NEW YORK STATE Department of Health

Medicaid Global Spending Cap Report

April 2022 through June 2022 Quarterly Report

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Overview

The Medicaid Global Spending Cap increased from $22.3 billion in Fiscal Year (FY) 2022 to $25.9 billion in FY2023, a net increase of $3.6 billion. The FY 2023 Enacted Budget included the modification of the Global Cap metric moving from the 10-year rolling average of the medical component of the Consumer Price Index (CPI) to the 5-year rolling average of the Medicaid annual growth rate within the National Health Expenditure Accounts produced by the Office of the Actuary in the Centers for Medicare and Medicaid Services [1](CMS).

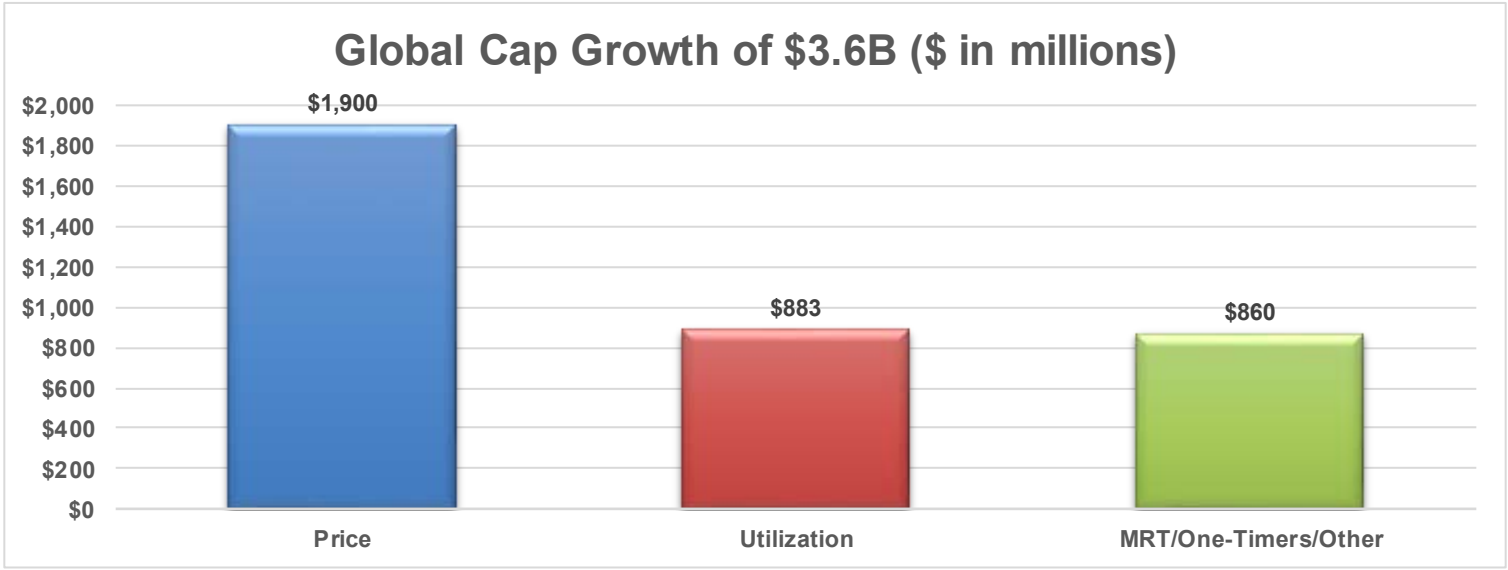
This net increase primarily includes the updated Global Cap index growth of $966 million (currently 4.7 percent trend), increased costs for minimum wage rate adjustments ($262M), including the FY 2023 Enacted Budget Home Care minimum wage increases ($363M), which is partially offset by Home and Community Based Services (HCBS) eFMAP (-$363M), and the annual change in COVID-19 enhanced Federal Medical Assistance Percentage (eFMAP) ($2.5 billion).

Anticipated DOH Medicaid Spending Outside the Global Cap Index:

($ millions)	FY22	FY23	$ Change
Medicaid Global Cap Index	**$20,572**	**$21,538**	**$966**
Medicaid Local Growth Takeover	$1,465	$1,648	$183
Minimum Wage	$1,961	$2,223	$262
Home Care Minimum Wage	$0	$363	($363)
Use of HCBS eFMAP	$0	($363)	$363
Medicaid Administration/Other	$643	$387	($256)
Health Conversion For-Profit Tax	$261	$261	$0
Federal Health Care Reform	($120)	($120)	$0
COVID eFMAP*	($2,487)	$0	$2,487
DOH Medicaid w/ Essential Plan	**$22,295**	**$25,937**	**$3,642**

**Additional COVID eFMAP passing through the Mental Hygiene Stabilization Fund. COVID eFMAP results in a cost shift from State to Federal funds, and does not result in a Medicaid program reduction.*

The chart below breaks out the major components of the annual increase including higher costs associated with both price and utilization increases.



