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Medicaid Spending Growth Distorted in the Financial Plan—Again

THE MYSTERY OF MEDICAID BUDGET GROWTH IN A TIME OF FEDERAL CUTS AND DECLINING ENROLLMENT.

Key Findings

- New York's FY 2027 Enacted Budget Financial Plan projects that State DOH Medicaid spending will rise by $5.6 billion, or 16.2 percent, in the current fiscal year—an astonishing rate of growth given that Medicaid enrollment is flat.
- This growth rate is artificially inflated by financing mechanisms related to the state's Managed Care Organization tax and an accounting sleight-of-hand related to the Medicaid Global Cap.
- When these distortions are accounted for, Medicaid spending is projected to rise less than half as quickly, by just $2.4 billion or 7.1 percent—stemming primarily from rate increases for nursing homes and hospitals in this year's budget.

Recommendations

- To ensure coverage, the legislature should repeal the Medicaid Global Cap, which exercises no meaningful constraint on Medicaid spending but significantly undermines transparency around it.
- The Executive should publish data allowing outside analysts to evaluate the key drivers of Medicaid spending.

Introduction

The Fiscal Year 2027 New York State Enacted Budget Financial Plan published in June offered analysts a more complete picture of how overall spending is projected to change in the current fiscal year. What it showed was another year of double-digit Medicaid spending growth. By one measure, state-share

Department of Health (DOH) Medicaid spending is projected to grow by an extraordinary 16.2 percent relative to FY26, increasing by $5.6 billion to nearly $40 billion.[1]

These figures are extremely surprising. After all, New York State Medicaid *enrollment* isn't growing rapidly. Indeed, enrollment in New York's largest Medicaid program, Mainstream Managed Care, has fallen dramatically in recent years and is now at levels last seen before the Covid-19 pandemic. Increased enrollment in the Managed Long-Term Care (MLTC) program, which covers home- and community-based services for the elderly and disabled, has driven spending in past years—but that changed dramatically with the Consumer Directed Personal Assistance Program (CDPAP) transition last year and MLTC enrollment has been flat for the past several months.[2] Meanwhile, New York is facing dramatic federal Medicaid cuts, with one million people due to lose health insurance over the next two years. Given all this, shouldn't Medicaid spending be projected to *shrink?* What's driving such dramatic growth?

In this piece, I will show that much of New York's DOH Medicaid growth is an accounting fiction. The way the state accounts for a complex financial mechanism known as the Managed Care Organization (MCO) tax, and the financial maneuvers the State of New York has used for years to maintain the Medicaid Global Cap, give a dramatically exaggerated picture of Medicaid growth. Correcting for these distortions, DOH Medicaid is growing at less than half the rate reported by the state—with year-on-year growth at 7.1 percent, not 16.2 percent. Most of that growth is easy to explain: It is caused by provider rate increases, largely for hospitals and nursing homes, proposed by Governor Hochul and enacted by the legislature this year.

Medicaid Accounting

Medicaid accounting is complex because Medicaid is a complex program. In New York, Medicaid is jointly financed by the state, the federal government, county governments, and New York City. Medicaid *spending* is divided across two main areas—"Department of Health Medicaid," which includes health insurance for low-income New Yorkers and long-term care for the elderly and disabled, and "Other State Agencies" Medicaid spending, most of which falls under the rubric of "Mental Hygiene" and funds the activities of the Office for People with Developmental Disabilities (OPWDD), the Office of Mental Health (OMH), and the Office of Addiction Services and Supports (OASAS). Table 1 shows the breakdown of spending across these areas, as depicted in the Financial Plan.

[1] Governor Kathy Hochul and Budget Director Blake G. Washington, "Fiscal Year 2027 New York State Enacted Budget Financial Plan," New York State Division of the Budget, June 2026, 105, https://www.budget.ny.gov/pubs/archive/fy27/en/fy27fp-en.pdf.
[2] For a detailed explanation of the CDPAP transition see: Fiscal Policy Institute, "Fiscal Year 2027 Annual Budget Briefing," February 19, 2026, 32–36, https://fiscalpolicy.org/wp-content/uploads/2026/02/FY-2027-Budget-Briefing.pdf.

Table 1. State-share Medicaid spending by program area, $ in millions.

