NEW YORK STATE | Department of Health

Medicaid Global Spending Cap Report

April 2023 through March 2024 Quarterly Report

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Overview

The Department of Health (DOH) and the Division of the Budget (DOB) report that spending for the Fiscal Year (FY) 2024 Medicaid Global Spending Cap was approximately $300,000 (or 0.001%) below the $28.3 billion target.

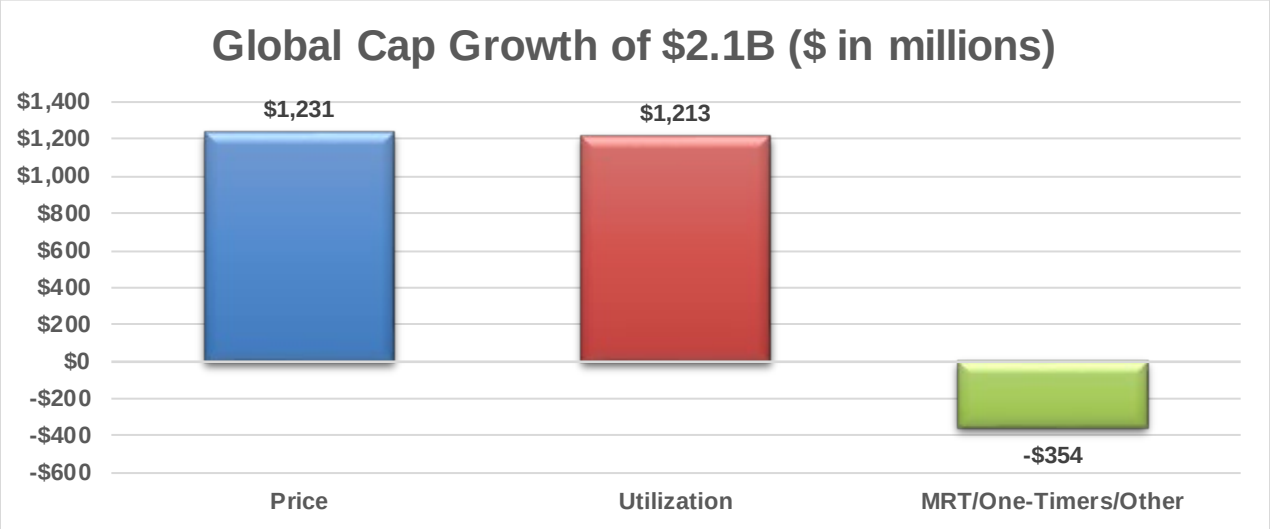
The Medicaid Global Spending Cap increased from $26.2 billion in FY 2023 to $28.3 billion in FY 2024, a net increase of $2.1 billion. The Global Cap growth index (6.9% for FY 2024) is based on the 5-year rolling average of the Medicaid annual growth rate within the National Health Expenditure Accounts produced by the Office of the Actuary in the Centers for Medicare and Medicaid Services (CMS).[1]

Overall, the year-to-year increase of $2.1 billion primarily includes the updated Global Cap index growth of $1.5 billion; increased costs for minimum wage rate adjustments ($190M), and Home Care minimum wage adjustments ($554M), which are partially offset by Home and Community Based Services (HCBS) enhanced Federal Medical Assistance Percentage (eFMAP) (-$340M).

Anticipated DOH Medicaid Spending Outside the Global Cap Index:

($ millions)	FY23	FY24	$ Change
Medicaid Global Cap Index	**$21,762**	**$23,265**	**$1,504**
DOH Medicaid Spending Outside of Global Cap Index	**$4,399**	**$4,986**	**$587**
Medicaid Local Growth Takeover	$1,648	$1,830	$183
Minimum Wage	$2,223	$2,413	$190
Home Care Minimum Wage	$363	$916	$554
Use of HCBS eFMAP	($363)	($702)	($340)
Medicaid Administration/Other	$528	$528	$0
Total DOH Medicaid Global Cap Target	**$26,161**	**$28,251**	**$2,090**

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



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

Price ($1.2B): Components of price growth include:

- Trend increases for Mainstream Managed Care rates ($75M);
- Trend increases for Managed Long Term Care rates ($310M);
- Minimum Wage increases (including Home Care) ($144M); and
- Various increases for Fee-for-Service (FFS) rates, which are primarily related to the Across-the-Board (ATB) increases included in the FY 2024 Enacted Budget ($702M).

Utilization ($1.2B): The Medicaid Global Cap assumed that Medicaid enrollment was projected to decrease by 836,306 New Yorkers or 10.5 percent, from 7.9 million enrollees as of March 2023 to 7.1 million enrollees by March 2024[2]. This decrease in enrollment is in large part due to the ending of the COVID-19 pandemic public health emergency (PHE); however, Managed Care enrollment costs are continuing to increase as result 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) were projected to increase by 74,553 individuals from March 2023 through the end of June 2023.
- Managed Long Term Care enrollment was projected to increase by 34,486 individuals (11.3 percent), which is on average the costliest population within Medicaid; and
- Due to the expiration of the PHE in June 2023, the total number of FFS recipients were expected to decrease by 187,657 by March 2024.

Medicaid Redesign Team (MRT) II/One-Timers/Other (-$354M): MRT budget actions, one-time costs/savings, or other payments that do not fall into price or utilization primarily include:

- Local Cap Contribution (-$663M) adjustments related to the FY 2024 Enacted Budget actions; and
- SMI Part A/B & Clawback Part D payments ($286M) related to price and utilization increases.

[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 $28.3 billion projected Medicaid State Funds Spending can be organized into three major components:

1. **Medicaid Claims:** Health care provider claim spending reflects the cost of FFS care and Managed Care capitation payments based on the price and utilization of services by sector (i.e., categories of spending) of the Medicaid program (e.g., hospitals, nursing homes, managed care, long-term care, pharmacy, transportation, etc.). These payments occur weekly **within** the Medicaid claiming system (eMedNY).

