Medicaid Global Spending Cap Report

April 2021 through March 2022 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. The Department of Health (DOH) and the Division of the Budget (DOB) report that spending for the FY 2022 Medicaid Global Spending Cap was $5 million below the $22.3 billion target.

This net increase primarily included 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 decreased by $1.2 billion year-to-year resulting in higher State share spending.

No changes were made to the FY 2022 Global Spending Cap Target between the Financial Plan's Mid-Year Update and the FY 2023 Enacted Budget. Major factors contributing to the year-to-year change in Medicaid expenditures include:

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 an initial rate of 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 5.1 percent for the period 2021-30 and reach $6.8 trillion by 2030[2]. Components of price growth included trend increases for Mainstream Managed Care, Managed Long Term Care (MLTC), and fee-for-service (FFS).

Utilization: Medicaid enrollment increased by 475,100 New Yorkers or 6.8 percent, increasing from 7.0 million enrollees as of March 2021 to 7.5 million enrollees by March 2022. This growth is due in large part to the COVID-19 pandemic, including pandemic related Federal requirements that have precluded 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), increased by approximately 321,400 individuals (6.2%) by March 2022;
- Long Term Managed Care (MLTC) enrollment increased by 3,600 individuals (1.3%); and
- Utilization partially returned to pre-COVID-19 levels in acute care, nursing homes, and transportation fee-for-service categories of spending. Enrollment in FFS increased by 150,100 individuals (10%).

COVID-19 Enrollment Supported by eFMAP: 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): Medicaid Redesign Team (MRT) budget actions, one-time costs/savings, or other payments that do not fall into price or utilization include:

- 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;
- 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; and
- Budget action savings from returning non-distressed providers to the payment lag.

[1] *https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsProjected*
[2] Of note, the FY 2023 Enacted Budget modified the current growth metric to incorporate the CMS actuary projection of spending growth which will better accommodate pandemic spending levels identified in this sector.

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 Maintenance-of-Effort (MOE) requirements under the Families First Coronavirus Response Act (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 11.5 months claimed in FY 2022 (for the period of March 2021 to February 2022). Due to the timing of reconciliations, the remaining February and March 2022 COVID-19 eFMAP will be realized in April 2022, which is the first month of FY 2023.

FY 2022 COVID 19 eFMAP $ in millions	
Projected State Share	($2,983)
Projected Local Share	($646)
Total Projected 6.2% eFMAP	**($3,629)**
Actual 6.2% eFMAP	($3,629)
Under/(Over) Collected eFMAP	**$0**

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 March 2022, the end of this reporting period, Medicaid enrollment increased by 1.4 million from 6,101,800 individuals. A month-by-month summary of Medicaid enrollment can be found at: NYS Medicaid Enrollment Databook.

Spending on Services:

The COVID-19 pandemic continues to impact both the utilization of services and the intensity of services provided as compared to prior years and as compared to expected spending during the reporting period. Some services are returning to pre-pandemic levels while others have only partially reverted or continued a divergent trend. The types of services experiencing the largest impact are discussed briefly below.

Total spend and utilization for Clinic began approaching, though not fully recovering to, pre-COVID-19 levels in FY

[3] As of the date of this Report, the Federal government has extended the public health emergency through July 15, 2022, which allows for COVID-19 eFMAP through at least September 30, 2022. Notwithstanding the Secretary's ability to revoke the emergency prior to the start of a new calendar quarter (i.e., prior to June 2022), the State's financial plan assumes COVID-19 eFMAP will continue through the end of FY 2023 Quarter 2.
[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.

2022 after decreasing in FY 2021.

Utilization across all Nursing Home services remain below pre-COVID-19 levels despite the appearance of year-to-year growth from FY 2021 to FY 2022. The FY 2021 shift of nursing home utilizers from Managed Care to FFS contributed to the appearance that nursing home spending was steady in FY 2021 and increasing beyond pre-COVID-19 levels in FY 2022.

Outpatient/Emergency Room utilization dropped 26 percent in FY 2021, and remained low, increasing only 4 percent in FY 2022. Despite this drop in utilization in FY 2021, total spend increased 2 percent in FY 2021 and decreased 9 percent in FY 2022. Spend and utilization trends not moving in parallel are explained by shifts in average unit price. Price increased in FY 2021 and began to return to pre-COVID-19 levels in FY 2022. Increased average price trends do not necessarily mean unit price was increasing for specific services, but rather the service mix was shifting towards services that were more expensive.

