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NEW YORK FY 2023-24 ENACTED BUDGET

May 2023

Sachs Policy Group

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New York State Fiscal Year 2024 Enacted Budget Summary

OVERVIEW

On May 2nd, the New York State (NYS) Legislature passed the Enacted Budget for NYS Fiscal Year (SFY) 2023-2024. Total spending across all sources (including NYS and federal funds) is estimated at approximately $229 billion, up from the Executive Budget's proposal of $227 billion, and a year-over-year increase from SFY 2022 of $8.6 billion.

Some notable changes in the Enacted Budget from Governor Hochul's Executive Budget include:

- **Medicaid Rates:** The Budget includes a 7.5% increase for inpatient hospital rates and a 6.5% for outpatient hospital rates, nursing homes, and assisted living programs. This is an increase from the 5% proposed by the Executive, but less than the 10% proposed by the Assembly and Senate.
- **Cost of Living Adjustment (COLA):** The Budget includes a 4% COLA for FY 2024 for eligible human services programs. This is an increase from the 2.5% proposed by the Executive, but less than the 8.5% proposed by the Assembly and Senate.
- **Workforce and Scope of Practice:** The Budget does not include the Governor's proposals to:
  - Join the Interstate Medical and Nurse Licensure Compacts;
  - Move oversight of health care professions from the State Education Department (SED) to the Department of Health (DOH);
  - Create an option for experienced physician assistants (PAs) to practice independently, and make other scope of practice expansions for nurses, PAs, and pharmacists; and
  - Create a credential for "qualified mental health associates."
- **Home Care Minimum Wage:** A new provision in the Budget removes the planned $1 per hour minimum wage increase for home care aides scheduled to take effect later this year, and replaces it with a new annual increase schedule through 2026. Beginning in 2027, minimum wage increases for home care workers will be indexed to inflation.

Other major proposals have been included, but with modifications. These include:

- **Capital Funding:** The Budget includes the proposed $1 billion for health care capital projects, with additional details on eligible projects within each competition pool.
- **Managed Long Term Care (MLTC) Plans:** The Budget includes the proposal to establish new "performance standards" for MLTC plans, with updated requirements. The Budget does not include the Executive proposal authorizing a competitive procurement process for MLTC plans.
- **Disclosure of "Material Transactions":** The Budget includes a modified form of the Executive's proposal to establish new reporting requirements for "material transactions" involving less-regulated health care providers and affiliates.

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- **Behavioral Health Network Adequacy:** The Budget includes the establishment of enhanced network adequacy standards for behavioral health but does not include the specific requirements outlined in the Executive Budget.

Administrative actions planned by the Executive, which are expected to be confirmed later, include:

- Increasing medical loss ratio (MLR) requirements for all mainstream Medicaid managed care plans and MLTC plans to 89%;
- Discontinuing supplemental funding for managed care quality pools;
- Expanding existing licensure thresholds;
- Increasing coverage and reimbursement for doulas; and
- Modifications to the Essential Plan, including increasing reimbursement rates and reducing consumer cost sharing.

The remainder of this document provides more detailed information on health care provisions and other highlights from the budget's Article VII legislation and appropriation bills. Where available, legislative sources are marked in [brackets].

The Article VII Health and Mental Hygiene (HMH) bill can be found here. Other FY 2024 budget materials are available on the Division of the Budget (DOB) website here. The Assembly has also published a Summary of Changes which is available here.

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CAPITAL FUNDING

Statewide Health Care Facility Transformation Program

As proposed in the Executive, the Enacted Budget allocates a new, fifth phase of the Statewide Health Care Facility Transformation Program (SHCFTP V). This program will make $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." Of this funding, $10 million is specifically allocated to the Community Health Care Revolving Capital Fund, a partnership between the State and the Primary Care Development Corporation (PCDC) that provides loan capital to eligible community-based health care providers to expand and improve preventive or primary care capacity.

Eligible recipients include, but are not 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 Enacted Budget also adds midwifery birthing centers as eligible recipients.

The funds would be split into the following two pools:

- $490 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." The Enacted Budget also adds the development of "capacity in underserved areas of the state" as an eligible project, which may include new construction and renovation projects in areas deemed to be underserved by DOH.
- $500 million "for technological and telehealth transformation projects." The Enacted Budget allows for such projects to include those that improve cybersecurity. Projects may also include unfunded applications submitted in response to SHCFTP IV.

