NEW YORK STATE | Department of Health

Medicaid Global Spending Cap Report

April 2026 through September 2026 Quarterly Report

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Overview

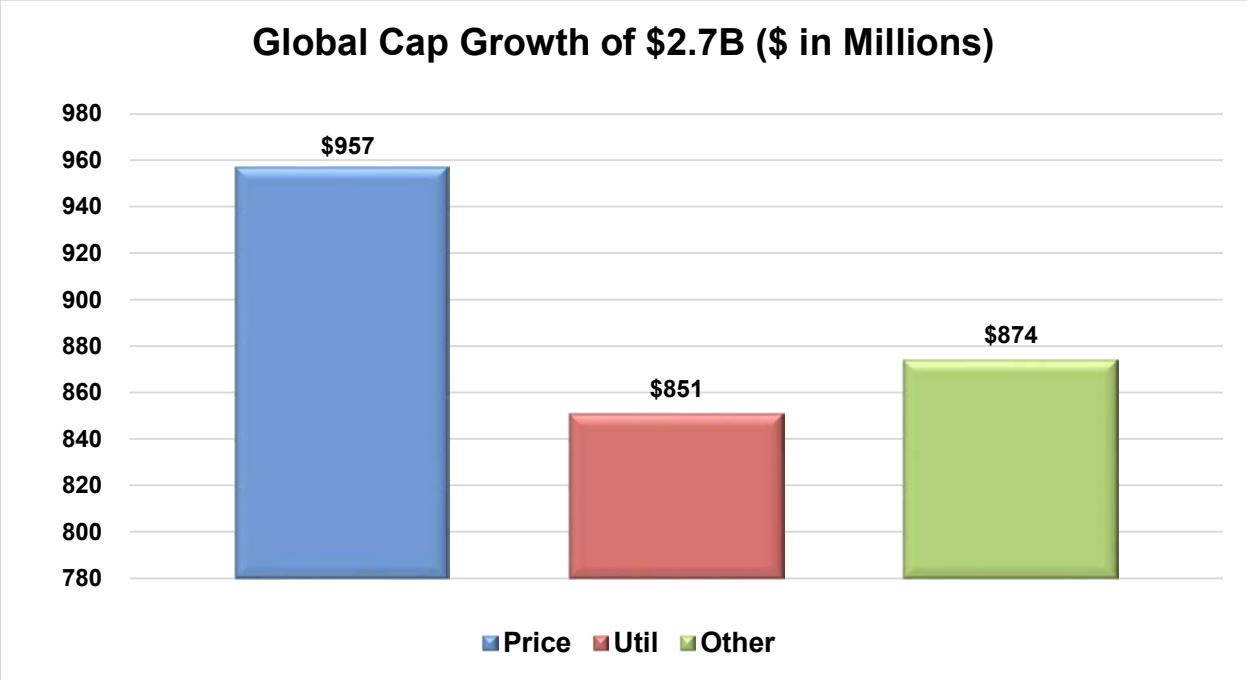
The Medicaid Global Spending Cap increased from $33.4 billion in FY 2026 to $36.1 billion in FY 2027, a net increase of $2.7 billion. The Global Cap growth index (8.0 percent for FY 2027) is based on the 5-year rolling average of the Medicaid annual growth rate within the National Health Expenditure 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 $2.1 billion; increased costs for minimum wage rate adjustments ($381M), and increases in funding for the takeover of local Medicaid growth ($183M).

Anticipated DOH Medicaid Spending Outside the Global Cap Index:

($ millions)	FY26	FY27	$ Change
Medicaid Global Cap Index	**$26,458**	**$28,576**	**$2,118**
DOH Medicaid Spending Outside of Global Cap Index	**$6,959**	**$7,523**	**$564**
Medicaid Local Growth Takeover	$2,195	$2,378	$183
Minimum Wage	$2,441	$2,451	$10
Home Care Minimum Wage	$1,794	$2,165	$371
Medicaid Administration/Other	$529	$529	$0
Total DOH Medicaid Global Cap Target	**$33,417**	**$36,099**	**$2,682**

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



Price ($957M): Components of price growth include:

- Increases in Pharmacy primarily driven by the increased availability and use of high-cost specialty drugs, such as GLP-1s and HIV prevention medications.

