Medicaid Global Spending Cap Report

April 2025 through December 2025 Quarterly Report

Table of Contents

Overview

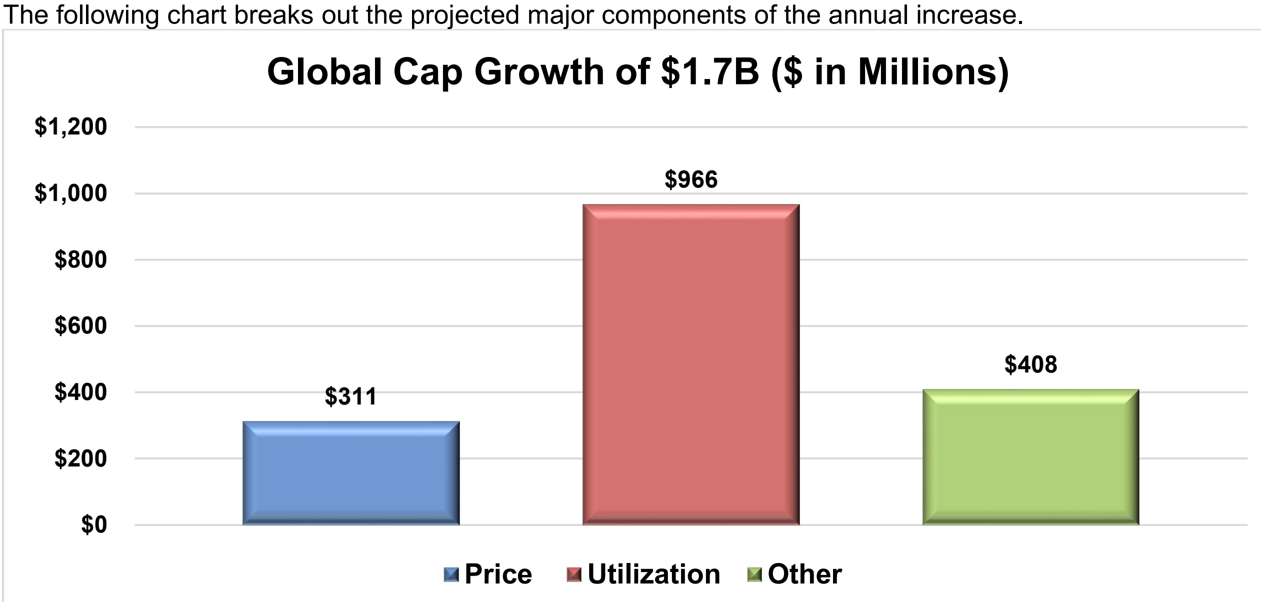
The Medicaid Global Spending Cap increased from $31.7 billion in FY 2025 to $33.4 billion in FY 2026, a net increase of $1.7 billion. The Global Cap growth index (6.1 percent for FY 2026) is based on the 5-year rolling average of the Medicaid annual growth rate within the National Health Expenditure Accounts produced by the Office of the Actuary in the Centers for Medicare and Medicaid Services (CMS).[1]

This net increase includes the updated Global Cap index growth of $1.5 billion; increased costs for minimum wage rate adjustments ($314M), increases in funding for the takeover of local Medicaid growth ($182M), decreases to account for Healthcare Stability Fund disbursements being shifted outside the Global Cap ($350M), and other Medicaid Administration/Other funds ($11M).

Anticipated DOH Medicaid Spending Outside the Global Cap Index:

($ millions)	FY25	FY26	$ Change
Medicaid Global Cap Index	**$24,930**	**$26,458**	**$1,528**
DOH Medicaid Spending Outside of Global Cap Index	**$6,802**	**$6,959**	**$157**
Medicaid Local Growth Takeover	$2,013	$2,195	$182
Minimum Wage	$2,430	$2,441	$11
Home Care Minimum Wage	$1,480	$1,794	$314
Medicaid Administration/Other	$529	$529	$0
Healthcare Stability Fund	$350	$0	($350)
Total DOH Medicaid Global Cap Target	**$31,732**	**$33,417**	**$1,685**

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



<u>Price ($311M)</u>: Components of price growth include:

- Increases in Mainstream Managed Care ($478M) are due to trend increases as well as an acuity adjustment to the mainstream rates. This adjustment recognizes shifting population mix under managed care plans as a result of the Public Health Emergency (PHE) unwind.