	FY 26 Actuals	FY 27 Projected	Growth ($)	Growth (%)
DOH Medicaid	**$34,397**	**$39,964**	**$5,567**	**16.2%**
Assistance and Grants	$33,984	$39,443	$5,459	16.1%
State Operations	$413	$521	$108	26.2%
Other State Agencies	**$8,789**	**$8,353**	**-$436**	**-5.0%**
Mental Hygiene	$8,575	$9,529	$954	11.1%
Mental Hygiene Stabilization Fund	-$58	-$1,441	-$1,383	-2384.5%
Foster Care	$164	$120	-$44	-26.8%
Education	$94	$140	$46	48.9%
Corrections	$14	$5	-$9	-64.3%
Total State-Share Medicaid (All Agencies)	**$43,186**	**$48,317**	**$5,131**	**11.9%**
Annual $ Change	$4,759	$5,131	$372	7.8%

Source: FY27 Enacted Budget Financial Plan, 105.

Most of this table is straightforward—and it does indeed show DOH Medicaid growing at the extraordinary rate of 16.2 percent. But a closer look creates a puzzle: What is the negative entry for the "Mental Hygiene Stabilization Fund"? Why does it grow from negative $58 million to negative $1.4 billion between FY26 and FY27? And what does it mean for our mental health system that this large negative entry causes mental hygiene spending overall to *decrease* by 5 percent?

Answering these questions will require some background.

The Global Cap Farce and the Mental Hygiene Stabilization Fund

It turns out the Mental Hygiene Stabilization Fund is an accounting fiction the state has used for the past several years to manipulate the Medicaid Global Spending Cap.

The Global Cap was instituted under Governor Andrew Cuomo in 2011 as part of a broader attempt to reduce Medicaid spending growth. Under the Global Cap law, year-on-year Department of Health Medicaid spending growth was limited to the rate of inflation. (The cap was updated in 2022 and is now linked to a measure of healthcare cost growth.) Over the years, the legislature has modified the Global Cap in a variety of ways to exclude specific types of spending, but they have never repealed it.

As a policy matter, the Global Cap never made much sense. Medicaid spending is driven by numerous factors, including changes to federal policy, economic cycles, and demographic changes; it makes sense for policymakers to avoid unnecessary spending growth, but an arbitrary, self-imposed cap on total spending is of little value. Nevertheless, sticking to the cap has been important for the Cuomo and Hochul administrations, in part because it can serve as an excuse to resist the legislature's desire to spend more on Medicaid.

One somewhat perverse feature of the cap, as implemented, is that in practice it is also a floor. The state is not allowed to *exceed* the cap, but policymakers also seek to avoid falling *under* the cap. Because the cap for any given year is based on the amount spent in the previous year, any present-year shortfall would reduce state flexibility in future years. Thus, the state aims to keep applicable spending precisely at the cap every year. In FY26, for example, the cap was set at $26.459 billion—and spending covered by the cap was precisely $26.459 billion.

That seems like quite an achievement—but appearances can be deceptive. In fact, the state has maintained the cap for the past several years through an accounting fiction.

Recall that the cap applies only to *DOH Medicaid* spending. "Other State Agencies" spending—again, primarily on "mental hygiene"—falls outside the cap. This offers the Executive a hidden flexibility: If DOH Medicaid threatens to exceed the cap, the Governor can reclassify some DOH Medicaid spending as Mental Hygiene spending. Conversely, if DOH Medicaid threatens to fall *under* the cap, limiting cap growth in future years, the Executive can reclassify some Mental Hygiene spending as DOH Medicaid spending, filling out the DOH Medicaid cap allotment for the year. For the past decade, this mechanism has been recorded—but not explained—in each year's State Financial Plan documents under the name of the "Mental Hygiene Stabilization Fund."

To give a concrete example: Suppose that in a given year, DOH Medicaid spending is $32 billion, Mental Hygiene spending is $10 billion, and the DOH Medicaid global cap is $30 billion. DOH Medicaid now risks exceeding the cap. To eliminate this overspending, the State will account for its disbursements as follows:

Table 2. Example Medicaid disbursements, $ in billions.

Category	Value
DOH Medicaid	**$30**
Mental Hygiene Total	**$12**
Mental Hygiene	$10
MHSF	$2
Total	$42

By reclassifying $2 billion of DOH Medicaid spending as Mental Hygiene spending, the state remains at the cap.