   Projections for most categories of spending begin with the number of eligible recipients reported at the end of the previous fiscal year and the average spending per recipient for that period. Adjustments to spending projections are then made for anticipated rate (i.e., price) changes, transitions of populations/benefits to managed care (if any), fluctuations in the amount and type of service units (i.e., utilization), and any non- recurring or one-time payments/credits.

2. **Supplemental Programs:** Payments through administrative or intergovernmental financial mechanisms occur **outside** the eMedNY billing system, such as Disproportionate Share Hospital (DSH), Upper Payment Limit (UPL), Medicare Clawback Part D, Medicare Supplemental Medical Insurance (SMI) Part A/B, Medicaid Local District Social Services Administration and State Operations. These supplemental programs are projected on an individual basis according to their historical spending trends and/or latest programmatic information.

3. **Offsets:** Additional financial resources are used to offset State Medicaid, such as additional Federal funding, audit collections, drug manufacturer rebates, and Local County contributions, all of which also occur outside the eMedNY billing system. These offsets are projected on an individual basis according to their historical spending trends and/or latest programmatic information.

Forecasting Methodology/Data:

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

Factors Impacting the Medicaid Forecast:

Medicaid spending is determined by:

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

Medicaid price and utilization are influenced by a multitude of factors, including:

- Economic conditions;
- 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 2024 Medicaid projections by major health care sector (i.e., category of spending) for Medicaid claims, supplemental programs, and offsets.

Projected FY 2024 Medicaid Spending ($ in millions)				
Category of Spending	**Medicaid Claims**	**Supplemental Programs**	**Offsets**	**Total**
Medicaid Managed Care	**$21,506**	**$2,570**	**($1,226)**	**$22,850**
Mainstream Managed Care	$11,924	$2,031	($494)	$13,461
Managed Long Term Care	$9,582	$539	($732)	$9,389
Total Fee-For-Service	**$12,082**	**$1,476**	**($2,190)**	**$11,367**
Inpatient	$1,977	$1,100	($27)	$3,050
Outpatient/Emergency Room	$376	$2	($3)	$375
Clinic	$600	$140	($65)	$675
Nursing Homes	$3,428	$146	$0	$3,573
Personal Care	$905	$28	($15)	$918
Home Health	$183	$0	($12)	$171
Other Long Term Care	$199	$8	$0	$207
Pharmacy	$3,224	$3	($1,975)	$1,252
Transportation	$378	$50	($1)	$427
Non-Institutional	$812	$0	($91)	$720
Other State Agencies	**$4,600**	**$0**	**($3,178)**	**$1,421**
Mental Hygiene Stabilization Fund (MHSF)	**$0**	**$0**	**($2,091)**	**($2,091)**
Medicare Part A/B & D	**$0**	**$3,278**	**$0**	**$3,278**
VAPAP	**$0**	**$919**	**$0**	**$919**
Net Hospital Advances	**$0**	**$0**	**($212)**	**($212)**
All Other	**$17**	**$1,161**	**($1,743)**	**($565)**
Medicaid Administration	**$0**	**$560**	**$0**	**$560**
State Operations	**$0**	**$444**	**$0**	**$444**
Local Cap Contribution	**$0**	**$0**	**($7,229)**	**($7,229)**
COVID-19 eFMAP	**$0**	**$0**	**($2,060)**	**($2,060)**
Audit Collections	**$0**	**$0**	**($433)**	**($433)**
TOTAL	$38,204	$10,409	($20,362)	$28,251

Major Supplemental Programs:

Medicaid Managed Care ($2.6 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 ($1.5 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

- Other Long Term Care: Assisted Living Demonstration Vouchers, and Traumatic Brain Injury (TBI) and Nursing Home Transition and Diversion (NHTD) payments.
- Transportation: Transportation Management Initiative, Supplemental Ambulance, and Rural Transportation Investments.

Medicare SMI Part A/B & Clawback Part D ($3.3 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) ($919 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:

- Health Care Worker Bonus ($660 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 2024. 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.
- Supportive Housing ($78 million): The Supportive Housing Initiative seeks to ensure that Medicaid members have proper housing and supportive services.

Medicaid Administration ($560 million)

The annual county Medicaid caps for Local Administration was projected to remain at their historic/current levels during FY 2024, 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 ($444 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 2024 Budget was projected to total $444 million which also includes Essential Plan administration costs. Contracts for the Enrollment Center, the NYSOH Customer Service Center, eMedNY/MMIS, and various MRT initiatives comprise a significant portion of the total non-personal service budget.

State Operations FY 2024 Budget ($ in millions)	
Service Costs	**Annual Budget**
Personal Services	**$64**
Medicaid	*$59*
Essential Plan	*$5*
Non-Personal Services	**$380**
Medicaid	*$294*
Essential Plan	*$86*
TOTAL	**$444**

Major Offsets:

Medicaid Managed Care (-$1.2 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 (-$2.2 billion)

- Pharmacy: 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 (-$5.3 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 Net Hospital Advances resulted in $1.1 billion in additional Medicaid spending in FY 2024 that required offsetting Financial Plan support through the MHSF.

All Other (-$1.7 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 (-$1.3 billion) 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, Undocumented Pregnant Women, and School Supportive Health Services.

Net Hospital Advances (-$212 million)

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. It was initially projected that any advances in FY 2024 would be recouped in FY 2024 as well with $212 million being recouped for prior year advances.

Local Cap Contribution (-$7.2 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 reduced in FY 2024 to account for the sharing of eFMAP.

COVID-19 eFMAP (-$2.1 billion)

Refer to the “Impact of the COVID-19 Pandemic” section for additional details.

