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NEW YORK FY 2023-24 EXECUTIVE BUDGET

February 2023

Sachs Policy Group

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New York State Fiscal Year 2024 Executive Budget Summary

OVERVIEW

On February 1st, Governor Kathy Hochul submitted her second Executive Budget to the Legislature, covering New York State Fiscal Year (FY) 2024, which will run from April 1, 2023 to March 31, 2024.

This year, the Division of the Budget (DOB) forecasts a "spectrum of uncertainty" around New York State's fiscal position. To date, New York's economy has outperformed previous expectations, resulting in significantly higher-than-expected tax receipts for the last two fiscal years. However, DOB now forecasts a "mild national recession" and accompanying declines in wage growth, resulting in reduced projections of tax receipts starting in FY 2024.

Overall, the Executive Budget proposes total spending of $227.0 billion, up from a projected $221.6 billion in FY 2023 (itself an increase from the original FY 2023 projection of $216 billion). The budget now includes outyear gaps totaling $22 billion over the next three years (FY 2025 through 2027).

The Budget includes major health proposals outlined in the Governor's State of the State, including:

- A $1 billion investment in increased inpatient and outpatient behavioral health care capacity;
- A new round of capital funding for health care transformation (totaling $1 billion);
- Reforms to the Certificate of Need (CON) process;
- A new process for DOH to conduct oversight of "material transactions" involving less-regulated health care providers and affiliates such as management services organizations (MSOs);
- New requirements for insurance plans to provide coverage of behavioral health services, including for plans to pay out-of-network licensed clinics the Medicaid rate if an in-network option is not available; and
- Creating an option for experienced physician assistants (PAs) to practice independently, and making other scope of practice expansions for nurses, PAs, and pharmacists.

It also includes a variety of other proposals, such as:

- A 5% increase to Medicaid inpatient hospital, nursing home, and assisted living program rates;
- A 2.5% cost of living adjustment (COLA) for eligible human services providers;
- A proposal to require managed long-term care (MLTC) plans to meet performance standards, including contracting with the minimum number of licensed home care services agencies (LHCSAs) and fiscal intermediaries (FIs), and authorizing the Department of Health (DOH) to conduct a competitive bid process to select MLTCs if not enough plans meet the standards;
- Creating a streamlined joint licensure for Certified Community Behavioral Health Clinics by the Office of Mental Health (OMH) and the Office of Addiction Supports and Services (OASAS);
- Insurance reforms, including:
    - Prohibiting insurers from making prospective denials for emergency services and associated inpatient admissions;
    - Establishing that a site of service review (i.e., a review of whether a service needed to be provided in a hospital-based outpatient setting) is a utilization review and must follow the associated procedures; and

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- Repeating the proposal from last year's Executive Budget to shift responsibility for health care professions regulation from the State Education Department to DOH.

Other major proposals from the State of the State, such as the Future of Health Care Commission, integrated licensure streamlining, and Medicaid primary care rate increases, may be implemented through administrative authority.

The below summary provides further detail on these and other highlights from the Budget. Where available, legislative sources are marked in [brackets]. The full Budget materials are available here.

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CAPITAL FUNDING

The Budget would allocate a new, fifth phase of the Statewide Health Care Facility Transformation Program (SHCFTP V). This program would make another $1 billion of capital funds available "for the purpose of transforming, redesigning, and strengthening quality health care services in alignment with statewide and regional health care needs, and in the ongoing pandemic response."

Eligible recipients would include, but not be limited to:

- Hospitals;
- Nursing homes;
- Adult care facilities;
- Article 28 diagnostic and treatment centers;
- Licensed clinics (including those under the Mental Hygiene Law);
- Article 31 children's residential treatment facilities (RTFs);
- Assisted living programs;
- Licensed behavioral health facilities under Article 31 or Article 32;
- Article 36 licensed home care services agencies (LHCSAs);
- Primary care providers;
- Hospice agencies;
- Community-based programs funded under OMH, OASAS, or the Office for People with Developmental Disabilities (OPWDD) or through local governmental units;
- Independent practice associations (IPAs) or organizations; and
- OPWDD residential or day programs licensed or certified under Article 16.

The funds would be split into the following two pools:

- $500 million "to build innovative, patient-centered models of care, increase access to care, to improve the quality of care and to ensure financial sustainability of health care providers."
- $500 million "for technological and telehealth transformation projects."

These two pools share language with two pools appropriated last year in SHCFTP IV, of $750 million and $200 million, respectively. As no application process for those pools has yet been released, total capital funding for these purposes of $1.25 billion and $700 million, respectively, will be available [HMH, Part P; Capital 357].

MEDICAID

Authority to Cover New Waiver Populations

New York has submitted 1115 waiver applications that would expand Medicaid coverage to provide certain services within two new populations:

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- In-reach services for incarcerated individuals with chronic conditions, starting 30 days prior to release; and
- Short-term stays in Institutions for Mental Disease (IMDs) for adults with behavioral health diagnoses, and in-reach services for others in IMDs, starting 30 days prior to discharge.

The Budget would make conforming changes to statute to allow such populations to become eligible for Medicaid [HMH, Part K].

Coverage of CHW, Nutrition, Dietician, and Arthritis Self-Management Services

The Budget would authorize the following new Medicaid benefits:

- Community health worker (CHW) services, which may be provided to children under 21 or to adults with health-related social needs (HRSN), when recommended by a qualified physician or health care practitioner, effective January 1, 2024 and pending federal approval [HMH, Part Q];
- Nutritionist and dietician services within their scope of services, effective July 1st [HMH, Part R, Section 1]; and
- Arthritis self-management training services, effective October 1st and pending federal approval [HMH, Part R, Section 1]. Such services could be reimbursed through non-Ambulatory Patient Group (APG) methodologies as a substitute for more acute services [HMH, Part R, Section 2].

