NEW YORK STATE Department of Health

# Medicaid Global Spending Cap Report

## April through December 2021 Quarterly Report

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## Year-to-Year Growth

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

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

No changes were made to the FY 2022 Global Cap Target between the Financial Plan's Mid-Year Update and the Executive Budget.

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


**Price ($965 million):** The annual growth in the Medicaid Global Spending Cap is limited to the 10-year rolling average of the Medical CPI, which has declined over time from the initial 4 percent to the current rate of 2.9 percent. This allowable growth rate is significantly less than national health spending projections prepared by the Office of the Actuary in the Centers for Medicare & Medicaid Services (CMS)[1]., which are expected to grow at an average annual rate of 5.4 percent for the period 2019-28 and reach $6.2 trillion by 2028[2] Components of price growth include:

- Trend increases for Mainstream Managed Care rates ($607M);
- Trend increases for Long Term Managed Care (MLTC) rates ($64M); and
- Various increases for fee-for-service (FFS) rates ($294M).

**Utilization ($2.4 billion):** Medicaid enrollment is projected to increase by 598,000 New Yorkers or 8.6 percent, increasing from 7.0 million enrollees as of March 2021 to 7.6 million enrollees by March 2022. This growth is in large part due to the COVID-19 pandemic, including pandemic related Federal requirements that have precluded

[1] *https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsProjected*
[2] Of note, the FY 2023 Executive Budget proposes to modify the current growth metric to incorporate the CMS actuary projection of spending growth which will better accommodate pandemic spending levels identified in this sector, "Global Cap Index Inflation - CMS Office of the Actuary Medicaid Projection (5-Year Rolling Average)."

most forms of involuntary disenrollment from Medicaid (e.g., eligibility redeterminations), and attendant loss of employer-sponsored coverage or changes in income. Components of utilization growth include:

- Mainstream Managed Care enrollment, including HIV Special Needs Plans (SNPs) & Health and Recovery Plans (HARPs), are projected to increase by approximately 401,000 individuals by March 2022;
- Long Term Managed Care enrollment is projected to increase 12,300 individuals (4.4 percent); and
- Utilization is expected to partially return to pre-COVID-19 levels in acute care, nursing homes, and transportation fee-for-service categories of spending, resulting in an increase of 184,700 individuals in fee-for-service (FFS).

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

**MRT II/One-Timers/Other ($401 million):** MRT budget actions, one-time costs/savings, or other payments that do not fall into price or utilization include:

- Anticipated timing related delays, due to new reporting requirements, in the collection of supplemental Federal revenue (i.e., 6% eFMAP) for Community First Choice Option (CFCO) services ($593M);
- Returning to the normal pattern of 52 weekly Medicaid fee-for-service payment cycles in FY 2022 as opposed to having an extra 53rd weekly cycle, as was the case in FY 2021 (-$132M); and
- Budget action savings from returning non-distressed providers to the payment lag (-$75M).

## Impact of the COVID-19 Pandemic

In response to the COVID-19 pandemic, the Federal government increased its share of Medicaid funding (i.e., eFMAP) by 6.2 percent for each calendar quarter occurring during the Federal public health emergency declared by the Secretary of Health and Human Services (HHS). The enhanced funding began January 1, 2020, and will continue into Fiscal Year 2023[3]. Certain expenditures, including expenditures for the Medicaid expansion population already eligible for enhanced federal match under the Affordable Care Act (ACA) and certain medical services already eligible for an enhanced Federal match did not qualify for the 6.2 percent eFMAP[4].

The additional Federal resources reduced State and Local government costs and helped support the significant increase in Medicaid enrollment resulting, in large part, from individuals losing income and/or job-related insurance coverage because of the COVID-19 pandemic. Due to Federal MOE requirements under the FFCRA, states are precluded from terminating an individual's Medicaid enrollment, except in very limited circumstances (e.g., death, moving out of state, voluntary termination, etc.) and, for a period, making any changes in the amount, duration, and scope of Medicaid benefits, as a condition of receiving eFMAP.

