Department of Health

Medicaid Global Spending Cap Report

March 2021 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 Fiscal Year (FY) 2021 Medicaid Global Spending Cap was $6 million below the $19.936 billion target; however, FY 2021 had its challenges. Based on a review of price and utilization trends as well as other factors, the State projected State-share Medicaid spending would have exceeded the Global Spending Cap, by $123 million absent any cash management actions (after payment deferral of $1.7 billion). Factors driving this growth were:

- 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 871,936 New Yorkers or 12.5 percent, growing from 6.1 million enrollees in March 2020 to 7.0 million enrollees as of March 2021, in large part, as a result of the COVID-19 pandemic and attendant loss of employer-sponsored coverage or changes in income.

- 53rd Cycle: This Fiscal Year included 53 weekly Medicaid payments cycles as opposed to 52 payment cycles. Because the Global Cap is on a cash basis, the extra cycle payment adds additional costs to the current fiscal year. The 53rd Medicaid Cycle payment resulted in an additional $132 million of costs.

- ACA Enhanced FMAP on Single and Childless Adults: The phase down of the Affordable Care Act (ACA) enhanced FMAP for single and childless adults from a 93 percent Federal match rate to a 90 percent federal match rate increased pressure on the Global Cap. The loss in Federal funding drove $450 million of the growth in State spending in FY 2021.

As a result, various savings initiatives were implemented to bring the Global Cap back into balance. Most notably, the State reduced Managed care premiums to account for lower health care utilization due to the COVID-19 pandemic ($584 million), and utilized available but unspent funding for the Vital Access Provider Assurance Program (VAPAP) not needed by providers ($250 million) due primarily to resources provided directly to health care providers through the Coronavirus Aid, Relief.

Impact of COVID-19 Pandemic on FY 2021 Global Cap Spending

Increased Federal Match:

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 Secretary of Health and Human Services (HHS). The enhanced funding began January 1, 2020 and will continue into Fiscal Year 2022 [1]. Certain expenditures, including expenditures for the Medicaid expansion population already eligible for enhanced Federal match under the ACA and certain medical services already eligible for an enhanced Federal match did not qualify for the 6.2 percent eFMAP.

The additional Federal resources reduced State and Local government costs and were used to support the costs of the significant increase in Medicaid enrollment that resulted, in large part, from individuals losing income and/or job-related insurance coverage because of the COVID-19 pandemic, and due to federal Maintenance of Effort requirements under the Families First Coronavirus Relief Act (FFCRA), which precluded states from terminating an individual's Medicaid enrollment, except in very limited circumstances (e.g. death, moving out of state,

[1] As of the date of this Report, the Federal government has extended eFMAP through at least September 30, 2021 and, notwithstanding the Secretary's ability to revoke the emergency prior to the state of a new calendar quarter (i.e. prior to October 2021), the State's financial plan assume eFMAP will continue through the end of Calendar Year 2021 consistent with HHS Secretary's Letter to State Governors on January 22, 2021.

voluntary termination, etc.) and, for a time period, making any changes in the amount, duration and scope of Medicaid benefits, as a condition of receiving eFMAP.

The following table provides the projected and actual fiscal impacts attributed to the pandemic related to the additional eFMAP in FY 2021. The slight underclaiming of eFMAP is attributed to a reduction in utilization as a result of the COVID-19 pandemic restrictions.

FY 2021 COVID 19 Impacts $ in millions	
Projected State Share	($3,481)
Projected Local Share	($754)
Total Projected 6.2% eFMAP	**($4,235)**
Actual 6.2% eFMAP	($4,174)
Under/(Over) Collected eFMAP	**$61**

Increased Enrollment:
As stated above, the COVID-19 pandemic resulted in the most significant one year increase in Medicaid enrollment since the inception of the program. Increased enrollment resulted as individuals lost income and/or job related insurance coverage and as the State was required to suspend termination of eligibility under Federal law as a condition of receiving eFMAP. Between March 2020, when the federal public emergency was declared by the Secretary, and March 2021, the end of this reporting period, Medicaid enrollment increased by 871,936. A month by month summary of Medicaid enrollment can be found at: NYS Medicaid Enrollment Databook.