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These two pools share language with two pools appropriated last year in SHCFTP IV, of $750 million and $150 million, respectively. As no application process for those pools has yet been released, total capital funding for these purposes of $1.24 billion and $650 million, respectively, will be available [HMH, Part P; Capital 426].

Community Resiliency, Economic Sustainability, and Technology Program

The Budget includes $385 million in new appropriations for the Community Resiliency, Economic Sustainability, and Technology (CREST) capital funding program. The CREST program provides grants of up to $50,000 for qualifying capital projects that improve the quality of life for NYS residents, such as grants that invest in workforce training and environmental sustainability [Capital 1107].

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:

- 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.

As proposed by the Executive, the Enacted Budget makes 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

As proposed by the Executive, the Enacted Budget authorizes 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. The Enacted Budget adds a definition of CHW services, which may include but not be limited to culturally appropriate patient education, health care navigation, care coordination (including the development of a care plan), patient advocacy, and support services for the management of chronic conditions [HMH, Part Q, Section 1];
- Nutritionist and dietician services within their scope of services, effective July 1st [HMH, Part R, Section 1]; and
- Chronic disease self-management programs for individuals with arthritis, 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].

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

As proposed by the Executive, effective January 1, 2024, the Budget removes 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 will be able to provide any allowable services in such settings. Additionally, such clinics will 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. As proposed by the Executive, 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

As proposed by the Executive, the Enacted 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 the federal poverty line (FPL) to 2,250% of FPL.
- 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 will allow up to 30,000 people to participate in the program. These changes will be conditional on federal approval of the required waivers [HMH, Part N].

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

The Executive Budget included a proposal to "graduate out" low and medium-acuity Health Home enrollees who "have had long-term enrollment." DOH projected that this would result in $30 million in savings in FY 2024 and $70 million in 2025 [DOH Agency Appropriations Report]. This proposal is expected to move forward, with the Enacted Budget appropriating $424.4 million for FY 2024, a decrease from $524 million in FY 2023 [AtL 826].

Inquiries into Home Care Wages and Plan Contracts

A new provision in the Enacted Budget provides explicit authorization to DOH to conduct inquiries into any Medicaid provider who employs home care aides (or officers thereof) "in relation to its contracts,

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employment or other relationship, and wages, compensation, and other benefits paid to home care aides." DOH may issue standard civil penalties of $2,000 per day if a response is not received within 15 business days.

DOH may also conduct any inquiry related to the provider contracts of any Article 44 HMO or MLTC plan, including but not limited to payment rates or terms and conditions. If a response is not received by the deadline that DOH sets for a reply, DOH may issue standard civil penalties of $2,000 per day.

Any materials submitted in response to such inquiries would be considered confidential for the purposes of Freedom of Information and related regulations. DOH will provide an annual report to the Governor and Legislature on information obtained through such inquiries [HMH, Part NN, Sections 4-5].

HOSPITALS

Inpatient and Outpatient Rate Increase

Effective April 1, 2023, the Budget will provide a uniform rate increase of 7.5% to Medicaid inpatient hospital rates, on top of the 1% across-the-board increase from last year. The Executive Budget had proposed a 5% increase, while both houses had proposed a 10% increase.

The Budget also adds a uniform rate increase of 6.5% to Medicaid outpatient hospital rates, on top of the 1% across-the-board increase from last year, effective April 1, 2023 [HMH, Part E, Section 9].

Safety Net Funding

The Executive Budget proposed to cut about $700 million of safety net funding overall, but the Enacted Budget restores about $500 million of these funds [Assembly Summary of Changes].

Indigent Care Pool Reduction

As proposed by the Executive, the Enacted Budget continues and extends 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 $969.9 million to $819.9 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 Enacted Budget further reduces the gross ICP by an additional $85.4 million ($42.7 million State share savings), to $734.6 million, through 2025, and extends the ESNH Transition Collar Pool [HMH, Part E].

Authorization of Rural Emergency Hospitals

As proposed by the Executive, the Enacted Budget authorizes hospitals to seek to operate under the new federal designation of Rural Emergency Hospitals (REHs). The REH category was established in statute

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

VAPAP Modifications

The Enacted Budget includes, with modifications, the Executive's proposal to indefinitely extend DOH's authority to make payments to facilities under the Vital Access Provider Assurance Program (VAPAP). As proposed by the Executive:

- Instead of a "transformation plan," VAPAP applicants will need to submit an "application" to DOH.
- A new provider type will be eligible for VAPAP, "an entity that was formed as a performing provider system […] and collaborated with an independent practice association that received VBP Innovator status." This description appears to apply only to the SOMOS Community Care PPS.