[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 2026 Enacted Budget or rates that were not fully implemented in FY 2025.
- Increases in price are partially offset by decreases in Managed Long-Term Care (-$312M); primarily as a result of lower premium rates. Some of these decreases are offset by increases to minimum wage.

Utilization ($966M): The Medicaid Global Cap model assumes that Medicaid enrollment will decrease by 140,699 New Yorkers or 2.0 percent, from 6.9 million enrollees as of March 2025 to 6.8 million enrollees by March 2026[2]. However, growth in certain high-cost programs has driven year-to-year increases:

- The Nursing Home Transition and Diversion (NHTD) waiver program, within Other Long Term Care, is projected to increase in enrollment, with the amount of utilizers growing by over 30 percent year-to-year.
- Pharmacy services have seen large year-to-year growth, primarily driven by the increased availability and use of high-cost specialty drugs, such as GLP-1s and HIV prevention medications. While the prices of these drugs have seen nominal increases, and utilization in the program fluctuates, projected growth is a result of changing member and provider preferences as well as the prevalence of new drugs.
- Mainstream Managed Care enrollment including HIV Special Needs (SNPs) & Health and Recovery Plans (HARPs) is projected to decline by 70,045 individuals from March 2025 through the end of March 2026.
- Managed Long Term Care enrollment is projected to increase by 4,904 individuals from March 2025 through the end of March 2026. Managed Long Term Care is on average the costliest population within Medicaid.
- The total number of FFS recipients is expected to decrease by 75,558 individuals from March 2025 through March 2026.

Medicaid Redesign Team (MRT) II/One-Timers/Other ($408M): MRT budget actions, one-time costs/savings, or other payments that do not fall into price or utilization primarily include various year-to-year changes in non-claims payments, as well as changes in the accounting mechanisms of Other State Agency Medicaid payments and timing revisions of expected recoupments within the Medicaid program.

[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 $33.4 billion projected Medicaid State Funds Spending can be organized into three major components:

1. **<u>Medicaid Claims:</u>** 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. **<u>Supplemental Programs:</u>** 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. **<u>Offsets:</u>** 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.

<u>Forecasting Methodology/Data:</u>

- 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.

<u>Factors Impacting the Medicaid Forecast:</u>

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 2026 Medicaid projections by major health care sector (i.e., category of spending) for Medicaid claims, supplemental programs, and offsets.

Executive Budget Projected FY 2026 Medicaid Spending ($ in millions)				
Category of Spending	**Medicaid Claims**	**Supplemental Programs**	**Offsets**	**Total**
Medicaid Managed Care	**$21,805**	**$1,915**	**($2,534)**	**$21,186**
Mainstream Managed Care	$11,859	$1,324	($1,034)	$12,149
Managed Long Term Care	$9,946	$591	($1,500)	$9,037
Total Fee For Service	**$15,048**	**$1,617**	**($2,652)**	**$14,013**
Inpatient	$2,238	$1,141	($15)	$3,364
Outpatient/Emergency Room	$470	$2	($3)	$469
Clinic	$777	$178	($75)	$880
Nursing Homes	$3,438	$192	$0	$3,630
Personal Care	$1,822	$30	($38)	$1,814
Home Health	$352	$0	($13)	$339
Other Long Term Care	$220	$8	$0	$228
Pharmacy	$4,251	$3	($2,468)	$1,786
Transportation	$568	$63	($1)	$630
Non-Institutional	$912	$0	($39)	$873
Other State Agencies	**$5,421**	**$0**	**($5,796)**	**($375)**
Mental Hygiene Stabilization Fund (MHSF)	**$0**	**$0**	**$0**	**$0**
Medicare Part A/B & D*	**$0**	**$4,670**	**$0**	**$4,670**
VAPAP	**$0**	**$644**	**$0**	**$644**
Net Hospital Advances	**$0**	**$0**	**($131)**	**($131)**
All Other	**$9**	**$843**	**($617)**	**$235**
Medicaid Administration	**$0**	**$1,056**	**($108)**	**$948**
State Operations	**$0**	**$405**	**$0**	**$405**
Local Cap Contribution	**$0**	**$0**	**($7,634)**	**($7,634)**
COVID-19 eFMAP	**$0**	**$0**	**($11)**	**($11)**
Audit Collections	**$0**	**$0**	**($533)**	**($533)**
TOTAL	**$42,283**	**$11,150**	**($20,016)**	**$33,417**

