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New York State Fiscal Year 2025 Executive Budget Summary

OVERVIEW

On January 16th, Governor Kathy Hochul announced highlights from her third Executive Budget, covering New York State Fiscal Year (FY) 2025, which will run from April 1, 2024 to March 31, 2025.

This year, the Division of the Budget (DOB) noted that New York's financial position is currently strong, with significantly increased reserves and moderate debt levels. However, in the longer term, DOB notes that there is a "structural imbalance" in the budget with tax receipts projected to grow at 4 percent while spending is expected to increase by over 5 percent through FY 2028.

Overall, the Executive Budget proposes total spending of $232.7 billion, a moderate increase from the most recent projection of $231.6 billion in the Mid-Year Financial Plan update. The budget now includes outyear gaps totaling $20 billion over the next three years (FY 2026 through 2028).

The State expects total Medicaid costs to be about $96.4 billion in FY 2025, including $52 billion in federal spending and $35.5 billion in State spending. This is down from almost $100 billion in FY 2024, owing to enrollment reductions associated with the unwind of the Covid-19 public health emergency (PHE). However, the State no longer projects Medicaid enrollment to return to pre-PHE levels, accounting for an additional $1.6 billion in new Medicaid costs over the life of the Financial Plan. As a result, the Budget sets a target of making $200 million in Medicaid long-term care savings and $200 million in other Medicaid savings, to be defined as part of a stakeholder process.

The Budget includes various important health proposals, including many of those outlined in the Governor's State of the State:

- A safety net hospital transformation program to "encourage partnerships that improve the resilience of and preserve long-term access to safety-net institutions", and the allocation of $500 million from existing capital programs for this initiative;
- Implementation support for the State's new 1115 Medicaid waiver amendment;
- Funding for 200 new psychiatric inpatient beds (State-operated inpatient beds and Transition to Home beds);
- Increases to Medicaid rates for mental health services provided in Article 28 clinics and private practices;
- New mental health parity enforcement authority;
- Scope of practice enhancements for a variety of professions;
- The elimination of cost-sharing for insulin across all regulated insurance plans; and
- Emergency medical services reforms, including the creation of a Paramedic Urgent Care program offering telehealth in rural areas.

Other items listed in the State of the State, such as a new designation process for Children and Family Treatment Services and Supports (CFTSS), are not included in the budget, but 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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MEDICAID

Medicaid Global Cap

The Executive Budget proposes to extend the Medicaid Global Cap by an additional year, through FY 2026 [HMH, Part A]. The Global Cap sets a spending limit on state share Medicaid costs at the five-year rolling average of national Medicaid spending projections. The State projects that the Global Cap will increase by a total of $15.6 billion between FY 2024 and 2028.

1115 Waiver Implementation

New York's new 1115 Medicaid waiver amendment makes available approximately $6 billion in federal funding for investments in health-related social needs (HRSN) services, Medicaid global budgets, and strengthening the workforce. The State expects to invest a total of $1.5 billion alongside this investment to support waiver activities, for a total of $7.5 billion. According to the Executive Budget Scorecard, this includes a two-year total across FY 2025 and FY 2026 of:

- $550 million for the Medicaid Hospital Global Budget initiative ($275 million in each year);
- $147.6 million to enhance rates for Patient-Centered Medical Homes (PCMH) for adults and children ($73.8 million in each year);
- $37.9 million to implement continuous Medicaid and CHIP eligibility for children aged up to six years ($7.6 million in FY 2025, $30.3 million in FY 2026);
- $233.4 million in additional state matching funds ($116.7 million per year). This item corresponds to the commitment to provide $350 million total in new matching funds (over three years) included in the waiver Special Terms and Conditions.

The Scorecard also includes a savings of $44 million ($22 million per year) due to the concurrent approval of the State's request to provide certain services to people with substance use disorder (SUD) residing in Institutions of Mental Disease (IMD), which are currently not Medicaid-eligible [Executive Budget Scorecard].