The Enacted Budget makes further modifications to VAPAP:

- The "severe financial distress" criterion is replaced with "serious financial instability," although the definition of the term has not been modified. It continues to require evidence that the entity has less than 15 days of cash on hand, lacks assets that can be monetized other than those vital to operations, and has exhausted efforts to obtain resources from corporate parents or affiliated entities.
- DOH may determine "criteria or requirements upon which an award of funds shall be conditioned," which may include a transformation plan, savings plan, or quality improvement plan.
- If DOH requires a recipient to contract with a vendor, DOH will have the ability to approve the vendor, but may not specify the vendor in advance.
- Additional new eligible entity types are added, including:
    - Public benefit corporations; and
    - Hospitals that, "in the discretion of the commissioner," serve a significant number of Medicaid beneficiaries, dual eligible, and/or uninsured individuals.
- The prohibition on using VAPAP funds for consultant fees and retirement of long-term debt is removed.
- The instruction for VAPAP payments to be made monthly is changed to being an option [HMH, Part E, Sections 4-7].

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LONG TERM CARE

MLTC Moratorium

As proposed by the Executive, the Enacted Budget continues the moratorium on new MLTC plans through FY 2027.

MLTC Performance Standards

The Enacted Budget includes, with modifications, the Executive proposal to establish new "performance standards" for MLTC plans. These standards will begin to apply to any MLTC plans with a certificate of authority under Section 4403-f of the Public Health Law in January 2024. Specifically, MLTC plans will be required to:

- Have a Medicare Dual Eligible Special Needs Plan (D-SNP) with a CMS quality star rating of at least three (or that has not been issued a CMS quality star rating);
- Make a "commitment to contracting with an adequate number" of Licensed Home Care Services Agencies (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;
- Commit to quality improvement;
- Meet standards for accessibility and geographic distribution of network providers;
- Demonstrate cultural and language competencies;
- 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.

The Enacted Budget removes the requirements proposed by the Executive for plans to implement a community reinvestment plan that would address social needs and show adequate breadth of services area across multiple regions, and changed contracting commitments from a "minimum" number of LHCSAs and FIs to an "adequate" number. The Enacted Budget also removes the minimum continuous enrollment requirements that were proposed in the Executive.

The Budget does not include the Executive proposal authorizing a competitive procurement process for MLTC plans if an "insufficient number" meet these standards. MLTC plans that have a CMS quality star rating of less than three stars will be required to establish and implement a performance improvement plan. These requirements do not apply to Program for All-Inclusive Care of the Elderly (PACE) programs [HMH, Part I, Sections 2-6].

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Nursing Home and ALP Rate Increase

Effective April 1, 2023, the Budget will provide a uniform rate increase of 6.5% 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].

This is an increase from the 5% proposed by the Executive, but less than the 10% proposed by the Assembly and Senate.

Minimum Wage for Home Care Aides

The Enacted Budget removes the planned $1 per hour minimum wage increase for home care aides that was scheduled to take effect on October 1st as per the FY 2023 Enacted Budget, and replaces it with the following:

- January 1, 2024: An increase of $1.55 in the eight-county downstate region of New York City, Long Island, and Westchester (to $18.55) and $1.35 (to $17.55) in the remainder of the state.
- January 1, 2025: An increase of $0.55 (to $19.10 downstate and $18.10 in the remainder of the state).
- January 1, 2026: An increase of $0.55 (to $19.65 downstate and $18.65 in the remainder of the state).

Beginning in 2027, minimum wage increases for home care workers will be indexed to inflation through a "home care worker wage adjustment," equal to the 3-year rolling average of the urban Consumer Price Index (CPI-W) for the Northeast region (which is also the factor of increase for the statewide standard minimum wage). The home care worker minimum wage will be limited to no greater than $3.00 per hour more than the statewide standard minimum wage.

The minimum wage increases above are being offset by a reduction in the supplemental home care wage tied to benefits (which may also be paid in the form of cash) for downstate regions. The benefit portion of the minimum rate for home care workers is being reduced by $1.55, from $4.09 per hour to $2.54 per hour in NYC and from $3.22 per hour to $1.67 in Westchester and Long Island [HMH, Part NN, Sections 1-3].

