



**Department
of Health**

Medicaid Global Spending Cap Report

April 2024 through September 2024 Quarterly
Report

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Overview

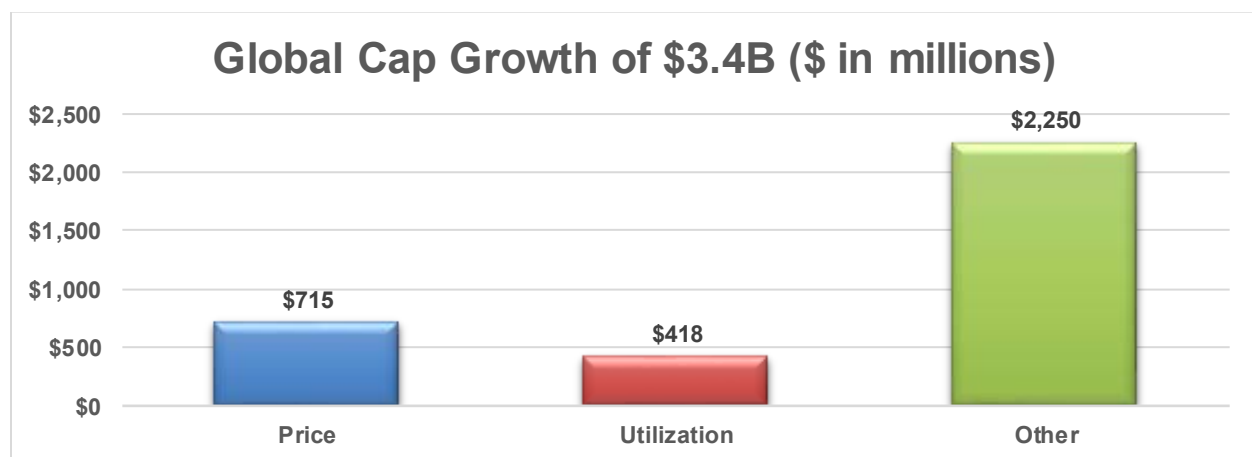
The Medicaid Global Spending Cap increased from \$28.3 billion in FY 2024 to \$31.6 in FY 2025, a net increase of \$3.4 billion. The Global Cap growth index (6.7% for FY 2025) is based on the 5-year rolling average of the Medicaid annual growth rate within the National Health Expenditure Accounts produced by the Office of the Actuary in the Centers for Medicare and Medicaid Services (CMS).¹

Overall, the year-to-year increase of \$3.4 billion primarily includes the updated Global Cap index growth of \$1.6 billion; 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	\$24,832	\$1,567
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	\$31,634	\$3,383

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



Price (\$715M): Components of price growth include:

- Trend increases for Mainstream Managed Care rates (\$115M);
- Trend increases for Managed Long Term Care rates (\$13M);
- Minimum Wage increases (including Home Care) (\$312M); and

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

- Various increases for Fee-for-Service (FFS) rates, which are primarily related to increases included in the FY 2025 Enacted Budget (\$275M).

Utilization (\$418M): The Medicaid Global Cap currently assumes that Medicaid enrollment is projected to decrease by 525,886 New Yorkers or 7.2 percent, from 7.3 million enrollees as of March 2024 to 6.8 million enrollees by March 2025², due in large part to the ending of the COVID-19 pandemic public health emergency (PHE). However, Managed Care enrollment costs are continuing to increase because of the annualization of FY 2023 enrollment, and increases in Managed Long Term Care (MLTC) enrollment:

- Mainstream Managed Care enrollment including HIV Special Needs Plans (SNPs) & Health and Recovery Plans (HARPs) is projected to decrease by 263,572 individuals from March 2024 through the end of March 2025.
- Managed Long Term Care enrollment is projected to increase by 36,127, 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 is expected to decrease by 298,440 individuals from March 2024 through March 2025.

Medicaid Redesign Team (MRT) II/One-Timers/Other (\$2,250M): 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).

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 \$31.6 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.