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

- Increases in premiums paid under Medicare Part A/B and Medicare Part D, also known as Clawback Part D. These increases reflect national trends in the healthcare use of the dual-eligible Medicaid/Medicare population, New York's specific Part D contribution increase is 16.5% per enrollee.
- Increases in Managed Long Term Care due to trend increases and an acuity adjustment to rates resulting from the two activities of daily living change that increased the acuity of members.
- Various increases for Fee-for-Service (FFS) rates, which are primarily related to increases included in the FY 2027 Enacted Budget or rates that were not fully implemented in FY 2026.

Utilization ($851M): The Medicaid Global Cap model assumes that Medicaid enrollment will increase by 16,798 New Yorkers or 0.3 percent, from 6.45 million enrollees as of March 2026 to 6.47 million enrollees by March 2027[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. Due to delays in Federal approval on capping enrollment, growth is expected to increase further before stabilizing in the out-years.
- Mainstream Managed Care enrollment including HIV Special Needs (SNPs) & Health and Recovery Plans (HARPs) is projected to decline by 8,874 individuals from March 2026 through the end of March 2027.
- Managed Long Term Care enrollment is projected to increase by 35,460 individuals from March 2026 through the end of March 2027. Managed Long Term Care is on average the costliest population within Medicaid.
- The total number of FFS recipients is expected to decrease by 9,788 individuals from March 2026 through March 2027.

Medicaid Redesign Team (MRT) II/One-Timers/Other ($874M): MRT budget actions, one-time costs/savings, or other payments that do not fall into price or utilization primarily consist of year-to-year changes in non-claims payments. They also include adjustments to the accounting mechanisms of Other State Agency Medicaid payments, cash management of offsets from discrete revenue sources, and timing of expected recoupments within the Medicaid program. Additionally, an anticipated loss in federal match related to certain qualified immigrants is expected to drive further growth.

[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 $36.1 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 spending categories begin with the number of eligible recipients at the end of the previous fiscal year and the average spending per recipient during that period. These baseline projections are then adjusted for anticipated rate (i.e., price) changes, transitions of populations or benefits to managed care, fluctuations in utilization (i.e., the volume and type of services), and any non-recurring or one-time payments or credits.

2. **Supplemental Programs:** Payments made through administrative or intergovernmental financial mechanisms occur **outside** the eMedNY billing system. These include 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 individually based on historical spending trends and/or latest programmatic information.

3. **Offsets:** Additional financial resources are used to offset State Medicaid spending. These offsets include Federal funding, audit collections, drug manufacturer rebates, enhanced funding for Child Health Plus, and local county contributions, all of which occur outside the eMedNY billing system. Each offset is projected individually based on historical spending trends and/or latest programmatic information.

Forecasting Methodology/Data:

- State Medicaid disbursements are forecasted on a cash basis and updated quarterly, consistent with the schedule for revising the State's Financial Plan.
- The Medicaid forecast evaluates all major spending categories using a specific approach, depending on whether expenditures are based on monthly Managed Care premiums or weekly fee-for-service payments.
- The forecast uses spending category specific data. This includes details on total paid claims and premiums, retroactive adjustments, caseloads, 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 generate time-series analyses.
- The models incorporate 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 demographic mix of the Medicaid population;
- Dynamics within the health care marketplace;
- Prescription drug pricing and product development by manufacturers;
- Complex reimbursement formulas which are themselves driven by variables such as length of hospital stays;
- Behavior and composition of recipients accessing services; and
- Litigation and legal rulings.

The State share of Medicaid spending is also dependent on two factors:

- Local government contributions toward Medicaid costs; and
- Federal funding levels, which are subject to federal statutory and administrative changes.

The following table outlines the FY 2027 Medicaid projections by major health care sector (i.e., category of spending) for Medicaid claims, supplemental programs, and offsets.