Telehealth Payment Parity Extension

The Budget would extend the current requirement, passed in the FY 2023 Budget, for telehealth payment parity for both Medicaid and commercial plans, by one year, through April 1, 2025 [HMH, Part B, Section 5]. It does not propose to change the accompanying requirement for DOH and DFS to submit a report on the impact of implementing telehealth parity, which has not yet been publicly published.

Children's Continuous Eligibility Expansions

As mentioned above, the Budget proposes to make statutory changes to expand children's eligibility to:

- Provide continuous Medicaid and CHIP coverage to all eligible children up to the age of six. Children would remain eligible continuously until the end of the month in which they turn six

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(or, if a determination is performed within in the preceding year, until 12 months after that determination, as is otherwise standard). The State is in the process of requesting the corresponding federal authority from CMS.
- Allow all children turning 19 to remain eligible for Medicaid until their next renewal date. Currently, their eligibility expires at the end of the month in which they turn 19.

This authority would be effective January 1, 2025 [HMH, Part M].

Children's Rate Enhancements

The Budget proposes to increase children's services rates as follows:

- Increasing Early Intervention (EI) reimbursements by 5% ($6.1 million per year).
- Providing an additional 4% EI rate modifier for rural and underserved areas, effective in FY 2026 ($0.5 million per year).
- Increasing rates for children's mental health services provided in an Article 28 setting or private practices ($7.6 million in FY 2025, $15.2 million in FY 2026) [Executive Budget Scorecard].

Primary Care and BH Rate Enhancements

The Budget proposes to increase Medicaid primary care investments in the following areas:

- Increasing enhanced payments for PCMHs serving adult and pediatric populations, as mentioned above under the 1115 Waiver section ($73.8 million per year).
- Increasing reimbursement rates for providers serving Medicaid members with disabilities, whether physical or I/DD ($5.2 million in FY 2025 and $10.4 million in FY 2026).
- Increasing reimbursement rates for adult mental health services provided in an Article 28 setting or private practices ($13.5 million in FY 2025 and $27 million in FY 2026).
- Expanding coverage for Adverse Childhood Experiences (ACE) screenings to adults ($1.2 million in FY 2025 and $0.9 million in 2026) [Executive Budget Scorecard].

Exclusion of Medicaid Services from DFS IDR Process

The Budget would remove the Medicaid program from being subject to the independent dispute resolution (IDR) process for surprise out-of-network bills [HMH, Part H, Section 1]. A separate policy for handling out-of-network claims for Medicaid enrollees is not provided, but Medicaid-participating providers are generally prohibited from balance billing Medicaid enrollees.

Shift of Dental Coverage in D-SNPs from Medicaid to Medicare

The Budget would remove dental benefits from the Medicaid portion of the benefit package for Dual Eligible Special Needs Plans (D-SNPs), so that they will be covered by Medicare [DOH Agency Appropriations Report].

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Discontinuation of Managed Care Quality Pool Supplemental Funding

As in previous years, the Budget proposes to eliminate the managed care and managed long-term care (MLTC) quality pool supplemental funding of $112 million per year [DOH Agency Appropriations Report]. The Legislature has repeatedly rejected this proposed cut.

Health Home Restructuring

The Budget proposes to build on last year's restructuring of the Health Home program to achieve an additional savings of $125 million, effective in FY 2026 [Executive Budget Scorecard]. Further details on this proposal have not yet been provided.

Increased Medicaid Audit Target

The Budget forecasts an increased recovery of $100 million in Medicaid audits due to the increased volume of Medicaid claims [DOH Agency Appropriations Report].

$200 Million Unallocated Savings Target

The Budget sets a target for other "unallocated savings" across the Medicaid program of $200 million. The State would work with "industry leaders and stakeholders" to develop an appropriate set of proposals to achieve this goal [DOH Agency Appropriations Report].