The following table provides the projected and actual fiscal impacts attributed to the pandemic related to the additional COVID-19 eFMAP that is claimed on a one-month lag. There is a year-to-year decline of eFMAP due to the claiming of 14 months in FY 2021 (for the period of January 2020 to February 2021) and 12 months projected to be claimed in FY 2022 (for the period of March 2021 to February 2022). Due to the timing of reconciliations, March 2022 COVID-19 eFMAP will be realized in April 2022, which is the first month of FY 2023 ($302 million combined State and Local shares).

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

**Increased Enrollment:**

As stated previously, the COVID-19 pandemic resulted in the most significant one-year increase in Medicaid enrollment since the inception of the program. Increased enrollment resulted as individuals lost income and/or job-related insurance coverage and as the State was required to suspend termination of eligibility under Federal law as a condition of receiving eFMAP.

Between March 2020, when the Federal public health emergency was declared by the Secretary of HHS, and December 2021, the end of this reporting period, Medicaid enrollment increased by 1.2 million. A month-by-month summary of Medicaid enrollment can be found at: NYS Medicaid Enrollment Databook.

**Spending on Services:**

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

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

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

[3] *As of the date of this Report, the Federal government has extended the public health emergency through April 16, 2022, which allows for COVID-19 eFMAP through at least June 30, 2022. Notwithstanding the Secretary's ability to revoke the emergency prior to the start of a new calendar quarter (i.e., prior to April 2022), the State's financial plan assumes COVID-19 eFMAP will continue through the end of FY 2023 Quarter 1.*

[4] *The ACA's Medicaid provisions allows New York to utilize Federal funding (90% Federal Share) to expand Medicaid to single and childless adults with incomes up to 138 percent of the Federal Poverty Limit.*

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

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

## Executive Budget Model Changes

DOH, in collaboration with the Division of the Budget, updated the Mid-Year Update Budget Medicaid Global Cap Model for price and utilization trends based on spending through September 2021, as well as other known factors. This Executive Budget Model projects spending to be aligned with the Global Cap spending target of $22.3 billion for FY 2022. The following table outlines the changes from the Mid-Year Update Budget Model of the 2nd Quarter Global Cap Report to the Executive Budget Model of the 3rd Quarter Global Cap Report. The "Results April through December 2021 – Global Cap Target vs. Actual Spending" section further in the report compares the Executive Budget Model against actuals through December of this fiscal year.

| Executive Budget Model Changes ($ in millions) | | | |
|---|---|---|---|
| **Category of Spending** | **Mid-Year Update Model** | **Executive Budget Model** | **$ Change Higher / (Lower)** |
| **Medicaid Managed Care** | **$20,910** | **$20,155** | **($755)** |
| Mainstream Managed Care | $12,896 | $12,241 | ($655) |
| Long Term Managed Care | $8,014 | $7,914 | ($100) |
| **Total Fee For Service** | **$7,249** | **$7,253** | **$4** |
| Inpatient | $2,529 | $2,558 | $29 |
| Outpatient/Emergency Room | $345 | $335 | ($10) |
| Clinic | $406 | $400 | ($6) |
| Nursing Homes | $3,189 | $3,191 | $2 |
| Other Long Term Care | $900 | $914 | $14 |
| Pharmacy | ($934) | ($937) | ($3) |
| Transportation | $267 | $269 | $2 |
| Non-Institutional | $547 | $523 | ($24) |
| **Other State Agencies** | **$1,186** | **$1,036** | **($150)** |
| **Medicare Part A/B & D** | **$2,672** | **$2,687** | **$15** |
| **All Other** | **$48** | **$933** | **$885** |
| **Medicaid Administration** | **$452** | **$452** | **$0** |
| **State Operations** | **$301** | **$302** | **$1** |
| **Local Cap Contribution** | **($6,482)** | **($6,482)** | **$0** |
| **COVID-19 eFMAP** | **($3,629)** | **($3,629)** | **$0** |
| **Audit Collections** | **($412)** | **($412)** | **$0** |
| **TOTAL** | **$22,295** | **$22,295** | **$0** |

**Medicaid Managed Care (-$755 million):** The fiscal impacts of the decrease in April 2021 Mainstream Managed Care (including HIV SNPs & HARPs) and MLTC rates were incorporated, which resulted in lower spending than initially projected; however, these savings were partially offset by anticipated timing related delays due to new reporting requirements in the collection of CFCO services supplemental Federal revenue (i.e., 6% eFMAP). The model-to-model decrease in Medicaid Managed Care rates was consistent with the service utilization decreases described above.