Reports indicate that savings from the supplemental wage decrease will be used for an increase in funding for the Quality Incentive Vital Access Provider Pool (QIVAPP), which supports eligible home care agencies to cover the cost of providing health insurance coverage for employees. Although not separately listed in appropriations, the Legislature has noted that the Budget provides "$70.6 million in additional QIVAPP funding" [Assembly Summary of Changes].

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Repeal of Verification Organization Requirements and Replacement with EVV

The Enacted Budget includes new provisions to repeal the Verification Organization (VO) requirements currently overseen by the Office of the Medicaid Inspector General (OMIG), which apply to personal care and home health providers with more than $15 million in Medicaid reimbursement. Currently, such providers must both comply with VO requirements as well as federal electronic visit verification (EVV) requirements.

In place of the VO requirements, the Budget codifies DOH and OMIG's authority to promulgate regulations to implement the federal EVV requirements for personal care and home health providers. These provisions will be effective January 1, 2024 [HMH, Part NN, Sections 6-8].

Omitted Proposals

Long-term care proposals from the Executive that were removed in the Enacted Budget include:

- The proposed repeal of the Fiscal Intermediary procurement;
- Removal of CDPAS from downstate wage parity laws and establishment of a supplemental premium assistance fund for CDPAS aides seeking ACA individual market coverage; and
- Implementation of new quality measure reporting requirements for assisted living residences (ALRs).

MANAGED CARE

Regulation of "Site of Service" Clinical Reviews

As proposed by the Executive, effective January 1, 2024, the Enacted Budget will regulate the performance of "site of service" clinical 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" includes Article 43 and Article 44 insurers as well as otherwise regulated insurers.

Site of service clinical reviews are considered Article 49 utilization reviews and are subject to all applicable Article 49 regulations, including 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 clinical reviews [HMH, Part L].

Omitted Proposals

The Enacted Budget does not include the Executive Budget proposal to create new requirements in Insurance Law to prohibit payers from engaging in prospective denials of claims for emergency or inpatient hospital services.

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ESSENTIAL PLAN

Authority to Seek Transition to 1332 Waiver

As proposed by the Executive, the Budget authorizes 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 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.

BEHAVIORAL HEALTH

Joint Licensure of CCBHCs and CCBHC Indigent Care Program

As proposed by the Executive, the Enacted Budget creates 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 supports CCBHCs with a new Indigent Care Program to "assist in meeting losses resulting from uncompensated care." Funding is based on "actual, reported losses," and will be distributed proportionally to such losses. CCBHCs with at least 3% of total visits by uninsured individuals are 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 will be halved [HMH, Part HH]. The total maximum state share appropriation in FY 2023-4 for this program is $33.75 million [AtL, 835].

Mandatory Coverage of Sub-Acute and Mobile BH Crisis Services

As proposed by the Executive, the Enacted Budget expands 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., crisis residence facilities and community residences for eating disorder integrated treatment programs) [HMH, Part II, Subpart A]. These services would not be subject to prior authorization or

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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;
- Critical Time Intervention (CTI) services and post-discharge 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].

No Prior Authorization for SUD Detox or Maintenance Prescriptions

As proposed by the Executive, the Enacted Budget clarifies and expands existing prohibitions on prior authorization for buprenorphine and certain other drugs. It states 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 Enacted Budget accepts, with modifications, the Executive proposal authorizing the Department of Financial Services (DFS), DOH, OMH, and OASAS to establish enhanced network adequacy standards for behavioral health. The Enacted Budget does not include the specific requirements outlined in the Executive Budget for the network adequacy standards, such as the establishment of appointment availability standards and a requirement that plans cover out-of-network services if in-network services are not available within the standards. The Enacted Budget instead directs the Commissioner of Health, in consultation with DFS, OMH, and OASAS, to propose regulations on network adequacy standards by December 31st.

The Enacted Budget also outlines specific services that will be included in these standards, including residential facility services, CTI services, ACT services, and mobile crisis intervention services [HMH, Part II, Subpart F].

Increased Civil Penalties for Closed Inpatient Beds

As proposed by the Executive, the Enacted Budget increases possible civil penalties under Article 31 for hospitals that have "failed to comply with the terms of the operating certificate," including for having closed inpatient beds without authorization. Such civil penalties will not exceed $2,000 per day or $25,000 per violation. Penalties may be considered at the individual bed level.

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The Enacted Budget includes new language indicating that any civil penalty imposed under this regulation will account for:

- Any officially declared national, state, or municipal emergency;
- Any unforeseen disaster or other catastrophic even that directly impacts access to health care services;
- The frequency, duration, scope, and nature of non-compliance; and
- Any other factors as established by the Commissioner of Health.