Audit Collections (-$433 million)

The Department of Health collaborates with the Office of the 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 2023 through March 2024 – Global Cap Target vs. Actual Spending

Through March 2024, total actual State Medicaid spending was approximately $300,000 below the Medicaid Global Spending Cap projection. Spending through March resulted in total expenditures of $28.3 billion compared to the allowable spending target of $28.3 billion.

April to March 2024 Medicaid Global Cap Target vs. Actual Spending ($ in millions)				
Category of Spending	**Global Cap Target**	**Actual**	**$ Variance Over / (Under)**	**% Variance Over / (Under)**
Managed Care	**$22,850**	**$22,013**	**($837)**	**-4%**
Mainstream Managed Care	$13,461	$13,148	($312)	-2%
Long Term Managed Care	$9,389	$8,865	($524)	-6%
Total Fee For Service	**$11,367**	**$11,107**	**($260)**	**-2%**
Inpatient	$3,050	$2,956	($93)	-3%
Outpatient/Emergency Room	$375	$343	($32)	-9%
Clinic	$675	$621	($54)	-8%
Nursing Homes	$3,573	$3,425	($148)	-4%
Personal Care	$918	$928	$10	1%
Home Health	$171	$182	$11	7%
Other Long Term Care	$207	$210	$4	2%
Pharmacy	$1,252	$1,286	$34	3%
Transportation	$427	$405	($22)	-5%
Non-Institutional	$720	$751	$30	4%
Other State Agencies	**$1,421**	**$1,405**	**($16)**	**-1%**
Mental Hygiene Stabilization Fund	**($2,091)**	**($1,536)**	**$555**	**-27%**
Medicare Part A/B & D	**$3,278**	**$3,564**	**$286**	**9%**
VAPAP	**$919**	**$683**	**($236)**	**-26%**
Net Hospital Advances	**($212)**	**$171**	**$383**	**-181%**
All Other	**($649)**	**($671)**	**($22)**	**3%**
Global Hospital Initiative	**$85**	**$275**	**$190**	**224%**
Medicaid Administration Costs	**$560**	**$605**	**$45**	**8%**
State Ops w/ EP	**$444**	**$385**	**($60)**	**-13%**
Local Funding Offset	**($7,229)**	**($7,229)**	**($0)**	**0%**
COVID eFMAP	**($2,060)**	**($2,060)**	**$0**	**0%**
Medicaid Audits	**($433)**	**($461)**	**($28)**	**7%**
TOTAL	**$28,251**	**$28,251**	**($0.3)**	**0%**

The category specific underspending detailed in the chart above resulted in the availability of additional one-time resources within the Global Spending Cap to manage the timing of certain payments and credits across fiscal years.

These end-of-fiscal year actions included items such as shifting Federal credits into FY 2025 (e.g. HCBS eFMAP), and executing pre-payments of FY 2024 liabilities (e.g., ACA Federal Financial Participation liability, Medicare Clawback Part D, and SMI). These actions represent payment advances, not deferrals, and did not impact deferrals (i.e., the cycle deferral for Managed Care Organizations) previously assumed. Further, these actions freed up out-year resources within the Global Spending Cap to support additional program costs in FY 2025.

The following explanations regarding the variances between the Global Cap Target through March and the actual spending are reserved for significant variances with the understanding that small variances do not require an explanation and equate to "being on target."

Medicaid Managed Care

Medicaid spending in major Managed Care categories was $837 million, or 3.7 percent, under anticipated spending.

- Mainstream Managed Care was $312 million, or 2.3 percent, under anticipated spending, which is primarily due to changes in the population mix. There are more single childless adults (who are eligible for enhanced FMAP) than expected, resulting in a lower non-federal share.
- Managed Long Term Care was $524 million, or 5.6 percent under anticipated spending. This is primarily due deferring a higher than expected March 2024 MLTC cycle payment into FY 2025, partially offset by excess enrollment projections.

Fee-For-Service

Medicaid spending in major fee-for-service categories was $260 million, or 2.3 percent, under target.

- Inpatient was $93 million, or 3.1 percent, under target, which is primarily due to lower than anticipated claims spending and a cyber-attack in February 2024 that impacted provider's ability to submit claims during that period.
- Outpatient/Emergency Room was $32 million, or 8.6 percent, under target, primarily due to lower than anticipated claims spending and the cyber-attack impact.
- Clinic was $54 million, or 8 percent, under target, primarily due to lower than anticipated claims spending, delayed implementation of budget actions, and the cyber-attack.
- Nursing Homes was $148 million, or 4.1 percent, under anticipated spending, largely due to the timing of rate packages.

Mental Hygiene Stabilization Fund (MHSF)

MHSF credits to the Global Cap were under projections ($555M) primarily attributable to the following closeout actions.

- Healthcare Worker Bonus ($230 million) – Funding was entirely supported with Financial Plan resources, and therefore underspending in this program was returned to the Financial Plan.
- Medical Loss Ratio (MLR)/Behavior Health Expenditure Target (BHET) Recoupments ($165M) – Returning plan recoupments related to behavioral health underspending to the Financial Plan to support other Mental Hygiene behavioral health programs. These funds were recouped from managed care plans for underutilizing behavioral health investment funding.

Medicare Part A/B & D

Medicare Part A/B & D was $286 million, or 8.7 percent over budget, which was the direct result of the State accelerating the payment of related invoices from the Federal government.

VAPAP

VAPAP underspent projections by $236 million, or 25.7 percent. A portion of VAPAP funding was reallocated to provide support for the State share of the Global Hospital Budgeting Initiative under the 1115 waiver amendment.

Net Hospital Advances

Net Hospital Advances under collected and overspent by $383 million, which is directly related to the timing of the recoupment of prior-year Net Hospital Advances and additional advances being made in FY 2024.