Enacted Budget Projected FY 2027 Medicaid Spending ($ in millions)				
Category of Spending	**Medicaid Claims**	**Supplemental Programs**	**Offsets**	**Total**
Medicaid Managed Care	**$22,017**	**$2,116**	**($3,517)**	**$20,616**
Mainstream Managed Care	$11,280	$1,588	($2,143)	$10,725
Managed Long Term Care	$10,737	$528	($1,374)	$9,891
Total Fee For Service	**$16,299**	**$1,704**	**($2,906)**	**$15,097**
Inpatient	$2,221	$1,264	($10)	$3,475
Outpatient/Emergency Room	$467	$2	($3)	$466
Clinic	$844	$160	($75)	$929
Nursing Homes	$3,543	$175	$0	$3,718
Personal Care	$2,276	$30	($38)	$2,268
Home Health	$480	$0	($13)	$467
Other Long Term Care	$233	$8	$0	$241
Pharmacy	$4,680	$3	($2,727)	$1,956
Transportation	$601	$62	($1)	$662
Non-Institutional	$954	$0	($39)	$915
Other State Agencies	**$6,004**	**$0**	**($6,127)**	**($123)**
Mental Hygiene Stabilization Fund (MHSF)	**$0**	**$1,441**	**$0**	**$1,441**
Medicare Part A/B & D	**$0**	**$4,707**	**$0**	**$4,707**
VAPAP	**$0**	**$724**	**$0**	**$724**
VAPAP Advances	**$0**	**$0**	**($91)**	**($91)**
All Other	**$421**	**$920**	**($679)**	**$662**
Medicaid Administration	**$0**	**$865**	**($153)**	**$712**
State Operations	**$0**	**$521**	**$0**	**$521**
Local Cap Contribution	**$0**	**$0**	**($7,634)**	**($7,634)**
Audit Collections	**$0**	**$0**	**($533)**	**($533)**
TOTAL	**$44,741**	**$12,998**	**($21,640)**	**$36,099**

Major Supplemental Programs:

Medicaid Managed Care ($2.1 billion)

- Mainstream Managed Care: 2 Percent Encounter Withhold Repayments and Directed Payment Template (DPT) payments for Financially Distressed, Safety Net, and Sole Community Hospitals, Patient Centered Medical Homes, and Office of the Medicaid Inspector General Encounter Reconciliation payments.
- Managed Long Term Care: 1.5 Percent Encounter Withhold Repayments; 3 Percent Enrollment Withhold Repayments.

Fee For Service ($1.7 billion)

- Inpatient: Disproportionate Share Hospital (DSH), 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). Certified Community Behavioral Health Clinic (CCBHC) Indigent Care Program.
- 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 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) ($724 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 funding may be available to hospitals meeting program eligibility requirements.
- Under Hospital VAPAP funding is directed to hospitals and health systems with serious financial instability. This extraordinary financial assistance enables 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 determines the need for VAPAP funds based on provider financial documentation, proposed plans for improving financial sustainability, and an assessment of the risk to vital community services in the absence of this assistance.

All Other ($920 million)

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

- The Safety Net Transformation Program: This program leverages partnerships with safety net facilities to implement critical operational improvements and to achieve long-term sustainability. Additional Safety Net Transformation funding, separate from Medicaid Global Cap funding, was provided in the Enacted Budget through the Healthcare Stability fund.
- HR1 / Federal Impacts: Increased costs reflect fiscal impacts associated with changes to eligibility and availability of federal matching funds under H.R. 1 and related federal Medicaid provisions

- Vital Access/Safety Net Provider Program: The Vital Access/Safety Net Provider Program (VAP) supports projects for facilities that were selected due to their severe financial condition and critical role in serving 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 primarily used to improve community care, such as expanding access to ambulatory services, opening urgent care centers, expanding services in rural areas, and delivering more effective services that meet community needs.
- Supportive Housing: This program ensures that certain high-risk Medicaid members have access to proper housing and supportive services.
- Remaining funding supports various miscellaneous programs including: NY Connects, Alzheimer's Caregiver Support, Ryan White Centers, End of AIDS and others.

Medicaid Administration ($865 million)

- The annual county Medicaid caps for Local Administration is projected to remain at their historic/current levels during FY 2027. However, county administration costs are anticipated to 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 transition 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 ($521 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 2027 budget was projected to total $521 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. As a result of the transition from the 1332 Waiver to the 1331 BHP, the Medicaid Global Cap is expected to see Essential Plan State Ops costs materialize in FY2027.