[1] https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and Reports/NationalHealthExpendData/NationalHealthAccountsProjected

Price ($1.9B): Components of price growth include:

- Trend increases for Mainstream Managed Care rates ($716M);
- Trend decreases for Long Term Managed Care rates (-$163M);
- Directed Payment Template (DPT) payments to provide funding increases to financially distressed providers ($581M);
- Home Care Minimum Wage ($363M); and
- Various increases for fee-for-service (FFS) rates ($403M).

Utilization ($883M): The Medicaid Global Cap is currently assuming that Medicaid enrollment is projected to decrease by 551,000 New Yorkers or 7.3 percent, decreasing from 7.6 million enrollees as of March 2022 to 7.0 million enrollees by March 2023. This decline is in large part due to the Enacted Budget assumption that the COVID-19 pandemic public health emergency (PHE) would have expired on July 15th, 2022[2]. However due to 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, there will be continued growth in Medicaid enrollment in the beginning of the year. 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 192,000 individuals from March 2022 through the end of September 2022. Starting in October 2022, enrollment is projected to begin decreasing toward pre-pandemic levels by approximately 597,000 through the end of March 2023. This results in an overall net decrease of 405,000 individuals.
- Long Term Managed Care enrollment is projected to increase 30,000 individuals (11 percent); and
- Utilization of services is expected to partially, but slowly, return to pre-COVID-19 levels in acute care, nursing homes, and transportation fee-for-service categories of spending. However due to the assumption that the PHE would have expired on July 15th, the total number of FFS recipients are expected to decrease by 176,000.

Medicaid Redesign Team (MRT) II/One-Timers/Other ($860M): MRT budget actions, one-time costs/savings, or other payments that do not fall into price or utilization primarily include:

- Additional investments allocated to several groups of hospitals, to support operating needs while providers implement pandemic transformation plans ($800M);
- Health Care and Direct Care Workers Bonuses ($923M)[3];
- Increases to Medicaid operating rates across-the-board (ATB) by an additional 1 percent to respond to market needs and compete in the labor market to attract qualified workers ($318M);
- Restorations of the 1.5 percent ATB payment reduction that was effectuated on April 2, 2020 ($141M);
- Allocated pools for distressed hospitals and nursing homes ($200M);
- Home Care Minimum Wage HCBS eFMAP Offset (-$363M); and
- Health Care and Direct Care Workers Bonuses Offset with Financial Plan General Fund resources (-$923M).

[2] *As of the date of this Report, HHS has extended the PHE from July 15th through October 13th, which provides an additional quarter of eFMAP through the end of December 2022. The First Quarterly Update to the FY 2023 Financial Plan reflects this PHE extension which will then be reflected in the Second Quarter Global Cap report.*

[3] *The First Quarterly Update to the FY 2023 Financial Plan expanded the eligibility for the Health Care and Direct Care Workers Bonuses program. The additional costs and corresponding financial plan support will be reflected in the Second Quarter Global Cap Report.*

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

The $25.9 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 (i.e., categories of spending) 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 occur **outside** the eMedNY billing system, 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. 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.

Forecasting Methodology/Data:

- State Medicaid disbursements are forecasted on a cash basis and updated on a quarterly basis, consistent with the schedule for revising the State's Financial Plan.
- The Medicaid forecast involves an evaluation of all major spending categories using a specific approach, depending on whether expenditures are based on monthly plan premiums for Managed Care or weekly fee-for-service payments.
- The forecast uses spending category specific data. This includes detail on total paid claims and premiums, retroactive spending adjustments, caseload, and service utilization.
- This data is incorporated into a forecast modeling application that uses historical expenditure patterns, as well as price and utilization trends to provide time-series analyses that are used to project future expenditures.
- The models also consider non-claims data (e.g., managed care enrollment, Federal Medicare premiums, and trends in the pharmaceutical industry) in certain areas to generate program specific expenditure projections.

Factors Impacting the Medicaid Forecast:

- Medicaid spending is determined by:
    - Price of services provided through the program (e.g., nursing homes, hospitals, prescription drugs);
    - Utilization of services (reflects both the number of individuals enrolled in Medicaid and the utilization of services); and
    - MRT budget actions, one-time costs/savings, or other payments that do not fall into price or utilization.
- Medicaid price and utilization are influenced by a multitude of factors, including:

- Economic conditions;
- Litigation;
- Changes in the health care marketplace;
- Prescription drug pricing and product development by manufacturers;
- Complex reimbursement formulas which themselves are affected by another set of factors (e.g., length of hospital stays);
- Total enrollment and population mix in Medicaid; and
- Behavior and composition of recipients accessing services.