Personal Care (PC) increases were driven by spend and utilization increases for Consumer Directed Personal Assistance Services (CDPAS) consumption across FFS utilizers and across PC/CDPAS consumption for the Nursing Home Transition and Diversion (NHTD) waiver utilizers in both FY 2021 and FY 2022. It is important to note that trends for FFS PC claims do not show COVID-19's full impact on personal care services because the bulk of Medicaid spend for personal care is located in Managed Care.

Transportation service spend dropped considerably in FY 2021. While services began to return to pre-COVID-19 levels in FY 2022, spending did not increase significantly year-over-year. In FY 2022, spend for Ambulette, Ambulance and Taxi services began recovering and are currently half-way recovered to their pre-COVID-19 levels, while spend for Livery continued to decrease.

Notable Events

FY 2023 Enacted Budget: DOH held an All-Stakeholder FY 2023 Enacted Medicaid Budget Briefing Webinar on Thursday, April 26, 2022. Materials from this webinar, including a copy of the slide presentation and a link to the recording, have been posted on MRT Budget Information webpage[5]. The full Medicaid Budget Scorecard can be found in Appendix B.

The Enacted Budget also added new Medicaid Global Cap reporting requirements, which will be incorporated into the first quarterly report of FY 2023 and include:

- Methodology by which Medicaid Global Cap projections are compiled or determined;
- Enacted Budget actions with targets compared to implemented savings/investments;
- Projected and actual spending for:
  - Vital Access Provider Assurance Program (VAPAP)
  - Home Care
  - Personal Care, including Consumer Directed Personal Assistance Program
  - To the extent practicable, any programs that were instituted subsequent to the last report issued under this subdivision and not reported;
- Program trends, including enrollment actuals and projections;
- Detail on the anticipated DOH Medicaid spending outside of the Medicaid Global Cap;
- Projected mental hygiene stabilization fund transfer;
- Number of fiscal intermediaries contracted with the DOH; and
- Links to the approved FFS rates for general hospitals and preferred drug list pharmaceutical drugs (included in Appendix F).

Global Cap Growth Rate Metric Update: The FY 2023 Enacted Budget includes an update to the method by which the allowable year-to-year growth rate for State share Medicaid spending is calculated. The new metric utilizes the 5-year rolling average of the national health expenditures projections for Medicaid, published by the CMS Office of the Actuary. CMS calculates projected growth rates for Medicaid by looking at national trends in enrollment, spending, inflation, and other relevant factors. Future publications of the quarterly Global Cap Report will utilize the new allowable growth rate (4.7% in FY 2023) to report on State-share of Medicaid spending.

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 MOE requirements associated with the 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 between now and the end of FY 2025.

Extension of the Public Health Emergency (PHE): The Secretary of Human Services has extended the COVID-19 PHE through July 15, 2022, which extends COVID-19 eFMAP through at least September 30, 2022 (the Executive Budget Global Cap Model assumed COVID-19 eFMAP through June 2022). Due to the timing of monthly reconciliations, February and 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 FFCRA, as well as the State's 12-month continuous coverage mandate.

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[5] *https://www.health.ny.gov/health_care/medicaid/redesign/mrt_budget.htm*

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 Enacted Budget Financial Plan assumes that enrollment levels will peak at over 7.7 million in FY 2023. Total COVID-19 Medicaid enrollment costs amounted to $912 million in FY 2021, $2.3 billion in FY 2022 and projected at over $2.8 billion in FY 2023, 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 2024 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, again on January 31, 2022, and a third partial approval was received on May 18, 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 May 6, 2022, 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 submitted an 1115 waiver extension request to CMS that preserves current Medicaid Managed Care Programs, Children's HCBS, and self-direction of Personal Care services. This waiver was approved on March 31, 2022, and is effective for five years.

Separately, DOH has developed a new programmatic amendment to the now-renewed 1115 waiver that focuses on addressing health disparities that have been highlighted and exacerbated by the COVID-19 pandemic and achieving health equity in the State through the greater integration of health, behavioral health, and social care. This request seeks approximately $13.5 billion in 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 will 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.