State Operations FY 2027 Budget ($ in millions)	
Service Costs	**Annual Budget**
Personal Services	**$78**
Medicaid	*$75*
Essential Plan	*$3*
Non-Personal Services	**$433**
Medicaid	*$340*
Essential Plan	*$93*
General State Charges	**$10**
TOTAL	**$521**

Major Offsets:

Medicaid Managed Care (-$3.5 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 initially paid through the Medicaid Global Cap and subsequently reimbursed.
- Health Related Social Needs (HRSN) initiatives approved under the State's 1115 waiver aim to integrate social care with physical and behavioral health care for Medicaid Members by establishing regional Social Care Networks (SCNs) to handle screening, navigation, and service delivery of HRSN services. While fully funded by the Federal Waiver, these costs are initially charged using the standard federal-state split in the first instance and are later credited as an offset once claims are reconciled.
- Healthcare Stability Fund: revenue received to offset costs that are paid out in the first instance from the Global Cap.
- 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 (-$2.9 billion)

Within Pharmacy, the Department collects Federally required (Omnibus Budget Reconciliation Act) and Supplemental rebates from drug manufacturers.

Other State Agencies (-$6.1 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).

All Other (-$679 million)

The FY 2027 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 (-$153 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 2027, local governments will have saved nearly $54 billion since FY 2016.

Net Hospital Advances (-$91 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 $91 million in FY 2027.

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) to recover 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 identifies inappropriately billed claims within Managed Care capitation payments and provider fee-for-service claims. To correct these errors, OMIG and DOH process the corrected claim, and reduce its payment by the inappropriate billing, thereby recouping the prior overpayment and reducing State spending. Beginning in FY 2017, void recoveries were integrated into audit collections to more accurately reflect cash accounting. These audit recoveries are used directly to offset Global Cap spending.

Results April through September 2026 – Global Cap Target vs. Actual Spending

Through September 2026, total actual Global Cap Medicaid spending was approximately $664 million below the Medicaid Global Spending Cap projection. Spending through September resulted in total expenditures of $21.3 billion compared to the projected cashflow of $21.9 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 2	Estimated	Actual	Variance	Percent
Managed Care	**$13,717**	**$13,181**	**($536)**	**-4%**
Mainstream Managed Care	$7,144	$6,690	($454)	-6%
Long Term Managed Care	$6,573	$6,491	($82)	-1%
Total Fee For Service	**$7,974**	**$7,836**	**($138)**	**-2%**
Inpatient	$1,815	$1,721	($94)	-5%
Outpatient/Emergency Room	$249	$235	($14)	-6%
Clinic	$529	$592	$63	12%
Nursing Homes	$1,909	$1,748	($161)	-8%
Personal Care	$1,202	$1,215	$13	1%
Home Health	$249	$262	$13	5%
Other Long Term Care	$125	$126	$1	1%
Pharmacy	$1,086	$1,118	$32	3%
Transportation	$332	$313	($19)	-6%
Non-Institutional	$478	$506	$28	6%
Other State Agencies	**$382**	**$268**	**($114)**	**-30%**
Mental Hygiene Stabilization Fund	**$360**	**$360**	**$0**	**0%**
Medicare Part A/B & D	**$2,270**	**$2,255**	**($15)**	**-1%**
VAPAP	**$407**	**$615**	**$208**	**51%**
VAPAP Advances	**($42)**	**($53)**	**($11)**	**26%**
All Other	**$394**	**$122**	**($272)**	**-69%**
Medicaid Administration Costs	**$488**	**$564**	**$76**	**16%**
State Operations	**$229**	**$252**	**$23**	**10%**
Local Funding Offset	**($3,964)**	**($3,964)**	**$0**	**0%**
Medicaid Audits	**($267)**	**($152)**	**$115**	**-43%**
TOTAL	**$21,948**	**$21,284**	**($664)**	**-3%**

The following explanations detail the significant variances between the Global Cap Target through September 2026 and the actual spending.

Medicaid Managed Care:

Medicaid spending in major Managed Care categories was $536 million, or 4 percent, under anticipated spending.

- Mainstream Managed Care spending was $454 million, or 6 percent under anticipated spending due to lower than expected claims, partially driven by lower overall enrollment, and greater than expected federal CHP credits.
- Managed Long Term Care was $82 million, or 1 percent under anticipated spending, which was primarily due to slower growth in enrollment and delays in processing of the Enrollment cap withhold.