Projected FY 2025 Medicaid Spending (\$ in millions)				
Category of Spending	Medicaid Claims	Supplemental Programs	Offsets	Total
Medicaid Managed Care	\$20,433	\$2,150	(\$2,028)	\$20,554
Mainstream Managed Care	\$10,410	\$1,634	(\$986)	\$11,058
Managed Long Term Care	\$10,023	\$516	(\$1,042)	\$9,496
Total Fee-For-Service	\$12,601	\$1,711	(\$2,328)	\$11,983
Inpatient	\$1,894	\$1,170	(\$13)	\$3,051
Outpatient/Emergency Room	\$392	\$1	(\$3)	\$390
Clinic	\$744	\$139	(\$65)	\$818
Nursing Homes	\$3,563	\$300	\$0	\$3,863
Personal Care	\$950	\$24	(\$15)	\$960
Home Health	\$201	\$0	(\$5)	\$196
Other Long Term Care	\$210	\$15	\$0	\$225
Pharmacy	\$3,250	\$3	(\$2,187)	\$1,066
Transportation	\$522	\$59	(\$1)	\$581
Non-Institutional	\$873	\$0	(\$39)	\$834
Other State Agencies	\$4,831	\$16	(\$3,239)	\$1,608
Mental Hygiene Stabilization Fund (MHSF)	\$0	(\$469)	\$1,833	\$1,363
Medicare Part A/B & D	\$0	\$3,935	\$0	\$3,935
VAPAP	\$0	\$744	\$0	\$744
Net Hospital Advances	\$0	\$0	(\$1,497)	(\$1,497)
All Other	\$17	\$1,220	(\$1,293)	(\$56)
Medicaid Administration	\$0	\$517	\$0	\$517
State Operations	\$0	\$377	\$0	\$377
Local Cap Contribution	\$0	\$0	(\$7,364)	(\$7,364)
COVID-19 eFMAP	\$0	\$0	\$0	\$0
Audit Collections	\$0	\$0	(\$533)	(\$533)
TOTAL	\$37,881	\$10,201	(\$16,449)	\$31,634

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.
- 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.

- Other Long Term Care: Assisted Living Demonstration Vouchers, and Traumatic Brain Injury (TBI) and Nursing Home Transition and Diversion (NHTD) payments, 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 (\$3.9 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) (\$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.

All Other (\$1.2 billion)

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): The Safety Net Transformation Program seeks to leverage partnerships with safety net facilities to make critical operational improvements and to achieve sustainability.
- Medicaid Hospital Global Budget Initiative (\$275 million): The Medicaid hospital global budget initiative seeks to incentivize transformation and multi-payer arrangements with the goal of improving population health and lowering costs.
- Health Care Worker Bonus (\$256 million): Health Care and direct 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): The Medicaid 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.

- 1115 State Matching Funds (\$117 million): A condition of the latest 1115 Waiver approval, which allows New York to leverage nearly \$6 billion in additional federal funds to improve health equity and disparity requires additional state matching funds over the course of the waiver period.
- Supportive Housing (\$93 million): The Supportive Housing Initiative seeks to ensure that certain high-risk Medicaid members have proper housing and supportive services.

Medicaid Administration (\$517 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](#).

State Operations (\$377 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 is projected to total \$377 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	\$56
Non-Personal Services	\$316
General State Charges	\$5
TOTAL	\$377

Major Offsets:

Medicaid Managed Care (-\$2 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 (-\$2.3 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 (-\$3.2 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. In FY 2025, that Financial Plan support is being paid back from the Global Cap to the Financial Plan through the MHSF.

All Other (-\$1.3 billion)

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

- The use of ARPA FMAP (-\$423 million) to offset HCBS investments that hit the Medicaid Global Spending Cap in the first instance; and
- Supplemental Federal Revenue (-\$156 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 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.

Results April through September 2024 – Global Cap Target vs. Actual Spending

Through September 2024, total actual State Medicaid spending was approximately \$322 million above the Medicaid Global Spending Cap projection. Spending through September resulted in total expenditures of \$17.9 billion compared to the projected cashflow of \$17.6 billion.