Repeal of Article 28 Restrictions on Social Workers and Coverage of LMHCs/LMFTs

Effective January 1, 2024, the Budget would remove the restriction that allows Article 28 clinics only to bill for social worker services if they are providing individual psychotherapy to children under 21 or pregnant or postpartum women. Going forward, social workers would be able to provide any allowable services in such settings. Additionally, such clinics would be able to employ licensed mental health counselors (LMHCs) or licensed marriage and family therapists (LMFTs) to their full scope of practice as well [HMH, Part Q, Section 2].

Delay of Medicaid-Equivalent Coverage for Older Immigrants

The FY 2023 Enacted Budget provided that individuals 65 or older who "are otherwise eligible for medical assistance […] but for their immigration status" are eligible to receive benefits through an Article 44 Medicaid managed care provider. This provision's effective date has been delayed to January 1, 2024 [HMH, Part H, Section 1].

Expansion of the Medicaid Buy-In for Working People with Disabilities

The Budget would expand the Medicaid Buy-In program for working people with disabilities to remove its age limit and dramatically increase the income and resources limits. Specifically:

- The maximum age of 65 would be removed (the minimum age of 16 remains).
- The maximum income would increase from 250% of FPL to 2,250% of FPL.

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- The maximum resources would increase from the current Medicaid resource limit for non-Modified Adjusted Gross Income (MAGI) populations ($28,133 for a one-person household in 2022) to a flat level of $300,000.

The legislation would allow up to 30,000 people to participate in the program. These changes would be conditional on federal approval of the required waivers [HMH, Part N]. The Budget would allocate $60 million to fund this program [AtL 623].

Increasing MLR Requirements for Plans

The Budget proposes administratively to increase the minimum medical loss ratio (MLR) requirement for all plans to 89%. Currently, only Health and Recovery Plans (HARPs) are subject to an 89% MLR requirement, while other plans are subject to an 86% MLR. DOH projects that this would result in $67 million in savings in FY 2025 [DOH Agency Appropriations Report].

Discontinuing Supplemental Managed Care Quality Pool Funding

The Budget proposes to discontinue supplemental funding for managed care quality pools. DOH projects that this would result in almost $112 million in state share savings in FY 2024 and FY 2025 [DOH Agency Appropriations Report].

Ending Long-Term Low-Acuity and Medium-Acuity Health Home Enrollment

The Budget proposes to "graduate out" low and medium-acuity Health Home enrollees who "have had long-term enrollment." DOH projects that this would result in $30 million in savings in FY 2024 and $70 million in 2025 [DOH Agency Appropriations Report].

HOSPITALS

Inpatient Rate Increase

Effective April 1st, the Budget would provide a uniform rate increase of 5% to Medicaid inpatient hospital rates, on top of the 1% across-the-board increase from last year [HMH, Part E, Section 9].

Indigent Care Pool Reduction

The Budget proposes to continue and extend modifications to the distribution of the Indigent Care Pool (ICP) that began in 2020. Under current law, the gross ICP for voluntary hospitals was reduced from $970 million to $820 million starting in 2020. Facilities that qualify as Enhanced Safety Net Hospitals (ESNHs) are exempted from the decrease and provided with an additional $64.6 million to offset the elimination of the previous transition collar (the "ESNH Transition Collar Pool").

The Budget proposes to further reduce the gross ICP by an additional $85.4 million ($42.7 million State share savings), to $734.6 million, through 2025, and extend the ESNH Transition Collar Pool [HMH, Part E].

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Authorization of Rural Emergency Hospitals

The Budget would authorize hospitals to seek to operate under the new federal designation of Rural Emergency Hospitals (REHs). The REH category was established in statute in the federal 2020 year-end omnibus spending bill to help small rural hospitals at risk of closure to close their inpatient units while continuing to provide 24-hour emergency services as well as observation and other outpatient services, if elected by the REH, of up to 24 hours per patient annually. By statute, Medicare will reimburse designated REHs at a rate 5% higher than the Outpatient Prospective Payment System (OPPS) rate and will provide an additional monthly payment to help subsidize costs, based on the additional amount paid by Medicare to Critical Access Hospitals (CAHs).

Facilities seeking to become an REH would need to hold a public community forum at least 30 days before submitting an application [HMH, Part E, Sections 2-3].

VAPAP Modifications

The Budget would indefinitely extend DOH's authority to make payments to facilities under the Vital Access Provider Assurance Program (VAPAP). Instead of a "transformation plan," VAPAP applicants would need to submit an "application." Finally, it would add a new eligible provider type, "an entity that was formed as a performing provider system […] and collaborated with an independent practice association that received VBP Innovator status" [HMH, Part E, Sections 4-8]. This description appears to apply only to the SOMOS Community Care PPS.