All Other

All Other spending underspent by $22 million, or 3 percent primarily related to the timing of ARPA HCBS credits and the pre-payment of the Affordable Care Act (ACA) Federal Financial Participation liabilities at closeout.

Medicaid Administration Costs

Medicaid Administration was $45 million, or 8.0 percent, over projected spending through March, resulting from delayed efficiency savings caused by delays in the State Takeover of Local District administration functions.

State Operations

OHIP State Operations underspent projections by $60 million, or 13.4 percent, which was primarily due to efficiency savings related to New York State of Health Exchange contract implementation.

Audit Collections

Audit collections received were $28 million, or 6.6 percent, above projections through March, which is due to the closeout of several contracts resulting in the processing of large recovery amounts in March.

Enrollment

Medicaid total enrollment reached 7,292,559 enrollees at the end of March 2024, a net decrease of 635,503 from March 2023. Overall enrollment exceeded projections by 198,257 individuals, which is in large part due to higher than expected enrollment throughout the COVID-19 PHE Unwind.

Mainstream Managed Care (includes HIV/SNPS and HARPs): Mainstream Managed Care enrollment in March 2024 reached 5,052,076 enrollees, a net decrease of 694,655 from March 2023, but higher than projected by 9,429.

Managed Long Term Care (includes Medicaid Advantage Plus, PACE and Partial Capitation): Managed Long Term Care (MLTC) enrollment reached 343,846 at the end of March 2024, a net increase of 35,520 individuals from March 2023, which was relatively on target compared to projections.

Medicaid Enrollment to Date

Medicaid Enrollment Summary Medicaid Managed Care vs Fee-for-Service				
	March 2023	**March 2024**	**Net Increase / (Decrease)**	**% Change**
Mainstream Managed Care	5,746,731	5,052,076	(694,655)	(12.1%)
Managed Long Term Care	308,326	343,846	35,520	11.5%
Fee-For-Service	1,873,005	1,896,637	23,632	1.3%
TOTAL	**7,928,062**	**7,292,559**	**(635,503)**	**(8.0%)**

Medicaid Enrollment Summary by NYC vs Rest of State				
	March 2023	**March 2024**	**Net Increase / (Decrease)**	**% Change**
NYC	4.510,880	4,242,412	(268,468)	(6.0%)
Rest of State	3,417,182	3,050,147	(367,035)	(10.7%)
TOTAL	**7,928,062**	**7,292,559**	**(635,503)**	**(8.0%)**

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 2023 through March 2024 based on data pulled March 2024.

Impact of the COVID-19 Pandemic

In response to the COVID-19 pandemic, the Federal government increased its share of Medicaid funding (i.e. eFMAP) by 6.2 percent, for each calendar quarter occurring during the Federal public health emergency declared by the Secretary of Health and Human Services (HHS). The enhanced funding began January 1, 2020, and continued at a reduced rate through December 31, 2023, as illustrated below.[3] Certain expenditures, including those for the Medicaid expansion population already eligible for enhanced federal match under the Affordable Care Act (ACA), and certain medical services already eligible for an enhanced Federal match, did not qualify for the eFMAP.[4]

- Q1: January 1 – March 31, 2023: 6.2 percent
- Q2: April 1 – June 30, 2023: 5.0 percent
- Q3: July 1 – September 30, 2023: 2.5 percent
- Q4: October 1 – December 31, 2023: 1.5 percent

The additional Federal resources reduced State and Local government costs and helped support the significant increase in Medicaid enrollment that resulted, in large part, from individuals losing income and/or job-related insurance coverage because of the COVID-19 pandemic. Due to Federal maintenance of effort (MOE) requirements under the Families First Coronavirus Response Act (FFCRA), states were precluded from terminating an individual's Medicaid enrollment, except in very limited circumstances (e.g., death, moving out of state, voluntary termination, etc.), and were also precluded from making any changes in the amount, duration, and scope of Medicaid benefits, as a condition of receiving eFMAP.

The following table provides projected and actual COVID-19 eFMAP fiscal impacts. There is a year-to-year decrease of eFMAP due to the claiming at 6.2% eFMAP in FY 2023 versus reduced rates throughout FY 2024.

COVID-19 eFMAP ($ in millions)			
	FY 2023	**FY 2024**	**Annual Change**
State Share	$3,652	$1,703	($1,949)
Local Share	$789	$357	($432)
Total eFMAP	**$4,441**	**$2,060**	**($2,381)**

Enrollment Changes:

The FY 2024 Executive Financial Plan reflects the extension of the PHE as outlined in the HHS guidelines[5]. This assumed that enrollment levels would start to return to near pre-pandemic levels in FY 2024, with expected enrollment to be at 7.1 million in March 2024. As the economy recovers and unemployment trends towards pre-pandemic levels, costs associated with individuals temporarily enrolled, but entitled to twelve months of continuous coverage, continued through the end of FY 2023, and were expected to decline in FY 2024.

The COVID-19 pandemic resulted in the most significant one-year increase in Medicaid enrollment since the inception of the program. Increased enrollment resulted as individuals lost income and/or job-related insurance coverage and as the State was required to suspend termination of eligibility under Federal law as a condition of receiving eFMAP.

[3] *HHS ended the PHE effective May 11, 2023.*
[4] *The ACA's Medicaid provisions allows New York to utilize Federal funding (90% Federal Share) to expand Medicaid to single and childless adults with incomes up to 138 percent of the Federal Poverty Limit.*
[5] *CMS published guidance for the unwind of the Public Health Emergency and eFMAP on January 31, 2023.* https://www.medicaid.gov/federal-policy-guidance/downloads/sho23002.pdf

Between March 2020, when the Federal public emergency was declared by the Secretary of HHS, and June 2023, prior to the PHE unwind, Medicaid enrollment increased by 1.9 million. A month-by-month summary of Medicaid enrollment can be found at: NYS Medicaid Enrollment Databook.