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

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

Long-term care services, which comprise a significant portion of Medicaid spending, were also impacted as utilization of nursing home days decreased as did home care services, including personal care services as enrollees deferred services due to the risk of exposure to COVID-19 and as enrollees sought additional informal supports. Certain other services in congregate settings were also closed resulting in lower overall long-term care utilization.

Increased flexibility for telehealth services, including the expansion of telehealth options for clinics, optometrists and dentists and the ability of enrollees to seek certain telehealth services through audio-only modalities, resulted in increases in utilization for certain types of services.

Other Notable Events

Pharmacy Transition from Managed Care to fee-for-service (FFS) Delay - The FY 2022 Enacted Budget delays the transition to move the pharmacy benefit for 4.3 million Medicaid managed care members back to FFS for two years, until April 1, 2023.

FFCRA Maintenance of Effort (MOE) Requirements - Section 6008 of the Families First Coronavirus Response Act imposed a MOE requirement conditioned on states receiving the 6.2 percent eFMAP during the Federal public health emergency. As a result, several MRT initiatives aimed at modifying eligibility and other Personal Care

Services/Consumer Directed Personal Assistance Program requirements have been delayed, and the Financial Plan supported the lost savings associated with these actions in the Global Cap in FY 2021.

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

Total actual State Medicaid spending was $6 million below the Medicaid Global Spending Cap for FY 2021. Spending through March resulted in total expenditures of $19.930 billion compared to the allowable spending target of $19.936 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	**$18,055**	**$17,686**	**($369)**
Mainstream Managed Care	$10,757	$10,471	($286)
Long Term Managed Care	$7,298	$7,215	($83)
Total Fee For Service	**$8,645**	**$8,575**	**($70)**
Inpatient	$2,524	$2,376	($148)
Outpatient/Emergency Room	$404	$348	($56)
Clinic	$387	$388	$1
Nursing Homes	$2,714	$2,579	($135)
Other Long Term Care	$868	$854	($14)
Non-Institutional	$1,748	$2,030	$282
Medicaid Administration Costs	**$467**	**$480**	**$13**
OHIP Budget / State Operations	**$275**	**$290**	**$15**
Medicaid Audits	**($429)**	**($365)**	**$64**
All Other	**($586)**	**($30)**	**$556**
Local Funding Offset	**($6,491)**	**($6,706)**	**($215)**
TOTAL	$19,936	$19,930	($6)

Note: The targets provided herein incorporate the current year savings initiatives adopted at the Executive Budget and Executive Budget Amendment Financial Plan events, as mentioned in the Medicaid Global Spending Cap April through December 2020 Report. Additionally, the overall FY 2021 Global Cap target was reduced pursuant to the use of eFMAP costs shifted to Federal funds.

- Medicaid Managed Care (MC): Managed Care was $369 million, or 2.0 percent under Global Cap projections through March.
  - *Mainstream Managed Care* spending was $286 million, or 2.7 percent, below estimates through March. The final cycle payments for Managed Care organizations that were delayed to FY 2022 came in higher than the original budget estimates. Consistent with prior years and in accordance with contractual obligations the State has managed the timing of payments across State fiscal years. This had no impact on provider services.
  - *Long Term Managed Care* was $83 million below estimates through March primarily due to higher than anticipated Federal revenue on Community First Choice Option (CFCO) expenditures.
- Fee-For-Service (FFS): Medicaid spending in major fee-for-service categories was $70 million, or 0.8 percent, below target.
  - *Inpatient* spending was $148 million below target. Paid claims, year over year, were down 10.5 percent and were 5.9 percent lower than current year estimates due to the pandemic. An overestimate of how quickly inpatient utilization would return to pre-COVID levels resulted in the forecast being higher than actuals.

- O*utpatient* spending was $56 million below estimates through March. Paid claims were roughly 26 percent lower when compared to the prior fiscal year and 13.9 percent lower than current year estimates. This is primarily due to the impact of the pandemic on utilization, which anticipated a near full return to pre-COVID levels by January 2021, but this did not occur.