LONG TERM CARE

MLTC Performance Standards and DOH Authority for Procurement

The Budget would establish new "performance standards" for managed long-term care (MLTC) plans, including a minimum enrollment size and a "commitment to contracting with the minimum number" of home care agencies and fiscal intermediaries. These standards would begin to apply to any MLTC plans with a certificate of authority under Section 4403-f of the Public Health Law in October 2024. Specifically, MLTC plans would be required to:

- Have "continuous" MLTC enrollment of at least 20,000 enrollees, or Medicare Dual Eligible Special Needs Plan (D-SNP) or DOH integrated Medicaid product enrollment of at least 5,000, in the last calendar year;
- Make a "commitment to contracting with the minimum number" of LHCSAs and fiscal intermediaries (FIs) needed to provide necessary personal care and Consumer Directed Personal Assistance Services (CDPAS);
- Demonstrate readiness to adhere to maximum wait time criteria;
- Implement a community reinvestment plan committing a percentage of the plan's surplus to addressing social needs;
- Commit to quality improvement;

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- Meet standards for accessibility and geographic distribution of network providers;
- Demonstrate cultural and language competencies;
- Show adequate breadth of service area across multiple regions;
- Demonstrate the ability to serve enrollees across the continuum of care, including dual eligibles, Children's Health Insurance Program (CHIP) enrollees, and the Essential Plan; and
- Demonstrate value-based care readiness and experience.

If DOH determines that, as of October 2024, an "insufficient number" of MLTC plans meet these standards, all plans would be required to submit a new application to continue their certificate of authority to operate an MLTC plan. Plans would be selected through a competitive bid. DOH would be required to take into account possible pending mergers in determining the necessity for such a procurement.

DOH would also have the ability to disqualify any plan that:

- Is designated as a poor performer by the Centers for Medicare and Medicaid Services (CMS);
- Experiences an "excessive volume" of penalties, enforcement actions, or other sanctions; or
- Is otherwise determined by DOH to be out of compliance.

If conducted, the procurement would select MLTC plans "no sooner than" April 1, 2026. It would need to result in at least two MLTC plans selected in each geographic region, if possible.

If the procurement is not conducted, DOH would require MLTC plans that do not meet the performance standards to establish and implement a performance improvement plan [HMH, Part I, Sections 2-6].

Repeal of Fiscal Intermediary Procurement

The Budget would repeal the current statute that would require a procurement for FIs, viewing it as no longer necessary after establishing the MLTC performance standards and possible procurement above [HMH, Part I, Sections 7-12].

Nursing Home and ALP Rate Increase

Effective April 1st, the Budget would provide a uniform rate increase of 5% to Medicaid nursing home and assisted living program rates, on top of the 1% across-the-board increase from last year [HMH, Part I, Section 13].

Removal of CDPAS from Downstate Wage Parity Laws

Subject to the establishment of a CDPAS premium assistance fund (below), the Budget would remove CDPAS personal care aides from the downstate wage parity laws contained in Section 3614-c of the Public Health Law, which affect New York City, Long Island, and Westchester. CDPAS aides would still be included in the home care minimum wage increase provisions passed in last year's Enacted Budget as Section 3614-f of the Public Health Law [HMH, Part I, Sections 14-15].

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CDPAS Premium Assistance Fund

No earlier than January 2025, the Budget would establish a supplemental premium assistance fund for CDPAS aides who are seeking ACA individual market coverage through New York State of Health and are eligible for federal tax credits for such coverage. The fund would pay for the premium cost of a benchmark silver plan in the aide's county of residence, for a full-time aide, and half of this amount, for a part-time aide [HMH, Part I, Sections 16-17].

The Budget would appropriate $62 million for this program [AtL 633].

Quality Standards for ALRs

The Budget would create new reporting requirements for assisted living residences (ALRs). ALRs are entities who provide housing and home care services to at least five residents, and should be distinguished from nursing homes, adult care facilities (ACFs) and assisted living programs (ALPs), and other residential services programs.

Under the Budget, ALRs would be required to report on quality measures and publicly disclose operational information, including monthly service rates, staffing, the admission agreement, and a "consumer-friendly summary of all service fees." These reports would commence January 1, 2024. DOH will identify top-performing ALRs and grant them an "advanced standing" classification. A facility that is both an ACF and an ALR may seek a national accreditation to be exempt from the DOH inspection process [HMH, Part Z].

MANAGED CARE

Elimination of Prospective Denials for Emergency or Inpatient Services

Effective January 1, 2024, the Budget would create new requirements in Insurance Law to prohibit payers from engaging in prospective denials of claims for emergency or inpatient hospital services.

Specifically, if a payer seeks to review clinical documentation for medical necessity (including if the services were emergency services or that the site or level of care was appropriate), but the obligation for such a claim is otherwise clear, the payer must pay the claim in a timely manner. The statute would then establish a timeline for further handling of the claim:

- Within 30 days of payment, the payer could request further clinical documentation to confirm medical necessity.
- Within 45 days of such a request, the hospital would be required to provide such documentation.
- Within 90 days of receiving such documentation, the payer would be able to submit the claim to a "joint committee" of the payer's and hospital's clinicians for a post-payment audit.
- Within 90 days of the committee receiving such a request, it would request and examine documentation and issue a determination whether the services were medically necessary. If a

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hospital does not provide documentation to the committee within 60 days of its request, the services would be considered not necessary.
- If the Committee cannot agree on a determination during this timeframe, the claim would be submitted to a third party review agent within 5 business days for a final judgment.

These requirements would apply to licensed Article 43 and Article 44 insurers as well as Article 47 municipal cooperative health benefit plans. Hospitals and insurers would be allowed to form alternative arrangements than those above, but the requirement to pay the claim first must remain [HMH, Part J].