Fee-For-Service:

Medicaid spending in major fee-for-service categories was $138 million, or 2 percent, under target.

- Inpatient $94 million, or 5 percent under due to the timing of certain budget action investments.
- Nursing Homes $161 million or 8 percent under anticipated spending due to timing of offline payments (Nursing Home Appeals) as well as the timing of implementation of certain investments.
- Clinic was $63 million, or 12 percent over anticipated spending due to growth in Certified Behavioral Health Clinics (CCBHCs) and other Behavioral Health clinic spending.

Other State Agencies:

Other State Agency spending was $114 million lower than expected as a result of the timing of offsets that shift Medicaid Mental Hygiene costs from the Medicaid Global Cap to the Mental Hygiene budgets of the Financial Plan.

VAPAP:

VAPAP was $208 million, or 51 percent over expected levels as a result of funding and cashflow constraints with financially distressed providers, largely due to higher than budgeted need and delays in federal VAP and other federal payments.

All Other:

All other was $272 million, or 69 percent under expected levels as a result of the timing of credits, supplemental payments, and delays in contracting agreements related to the Safety Net Transformation Program.

Medicaid Administration Costs:

Medicaid Administration was $76 million, or 16 percent higher, 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 are charged against State funds in the first instance until the NYHER Waiver Federal funding can be claimed and adjudicated within the fiscal year. Additionally, increased costs from local districts have contributed to overspending, despite the State taking over the remaining administrative functions from the districts.

Medicaid Audits:

Medicaid audits were $115 million, or 43 percent under, primarily due to OMIG entering audit periods of COVID years, in which program utilization was suppressed leading to lower claim volume.

State Operations

State Operations exceeded projections by $23 million, or 10 percent, which was primarily due to the timing in processing contractual payments.

Enrollment

Medicaid total enrollment reached 6,370,899 enrollees at the end of September 2026, a net decrease of 84,487 from March 2026.

Mainstream Managed Care (includes HIV/SNPS and HARPs): Mainstream Managed Care enrollment in September 2026 reached 4,406,554 enrollees, a net decrease of 84,898 from March 2026. This includes a decline in enrollment for individuals under the age of 5 whose eligibility was redetermined following the end of the continuous coverage in July 2026.

Managed Long Term Care (includes Medicaid Advantage Plus, PACE and Partial Capitation): MLTC enrollment reached 371,111 at the end of September 2026, a net increase of 2,415 individuals from March 2026.

Medicaid Enrollment Summary Medicaid Managed Care vs Fee-for-Service				
	March 2026	**September 2026**	**Net Increase / (Decrease)**	**% Change**
Mainstream Managed Care	4,491,452	4,406,554	(84,898)	(1.89%)
Managed Long Term Care	368,696	371,111	2,415	0.66%
Fee-For-Service	1,595,238	1,593,234	(2,004)	(0.13%)
TOTAL	**6,455,386**	**6,370,899**	**(84,487)**	**(1.31%)**

Medicaid Enrollment Summary by NYC vs Rest of State				
	March 2026	**September 2026**	**Net Increase / (Decrease)**	**% Change**
NYC	3,663,931	3,604,701	(59,230)	(1.62%)
Rest of State	2,791,455	2,766,198	(25,257)	(0.90%)
TOTAL	**6,455,386**	**6,370,899**	**(84,487)**	**(1.31%)**

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 significantly altered Federal assistance for critical support programs that provide services to New York families and individuals. Beginning January 1, 2026, certain non-citizen populations were disqualified from obtaining premium tax credits, which eliminated the Federal funding received for this population in the EP. Due to this reduction in programmatic funding, the EP was no longer able to operate under the 1332 Waiver, generating a fiscal risk as individuals with incomes below 138 percent of the Federal Poverty Level (FPL), pregnant/post-partum individuals, and Deferred Action for Childhood Arrivals individuals who qualified and were enrolled in the EP under the 1332 Waiver but are also eligible for Medicaid could have 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 submitted a request to the 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). This request was approved by CMS effective July 1, 2026, temporarily delaying certain state-only Medicaid costs.

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 once every six months to maintain eligibility or earn an equivalent income at the federal minimum wage ($580). Exempted recipients include, but are not limited to, pregnant women, people with disabilities, and caregivers of young children. 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.