**Other State Agencies (-$150 million):** Reflects services from Other State Agencies (OSA) not recovering from COVID-19 as quickly as initially projected.

**All Other ($885 million):** Includes the Distressed Provider Assistance Account payment, which supports providers that are financially distressed; funded by an equal offset of revenue collected and transferred to the Health Care Reform Act (HCRA) fund from the Distressed Provider Assistance Account. Other components include timing related delays in NYC Health and Hospitals (H+H) Budget Actions and supplemental Federal revenue, combined with accelerated payments for ACA Federal Financial Participation Liabilities.

## Notable Events

**MRT II:** The FY 2021 Enacted Budget included $2.2 billion in recommendations put forward by the MRT II to create efficiencies within the Medicaid program and address the Medicaid imbalance, including identifying efficiencies in long term care services through administrative reforms. Over two-thirds of the $2.2 billion in savings actions have been implemented, with the remaining savings pending due to Federal government approval of Maintenance-of-Effort (MOE) requirements associated with the Families First Coronavirus Response Act (FFCRA) eFMAP of 6.2 percent on Medicaid payment and the American Rescue Plan Act (ARPA) eFMAP of 10 percent for certain home and community-based services (HCBS), or other legally related delays. The Financial Plan assumes the remaining savings actions will be implemented in FY 2023 and FY 2024.

**Extension of the Public Health Emergency:** The Secretary of Human Services has extended the COVID-19 PHE through April 16, 2022, which extends COVID-19 eFMAP through at least June 30, 2022 (the Mid-Year Global Cap Model assumed COVID-19 eFMAP through March 2022). Due to the timing of monthly reconciliations, March 2022 COVID-19 eFMAP will be realized in April 2022 (the first month of FY 2023). The extension of the PHE (and COVID-19 eFMAP) is accompanied by cost increases for enrollees whose coverage has been extended due to CMS MOE provisions in the Families First Coronavirus Response Act (FFCRA), as well as the State's 12-month continuous coverage mandate.

**FFCRA & ARPA MOE Requirements:** Section 6008 of the March 2020 FFCRA imposed an MOE requirement conditioned on states receiving the 6.2 percent eFMAP during the Federal PHE. Additionally, Section 9817 of the March 2021 ARPA imposed an MOE requirement for the duration of the period over which states are able to spend the 10 percent eFMAP related to certain home and community-based services. As a result, several MRT II initiatives aimed at modifying eligibility (i.e., the 30-month lookback) and other Personal Care Services/Consumer Directed Personal Assistance Program requirements have been delayed. The MOEs additionally preclude states from utilizing most forms of involuntary disenrollment from Medicaid, which has also resulted in the suspension of eligibility redeterminations.

**Financial Plan Enrollment Projections:** The Executive Budget Financial Plan assumes that enrollment levels will peak at nearly 7.7 million in FY 2023. Total COVID-19 Medicaid enrollment costs amounted to $912 million in FY 2021 and an estimated $2.3 billion in FY 2022, which eroded the value of the eFMAP benefit. As the economy recovers and unemployment trends towards pre-pandemic levels, costs associated with individuals temporarily enrolled, are expected to begin declining in FY 2023 due to the Federal requirement that enrollees receive a minimum of twelve-months continuous coverage regardless of changes in eligibility status.

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

**Home & Community-Based Services (HCBS) eFMAP**: In addition to the 6.2 percent COVID-19 eFMAP increase, the Federal ARPA bill provided a temporary 10 percentage point increase to the FMAP for certain Medicaid HCBS claimed through March 31, 2022. Such additional funding must supplement, not supplant, current Medicaid funding. After a collaborative, multi-agency effort with the Department's partner agencies that touch on the categories of HCBS for which the eFMAP is being provided, the Department submitted New York's initial spending plan to CMS on July 9th. CMS partially approved the spending plan on August 25, 2021, and provided a second partial approval on January 31, 2022. The Department continues to work with CMS on receiving approval for the balance of the spending plan. The Department may modify the spending plan, subject to CMS's approval, on a quarterly basis.