Regulation of "Site of Service" Reviews

Effective January 1, 2024, the Budget would regulate the performance of "site of service" reviews. This is defined as when an insurer reviews whether a service should be covered if it is provided in a hospital outpatient setting, rather than a free-standing ambulatory surgery center. "Insurer" would include Article 43 and Article 44 insurers as well as otherwise regulated insurers.

Under the proposal, site of service reviews would be considered Article 49 utilization reviews and would be subject to all applicable Article 49 regulations. In particular, such reviews would be subject to both internal and external appeals processes. The Budget also sets out criteria under which plans must approve services in a hospital outpatient setting and criteria which must be taken into consideration during site of service reviews [HMH, Part L].

ESSENTIAL PLAN

Authority to Seek Transition to 1332 Waiver

The Budget would authorize DOH to seek to move the authority for New York's Essential Plan, which is authorized under the Basic Health Program in Section 1331 of the Affordable Care Act (ACA), to an ACA Section 1332 State Innovation Waiver, "if it is in the financial interest of the state to do so."

Under this authority, DOH would seek to expand the maximum eligible income for the Essential Plan from 200% of the federal poverty line (FPL) to 250% of FPL. Essential Plan coverage would also provide continuous coverage for postpartum women and their newborns for one year, regardless of changes in income [HMH, Part H]. It remains highly uncertain if the federal government can or will approve such a transition.

Other Modifications

DOH also intends to:

- Increase reimbursement rates by aligning rates across all tiers of Essential Plan coverage;
- Reduce consumer cost sharing further "to move closer to Medicaid parity";
- Expand the Essential Plan quality pool and fund grants to incentivize plan investments in mental health and social services addressing social determinants of health; and
- Increase MLR requirements from 85% to 86% [DOH Agency Appropriations Report].

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BEHAVIORAL HEALTH

Joint Licensure of CCBHCs and CCBHC Indigent Care Program

The Budget would create a joint licensure process between OMH and OASAS for CCBHCs. Currently, CCBHCs are required to receive separate Article 31 and Article 32 clinic licenses. Existing CCBHCs in the federal demonstration would be certified under this new licensure "where the clinic demonstrates compliance with the certification standards."

Additionally, the Budget would support CCBHCs with a new Indigent Care Program to "assist in meeting losses resulting from uncompensated care." Funding would be based on "actual, reported losses," and would be distributed proportionally to such losses. CCBHCs with at least 3% of total visits by uninsured individuals would be eligible for the program. The legislation provides allocations for three years, from July 2023 through June 2026:

- July 1, 2023 through June 30, 2024: $22.5 million
- July 1, 2024 through June 30, 2025: $41.25 million
- July 1, 2025 through June 30, 2026: $45 million

If federal matching funds are not obtained, this amount would be halved [HMH, Part HH]. The total maximum appropriation in FY 2023-4 for this program is $33.75 million [AtL, 634].

Mandatory Coverage of Sub-Acute and Mobile BH Crisis Services

The Budget would expand BH coverage requirements for insurance plans that cover inpatient services to also include:

- Sub-acute care in an OMH-authorized medically-monitored residential setting (i.e., a Residential Treatment Program, Residential Crisis Support, or Intensive Crisis Residence) [HMH, Part II, Subpart A]. These services would not be subject to prior authorization or concurrent review, for the first 14 days (for children) or 30 days (for adults, subject to conditions) [HMH, Part II, Subpart B];
- Licensed mobile crisis intervention services. These services also would not be subject to prior authorization, and insurers would be required to cover them on an in-network basis even if the provider is out of network;
- Post-discharge outpatient care coordination services, Critical Time Intervention (CTI) services, and Assertive Community Treatment (ACT) services; and
- School-based mental health clinic services. These services would also be required to be covered regardless of network participation, and insurers would have to pay at minimum the Medicaid rate for such services [HMH, Part II, Subpart A].

Additionally, no prior authorization or concurrent review would be applied for the first 30 days of mental health treatment for adults in any OMH-licensed inpatient hospital setting, unless the patient meets certain clinical criteria [HMH, Part II, Subpart B].

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Expansion of Telehealth Parity to Other Insurers

The Budget would expand on last year's requirement for Medicaid plans to reimburse Article 16, 31, and 32 services delivered by telehealth at the in-person rates as established by OPWDD, OMH, and OASAS.

Specifically, the Budget would apply an equivalent payment parity provision in Articles 32 and 43 of the Insurance Law and Article 44 of the Public Health Law, such that all regulated plans would need to pay for these services at the in-person rate, although not necessarily the government-established Medicaid rate [HMH, Part II, Subpart C].

Right of Action for Parity Violations

The Budget would allow insured individuals to sue plans for violations of telehealth parity, and to potentially recover the greater of actual damages or $1,000. This would not apply to Medicare, Medicaid, CHIP, Essential Plan, or other federal or state "insurance affordability program" coverage [HMH, Part II, Subpart D].

No Prior Authorization for SUD Detox or Maintenance Prescriptions

The Budget would clarify and expand existing prohibitions on prior authorization for buprenorphine and certain other drugs. It would state that Article 32 and 43 regulated insurers may not conduct prior authorization for any prescription for "the detoxification or maintenance treatment of a substance use disorder," including naloxone [HMH, Part II, Subpart E].

