



Department
of Health

Medicaid Global Spending Cap Report

April 2024 through March 2025 Quarterly
Report

Table of Contents

Overview.....	4
Projected Medicaid Spending (Medicaid Claims, Supplemental Programs & Offsets).....	6
Executive Budget Model Changes.....	12
Results April through March 2025 – Global Cap Target vs. Actual Spending..	14
Enrollment	16
Notable Events	17
Appendix A. Inventory of Rate Packages	18
Appendix B. FY 2025 Enacted Budget	19
Appendix C. Regional Spending Data	22
Appendix D. State-Only Payments (YTD).....	23
Appendix E. Additional Information.....	24
Appendix F. Results April through December 2024 – Global Cap Target vs. Actual Spending	25

Overview

The Department of Health (DOH) and the Division of the Budget (DOB) report that spending for the Fiscal Year (FY) 2025 Medicaid Global Spending Cap was approximately \$8.7 million (or 0.03%) below the \$31.7 billion target.

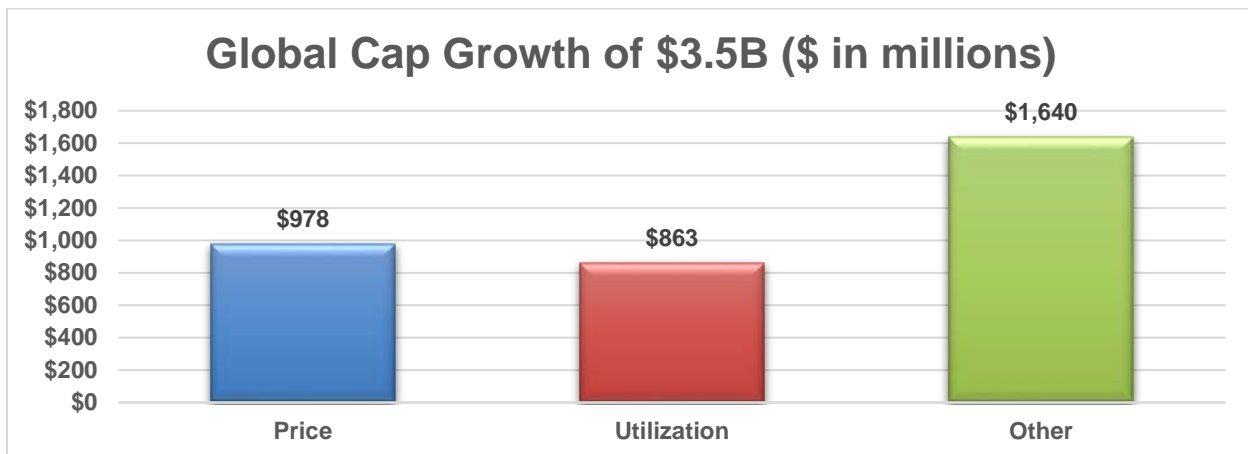
The Medicaid Global Spending Cap increased from \$28.3 billion in FY 2024 to \$31.7 in FY 2025, a net increase of \$3.5 billion. The Global Cap growth index (7.2% for FY 2025) is based on the 5-year rolling average of the Medicaid annual growth rate within the National Health Expenditure Accounts produced by the Office of the Actuary in the Centers for Medicare and Medicaid Services (CMS).¹

The FY 2025 Global Cap target was updated as a part of the FY 2026 Executive Budget Financial Plan to reflect an update to the Medicaid Global Cap index allowable growth metric from 6.7 percent to 7.2 percent. This net increase included the updated Global Cap index growth of \$1.7 billion (\$98M additional growth above Enacted); increased costs for minimum wage rate adjustments (\$17M), Home Care minimum wage adjustments (\$564M), the expiration of Home and Community Based Services (HCBS) enhanced Federal Medical Assistance Percentage (eFMAP) (\$702M), and funds added in the FY 2025 Enacted Budget for the Healthcare Stability Fund.

Anticipated DOH Medicaid Spending Outside the Global Cap Index:

(\$ millions)	FY24	FY25	\$ Change
Medicaid Global Cap Index	\$23,265	\$24,930	\$1,665
DOH Medicaid Spending Outside of Global Cap Index	\$4,986	\$6,802	\$1,816
Medicaid Local Growth Takeover	\$1,830	\$2,013	\$183
Minimum Wage	\$2,413	\$2,430	\$17
Home Care Minimum Wage	\$916	\$1,480	\$564
Use of HCBS eFMAP	(\$702)	\$0	\$702
Medicaid Administration/Other	\$529	\$529	\$0
Healthcare Stability Fund	\$0	\$350	\$350
Total DOH Medicaid Global Cap Target	\$28,251	\$31,732	\$3,481

The following chart breaks out the projected major components of the annual increase.



Price (\$978M): Components of price growth include:

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

- Trend increases for Mainstream Managed Care rates (\$115M);
- Trend increases for Managed Long Term Care rates (\$13M);
- Fee For Service Minimum Wage increases (including Home Care) (\$312M);
- Other State Agency (OSA) increases (\$218M) primarily related to retro rate packages that included a local share component; and minor increases in Clinic for updated rate appeal assumptions (\$45M).
- Various increases for Fee-for-Service (FFS) rates, which are primarily related to increases included in the FY 2025 Enacted Budget (\$275M).