Medicaid Funding: Federal funding for Medicaid, authorized under NYS 1115 demonstration waiver, is subject to review by CMS every five years The State is currently in the process of requesting an extension of the 1115 waiver, which is set to expire on March 31, 2027. The required state public comment period closed on August 21, with over 200 comments received largely in support of the waiver and continuing services. The final extension request was submitted to CMS in September 2026. The 1115 waiver supports the managed care and managed long-term care programs, HRSN services, and workforce initiatives among other services and programs.

Appendix A. Inventory of Rate Packages

Below are the largest rate packages processed in FY 2027 so far:

Category of Service	Rate Package Description	Month Paid
Managed Care	Mainstream Initial Rates FY 2027	July
	HARP Initial Rates FY 2027	July
	HIV SNP Initial Rates FY 2027	July
	IMD Per Diem Rates FY 2027	August
	Mainstream Supplemental Rates FY 2026	
	HIV SNP Supplemental Rates FY 2026	April
	HARP Supplemental Rates FY2026	
Managed Long Term Care	MAP Initial Rates FY 2027	May
	Partial Cap Initial Rates FY 2027	May
	PACE Initial Rates FY 2027	July
	PACE Supplemental Rates FY 2026	May
	Partial Cap FY 2026 Final Rates	
	MAP Final Rates FY 2027	
	Partial Cap Supplemental Rates FY 2027	
	MAP Supplemental Rates FY 2027	
Inpatient	Statewide Inpatient Rates CY 2026	September
	Statewide Inpatient Rates CY 2025	June
	Acute & Exempt Unit Inpatient Rates CY 2025	August
	Final State DSH IGT Reconciliation CY 2022	August
	Inpatient Rate Increase 7.5% FY 2024	September
	ATB Inpatient Rate Increase CY 2026	
Outpatient / Emergency Room	Hospital APG Capital Updates CY 2026	September
	PROS Capital Update CY 2022 - CY 2025	May
	FQHC Rates Update based on MEI CY 2026	
	ATB Hospital Rate Increase CY2026	
Clinic	Minimum Wage add-on CY 2023	September
	APG Capital Update CY 2021-CY 2024	August
	FQHC Appeal Wrap Rate Updates CY 2025	September
	Wrap Audit CY 2016-CY 2018	September
	FQHC NYRx Reinvestment Payment CY2026	June
Nursing Homes	NH Initial Rates CY 2025	August
	NH Initial Rates CY 2026	
	NH UPL CY 2025	July
	CRA Reconciliation CY 2024	July
	NHQP CY 2024	
Personal Care	Personal Care/CDPAP NYC HRA Rates CY 2024	June
	Personal Care/CDPAP Rates CY 2025	September
	FFS Personal Care and CDPAP Rates CY 2024	April

Appendix B. FY 2027 Enacted Budget

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

Below is a condensed version of the FY 2027 Enacted Scorecard which focuses on budget actions anticipated to be implemented in FY 2027. Any lost savings or availed spending will be accommodated within the Medicaid Global Cap.

