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New York State SFY 2021 Enacted Budget Highlights

OVERVIEW

On April 3rd, the $178 billion State Budget for State Fiscal Year (SFY) 2021 was passed by the New York State Legislature and signed by the Governor.

As a result of economic volatility due to the COVID-19 crisis, the State anticipates a revenue shortfall of $10 billion and an overall budget deficit of up to $15 billion. The Budget authorizes a $10 billion reduction in spending in the absence of federal assistance, granting the Budget Director the broad authority to control spending throughout the year by making quarterly spending adjustments based on actual revenue. To adjust for COVID-19-related expenses, the Director will review the budget during three periods of one month, two months, and six months, respectively, starting April 1st. If actual tax receipts are lower than estimates by more than 1%, or if actual spending is more than 1% higher than estimates, the Director will be empowered to propose adjustments to appropriations during each period in order to balance the budget due to COVID-19 effects. The legislature will have the ability to approve a different plan, but if they do not, the Executive plan will go into effect.

The enacted Budget includes many of the Medicaid Redesign Team (MRT) II panel's recommendations to contain Medicaid spending growth. However, the Budget also proposes to delay the effective dates of some of these provisions up to 90 days after the termination of an executive order declaring a state disaster emergency (i.e. COVID-19), which may allow the State to access a 6.2% federal enhanced match percentage (FMAP) increase, representing approximately $5 billion in new federal funds if the state of emergency lasts through the end of the year. Several of the MRT II-recommended provisions would impose stricter eligibility restrictions on receiving certain services, which would otherwise violate the federal requirement for states to maintain unchanged Medicaid eligibility standards and coverage during the COVID-19 emergency. The total savings for SFY 2021 from enacted MRT II recommendations is budgeted at $2.2 billion.

Below is a summary of health-related provisions included in the Budget's appropriations bills and Article VII legislation. A standalone Health and Mental Hygiene Article VII bill was not released this year; instead, health-related provisions were incorporated into the other Article VII bills, most notably the Education, Labor, and Family Assistance (ELFA) Article VII bill.

The full SFY 2021 budget is available here.

COVID-19

Provisions addressing the COVID-19 emergency are outlined below.

State Revenue

- The Budget authorizes the State, through the Dormitory Authority and Urban Development Corporation, to issue up to $8 billion in short-term bonds to raise funds necessary to replace quarterly taxes postponed due to COVID-19 and to establish lines of credit of up to $3 billion to

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cover state expenses temporarily. These facilities would mature in one year but could be rolled over and refinanced in future years, without regard to debt limits in existing law.
- The budget establishes a Distressed Provider Assistance Account of $250 million per year to be contributed by local governments ($200 million by New York City and $50 million by other localities proportional to population). However, the first instance of these payments will be deferred until January 2021.
- The Budget Director will have the authority to review and approve an allocation plan for any disbursement of federal aid received in response to COVID-19.
- The budget establishes the Public Health Emergency Charitable Gifts Trust Fund, in which the State would be able to receive donations related to a public health emergency (i.e., COVID-19).

Providers and Payers

- The Budget enacts the Emergency or Disaster Treatment Protection Act, which grants health care facilities, professionals, and volunteer organizations immunity from criminal or civil liability for actions that occur in the course of providing health care services during the COVID-19 emergency, unless due to intentional misconduct or gross negligence. The waiver is not strictly limited to COVID-19 treatment.
    - "Facilities" include Article 28, 31, and 16 licensed programs or any other facility authorized by a COVID-19 emergency rule.
    - "Professionals" include physicians, physician extenders, pharmacists, nurses, midwives, psychologists, social workers, other mental health practitioners, respiratory therapists, clinical laboratory workers, nursing attendants or certified nursing aides, emergency medical technicians, home care services workers, administrators and executives, and any other person authorized by a COVID-19 emergency rule.
- Insurers will not be permitted on retrospective review to deny claims for emergency department and inpatient services related to COVID-19 treatment during the emergency.

Other

- Up to $4 billion is appropriated in a special purpose fund which may be freely transferred at the direction of the Governor to any agency, department, or authority for services and expenses related to the COVID-19 outbreak, including additional personnel, equipment and supplies, travel costs, and training. Funds may also be used as state aid to municipalities.
- The EFLA bill also allows for an immediate transfer of $250 million to "any funds or accounts" needed to maintain "essential governmental operations" that have been impacted by executive orders or other responses to COVID-19.
- $1.2 billion is appropriated for elementary and secondary schools through the Education Stabilization Fund, to be funded with federal aid through the CARES Act.