Utilization (\$863M): The Medicaid Global Cap assumed that Medicaid enrollment would decrease by 278,874 New Yorkers or 3.8 percent, from 7.3 million enrollees as of March 2024 to 7 million enrollees by March 2025², due in large part to the ending of the COVID-19 pandemic public health emergency (PHE).

- Mainstream Managed Care enrollment including HIV Special Needs Plans (SNPs) & Health and Recovery Plans (HARPs) was projected to decrease by 329,577 individuals from March 2024 through the end of March 2025.
- Managed Long Term Care enrollment was projected to increase by 38,272, individuals from March 2024 through the end of March 2025. Managed Long Term Care is on average the costliest population within Medicaid.
- Due to the expiration of the PHE in June 2023, the total number of FFS recipients was expected to increase by 12,431 individuals from March 2024 through March 2025.

Medicaid Redesign Team (MRT) II/One-Timers/Other (\$1,640M): MRT budget actions, one-time costs/savings, or other payments that do not fall into price or utilization primarily include:

- The loss of the increased Federal Share of Medicaid funding (i.e. eFMAP), for the Federal PHE declared by the Secretary of Health and Human Services (HHS). The enhanced funding began January 1, 2020, and continued at a reduced rate through December 31, 2023 (\$2B);
- FY 2025 Enacted Budget one-time Investments for Hospitals & Nursing Homes (\$350M).
- Adjustments within the Mental Hygiene Stabilization Fund related to financial plan relief to stabilize the Global Cap (-\$937M)

² 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.

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

The \$31.7 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, enhanced funding offsets for Child Health Plus, 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;
- Total enrollment and population mix in Medicaid;
- 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);
- Behavior and composition of recipients accessing services; and
- Litigation.

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 2025 Medicaid projections by major health care sector (i.e., category of spending) for Medicaid claims, supplemental programs, and offsets.

Executive Budget Projected FY 2025 Medicaid Spending (\$ in millions)				
Category of Spending	Medicaid Claims	Supplemental Programs	Offsets	Total
Medicaid Managed Care	\$20,513	\$2,228	(\$1,980)	\$20,761
Mainstream Managed Care	\$10,161	\$1,719	(\$948)	\$10,932
Managed Long Term Care	\$10,352	\$509	(\$1,032)	\$9,829
Total Fee-For-Service	\$13,297	\$1,794	(\$2,503)	\$12,588
Inpatient	\$2,181	\$1,086	(\$10)	\$3,257
Outpatient/Emergency Room	\$437	\$1	(\$3)	\$435
Clinic	\$633	\$160	(\$73)	\$720
Nursing Homes	\$3,319	\$433	\$0	\$3,752
Personal Care	\$1,318	\$30	(\$15)	\$1,333
Home Health	\$244	\$0	(\$5)	\$239
Other Long Term Care	\$212	\$15	\$0	\$227
Pharmacy	\$3,561	\$3	(\$2,355)	\$1,209
Transportation	\$526	\$59	(\$1)	\$584
Non-Institutional	\$866	\$7	(\$41)	\$832
Other State Agencies	\$5,049	\$0	(\$3,504)	\$1,545
Mental Hygiene Stabilization Fund (MHSF)	\$0	\$0	\$427	\$427
Medicare Part A/B & D	\$0	\$3,554	\$0	\$3,554
VAPAP	\$0	\$744	\$0	\$744
Net Hospital Advances	\$0	\$0	(\$1,497)	(\$1,497)
All Other	\$26	\$966	(\$707)	\$285
Medicaid Administration	\$0	\$868	\$0	\$868
State Operations	\$0	\$385	\$0	\$385
Local Cap Contribution	\$0	\$0	(\$7,364)	(\$7,364)
COVID-19 eFMAP	\$0	(\$31)	\$0	(\$31)
Audit Collections	\$0	\$0	(\$533)	(\$533)
TOTAL	\$38,885	\$10,508	(\$17,661)	\$31,732

Major Supplemental Programs:

Medicaid Managed Care (\$2.2 billion)

- Mainstream Managed Care: 2 Percent Encounter Withhold Repayments and HIV Special Needs Plans (SNP) Quality Pool and Directed Payment Template (DPT) payments for Financially Distressed, Safety Net, and Sole Community Hospitals.
- Managed Long Term Care: 1.5 Percent Encounter Withhold Repayments, 3 Percent Enrollment Withhold Repayments, and Quality Pools.

Fee For Service (\$1.7 billion)

- Inpatient: Disproportionate Share Hospital (DSH), Voluntary Upper Payment Limit (UPL), and Indigent Care Payments.
- 1115 State Matching Funds: A condition of the latest 1115 Waiver approval requires additional state matching funds over the course of the waiver period.
- Clinic: NYRx reinvestments included in the FY 2024 Enacted Budget to support Federally Qualified Health Centers (FQHCs).