- The State share of Medicaid spending is also dependent on two factors:
  - Local government contributions toward Medicaid costs; and
  - Federal funding, which can be affected by both statutory and administrative changes at the Federal level.

The following table outlines the FY 2023 Medicaid projections by major health care sector (i.e., category of spending) for Medicaid claims, supplemental programs, and offsets.

Projected FY 2023 Medicaid Spending ($in millions)				
Category of Spending	**Medicaid Claims**	**Supplemental Programs**	**Offsets**	**Total**
Medicaid Managed Care	**$22,268**	**$1,146**	**($1,252)**	**$22,162**
Mainstream Managed Care	$13,880	$619	($431)	$14,069
Long Term Managed Care	$8,388	$527	($822)	$8,093
Total Fee For Service	**$8,024**	**$1,226**	**($1,517)**	**$7,733**
Inpatient	$1,833	$838	($13)	$2,657
Outpatient/Emergency Room	$345	$1	($3)	$342
Clinic	$494	$3	($65)	$432
Nursing Homes	$3,098	$302	$0	$3,401
Personal Care	$604	$23	($48)	$580
Home Health	$113	$0	($13)	$100
Other Long Term Care	$160	$8	$0	$168
Pharmacy	$395	$3	($1,301)	($903)
Transportation	$302	$46	($1)	$347
Non-Institutional	$680	$2	($73)	$608
Other State Agencies	**$4,547**	**$0**	**($3,192)**	**$1,355**
Mental Hygiene Stabilization Fund (MHSF)	**$0**	**$0**	**($1,060)**	**($1,060)**
Medicare Part A/B & D	**$0**	**$2,854**	**$0**	**$2,854**
VAPAP	**$0**	**$1,284**	**$0**	**$1,284**
All Other	**$13**	**$1,647**	**($1,023)**	**$636**
Medicaid Administration	**$0**	**$439**	**$0**	**$439**
State Operations	**$0**	**$375**	**$0**	**$375**
Local Cap Contribution	**$0**	**$0**	**($6,833)**	**($6,833)**
COVID-19 eFMAP	**$0**	**$0**	**($2,576)**	**($2,576)**
Audit Collections	**$0**	**$0**	**($433)**	**($433)**
TOTAL	**$34,852**	**$8,972**	**($17,887)**	**$25,937**

Major Supplemental Programs:

Medicaid Managed Care ($1.1 billion)

- 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 ($1.2 billion)

- Inpatient: Disproportionate Share Hospital (DSH) and Voluntary Upper Payment Limit (UPL).
- Nursing Homes: Advance Training Initiatives, 2% Supplemental Payments, Reform Initiative, and Young Adult Demonstration.
- 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 ($2.9 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.

Vital Access Provider Assurance Program (VAPAP) ($1.3 billion)

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.

All Other ($1.6 billion)

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

- Health Care Worker Bonus ($923 million): Health Care and direct workers earning less than $125,000 annually will receive a State-funded bonus payment of up to $3,000 in FY 2023. The amount of the bonus will be based on hours worked and length of time in service. State employees in comparable titles will receive bonuses, as well.

- Vital Access/Safety Net Provider Program ($186 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.

- ACA FFP Correction ($154 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 ($116 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.

- 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 ($439 million)

The annual county Medicaid caps for Local Administration will remain at their historic/current levels during FY 2023, 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 State assumption of Medicaid administrative functions is behind schedule due to challenges with

systems upgrades to the State's Welfare Management System (WMS). In addition, extensive attention has been given to refining the MAGI eligibility and enrollment rules for NY State of Health (NYSOH) applicants to ensure Medicaid coverage is correctly provided and continuity of care is maintained.

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 ($375 million)

The OHIP State Operations budget reflects the Non-Federal share of personal services (i.e., salariesof OHIP staff) and non-personal services costs (i.e., contractual services). The FY 2023 Budget is projected to total $375 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 2023 Budget ($ in millions)	
Service Costs	**Annual Budget**
Personal Services	**$57.5**
Medicaid	*$52.9*
Essential Plan	*$4.6*
Non-Personal Services	**$317.8**
Medicaid	$251.2
Essential Plan	$66.6
TOTAL	**$375.3**

Major Offsets:

Medicaid Managed Care (-$1.3 billion)

- Mainstream Managed Care: 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.

- Long Term Managed Care: Supplemental Federal Revenue (i.e., 6% eFMAP) for Community First Choice Option (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.

Fee For Service (-$1.5 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 (see above for additional information regarding CFCO).

- Pharmacy: OBRA and Supplemental Rebate collections from Drug Manufacturers.