In its quarterly spending plan update from October 18, 2021, New York continued to recommend investments that will support the needs of our most vulnerable populations, including children, individuals with intellectual and developmental disabilities (I/DD), those suffering from addiction, those with behavioral health needs, and older adults. New York's approach prioritizes investments with long-term sustainable benefits, including building workforce capacity and digital infrastructure to streamline service delivery, improving the quality and efficiency of services in the more immediate term, and helping HCBS providers overcome pandemic-related expenses and service disruptions.

**1115 Medicaid Waiver:** The State has submitted subsequent wavier extension requests to continue its Medicaid Redesign and healthcare delivery system transformation efforts. CMS has approved, through at least March 31,

2022, an 1115 Medicaid waiver extension that preserves the State's Medicaid Managed Care Programs, Children's HCBS, and self-direction of Personal Care services. Subsequently, on August 24, 2021, the Department of Health submitted a 1115 waiver amendment concept paper to CMS. This concept paper proposes a framework for substantial new Federal funding over five years to invest in an array of multi-faceted and related initiatives that would change the way the Medicaid program integrates and pays for social care and health care in NYS. This comprehensive initiative would also lay the groundwork for reducing long standing racial, disability-related, and socioeconomic health care disparities, increasing health equity through measurable improvement of clinical outcomes, and keeping overall Medicaid program expenditures budget neutral to the Federal government.

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

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

The $22.3 billion projected Medicaid State Funds Spending can be organized into three major components:

(1) **Medicaid Claims:** Health care provider claim spending reflects the cost of FFS care and Managed Care capitation payments based on the price and utilization of services by sector of the Medicaid program (e.g., hospitals, nursing homes, managed care, long-term care, pharmacy, transportation, etc.). These payments occur weekly **within** the Medicaid claiming system (eMedNY).

Projections for most categories of spending begin with the number of eligible recipients reported at the end of the previous fiscal year and the average spending per recipient for that period. Adjustments to spending projections are then made for anticipated rate (i.e., price) changes, transitions of populations/benefits to managed care (if any), fluctuations in the amount and type of service units (i.e., utilization), and any non-recurring or one-time payments/credits.

(2) **Supplemental Programs:** Payments through administrative or intergovernmental financial mechanisms, such as Disproportionate Share Hospital (DSH), Upper Payment Limit (UPL), Medicare Clawback Part D, Medicare Supplemental Medical Insurance (SMI) Part A/B, Medicaid Local District Social Services Administration and State Operations, occur **outside** of the eMedNY billing system. These supplemental programs are projected on an individual basis according to their historical spending trends and/or latest programmatic information.

(3) **Offsets:** Additional financial resources are used to offset State Medicaid, such as additional Federal funding, audit collections, drug manufacturer rebates, and Local County contributions, all of which also occur **outside** the eMedNY billing system. These offsets are projected on an individual basis according to their historical spending trends and/or latest programmatic information.

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

| Projected FY 2022 Medicaid Spending ($ in millions) | | | | |
|---|---|---|---|---|
| **Category of Spending** | **Medicaid Claims** | **Supplemental Programs** | **Offsets** | **Total** |
| **Medicaid Managed Care** | **$20,161** | **$852** | **($858)** | **$20,155** |
| Mainstream Managed Care | $12,779 | $319 | ($858) | $12,241 |
| Long Term Managed Care | $7,382 | $532 | $0 | $7,914 |
| **Total Fee For Service** | **$8,095** | **$1,127** | **($1,969)** | **$7,253** |
| Inpatient | $2,150 | $758 | ($350) | $2,558 |
| Outpatient/Emergency Room | $424 | $0 | ($89) | $335 |
| Clinic | $458 | $4 | ($62) | $400 |
| Nursing Homes | $2,952 | $294 | ($55) | $3,191 |
| Other Long Term Care | $903 | $31 | ($20) | $914 |
| Pharmacy | $361 | $2 | ($1,301) | ($937) |
| Transportation | $271 | $36 | ($38) | $269 |
| Non-Institutional | $576 | $1 | ($54) | $523 |
| **Other State Agencies** | **$3,966** | **$0** | **($2,929)** | **$1,036** |
| **Medicare Part A/B & D** | **$0** | **$2,687** | **$0** | **$2,687** |
| **All Other** | **$0** | **$1,406** | **($473)** | **$933** |
| **Medicaid Administration** | **$0** | **$452** | **$0** | **$452** |
| **State Operations** | **$0** | **$302** | **$0** | **$302** |
| **Local Cap Contribution** | **$0** | **$0** | **($6,482)** | **($6,482)** |
| **COVID-19 eFMAP** | **$0** | **$0** | **($3,629)** | **($3,629)** |
| **Audit Collections** | **$0** | **$0** | **($412)** | **($412)** |
| **TOTAL** | **$32,221** | **$6,825** | **($16,752)** | **$22,295** |

