Extract from pp. 41-42 of the October 2019 Annual Information Statement Update on Medicaid (link here**: https://www.budget.ny.gov/pubs/archive/fy20/enac/ais/2019-ais-oct.pdf):**

Medicaid Global Cap

In FY 2012, the State enacted legislation intended to limit the year-to-year growth in DOH State funds Medicaid spending to the ten-year rolling average of the medical component of the CPI. The statutory provisions of the Medicaid spending cap ("Global Cap") allow for flexibility in adjusting Medicaid projections to meet unanticipated costs resulting from a disaster, and grant the Commissioner of Health certain powers to limit Medicaid disbursements to the level authorized by the Global Cap. The Commissioner's powers are intended to limit the rate of annual spending growth to the levels set by the Global Cap indexed rate for the current fiscal year, through actions which may include reducing rates to providers. These actions may be dependent upon timely Federal approvals and other elements of the program that govern implementation. Major changes to the State share of Medicaid spending include State costs for the takeover of Medicaid growth from local governments and reimbursement to providers for minimum wage costs. It should further be noted that General Fund spending remains sensitive to revenue performance in the State's HCRA fund that finances approximately one-quarter of the DOH State-share costs of Medicaid.

Since enactment of the Global Cap, the portion of DOH State Funds Medicaid spending subject to the Global Cap has remained at or below indexed levels. However, the DOH has, at times, taken management actions, including adjustments to the timing of Medicaid payments, to ensure compliance with the Global Cap. Between FY 2015 and FY 2018, DOH managed the timing of payments across State fiscal years (payments managed across fiscal years during this period ranged from $50 million to roughly $435 million, according to DOH).

At the close of FY 2019, DOH deferred, for three business days, the final cycle payment to Medicaid Managed Care Organizations, as well as other payments. The FY 2019 deferral had a State-share value of $1.7 billion and was paid from available funds in the General Fund in April 2019, in time to satisfy contractual obligations. According to DOH, the deferral had no impact on provider services. However, absent the deferral and any other actions, Medicaid spending under the Global Cap would have exceeded the statutorily indexed rate for FY 2019 and the State would have used available General Fund resources to fund the payments in FY 2019. The General Fund ended FY 2019 with sufficient resources. According to DOH, the higher spending in FY 2019 reflected growth in managed care and long-term managed care enrollment and utilization costs above projections, as well as the timing of certain savings actions and offsets that were not processed by year-end.

The Global Cap Imbalance

Based on a review of price and utilization trends, FY 2019 results, and other factors, DOB has concluded that a structural imbalance exists within the Global Cap. A structural imbalance in this case means that estimated expense growth in State-share Medicaid, absent measures to control costs, is growing faster than allowed under the Global Cap spending growth index (currently 3 percent).12 DOB estimates that, absent the actions described below, State-share Medicaid spending could exceed the Global Cap by a range of $3 billion to $4 billion in FY 2020 (including the FY 2019 deferral of $1.7 billion). The amount by which State-share Medicaid spending could exceed the Global Cap in FY 2021 will depend in part on the actions taken by the State to control costs in FY 2020. However, it is expected that additional actions will

need to be taken in FY 2021 in addition to those taken to contain spending within the Global Cap in FY 2020.

Factors that have placed upward pressure on State-share Medicaid spending include, but are not limited to: provider reimbursement for the cost of the increase in minimum wage; the phase-out of enhanced federal Medicaid match rates that were designed as part of the Affordable Care Act to support additional coverage; increased enrollment and costs in managed long-term care; and payments to financially distressed hospitals.

In FY 2020, it is expected that, to the extent practicable, management actions will be taken to limit Medicaid spending in FY 2020 to avoid piercing the Global Cap. It is expected that up to $2.0 billion in FY 2020 savings will be realized from adjusting the timing of payments consistent with contractual terms and past practice, leaving an imbalance in the range of $1.5 billion. Other actions to limit spending under the Global Cap in the current year may include, but are not limited to, the imposition of statutorily-authorized cost controls, including across-the-board reductions in rates paid to providers and health plans and reductions in discretionary payments.

In FY 2021, the imbalance remaining after FY 2020 actions is expected to be addressed within the Global Cap and in the context of the State's overall gap-closing plan. The imbalance that needs to be closed within the Global Cap will depend in part on the actions taken by the State to control costs in FY 2020. The Governor is expected to issue the FY 2021 Executive Budget in January 2020.

If State Funds Medicaid spending is not reduced to levels that adhere to the Global Cap or other savings are not identified, it could have a materially adverse impact on General Fund budget balance and the State's ability to limit annual State Operating Funds spending growth to 2 percent in FY 2020 and FY 2021.

The current Financial Plan estimates described in this AIS Update, which report that the General Fund is balanced and has a projected budget gap of $4.0 billion in FY 2021, do not reflect the estimated imbalance in the Global Cap, or the actions expected to be taken to address it. DOB expects to provide additional information in the Mid-Year update to the FY 2020 Financial Plan. The annual growth in Medicaid spending subject the Global Cap is limited to the ten-year rolling average of the medical component of the CPI.