(State Share - $ in millions)	Eff. Date	Art. VII/ Admin	FY 2027	Implemented - Y/N	Achieved Amount
Global Cap Forecast (Surplus) / Deficit			**$131.4**		**$131.4**
Signed Legislation			**$1.3**		**$0.0**
3 Day Buprenorphine	2/19/2026	Leg	$1.3	N	$0.0
Federal Impacts (H.R. 1)	7/4/2025	Admin	**$504.0**	N	**$0.0**
Global Cap Metric Update	4/1/2023	Admin	**($715.7)**	Y	**($715.7)**
Executive Base (Surplus) / Deficit			**($79.0)**		**($584.3)**
Budget Actions			**($98.0)**		**($70.0)**
Other Long-Term Care Actions			**($7.5)**		**$0.0**
Aligning Personal Care FFS Admin Reimbursement	4/1/2026	Admin	($7.5)	N	$0.0
Managed Care Actions			**($92.2)**		**($50.0)**
Carve Out Medicaid from the IDR Process	4/1/2026	Art. VII	($28.5)	Y	$0.0
Applied Behavioral Analysis Reforms	10/1/2026	Admin	($13.7)	N	$0.0
Amend Biomarker Coverage	4/1/2026	Art. VII	($50.0)	Y	($50.0)
Nursing Home Actions			**$8.8**		**($20.0)**
Re-allocate Nursing Home VAPAP	4/1/2026	Admin	($20.0)	Y	($20.0)
Restore Capital Rate	4/1/2026	Art. VII	$28.8	N	$0.0
Other Actions			**($7.1)**		**$0.0**
Medicaid Enterprise Client Management System	4/1/2026	Admin	$17.9	N	$0.0
Reduce Cross-over Payments	4/1/2027	Art. VII	$0.0	N	$0.0
NYRx Enhanced Rebate Purchasing Pool	4/1/2026	Admin	($25.0)	Y	$0.0
Total Global Cap (Surplus) / Deficit			**($177.0)**		**($654.3)**
Legislative Adds			**$500.0**		**$500.0**
Pediatric Clinic Rate Extension	4/1/2027	Art VII	$0.0	N	$0.0
Financially Distressed Hospitals	4/1/2026	Admin	$500.0	Y	$500.0
Timing of Payments and Financial Plan Support		**Admin**	**($323.0)**	N	$0.0
Total Global Cap (Surplus) / Deficit			**$0.0**		**($154.3)**

Appendix C. Regional Spending Data

The chart below represents total provider spending that occurred within the Medicaid claiming system (eMedNY) through September 2026 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	$11,961
Long Island	$1,937
Mid-Hudson	$1,883
Western	$869
Finger Lakes	$735
Capital District	$550
Central	$443
Mohawk Valley	$373
Southern Tier	$299
North Country	$223
Out of State	$308
TOTAL	**$19,581**

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	$615
Net Hospital Advances	($53)
Supportive Housing	$39
Alzheimer's Caregiver Support	$10
Ryan White Clinics	$8
End of AIDS	$6
Assisted Living Voucher Demo	$4
MLTC Ombudsman	$4
CSEA Buy-in	$2
Rural Transportation	$2
TOTAL	**$637**

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.

Appendix F. Results April through June 2026 – Global Cap Target vs. Actual Spending

Medicaid spending was $817 million below forecasted expenditures through June due to the following factors:

- Managed Care and Long Term Managed Care was lower due to delayed billings from plans to the state, it has normalized post quarter 1.
- Fee For Service was higher than projected primarily due to timing in Inpatient from SUNY IGT DSH payments that occurred earlier than expected.
- VAPAP was delayed due to timing of the budget.

Quarter 1	Estimated	Actual	Variance*	Percent
Managed Care	**$7,229**	**$6,452**	**($777)**	**-11%**
Mainstream Managed Care	$3,788	$3,453	($335)	-9%
Long Term Managed Care	$3,441	$2,999	($442)	-13%
Total Fee For Service	**$3,713**	**$3,919**	**$206**	**6%**
Inpatient	$699	$891	$192	27%
Outpatient/Emergency Room	$114	$118	$4	4%
Clinic	$325	$344	$19	6%
Nursing Homes	$838	$853	$15	2%
Personal Care	$615	$583	($32)	-5%
Home Health	$120	$118	($2)	-2%
Other Long Term Care	$61	$61	$0	0%
Pharmacy	$554	$552	($2)	0%
Transportation	$156	$149	($7)	-4%
Non-Institutional	$231	$250	$19	8%
Other State Agencies	**($14)**	**($38)**	**($24)**	**171%**
Mental Hygiene Stabilization Fund	**$360**	**$360**	**$0**	**0%**
Medicare Part A/B & D	**$1,126**	**$1,124**	**($2)**	**0%**
VAPAP	**$248**	**$90**	**($158)**	**-64%**
VAPAP Advances	**($18)**	**($26)**	**($8)**	**44%**
All Other	**$224**	**$116**	**($108)**	**-48%**
Medicaid Administration Costs	**$238**	**$220**	**($18)**	**-8%**
State Operations	**$84**	**$107**	**$23**	**27%**
Local Funding Offset	**($1,908)**	**($1,908)**	**$0**	**0%**
Medicaid Audits	**($133)**	**($84)**	**$49**	**-37%**
TOTAL	**$11,149**	**$10,332**	**($817)**	**-7%**

* 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.