**Major Supplemental Programs:**

**Medicaid Managed Care ($852 million)**

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

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

- Inpatient: Disproportionate Share Hospital (DSH) and Voluntary Upper Payment Limit (UPL).
- Nursing Homes: Advance Training Initiatives and 2% Supplemental Payments.
- Other Long Term Care: Assisted Living Demonstration Vouchers, and Traumatic Brain Injury (TBI) and Nursing Home Transition and Diversion (NHTD) payments.
- Transportation: Supplemental Ambulance and Rural Transportation Investments.

**Medicare SMI Part A/B & Clawback Part D ($2.7 billion)**

- Supplemental Medical Insurance (SMI) Part A/B: This voluntary Social Security insurance pays a substantial part of Medicare dual enrollees' expenses for hospital, physician, home health, and other medical health services. States must contribute to the Federal Government a portion of the total expenses.

- Clawback Part D: Under the Medicare Part D drug benefit program, most costs are paid by beneficiary premiums and general tax revenues. States must contribute to the Federal Government for beneficiaries who are eligible for both Medicare and Medicaid who receive drug coverage through Part D.

**All Other ($1.4 billion)**

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

- Distressed Provider Assistance Account Payment ($250 million): Supports hospitals and nursing homes that are critical safety-net providers; funded by an equal offset from the local distressed tax intercept fund.

- Vital Access Provider Assurance Program (VAPAP) ($225 million): The VAPAP program provides State-only support for facilities in need of essential and immediate cash assistance with the ultimate requirement of sustainability and access to care.

- ACA Federal Financial Participation Liability ($149 million): 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. 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.

- Patient Centered Medical Homes ($117 million): The Medicaid Patient Centered Medical Home (PCMH) incentive program gives incentive payments to National Committee for Quality Assurance PCMH-recognized providers to support their ongoing efforts to deliver high-quality, coordinated care to Medicaid members.

- 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.

- Affordable Housing ($63 million): The Supportive Housing Initiative seeks to ensure that Medicaid members have proper housing that promotes a healthy environment and lifestyle.

**Medicaid Administration ($452 million)**

The annual county Medicaid caps for Local Administration will remain at their historic/current levels during FY 2022, although it is anticipated that county Administration costs will continue to decrease over time as the State assumes more administrative functions previously borne by local districts.

The Department of Health continues to work collaboratively with local governments and the Division of Budget to facilitate the transition of Medicaid administrative functions and associated costs to the State. The latest annual report detailing the Medicaid Administration Takeover can be found at: Medicaid Administration Annual Report.

**State Operations ($302 million)**

The OHIP State Operations budget reflects the Non-Federal share of personal services (i.e., salaries of OHIP staff) and non-personal services costs (i.e., contractual services). The FY 2022 Budget is projected to total $302 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 a significant portion of the total non-personal service budget.

| State Operations FY 2022 Budget ($ in millions) | |
|---|---|
| **Service Costs** | **Annual Budget** |
| **Personal Services** | **$45** |
| *Medicaid* | *$41* |
| *Essential Plan* | *$4* |
| **Non-Personal Services** | **$257** |
| *Medicaid* | *$197* |
| *Essential Plan* | *$60* |
| **TOTAL** | **$302** |

**Major Offsets:**

**Medicaid Managed Care (-$858 million)**

Transfer of Child Health Plus (CHP) claims out of the Medicaid Global Cap to the General Fund. Historically, the cost of the CHP program has been paid by the General Fund; however, in the first instance, those costs are paid by the Medicaid Global Cap and then reimbursed.