Quarter 2	Estimated	Actual	Variance	Percent
Managed Care	\$11,669	\$11,785	\$116	1%
Mainstream Managed Care	\$5,959	\$5,954	(\$5)	0%
Long Term Managed Care	\$5,710	\$5,831	\$121	2%
Total Fee For Service	\$6,366	\$6,289	(\$76)	(1%)
Inpatient	\$1,755	\$1,709	(\$46)	(3%)
Outpatient/Emergency Room	\$195	\$198	\$2	1%
Clinic	\$409	\$360	(\$49)	(12%)
Nursing Homes	\$1,817	\$1,798	(\$19)	(1%)
Personal Care	\$501	\$629	\$128	25%
Home Health	\$107	\$117	\$10	9%
Other Long Term Care	\$112	\$110	(\$3)	(2%)
Pharmacy	\$783	\$676	(\$107)	(14%)
Transportation	\$280	\$285	\$5	2%
Non-Institutional	\$406	\$408	\$2	0%
Other State Agencies	\$763	\$836	\$72	9%
Mental Hygiene Stabilization Fund	\$682	\$682	\$0	0%
Medicare Part A/B & D	\$1,958	\$1,941	(\$17)	(1%)
VAPAP	\$300	\$109	(\$191)	(64%)
Net Hospital Advances	(\$396)	(\$134)	\$262	66%
All Other	(\$234)	(\$289)	(\$54)	(23%)
Medicaid Administration Costs	\$248	\$298	\$50	20%
State Ops w/ EP	\$150	\$211	\$61	41%
Local Funding Offset	(\$3,682)	(\$3,683)	(\$1)	0%
COVID eFMAP	\$0	(\$11)	(\$11)	-
Medicaid Audits	(\$218)	(\$108)	\$111	51%
TOTAL	\$17,605	\$17,926	\$322	2%

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

Medicaid Managed Care

Medicaid spending in major Managed Care categories was \$116 million, or 1 percent, over anticipated spending.

- Mainstream Managed Care was \$5 million, or 0 percent, under anticipated spending, which is primarily due to lower than expected enrollment driving down claims.
- Long term Managed Care was \$121 million, or 2 percent over anticipated spending, which is primarily due to higher than expected utilization.

Fee-For-Service

Medicaid spending in major fee-for-service categories was \$76 million, or 1 percent, under target.

- Inpatient was \$46 million, or 3 percent, under target, which is primarily due to the timing of supplemental payments which did not disburse as initially projected.
- Pharmacy was \$107 million, or 14 percent, under target, which is primarily due to timing of Rebates.
- Clinic was \$49 million, or 12 percent, under target, which is primarily due to the timing of budget actions which have not been fully implemented yet.
- Personal Care was \$128 million, or 25 percent, over target, which is primarily attributable to higher than projected utilization growth of the Nursing Home Transition & Diversion (NHTD) waiver program.

VAPAP

VAPAP underspent projections by \$191 million, or 64 percent, primarily due to the timing of other payments, including FY 2024 and FY 2025 State Directed Payment (SDP) revenue.

All Other

All Other spending underspent projections by \$54 million, or 23 percent, primarily related to the timing of Accounts Receivable associated with increased collections from the Medical Loss Ratio as well as an increase in the Home and Community based services collections which contributed to the overall underspend.

State Operations

OHIP State Operations overspent projections by \$61 million, or 41 percent, which was primarily due to a lag in shifting Essential Plan costs to the new 1332 Waiver fund, which is expected to be effectuated in Quarter 3.

Audit Collections

Audit collections received were \$111 million, or 51 percent, under projections through June, primarily due to the Office of Medicaid Inspector General (OMIG) entering audits 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 quarter is not indicative of future quarter results.

Enrollment

Medicaid total enrollment reached 7,009,581 enrollees at the end of September 2024, a net decrease of 282,978, from March 2024.

Mainstream Managed Care (includes HIV/SNPS and HARPs): Mainstream Managed Care enrollment in September 2024 reached 4,736,682 enrollees, a net decrease of 317,167 from March 2024.

Managed Long Term Care (includes Medicaid Advantage Plus, PACE and Partial Capitation): Managed Long Term Care (MLTC) enrollment reached 363,146 at the end of September 2024, a net increase of 21,073 individuals from March 2024.

Medicaid Enrollment Summary Medicaid Managed Care vs Fee-for-Service				
	March 2024	September 2024	Net Increase / (Decrease)	% Change
Mainstream Managed Care	5,053,849	4,736,682	(317,167)	(6%)
Managed Long Term Care	342,073	363,146	21,073	6%
Fee-For-Service	1,896,637	1,909,753	13,116	(1%)
TOTAL	7,292,559	7,009,581	(282,978)	(4%)

Medicaid Enrollment Summary by NYC vs Rest of State				
	March 2024	September 2024	Net Increase / (Decrease)	% Change
NYC	4,242,412	4,098,908	(143,504)	(3%)
Rest of State	3,050,147	2,910,673	(139,474)	(5%)
TOTAL	7,292,559	7,009,581	(282,978)	(4%)

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 September 2024 based on data pulled October 2024.

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 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 also resulted in the suspension of eligibility redeterminations as was done previously.

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 has approved all spending plan initiatives.