- Nursing Homes: Advance Training Initiatives, 2 Percent Supplemental Payments, and one-time supplemental Nursing Home payments included as a part of the FY 2025 Enacted Budget investments.
- Personal Care: Traumatic Brain Injury (TBI) and Nursing Home Transition and Diversion (NHTD) payments related to contractual services and rental subsidies.
- Other Long Term Care: Assisted Living Demonstration Vouchers, and one-time supplemental Assisted Living Program investments.
- Transportation: Transportation Management Initiative, Supplemental Ambulance, and Rural Transportation Investments.

Medicare SMI Part A/B & Clawback Part D (\$3.6 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) (\$744 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. At the discretion of the Department and the Division of the Budget, VAPAP may be available to hospitals meeting program eligibility requirements. Funding is made available under Hospital VAPAP to hospitals and health systems with serious financial instability and requiring extraordinary financial assistance to enable these facilities to maintain operations and provision of vital services while they implement longer-term solutions to achieve sustainable health care service delivery. The Department has determined need for VAPAP funds based on provider submission of financial documentation, plans for improving financial sustainability, and the Department's assessment of the risk of loss of vital services in the absence of this assistance.

All Other (\$965 million)

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

- The Healthcare Safety Net Transformation Program (\$300 million): This program seeks to leverage partnerships with safety net facilities to make critical operational improvements and to achieve sustainability.
- Health Care Worker Bonus (\$256 million): Health care and direct care workers earning less than \$125,000 annually received a State-funded bonus payment of up to \$3,000 in FY 2025. The amount of the bonus was based on hours worked and length of time in service. State employees in comparable titles received 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.

- Patient Centered Medical Homes (PCMH) (\$183 million): Provides incentive payments to National Committee for Quality Assurance PCMH-recognized providers to support their ongoing efforts to deliver high-quality, coordinated care to Medicaid members.
- Supportive Housing (\$93 million): This program seeks to ensure that certain high-risk Medicaid members have proper housing and supportive services.

Medicaid Administration (\$868 million)

- The annual county Medicaid caps for Local Administration was projected to remain at their historic/current levels during FY 2025, 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 the 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](#).
- Additionally, the Executive Model reflects recategorization of Medicaid Hospital Global Budget Initiative (\$275 million): This initiative seeks to incentivize transformation and multi-payer arrangements with the goal of improving population health and lowering costs and has been required to be paid from the Administration Grant.

State Operations (\$385 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 2025 budget was projected to total \$385 million. 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 2025 Budget (\$ in millions)	
Medicaid Service Costs	Annual Budget
Personal Services	\$58
Non-Personal Services	\$322
General State Charges	\$5
TOTAL	\$385

Major Offsets:

Medicaid Managed Care (-\$2.0 billion)

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

- Managed Long Term Care (MLTC): 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 (-\$2.5 billion)

- Pharmacy: Federally required (OBRA) and Supplemental rebate collections from drug manufacturers.
- Other Long Term Care: Supplemental Federal Revenue for CFCO services (see above for additional information regarding CFCO).
- Inpatient: Similar to CHP, the transfer of Department of Corrections and Community Supervision (DOCCS) medical expenditures for inmates that are funded initially through the Medicaid Global Cap.

Other State Agencies & MHSF (-\$3.5 billion)

Transfers from Other State Agencies (OSA) 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). Additionally, the delayed recoupment of prior-year Hospital Advances resulted in \$1.1 billion in additional Medicaid spending in FY 2024 that required offsetting Financial Plan support through the MHSF. The Executive model assumed that prior year financial support would be paid back from the Global Cap to the Financial Plan through the MHSF.

All Other (-\$707 million)

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

- The use of ARPA FMAP (-\$459 million) to offset HCBS investments that hit the Medicaid Global Spending Cap in the first instance; and
- Supplemental Federal Revenue (-\$150 million): Includes claiming Federal revenue for Family Planning Services, and School Supportive Health Services.

Net Hospital Advances (-\$1.5 billion)

These State-only Net Hospital Advances were to be used as a short-term financial bridge for the recipient hospitals while they were awaiting Federal payment approval and processing from FY 2022 to FY 2024. The Executive Financial Plan assumes full repayment of prior-year advances by the end of FY 2025.

Local Cap Contribution (-\$7.4 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 District contributions have been increased in FY 2025 to account for a portion of eFMAP that was shared with the districts.

Audit Collections (-\$533 million)

The Department of Health collaborates with the Office of the Medicaid 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 regulations. 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.

Executive Budget Model Changes

DOH, in collaboration with the Division of the Budget, updated the Executive Medicaid Global Cap Model for price and utilization trends based on actuals through September 2024, as well as other known factors. This Executive Budget Model projects spending to be aligned with the Global Cap spending target of \$31.7 billion. The following table outlines the changes from the Enacted Model outlined in the Second Quarter Global Cap Report to the Executive Budget Model of the Fourth Quarter Global Cap Report.