**Fee For Service (-$2.0 billion)**

- Inpatient: Similar to CHP, the transfer of Department of Corrections and Community Supervision (DOCCS) medical expenditures for inmates that are coded in eMedNY as DOH Inpatient claims out of the Medicaid Global Cap to the General Fund.
- Other Long Term Care: Supplemental Federal Revenue for CFCO services to expand home and community–based services and supports to individuals in need of long term care for help with everyday activities and health–related tasks that can be performed by an aide or direct care worker.
- Pharmacy: OBRA and Supplemental Rebate collections from Drug Manufacturers.
- Transportation: Certified Public Expenditures (CPE) supplemental claim for Federal Revenue.

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

Transfers from Other State Agencies to support State-share Medicaid expenditures for services of OPWDD, the Office of Mental Health (OMH), Office of Children and Family Services (OCFS), State Education Department (SED), Department of Corrections & Community Supervision (DOCCS) and Office of Addiction Services And Supports (OASAS).

**All Other (-$473 million)**

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

- Budget Actions (-$405 million): Includes New York City H+H Budget Actions (-$226 million), Return Non-Distressed Medicaid providers back on the State's two-week payment lag schedule (-$75 million), and the 1.5 percent Across-the-Board payment reduction (-$104 million).
- Supplemental Federal Revenue (-$57 million): Includes claiming Federal revenue for Family Planning services and School Supportive Health services.
- Accounts Receivable (-$23 million): Represents the collection of Medicaid provider liabilities owed to the State resulting from processing retroactive rate adjustments.

**Local Cap Contribution (-$6.5 billion)**

The Local Cap Contribution represents the contribution the State receives from Local Districts for their share of the Medicaid program. The Local share of Medicaid expenditures has been capped since FY 2016. However, Local Districts still share in the benefit of the COVID-19 eFMAP, and contributions have been reduced in FY 2022.

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

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

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

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

The Department of Health collaborates with the Office of the Medical Inspector General (OMIG) and the Office of the Attorney General (AG) in recovering improperly expended Medicaid funds. OMIG conducts and coordinates the investigation, detection, audit, and review of Medicaid providers and recipients to ensure they are complying with all applicable laws and regulation. OMIG recovers any improper payments through cash collections and voided claim recoveries. Cash collections are recovered through three avenues: direct payments, payment plans, and withholds.

In addition to cash collections, OMIG finds inappropriately billed claims within Managed Care capitation payments or provider fee-for-service claims. To correct an error, OMIG and DOH process the current accurate claim, and reduce this claim by the inappropriate claim value to recoup the previous overclaim and decrease state spending. Beginning in FY 2017, void recoveries were included as part of the audit collections to more accurately reflecting accounting for cash collections. These cash audit collection recoveries are used to offset Global Cap spending.

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

Through December 2021, total actual State Medicaid spending is $12 million below the Medicaid Global Spending Cap projection. Spending through December resulted in total expenditures of 17.542 billion compared to the allowable spending target of $17.554 of the Executive Budget Model. However, due to the complex projected fluctuations in monthly spending, simply trending the variance in a linear fashion would not be an accurate method for gauging year-end results.

| April to December 2021 Medicaid Global Cap Target vs. Actual Spending ($ in millions) | | | | |
|---|---|---|---|---|
| **Category of Spending** | **Global Cap Target** | **Actual** | **$ Variance Over / (Under)** | **% Variance Over / (Under)** |
| **Medicaid Managed Care** | **$16,547** | **$16,571** | **$24** | **0.1%** |
| Mainstream Managed Care | $10,224 | $10,222 | ($2) | 0.0% |
| Long Term Managed Care | $6,323 | $6,349 | $26 | 0.4% |
| **Total Fee For Service** | **$5,331** | **$5,336** | **$5** | **0.1%** |
| Inpatient | $1,928 | $1,955 | $27 | 1.4% |
| Outpatient/Emergency Room | $244 | $240 | ($4) | -1.7% |
| Clinic | $303 | $300 | ($3) | -1.0% |
| Nursing Homes | $2,296 | $2,265 | ($30) | -1.3% |
| Other Long Term Care | $684 | $674 | ($10) | -1.5% |
| Pharmacy | ($747) | ($711) | $36 | 4.8% |
| Transportation | $229 | $232 | $3 | 1.1% |
| Non-Institutional | $393 | $380 | ($12) | -3.1% |
| **Other State Agencies** | **$764** | **$764** | **$0** | **0.0%** |
| **Medicare Part A/B & D** | **$1,995** | **$1,997** | **$2** | **0.1%** |
| **All Other** | **$295** | **$340** | **$45** | **15.2%** |
| **Medicaid Administration** | **$355** | **$350** | **($5)** | **-1.5%** |
| **State Operations** | **$218** | **$224** | **$6** | **2.6%** |
| **Local Cap Contribution** | **($4,920)** | **($4,920)** | **$0** | **0.0%** |
| **COVID-19 eFMAP** | **($2,727)** | **($2,838)** | **($111)** | **-4.1%** |
| **Audit Collections** | **($303)** | **($282)** | **$22** | **7.1%** |
| **TOTAL** | **$17,554** | **$17,542** | **($12)** | **-0.1%** |