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 programmatic 1115 waiver amendment, titled New York Health Equity Reform (NYHER): Making Targeted, Evidence-Based Investments to Address the Health Disparities Exacerbated by the COVID-19 Pandemic. The NYHER amendment provides Federal funding to change the way the Medicaid program integrates and pays for social, physical health, and behavioral health care in New York State. The NYHER amendment's central goal is to advance health equity, reduce health disparities, and support the delivery of social care. NYHER includes programs that will increase access to health-related social need services; enhance integration between health, behavioral health, and social care; augment whole person care through primary care; support access and quality of care improvements at financially distressed safety net hospitals; and expand workforce capacity.

Appendix A. Inventory of Rate Packages

Below are the largest of the anticipated rate packages to be 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	
	April 2023 Mainstream Supplemental Rates	
	April 2023 HARP Supplemental Rates	
	Encounter Withhold 2024	
	Quality Pools FY 2023	July/August
	HIV SNP Incentive Pool Payment CY 2023	
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	
	Partial Cap FY 2025 Supplemental Rates	
	QIVAPP FY 2024	
	Quality Pool FY 2023	
	Partial Cap and MAP Encounter Data Withhold Payments	
Inpatient	Partial Cap Enrollment Cap Withhold Payments	
	Acute & Exempt Unit Inpatient Rates eff 10/1/2024	
	Statewide Inpatient Rates CY2024	August
	Rural Designation Inpatient Psych Services	
	Elimination of C-Section Reduction	
Outpatient / Emergency Room	Out of State Rates	
	APG Capital Update	
Clinic	10/1/2024 FQHC MEI Increase	
	FQHC Wrap Rate	July
	H+H Clinic Capital Rate Packages	
	Pediatric Rate Increases	
	Expand the Comprehensive Psychiatric Emergency Program (CPEP)	
	Expand Article 31 Clinic Capacity	
	Integrated Licensure Standards	
Nursing Homes	1% of 7.5% FY2024 Budget Increase – NH & ADHC	August
	NH 2% Supplemental ATB Increase	
	NH Advanced Training Initiative	
	NH Enhanced ATI	September
Personal Care	NHTD/TBI Rate Rebasing	July
	Personal Care CY 23-24 Budgeted Rates	
	Personal Care/CDPAP NYC Initial Rates CY2024	
Assisted Living Providers	FY2025 One-Time ATB Increase – ALP	
	ALP Rates CY 2024	
Hospice	Hospice Non-Residence Rates FFY 2025	
	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		\$0.0
S1466 - Ambulance Bill	1/1/24	Admin	\$2.5	N	\$0.0
S1196A - Biomarkers Coverage	4/1/24	Admin	\$3.1	N	\$0.0
Base Revisions			(\$548.6)		\$67.3
Medicaid Enrollment Above Financial Plan Projections	1/1/24	Admin	\$402.0	Y	\$201.0
Delayed Recoupment of Hospital Advances	1/1/24	Admin	(\$950.6)	Y	(\$133.7)
Financial Plan Support			\$950.6		\$133.7
Reimbursement of Prior-Year Financial Plan Support of Delayed Hospital Recoupments	1/1/24	Admin	\$950.6	Y	\$133.7
Global Cap Index Update			(\$263.1)	Y	(\$263.1)
Global Cap (Surplus)/Deficit			\$735.1		\$528.6
Budget Actions			(\$768.0)		(\$138.8)
Hospital Actions			(\$21.3)		\$0.0
Reduce Hospital Capital Rate Add-on by 10%	10/1/24	Art. VII	(\$21.3)	N	\$0.0
Nursing Home Actions			(\$102.4)		(\$75.0)
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)	N	\$0.0
Other Long-Term Care Actions			(\$232.6)		\$0.0
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)	N	\$0.0
Require Dual-Eligible Special Needs Plans (DSNPs) to Cover Medicaid Dental Benefits in Medicare	1/1/25	Admin	(\$3.0)	N	\$0.0
Transition to One Statewide Fiscal Intermediary & Recalibrate Administrative Reimbursement	4/1/24	Art. VII/Admin	(\$200.0)	N	\$0.0
Managed Care Actions			(\$238.2)		(\$33.8)
Remove 1% Across the Board Increase for Health Plans	4/1/24	Art. VII	(\$204.4)	N	\$0.0
Reduce Mainstream Managed Care (MMC) Quality Pool	4/1/24	Admin	(\$33.8)	Y	(\$33.8)