Projected FY 2025 Medicaid Spending (\$ in millions)			
Category of Spending	Enacted Model	Executive Model	Difference
Medicaid Managed Care	\$20,555	\$20,761	\$206
Mainstream Managed Care	\$11,058	\$10,931	(\$127)
Managed Long Term Care	\$9,497	\$9,830	\$333
Total Fee For Service	\$11,984	\$12,587	\$603
Inpatient	\$3,051	\$3,257	\$206
Outpatient/Emergency Room	\$390	\$435	\$45
Clinic	\$818	\$720	(\$98)
Nursing Homes	\$3,863	\$3,752	(\$111)
Personal Care	\$959	\$1,332	\$373
Home Health	\$196	\$239	\$43
Other Long Term Care	\$225	\$227	\$2
Pharmacy	\$1,066	\$1,208	\$142
Transportation	\$580	\$584	\$4
Non-Institutional	\$834	\$832	(\$2)
Other State Agencies	\$1,608	\$1,545	(\$63)
Mental Hygiene Stabilization Fund (MHSF)	\$1,364	\$427	(\$937)
Medicare Part A/B & D*	\$3,619	\$3,554	(\$65)
VAPAP	\$744	\$744	\$0
VAPAP Advances	(\$1,497)	(\$1,497)	\$0
All Other	\$261	\$285	\$24
Medicaid Administration	\$517	\$868	\$351
State Operations	\$377	\$385	\$8
Local Cap Contribution	(\$7,364)	(\$7,364)	\$0
COVID-19 eFMAP	\$0	(\$31)	(\$31)
Audit Collections	(\$533)	(\$533)	(\$0)
TOTAL	\$31,634	\$31,732	\$98

*Quarter 2 report showed \$3,935, this report corrects the Enacted estimate which inadvertently excluded a cash management actions.

Mainstream Managed Care (-\$127M): Mainstream Managed Care reductions are attributed to lower than anticipated enrollment due to the public health emergency unwind, which resulted in lower utilization and slightly decreased claims spending. With continued decreases, these enrollment trends were applied through the conclusion of the fiscal year, resulting in lower category spend projections.

Managed Long Term Care (\$333M): Increased Managed Long Term Care projections due to increasing enrollment trends.

Fee For Service (\$603M): Changes in fee for service categories are results of updates to claims trends based on actual spending data through September, and other factors. Major changes include:

- Personal Care (\$373M) – Price and utilization increases associated with the Nursing Home Transition and Diversion (NHTD) and Traumatic Brain Injury (TBI) waiver programs.
- Inpatient (\$206M) – Impact of delayed claims from FY 2024, that were claimed in FY 2025. Delays were a result of system issues in some hospital systems. Additional differences are a result of recategorizing costs related to NY's 1115 waiver to inpatient services, from all other.
- Pharmacy (\$142M) – Increases related to greater utilization of higher priced HIV and diabetes related medications.
- Nursing Homes (-\$111M) – Decreases related to lower than anticipated utilization, primarily as a result of higher use of home-based community services and staffing constraints lowering nursing home bed capacity statewide.

Mental Hygiene Stabilization Fund (MHSF) (\$937M): Decreases in the MHSF are resulting from the recognition of one-time credits not materializing and funds being backfilled by financial plan resources to avoid severe mid-year cuts to providers and the healthcare industry.

Medicaid Administration (\$351M): Increases due to anticipated spending which reflect recent levels of administrative costs as the State continues to transition functions through the State Takeover (\$76M), as well as the recategorization of costs related to the Global Hospital Budget Initiative, which is now required to be charged against the Medicaid Administration grant (\$275M).

Global Cap Target (\$98M): Updates the Global Cap Index to reflect the most recent five-year rolling average of the Medicaid annual growth rate from the National Health Expenditure (NHE) Accounts analysis produced by the Office of the Actuary in CMS. The updated growth rate is now 7.2 percent, an increase from the Enacted trend of 6.7 percent.

Results April through March 2025 – Global Cap Target vs. Actual Spending

Through March 2025, total actual State Medicaid spending was approximately \$8 million below the Medicaid Global Spending Cap projection. Spending through March resulted in total expenditures of \$31.72 billion compared to the projected cashflow of \$31.73 billion.

Quarter 4	Estimated	Actual	Variance	Percent
Managed Care	\$20,763	\$20,264	(\$499)	-2%
Mainstream Managed Care	\$10,931	\$10,536	(\$395)	-4%
Long Term Managed Care	\$9,832	\$9,728	(\$104)	-1%
Total Fee For Service	\$12,586	\$12,721	\$135	1%
Inpatient	\$3,257	\$3,271	\$14	0%
Outpatient/Emergency Room	\$435	\$404	(\$31)	-7%
Clinic	\$720	\$674	(\$46)	-6%
Nursing Homes	\$3,752	\$3,728	(\$24)	-1%
Personal Care	\$1,332	\$1,323	(\$9)	-1%
Home Health	\$239	\$253	\$14	6%
Other Long Term Care	\$227	\$230	\$3	1%
Pharmacy	\$1,208	\$1,443	\$235	19%
Transportation	\$584	\$569	(\$15)	-3%
Non-Institutional	\$832	\$826	(\$6)	-1%
Other State Agencies	\$1,545	\$1,698	\$153	10%
Mental Hygiene Stabilization Fund	\$427	(\$298)	(\$725)	-170%
Medicare Part A/B & D	\$3,554	\$3,630	\$76	2%
VAPAP	\$744	\$592	(\$152)	-20%
Net Hospital Advances	(\$1,497)	(\$196)	\$1,301	-87%
All Other	\$285	(\$218)	(\$503)	-176%
Medicaid Administration Costs	\$868	\$864	(\$4)	0%
State Ops w/ EP	\$385	\$396	\$11	3%
Local Funding Offset	(\$7,364)	(\$7,364)	\$0	0%
COVID eFMAP	(\$31)	(\$45)	(\$14)	44%
Medicaid Audits	(\$533)	(\$320)	\$213	-40%
TOTAL	\$31,732	\$31,724	(\$8)	0%