The following explanations regarding the variances between the Global Cap Target through December and the actual spending are reserved for significant variances with the understanding that small variances do not require an explanation and equate to being "on target."

**Medicaid Managed Care**

Medicaid spending in major Managed Care categories was $24 million over anticipated spending, or 0.1 percent.

- MLTC was $26 million over anticipated spending, or 0.4 percent. This variance is largely attributed to enrollment, which has thus far actualized higher than anticipated.

**Fee-For-Service**

Medicaid spending in major fee-for-service categories was $28 million, or 0.5 percent, under target.

- Inpatient was $27 million over anticipated spending, or 1.4 percent. This is driven by the timing of Disproportionate Share Program (DSH) payments to hospitals, but there is an expectation that the

DSH annual targets will not be exceeded by fiscal year's end because the program has an annual capped allotment.

- Nursing Homes were $30 million under anticipated spending, or 1.3 percent. This variance is largely attributed to slower than anticipated growth in the number of residents reported to be enrolled in nursing homes and adult day care centers.

- Other Long Term Care was $10 million under anticipated spending, or 1.5 percent. This variance is largely attributable to slower than projected growth in the utilization of services as a result of the current COVID-19 environment. The Medicaid program is not experiencing as rapid of an increase as expected in utilization following the easing of COVID-19 related restrictions, and thus service utilization is currently trending lower than anticipated.

- Pharmacy was $36 million over anticipated spending, or 4.8 percent. This variance is largely attributed to the timing of rebate collections, which came in less than projected. Additionally, the pharmacy category did not appear to experience similar decreases in enrollee utilization consistent with other services as a result of the COVID-19 pandemic.

- Non-Institutional was 12 million under anticipated spending, or 3.1 percent. This variance is largely attributable to slower than projected growth in the utilization of services as a result of the current COVID-19 environment. The Medicaid program is not experiencing as rapid of an increase as expected in utilization following the easing of COVID-19 related restrictions, and thus service utilization is currently trending lower than anticipated.

**All Other**

All Other spending underspent by $45 million or 15.2 percent. Variances from the projected budget throughout the year are commonly due to the timing of approvals/disbursements, but with an expectation that the annual targets will be achieved by fiscal year's end. The large variance experienced here mainly result from the timing of Accounts Receivable collections.

**COVID-19 eFMAP**

The drawdown of COVID-19 eFMAP through December was larger than projected by $111 million, or 4.1 percent, which is directly correlated with the overspending seen in the supplemental programs.

**Audit Collections**

Audit collections received were $22 million, or 7.1 percent, below projections through December, which is due to the timing in processing of audits and resulting recoveries.

## Medicaid Enrollment

Due to enrollment of individuals who lost their employment or had lower income because of the COVID-19 pandemic Medicaid enrollment is expected to grow to 7,560,000 individuals by March 2022, an increase of 598,000 individuals from March 2021.

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

**Long Term Managed Care (includes PACE, FIDA IDD, MA and MAP):** Long Term Managed Care (MLTC) enrollment reached 280,000 by the end of FY 2021. This was a net increase of 5,000 individuals consisting of an increase of 22,000 individuals, offset by the Nursing Home carveout initiative (implemented September 2020) that disenrolled approximately 17,000 long term stay individuals from MLTC partial capitation plans and placed into Medicaid fee-for-service. The FY 2022 projections assume that enrollment will grow by4.4 percent, approximately 12,300 individuals, over March 2021 levels[5].

