**($2,862)**	**($2,862)**	**$0**
TOTAL	**$9,219**	**$9,284**	**$65**

April to September Medicaid Global Cap Target vs. Actual Spending ($ in millions)			
Category of Service	**Estimated**	**Actual**	**Variance Over / (Under)**
Medicaid Managed Care	**$10,780**	**$10,891**	**$111**
Mainstream Managed Care	$5,951	$6,016	$65
Long Term Managed Care	$4,829	$4,875	$46
Total Fee For Service	**$4,577**	**$4,535**	**($43)**
Inpatient	$1,477	$1,481	$4
Outpatient/Emergency Room	$202	$196	($6)
Clinic	$198	$192	($7)
Nursing Homes	$1,173	$1,164	($10)
Other Long Term Care	$432	$428	($5)
Non-Institutional	$1,094	$1,075	($19)
Medicaid Administration Costs	**$172**	**$172**	**$0**
OHIP Budget / State Operations	**$133**	**$133**	**$0**
Medicaid Audits	**($217)**	**($217)**	**$0**
All Other	**($681)**	**($687)**	**($6)**
Local Funding Offset	**($3,503)**	**($3,503)**	**$0**
TOTAL	**$11,261**	**$11,323**	**$62**

April to October	Medicaid Global Cap Target vs. Actual Spending ($ in millions)		
Category of Service	**Global Cap Target**	**Actual**	**Variance Over / (Under)**
Medicaid Managed Care	**$12,138**	**$12,264**	**$125**
Mainstream Managed Care	$6,819	$6,895	$76
Long Term Managed Care	$5,319	$5,369	$49
Total Fee For Service	**$5,039**	**$5,020**	**($19)**
Inpatient	$1,583	$1,592	$9
Outpatient/Emergency Room	$224	$220	($4)
Clinic	$225	$220	($5)
Nursing Homes	$1,369	$1,377	$8
Other Long Term Care	$505	$493	($11)
Non-Institutional	$1,133	$1,118	($16)
Medicaid Administration Costs	**$175**	**$175**	**$0**
OHIP Budget / State Operations	**$159**	**$159**	**$0**
Medicaid Audits	**($255)**	**($255)**	**$0**
All Other	**($489)**	**($496)**	**($7)**
Local Funding Offset	**($4,016)**	**($4,016)**	**$0**
TOTAL	**$12,751**	**$12,850**	**$99**

April to November	Medicaid Global Cap Target vs. Actual Spending ($ in millions)		
Category of Service	**Global Cap Target**	**Actual**	**Variance Over / (Under)**
Medicaid Managed Care	**$13,520**	**$13,657**	**$137**
Mainstream Managed Care	$7,539	$7,624	$84
Long Term Managed Care	$5,981	$6,034	$53
Total Fee For Service	**$5,831**	**$5,800**	**($31)**
Inpatient	$1,751	$1,749	($2)
Outpatient/Emergency Room	$245	$244	($1)
Clinic	$255	$253	($1)
Nursing Homes	$1,586	$1,591	$5
Other Long Term Care	$571	$556	($15)
Non-Institutional	$1,424	$1,407	($16)
Medicaid Administration Costs	**$182**	**$182**	**$0**
OHIP Budget / State Operations	**$180**	**$180**	**$0**
Medicaid Audits	**($284)**	**($284)**	**$0**
All Other	**($621)**	**($629)**	**($8)**
Local Funding Offset	**($4,528)**	**($4,528)**	**$0**
TOTAL	**$14,280**	**$14,379**	**$99**