Other State Agencies & MHSF (-$4.3 billion)

Transfers from Other State Agencies to support State-share Medicaid expenditures for services of the

Office for People With Developmental Disabilities (OPWDD), 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 (-$1.0 billion)

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

- New York City H+H Budget Actions (-$448 million),
- Supplemental Federal Revenue (-$440 million): Includes claiming Federal revenue for Family Planning services, Home and Community Based Services, and School Supportive Health services.
- Accounts Receivable (-$10 million): Represents the collection of Medicaid provider liabilities owed to the State resulting from processing retroactive rate adjustments.

Local Cap Contribution (-$6.8 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 2023.

COVID-19 eFMAP (-$2.6 billion)

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

Audit Collections (-$433 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 June 2022 – Global Cap Target vs. Actual Spending

Through June 2022, total actual State Medicaid spending is $189 million below the Medicaid Global Spending Cap projection. Spending through June resulted in total expenditures of $6.6 billion compared to the allowable spending target of $6.8 billion. 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 June 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	**$6,882**	**$6,849**	**($33)**	**-0.5%**
Mainstream Managed Care	$4,482	$4,505	$24	0.5%
Long Term Managed Care	$2,400	$2,344	($56)	-2.3%
Total Fee For Service	**$2,017**	**$2,003**	**($14)**	**-0.7%**
Inpatient	$823	$808	($16)	-1.9%
Outpatient/Emergency Room	$81	$85	$4	5.5%
Clinic	$112	$111	($0)	-0.3%
Nursing Homes	$734	$717	($17)	-2.4%
Personal Care	$171	$173	$3	1.5%
Home Health	$33	$45	$12	35.8%
Other Long Term Care	$42	$43	$2	3.6%
Pharmacy	($206)	($220)	($13)	-6.4%
Transportation	$95	$95	$0	0.2%
Non-Institutional	$133	$145	$12	8.9%
Other State Agencies	**$328**	**$328**	**$0**	**0.0%**
Mental Hygiene Stabilization Fund	**($265)**	**($265)**	**$0**	**0.0%**
Medicare Part A/B & D	**$743**	**$747**	**$4**	**0.6%**
VAPAP	**$509**	**$509**	**$0**	**0.0%**
All Other	**($410)**	**($546)**	**($136)**	**-33.2%**
Medicaid Administration	**$102**	**$104**	**$2**	**2.1%**
State Operations	**$93**	**$72**	**($21)**	**-22.3%**
Local Cap Contribution	**($1,630)**	**($1,630)**	**$0**	**0.0%**
COVID-19 eFMAP	**($1,450)**	**($1,450)**	**$0**	**0.0%**
Audit Collections	**($108)**	**($99)**	**$9**	**8.1%**
TOTAL	**$6,811**	**$6,622**	**($189)**	**-2.8%**

The following explanations regarding the variances between the Global Cap Target through June 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 $33 million, or 0.5 percent, under anticipated spending.

- Mainstream Managed Care was $24 million, or 0.5 percent, above anticipated spending. The price and utilization assumptions were essentially on target through June.
- Long Term Managed Care was $56 million, or 2.3 percent, under anticipated spending. This variance is largely attributed to a minor billing delay for some partial capitation claims that

caused some June capitation payments to be processed in July.

Fee-For-Service

Medicaid spending in major fee-for-service categories was $14 million, or 0.7 percent, under target.

- Inpatient was $16 million, or 1.9 percent, under budget through June due to processing recoupments for end of year reconciliations of the 2021 Inpatient and Outpatient voluntary Upper Payment Limit (UPL) program.
- Nursing Homes was $17 million, or 2.4 percent, under anticipated spending. The budget projected higher spending for rate appeals than what was processed in the first quarter.
- Pharmacy was $13 million, or 6.4 percent, under anticipated spending. This variance is largely attributed to higher than expected rebate collections.

All Other

All Other spending underspent by $136 million, or 33.2 percent, which is largely due to the timing of accounts receivable payments and collections. 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.

Medicaid Administration Costs

Medicaid Administration was on target through June.

State Operations

OHIP State Operations underspent by $21 million, or 22.3 percent through June, which is due to the timing in processing contractual payments.

COVID-19 eFMAP

The drawdown of COVID-19 eFMAP was on target through June.

Audit Collections

Additional audit collections received were $9 million, or 8.1 percent, below projections through June, which is due to the timing in processing of audits and resulting recoveries.

Enrollment

Medicaid enrollment is expected to decrease to 7,009,108 individuals by March 2023, which is a decline of 551,000 individuals from March 2022. This decline is in large part due to the Enacted Budget assumption that the COVID-19 pandemic expired on July 15th, 2022; however, HHS has extended the PHE through October 13th, 2022. Current enrollment assumptions do not yet reflect the recent PHE extension; the next quarterly Global Cap Report will incorporate these changes.

Mainstream Managed Care (includes HIV/SNPs and BHO/HARPs): Mainstream Managed Care enrollment including (HIV SNPs & HARPs) are projected to increase by approximately 192,000 individuals from March 2022 through the end of September 2022. Starting in October 2022, enrollment is projected to begin decreasing toward pre-pandemic levels by approximately 597,000 individuals through the end of March 2023. This results in an overall net decrease of 405,000 individuals.