Conversely, suppose that in a different year DOH Medicaid spending is $28 billion, Mental Hygiene spending is $10 billion, and the Global Cap is $30 billion. Now, the state risks falling *below* the gap, permanently decreasing its spending capacity. In that year, the state will record its spending as follows:

Table 3. Example Medicaid spending, $ in billions.

Category	Value
DOH Medicaid	**$30**
Other State Agencies	**$8**
Mental Hygiene	$10
MHSF	-$2
Total	$38

By reclassifying in the other direction—treating $2 billion of Mental Hygiene spending as DOH Medicaid spending—the state can fill out its Global Cap allowance.

Table 4. The History of the Mental Hygiene Stabilization Fund, $ in millions.

Year	MHSF
FY21 Actuals	-$2,157
FY22 Actuals	$307
FY23 Actuals	-$382
FY24 Actuals	$1,536
FY25 Actuals	$298
FY26 Actuals	-$58
FY27 Projected	-$1,441

Source: Figures are "Actuals" for each year from the Enacted Budget Financial Plan for the subsequent year.

The state has used this maneuver for at least a decade, in both directions. In FY21, when abundant federal aid threatened to reduce state Medicaid spending below capped levels, the state recategorized $2.2 billion of Mental Hygiene spending as DOH Medicaid spending to fill out its cap. In FY24, when unexpected timing issues with federal approvals caused state Medicaid spending to rise, it reclassified $1.5 billion of DOH Medicaid spending as Mental Hygiene spending to stay under the cap. The system is described with unusual clarity in the FY25 Enacted Budget Financial Plan: "Other spending increases include additional assistance to distressed hospitals and safety net providers that are funded outside of the Medicaid Global Cap through the Mental Hygiene Stabilization Fund (MHSF). . . . Mental Hygiene ($2 billion higher) due to a $1.9 billion increase in mental hygiene spending moved out of the Global Cap

through the Local Share Adjustment and Mental Hygiene Stabilization Fund."[3] (Actual MHSF use turned out to be substantially lower in FY25 for various reasons, as shown in table 4.)

To be clear, the MHSF is purely a matter of accounting—there is no actual pot of money in the fund, and recategorizing spending does not affect programs in the real world. It simply allows the state to always remain precisely at the Medicaid Global Cap, neither above nor below it.

Needless to say, this mechanism comes at enormous cost to program transparency. It is nowhere clearly disclosed in the state's Financial Plan documents, and it systematically distorts trends in DOH Medicaid spending. That is especially true in the FY27 Enacted Budget: A $1.4 billion increase in use of the MHSF is reported as an enormous increase in DOH Medicaid. In fact, this increase reflects, if anything, *lower* than expected DOH Medicaid spending, since the State uses the MHSF to transfer mental health spending onto the DOH budget when spending is lower than projected. But only the most careful budget analysts are likely to notice that this does not represent a genuine spending increase.

The MCO Tax

A second accounting issue further distorts the picture of DOH Medicaid spending. This has to do with the state's Managed Care Organization tax, which was implemented at the beginning of CY25 and scheduled to sunset at the end of CY26, having generated approximately $3.4 billion over two years. The MCO tax was always expected to be a temporary source of financing, but provisions in the federal One Big Beautiful Bill Act (OBBBA) required that it end sooner than expected; the tax was originally projected to raise $3.7 billion on net. (The tax will now be replaced with a much smaller levy on insurance, which is set to raise just $163 million per year.)

The MCO tax is a so-called "provider tax," designed to generate extra federal Medicaid matching revenue without burdening New York State taxpayers. Such mechanisms were heavily restricted by the passage of the OBBBA last summer, which is why the tax is set to end this December.