- *Nursing Home* spending was $135 million lower than projected for the Fiscal Year. This was mainly driven by the delay in processing various rate packages due to pending Federal approval of State Plan Amendments.

- *Non-Institutional* spending (includes Pharmacy, Transportation, Medical Supplies, Physicians, Supplemental Medical Insurance, etc.) was $282 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 made to the Federal government as well as lower than expected rebate collections. This overspending was partially offset by underutilization in transportation services, which were anticipated initially to return to pre-COVID levels sooner than reality.

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 totals $275 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 $15 million above projections through March.

OHIP Budget FY 2021 ($ in millions)		
Service Costs	**Annual Budget**	**Actual**
Personal Services	$40	$38
Non-Personal Services	$168	$186
Essential Plan All Others	$67	$66
TOTAL	**$275**	**$290**

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 $556 million in this category is mainly attributed to accelerating payments on an Affordable Care Act (ACA) Federal Financial Participation liability. As part of the ACA, CMS anticipated states that adopted continuous eligibility for adults would experience a two percent increase in enrollment. Based on this estimate, CMS determined that 97.4 percent of Medicaid enrollee member months for newly eligible individuals in the Adult Group will be matched at the enhanced FMAP rate (90%) and 2.6 percent will be matched at the regular FMAP rate (50%). This liability began accruing on January 1, 2014 and accrues on a quarterly basis going forward.The State's electronic Medicaid system (eMedNY) is unable to carve out a portion of the Adult Group. As a result, the State claims for the entire group at the eFMAP rate and thus overclaims for 2.6 percent of the Adult Group, resulting in the liability which is then repaid manually to the Federal government.

Accounts Receivable

Through the end of March 2021, the A/R balance increased by $15 million. Due to the timing of the Managed Care premium reductions implemented in January 2021 the State was unable to fully recoup all Managed Care liabilities, however these will be fully recovered in FY 2022.

Local Funding Offset

The Local Funding Offset represents the Medicaid contributions paid by counties for their share of the Medicaid program. Counties contributed $215 million higher than projections due to the timing of the release of the counties' share of the 6.2 percent eFMAP related to the public health emergency. Specifically, County contributions were reduced for the period January 2020 through September 2020 while the eFMAP received for the period October 2020 through March 2021 will be reflected as a reduction to the FY 2022 Local Cap Contribution.

Enrollment

Medicaid Enrollment

Medicaid total enrollment reached 6,959,095 enrollees at the end of March 2021. This reflects a *net* increase of 871,936 enrollees since March 2020, due to enrollment of individuals who lost their employment or had lower income because of the COVID-19 pandemic.

Medicaid Enrollment Summary				
	March 2020	**March 2021**	**Net Increase / (Decrease)**	**% change**
Managed Care	4,332,367	5,194,634	862,267	16.6%
Long Term Managed Care	285,564	280,607	(4,957)	-1.8%
Fee-For-Service	1,469,228	1,483,854	14,626	1.0%
TOTAL	**6,087,159**	**6,959,095**	**871,936**	**14.3%**

Note: Enrollment counts come from the Medicaid Data Warehouse (enrollment database) and are reported on DOH's website here: NYS Medicaid Enrollment Databook. 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 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
	2019 HIV SNP Incentive Pool Payment	1/1/2019	January
	April 2020 Mainstream and HARP Revised Rates – COVID Adjustment	4/1/2020	January
Long Term Managed Care	April 2020 Partial Capitation Rates	4/1/2020	October
	January 2020 Medicaid Advantage (MA) Rates	1/1/2020	July
	QIVAPP	4/1/2020	March
	Quality Pools	Various	December
	April 2020 Revised Partial Capitation Rates – COVID Adjustment	4/1/2020	January
Inpatient	Inpatient Psychiatric Rates	10/1/2018	December
	January 2020 Statewide Inpatient Rates	1/1/2020	November
Outpatient / Emergency room	FQHC Hold Harmless	1/1/2019	October
Clinic	FQHC Hold Harmless	1/1/2019	October
Nursing Homes	MRT Capital Reduction Package	4/1/2020	September
	2020 NH Initial Rates	1/1/2020	September
	NH Rate Corrections	Various	November
	Quality Pool and 1% Supplemental	4/1/2020	January
	MDS Audits	Various	February
	Cash Receipts Assessment Rates	Various	March
Assisted Living	2020 ALPs Initial Rates	1/1/2020	August
Hospice	2020 Non-Residence Rates	1/1/2020	March
	2020 Residence Rates	1/1/2020	February
Home Health	2020 CHHA Pediatric Rates	1/1/2020	September
	2020 CHHA Episodic Rates	1/1/2020	March