The following explanations detail the significant variances between the Global Cap Target through March and the actual spending.

Medicaid Managed Care

Medicaid spending in major Managed Care categories was \$498 million, or 2 percent, under anticipated spending.

- Mainstream Managed Care was \$395 million, or 4 percent, under anticipated spending, which was primarily due to delays in spending related to hospital funding included in the Enacted Budget. These payments were anticipated to disburse from Managed Care in the first instance but did not materialize in FY 2025.
- Long Term Managed Care was \$104 million, or 1 percent under anticipated spending, which was primarily due to timing of payments and rate packages.

Fee-For-Service

Medicaid spending in major fee-for-service categories was \$135 million, or 1 percent, over target.

- Pharmacy was \$235 million, or 19 percent, over target, which was primarily due to increased utilization of higher priced drugs and the timing of rebate collections.

Mental Hygiene Stabilization Fund

Mental Hygiene Stabilization Fund was \$725 million, or 170 percent, under target. This variance is largely a result of a shortfall in hospital advance recoupments which were assumed to be fully remitted in FY 2025; however, due to an inability by certain hospitals to repay advances resulting from a continuing erosion of their financial solvency, the General Fund provided relief to the Global Cap at the end of FY 2025 through the Mental Hygiene Stabilization Fund.

VAPAP

VAPAP spending was \$152 million, or 20 percent, under projections primarily due to the timing of other payments, including FY 2024 and FY 2025 State Directed Payment (SDP) revenue that reduced the need for extraordinary aid to Financially Distressed facilities.

All Other

All Other spending underspent projections by \$503 million, or 176 percent, primarily related to the timing of Accounts Receivable associated with increased collections from the Medical Loss Ratio, an increase in the Home and Community Based Services collections, as well as pre-payment of liability associated with ACA FFP.

Medicaid Administration Costs

Medicaid Administration was \$4 million under projected spending through March, primarily due to additional costs related to Workforce Investment Organizations (WIOs) and Social Care Network (SCNs) grants that are part of New York's Health Equity Reform (NYHER) 1115 Waiver. The WIO and SCN grant costs were charged against State funds in the first instance until the NYHER Waiver Federal funding is claimed and adjudicated. These additional costs are offset by the delay in disbursements related to the Global Hospital Budget Initiative payments.

State Operations

OHIP State Operations overspent projections by \$11 million, or 3 percent, which was primarily due to a lag in shifting Essential Plan costs to the new 1332 Waiver fund.

Audit Collections

Audit collections received were \$213 million, or 40 percent, under projections through March, primarily due to OMIG entering audit periods of COVID years, in which program utilization was suppressed leading to lower claim volume. It should be noted that audit results vary, and that one period is not indicative of future period results.

Enrollment

Medicaid total enrollment reached 6,932,080, enrollees at the end of March 2025, a net decrease of 402,841 from March 2024.

Mainstream Managed Care (includes HIV/SNPS and HARPs): Mainstream Managed Care enrollment in March 2025 reached enrollees 4,632,408 a net decrease of 424,603 from March 2024.

Managed Long Term Care (includes Medicaid Advantage Plus, PACE and Partial Capitation): Managed Long-Term Care (MLTC) enrollment reached 377,432 at the end of March 2025, a net increase of 36,203 individuals from March 2024.

Medicaid Enrollment Summary Medicaid Managed Care vs Fee-for-Service				
	March 2024	March 2025	Net Increase / (Decrease)	% Change
Mainstream Managed Care	5,057,011	4,632,408	(424,603)	(8%)
Managed Long Term Care	341,229	377,432	36,203	11%
Fee-For-Service	1,936,681	1,922,240	(14,441)	(1%)
TOTAL	7,334,921	6,932,080	(402,841)	(5%)

Medicaid Enrollment Summary by NYC vs Rest of State				
	March 2024	March 2025	Net Increase / (Decrease)	% Change
NYC	4,267,056	4,040,680	(226,376)	(5%)
Rest of State	3,067,865	2,891,400	(176,465)	(6%)
TOTAL	7,334,921	6,932,080	(402,841)	(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 March 2024 through March 2025 based on data pulled March 2025.