The Fiscal Policy Institute explained the mechanics of provider taxes two years ago, when New York first decided to pursue one.[4] The details are highly technical, but to simplify, a Medicaid provider tax works by taxing high-Medicaid providers, then reimbursing them *with the federal match.* For example, a state might tax a safety net hospital $100, then use $50 of this revenue to reimburse the hospital through Medicaid payments. Because Medicaid spending is federally matched, this $50 in state-share reimbursement would generate $100 in total reimbursement for the hospital, leaving it no worse off than if the tax had not been levied. Meanwhile, the state would be left with an extra $50 in tax revenue to spend—and if it used the money to fund Medicaid, for instance by giving a rate increase to hospitals and nursing homes, this money, too, would generate a federal match, resulting in $100 in total spending. Overall, the state would have (1) taxed the hospital $100, (2) paid the hospital back $100, and (3) generated an extra $100 in federal matching funds, which can support rate increases or service expansion. On net, the hospital has broken even, the state has broken even, and the federal government has contributed an extra $100 to the state's Medicaid program.

[3] Governor Kathy Hochul and Budget Director Blake G. Washington, "Fiscal Year 2025 New York State Enacted Budget Financial Plan," New York State Division of the Budget, May 2024, 24, 156, https://www.budget.ny.gov/pubs/archive/fy25/en/fy25fp-en.pdf.
[4] Michael Kinnucan, "The Medicaid MCO Tax Strategy," Fiscal Policy Institute, March 19, 2024, https://fiscalpolicy.org/the-medicaid-mco-tax-strategy.

Table 5. An Example MCO Tax

Source	Funding
Revenue Raised from Provider Tax	$100
Federal Match	$100
Gross Revenue	**$200**
Reimbursement to Taxpayers	-$100
Net Revenue	**$100**

This complex structure raises a tricky accounting issue. In our example, has the state's Medicaid *spending* increased by $100, or by $200? Naïve accounting would show that the state is outlaying an extra $200 in all-funds spending—$100 in repayments to the providers who paid the tax and another $100 in increased Medicaid spending in other areas.

But this would be misleading. In our example, $100 of the new spending simply reimburses the hospital that paid the original tax; it does not represent any *net* increase to Medicaid spending. To see the issue, imagine that the tax was suddenly cancelled. The state would need to find a way to replace the $100 in extra federal revenue used to fund rate increases—but it would *not* need to replace the $100 used to reimburse the hospital for its share of the tax. That spending would simply disappear, since the hospital would no longer be paying the tax.

This is where the Enacted Budget Financial Plan paints a confusing picture. As we shall see, the Financial Plan presents both the new spending *and* the tax offsets as increased DOH Medicaid spending. But as described above, these tax offsets should not really be counted as Medicaid spending, since they are simply making whole the providers that have paid an additional tax, and are not being spent on service provision. This artificially inflates New York's DOH Medicaid spending by $1.9 billion in FY27.

New York's version of this mechanism places a tax not on hospitals but on Medicaid Managed Care Organizations—hence the name MCO tax. Its complex structure raises complex accounting issues, which are not clarified by the state's complex presentation (see table 5). The state has chosen to raise and spend MCO tax revenue through a new vehicle, the "Healthcare Stability Fund" (HSF), which is legally excluded from the Global Cap. This allows the state to increase reimbursement rates to hospitals, nursing homes, and other providers without Global Cap limitations. The state reports dramatic growth in HSF disbursements, from $1.2 billion to $4.1 billion—an increase which accounts for much of the rise in DOH Medicaid spending. But much of this is due to a $1.75 billion increase in "Assessment Offsets." What are these?

Table 6: MCO Tax Spending as Presented in the Budget, $ in millions.

	FY26 Actual	FY27 Projected	Growth 26–27 ($)
Opening Balance	$201	$1,757	$1,556
Receipts	**$2,801**	**$3,403**	**$602**
Miscellaneous Receipts	$2,801	$2,653	-$148
General Fund Transfer	$0	$750	$750
Disbursements	$1,245	$4,139	$2,894
Global Cap Offset	$500	$500	$0
Hospitals	$174	$711	$537
Nursing Homes	$223	$433	$210
Safety Net Transformation	$0	$330	$330
FQHCs	$0	$40	$40
ALPs	$8	$18	$10
Assessment Offsets	**$142**	**$1,892**	**$1,750**
All Other	$198	$215	$17
Closing Balance	$1,757	$1,021	

Source: FY27 Enacted Budget Financial Plan, 109.

Rearranging the table, as we do in table 7, offers a clearer picture of what is happening.

Table 7: MCO Tax Spending Clarified, $ in millions.