GENERAL MEDICAID

The budget extends the Medicaid Global Cap of 3% for two years (through March 2022) without requiring any changes to the local share of Medicaid, effective April 1st, and implements (as an

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administrative action) the total 1.5% across-the-board cuts to Medicaid reimbursement, effective April 1st. It also expands telehealth services by enabling DOH, in consultation with other State agencies, to:

- Allow for additional modalities for the delivery of telehealth series, including but not limited to, audio-only telephone communications, online portals and survey applications;
- Consider additional categories of originating sites where patients may be located; and
- Adding care managers as an eligible provider type.

HOSPITALS

- For calendar years 2020 through 2022, the Indigent Care Pool funds distributed to non-public general hospitals that do not qualify as enhanced safety net hospitals will be reduced by an aggregate of $150 million annually. The reductions will be distributed by a to-be-determined methodology which may take into account the payor mix of each non-public general hospital, including the percentage of inpatient days paid by Medicaid.
- For inpatient Medicaid rates, the capital add-on payment is reduced by 5% and reconciliation add-on payments are reduced by 10%.
- The budget repeals the Indigent Care Pool transition collar and replaces it (for the next two years) with a distribution of $64.6 million to eligible enhanced safety net hospitals, proportional to reductions experienced due to the removal of the transition collar.
- The budget provides unchanged funding for essential community providers and VAP ($66 million).

LONG TERM CARE

Many of the MRT II's recommendations for long-term care reform have been included in the enacted budget. However, the changes to eligibility standards would only go into effect after six months (i.e., October 1st), and the Executive may choose to delay any and all implementation dates during the COVID-19 emergency and for up to 90 days after the end of the State disaster emergency. The budget:

- Introduces new restrictions on eligibility for Consumer Directed Personal Assistance Program (CDPAP) services and personal cares services (other than personal emergency response services) by allowing these services for the following individuals seeking initial services beginning October 1st :
    - individuals needing assistance for more than two activities of daily living (ADL), and
    - individuals with dementia or Alzheimer's diagnosis needing assistance with more than one ADL;
- Requires eligibility for CDPAP services and personal care services to be determined by an independent assessor using an approved assessment tool, who must be procured by October 1, 2022, instead of the local departments of social services, Medicaid managed care providers, and MLTC plans who currently perform the assessments;
- Requires MLTC plans to conduct assessments of enrollees on an annual basis;
- Establishes a 30-month "look back period" for asset transfers to determine non-institutionalized individual's eligibility for Medicaid community-based long-term care services;
- Requires dual eligibles enrolled in a Medicare dual-eligible special needs plan (D-SNP) who do not require more than 120 days of LTSS to enroll in an affiliated Medicaid managed care plan, if available;

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- Imposes an annual enrollment cap on MLTC plans (excluding PACE or D-SNPs) that is calculated based on the plan's quality of care scores, historical disenrollment data, and other factors, with plans exceeding the cap subjected to premium withholdings of 3%, effective October 1st;
- Places a moratorium on the approval of new managed long term care (MLTC) plans and applications from existing MLTCs trying to expand their service area or eligible enrollee populations. The moratorium does not apply to MLTCs in geographic areas with health delivery concerns or PACE programs and D-SNPs;
- Enables the Commissioner to assess the public need for MLTC plans that are not integrated with an affiliated Medicare plan and develop a process to sunset such plans if needed;
- Prevents licensed home care services agencies (LHCSAs) from participating in Medicaid unless authorized by DOH, and provides criteria for DOH to select such LHCSAs, including geographic distribution to ensure statewide access;
- Reduces the capital component of nursing home payment rates by 5% and eliminates residual equity reimbursement;
- Establishes reimbursement fees for private nursing duties for medically fragile children; and
- Modifies the EQUAL program, which provides grants to improve the quality of life at adult care facilities, by developing methodology to disburse program funds based on facility needs and population of residents receiving SSI, Medicaid, or other safety net assistance.