Notable Events

FFCRA & ARPA MOE Requirements: Section 6008 of the March 2020 Families First Coronavirus Response Act (FFCRA) imposed a Maintenance of Effort (MOE) requirement conditioned on states receiving the 6.2 percent enhanced Federal Medical Assistance Percentage (eFMAP) during the Federal PHE. Additionally, Section 9817 of the March 2021 American Rescue Plan Act (ARPA) imposed an MOE requirement for the duration of the period over which states can spend the 10 percent eFMAP related to certain home and community-based services. As a result, several MRT II initiatives aimed at 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 also resulted in the suspension of eligibility redeterminations as was done previously. As of January 17, 2025, New York's ARPA HCBS spending plan is officially closed out. Accordingly, CMS has confirmed that the associated MOE requirements have been lifted from the State.

Home & Community-Based Services (HCBS) eFMAP: In addition to the 6.2 percent COVID-19 eFMAP increase as a result of the Public Health Emergency (PHE), 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 9, 2021. CMS approved New York's final HCBS spending plan on January 17, 2025, signaling the conclusion of the ARPA HCBS eFMAP spending period.

New York made investments that 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.

Medicaid Funding: Federal funding for Medicaid, authorized under NYS 1115 demonstration waiver, is subject to review by CMS every five years. Funding has been extended at current levels through March 31, 2027, which supports the Medicaid Managed Care programs, children's HCBS, and self-directed personal care services.

In addition, on January 9, 2024, the State received approval for a new three-year programmatic 1115 waiver amendment that allows the state to scale healthcare delivery system transformation, improve access to services, advance health outcomes, and generate Medicaid cost savings. This is being achieved through a series of investments in HRSN services, population health, and workforce capacity that augment each other and are tied to accountability measures.

Appendix A. Inventory of Rate Packages

Below are the largest rate packages processed in FY 2025:

Category of Service	Rate Package Description	Month Paid
Managed Care	April 2024 Mainstream Rates	July
	April 2024 HARP Rates	July
	April 2024 HIV Special Needs Plans (HIV SNP) Rates	July
	April 2023 Mainstream Supplemental Rates	October
	April 2023 HARP Supplemental Rates	October
	Encounter Withhold 2024	September
	Quality Pools FY 2023	July/August
	HIV SNP Incentive Pool Payment CY 2023	October
Managed Long Term Care	MAP FY 2025 Initial Rates	July
	Partial Cap FY 2025 Initial Rates	July
	PACE FY 2025 Initial Rates	July
	MAP FY 2025 Supplemental Rates	November
	Partial Cap FY 2025 Supplemental Rates	November
	QIVAPP FY 2024	November
	Quality Pool FY 2023	October
	Partial Cap and MAP Encounter Data Withhold Payments	October
	Partial Cap Enrollment Cap Withhold Payments	November
Inpatient	Acute & Exempt Unit Inpatient Rates eff 10/1/2024	August
	Statewide Inpatient Rates CY2024	August
	Elimination of C-Section Reduction	January
	Out of State Rates	Various
Outpatient / Emergency Room	10/1/2024 FQHC MEI Increase	February
Clinic	FQHC Wrap Rate	July
	10/1/2024 FQHC MEI Increase	February
	H+H Clinic Capital Rate Packages	December
	Expand the Comprehensive Psychiatric Emergency Program (CPEP)	January
Nursing Homes	1% of 7.5% FY2024 Budget Increase – NH & ADHC	August
	NH 2% Supplemental ATB Increase	March
	NH Advanced Training Initiative	March
	NH Enhanced ATI	September
Personal Care	NHTD/TBI Rate Rebasing	July
	Personal Care CY 23-24 Budgeted Rates	October
Assisted Living Providers	FY2025 One-Time ATB Increase – ALP	October
	ALP Rates CY 2024	February
Hospice	Hospice Non-Residence Rates FFY 2025	March
	Hospice Residence Rates CY 2024	July

Appendix B. FY 2025 Enacted Budget

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

Below is a condensed version of the FY 2025 Enacted Scorecard which focuses the list on budget actions anticipated to be implemented in FY 2025. Any lost savings or availed spending will be accommodated within the Medicaid Global Cap.