<u>Major Supplemental Programs:</u>

Medicaid Managed Care ($1.9 billion)

- Mainstream Managed Care: 2 Percent Encounter Withhold Repayments 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.

Fee For Service ($1.6 billion)

- Inpatient: Disproportionate Share Hospital (DSH), Voluntary Upper Payment Limit (UPL), Indigent Care Payments, and 1115 Waiver State Matching Funds.
- Clinic: NYRx reinvestments included in the FY 2024 Enacted Budget to support Federally Qualified Health Centers (FQHCs).
- Nursing Homes: Advance Training Initiatives, Historic Appeals, and 2 Percent Supplemental Payments.
- Transportation: Transportation Management Initiative, Supplemental Ambulance, and Rural Transportation Investments.

Medicare SMI Part A/B & Clawback Part D ($4.7 billion)

- Supplemental Medical Insurance (SMI) Part A/B: This voluntary Social Security insurance pays a substantial part of Medicare dual enrollees' expenses for hospital, physician, home health, and other medical health services. States must contribute to the Federal Government a portion of the total expenses.
- Clawback Part D: Under the Medicare Part D drug benefit program, most costs are paid by beneficiary premiums and general federal 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) ($644 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 ($843 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 ($240 million): This program seeks to leverage partnerships with safety net facilities to make critical operational improvements and to achieve sustainability. Additional Safety Net Transformation funding, separate from Medicaid Global Cap funding, was provided in the Enacted Budget through the Healthcare Stability fund.
- 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.

- Supportive Housing ($93 million): This program seeks to ensure that certain high-risk Medicaid members have proper housing and supportive services.
- Remaining funding is for various miscellaneous programs including: NY Connects, Alzheimer's Caregiver Support, Ryan White Centers, End of AIDS and others.

Medicaid Administration ($1.1 billion)

- The annual county Medicaid caps for Local Administration is projected to remain at their historic/current levels during FY 2026, 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.

- Medicaid Administration estimates are currently comprised of costs related to local district reimbursement, the Managed Care Broker contract, and the Global Hospital Budget Initiative.

State Operations ($405 million)

The State Operations budget reflects the Non-Federal share of personal services (i.e., salaries of staff) and non-personal services costs (i.e., contractual services). The FY 2026 budget is projected to total $405 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 2026 Budget ($ in millions)	
Medicaid Service Costs	**Annual Budget**
Personal Services	$73
Non-Personal Services	$322
General State Charges	$10
TOTAL	**$405**

Major Offsets:

Medicaid Managed Care (-$2.5 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. Certain claims and populations eligible for enhanced CHP funding are paid in the first instance by the Medicaid Global Cap and are then reimbursed.
- Health Related Social Needs (HRSN) initiatives approved in the State's 1115 waiver aims to integrate social care with physical and behavioral health care for Medicaid Members in the state by establishing regional Social Care Networks (SCNs) to provide screening, navigation, and delivery of HRSN services. These costs are fully funded by the Federal Waiver; however, they are charged with the standard federal-state split in the first instance and are credited as an offset once claims are reconciled.

- Managed Long Term Care (MLTC): Supplemental Federal Revenue (i.e., 6 percent 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 (-$2.7 billion)

Within Pharmacy, the Department collects Federally required (OBRA) and Supplemental rebates from drug manufacturers.

Other State Agencies (-$5.8 billion)

The Department receives transfers from Other State Agencies (OSA) to support State and Local-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). As of the FY 2026 Enacted Budget, the local share of Medicaid expenses that would typically be charged to the DOH budget will be included in the quarterly transfers along with the State-share of claims.