However, a hospital may not argue that it was unable to secure proper staff or other necessary resources if "the lack of staff or other resources was foreseeable and could be prudently planned for," such as routine staffing needs due to vacation and sick leave [HMH, Part JJ].

Daniel's Law Task Force

The Enacted Budget includes a new provision directing OMH, in collaboration with OASAS and subject to available appropriations, to establish the "Daniel's Law Task Force." This task force will be comprised of mental health and substance use response and diversion subject matter experts as well as individuals affected by police responses to mental health and substance use crises.

The task force will be responsible for:

- Identifying potential operational and financial needs to support trauma-informed, community-based crisis response and diversion for individuals in crisis;
- Reviewing and recommending programs and systems operating within the state or nationally that could be deployed as a model crisis and emergency services system; and
- Identifying potential funding sources for expanding mental health, alcohol use, and substance use crisis response and diversion services.

OMH will prepare a written report on the opinion and recommendations of the task force to be submitted to the Governor and NYS Legislature by December 31, 2025 [HMH, Part OO]. The Budget appropriates $1 million for the task force [AtL 1115].

Maternal Mental Health Workgroup

The Enacted Budget includes a new provision directing OMH to establish a maternal mental health workgroup to study and issue recommendations related to maternal mental health and perinatal and postpartum mood and anxiety disorders. The workgroup will be composed of representatives from mental health organizations, maternal health care provider organizations, insurance plans, and communities that are disproportionately impacted by maternal mental health disorders.

The workgroup will submit a final report with recommendations to the Governor, NYS Legislature, and relevant agency commissioners by December 31, 2024 [HMH, Part PP]. The Budget appropriates $250,000 for this workgroup [AtL 1115].

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Omitted Proposals

Behavioral health-related proposals that were included in the Executive but removed from the Enacted Budget include:

- Expanding telehealth parity requirements to all regulated insurance plans; and
- Allowing insured individuals to sue plans for violations of telehealth parity.

DEVELOPMENTAL DISABILITIES

Establishment of Independent Developmental Disability Ombudsman Program

A new provision in the Enacted Budget establishes an independent developmental disability ombudsman program to assist individuals with intellectual and/or developmental disabilities (I/DD) "access services and preserve their rights." The ombudsman program will be responsible for identifying, investigating, referring, and resolving complaints regarding access to services and supports that are made by, or on behalf of, individuals with I/DD. All notices and materials provided to such individuals by OPWDD and providers must include the name, phone number, and website of the independent developmental disability ombudsman program.

OPWDD will put forth a Request for Proposals seeking applicants for the ombudsman program with experience providing advocacy or assistance to individuals with I/DD [HMH, Part KK].

PHARMACY

Continuation of Pharmacy Carveout to FFS

The Enacted Budget did not repeal the transition of the Medicaid pharmacy benefit from managed care to fee-for-service (FFS), which was implemented statewide on April 1, 2023. The Legislature notes that the Budget "reinvests $30 million of associated savings to support Ryan White Clinics, $125 million to support Federally Qualified Health Centers and Diagnostic Treatment Centers, and $45 million in flexible funding" to make safety net providers whole for their loss of 340B revenue [Assembly Summary of Changes.]

Omitted Proposals

The following Executive proposals were omitted from the Enacted Budget:

- Ending the "prescriber prevails" provision and giving DOH the authority to remove coverage of over-the-counter drugs that are reimbursable by Medicaid; and
- Directing DFS to conduct oversight of drug price increases and requiring all pharmacy services administration organizations (PSAOs) to register with DFS.

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OVERSIGHT OF HEALTH CARE TRANSACTIONS

Investor-Backed Physician Networks and Other Non-CON Entities

The Enacted Budget includes a modified form of the Executive's proposal to establish new disclosure and reporting requirements for "material transactions," such as mergers, acquisitions, affiliations, and partnerships of health care entities not currently subject to existing review under Article 28 or other parts of Public Health Law.

"Material transactions" are defined to include any of the following actions, or a series of such actions that take place within a rolling 12-month period:

- A merger with a health care entity;
- An acquisition of one or more health care entities, including any "transfer of control", where "control" would be presumed to exist if any person owns or controls 10% of the voting securities of a health care entity;
- An affiliation agreement or contract formed between a health care facility and any other person; and
- The formation of a joint venture, such as an accountable care organization (ACO) or management services organization (MSO).