<i>(State Share - \$ in millions)</i>	Eff. Date	Article VII/ Admin	FY 2025	Implemented - Y/N	Amount Achieved
Global Cap Forecast (Surplus)/Deficit			\$590.7		\$590.7
Signed Legislation			\$5.6		\$5.6
S1466 - Ambulance Bill	1/1/24	Admin	\$2.5	Y	\$2.5
S1196A - Biomarkers Coverage	4/1/24	Admin	\$3.1	Y	\$3.1
Base Revisions			(\$548.6)		\$206.0
Medicaid Enrollment Above Financial Plan Projections	1/1/24	Admin	\$402.0	Y	\$402.0
Delayed Recoupment of Hospital Advances	1/1/24	Admin	(\$950.6)	Y	(\$196.0)
Financial Plan Support			\$950.6		\$196.0
Reimbursement of Prior-Year Financial Plan Support of Delayed Hospital Recoupments	1/1/24	Admin	\$950.6	Y	\$196.0
Global Cap Index Update			(\$263.1)	Y	(\$263.1)
Global Cap (Surplus)/Deficit			\$735.1		\$735.1
Budget Actions			(\$768.0)		(\$613.0)
Hospital Actions			(\$21.3)		(\$4.8)
Reduce Hospital Capital Rate Add-on by 10%	10/1/24	Art. VII	(\$21.3)	Y	(\$4.8)
Nursing Home Actions			(\$102.4)		(\$102.4)
Unallocated Nursing Home VAPAP Reduction	4/1/24	Admin	(\$75.0)	Y	(\$75.0)
Reduce Nursing Home Capital Rate Add-on by 10% (Excluding NH Pediatric Beds)	4/1/24	Art. VII	(\$27.4)	Y	(\$27.4)
Other Long-Term Care Actions			(\$232.6)		(\$232.6)
Institute Plan Penalty for Electronic Visit Verification (EVV) Non-Compliance	1/1/25	Admin	\$0.0	N	\$0.0
Reduce Managed Long-Term Care (MLTC) Quality Pool	4/1/24	Admin	(\$29.6)	Y	(\$29.6)
Require Dual-Eligible Special Needs Plans (DSNPs) to Cover Medicaid Dental Benefits in Medicare	1/1/25	Admin	(\$3.0)	Y	(\$3.0)
Transition to One Statewide Fiscal Intermediary & Recalibrate Administrative Reimbursement	4/1/24	Art. VII/Admin	(\$200.0)	Y	(\$200.0)
Managed Care Actions			(\$238.2)		(\$238.2)

Remove 1% Across the Board Increase for Health Plans	4/1/24	Art. VII	(\$204.4)	Y	(\$204.4)
Reduce Mainstream Managed Care (MMC) Quality Pool	4/1/24	Admin	(\$33.8)	Y	(\$33.8)
Pharmacy Actions			(\$32.4)		(\$5.0)
Streamline Medicaid Drug Cap	10/1/24	Art. VII	(\$5.0)	Y	(\$5.0)
Pharmacy Enhancements and Integration Specialty Drug Management	10/1/24	Art. VII	(\$9.4)	N	\$0.0
Reduce Coverage for Certain Over-The-Counter (OTC) Pharmaceuticals	10/1/24	Art. VII	(\$18.0)	N	\$0.0
Other Actions			(\$141.2)		(\$30.0)
Procurement Savings and Efficiencies	4/1/24	Admin	(\$5.0)	Y	(\$5.0)
OHIP Non-Personal Service Reduction	4/1/24	Admin	(\$25.0)	Y	(\$25.0)
Increase in Expected Audit Recoveries	4/1/24	Admin	(\$100.0)	N	\$0.0
Early Intervention - Teletherapy Reimbursement	4/1/24	Admin	(\$6.5)	N	\$0.0
Early Intervention - Group Session Billing	4/1/24	Admin	(\$4.7)	N	\$0.0
Total Global Cap (Surplus) / Deficit			(\$32.8)		\$122.2
1115/SOTS/Additional Investments			\$492.8		\$166.8
1115 Waiver (State Share)			\$451.0		\$165.6
Medicaid Hospital Global Budget Initiative (\$550M Gross)	1/1/24	Admin	\$275.0	Y	\$169.0
Patient Centered Medical Homes (PCMH) Enhancement for Adults/Kids	4/1/24	Admin	\$73.8	N	\$0.0
Substance Use Disorder Amendment	1/1/24	Admin	(\$22.0)	Y	(\$11.0)
Continuous Eligibility for Kids (0-6) in Medicaid and CHIP	1/1/25	Art. VII	\$7.6	Y	\$7.6
1115 Additional State Match	4/1/24	Admin	\$116.7	N	\$0.0
State of the State Investments			\$41.8		\$1.2
Increase Children's Access to Healthcare			\$13.7		\$0.0
Increase reimbursement rates for Early Intervention by 5%	4/1/24	Admin	\$6.1	N	\$0.0
4% Early Intervention Rate Modifier for Rural and Underserved Areas	4/1/25	Admin	\$0.0	N	\$0.0
Increase rates for children's mental health provided in integrated settings	10/1/24	Admin	\$7.6	N	\$0.0
Expand Access to Primary Care			\$19.9		\$1.2