After working directly with CMS and stakeholders on concepts contained in this new programmatic waiver amendment, DOH will submit the application formally to CMS in mid-2022 upon completion of the public transparency process required by federal regulations. To satisfy these transparency requirements, DOH submitted a Federal public notice to the NYS Registry on April 13, 2022 and has commenced two public hearings, scheduled on May 3, 2022 and May 10, 2022, with the 30-day public comment period ending May 20, 2022. During the public comment period, DOH received 246 comments and heard from 75 speakers at two public hearings. The

presentation slides and recordings from the May 3, 2022 webinar are available on the DOH website[6].

After submission to CMS, the review and approval process can take several months or longer. DOH plans to begin the five-year waiver demonstration period upon approval from CMS, which DOH anticipates could begin as soon as January 1, 2023.

[6] *https://www.health.ny.gov/health_care/medicaid/redesign/medicaid_waiver_1115.htm*

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

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.

Executive Budget 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 (including HIV SNPs & HARPs): 2 Percent Encounter Withhold Repayments and Quality Pools.
- 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): Funds collected through the local sales tax intercept to support hospitals and nursing homes that are critical safety-net providers.
- 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 (OSAs) 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 March 2022 – Global Cap Target vs. Actual Spending

Through March 2022, total actual State Medicaid spending is $5 million below the Medicaid Global Spending Cap projection. Spending through March resulted in total expenditures of $22.290 billion compared to the allowable spending target of $22.295.

April to March 2022 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	**$20,155**	**$19,634**	**($521)**	**-2.6%**
Mainstream Managed Care	$12,241	$11,937	($304)	-2.5%
Long Term Managed Care	$7,914	$7,697	($217)	-2.7%
Total Fee For Service	**$7,252**	**$7,050**	**($201)**	**-2.8%**
Inpatient	$2,558	$2,561	$3	0.1%
Outpatient/Emergency Room	$335	$311	($24)	-7.1%
Clinic	$400	$394	($5)	-1.3%
Nursing Homes	$3,191	$3,017	($173)	-5.4%
Other Long Term Care	$914	$913	($1)	-0.1%
Pharmacy	($937)	($982)	($44)	-4.7%
Transportation	$269	$310	$41	15.2%
Non-Institutional	$523	$525	$2	0.3%
Other State Agencies	**$1,036**	**$868**	**($168)**	**-16.2%**
Medicare Part A/B & D	**$2,687**	**$2,964**	**$277**	**10.3%**
All Other	**$934**	**$1,348**	**$414**	**44.3%**
Medicaid Administration	**$452**	**$545**	**$93**	**20.5%**
State Operations	**$303**	**$317**	**$14**	**4.7%**
Local Cap Contribution	**($6,482)**	**($6,482)**	**$0**	**0.0%**
COVID-19 eFMAP	**($3,629)**	**($3,629)**	**$0**	**0.0%**
Audit Collections	**($412)**	**($326)**	**$86**	**20.9%**
TOTAL	**$22,295**	**$22,290**	**($5)**	**0.0%**

Due primarily to COVID-19 related impacts, several categories of spending within the Medicaid program experienced lower than anticipated utilization in FY 2022, which drove underspending relative to the Department's spending projections. This underspending resulted in the availability of additional one-time resources within the Global Spending Cap to manage the timing of payments and credits across fiscal years.

These end-of-fiscal year actions included shifting Federal credits into FY 2023 & FY 2024 (e.g., CFCO, Family Planning Services, and HCBS eFMAP) and executing pre-payments of FY 2023 liabilities (e.g., ACA Federal Financial Participation liability, Medicare Clawback Part D, and SMI). These actions represent advancements, not deferrals, and did not impact payment deferrals previously assumed. Further, these actions freed up out-year resources within the Global Spending Cap to support additional program investments in FY 2023 and beyond as referenced in the Enacted Budget Medicaid Scorecard (Appendix B).

The following explanations regarding the variances between the Global Cap Target through March 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 $521 million under anticipated spending, or 2.6 percent.