BH Network Adequacy Standards

The Budget would authorize the Department of Financial Services (DFS), DOH, OMH, and OASAS to establish enhanced network adequacy standards for behavioral health. These would include:

- Requiring "timely and proximate" access to BH treatment;
- Establishing appointment availability standards, including timeframes for initial, follow-up, and post-discharge visits;
- Establishing time and distance standards, based on geography and other factors; and
- Requiring plans to cover out-of-network services if in-network services are not available within the above standards (and out-of-network services are). If the relevant out-of-network provider is a licensed OMH or OASAS provider, the insurer would reimburse at minimum the Medicaid rate for such programs [HMH, Part II, Subpart F].

Increased Fines for Closed Inpatient Beds

As promised in the State of the State, the Budget would increase possible fines under Article 31 for hospitals that "fail to comply with the terms of the operating certificate," including for having closed

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inpatient beds without authorization, to $2,000 per day. Penalties may be considered at the individual bed level [HMH, Part JJ].

PHARMACY

Continuation of Pharmacy Carveout to FFS

The Executive Budget proposes to implement the planned transition of the Medicaid pharmacy benefit from managed care to fee-for-service (FFS), and notes that it will reinvest savings to backfill the loss of 340B revenues for safety net providers [DOH Agency Appropriations Report].

Prescriber Prevails and DOH Authority to Modify the OTC Formulary

The Budget proposes to end the "prescriber prevails" provision. It also proposes to give DOH the authority to remove coverage of over-the-counter drugs that are reimbursable by Medicaid (rather than only to add new drugs, as in current law) [HMH, Part D].

Prescription Drug Transparency and Registration of Pharmacy-Related Companies

Effective April 1, 2024, the Budget would direct DFS to conduct oversight of drug price increases. Manufacturers would be required to file reports that describe the drug, the amount of the increase, and a justification, among other items, and to pay a filing fee to DFS.

Additionally, all pharmacy services administration organizations (PSAOs) would be required to register with DFS. A PSAO would be defined as an entity that contracts on behalf of pharmacies with payers, pharmacy benefit managers (PBMs), or other drug buyers. PSAOs would also be subject to reporting requirements, including the disclosure of the aggregate amounts of any discounts or vouchers that they receive. DFS would also conduct registration of pharmacy switch companies (pharmacy clearinghouses) and rebate aggregators [HMH, Part Y, Subpart B].

OVERSIGHT OF HEALTH CARE TRANSACTIONS

CON Reforms

The Budget proposes a series of reforms to the CON process, which include:

- Reducing the review window of the level of care provided in an applicant's affiliated health care providers from ten to seven years;
- Clarifying the rules around stock or ownership transfers. In particular, the statute specifies transactions "will be final" after a 90-day review period passes with no objection;
- Increasing the construction fee for CON applications by Article 28 hospitals, nursing homes, or diagnostic and treatment centers by 0.05% of the capital cost (to 0.6% if they require Public Health and Health Planning Council approval, or 0.35% if not); and

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- Reducing the character and competence requirement for LHCSA applications by removing stockholders or members of "third level or higher entities that will exercise no control of the agency functions" from review [HMH, Part M].

Oversight of Investor-Backed Physician Networks and Other Non-CON Entities

Effective April 1, 2024, the Budget would provide DOH with new oversight authority around mergers, acquisitions, affiliations, and partnerships of health care entities not currently subject to CON. This authority is meant to address the "proliferation of large physician practices being managed by entities that are investor-backed."

Specifically, DOH would be required to approve certain "material transactions" among health care entities that are not subject to existing review under Article 28 or other parts of Public Health Law. "Material transactions" could include mergers, acquisitions, affiliations, or the formation of an accountable care organization (ACO) or management services organization (MSO), that meet DOH's standards for review (such as exceeding a revenue threshold). "Health care entities" would be defined broadly to include any physician practice or MSO that provides "all or substantially all administrative or management services" associated with a provider.

Entities would be required to seek DOH approval before engaging in a "material transaction." DOH could consider a wide range of factors, such as the effects on the health care ecosystem, anticompetitive effects, the financial condition of the participants, the character and competence of parties, the source of funds, the "fairness" of any exchange of shares or cash, and other relevant information.

If DOH does not withhold approval within 30 days, the transaction would be deemed approved. During that 30-day period, DOH would provide public notice of the proposed transaction and provide an opportunity for public comments. DOH may also "require undertakings" as a condition of approving transactions, including contributions to state-controlled funds.

Finally, DOH would have the authority to issue civil penalties of up to $10,000 per day for violations of the article. All fines would be deposited in the state's Health Care Transformation fund [HMH, Part M].

WORKFORCE

Licensure and Scope of Practice

The Executive Budget would authorize experienced physician assistants (PAs), defined as those with at least 8,000 hours of experience, to independently practice in primary care or, if employed by a hospital, in any subspecialty. It would also repeal the current limits on the number of PAs that a physician may supervise (generally a maximum of four, under current law). Conforming changes to allow PAs to prescribe controlled substances and other items necessary for a course of therapy would also be made.

The Budget also proposes the following scope of practice flexibilities:

- Physicians or nurse practitioners (NPs) may issue non-patient specific orders to pharmacists to provide patients with 30 to 60-day supplies of HIV pre-exposure prophylaxis (PrEP). Current

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law permits such an order for a seven-day "starter pack." Additionally, the law would establish certain guardrails and requirements for pharmacists who dispense such supplies, including that any given patient would only be eligible for up to one 60-day supply per year, unless otherwise directed by a prescriber.