Long Term Managed Care (includes Partial Cap, PACE, FIDA IDD and MAP): Long Term Managed Care (MLTC) enrollment reached 281,500 by the end of FY 2022, a net increase of 1,500 individuals. Two factors contributed to the modest growth, a slower return to pre-pandemic growth rate levels and the Nursing Home carveout initiative (implemented September 2020) that disenrolled long term stay individuals from MLTC plans and placed them into Medicaid fee-for-service. The FY 2023 projections assume that enrollment will grow by eleven percent, approximately 30,000 individuals, over March 2022 levels[4]. This growth rate is higher than last year's trends however it is still lower than pre-pandemic growth rates.

Medicaid Enrollment to Date

Medicaid Enrollment Summary Medicaid Managed Care vs Fee-for-Service				
	Mar-22	**Jun-22***	**Net Increase / (Decrease)**	**% Change**
Mainstream Managed Care	5,521,680	5,536,585	14,905	0.3%
Long Term Managed Care	281,538	290,892	9,354	3.3%
Fee-For-Service	1,756,935	1,698,172	-58,763	-3.3%
TOTAL	**7,560,153**	**7,525,649**	**-34,504**	**-0.5%**

Medicaid Enrollment Summary by NYC vs Rest of State				
	Mar-22	**Jun-22***	**Net Increase / (Decrease)**	**% Change**
NYC	4,292,907	4,201,696	-91,211	-2.1%
Rest of State	3,267,246	3,323,953	56,707	1.7%
TOTAL	**7,560,153**	**7,525,649**	**-34,504**	**-0.5%**

**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 June based on data pulled 8/1/2022.*

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

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 has continued into Fiscal Year 2023[5]. 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[6].

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 11.5 months in FY 2022 (for the period of March 2021 to February 2022) and 7.5 months projected to be claimed in FY 2023 (for the period of March 2022 to September 2022).

COVID-19 eFMAP $ in millions			
	FY 2022	**FY 2023**	**Annual Change**
State Share	$2,983	$2,117	($866)
Local Share	$646	$458	($188)
Total 6.2% eFMAP	**$3,629**	**$2,576**	**($1,053)**

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 emergency was declared by the Secretary of HHS, and June 2022, the end of this reporting period, Medicaid enrollment increased by 1.4 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 was particularly the case for certain types of services discussed briefly below.

At the height of the pandemic, spending on Acute Care (Inpatient/Outpatient/Clinic) services increased significantly due to higher intensity COVID-19 related inpatient care (e.g., ventilation, intubation) and emergency related services. Spending has subsequently trended downwards as costs have declined with a decrease in COVID-19 hospitalizations and utilization remains below pre-pandemic levels.

Long-term care services that comprise a significant portion of Medicaid spending has risen significantly from pre-pandemic levels primarily attributable to increased costs for Nursing Homes, Personal Care, and Home Health services, partially offset by continued lower utilization compared to pre-pandemic usage.

[5] As of the date of this Report, HHS has extended the PHE from July 15th through October 13th, which provides an additional quarter of eFMAP through the end of December 2022. The First Quarterly Update to the FY 2023 Financial Plan reflects this PHE extension which will then be reflected in the Second Quarter Global Cap report.

[6] 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.

Non-Institutional Fee-for-Service spending remains relatively flat compared to pre-pandemic levels with transportation utilization continuing to trend below pre-pandemic levels with the 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 increases in utilization for certain types of services, with much of the telehealth spend during the COVID-19 period tied directly to behavioral health services.

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[7]. The full Medicaid Budget Scorecard can also be found online on the Department's website[8], and additionally, in Appendix B as part of this report.

Major investments within the FY 2023 Enacted Medicaid Budget include:

- **New Global Cap Index.** This revised index is based on the five-year rolling average of CMS annual projections of health care spending. The CMS projections account for enrollment, including specific populations, such as the aging and disabled populations.

- **Bonus for Health Care and Direct Care Workers.** Health care and direct workers earning less than $125,000 base salary (annualized) are eligible to receive a State-funded bonus payment of up to $3,000 in FY 2023. The amount of the bonus will be based on hours worked and length of time in service. State employees in comparable titles will receive bonuses, as well. Additional information can be found on the Department's website[9].

- **Home Care Wage Increase.** The minimum wage for certified home health workers and personal care aides will be increased to $3.00 over two years, with a $2.00 increase on October 1, 2022, and a $1.00 increase on October 1, 2023.

- **Additional Hospital Funding.** Invests $800 million of additional funding, allocated to several groups of hospitals, to support operating needs while providers implement pandemic transformation plans.