BEHAVIORAL HEALTH

- Establishes a behavioral health parity compliance fund, to be funded by penalties collected from insurers which violated behavioral health parity requirements. Funds will be used for initiatives supporting parity implementation and enforcement on behalf of consumers, including the behavioral health ombudsman program;
- Establishes a separate appointing authority for a Secure Treatment and Rehabilitation Center within the Office of Mental Health (OMH) for the care and treatment of dangerous sex offenders requiring confinement, and transfers all OMH employees who are substantially engaged in the care of Article 10 sex offenders to this center;
- The role of the Pre-Admissions Certification Committee (PACC) in admissions to OMH Residential Treatment Facilities (RTFs) has been eliminated.
    - Decisions to recommend admission or priority admission shall occur in consultation with the RTF and be based on a determination of appropriateness including consideration of facility staffing, patient mix and acuity, and the safety of other residents.
    - OCFS may review such admissions for appropriateness up to 14 days after admission.
    - OCFS will establish an RTF advisory board to issue an annual report on admissions to RTFs.
- Extends the ability of general hospitals, local governmental units, and voluntary agencies to be approved to operate comprehensive psychiatric emergency programs (CPEPs) until July 1, 2024
    - Authorizes psychiatric nurse practitioners and physicians to provide triage and referral services, at which point the individual is to be appropriate treated and discharged or referred for further crisis intervention services;
    - Removes crisis residence services from the list of psychiatric emergency services that CPEPs should provide;
    - Allows for CPEP programs to operate in satellite facilities.
- The typical Behavioral Health VAP appropriation has not been included.

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DEVELOPMENTAL DISABILITIES

- The autism awareness and research fund has been moved from the DOH auspices into the OPWDD auspice.
- Providers of 1915(g) case management services (including optional waiver services) designated for people with I/DD, i.e., Care Coordination Organizations, must have a certificate of authority from OPWDD, and are removed from the jurisdiction of DOH.

WORKFORCE

- Enacts the following mandatory paid sick leave program for employers, based on company size:
  - Employers with 4 or fewer employees must provide employees with 5 days of unpaid sick leave annually;
  - Employers with 5-99 employees must guarantee at least 5 days of sick leave annually;
  - Employers with at least 100 employees must guarantee at least 7 days of paid sick leave annually.
- Requires that construction workers be paid a prevailing wage when working on projects with construction expenses exceeding $5 million and where at least 30% of those costs are supported by public funds;
- Strengthens wage parity laws by levying fines and/or short imprisonment sentences on LHCSAs, certified home health agencies (CHHAs), long term home health care programs, managed care plans, fiscal intermediaries, or other third parties who fail to compensate home care aide employees their due wages and benefits;
- Extends permission for licensed pharmacists and certified nurse practitioners to administer vaccines through July 1, 2022;
- Extends for another five years the ability for individuals employed in programs regulated by the Office for People with Developmental Disabilities (OPWDD), the Office of Children and Family Services (OCFS), and the Office of Mental Health (OMH) to perform the duties of a licensed behavioral analyst assistant (provided that they do not use that title).

PHARMACY

- Carves out the pharmacy benefit from the managed care benefit package back into fee-for-service;
- Grants the Department of Financial Services (DFS) to investigate prescription drugs that have increased prices by more than 50% to an amount greater than $5 per unit, over the course of a year;
- Establishes a nine-member drug accountability board;
- Extends and enhances the Medicaid drug cap;
- Allows the Commissioner, in the absence of a managed care provider or pharmacy benefit manager, to negotiate directly and enter into supplemental rebate arrangements with pharmaceutical manufacturers, limited to antiretrovirals for HIV/AIDS, opioid dependence agents and opioid antagonists listed in a statewide formulary, hepatitis C agents, high cost drugs, gene therapies, etc.
- Establishes a statewide formulary of opioid dependence drugs and opioid antagonists;
- Caps individuals' out-of-pocket cost-sharing for prescription insulin at $100 per 30-day supply.

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HEALTH INSURERS

- Several of the insurance provisions proposed in the Governor's original Executive Budget are included (some with modifications):
    - Utilization review for inpatient rehabilitation services following an inpatient admission must be made within one business day.
    - Insurers must respond to appeals within 30 days instead of 60 days, and, if the adverse determination is overturned, must comply with prompt payment requirements.
    - Insurers must offer provisional credentialing to physicians who are newly-licensed, new to New York State, or who have a new tax identification number and who are employed by Article 28 hospitals or clinics, or Article 16, Article 31, or Article 32 licensed facilities.
    - Insurers may not deny a general hospital's claims for medically necessary inpatient services, observation services, or emergency department services solely on the basis that the general hospital did not comply with the insurer's administrative requirements. This does not prevent claims from being denied during pre-authorization.
    - If it is unclear whether a plan is liable to pay a claim, the plan must provide (electronically) specific product information to the provider, and once its liability is determined, or increased, that amount must be paid within 15 days.
    - When a claim is adjusted downwards, and a hospital resubmits additional information to justify the original coding, insurers must base their coding appropriateness determinations on national guidelines. If, on review, the insurer must pay the hospital an additional amount, they will owe interest beginning 30 days after the initial claim if submitted electronically (down from 45).
    - The State will convene an administrative simplification workgroup, including insurers, hospitals, and other stakeholders, to submit a report on possible measures within 18 months.
- Surprise billing reforms have been enacted:
    - Inpatient services following an ED visit are explicitly included in the category of "emergency services" for the purposes of surprise billing. Existing surprise billing regulations apply to such services.
    - A non-participating provider may not balance bill (or bill for any amount other than applicable cost-sharing if the provider were participating) a beneficiary for emergency services, if the beneficiary assigns their benefit to the provider.
- The Medicaid Inspector General may apply penalties to managed care organizations and MLTCs for untimely or inaccurate submissions of encounter data, clarified as all encounter records or adjustments to previously submitted records.
- The penalties for plans who miss reporting requirements (e.g., late or incomplete encounter data) have been amended. Different penalties are established for MLTC and non-MLTC plans (the MLTC penalties are slightly lower).
- Utilization review processes must include procedures for obtaining an enrollee's preference for receiving notifications, including allowances for electronic notifications.
- Various MRT recommendations are incorporated for the previous and future fiscal years, including:

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- Discontinue the Enhanced Safety Net Program, the Value-Based Payment Stimulus, and new Social Determinants of Health Investments.
- The Managed Care Quality Pool is reduced by 50%.
- Continue Mainstream Managed Care and MLTC rate reductions.

PILOT PROGRAMS

The budget authorizes the implementation of one or more five-year regional global-budget demonstration programs, contingent on federal funding. It also authorizes the establishment of the following pilot programs, to be effective September 1st:

- A diabetes and chronic disease self-management pilot program in one or more counties or regions for the purpose of improving clinical outcomes, subject to federal financial participation;
- One or more maternal health promotion pilot programs which provide Medicaid reimbursement of prenatal maternal childbirth education and preparation classes for enrollees, transportation to and from classes, etc.
- A program to promote the use of nonpharmacologic alternatives to opioid treatment for individuals suffering from chronic pain;
- Programs in one or more counties or regions to promote social determinants of health interventions, including:
  - Up to three projects targeted at the provision of medically tailored meals for individuals diagnosed with cancer, diabetes, heart failure, and/or HIV/AIDS;
  - Up to five medical respite programs to provide care to homeless patients;
  - A street medicine program to allow Article 28 diagnostic and treatment centers to provide and bill for certain services for the chronically street homeless population.

TRANSPORTATION

MRT II reforms to transportation were included in the budget:

- Subject to federal financial participation, DOH is authorized to contract with one or more transportation management brokers to provide non-emergency transportation to Medicaid beneficiaries, on a statewide or regional basis. These transportation broker(s) will be selected through a competitive bidding process based on experience, performance, references, resources, qualifications, and costs.
  - The broker(s) may be paid a per member per month capitated fee or a combination of capitation and fixed cost reimbursement;
  - Adult day health care providers and PACE programs and other plans that integrate benefits for dually-eligible Medicare/Medicaid beneficiaries are not required to use the services of the transportation management broker;
- Medicaid rates for non-ambulance transportation (e.g. taxi/livery/van) are reduced by 7.5%.

OTHER

- Reauthorizes the Health Care Reform Act (HCRA) through the end of FY 2023, which includes the following provisions:
  - Extend the continuation of the Medicaid inpatient hospital reimbursement methodology and collection of HCRA surcharges and assessments, including the Covered Lives Assessment;

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    - Extend the Home Care Workforce Recruitment and Retention Program and Personal Care Workforce Recruitment programs;
    - Discontinue select public health programs, including several Doctors Across NY (DANY) programs.
- Extends the authorization for the statewide health information network of New York (SHIN-NY) and the statewide planning and research cooperative system (SPARCS) for three more years.
- Extends the process for certifying Medicaid ACOs through December 31, 2024.
- Authorizes the Office of the Medicaid Inspector General to impose penalties on Medicaid providers who do not grant timely access to the Medicaid Fraud Control Unit of the Attorney General's Office or the Department of Health regarding audits, investigations, and reviews.
    - Authorizes the Medicaid Inspector General to levy penalties based off a number of factors, including the number and total value of Medicaid claims, the quality of medical care, the degree of culpability of the provider, etc, with a monetary penalty not to exceed $15,000.
- Requires Medicaid providers to adopt and implement an effective compliance program, with a compliance officer and a compliance committee, that includes measures that prevent, detect, and correct fraud, abuse, waste, and non-compliance with Medicaid requirements and implements effective training and education for its employees.
    - If it is determined that the provider has failed to adopt and implement a compliance program, the inspector general can impose a penalty on the provider of up to $10,000 a month for up to a year.