- Pharmacists would be authorized to order and administer any Clinical Laboratory Improvement Amendments (CLIA) waived diagnostic tests. Current law permits such orders only for Covid-19 and influenza tests.
- Pharmacists would be authorized under their scope of practice to prescribe and order:
    - Approved nicotine dependence medications; and
    - Naloxone and opioid antagonists.
- The following two-year temporary scope of practice expansions authorized in the FY 2023 Enacted Budget would be made permanent:
    - Enabling licensed pharmacists to direct a limited service laboratory to order and administer Covid-19 and influenza tests; and
    - Allowing physicians and NPs may issue non-patient specific orders to registered nurses (RNs) to test patients for Covid-19 or influenza.
- The Collaborative Drug Therapy Management (CDTM) demonstration program, which allows participating pharmacists to adjust or manage a patient's drug regimen in line with their physician's patient-specific order or protocol, would be made permanent and expanded as follows:
    - NPs and health care facilities with a medical director would be able to form CDTM agreements with pharmacists.
    - CDTM may occur in any Article 28 facility.
- Dentists would be authorized to conduct HIV and hepatitis C tests.
- Physicians and NPs would be authorized to issue non-patient specific orders to RNs to conduct:
    - Orders for asthma and diabetes self-management programs;
    - Urgent or emergency treatment of asthma; and
    - Stool tests for colorectal cancer.
- Pharmacists would be authorized directly to order asthma and diabetes self-management programs, and these services would be added to the definition of Medicaid "standard coverage."
- Authorization for the Advanced Home Health Aide program would be extended through FY 2029, and supervision requirements for advanced aides would be reduced.
- As proposed in the FY 2023 Executive Budget, the scope of practice for certified medication aides would be expanded to allow them to administer routine and prefilled medications, under the supervision of RNs, in residential health care facilities. This authority would expire in two years if not extended [HMH, Part W].

OPWDD Direct Care Staff Providing Nursing Services under Self-Direction

The Budget would clarify that direct care staff in non-facility-based OPWDD programs may provide services that fall under the scope of practice of nursing. However, such staff may not be employed

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"solely for performing such care," and the care must be delivered under self-direction or family direction, when determined by an RN to be capable of such direction. This would create consistency between OPWDD community-based self-directed services and the mainstream long-term care CDPAS program [HMH, Part FF].

Qualified Mental Health Associate Credentialing

The Budget would establish a new OMH credential for "qualified mental health associates." These associates would be paraprofessional staff who are considered qualified to "provide counseling and supportive assistance" to people with mental health issues. OMH will establish a credentialing process and minimum qualifications for such staff, including appropriate study or on-the-job experience. The scope of practice would be limited to counseling and assessment type services [HMH, Part GG].

Interstate Licensure Compacts

The Budget repeats last year's proposal for New York to join the Interstate Medical Licensure Compact and the Nurse Licensure Compact, which will simplify the process by which physicians and nurses can use their existing license from other states to practice in New York [HMH, Part W, Sections 30-31].

Registration of Staffing Agencies

The Budget would create a new Article 29-K regulating temporary staffing agencies. Such agencies employ nurses, certified nurse aides, and other licensed or unlicensed direct care workers and contract with other health care entities to provide temporary staffing. Article 29-K would require these agencies to register with DOH on a yearly basis and meet other compliance requirements, including reporting "a full disclosure of charges and compensation" (such as hourly bill rates). DOH would be authorized to issue regulations regarding business practices, including permissible pricing and fees [HMH, Part X].

COLA for Human Services Agencies

The Budget proposes a new 2.5% COLA for FY 2024 for eligible human services programs, with the same language and provisions as the 5.4% COLA enacted in FY 2023. Eligible programs include most programs certified, licensed, or funded by:

- OMH;
- OASAS;
- OPWDD; and
- The Office of Children and Family Services (OCFS).

The COLA would also be applied to certain programs under the auspices of the State Office for Aging (SOFA) and the Office of Temporary and Disability Assistance (OTDA).

Any Local Government Units (LGUs) or direct contract providers receiving this funding would be required to submit a written certification of how funds will be used first to recruit and retain direct care

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staff [HMH, Part DD]. This will require $188.6 million in State funding for OPWDD, OMH, and OASAS voluntary operated programs [Executive Budget Briefing Book].

Regulation of Health Professions

The Budget repeats last year's proposal to transfer oversight of all licensed health professions from the State Education Department (SED) to DOH and would expand on it by codifying all existing regulations in a new Article 51 of the Public Health Law and transferring SED employees to DOH as well. Effective January 1, 2024, DOH would have oversight over the licensure of physicians, nurses, psychologists, social workers, mental health practitioners, and pharmacists, among other professions [HMH, Part CC].

EMERGENCY MEDICAL SERVICES

The Budget repeats, with some modifications, last year's proposals around emergency medical services (EMS). Specifically, it seeks to:

- Develop an expanded definition of emergency medical services;
- Create a comprehensive statewide emergency medical services (EMS) plan and system; and
- Establish standardized training and treatment protocols across regional EMS agencies.

Additionally, DOH would develop a new "mobile integrated healthcare" service model, incorporating EMS providers, which would provide integrated patient care. Under the auspices of such programs, EMS practitioners would be authorized to provide additional services, including the administration of immunizations and buprenorphine. [HMH, Part S].