Pharmacy Actions			(\$32.4)		\$0.0
Streamline Medicaid Drug Cap	10/1/24	Art. VII	(\$5.0)	N	\$0.0
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)		\$389.8
1115/SOTS/Additional Investments			\$492.8		\$97.0
1115 Waiver (State Share)			\$451.0		\$97.0
Medicaid Hospital Global Budget Initiative (\$550M Gross)	1/1/24	Admin	\$275.0	Y	\$108.0
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	N	\$0.0
1115 Additional State Match	4/1/24	Admin	\$116.7	N	\$0.0
State of the State Investments			\$41.8		\$0.0
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		\$0.0
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	N	\$0.0

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		\$486.8
Legislative Adds			(\$460.0)		(\$1,550.9)
Adds			\$1,177.6		\$86.7
Financially Distressed and Safety-Net Hospitals Support	4/1/24	Admin	\$500.0	Y	\$73.4
Healthcare Safety Net Transformation Program	4/1/24	Art. VII	\$300.0	N	\$0.0
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	N	\$0.0
Local Medicaid Share of Additional 1.3% COLA	4/1/24	Art. VII	\$26.6	Y	\$13.3
Pediatric Clinic Rate Increase	4/1/24	Art. VII	\$1.0	N	\$0.0
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		(\$1,064.0)

Appendix C. Regional Spending Data

The chart below represents total provider spending that occurs within the Medicaid claiming system (eMedNY) through September 2024 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	\$11,974
Long Island	\$1,891
Mid-Hudson	\$1,698
Western	\$827
Finger Lakes	\$719
Capital District	\$544
Central	\$412
Mohawk Valley	\$356
Southern Tier	\$290
North Country	\$207
Out of State	\$266
TOTAL	\$19,183

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
Net Hospital Advances	(\$134)
VAPAP	\$109
Supportive Housing	\$23
Safety Net Transformation Program	\$12
Alzheimer's Caregiver Support	\$8
End of AIDS	\$5
Assisted Living Voucher Demo	\$4
MLTC Ombudsman	\$2
CSEA Buy-in	\$1
Rural Transportation	\$1
TOTAL	\$31

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 PP:

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 June 2024 – Global Cap Target vs. Actual Spending

Medicaid spending was \$744 million below forecasted expenditures through June due to the following factors:

- Timing of Enhanced Child Health Plus credits, which offset managed care payments
- Increased costs in the Nursing Home Transition & Diversion/Traumatic Brain Injury waiver programs under Other Long Term Care.
- VAPAP underspending, primarily due to the timing of other payments, including FY 2024 and FY 2025 State Directed Payment (SDP) revenue, and Other timing related expenditures, such as Accounts Receivable and underspending resulting from the Healthcare worker bonus vesting period.

Quarter 1	Estimated	Actual	Variance	Percent
Managed Care	\$6,451	\$5,925	(\$526)	(8%)
Mainstream Managed Care	\$3,157	\$2,641	(\$516)	(16%)
Long Term Managed Care	\$3,295	\$3,284	(\$11)	(0%)
Total Fee For Service	\$3,367	\$3,451	\$83	2%
Inpatient	\$1,128	\$1,007	(\$121)	(11%)
Outpatient/Emergency Room	\$99	\$102	\$4	4%
Clinic	\$254	\$254	(\$0)	(0%)
Nursing Homes	\$838	\$844	\$7	1%
Personal Care	\$276	\$299	\$23	8%
Home Health	\$50	\$56	\$6	11%
Other Long Term Care	\$56	\$55	(\$0)	(1%)
Pharmacy	\$334	\$492	\$158	47%
Transportation	\$135	\$139	\$5	4%
Non-Institutional	\$198	\$202	\$4	2%
Other State Agencies	\$382	\$404	\$22	6%
Mental Hygiene Stabilization Fund	\$341	\$341	\$0	0%
Medicare Part A/B & D	\$960	\$955	(\$5)	(1%)
VAPAP	\$232	\$12	(\$221)	(95%)
Net Hospital Advances	(\$158)	(\$92)	\$66	42%
All Other	(\$204)	(\$519)	(\$315)	(155%)
Medicaid Administration Costs	\$118	\$150	\$32	27%
State Ops w/ EP	\$67	\$100	\$33	49%
Local Funding Offset	(\$1,841)	(\$1,841)	(\$0)	(0%)
COVID eFMAP	\$0	\$0	\$0	0%
Medicaid Audits	(\$125)	(\$37)	\$87	70%
TOTAL	\$9,591	\$8,847	(\$744)	(8%)