All Other (-$617 million)

The FY 2026 Enacted Budget includes an assessment on managed care organizations (MCO) which took effect on January 1, 2025. These resources will be used to offset existing Global Cap Medicaid spending and allow for additional funding for the Healthcare Safety Net Transformation Program, as well as increased funding for hospitals, nursing homes, clinics, and other health care providers.

Medicaid Administration Local (-$108 million)

Administrative advances made to Workforce Innovation Organizations (WIOs) and Social Care Networks (SCNs) under Medicaid Administration for NYHER related initiatives that are charged to the state in the first instance and credited back once the claims are adjudicated.

Local Cap Contribution (-$7.6 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. Through FY 2026, local governments will have saved nearly $54 billion since FY 2016.

Net Hospital Advances (-$131 million):

These State-only Hospital Advances were used as a short-term financial bridge for the recipient hospitals while they were awaiting Federal payment approval and processing of the related FY 2022 to FY 2024 payments for Financially Distressed, Safety Net, and Sole Community Hospitals. The Enacted Financial Plan assumes partial repayment of prior year advancements of $131 million in FY 2026.

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 2025, as well as other known factors. This Executive Budget Model projects spending to be aligned with the Global Cap spending target of $33.4 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 this quarter's Global Cap Report.

Projected FY 2026 Medicaid Spending ($ in millions)			
Category of Spending	**Enacted Model**	**Executive Model**	**Difference**
Medicaid Managed Care	**$21,741**	**$21,186**	**($555)**
Mainstream Managed Care	$11,576	$12,149	**$573**
Managed Long Term Care	$10,165	$9,037	($1,128)
Total Fee For Service	**$12,970**	**$14,013**	**$1,043**
Inpatient	$3,245	$3,364	$119
Outpatient/Emergency Room	$444	$469	$25
Clinic	$850	$880	$30
Nursing Homes	$3,670	$3,630	($40)
Personal Care	$1,585	$1,814	$229
Home Health	$299	$339	$40
Other Long Term Care	$230	$228	($2)
Pharmacy	$1,167	$1,786	$619
Transportation	$598	$630	$32
Non-Institutional	$882	$873	($9)
Other State Agencies	**($557)**	**($375)**	**$182**
Mental Hygiene Stabilization Fund (MHSF)	**$723**	**$0**	**($723)**
Medicare Part A/B & D*	**$4,214**	**$4,670**	**$456**
VAPAP	**$744**	**$644**	**($100)**
Net Hospital Advances	**($131)**	**($131)**	**$0**
All Other	**$534**	**$235**	**($299)**
Medicaid Administration	**$948**	**$948**	**$0**
State Operations	**$398**	**$405**	**$7**
Local Cap Contribution	**($7,634)**	**($7,634)**	**($0)**
COVID-19 eFMAP	**$0**	**($11)**	**($11)**
Audit Collections	**($533)**	**($533)**	**$0**
TOTAL	**$33,417**	**$33,417**	**$0**

Medicaid Managed Care (-$555 million): Changes in Managed Long-Term Care ($1.2B) are primarily a result of updated enrollment assumptions based on actual data through September 2025.

Increases in Mainstream Managed Care ($573M) are primarily a result of the timing of claim offsets related to HRSN services and the Healthcare Stability Fund.

Fee For Service ($1,042 million): Changes in fee-for-service categories are a result of updates to claim trends based on data through September, major changes include:

- Pharmacy ($619M) rising pharmacy spending is attributed to increased utilization of higher priced drugs, including GLP-1s, and HIV drugs.
- Personal Care ($229M) increased spending is attributable to increases in enrollment in the NHTD waiver program resulting from delays in implementation of the NHTD cap.
- Home Health ($40M) increased spending is attributable to higher than anticipated utilization of home health services.
- Various changes in other Fee-for-Service categories are a result of updated price and utilization data.

Mental Hygiene Stabilization Fund (MHSF) ($723 million): Decreases in the MHSF are a result of Financial Plan support to the Medicaid Global Cap. Support was provided in the current year to manage liabilities and create a benefit in the budget year that will help offset the increased costs related to H.R. 1.