STATE AGENCIES

Modernizing Health Reporting Systems

The Budget allocates the following new funding for the Governor's State of the State proposal to replace New York's "outdated health care reporting infrastructure with a nation-leading health monitoring and surveillance system to inform targeted and appropriate responses to public health crises and to drive broader health care insights":

- $30 million in capital funding for a new electronic health record (EHR) connectivity incentive program [Capital 358];
- $1.5 million in capital funding for "the development of modernized health care data systems," as part of a plan to be developed by DOH in consultation with the Office of Information Technology Systems [Capital 358];
- $32.5 million in capital funding for the Statewide Health Information Network (SHIN-NY), which includes an increase of $2.5 million "for modernizing health reporting systems" [Capital 360]; and

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- Additional capital and operating fund investments for the Hospital Electronic Data Response System (HERDS) and the capacity for hospitals to have direct access [DOH Agency Appropriations Report].

Minimum Wage Funding

The Budget continues funding for minimum wage increases at OMH, OASAS, and OPWDD authorized programs. It would provide a total of $39 million, as follows:

- $6.5 million for OMH [AtL 830]
- $2.7 million for OASAS [AtL 806]
- $30.1 million for OPWDD [AtL 859]

OMH

The Budget would recommend $6.36 billion in all-funds appropriations (an increase from $5.21 billion in all-funds appropriations from FY 2023), which includes:

- $2.66 billion in aid to localities, an increase of $48 million from last year [AtL 824]
- $1.45 billion in capital projects, an increase of $97 million from last year [Capital 430]
- $2.25 billion in state operations, an increase of $1 billion from last year [State Ops 503].

The Budget proposes the $1 billion in new capital funding to be distributed as follows:

- $890 million to build 2,150 new residential beds for people with mental illness, including:
  - 500 new community residence-single room occupancy (CR-SRO) beds;
  - 900 transitional step-down beds; and
  - 750 permanent supportive housing.
- $25 million to develop 60 community step-down units to serve formerly unhoused individuals transitioning from inpatient care [OMH Agency Appropriations Summary; Capital 431].
- $60 million for 12 new or expanded Comprehensive Psychiatric Emergency Programs (CPEPs) or psychiatric inpatient programs [Capital 431].

The Governor's plan additionally calls for 600 licensed Apartment Treatment beds and 750 scattered-site Supportive Housing beds, for a total of 3,500 new beds [OMH Agency Appropriations Summary].

In operating funds, the Budget would allocate:

- $49 million (an increase of $30 million from last year) to support emergency programs, including the creation of new transitional beds and CTI teams;
- $914 million (an increase of $107 million from last year) for residential programs, including the development of new transitional stepdown units to help individuals transition back to the community;
- $60 million (up from $35 million last year) for the 988 BH crisis hotline;
- A new $3.25 million for the Individual Placement and Supports program;

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- A new $2.8 million for the Intensive and Sustained Engagement Treatment (INSET) program; and
- A new $2 million to expand access to eating disorder treatment [AtL 828-831].

It would also allocate $14 million, up from $9 million last year, to fund the recruitment and retention of psychiatrists, psychiatric nurse practitioners, and other licensed clinicians in mental health programs deemed to have critical capacity shortages, including:

- Psychiatric inpatient units;
- CPEP programs; and
- Crisis, residential and outpatient programs [AtL 826].

For children's services, it would allocate:

- Up to $5 million to reimburse residential treatment facilities for children and youth (RTFs) for expenditures related to the transition to managed care and redesign projects;
- $10 million for youth suicide prevention;
- $5 million for high fidelity wraparound services for children;
- An increase of approximately $24 million to expand the Healthy Steps program for children, the home-based crisis intervention program for children, and school-based clinics [AtL 835-836].

OASAS

The Budget would appropriate $1.24 billion in all funds for OASAS, which includes:

- $968.6 million in aid to localities, a $240 million decrease from last year [AtL 803]
- $174.6 million for state operations, an increase of $10 million from last year [State Ops 494]
- $92 million for capital projects, a decrease of $10 million from last year [Capital Projects 412]

The decrease is primarily attributable to the expiration of one-time appropriations for workforce bonuses and the Opioid Stewardship Fund.

The Budget would also appropriate $123.6 million for the Opioid Settlement Fund, which along with reappropriation amounts of $208 million (for a total of $331.6 million, of which at least $79 million will be paid to local governments), will be used to implement a range of harm reduction initiatives to address the opioid crisis, including grants to establish 15 community-based harm reduction programs; the development of a training program for police departments and other elements of the criminal justice system to implement harm reduction strategies; and funding equipment for street outreach teams. [AtL 810 and 820]

OPWDD

The Budget would provide $7.42 billion in all funds for OPWDD:

- $4.95 billion in aid to localities, an increase of $124.5 million from last year [AtL 851]
- $2.36 billion in state operations, an increase of $57.4 million from last year [State Ops 516]

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- $119.5 million in capital projects, an increase of $6.9 million from last year[Capital Projects 467]

These figures are affected by the expiration of one-time funding for workforce bonuses. Overall, the OPWDD state share appropriations for Medicaid services would increase from $3.95 billion to $4.25 billion (by $300 million). New and expanded initiatives include:

- $2 million to establish an ombudsman program, which will provide client advocacy services for individuals eligible for OPWDD services [State Ops 518];
- An additional $30 million for residential services; and
- An additional $10 million for day services [AtL 858].

The Budget notes that OPWDD intends this year to evaluate the proposed transition to OPWDD managed care "by assessing the potential effectiveness and sustainability of the proposed delivery system" [OPWDD Agency Approprations Summary].

OCFS

The Budget would appropriate $5.8 billion overall for OCFS programs, a significant increase from previous years. However, this change is the result of technical modifications and does not signal programmatic modifications.

Among other items, the Budget would appropriate $17 million to assist certain foster care congregate care providers that meet the definition of an IMD by providing support for medical staffing needs, services, and other necessary investments [AtL 333].