- Mainstream Managed Care was $304 million under target which is largely due to the value of the cycle payment deferral coming in higher than anticipated. DOH continued the payment restructuring of the final cycle payments to Medicaid Managed Care Organizations. The payment restructuring was paid utilizing cash on hand in April 2022, consistent with contractual obligations and had no impact on provider services.

- Long Term Managed Care was $217 million under anticipated spending, or 2.7 percent. This variance is largely attributed to lower than budgeted enrollment. The Global Cap budget assumed the MLTC program would expand by 12,300 individuals; however, enrollment only grew by 3,600 members.

Fee-For-Service

Medicaid spending in major fee-for-service categories was $201 million, or 2.8 percent, under target.

- Nursing Homes were $173 million under anticipated spending, or 5.4 percent. This variance is attributed to slower than anticipated growth in the number of residents reported to be enrolled in nursing homes and adult day care centers. Additionally, underspending is also partially attributed to the timing of processing rate appeals and supplemental payments.

- Pharmacy was $44 million under anticipated spending, or 4.7 percent. This variance is largely attributed to higher than expected rebate collections.

- Transportation was $41 million over the annual spending target, or 15 percent, which is mainly due to the delay in implementing the Public Emergency Certified Public Expenditure (CPE) in order to claim Federal reimbursement.

Other State Agencies (OSAs)

OSAs underspent by $168 million or 16 percent, which was primarily related to OSAs not recovering from COVID-19 as quickly as projected.

Medicare Part A/B & D

SMI Part A/B and Clawback Part D payments exceeded its budget by $277 million, or 10 percent, which was the direct result of the State accelerating the payment of related invoices from the Federal government.

All Other

All Other spend exceeded its budget by $414 million or 44 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 results from the delayed timing of offsetting the Global Cap for HCBS ARPA reinvestment expenses.

Medicaid Administration

Medicaid Administration expenses exceeded its budget by $93 million, or 21 percent, which was primarily the result of the State catching up on invoices previously on a lagged payment schedule.

Audit Collections

Audit collections received were $86 million, or 20.9 percent, below projections through March, 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 reached 7,452,000 individuals by March 2022, an increase of 475,100 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 321,400 in FY 2022.

Long Term Managed Care (includes PACE, FIDA IDD, MA and MAP): 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 program increased by 3,600 individuals in FY 2022.

Medicaid Enrollment to Date

Medicaid Enrollment Summary Medicaid Managed Care vs Fee for Service				
	March 2021	**March 2022**	**Net Increase / (Decrease)**	**% Change**
Mainstream Managed Care	5,185,045	5,506,468	321,423	6.2%
Long Term Managed Care	280,250	283,855	3,605	1.3%
Fee-For-Service	1,511,609	1,661,687	150,078	9.9%
TOTAL	**6,976,904**	**7,452,010**	**475,106**	**6.8%**

Medicaid Enrollment Summary by NYC vs Rest of State				
	March 2021	**March 2022**	**Net Increase / (Decrease)**	**% Change**
NYC	3,895,103	4,229,930	334,827	8.6%
Rest of State	3,081,801	3,222,080	140,279	4.6%
TOTAL	**6,976,904**	**7,452,010**	**475,106**	**6.8%**

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 March based on data pulled April 4, 2022.

Appendix A – Inventory of Rate Packages

Below are the largest rate packages that were 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
	January 2020 HIV SNP Rates	December 2021
	FY 2021 Encounter Withhold	June 2021
	CY 2020 HIV SNP Incentive Pool Payment	February 2022
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	December 2021
	FY 2021 Encounter Withhold	June 2021
	FY 2021 QIVAPP	March 2022
	CY 2020 Quality Pools	November 2021
Inpatient	January 2021 Acute & Exempt Unit Inpatient Rates	June 2021
Outpatient / Emergency Room	January 2020 Hold Harmless	January 2022
Clinic	October 2021 FQHC MEI Increase	October 2021
	CY 2020 APG Capital Update	April 2021
Nursing Homes	January 2021 NH Initial Rates	September 2021
	July 2021 NH Rate Updates	October 2021
	January 2021 NH Rate Corrections	October 2021
	CY 2020 Cash Receipts Assessment Reconciliation	December 2021
	FY 2022 Advanced Training Initiative	March 2022
	FY 2022 Quality Incentive Pool and 2% Supplemental	December 2021
Personal Care	January 2021 Initial Rates	March 2022
	January 2021 Private Duty Nursing Rates	March 2022
Hospice	January 2021 Non-Residence Rates	March 2022
	January 2021 Residence Rates	March 2022
Home Health	January 2021 CHHA Pediatric Rates	March 2022
Other	July 2020 Patient Centered Medical Homes	December 2021
	January 2021 Patient Centered Medical Homes	February 2022