Increase rates for mental health provided in integrated settings	10/1/24	Admin	\$13.5	N	\$0.0
Increase rates for healthcare providers serving individuals with physical, intellectual, or developmental disabilities.	10/1/24	Admin	\$5.2	N	\$0.0
Expand coverage for Adverse Childhood Experiences (ACE) Screening to adults	10/1/24	Admin	\$1.2	Y	\$1.2
Other SOTS			\$0.1		\$0.0
Ensure access to comprehensive gender-affirming treatments in Medicaid	1/1/25	Admin	\$0.1	N	\$0.0
Other Mental Health SOTS (Medicaid Impacts)			\$8.1		\$0.0
Fund New Community-Based Mental Health Teams	4/1/24	Admin	\$4.0	N	\$0.0
Establish New Youth Assertive Community Treatment (ACT) Teams Statewide	4/1/24	Admin	\$4.0	N	\$0.0
Total Global Cap (Surplus)/Deficit			\$460.0		\$289.0
Legislative Adds			(\$460.0)		(\$1,087.2)
Adds			\$1,177.6		\$550.4
Financially Distressed and Safety-Net Hospitals Support	4/1/24	Admin	\$500.0	Y	\$311.1
Healthcare Safety Net Transformation Program	4/1/24	Art. VII	\$300.0	Y	\$61.7
Hospital One-Time Investment	4/1/24	Art. VII	\$200.0	N	\$0.0
Nursing Home/ALP/Hospice One-Time Investment	4/1/24	Art. VII	\$150.0	Y	\$150.0
Local Medicaid Share of Additional 1.3% COLA	4/1/24	Art. VII	\$26.6	Y	\$26.6
Pediatric Clinic Rate Increase	4/1/24	Art. VII	\$1.0	Y	\$1.0
Avails			(\$1,637.6)		(\$1,637.6)
Support Essential Plan Operations with Federal Funds	4/1/24	Admin	(\$95.3)	Y	(\$95.3)
Available HCBS eFMAP	4/1/24	Admin	(\$365.6)	Y	(\$365.6)
Financial Plan Support of Hospital Investments and OSA COLA	4/1/24	Admin	(\$826.6)	Y	(\$826.6)
Healthcare Stability Fund Offsets	4/1/24	Art. VII	(\$350.0)	Y	(\$350.0)
Total Global Cap (Surplus)/Deficit			\$0.0		(\$798.2)

Appendix C. Regional Spending Data

The chart below represents total provider spending that occurred within the Medicaid claiming system (eMedNY) through March 2025 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	\$23,855
Long Island	\$3,849
Mid-Hudson	\$3,575
Western	\$1,692
Finger Lakes	\$1,446
Capital District	\$1,095
Central	\$837
Mohawk Valley	\$727
Southern Tier	\$585
North Country	\$415
Out of State	\$554
TOTAL	\$38,630

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

Appendix D. State-Only Payments (YTD)

State-only Payments (\$ in millions)	Non-Federal Total Paid
VAPAP	\$592
Net Hospital Advances	(\$196)
ACA Federal Financial Participation Liability	\$265
Supportive Housing	\$54
Ryan White Clinics	\$18
Alzheimer's Caregiver Support	\$17
VAPAP: Nursing Homes	\$13
End of AIDS	\$12
Assisted Living Voucher Demo	\$7
MLTC Ombudsman	\$5
CSEA Buy-in	\$3
TOTAL	\$790

Appendix E. 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 HH:

The FY 2025 Enacted Budget provided new provisions regarding Fiscal Intermediaries, which now require DOH to procure a single statewide fiscal intermediary.

Appendix F. Results April through December 2024 – Global Cap Target vs. Actual Spending

Medicaid spending was \$111 million above forecasted expenditures through December due to the following factors:

- Fee For Service was higher than projected primarily due to increases in Personal Care, largely as a result of increasing enrollment in the NHTD waiver program and increases in Pharmacy category due to greater utilization of higher priced drugs. These variances are slightly offset by the timing of Clinic rate appeals,
- Lower than anticipated collection of hospital advances that were advanced to hospitals in FY 2022-24 and expected to be remitted in FY 2025,
- VAPAP underspending, primarily due to the timing of other payments effecting hospital operating deficits, including FY 2024 and FY 2025 State Directed Payment (SDP) revenue.

Other timing related expenditures, such as Accounts Receivable and underspending resulting from the Healthcare worker bonus vesting period.

Quarter 3	Estimated	Actual	Variance	Percent
Managed Care	\$17,393	\$17,578	\$185	1%
Mainstream Managed Care	\$8,762	\$8,819	\$57	1%
Long Term Managed Care	\$8,631	\$8,759	\$128	1%
Total Fee For Service	\$9,254	\$9,651	\$397	4%
Inpatient	\$2,386	\$2,442	\$56	2%
Outpatient/Emergency Room	\$292	\$309	\$17	6%
Clinic	\$639	\$518	(\$121)	-19%
Nursing Homes	\$2,901	\$2,846	(\$55)	-2%
Personal Care	\$730	\$1,009	\$279	38%
Home Health	\$162	\$189	\$27	16%
Other Long-Term Care	\$169	\$177	\$8	5%
Pharmacy	\$936	\$1,097	\$161	17%
Transportation	\$425	\$439	\$14	3%
Non-Institutional	\$614	\$625	\$11	2%
Other State Agencies	\$1,145	\$920	(\$225)	-20%
Mental Hygiene Stabilization Fund	\$1,023	\$1,023	\$0	0%
Medicare Part A/B & D	\$2,996	\$2,930	(\$66)	-2%
VAPAP	\$669	\$159	(\$510)	-76%
Net Hospital Advances	(\$633)	(\$168)	\$465	-73%
All Other	\$15	(\$516)	(\$531)	-3552%
Medicaid Administration Costs	\$400	\$670	\$270	68%
State Ops w/ EP	\$253	\$309	\$56	22%
Local Funding Offset	(\$5,666)	(\$5,666)	\$0	0%
COVID eFMAP	\$0	(\$31)	(\$31)	-
Medicaid Audits	(\$326)	(\$225)	\$101	-31%
TOTAL	\$26,523	\$26,634	\$111	0%