OTHER HEALTH CARE PROVISIONS

Consumer Protections for Medical Debt

The Budget would enact several consumer protections related to medical debt, including:

- In medical debt default cases where the plaintiff is not a hospital or practitioner (i.e., if the debt has been purchased by a third-party collector), the plaintiff must provide an affidavit from the hospital regarding the facts of the debt and demonstrate their rightful title to the debt [HMH, Part Y, Subpart A].
- Hospitals participating in the ICP would be required to use a DOH-developed "uniform financial assistance form" as part of collection procedures [HMH, Part Y, Subpart C].
- No insured person would be liable to a provider for debts that arise because of the insolvency of any Article 32 covered commercial insurer. The State would expand the current Life Insurance Guaranty program to include commercial health care and long-term care insurers, so that in cases where an insurer becomes insolvent, providers could make claims to the Guaranty Fund. Medicare, Medicaid, and Essential Plan insurers would not be included [HMH, Part Y, Subpart D].

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Hepatitis C and Syphilis Screening

The Budget would make permanent the requirement for Article 28 hospitals and diagnostic and treatment centers to offer hepatitis C screenings to all adults receiving inpatient or outpatient services. Physicians attending pregnant individuals will also be required to order hepatitis C testing during pregnancy and a second round of syphilis testing (along with the existing requirement to conduct syphilis testing on first examination) in the third trimester [HMH, Part AA].

Increase DASNY Authority to Issue Hospital and Nursing Home Bonds

The Budget would increase the ability of the Dormitory Authority of the State of New York (DASNY) to issue bonds for projects involving hospitals and nursing homes. Currently, this authority is limited to $17.4 billion, and the Budget would increase it to $18.2 billion [TED, Part Z].

Private Pay Eligibility

The Budget would reduce the income eligibility threshold for the Private Pay option to receive services from area agencies on aging from 400% of FPL to 250% of FPL [HMH, Part G].

Extenders

The Budget proposes to extend the authority for various existing provisions, such as:

- The Medicaid Global Cap would be reauthorized through FY 2025 [HMH, Part A].
- The requirement for a two-month cooling off period after a contract between an Article 44 insurer and a hospital is terminated would be extended through June 30, 2025 [HMH, Part B, Section 1].
- Spousal budgeting in MLTC would be extended through FY 2028 [HMH, Part B, Section 2].
- Authorization for the Care at Home (CAH) I and II waivers would be extended through FY 2028, and the age limit would be raised from 18 to 21 to conform with children's waiver criteria [HMH, Part B, Sections 3-6].
- The authorization of 60-day episodic payments for Certified Home Health Agencies (CHHAs) would be extended through FY 2027 [HMH, Part B, Section 13].
- Authorization for the Statewide Health Information Network (SHIN-NY) and the Statewide Planning and Research Cooperative System (SPARCS) would be made permanent [HMH, Part B, Section 18].
- Limits on administrative reimbursement for CHHAs and long-term home health care programs would be extended through FY 2027 [HMH, Part B, Sections 30-31].
- The Health Care Reform Act (HCRA) programs would be extended through FY 2026, and the Covered Lives Assessment will be increased by $40 million to conform with the special HCRA increase passed in 2021 to support Early Intervention [HMH, Part C].
- The Physicians Excess Medical Malpractice Program would be extended through June 30, 2024 [HMH, Part F].

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- Mandatory MLTC enrollment for individuals needing 120 days or more of community-based long-term care services would be extended through FY 2027 [HMH, Part I, Section 1].
- Authority for the Developmental Disability Individual Support and Care Coordination Organization (DISCO) program would be extended through September 30, 2028, "to preserve statutory flexibility if OPWDD was to transition its service delivery system to managed care" [HMH, Part EE].
- The current structure of financing for Committee on Special Education (CSE) placements outside New York City would be made permanent. This structure eliminates the approximately 18% State share for such placements and shifts responsibility to the school district (to approximately 57%) [ELFA, Part V].

OTHER NON-HEALTH PROVISIONS

Indexing the Minimum Wage to Inflation

The Budget proposes to index the state minimum wage to inflation, measured as the urban Consumer Price Index (CPI-W). This would begin in the year after the area's minimum wage reaches $15, as phased in under current law. In the eight-county downstate area, where the minimum wage is already $15, it would begin in 2024.

However, increases would be capped at 3%, and would not apply if the CPI-W is negative, if the U-3 unemployment rate increases by 0.5% or more, or if employment levels in New York at time of calculation have decreased from both three and six months before. [ELFA, Part S]

New Homes Targets and Housing Fast-Track

The Budget proposes a package of housing reforms meant to encourage development. In particular, it would set three-year housing growth targets for all cities, towns, and villages in New York, set at 3% downstate (a 12-county region) and 1% elsewhere. If a locality does not meet its growth target during a three-year cycle or at enact at least two of a list of five "preferred land use actions," the locality would lose its right to deny certain housing projects. Specifically, for the next three years, it would face limits on the criteria it could use to review projects and would be prohibited from rejecting projects that meet unit-count and affordability criteria based on noncompliance with land use criteria. Projects would also be exempted from state and local environmental review. Rejected projects would be able to use a "fast track" appeals process [ELFA, Part F].

The Budget would also require downstate cities, towns, and villages to amend zoning and other land use tools to increase average housing density within 0.5 miles of a non-seasonal rail station. A variety of conditions would apply to this proposal as well [ELFA, Part G].