Appendix B – Enacted Budget Initiatives

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

FY 2022 Enacted Budget

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)**

FY 2023 Enacted Budget

(State Share $ millions)	FY 2023	FY 2024
Global Cap Forecast with Legislation (Surplus)/Deficit	**($437.036)**	**$344.571**
Global Cap Index Inflation - CMS Office of the Actuary Medicaid Projection (5-Year Rolling Average)	($366.000)	($899.380)
Health Care Bonus - State Total	$922.748	$0.000
Financial Plan Support for Health Care Bonuses	($922.748)	$0.000
Global Cap (Surplus)/Deficit	**($803.036)**	**($554.809)**
Budget Actions	**$844.246**	**$627.009**
Hospital Actions	**$350.000**	**$350.000**
Distressed Hospital Pool	$100.000	$100.000
Distressed Provider Account Investment (inc. $100M of Financial Plan Resources)	$250.000	$250.000
Long Term Care Actions	**$48.803**	**($15.297)**
Nursing Home Reforms	*$161.500*	*$161.500*
Nursing Home Support for Compliance with Staffing Regulations	$61.500	$61.500
Increase Nursing Home Vital Access Provider (VAP) Funding	$100.000	$100.000
LTC--Medicaid Diversion	*($110.564)*	*($150.564)*
Expansion of Licensed Home Care Service Agencies (LHCSA) Marketplace	$0.000	($40.000)
Long Term Service and Support (LTSS) Coverage in Essential Plan	($110.564)	($110.564)
LTC Other Reforms	*($2.133)*	*($26.233)*
LHCSA Request for Offer (RFO) Re-estimate	$0.000	($25.000)
LTSS Services Authorization Guidelines	$0.000	($5.000)
Increasing Private Duty Nursing (PDN) Reimbursement for Nurses Servicing Adult Members	$19.450	$25.600
Use of Federal HCBS funding to support PDN Reimbursement	($19.450)	$0.000
Alzheimer's Program under Medicaid	$1.367	$1.367
Fully Implement the Duals Integration Roadmap	($3.500)	($23.200)
Managed Care Actions	**($34.428)**	**($264.678)**
Postpartum Women in Essential Plan	$0.000	($165.000)
Moving Integrated Plans to Middle of the Rate Range	$20.000	$20.000
Restore MMC/MLTC Quality Pools (1-Year Restoration)	$77.250	$0.000
Utilize Child Health Plus (CHP) to Access Federal Funding for Enhanced Pregnancy Coverage	($183.000)	($171.000)
Applied Behavior Analysis (ABA) Rates to Incentivize Providers in Managed Care	$36.605	$36.605
Adjust HIV SNP Rates to Reflect High Needs Model	$14.717	$14.717
Pharmacy Actions	**$0.000**	**$5.000**
Establishing Parity and Uniform Clinical Standards across both Medical and Retail Pharmacy Benefits in Fee-For-Service (FFS)	$0.000	$5.000
Other Actions	**$462.349**	**$498.369**
Increase Medicaid Trend Factor by 1% to Recognize Provider Cost Increases	$318.310	$318.310
Restoration of 1.5% Across the Board (ATB)	$140.759	$140.759
Investment in Children's Behavioral Health Services	$37.260	$42.830
Use of Federal HCBS funding to support Children's Behavioral Health Services	($37.260)	$0.000
Increase Top 20 Orthotics and Prosthetics Codes to Medicare Rates	$3.750	$3.750
Establish Unique Identifier for All Unenrolled Provider Types	($5.000)	($5.000)
Promote Access to Primary Care	$4.930	$6.600
Eliminate Unnecessary Requirements from the Utilization Threshold (UT) Program	($0.230)	($0.230)
Enhanced Durable Medical Equipment (DME) Management	($0.170)	($8.650)
Maternal Health Actions	**$4.335**	**$26.760**
Improve and Expand Access to Prenatal and Postnatal Care	$6.335	$18.760
Advancing Comprehensive Maternal Care in Managed Care	$15.000	$25.000
Maternal Health Investments - Avoided Costs	($17.000)	($17.000)
Other State of the State Actions	**$13.187**	**$26.855**