The transactions would not be considered material transactions:

- A clinical affiliation for the purpose of collaborating on clinical trials or graduate medical education;
- Any transaction that is already subject to oversight by DOH through Articles 28, 30, 36, 40, 44, 46, 46-A, or 46-B.

The Executive Budget had proposed that DOH would establish further thresholds for "material transactions" entirely in regulation. However, the Enacted Budget adds a specification that material transactions will not include "de minimis" transactions in which a health care entity increases its total gross in-state revenues by less than $25 million.

"Health care entities" are defined broadly to include any physician practice, group, or MSO that provides "all or substantially all administrative or management services" associated with a provider.

Unlike the Executive Budget, the Enacted Budget will not require entities to seek DOH approval before engaging in a material transaction. Instead, it will instead require such entities to notify DOH at least 30 days prior to the closing date of the transaction. DOH will submit copies of the notice and supporting documentation to the antitrust, health care, and charities bureaus of the New York Attorney General. DOH will also provide public notice of the proposed transaction and provide an opportunity for public comments.

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The written notice must include a brief description of the proposed transaction, including the anticipated impact on cost, quality, access, health equity, and competition in the impacted markets, as well as any commitments by the health care entity to address the anticipated impacts.

While the Executive Budget proposed civil penalties of up to $10,000 per day for violations of the article, the Enacted Budget reduces the penalties to standard amounts of $2,000 per violation in accordance with Section 12 of the Public Health Law. Each day in which the violation continues will constitute a separate violation [HMH, Part M].

Omitted Proposals

The Enacted Budget does not include the Executive proposal to implement a series of reforms to the Certificate of Need (CON) process.

WORKFORCE

Registration of Staffing Agencies

As proposed by the Executive, the Enacted Budget creates 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. The Enacted Budget adds "Health Care Technology Platforms" to the title of the article, but the legislative text remains the same as proposed by the Executive.

Article 29-K requires 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 is authorized to issue regulations regarding business practices, including permissible pricing and fees [HMH, Part X].

COLA for Human Services Agencies

The Budget includes a 4% COLA for FY 2024 for eligible human services programs, with the same language and provisions as the 5.4% COLA enacted in FY 2023. This is an increase from the 2.5% proposed in the Executive Budget but less than the 8.5% proposed by the Assembly and Senate. 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).

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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 staff [HMH, Part DD].

The Budget appropriates $222 million in State funding for OPWDD, OMH, and OASAS voluntary operated programs to enact the COLA, as follows:

- OMH: $81 million [AtL 1112]
- OASAS: $21.3 million [AtL 1084]
- OPWDD: $119.7 million [AtL 1145]

Omitted Proposals

Workforce-related proposals from the Executive that were removed in the Enacted Budget include:

- Joining the Interstate Licensure Compacts for physicians and nurses;
- Creating an option for experienced physician assistances (PAs) to practice independently, and making other scope of practice expansions for nurses, PAs, and pharmacists;
- Transferring oversight of all licensed health professions from the State Education Department (SED) to DOH;
- Clarifying that direct care staff in non-facility-based OPWDD programs may provide services that fall under the scope of nursing; and
- Creating a new OMH credential for "qualified mental health associates."

EMERGENCY MEDICAL SERVICES

The Enacted Budget includes the following Emergency Medical Services (EMS) reforms that were proposed by the Executive:

- Codifying the Regional Emergency Medical Services (EMS) Councils (REMSCOs) and the State EMS Council (SEMSCO) and providing for feedback from REMSCOs and SEMSCO to DOH;
- Directing the SEMSCO, with feedback from the REMSCOs, to create performance standards for EMS agencies;
- Developing an EMS task force to coordinate and operate state resources during disasters or other situations requiring specialized response or community need; and
- Establishing a public service campaign and mental health and wellness program to promote recruitment and retention of EMS workers.

The Enacted Budget does not include the Executive proposals to:

- Expand the definition of emergency medical services;
- Develop a comprehensive statewide EMS plan and system;
- Establish EMS training programs; and

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- Develop a new "mobile integrated healthcare" service model that would incorporate EMS providers and allow them to provide integrated care.

The Enacted Budget also includes a provision that makes active members of volunteer ambulance companies eligible for health benefits [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 427];
- $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 429]; and
- 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, Executive Budget].