Other State Agencies (OSA) ($182 million): Changes to the OSA estimates reflect updated assumptions related to the amount of offsets provided by the OSAs for spending that occurs under the Global Cap in the first instance. This change is primarily related to correcting estimates related to the local share impact of minimum wage, that will no longer impact the Global Cap as a result of shifting the local share to their respective agencies.

Medicare Part A/B & D ($456 million): Changes to these estimates are a result of revised expectations on the timing of payments made this year. Estimates currently reflect the assumption of 13 payments, necessary to bring State payments in alignment with billable claims received by the State.

VAPAP (-$100 million): Changes to the Vital Access Provider Assurance Program (VAPAP) estimate are due to a shift from unallocated VAPAP to the DASNY Health Facility Restructuring Program (HFRP), to provide transitional support to distressed facilities as they finalize their contracts under the Safety Net Transformation Program (SNTP).

All Other (-$299 million): Changes in all other are primarily a result of reflecting updates to certain federal and other one-time credits, and the timing and classification of supplemental programs.

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

Through December 2025, total actual Global Cap Medicaid spending was approximately $677 million above the Medicaid Global Spending Cap projection. Spending through December resulted in total expenditures of $28.144 billion compared to the projected cashflow of $27.467 billion. 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.

Quarter 3 ($ in millions)	Estimated	Actual	Variance	Percent
Managed Care	**$17,907**	**$18,034**	**$127**	**1%**
Mainstream Managed Care	$9,436	$9,639	$203	2%
Long Term Managed Care	$8,471	$8,395	($76)	-1%
Total Fee For Service	**$10,568**	**$10,962**	**$394**	**4%**
Inpatient	$2,381	$2,418	$37	2%
Outpatient/Emergency Room	$313	$328	$15	5%
Clinic	$679	$696	$17	3%
Nursing Homes	$2,651	$2,611	($40)	-2%
Personal Care	$1,371	$1,454	$83	6%
Home Health	$249	$282	$33	13%
Other Long Term Care	$175	$176	$1	1%
Pharmacy	$1,628	$1,885	$257	16%
Transportation	$455	$464	$9	2%
Non-Institutional	$666	$648	($18)	-3%
Other State Agencies	**($232)**	**($191)**	**$41**	**-18%**
Mental Hygiene Stabilization Fund	**$542**	**$542**	**$0**	**0%**
Medicare Part A/B & D	**$3,270**	**$3,172**	**($98)**	**-3%**
VAPAP	**$556**	**$436**	**($120)**	**-22%**
VAPAP Advances	**($100)**	**($88)**	**$12**	**-12%**
All Other	**$150**	**$154**	**$4**	**3%**
Medicaid Administration Costs	**$790**	**$976**	**$186**	**24%**
State Operations	**$299**	**$314**	**$15**	**5%**
Local Funding Offset	**($5,872)**	**($5,872)**	**$0**	**0%**
COVID eFMAP	**($11)**	**($11)**	**$0**	**0%**
Medicaid Audits	**($400)**	**($276)**	**$124**	**-31%**
TOTAL	**$27,467**	**$28,152**	**$685**	**2%**

The following explanations detail the significant variances between the Global Cap Target through December 2025 and the actual spending.

Medicaid Managed Care:

Medicaid spending in major Managed Care categories was $127 million, or 1 percent, over anticipated spending.

- Mainstream Managed Care spending was $203 million, or 2 percent over anticipated spending due to pending offsets associated with the reconciliation of MCO assessment revenues in the Healthcare Stability Fund (HSF) that have yet to be processed which will be credited later in the fiscal year.

- Managed Long Term Care was $76 million, or 1 percent under anticipated spending, which was primarily due to lower than projected enrollment levels through December, partially offset by acceleration of timing of certain offline payments.

Fee-For-Service:

Medicaid spending in major fee-for-service categories was $394 million, or 4 percent, over target.

- Personal Care $83 million, or 6 percent over anticipated spending due to increased claims, driven by increased utilization of the NHTD waiver.
- Home Health $33 million, or 13 percent over anticipated spending due to increased utilization.
- Pharmacy was $257 million, or 16 percent over anticipated spending due to fluctuations and timing of rebates and claims.