- **ATB Restoration and Increase.** A restoration of the 1.5 percent across-the-board (ATB) reduction to fee-for-service providers implemented in the FY 2021 Enacted Budget, as well as an increase of 1 percent to all provider operating reimbursement rates. The increased rates recognize growth in service costs and will provide flexibility to respond to market needs and compete in the labor market to attract qualified workers.

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

- Methodology by which Medicaid Global Cap projections are compiled or determined (included in Projected Medicaid Spending Section);

- Enacted Budget actions with targets compared to implemented savings/investments (included in Appendix B);

- 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 (included in Results from April through June 2022 Section);

- Program trends, including enrollment actuals and projections (included in Enrollment Section);

- Detail on the anticipated DOH Medicaid spending outside of the Medicaid Global Cap (included in

[7] *https://www.health.ny.gov/health_care/medicaid/redesign/mrt_budget.htm*
8 https://www.health.ny.gov/health_care/medicaid/redesign/2022/2023_enacted_budget_scorecard.htm
[9] https://www.health.ny.gov/health_care/medicaid/providers/hwb_program/

Overview Section).

- Projected mental hygiene stabilization fund transfer (included in Projected Medicaid Spending Section);
- Number of fiscal intermediaries contracted with the DOH (included in Appendix F); and
- Links to the approved FFS rates for general hospitals and preferred drug list pharmaceutical drugs (included in Appendix F).

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, as well as administrative reforms. Over two-thirds of the $2.2 billion in savings actions have been implemented, with the remaining savings pending due to ongoing litigation, and Federal government approval of Maintenance-of-Effort (MOE) requirements associated with the Families First Coronavirus Response Act (FFCRA) enhanced Federal Medical Assistance Percentage (eFMAP) of 6.2 percent on Medicaid payment (see next paragraph for additional information) and the American Rescue Plan Act (ARPA) eFMAP of 10 percent for certain home and community-based services.

The Financial Plan assumes the remaining savings actions will be implemented in FY 2023, aside from those actions limited to the maintenance of effort requirements associated with the recent Federal public health emergency extension, which extends the eFMAP benefit through December 2022, and will be implemented through FY 2025.

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 First Quarterly Update to the Financial Plan reflects the extension of the PHE through October 13th, 2022, and assumes that enrollment levels will peak at nearly 7.7 million in mid-FY 2023, declining to approximately 7.0 million in March 2023, and return to near pre-pandemic levels in FY 2024. As the economy recovers and unemployment trends towards pre-pandemic levels, costs associated with individuals temporarily enrolled, but entitled to twelve months of continuous coverage, are anticipated to persist into FY 2023 and decline in FY 2024.

Extension of the Public Health Emergency (PHE): The Secretary of Human Services has extended the COVID-19 PHE through October 13, 2022, which extends COVID-19 eFMAP through at least December 31, 2022 (the Enacted Budget Global Cap Model assumed COVID-19 eFMAP through September 2022). Due to the timing of monthly reconciliations, February and March 2022 COVID-19 eFMAP was 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.

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, 2021. CMS partially approved the spending plan on August 25, 2021, on January 31, 2022, and on May 18, 2022, and on August 16, 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 spending plan update from July 28, 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 renewal 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, titled *New York Health Equity Reform (NYHER): Making Targeted, Evidence-Based Investments to Address the Health Disparities Exacerbated by the COVID-19 Pandemic*. This amendment 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, physical health, and behavioral 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 and in accordance with federal transparency requirements, DOH submitted a Federal public notice to the NYS Registry on April 13, 2022, and hosted two public hearings, one on May 3, 2022, and one on May 10, 2022. The presentation slides, recordings, and transcripts from both hearings are available on the DOH website[10]. The 30-day public comment period closed on May 20, 2022.

During the public comment period, DOH received 358 written comment submissions and heard from 75 speakers at the two public hearings. DOH has worked with partner agencies to review and evaluate the approximately 1,800 unique comments received and is incorporating the feedback from stakeholders where possible and appropriate. DOH formally submitted the final waiver amendment application to CMS on September 2, 2022. CMS deemed the application submission complete on September 15, 2022; The Federal Public Comment period is open from September 19, 2022, to October 19, 2022.