Minimum Wage Funding

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

- $5.3 million for OMH [AtL 1113]
- $2.9 million for OASAS [AtL 1084]
- $31.1 million for OPWDD [AtL 1150]

OMH

The Budget includes $6.41 billion in all-funds appropriations (an increase from $5.21 billion in all-funds appropriations from FY 2023), which includes:

- $2.69 billion in aid to localities, an increase of $134 million from last year [AtL 1106]
- $1.46 billion in capital projects, an increase of $1.016 billion from last year [Capital 511]
- $2.25 billion in state operations, an increase of $47 million from last year [State Ops 585].

The Budget proposes new capital funding to be distributed as follows:

- $915 million to develop new residential housing options for people with mental illness, such as community residence-single room occupancy (CR-SRO) beds, transitional step-down beds,

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permanent supportive housing, and community step-down units to serve formerly unhoused individuals transitioning from inpatient care. [Capital 513]
- $60 million for the development of new or relocation of existing Comprehensive Psychiatric Emergency Programs (CPEPs) or psychiatric inpatient programs [Capital 513].
- An additional $9 million in funding, on top of the typical appropriation of $60 million, for the development of new or relocation of existing community mental health facilities, with the new $9 million subject to approval by the Senate [Capital 512].

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, Executive Budget].

In operating funds, the Budget allocates:

- $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 community mental health residential programs, including the development of new transitional stepdown units to help individuals transition back to the community;
- $60 million (an increase of $25 million from last year) for the 988 BH crisis hotline;
- A new $3.25 million for the Individual Placement and Supports program;
- A new $2.8 million for the Intensive and Sustained Engagement Treatment (INSET) program [AtL 1111].

It also allocates $14 million (an increase of $5 million from 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 1109].

For children's services, it would allocate:

- $166.9 million (an increase of $15.1 million from last year) for various community mental health non-residential programs, including:
    - Up to $5 million for residential treatment facilities for children and youth (RTFs), the same as last year; and
    - An unspecified allocation available to expand the Healthy Steps program;
- $10 million for youth suicide prevention;
- $5 million for high fidelity wraparound services for children; and
- $46.6 million (an increase of $13.7 million from last year) for various community mental health emergency programs. An unspecified allocation of these funds is available for the home-based crisis intervention (HBCI) program for children [AtL 1121-1122].

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OASAS

The Budget appropriates $1.34 billion in all funds for OASAS, a decrease of $135 million in all funds appropriations from FY 2023, and includes:

- $1.07 billion in aid to localities, a $139 million decrease from last year [AtL 1080]
- $92 million for capital projects, a decrease of $10 million from last year [Capital Projects 489]
- $179.2 million for state operations, an increase of $14.8 million from last year [State Ops 576].

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

The Budget also appropriates $212.25 million for the Opioid Settlement Fund, which along with reappropriation amounts of $208 million (for a total of $420.25 million, of which at least $107.4 million will be paid to local governments), will be used to implement a range of initiatives to address the opioid crisis, including harm reduction, treatment, investments across the service continuum and for priority populations, and housing [AtL 1088 and 1101] .

OPWDD

The Budget provides $7.47 billion in all funds for OPWDD:

- $4.99 billion in aid to localities, an increase of $172 million from last year [AtL 1140]
- $119.5 million in capital projects, an increase of $6.9 million from last year [Capital Projects 555]
- $2.36 billion in state operations, an increase of $57.2 million from last year [State Ops 598]

These figures are affected by the expiration of one-time funding for workforce bonuses. Overall, the OPWDD state share appropriations for Medicaid services will increase from $3.95 billion to $4.25 billion (by $300 million) [AtL 1144, AtL 1153]. 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 600];
- An additional $38.7 million for residential services [AtL 1148, 1156]; and
- An additional $10 million for day services [AtL 1149, 1156].

OCFS

The Budget appropriates $5.92 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 appropriates $17 million to assist certain foster care congregate care providers that meet the definition of an Institution for Mental Disease (IMD) by providing support for medical staffing needs, services, and other necessary investments [AtL 455].

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OTHER HEALTH CARE PROVISIONS

Consumer Protections for Medical Debt

As proposed by the Executive, the Enacted Budget implements 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 are required to use a DOH-developed "uniform financial assistance form" as part of collection procedures [HMH, Part Y, Subpart C].
- No insured person is liable to a provider for debts that arise because of the insolvency of any Article 32 covered commercial insurer. The State is expanding 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 are not included [HMH, Part Y, Subpart D].

Hepatitis C and Syphilis Screening

As proposed by the Executive, the Enacted Budget makes 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].

Private Pay Eligibility

As proposed by the Executive, the Budget reduces 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].