**Medicaid Enrollment to Date**

| Medicaid Enrollment Summary Medicaid Managed Care vs Fee-for-Service | | | | |
|---|---|---|---|---|
| | **March 2021** | **December 2021** | **Net Increase / (Decrease)** | **% Change** |
| Mainstream Managed Care | 5,185,045 | 5,420,076 | 235,031 | 4.5% |
| Long Term Managed Care | 280,250 | 286,509 | 6,259 | 2.2% |
| Fee-For-Service | 1,496,429 | 1,627,051 | 130,622 | 8.7% |
| **TOTAL** | **6,961,724** | **7,333,636** | **371,912** | **5.3%** |

| Medicaid Enrollment Summary by NYC vs Rest of State | | | | |
|---|---|---|---|---|
| | **March 2021** | **December 2021** | **Net Increase / (Decrease)** | **% Change** |
| NYC | 3,966,428 | 4,168,807 | 202,379 | 5.1% |
| Rest of State | 2,995,296 | 3,164,829 | 169,533 | 5.7% |
| **TOTAL** | **6,961,724** | **7,333,636** | **371,912** | **5.3%** |

*Note: Enrollment counts are from the Medicaid Data Warehouse (enrollment database) and are reported on DOH's website: NYS Medicaid Enrollment Databook. Data is pulled monthly to account for any retroactive updates. These counts reflect the net impact of new enrollment and disenrollment that occurred from April through December based on data pulled January 3, 2022.*

[5] *These enrollment assumptions will be adjusted, as necessary, through approved rate packages.*

## Appendix A – Inventory of Rate Packages

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

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

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

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

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

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

## Appendix C – Regional Spending Data

The chart below represents total provider spending that occurs within the Medicaid claiming system (eMedNY) through December 2021 for each region. These values represent physically where the services were provided, but not necessarily where the recipient of the services reside.

| Medicaid Regional Spending ($ in millions) | |
|---|---|
| **Economic Region** | **Non-Federal Total Paid** |
| New York City | $14,037 |
| Long Island | $2,244 |
| Mid-Hudson | $2,175 |
| Western | $1,125 |
| Finger Lakes | $936 |
| Capital District | $736 |
| Central | $538 |
| Mohawk Valley | $479 |
| Southern Tier | $412 |
| North Country | $295 |
| Out of State | $86 |
| **TOTAL** | **$23,062** |

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)

| State-only Payments ($ in millions) | Non-Federal Total Paid |
|---|---|
| VAPAP | $99.8 |
| Supportive Housing | $30.0 |
| Alzheimer's Caregiver Support | $15.3 |
| End of AIDS | $8.3 |
| Assisted Living Voucher Demo | $5.1 |
| Rural Transportation | $4.0 |
| MLTC Ombudsman | $3.8 |
| CSEA Buy-in | $1.7 |
| Primary Care Service Corps | $0.4 |
| **TOTAL** | **$168.4** |

# Appendix E – Medicaid Drug Cap

- The FY 2018 Enacted Budget established a Medicaid Drug Cap that limits pharmacy spending growth in the Medicaid program to an annual growth rate built on the 10-year rolling average of the medical component of the Consumer Price Index, which is determined annually according to statute (2.9% in FY 2022).

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

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

- In determining whether to recommend a target supplemental rebate for a drug the DURB must consider the cost of the drug to the NYS Medicaid program and may consider, among other things: the drug's impact on the Medicaid drug spending, significant and unjustified increases in the price of the drug, and whether the drug may be priced 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- FY 2020), the Medicaid Drug Cap has stayed under the allowable growth rate and achieved savings through spending reductions and additional supplemental rebate contracts with pharmaceutical manufacturers for over 50 high-cost drugs.

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

- Consistent with the statutory formula, the Medicaid Drug Cap for FY 2022 is $1.75 billion and reflects a growth rate of 2.9 percent consistent with the Medicaid Global Spending Cap. By comparison, the projected growth in annual drug spending is expected to be closer to 13 percent, or $228 million in excess of the FY 2022 Medicaid Drug Cap.