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.

Extension of the Public Health Emergency (PHE): The Secretary of Human Services extended the COVID-19 PHE through May 11, 2023. The extension of the PHE (and COVID-19 eFMAP) was accompanied by cost increases for enrollees whose coverage had been extended due to the CMS MOE provisions in the FFCRA, as well as the State's 12-month continuous coverage mandate.

On December 29, 2022, the Consolidated Appropriations Act was signed into law. This legislation made the expiration of the continuous enrollment requirement separate from the end of the COVID-19 PHE. The continuous enrollment condition ended on March 31, 2023. States had up to 12 months to initiate, and 14 months to complete, a renewal for all individuals enrolled in Medicaid, Child Health Insurance Program (CHIP), and the Basic Health Program (BHP) following the end of the continuous enrollment condition.

Since April 1, 2023, the FFCRA's temporary FMAP increase had been gradually reduced and ended on December 31, 2023. The Department of Health is continually evaluating guidance provided by CMS in determining the impacts of the PHE unwind and effectuating redeterminations.

Home & Community-Based Services (HCBS) eFMAP: In addition to the 6.2 percent COVID-19 eFMAP increase, the Federal ARPA bill provided a temporary 10 percentage point increase to the FMAP for certain Medicaid HCBS claimed through March 31, 2022. Such additional funding must supplement, not supplant, current Medicaid funding.

After a collaborative, multi-agency effort with the Department's partner agencies that touch on the categories of HCBS for which the eFMAP is being provided, the Department submitted New York's initial spending plan to CMS on July 9, 2021. CMS has approved all spending plan initiatives.

New York continues to make 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 2024:

Category of Service	Rate Package Description	Month Paid
Managed Care	April 2023 Mainstream Rates	Sept 2023
	April 2023 HARP Rates	Sept 2023
	April 2023 HIV Special Needs Plans (HIV SNP) Rates	Sept 2023
	Encounter Withhold 2023	Aug 2023
	Quality Pools FY 2022	Sept 2023
	HIV SNP Incentive Pool Payment CY 2022	Sept 2023
Managed Long Term Care	MAP FY 2024 Initial	May 2023
	Partial Cap FY 2024 Initial	May 2023
	PACE FY 2024 Initial	June 2023
	QIVAPP FY 2023	Dec 2023
	Quality Pool FY 2022	June 2023
	Partial Cap and MAP Encounter Data Withhold Payments	June 2023
	Partial Cap Enrollment Cap Withhold Payments	Mar 2024
Inpatient	Acute & Exempt Unit Inpatient Rates CY 2023	July 2023
	Acute Inpatient Rates UPL Conversion Add-on	Dec 2023
	Inpatient Psych Statewide Price Increase	June 2023
	FY 2024 Enacted Inpatient Rate Increase – 7.5%	Sept 2023
Outpatient / Emergency Room	APG Capital Update	Jan 2024
	APG Rate Update	Jan 2024
	FY 2024 Enacted Outpatient Rate Increase – 6.5%	Oct 2023
Clinic	APG Capital Rate Update	Jan 2024
	10/1/2023 FQHC MEI Increase	Feb 2024
	2021 MW add-on	Jan 2024
	2022 MW add-on	Jan 2024
	2023 MW add-on	Sept 2023
	Wrap Audit CY 2016 to CY 2018	Sept 2023
Nursing Homes	6.5% Budget Increase NH & ADHC	Nov 2023
	NH Operating - Case Mix	Oct 2023
	NH 2% Supplemental ATB Increase	Mar 2024
	NH Advanced Training Initiative	Feb 2024
	NH Enhanced ATI	Sept 2023
Personal Care	Personal Care and CDPAP/FI Rates CY 2022	Jan 2024
Assisted Living Providers	6.5% Budget Increase - ALP	Nov 2023
	ALP Rates CY 2022	April 2023
Hospice	Hospice Residence Rates CY 2023	June 2023
	Hospice Non-Residence Rates FFY 2023	June 2023
	Hospice Non-Residence Rates FFY 2024	Mar 2024

Appendix B. FY 2024 Enacted Budget

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

Below is a condensed version of the FY 2024 Enacted Scorecard which focuses the list on budget actions anticipated to be implemented in FY 2024. Any lost savings or availed spending will be accommodated within the Medicaid Global Cap.