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

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

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 2022 Mainstream Rates	May 2022
	April 2022 HARP Rates	May 2022
	April 2022 HIV Special Needs Plans (HIV SNP) Rates	
	Encounter Withhold FY 2022	
	Quality Pools CY 2021	June 2022
	HIV SNP Incentive Pool Payment CY 2021	
Long Term Managed Care	April 2022 Partial Capitation Rates	May 2022
	April 2022 Medicaid Advantage Plan (MAP) Rates	May 2022
	April 2022 Program of All-Inclusive Care for the Elderly (PACE) Rates	
	Encounter Withhold FY 2022	
	QIVAPP FY 2022	June 2022
	Quality Pools CY 2021	June 2022
Inpatient	Acute & Exempt Unit Inpatient Rates CY 2022	May 2022
	Acute & Exempt Unit Inpatient Rates CY 2023	
Outpatient / Emergency Room	APG capital update CY 2017	
	APG capital update CY 2018	
	APG capital update CY 2019	
	APG capital update CY 2020	
	APG capital update CY 2021	
	Hold Harmless CY 2021	
Clinic	APG Capital Rate Update CY 2023	
	Article 28 Minimum Wage CY 2021	
	Article 28 Minimum Wage CY 2022	
	October 2022 FQHC MEI Increase	
	Hold Harmless CY 2021	
Nursing Homes	NH Operating Initial Rates CY 2022	
	NH Operating Initial Rates CY 2023	
	July 2022 NH Case Mix Rate Update	
	NH Capital Initial Rates CY 2022	
	NH Capital Initial Rates CY 2023	
	NH Case Mix 5% Cap Release	
Personal Care	PC Initial Rates CY 2021	June 2022
	PC Initial Rates CY 2022	
Assisted Living Providers	ALP Rates CY 2022	
	ALP Rates CY 2023	
Hospice	Hospice Residence Rates CY 2022	
	Hospice Non-Residence Rates FFY 2023	
Home Health	CHHA Pediatric (includes MW) CY 2021	June 2022
	CHHA Pediatric (includes MW) CY 2022	

Other	July 2021 Patient Centered Medical Homes	
	January 2022 Patient Centered Medical Homes	

Appendix B
FY 2023 Enacted Budget (http://www.health.ny.gov/health_care/medicaid/redesign/mrt_budget.htm)

Below is a condensed version of the FY 2023 Enacted Scorecard which focuses the list on budget actions anticipated to be implemented in FY 2023. Any lost savings or availed spending will be accommodated within the Medicaid Global Cap.

(State Share -- $ millions)	FY 2023 Enacted	Fully Implemented Y/N	Achieved through June 2022
Global Cap Forecast with Legislation (Surplus)/Deficit	**($437.036)**		
Global Cap Index Inflation - CMS Office of the Actuary Medicaid Projection (5-Year Rolling Average)	($366.000)	Y	($366.000)
*Health Care Bonus - State Total	$922.748	N	$0.000
*Financial Plan Support for Health Care Bonuses	($922.748)	N	$0.000
Global Cap (Surplus)/Deficit	**($803.036)**		
Budget Actions	**$844.246**		
Hospital Actions	**$350.000**		
Distressed Hospital Pool	$100.000	N	$0.000
*Distressed Provider Account Investment (inc. $100M of Financial Plan Resources)	$250.000	N	$0.000
Long Term Care Actions	**$48.803**		
Nursing Home Reforms	*$161.500*		
Nursing Home Support for Compliance with Staffing Regulations	$61.500	N	$0.000
Increase Nursing Home Vital Access Provider (VAP) Funding	$100.000	N	$0.000
LTC--Medicaid Diversion	*($110.564)*		
*Long Term Service and Support (LTSS) Coverage in Essential Plan	($110.564)	N	$0.000
LTC Other Reforms	*($2.133)*		
Increasing Private Duty Nursing (PDN) Reimbursement for Nurses Servicing Adult Members	$19.450	Y	$4.863
Use of Federal HCBS funding to support PDN Reimbursement	($19.450)	Y	$0.000
Alzheimer's Program under Medicaid	$1.367	Y	$1.367
Fully Implement the Duals Integration Roadmap	($3.500)	N	$0.000
Managed Care Actions	**($34.428)**		
Moving Integrated Plans to Middle of the Rate Range	$20.000	Y	$5.000
Restore MMC/MLTC Quality Pools (1-Year Restoration)	$77.250	Y	$77.250
*Utilize Child Health Plus (CHP) to Access Federal Funding for Enhanced Pregnancy Coverage	($183.000)	N	$0.000
Applied Behavior Analysis (ABA) Rates to Incentivize Providers in Managed Care	$36.605	N	$0.000
Adjust HIV SNP Rates to Reflect High Needs Model	$14.717	N	$0.000
Other Actions	**$462.349**		
Increase Medicaid Trend Factor by 1% to Recognize Provider Cost Increases	$318.310	N	$0.000
Restoration of 1.5% Across the Board (ATB)	$140.759	Y	$35.190