	FY26 Actual	FY27 Projected	Total
Opening Balance	$201	$1,757	
Gross MCO Tax Receipts	$2,801	$2,653	$5,454
MCO Tax Assessment Offsets	- $142	- $1,892	-$2,034
Net MCO Tax Revenue	$2,659	$761	$3,420
General Fund Transfer Into HSF	$0	$750	
Disbursements (Excluding MCO Tax Assessments)	$1,103	$2,247	$3,350
Closing Balance	$1,757	$1,021	

Source: FY27 Enacted Budget Financial Plan, 109.

Table 7 allows us to trace the tax much more clearly. The tax generates $2.8 billion in *gross* revenue in FY26 and a further $2.7 billion in FY27—a total of $5.45 billion. The state uses $2.03 billion of this revenue (plus associated federal match) to reimburse the taxpayers—that's what the Assessment Offsets are. This generates $3.4 billion in *net* MCO tax revenue—and this revenue is in turn used for a variety of purposes, including rate increases to hospitals, nursing homes, Federally Qualified Health Centers (FQHCs), and other providers, as well as general Medicaid spending (the Global Cap Offset in table 5). Overall, this program spending amounts to $1.1 billion in FY26 and $2.2 billion in FY27. The $4.1 billion in FY27 spending presented in the Financial Plan and in table 5 is misleading, since it includes $1.9 billion in one-time MCO tax offsets that do not represent real program spending, will not recur, and will not need to be replaced with state spending when the MCO tax ends.

Thus, a proper accounting would show Medicaid spending from this source growing from $1.1 billion to $2.2 billion—an increase of $1.1 billion. But, as shown in table 5, the Financial Plan shows a much more rapid increase in spending—from $1.2 billion to $4.1 billion, an increase of $3.9 billion. This is because the state has (for unclear reasons) chosen to reimburse the MCOs almost entirely in FY27 and has chosen to count this $1.9 billion in reimbursements as new Medicaid spending—despite the fact that the reimbursements, along with the tax, will disappear entirely from FY28 on. This artificially inflates DOH Medicaid spending by $142 million in FY26 and a whopping $1.9 billion in FY27.

The Real Picture of Medicaid Spending Growth

Table 8 shows the real trend in DOH Medicaid spending, accounting for both the Mental Hygiene Stabilization Fund and the MCO tax accounting issues. Adjusting for both items eliminates more than *three billion dollars* in state-share DOH Medicaid spending in FY27, reducing the rate of growth from 16.2 percent to 7.1 percent.

Table 8. Medicaid Spending Growth, FY27, $ in millions.

	FY26 Actuals	FY27 Projected	Growth 26–27 ($)	Growth 26–27 (%)
DOH Medicaid (Reported)	$34,397	$39,964	$5,567	16.2%
MHSF	-$58	-$1,441		
MCO Tax Assessment Offsets	-$142	-$1,892		
DOH Medicaid (Adjusted)	$34,197	$36,631	$2,434	7.1%

Given flat enrollment trends, why is Medicaid spending growing at all? The answer is fairly straightforward: provider rate increases. The Healthcare Stability Fund pays for $1.1 billion in state-share funding increases to nursing homes and hospitals, while rate increases to home care agencies linked to the minimum wage and home care wage account for hundreds of millions more. Absent this spending, the Medicaid program would be growing at roughly the rate of inflation, and far more slowly than the state budget overall.

Where Are the Cuts?

Still, given the scale of federal Medicaid cuts involved in the OBBBA, wouldn't one expect Medicaid spending to be *shrinking?* What about all the federal cuts?

Medicaid Cuts are Unaccounted For

Within the Medicaid program, two factors are responsible for the apparent lack of fiscal pain caused by the OBBBA. First and foremost, the state has chosen to *simply not account for* any potential enrollment loss due to Medicaid work requirements, which are due to go into effect on January 1, 2027. The state has previously suggested that more than one million people could lose Medicaid coverage due to these work requirements—but the state's projected Medicaid enrollment figures simply ignore this possibility, projecting modest enrollment *increases* during the next three years.[5]

[5] Hochul and Washington, "FY27 NYS Enacted Budget Financial Plan," 97.