(State Share - $ in millions)	Eff. Date	FY 2024	Implemented Y/N	Achieved
Executive Global Cap Forecast (Surplus)/Deficit		**$1,225.7**		**$1,225.7**
Signed Legislation		**$6.3**		**$6.3**
A.9542 Programs of All–Inclusive Care for the Elderly (PACE) Licensure	6/27/23	$0.3	Y	$0.3
A.299B Applied Behavioral Analyst Expansion	10/1/22	$6.0	Y	$6.0
Enrollment Update		**$0.0**		**$0.0**
Forecasted Enrollment Projections	4/1/23	$547.0	Y	$547.0
Financial Plan adjustment for COVID Enrollment	4/1/23	($547.0)	Y	($547.0)
Global Cap Index Update	4/1/23	**($475.2)**	Y	**($475.2)**
Global Cap (Surplus)/Deficit		**$756.8**		**$756.8**
Budget Actions		**($253.2)**		**($191.5)**
Hospital Actions		**$28.9**		**$28.9**
Additional SUNY Disproportionate Share Hospital (DSH) Support	4/1/23	$71.6	Y	$71.6
Voluntary Hospital Indigent Care Reduction	4/1/23	($42.7)	Y	($42.7)
Nursing Home Actions		**$121.4**		**$121.4**
Removal of Nursing Home Staffing Pool	4/1/23	($93.5)	Y	($93.5)
Increase Nursing Home reimbursement by 6.5% (up to 7.5% total, subject to FFP)	4/1/23	$204.8	Y	$204.8
Increase Assisted Living Program (ALPs) reimbursement by 6.5%	4/1/23	$11.7	Y	$11.7
DOH Veterans Homes Investment	4/1/23	($1.5)	Y	($1.5)
Other Long-Term Care Actions		**($15.0)**		**($15.0)**
Discontinue Managed Long Term Care (MLTC) Distressed Plan Pool	4/1/23	($15.0)	Y	($15.0)
Managed Care Actions		**($213.2)**		**($171.9)**
Delay Implementation of Undocumented Coverage Expansion for 65+	1/1/24	($171.9)	Y	($171.9)
Keep Pregnancy Coverage in Essential Plan	1/1/24	($41.3)	N	$0.0
Pharmacy Actions		**$73.7**		**$64.2**
NYRx Transition	4/1/23	($410.0)	Y	($410.0)
Support for Ryan White Centers (NYRx Reinvestment)	4/1/23	$30.0	Y	$20.4
FQHC and DTC Supplemental Payments (NYRx Reinvestment)	4/1/23	$135.0	Y	$135.0
Increase Hospital Inpatient reimbursement by 7.5% (NYRx Reinvestment)	4/1/23	$318.8	Y	$318.8

Other Actions		**($249.1)**		**($219.1)**
Utilize Available Federal Funding	4/1/23	($219.1)	Y	($219.1)
Recalibrate Health Homes	10/1/23	($30.0)	Y	$0.0
State of the State Investments		**$180.4**		**$127.7**
Expand Medicaid Coverage of Preventative Care		**$53.6**		**$45.2**
Expand nutritionist coverage to all populations	10/1/23	$13.5	Y	$13.5
Increase in supportive housing funding	10/1/23	$15.0	Y	$15.0
Increase reimbursement rates for dental services to ensure access for all Medicaid members	7/1/23	$1.0	Y	$1.0
Increase Medicaid reimbursement for private practice dentists serving the IDD population	7/1/23	$0.3	Y	$0.3
Increase reimbursement for ambulatory surgery dental services for IDD population	7/1/23	$4.3	Y	$4.3
Establish Medicaid reimbursement for CDSMP (chronic disease self-management program) for arthritis management	10/1/23	$0.1	Y	$0.1
Establish Adverse Childhood Experience screening reimbursement	1/1/24	$4.8	N	$0.0
Ensure Medicaid coverage of Preventive Mental Health Services	10/1/23	$6.0	Y	$6.0
Statewide Medicaid coverage and Higher Reimbursement for Doulas	1/1/24	$2.3	Y	$0.0
Medicaid coverage of spinal muscular atrophy screening	10/1/23	$3.7	Y	$3.7
Increased vaccine administration fees to expand access to children	7/1/23	$2.7	Y	$1.3
-				
Improve Access to Primary Care		**$46.0**		**$28.9**
Benchmarking primary care reimbursement to 80% of Medicare	10/1/23	$17.7	Y	$17.7
Promote Telehealth through eVisits	10/1/23	$0.8	Y	$0.8
Increase reimbursement for School Based Health Centers	4/1/23	$1.4	Y	$0.7
Establish Medicaid reimbursement for Community Health Workers for more populations (including high-risk populations, maternity, children under 21, etc.)	1/1/24	$8.7	Y	$8.7
Integrated Licensure Standards	10/1/23	$16.3	N	$0.0
Eliminate Hepatitis C by Implementing Universal Hepatitis C (HCV) Screening	4/1/23	$1.0	Y	$1.0
Reimburse Screening for Congenital Syphilis during the 3rd Trimester	4/1/23	$0.2	N	$0.0
Ensure Adequate Medicaid Reimbursement for Transportation Services by Increasing Reimbursement Rates	7/1/23	**$13.7**	Y	**$13.7**
Stabilize and Strengthen New York's Reproductive Health System	10/1/23	**$8.3**	Y	**$8.3**
Mental Hygiene SOTS Impacts		**$58.9**		**$31.6**
Expand the Comprehensive Psychiatric Emergency Program (CPEP)	10/1/23	$12.0	N	$0.0
Expand the Assertive Community Treatment (ACT) Program	10/1/23	$4.6	N	$0.0
Expand the Certified Community Behavioral Health Clinic (CCBHC) Program	4/1/23	$3.5	Y	$3.5

Certified Community Behavioral Health Clinic (CCBHC) Indigent Care Program	4/1/23	$11.3	Y	$11.3
Health Home Plus Expansion	4/1/23	$2.5	Y	$2.5
Expand Article 31 Clinic Capacity	7/1/23	$15.0	Y	$14.3
Increase reimbursement rates for School Based Mental Health Clinics	10/1/23	$10.0	N	$0.0
Total Global Cap (Surplus)/Deficit		**$684.0**		**$693.0**
Enacted Adds		**($684.0)**		**($684.0)**
Adds		**$606.0**		**$606.0**
Financially Distressed and Safety-Net Hospitals Support	4/1/23	$500.0	Y	$500.0
Increase Hospital Outpatient reimbursement by 6.5%	4/1/23	$76.1	Y	$76.1
Additional 1.5% OSA COLA	4/1/23	$29.9	Y	$29.9
Wage Actions		**($44.4)**		**($44.4)**
Wage Parity Savings	1/1/24	($115.0)	Y	($115.0)
Additional QIVAP Support	4/1/23	$70.6	Y	$70.6
Additional NYRx Reinvestment	4/1/23	**$35.0**	Y	**$35.0**
Avails		**($1,280.6)**		**($1,280.6)**
Prior Year State Funding Advance Recoveries	4/1/23	($177.6)	Y	($177.6)
Financial Plan Support of OSA COLA	4/1/23	($29.9)	Y	($29.9)
Available HCBS eFMAP	4/1/23	($214.0)	Y	($214.0)
Timing of Payments and Other Revisions	4/1/23	($859.1)	Y	($859.1)
Total Global Cap (Surplus) / Deficit		**$0.0**		**$9.0**
Minimum Wage Index Increase	10/1/23	$52.7	Y	$52.7
Delay $1 Homecare Wage to 1/1/24	1/1/24	($96.5)	Y	($96.5)
Total Financial Plan Support for Minimum Wage (Outside the Global Cap)		**($43.8)**		**($43.8)**