Appendix B

MRT II Initiatives – FY 2021 Enacted Budget

(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 B

MRT II Initiatives – FY 2022 Enacted Budget

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

(State Share $ millions)	Implementation Date	FY22 Enacted	FY23 Enacted
Global Cap Base Deficit / (Surplus)		**$395.84**	**$284.94**
Base Actions		**($98.24)**	**($52.07)**
COVID-19 Managed Care Rate Reductions (FY21 Rate Action)	2/1/21	($33.12)	$0.00
COVID-19 Long Term Care Rate Reduction (FY21 Rate Action)	2/1/21	($20.00)	$0.00
Global Cap Base Re-Estimate	2/1/21	($45.12)	($52.07)
Mainstream Managed Care (MMC) Actions		**($4.40)**	**$0.00**
FY18 MMC Medical Loss Ratio (MLR) Recoupment	4/1/21	($4.40)	$0.00
Hospital Actions		**($16.12)**	**($24.62)**
Reduce Hospital Capital Rate Add-on (from 5% to 10%)	10/1/21	($8.50)	($17.00)
Discontinue Value Base Payment (VBP) Readiness Funding	2/1/21	($7.62)	($7.62)
Long-Term Care Actions		**($42.35)**	**($20.00)**
Electronic Visit Verification (EVV) Savings	4/1/21	($20.00)	($20.00)
FY18 Managed Long-Term Care MLR Recoupment	4/1/21	($22.35)	$0.00
Other		**($115.81)**	**($59.68)**
Return Non-Distressed Providers to Lag	4/1/21	($75.00)	$0.00
Pilot Medical Respite	4/1/21	($1.31)	($1.68)
Comprehensive Telehealth Reform Package	4/1/21	($39.50)	($58.00)
Total Enacted Savings Actions		**($276.92)**	**($156.37)**
Adds		**$129.00**	**$147.55**
Nursing Home Reforms	4/1/21	$32.00	$32.00
Young Adult Nursing Home - Pilot	4/1/21	$8.75	$8.75
Housing Disregard for Personal Care Services (PCS) and Consumer Directed Personal Assistance Program (CDPAP)	1/1/22	$0.10	$0.10
Expands Post-Partum Eligibility Coverage Between 200% and 223% Federal Poverty Level (FPL)	10/1/21	$0.95	$1.90
Delay Pharmacy Fee-For-Service (FFS) Transition to FY24	4/1/21	$87.20	$104.80
Avails		**($398.18)**	**($301.50)**
Expanded In-Home Services for the Elderly (EISEP) Investment Savings	4/1/21	($11.30)	($11.30)
Updated State Support Associated with the Delay Pharmacy FFS Transition to FY24	4/1/21	($15.00)	($15.00)
Updated State Support Associated with Home and Community Based Service (HCBS) Training Programs	4/1/21	($5.00)	$0.00
Health+Hospitals (H+H) VBP Credit	4/1/21	($30.78)	$0.00
Strengthen H+H Delay to FY22	4/1/21	($207.00)	($38.10)
Nursing Home Case Mix	7/1/21	($83.33)	($100.00)

COVID-19 Managed Care Rate Reduction Account Receivable	4/1/21	($45.77)	$0.00
Community First Choice Options (CFCO) Additional Federal Match	4/1/21	$0.00	($137.10)
Net Global Cap Savings		**($150.26)**	**($25.39)**
Updated Financial Plan Minimum Wage Spending	2/1/21	($50.17)	($50.17)
Net DOH Medicaid Savings		**($200.43)**	**($75.55)**
Offset of State-Only Medicaid Costs	4/1/21	($110.00)	$0.00
Net Financial Plan Savings		**($310.43)**	**($75.55)**

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 March 2021 for each region.