Investment in Children's Behavioral Health Services	$37.260	N	$0.000
Use of Federal HCBS funding to support Children's Behavioral Health Services	($37.260)	N	$0.000
Increase Top 20 Orthotics and Prosthetics Codes to Medicare Rates	$3.750	Y	$0.938
Establish Unique Identifier for All Unenrolled Provider Types	($5.000)	N	$0.000
Promote Access to Primary Care	$4.930	N	$0.000
Eliminate Unnecessary Requirements from the Utilization Threshold (UT) Program	($0.230)	N	$0.000
*Enhanced Durable Medical Equipment (DME) Management	($0.170)	N	$0.000
Maternal Health Actions	**$4.335**		
Improve and Expand Access to Prenatal and Postnatal Care	$6.335	N	$0.000
*Advancing Comprehensive Maternal Care in Managed Care	$15.000	N	$0.000
Maternal Health Investments - Avoided Costs	($17.000)	N	$0.000
Other State of the State Actions	**$13.187**		
Create a Center of Medicaid Innovation to Lower Costs and Improve Care	$1.200	N	$0.000
*Promote Health Equity and Continuity of Coverage for Vulnerable Seniors	$5.000	N	$0.000
Patient Access and Developer Portals	$4.06	N	$0.000
Health Care Bonus Enforcement	$2.930	N	$0.000
Adds	**$904.825**		
Additional Hospital Funding	$800.000	Y	$78.500
*Maternal Health for Postpartum Coverage for Undocumented	$2.325	N	$0.000
*Medicaid Coverage for Undocumented Age 65+	$56.454	N	$0.000
Additional QIVAPP Support	$37.400	Y	$38.741
*Medicare Savings Program Expansion	$5.200	N	$0.000
*Medicaid Ambulance Billing	$3.446	N	$0.000
Avails	**($946.035)**		
Other Revisions and Timing of Payments Across Fiscal Years	($342.335)	Y	($342.335)
Mainstream Managed Care Non-Federal Share Assumption	($486.000)	Y	($121.500)
Temporary Support for One-time COVID-related Hospital Expenses	($84.000)	N	$0.000
CDPAP Request for Offer (RFO) Re-estimate	($25.000)	N	$0.000
*Elderly Pharmaceutical Insurance Coverage (EPIC) Savings Offset related to MSP Expansion	($8.700)	N	$0.000
Total Global Cap (Surplus)/Deficit	**$0.000**		
*Home Care Minimum Wage Increase	$362.578	N	$0.000
*Use of Federal HCBS funding to support Home Care Minimum Wage Increase	($362.578)	N	$0.000
Home Care Minimum Wage Increase Supported Outside the Global Cap	**$0.000**		

*Includes Budget Actions with an effective date that is beyond the time period of this report.

Appendix C
Regional Spending Data

The chart below represents total provider spending that occurs within the Medicaid claiming system (eMedNY) through June 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	$4,882
Long Island	$789
Mid-Hudson	$806
Western	$385
Finger Lakes	$323
Capital District	$261
Central	$186
Mohawk Valley	$163
Southern Tier	$140
North Country	$100
Out of State	$27
TOTAL	**$8,061**

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 (through VAPAP)	$310.3
VAPAP	$198.5
Supportive Housing	$15.2
Rural Transportation	$8.0
Alzheimer's Caregiver Support	$7.9
End of AIDS	$1.8
Assisted Living Voucher Demo	$1.8
MLTC Ombudsman	$0.7
CSEA Buy-in	$0.6
TOTAL	**$544.8**

Appendix E – Medicaid Drug Cap

- The FY 2018 Enacted Budget established a Medicaid Drug Cap that limits pharmacy spending growth in the Medicaid program tied to the annual growth rate of the Medicaid Global Cap, which is determined annually according to statute (4.7% in FY 2023).

- 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 past five years of implementation (FY 2018- FY 2022), the Medicaid Drug Cap has achieved over $500 million in gross savings through spending reductions and additional supplemental rebate agreements with pharmaceutical manufacturers for over 60 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 2023 is $1.9 billion (State share) and reflects a growth rate of 4.7 percent consistent with the Medicaid Global Spending Cap. The Department is still evaluating the projected net drug spend for FY 2023 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
- Fiscal Intermediaries: Article VII – HMH Part PP: At this time, there are 0 Fiscal Intermediaries contracted with the State, below is the current status:
    - The FY 2023 Enacted Budget revised Social Services Law Section 365-f with a material modification of the approach underlying the fiscal intermediary Request for Offers (RFO) issued in December 2019 and the Survey of Qualified Offerors issued in June 2021.
    - The new legislative provisions now require DOH to offer contracts to the 68 awardees from February 2021 and all other qualified offerors from the initial RFO if such other qualified offerors affirmatively attest that they served at least 200 consumers in NYC, or 50 consumers in other areas of the state, at any point during the first calendar quarter of 2020.
    - DOH is currently working on developing the attestation and contracting process to effectuate the new provisions and will provide all qualified offerors with more information as it becomes available. OMIG will audit attestations.
    - MLTC Policy 21.01 outlining the transition policies for non-contracted fiscal intermediaries remains in effect. Please note, DOH has not announced a “contract notification date” and therefore all fiscal intermediaries can continue to operate at this time.