Appendix C. Regional Spending Data

The chart below represents total provider spending that occurs within the Medicaid claiming system (eMedNY) through September 2023 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	$22,320
Long Island	$3,623
Mid-Hudson	$3,465
Western	$1,978
Finger Lakes	$1,434
Capital District	$1,110
Central	$832
Mohawk Valley	$706
Southern Tier	$592
North Country	$415
Out of State	$473
TOTAL	**$36,949**

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

Appendix D. State-Only Payments (YTD)

State-only Payments ($ in millions)	Non-Federal Total Paid
VAPAP	$683.0
Net Hospital Advances	$171.0
Supportive Housing	$55.6
ACA Federal Financial Participation Liability	$45.0
Alzheimer's Caregiver Support	$24.5
End of AIDS	$12.3
Assisted Living Voucher Demo	$7.7
MLTC Ombudsman	$5.9
Rural Transportation	$4.0
CSEA Buy-in	$2.6
Primary Care Service Corps	$0.1
TOTAL	**$1,011.7**

Appendix E. Medicaid Drug Cap

The FY 2018 Enacted Budget established a Medicaid Drug Cap that limits pharmacy spending growth in the Medicaid program tied to the annual growth rate of the Medicaid Global Cap, which is determined annually according to statute (6.3% in FY 2024).

Prior to FY 2023, the Global Cap allowable growth was previously calculated using the ten-year rolling average of the medical component of the CPI for all urban consumers. The FY 2023 Enacted Budget modified the metric by which Medicaid Global Cap and Medicaid Drug Cap allowable spending growth is calculated, utilizing the five-year rolling average of health care spending, using projections from the CMS Actuary.

If the Budget Director determines that expenditures will exceed the annual growth limitation imposed by the Medicaid Drug Cap, the Commissioner of Health may refer drugs to the State's Drug Utilization Review Board (DURB) for a recommendation as to whether a supplemental rebate should be paid by the manufacturer.

If the Department intends to refer drugs to the DURB, it will notify affected manufacturers and will attempt to reach agreement on rebate amounts prior to DURB referral.

In determining whether to recommend a target supplemental rebate for a drug, the DURB must consider the cost of the drug to the NYS Medicaid program and may consider, among other things: the drug's impact on the Medicaid drug spending, significant and unjustified increases in the price of the drug, and whether the drug may be priced disproportionally to its therapeutic benefits.

In formulating a recommendation, the DURB may consider, among other things: publicly available and DOH supplied pricing information, the seriousness and prevalence of the disease or condition being treated, Medicaid utilization, the drug's effectiveness or impact on improving health, quality of life, or overall health outcomes, the likelihood that the drug will reduce the need for other medical care (including hospitalization), the average wholesale price, wholesale acquisition cost, and retail price of the drug, and the cost of the drug to Medicaid minus rebates.

If, after the DURB recommends a target rebate amount, DOH and the manufacturer are unable to reach an agreement regarding supplemental rebate amounts, the manufacturer will be required to provide DOH with certain information including, but not limited to, marketing, research, and development costs for the drug.

Over the past six years of implementation (FY 2018-FY 2024), the Medicaid Drug Cap has achieved over $785 million in gross savings through spending reductions and additional supplemental rebate agreements with pharmaceutical manufacturers for over 98 high-cost drugs.

In FY 2021, the COVID-19 pandemic significantly altered underlying assumptions historically used to project pharmacy specific utilization and spending in the Medicaid program. Specifically, the COVID-19 pandemic and associated MOE requirements under Section 6008 of FFCRA resulted in a rapid (and unpredictable) escalation in Medicaid enrollment with newly eligible populations having different risk profiles or spending patterns than existing Medicaid enrollees. Given the uncertainty of underlying enrollment and spending assumptions it was not possible to accurately project whether Medicaid pharmacy spending would exceed the statutory growth rate. Therefore, the Medicaid Drug Cap was not triggered in FY 2021.

Consistent with the statutory formula, the Medicaid Drug Cap for FY 2024 was $2.3 billion (State share) and reflected a growth rate of 6.3 percent consistent with the Medicaid Global Spending Cap. The FY 2024 Drug Cap was not pierced and the FY 2025 Enacted Budget converted the Medicaid Drug Cap into a supplemental rebate program to allow for expanded supplemental rebate negotiations.