Medicaid Regional Spending ($ in millions)	
Economic Region	**Non-Federal Total Paid**
New York City	$18,123
Long Island	$2,800
Mid-Hudson	$2,713
Western	$1,419
Finger Lakes	$1,203
Capital District	$936
Central	$700
Mohawk Valley	$628
Southern Tier	$520
North Country	$386
Out of State	$101
TOTAL	**$29,529**

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

Payments ($ in thousands)	Non Federal Total Paid
VAPAP	$35,239
ACA FFP Correction	$456,000
Supportive Housing	$46,309
Alzheimer's Caregiver Support	$26,322
End of AIDS	$10,982
Assisted Living Voucher Demo	$7,705
MLTC Ombudsman	$5,690
Rural Transportation	$4,000
CSEA Buy-in	$2,425
Water Fluoridation	$751
Primary Care Service Corps	$477
TOTAL	**$595,900**

Appendix E
Medicaid Drug Cap

- The State Fiscal Year 2018 Enacted Budget established a Medicaid Drug Cap that limits pharmacy spending growth in the Medicaid program to an annual growth rate built on the 10-year rolling average of the medical component of the Consumer Price Index, which is determined annually according to statute (5.2% in FY 2021).

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

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

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

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

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

- Over the first three years of implementation (FY 2018-2020), the Medicaid Drug Cap has stayed under the allowable growth rate and achieved savings through spending reductions and additional supplemental rebate contracts with pharmaceutical manufacturers for over 50 high cost drugs.

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

- The Department, in collaboration with the Division of the Budget, is currently evaluating whether pharmacy expenditures will exceed the annual growth limitation imposed by the Medicaid Drug Cap (approximately 3%) in FY 2022.

Appendix F
Monthly Results (January-February 2021)

April to January Medicaid Global Cap Target vs. Actual Spending ($ in millions)			
Category of Service	**Global Cap Target**	**Actual**	**Variance Over / (Under)**
Medicaid Managed Care	**$16,922**	**$17,003**	**$81**
Mainstream Managed Care	$9,825	$9,879	$54
Long Term Managed Care	$7,097	$7,124	$27
Total Fee For Service	**$7,274**	**$7,223**	**($51)**
Inpatient	$2,127	$2,122	($5)
Outpatient/Emergency Room	$298	$294	($4)
Clinic	$321	$321	($0)
Nursing Homes	$2,119	$2,118	($1)
Other Long Term Care	$720	$707	($13)
Non-Institutional	$1,689	$1,661	($28)
Medicaid Administration Costs	**$323**	**$323**	**$0**
OHIP Budget / State Operations	**$226**	**$226**	**$0**
Medicaid Audits	**($286)**	**($286)**	**$0**
All Other	**($1,247)**	**($1,255)**	**($8)**
Local Funding Offset	**($5,675)**	**($5,673)**	**$2**
TOTAL	**$17,537**	**$17,561**	**$24**

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	**$17,413**	**$17,508**	**$95**
Mainstream Managed Care	$10,095	$10,144	$49
Long Term Managed Care	$7,318	$7,364	$46
Total Fee For Service	**$7,962**	**$7,889**	**($73)**
Inpatient	$2,268	$2,237	($31)
Outpatient/Emergency Room	$326	$314	($12)
Clinic	$345	$341	($4)
Nursing Homes	$2,280	$2,292	$12
Other Long Term Care	$770	$757	($13)
Non-Institutional	$1,971	$1,949	($22)
Medicaid Administration Costs	**$331**	**$331**	**$0**
OHIP Budget / State Operations	**$236**	**$236**	**$0**
Medicaid Audits	**($320)**	**($320)**	**$0**
All Other	**($158)**	**($166)**	**($8)**
Local Funding Offset	**($6,135)**	**($6,132)**	**$3**
TOTAL	**$19,329**	**$19,346**	**$17**