Create a Center of Medicaid Innovation to Lower Costs and Improve Care	$1.200	$1.200
Promote Health Equity and Continuity of Coverage for Vulnerable Seniors	$5.000	$20.000
Patient Access and Developer Portals	$4.057	$2.725
Health Care Bonus Enforcement	$2.930	$2.930
Adds	**$904.825**	**$408.628**
Additional Hospital Funding	$800.000	$100.000
Maternal Health for Postpartum Coverage for Undocumented	$2.325	$53.880
Medicaid Coverage for Undocumented Age 65+	$56.454	$229.253
Additional QIVAPP Support	$37.400	$0.000
Medicare Savings Program Expansion	$5.200	$20.900
Medicaid Ambulance Billing	$3.446	$4.595
Avails	**($946.035)**	**($480.828)**
Other Revisions and Timing of Payments Across Fiscal Years	($342.335)	($336.928)
Mainstream Managed Care Non-Federal Share Assumption	($486.000)	$0.000
Temporary Support for One-time COVID-related Hospital Expenses	($84.000)	($84.000)
CDPAP Request for Offer (RFO) Re-estimate	($25.000)	($25.000)
Elderly Pharmaceutical Insurance Coverage (EPIC) Savings Offset related to MSP Expansion	($8.700)	($34.900)
Total Global Cap (Surplus)/Deficit	**$0.000**	**$0.000**
Home Care Minimum Wage Increase	$362.578	$964.906
Lost MOE Savings associated with the use of Federal HCBS funding in FY 2024	$0.000	$289.000
Use of Federal HCBS funding to support Home Care Minimum Wage Increase	($362.578)	($702.423)
Home Care Minimum Wage Increase Supported Outside the Global Cap	**$0.000**	**$551.483**
Financial Plan Support of Home Care Minimum Wage Increase	$0.000	($262.483)
Financial Plan Support of Lost MOE Savings	$0.000	($289.000)
Total Financial Plan Support For Min Wage Increase in FY 2024	**$0.000**	**($551.483)**

Appendix C – Regional Spending Data

The chart below represents total provider spending that occurs within the Medicaid claiming system (eMedNY) through March 2022 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	$18,750
Long Island	$3,005
Mid-Hudson	$2,916
Western	$1,504
Finger Lakes	$1,258
Capital District	$989
Central	$722
Mohawk Valley	$644
Southern Tier	$554
North Country	$393
Out of State	$113
TOTAL	**$30,848**

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
DPT Advance	$310
VAPAP	$273
Safety Net Payments	$150
ACA Federal Financial Participation Liability	$122
Supportive Housing	$47
Alzheimer's Caregiver Support	$21
End of AIDS	$12
Assisted Living Voucher Demo	$7
MLTC Ombudsman	$6
Rural Transportation	$4
CSEA Buy-in	$2
Primary Care Service Corps	$0.4
TOTAL	**$954**

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).
- However, the FY 2023 Enacted Budget modified the metric by which Medicaid Global Cap and Medicaid Drug Cap allowable spending growth is calculated. Future quarterly updates will report on the Medicaid Drug Cap using the CMS Actuary Medicaid growth projections in alignment with the Medicaid Global Cap.
- 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 was $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. The Department is still evaluating the year end results which will be reported on in a future update.

Appendix F – Additional Information

- Fee-For-Service Rates for General Hospitals:
    - Inpatient Rates: https://www.health.ny.gov/facilities/hospital/reimbursement/apr-drg/rates/ffs/index.htm
    - Outpatient Rates: https://www.health.ny.gov/health_care/medicaid/rates/apg/rates/hospital/index.htm

- Fee-For-Service Rates of Pharmaceutical Drugs on the Preferred Drug List (PDL): https://newyork.fhsc.com/downloads/providers/NYRx_PDP_PDL.pdf