Appendix F. Additional Information

Fee-For-Service Rates for General Hospitals:

- Inpatient Rates: https://www.health.ny.gov/facilities/hospital/reimbursement/apr-drg/rates/ffs/index.htm
- Outpatient Rates: https://www.health.ny.gov/health_care/medicaid/rates/apg/rates/hospital/index.htm

Fee-For-Service Rates of Pharmaceutical Drugs on the Preferred Drug List (PDL):
https://newyork.fhsc.com/downloads/providers/NYRx_PDP_PDL.pdf

Fiscal Intermediaries: Article VII – HMH Part PP:

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

Appendix G. Quarterly Results

Q1 (April 2023 to June 2023)	Estimated	Actual	$ Variance Over / (Under)	% Variance Over / (Under)
Managed Care	**$8,314**	**$8,057**	**($257)**	**(3%)**
Mainstream Managed Care	$5,556	$5,345	($211)	(4%)
Managed Long Term Care	$2,758	$2,712	($46)	(2%)
Total Fee For Service	**$2,743**	**$2,630**	**($113)**	**(4%)**
Inpatient	$853	$833	($20)	(2%)
Outpatient/Emergency Room	$86	$92	$6	7%
Clinic	$137	$147	$10	7%
Nursing Homes	$765	$750	($15)	(2%)
Personal Care	$213	$225	$12	6%
Home Health	$36	$39	$3	8%
Other Long Term Care	$48	$48	$0	0%
Pharmacy	$323	$245	($78)	(24%)
Transportation	$97	$98	$1	1%
Non-Institutional	$185	$154	($32)	(17%)
Other State Agencies	**$399**	**$342**	**($57)**	**(14%)**
Mental Hygiene Stabilization Fund	**($316)**	**($316)**	**$0**	**0%**
Medicare Part A/B & D	**$826**	**$873**	**$47**	**6%**
VAPAP	**$216**	**$216**	**$0**	**0%**
Net Hospital Advances	**$202**	**$168**	**($33)**	**(16%)**
All Other	**($420)**	**$218**	**$638**	**(152%)**
Medicaid Administration Costs	**$130**	**$89**	**($42)**	**(32%)**
State Ops w/ EP	**$73**	**$76**	**$4**	**5%**
Local Funding Offset	**($1,619)**	**($1,619)**	**$0**	**0%**
COVID eFMAP	**($1,037)**	**($1,128)**	**($91)**	**9%**
Medicaid Audits	**($83)**	**($147)**	**($64)**	**77%**
TOTAL	**$9,428**	**$9,461**	**$32**	**0%**

Note: 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.

Q2 (April 2023 to September 2023)	Estimated	Actual	$ Variance Over / (Under)	% Variance Over / (Under)
Managed Care	**$13,495**	**$14,438**	**$943**	**7%**
Mainstream Managed Care	$8,198	$9,360	$1,162	14%
Managed Long Term Care	$5,297	$5,078	($219)	(4%)
Total Fee For Service	**$5,679**	**$5,493**	**($186)**	**(3%)**
Inpatient	$1,500	$1,480	($21)	(1%)
Outpatient/Emergency Room	$183	$171	($11)	(6%)
Clinic	$363	$408	$44	12%
Nursing Homes	$1,797	$1,585	($212)	(12%)
Personal Care	$419	$453	$34	8%
Home Health	$74	$83	$9	12%
Other Long Term Care	$102	$97	($5)	(5%)
Pharmacy	$652	$712	$59	9%
Transportation	$205	$196	($9)	(4%)
Non-Institutional	$384	$309	($74)	(19%)
Other State Agencies	**$723**	**$695**	**($28)**	**(4%)**
Mental Hygiene Stabilization Fund	**($633)**	**($633)**	**$0**	**0%**
Medicare Part A/B & D	**$1,692**	**$1,734**	**$42**	**2%**
VAPAP	**$376**	**$462**	**$86**	**23%**
Net Hospital Advances	**$300**	**$330**	**$30**	**10%**
All Other	**$342**	**$574**	**$233**	**68%**
Medicaid Administration Costs	**$251**	**$271**	**$20**	**8%**
State Ops w/ EP	**$188**	**$159**	**($29)**	**(15%)**
Local Funding Offset	**($3,489)**	**($3,469)**	**$19**	**(1%)**
COVID eFMAP	**($1,593)**	**($1,721)**	**($128)**	**8%**
Medicaid Audits	**($191)**	**($228)**	**($37)**	**19%**
TOTAL	**$17,140**	**$18,106**	**$965**	**6%**

Note: 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.

Q3 (April 2023 to December 2023)	Estimated	Actual	$ Variance Over / (Under)	% Variance Over / (Under)
Managed Care	**$20,218**	**$19,119**	**($1,098)**	**(5%)**
Mainstream Managed Care	$11,862	$11,327	($535)	(5%)
Long Term Managed Care	$8,356	$7,793	($563)	(7%)
Total Fee For Service	**$9,346**	**$9,149**	**($197)**	**(2%)**
Inpatient	$2,533	$2,451	($82)	(3%)
Outpatient/Emergency Room	$299	$290	($9)	(3%)
Clinic	$625	$596	($29)	(5%)
Nursing Homes	$2,946	$2,829	($117)	(4%)
Personal Care	$676	$801	$125	18%
Home Health	$142	$148	$6	4%
Other Long Term Care	$172	$173	$1	1%
Pharmacy	$966	$991	$25	3%
Transportation	$312	$336	$25	8%
Non-Institutional	$675	$532	($143)	(21%)
Other State Agencies	**$820**	**$827**	**$7**	**1%**
Mental Hygiene Stabilization Fund	**($610)**	**($610)**	**$0**	**0%**
Medicare Part A/B & D	**$2,929**	**$2,932**	**$3**	**0%**
VAPAP	**$629**	**$605**	**($24)**	**(4%)**
Net Hospital Advances	**$341**	**$389**	**$48**	**14%**
All Other	**($52)**	**($86)**	**($34)**	**65%**
Medicaid Administration Costs	**$365**	**$324**	**($42)**	**(12%)**
State Ops w/ EP	**$323**	**$306**	**($17)**	**(5%)**
Local Funding Offset	**($6,059)**	**($6,063)**	**($4)**	**0%**
COVID eFMAP	**($2,060)**	**($2,060)**	**($1)**	**0%**
Medicaid Audits	**($358)**	**($268)**	**$90**	**(25%)**
TOTAL	**$25,832**	**$24,564**	**($1,269)**	**(5%)**

Note: 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.