Other State Agencies:

Other State Agency spending was $41 million, or 18 percent under expected levels as a result of the timing of transfers from the Mental Hygiene budgets to the Medicaid Global Cap.

VAPAP:

VAPAP spending was $120 million, or 22 percent, under projections primarily attributable to the timing of payments and facility needs. Provider needs are impacted by other support including DPT payments, which mitigated the immediate need for VAPAP support to hospitals.

Medicaid Administration Costs:

Medicaid Administration was $186 million, or 24 percent, over primarily due to the timing of 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 can be claimed and adjudicated within the fiscal year.

Medicaid Audits:

Medicaid audits were $124 million, or 31 percent under 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.

State Operations

State Operations exceeded projections by $15 million, or 5 percent, which was primarily due to the timing in processing contractual payments.

Enrollment

Medicaid total enrollment reached 6,805,143 enrollees at the end of December 2025, a net decrease of 126,937 from March 2025.

Mainstream Managed Care (includes HIV/SNPS and HARPs): Mainstream Managed Care enrollment in December 2025 reached enrollees 4,582,909 a net decrease of 49,499 from March 2025.

Managed Long Term Care (includes Medicaid Advantage Plus, PACE and Partial Capitation): MLTC enrollment reached 377,528 at the end of December 2025, a net increase of 96 individuals from March 2025.

Medicaid Enrollment Summary Medicaid Managed Care vs Fee-for-Service				
	March 2025	**December 2025**	**Net Increase / (Decrease)**	**% Change**
Mainstream Managed Care	4,632,408	4,582,909	(49,499)	(1.07%)
Managed Long Term Care	377,432	377,528	96	0.03%
Fee-For-Service	1,922,240	1,844,706	(77,534)	(4.03%)
TOTAL	**6,932,080**	**6,805,143**	**(126,937)**	**(1.83%)**

Medicaid Enrollment Summary by NYC vs Rest of State				
	March 2025	**December 2025**	**Net Increase / (Decrease)**	**% Change**
NYC	4,040,680	3,916,004	(124,676)	(3.09%)
Rest of State	2,891,400	2,889,139	(2,261)	(0.08%)
TOTAL	**6,932,080**	**6,805,143**	**(126,937)**	**(1.83%)**

Notable Events

Federal Budget Reconciliation Bill: On July 4, 2025, the United States Congress passed House Resolution 1 (H.R.1) of the 119th Congress that would significantly alter Federal assistance for critical supports programs that provide services to New York families and individuals. Beginning January 1, 2026, certain non-citizen populations will be disqualified from obtaining premium tax credits, which eliminates the Federal funding received for this population in the EP. Individuals with incomes below 138 percent of the Federal Poverty Level (FPL), pregnant/post-partum individuals, and Deferred Action for Childhood Arrivals individuals who currently qualify and are enrolled in the EP but are also eligible for Medicaid may be moved to Medicaid at a projected State cost of $3 billion per year when fully annualized. To alleviate new State costs and maintain coverage for as many individuals as possible, DOH has submitted a request to Centers for Medicare & Medicaid Services (CMS) to terminate its 1332 State Innovation Waiver (1332 Waiver) and EP expansion and reactivate its (currently suspended) Basic Health Program authorized under Section 1331 of the Affordable Care Act (ACA).

Effective January 1, 2027, States are required to establish Medicaid community engagement requirements for certain individuals. Non-exempted Medicaid recipients must participate in at least 80 hours of work, education, and/or community service per month to maintain eligibility. Exempted recipients include, but are not limited to, pregnant women, people with disabilities, and caregivers of young children. DOH estimates as many as 750,000 enrollees may be impacted. In addition, the loss of Federal funding previously provided for reproductive healthcare services and the coverage of vaccinations will cost the State over $100 million over the multi-year Financial Plan.

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 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. This has enabled the State to move forward with implementing the MRT II initiative to modify benefit eligibility criteria for Personal Care Services (PCS)/Consumer Directed Personal Assistance Program (CDPAP) benefits, effective September 1, 2025. This proposal, which was previously on hold due to associated MOE requirements, would require that individuals need to require assistance with more than 2 activities of daily living (ADL) in order to receive PCS/CDPAP, with an exception for individuals with Alzheimer's or Dementia who need to require assistance with more than 1 ADL.