A precise accounting for the impact of Medicaid work requirements would be challenging, given the uncertainty involved in the unprecedented program. Broadly speaking, the cuts would be expected to reduce Medicaid spending, but since the federal government pays most of the coverage costs for the Medicaid expansion population, this reduction would show up largely in federal or all-funds Medicaid spending. It is not reflected in any way in the Financial Plan.
Second, some of the cuts have not yet hit. The federal government allowed the state to maintain the MCO tax through the end of CY26, but after that it cannot be renewed; the approximately $1.7 billion a year in (net) MCO tax revenue generated in FY26 and FY27 will need to be replaced from state tax dollars—but this replacement won't be required until FY28. Likewise, the OBBBA will dramatically cut New York's largest source of safety net hospital funding, the Directed Payment Template (DPT) or state-directed payment program—but these cuts are not scheduled to phase in until January 1, 2028, and are not addressed in the FY27 financial plan.

In sum, New York's Medicaid program will experience dramatic cuts both in FY27 and in future years—but the former are ignored in the Financial Plan, while the latter have yet to occur.

The Essential Plan

Cuts to the Essential Plan (EP) will go into effect immediately. While not a Medicaid program, EP is frequently treated as part of the Medicaid budget. Federal cuts to this program are substantial and will occur beginning in FY27.[6] In FY26, New York funded EP entirely with $14.6 billion in federal funding; this funding is set to drop by more than half to $9.1 billion in FY27 and $6.9 billion in FY28.

The state is responding to the Essential Plan cut in two ways—by reducing eligibility for the program, immediately and dramatically, and by funding it out of reserves. On July 1, 2026, 450,000 New Yorkers lost EP coverage, reducing the annual cost of the program by over $3 billion to $11.3 billion per year. The state will make up the remaining shortfall by spending down an accumulated reserve associated with EP, the Basic Health Program Trust Fund, which currently has a balance of nearly $10 billion. This funding source will last the state only through FY29, however, and absent federal policy changes New York will need to invest state money or it will be forced to eliminate the program.

Protecting Medicaid Requires Better Financial Accounting

New York's Medicaid program, then, remains under severe fiscal pressure—and the screws will only tighten in future years. Addressing these challenges requires honest conversations among stakeholders—and those conversations must be based on shared facts. The distorted picture of Medicaid spending presented in this year's Financial Plan provides no workable basis for understanding, much less addressing, the fiscal challenges to New York's healthcare system.

What can the state do to present a clearer picture? Two key measures are required.

First, New York should repeal the Medicaid Global Cap. As explained above, the Global Cap is a fiction and has been for many years; it provides no meaningful containment of New York State Medicaid costs.

[6] Hochul and Washington, "FY27 NYS Enacted Budget Financial Plan," 135.

But preserving the fiction has required the Department of Budget to systematically manipulate the state's DOH Medicaid spending figures in a way that makes tracking year-on-year changes in Medicaid spending extremely difficult. It is time to acknowledge publicly what those close to the program have known for many years: That the Global Cap is a failed policy framework. This simple step would have no impact on spending (since the cap is effectively inoperative already) but would greatly improve transparency.

Second, the state should present state, federal and all-funds Medicaid spending *by program area* in its budget documents. Medicaid is an enormously complex program and Medicaid spending accounts for nearly half of the all-funds state budget; the public needs disaggregated data to have any meaningful understanding of what drives spending patterns in Medicaid. Programs such as Mainstream Managed Care, Managed Long-Term Care, safety net hospital spending, the Medicare Savings Program, the Nursing Home Transition and Diversion waiver—each of which accounts for between several billion and tens of billions of dollars in all-funds spending—are very different from each other, face different enrollment pressures, and spend money in different ways for different reasons. It is not possible to meaningfully discuss the state Medicaid budget when all these programs are lumped together in a single line.[7]

New York's Medicaid program is under attack by the federal government on multiple fronts, and facing this threat requires trust and accountability. The State of New York can best promote such accountability by providing transparent and usable information to the public about how Medicaid spending is changing and why.

[7] The quarterly Medicaid Global Cap reports provide some level of transparency, but their publication is frequently delayed, they are based on opaque and frequently changed accounting practices, and they provide only state-share, not all-funds spending information. These reports serve a useful function but are no replacement for the transparent presentation of spending data in the state budget. See New York State Department of Health, Medicaid Global Spending Cap Updates, accessed August 11, 2026, https://www.health.ny.gov/health_care/medicaid/regulations/global_cap/.