Coverage of Abortion Services

The Enacted Budget includes a new provision that requires commercial insurance plans to cover any drug prescribed for the purpose of an abortion, even if the drug has not been approved by the Food and Drug Administration (FDA) for abortion but is a recognized abortion medication by one of the following:

- The WHO Model Lists of Essential Medications;
- The WHO Abortion Care Guidance; or
- The National Academies of Science, Engineering, and Medicine Consensus Study Report.

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Additionally, medical malpractice insurers are prohibited from refusing to issue or renew, canceling, charging an increased premium, or excluding, limiting, or reducing coverage under a medical malpractice insurance policy based on the legal use or prescription of abortion medications in accordance with the requirements above [HMH, Part LL].

Utilization Review

The Enacted Budget includes a new provision that updates definitions for clinical peer reviewers performing utilization review in both the Insurance Law and the Public Health Law as follows:

- Repeals the special requirement, for services related to medically fragile children, that clinical peer reviewers must be certified in pediatric rehabilitation, pediatric critical care, neonatology, or another pediatric subspecialty "directly relevant to the patient's medical condition";
- For reviews of adverse determinations, applies a requirement that clinical peer reviewers must have at least 5 years' experience in their specialty;
- For external appeals of mental health and substance use services, applies a requirement that clinical peer reviewers must "specialize in behavioral health" and have "experience in the delivery of" mental health or substance use treatment, respectively [HMH, Part MM].

Extenders

The Budget extends the authority for various existing provisions, such as:

- The Medicaid Global Cap is reauthorized through FY 2025 [HMH, Part A].
- The requirement for a two-month cooling off period after the termination of a contract between an Article 44 insurer and a hospital is extended through June 30, 2025 [HMH, Part B, Section 1].
- Spousal budgeting in MLTC is extended through FY 2028 [HMH, Part B, Section 2].
- Authorization for the Care at Home (CAH) I and II waivers are extended through FY 2028, and the age limit is 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) is extended through FY 2025 [HMH, Part B, Section 13]. The Executive had proposed an extension through FY 2027.
- The authorization for the Statewide Health Information Network (SHIN-NY) and the Statewide Planning and Research Cooperative System (SPARCS) is extended through FY 2026 [HMH, Part B, Section 18]. The Executive had proposed a permanent authorization.
- Limits on administrative reimbursement for CHHAs and long-term home health care programs are extended through FY 2025 [HMH, Part B, Sections 30-31]. The Executive had proposed an extension through FY 2027.
- The Nurse Practice Act, which permits Advanced Home Health Aides to perform certain advanced tasks with appropriate training and under nurse supervision, is extended through FY

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2029, and its definition of providers is extended through 2032. The Enacted Budget does not include the reduced supervision requirements for advanced aides proposed by the Executive [HMH, Part B, Section 35-a; HMH, Part W].

- The exception to the electronic prescription mandate for providers that issue less than 25 prescriptions (for both controlled and non-controlled substances) annually is extended through June 1, 2026 [HMH, Part B, Section 35-b].
- The Health Care Reform Act (HCRA) programs are 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 is extended through June 30, 2024 [HMH, Part F].
- Mandatory MLTC enrollment for individuals needing 120 days or more of community-based long-term care services is extended through FY 2027 [HMH, Part I, Section 1].
- Authority for the Developmental Disability Individual Support and Care Coordination Organization (DISCO) program is extended through December 31, 2025 [HMH, Part EE]. The Executive had proposed an extension through September 30, 2028.
- The current structure of financing for Committee on Special Education (CSE) placements outside New York City is extended through FY 2024. This structure eliminates the approximately 18% State share for such placements and shifts responsibility to the school district (to approximately 57%) [ELFA, Part V]. The Executive had proposed a permanent extension of the structure.

OTHER NON-HEALTH PROVISIONS

Indexing the Minimum Wage to Inflation

The Enacted Budget would modify the Executive proposal to increase the State's minimum hourly wage as follows ("Downstate" refers to the eight-county area of New York City, Long Island, and Westchester):

- January 1, 2024: $16 downstate, $15 in the rest of the state
- January 1, 2025: $16.50 downstate, $15.50 in the rest of the state
- January 1, 2026: $17 downstate, $16 in the rest of the state

From the start of 2027 onwards, the minimum wage would be indexed to inflation, measured as the 3-year rolling average of the CPI-W for the Northeast region. Increases would not be capped. However, the minimum wage increase will 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. These exceptions would not apply for more than two consecutive years at a time [ELFA, Part S].