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 2026 so far:

Category of Service	Rate Package Description	Month Paid
Managed Care	Mainstream FY 2026 Initial Rates	May
	HARP FY 2026 Initial Rates	May
	HIV Special Needs Plans (HIV SNP) FY 2026 Initial Rates	May
	Mainstream FY 2025 Supplemental Rates	November
	HARP FY 2025 Supplemental Rates	November
	Mainstream Encounter Withhold CY 2025	September
	HARP Encounter Withhold CY 2025	August
	HARP Quality Pools FY 2024	August
	HIV SNP Incentive Pool Payment CY 2023	August
Managed Long Term Care	MAP FY 2026 Initial Rates	June
	Partial Cap FY 2026 Initial Rates	June
	PACE FY 2026 Initial Rates	June
	MAP FY 2025 Supplemental Rates	July
	Partial Cap FY 2025 Supplemental Rates	July
	MAP FY 2025 Final Rates	October
	Partial Cap FY 2025 Final Rates	October
	MAP FY 2025 Updated Rates	May
	Partial Cap FY 2025 Updated Rates	May
	MLTC Encounter Withhold	Sept
	MLTC Enrollment Withhold	August
Inpatient	Acute & Exempt Unit Inpatient Rates eff 1/1/2025	August
	Statewide Inpatient Rates CY 2025 & CY 2026	August
	Acute & Exempt Capital Reduction	
Outpatient / Emergency Room	FQHC MEI Increase FY 2026	November
	APG Capital Update CY 2023 - CY 2025	August
	PROS Capital Update CY 2022 - CY 2025	May
Clinic	Expand the Comprehensive Psychiatric Emergency Program (CPEP) FY 2024	
	APG Capital Update CY 2021-CY 2024	August
	FQHC MEI Increase FY 2026	November
	FQHC Wrap	December
Nursing Homes	NH Initial Rates CY 2025	
	CRA Reconciliation CY 2023	August
	CRA Reconciliation CY 2024	
	NH Advanced Training Initiative (ATI) FY 2026	
	NH 2% Supplemental Payment FY 2026	
Personal Care	Personal Care/CDPAP NYC HRA Rates CY 2024	June
	Personal Care/CDPAP ROS Rates CY 2024	
	Personal Care/CDPAP Rates CY 2025	

Appendix B. FY 2026 Enacted Budget

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

Below is a condensed version of the FY 2026 Enacted Scorecard which focuses the list on budget actions anticipated to be implemented in FY 2026. Any lost savings or availed spending will be accommodated within the Medicaid Global Cap.

(State Share - $ in millions)	Eff. Date	Article VII/ Admin	FY 2026	Implemented - Y/N	Achieved Amount
Global Cap Forecast (Surplus)/Deficit			**$2,935.6**		**$2,935.5**
Signed Legislation			**$41.5**		**$0.5**
Medically Fragile Young Adults (S5969A/A3674A)	4/1/25	Legal	$11.7	N	$0.0
Medically Fragile Adult Demo Program (A10189B/S9519A)	12/21/24	Legal	$29.8	N	$0.0
Treatment in Place (A9102C/S8486C)	10/1/24	Legal	($0.5)	N	$0.0
Enhancing Access for Opioid Use Disorder (S7177B/A5984B)	2/20/25	Legal	$0.5	Y	$0.5
Global Cap Index Update	4/1/23	Admin	**($209.2)**	**Y**	**($209.2)**
Reallocation of Other State Agency Costs	4/1/25	Admin	**($2,111.3)**	**Y**	**($2,111.3)**
Global Cap (Surplus)/Deficit			**$656.6**		**$615.5**
Budget Actions			**($138.6)**		**($107.8)**
Hospital Actions			**($56.7)**		**($56.7)**
Restructure the Public Indigent Care Pool	4/1/25	Art. VII	($56.7)	Y	($56.7)
Other Long-Term Care Actions			**($40.6)**		**($22.4)**
Discontinue Funding for Managed Long-Term Care Quality Pool	4/1/25	Admin	($22.4)	Y	($22.4)
Reform the Nursing Home Transition & Diversion (NHTD) Waiver	7/1/25	Admin	($18.2)	N	$0.0
Managed Care Actions			**($41.3)**		**($28.7)**

Shift Funding for Managed Care Quality Pool	4/1/25	Admin	($26.3)	Y	($26.3)
MMC to FFS Shift for Nursing Home Long-Term Stays	10/1/25	Art. VII	($7.6)	N	$0.0
Authorize Plan Penalties	4/1/25	Art. VII	($5.0)	Y	$0.0
Applied Behavior Analysis (ABA) Reforms	10/1/25	Admin	($2.4)	Y	($2.4)
State of the State Investments			**$9.6**		**$0.0**
Improve & Expand Access to Infertility Treatments	10/1/25	Art. VII	$2.3	N	$0.0
-					
Support Mobility for People with Physical Disabilities	1/1/26	Admin	$4.1	N	$0.0
-					
Health Equity for Justice-Involved Youth	7/1/25	Admin	$3.2	N	$0.0
Total Global Cap (Surplus)/Deficit			**$527.6**		**$507.7**
Healthcare Stability Fund Investments			**$1,470.0**		**$205.0**
Hospital Investments	4/1/25	Art. VII	$305.0	Y	$155.0
Nursing Home/Hospice Investments	4/1/25	Art. VII	$222.5	N	$0.0
Assisted Living Program (ALP) Investments	4/1/25	Art. VII	$7.5	N	$0.0
Physician Fee Schedule Investments	4/1/25	Admin	$50.0	N	$0.0
Clinic Investments	4/1/25	Art. VII	$20.0	N	$0.0
Value Based Provider Investments	4/1/25	Admin	$15.0	N	$0.0
Managed Care Quality Pool Investments	4/1/25	Admin	$50.0	Y	$50.0
Safety Net Transformation Program Investments	4/1/25	Admin	$300.0	N	$0.0
Healthcare Stability Fund Global Cap Offset	4/1/25	Admin	$500.0	N	$0.0
Global Cap Adjustments			**($1,970.0)**		**($155.0)**
Healthcare Stability Fund Investment Exclusion	4/1/25	Admin	($1,470.0)	Y	($155.0)
Global Cap Offset	4/1/25	Admin	($500.0)	N	$0.0
Total Global Cap			**$27.6**		**$557.7**
Adds			**$502.3**		**$436.3**

Financially Distressed and Safety-Net Hospital Support	4/1/25	Admin	$500.0	Y	$434.0
Neoplastic Disease Care Hospital Investments	4/1/25	Admin	$2.3	Y	$2.3
Financial Plan Resources			**($529.9)**		**($529.9)**
Financial Plan Support for Restorations and Adds	4/1/25	Admin	($529.9)	Y	($529.9)
Total Global Cap			**($0.0)**		**$464.1**

Appendix C. Regional Spending Data

The chart below represents total provider spending that occurred within the Medicaid claiming system (eMedNY) through December 2025 for each region. These values represent physically where the services were provided, but not necessarily where the recipient of the services resides.

Medicaid Regional Spending ($ in millions)	
Economic Region	**Non-Federal Total Paid**
New York City	$19,257
Long Island	$3,119
Mid-Hudson	$3,077
Western	$1,395
Finger Lakes	$1,215
Capital District	$906
Central	$715
Mohawk Valley	$607
Southern Tier	$480
North Country	$355
Out of State	$503
TOTAL	**$31,629**

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
Hospital & Nursing Home VAPAP	$436
Net Hospital Advances	($88)
Supportive Housing	$42
Alzheimer's Caregiver Support	$21
Ryan White Clinics	$11
Rural Transportation	$8
End of AIDS	$7
Assisted Living Voucher Demo	$6
MLTC Ombudsman	$3
CSEA Buy-in	$2
ACA Federal Financial Participation Liability	$0
TOTAL	**$448**

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 required DOH to procure a single statewide fiscal intermediary, which has been established as of April 1, 2025.