HOSPITALS

Safety Net Transformation Program

The Budget proposes to establish a new Healthcare Safety Net Transformation Program to support safety net hospitals to improve care and achieve sustainability. Up to $500 million of the funding from Phases IV and V of the Statewide Health Care Facility Transformation Program (SHCFTP) would be allocated to this program during FY 2025.

Safety net hospitals may include:

- Public hospitals, rural emergency hospitals (REH), critical access hospitals (CAHs), or sole community hospitals;
- Hospitals with an inpatient payer mix of at least 30% Medicaid enrollees, duals, or uninsured and an outpatient payer mix of at least 35% of these populations;
- Hospitals that serve at least 30% of the residents of a county or multi-county area who are enrolled in Medicaid, dually eligible, or uninsured; or
- Hospitals that DOH determines to serve a significant population of such individuals.

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Safety net hospitals may jointly participate with one or more partner organizations that can help with its transformation activities. The partner organization may be another health system or Article 28 facility, a physician group, a community-based organization, or any other entity deemed to be helpful by DOH. The partnership may, but is not required to, culminate in a merger, acquisition, management services contract, or clinical integration.

DOH would be authorized to waive regulations to allow participants in this program to more efficiently implement projects awarded funding through this program. This would exclude regulations that concern:

- Patient safety, privacy, autonomy, or other rights;
- Due process;
- Scope of practice and professional licensure;
- Environmental protections;
- Provider reimbursement methodologies; and
- Occupational standards and employee rights.

To participate in the program, a hospital and its partner organizations will submit a detailed five-year transformation plan outlining their key metrics and goals as part of the project. Funds will be released contingent on compliance with this plan [HMH, Part S].

Inpatient Capital Add-on Reduction

The Budget proposes a further reduction in capital add-on payments for inpatient Medicaid rates for general hospitals. The FY 2021 Budget reduced the add-on by 10%, and this proposal would increase this reduction to a total of 20%, effective October 2024 [HMH, Part D, Section 1].

Hospital/Home Care Collaborative Program Expansion

The Budget proposes to rename and expand the Hospital-Home Care-Physician Collaboration demonstration program. The new Health Care Delivery Collaboration program would now expressly cover collaborations that go beyond hospitals, home care, and physician groups, to also include:

- Emergency medical services;
- Skilled nursing facilities;
- Hospices; and
- Other providers.

Integration initiatives could include partnerships between two or more of any of these types of entity. Proposed collaborations must "specifically identify the service gaps and/or community need the collaboration seeks to address" and provide a projected timeline and deliverables. Other provisions of the current program would be unchanged, including the authorization for DOH to consult with stakeholders to develop "an application process for grant funding or rate adjustment, and for request of state regulatory waivers," to facilitate initiatives under this program [HMH, Part V, Section 1].

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Hospital Exemption from LHCSA Definition

The Budget proposes to modify the definition of "licensed home care services agency" (LHCSA) to clarify that Article 28 hospitals may be exempted from the definition if they:

- Provide a majority of their patient hours in the hospital; and
- Have a pre-existing clinical relationship with any patients treated at home.

Hospitals meeting these criteria may provide patients who are homebound or at clinical risk if they leave their home (e.g., immunocompromised persons) with "off-site primary care and medical care services" in the patient's home, without being subject to LHCSA requirements. Such services may include preventive and acute care, but may not include home care services as defined in Article 36 of the Public Health Law. DOH may establish Medicaid rates for these services [HMH, Part V, Sections 2-3].

New Hospital Financial Assistance Law Requirements

The Budget proposes new consumer protections as part of the State's Hospital Financial Assistance Law, which would include the following:

- Hospitals must include "underinsured" individuals in their financial assistance policies. Underinsured individuals are defined as people whose out-of-pocket medical costs in the last year have been more than 10% of their gross annual income.
- Hospital financial assistance policies must apply to people with incomes of up to 400% of the federal poverty line (FPL), up from the current requirement of 300% of FPL.
- The maximum level of charges permitted for people receiving hospital financial assistance is reduced. Under current law, hospitals may charge up to the highest amount that would be charged if the person were covered by Medicare, Medicaid, or the facility's highest volume payer, subject to a sliding scale based on income and waived entirely under 100% of FPL. The Budget proposes to:
    - Reduce the maximum level uniformly to the amount that Medicaid would pay;
    - Increase the income threshold for waiving charges to 200% of FPL;
    - Increase the sliding scale income ranges and decrease the maximum charges allowable within the sliding scales; and
    - Decrease the maximum monthly payment a hospital may require under a payment plan to 5% of the patient's gross monthly income, and the interest rate to 2%.
- Patients may apply for assistance at any time during the collection process.
- Hospitals may not deny admission or treatment based on an unpaid bill.
- Hospitals may not pursue legal action concerning debts of people with incomes below 400% of FPL. In any legal action, the hospital's CFO must affirm that the hospital has made its best effort to verify compliance with this provision.
- Hospitals may not sell medical debt accumulated under this section to a third party, unless the third party is specifically purchasing the debt to offer relief.

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- Hospitals may not start a civil action or delegate collection to a third party for at least 180 days after the bill is issued, and must make reasonable efforts to first determine whether the patient qualifies for assistance [HMH, Part O, Sections 1-2].

Incentives to Reduce Unnecessary C-Sections

The Budget proposes to create new Medicaid financial incentives to reduce unnecessary C-sections, although details on these incentives do not yet appear to be available [Briefing Book].

LONG TERM CARE

Removal of CDPAS from All Wage Parity Laws

This Budget expands on the proposal from last year's Executive Budget to remove consumer-directed personal aide services (CDPAS) workers from downstate wage parity laws, effective October 1, 2024 [HMH, Part G].

Unlike last year's proposal, this Budget would also exclude CDPAS aides from the home care minimum wage increase provisions passed in the FY 2023 Enacted Budget as Section 3614-f of the Public Health Law. It also omits the proposed establishment of a CDPAS premium assistance fund. Overall, this would produce State share savings of $200 million in FY 2025.

$200 Million LTC Savings Target

The Governor proposes to set a target of $200 million in annual savings from long-term care programs (outside of community-based services). The State will collaboratively work with stakeholders to identify appropriate ways to achieve this savings.

Nursing Home Rate Freeze and Capital Reduction

The Budget would establish a freeze on the operating component of skilled nursing facility (SNF) rates "until full implementation of a case mix methodology using the Patient Driven Payment Model." Rates would be maintained at the January 2024 rates until then [HMH, Part E, Section 1].

Starting in FY 2020, the capital add-on component of SNF rates was decreased by 5%. This Budget would implement an additional reduction of 10%, effective April 2024 [HMH, Part E, Section 2].

Quality Standards for ALRs

The Budget renews the proposal from last year's Executive Budget to create new reporting requirements for assisted living residences (ALRs). ALRs are entities who provide housing and home care services to at least five residents. They are distinct from nursing homes, adult care facilities (ACFs) and assisted living programs (ALPs), and other residential services programs.

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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 reporting requirements would take effect in January 2025. 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 F, Section 2].

Safety Net ALR Program

The Budget proposes to continue the pilot Safety Net ALR program, offering subsidies for up to two hundred vouchers to subsidize up to 75% of the private pay rate for people who are not Medicaid-eligible. Although the Executive Budget memo suggests the program would be made permanent, the proposed legislative language only specifies that the recipients would reside in a certified enhanced ALR (under Section 4655 of Article 46-B of the Public Health Law) for people with special needs [HMH, Part F, Section 1].

Elder Justice Coordinating Council

The Budget would establish a new interagency Elder Justice Coordinating Council with the goal of protecting older adults from abuse and mistreatment. The Council would be led by the State Office for the Aging (SOFA). Its mission will be to develop and implement a comprehensive state plan on elder justice [HMH, Part W].

MANAGED CARE

MCO Procurement and Moratorium

The Budget renews a proposal from the FY 2023 Executive Budget to authorize DOH to issue a new Request for Proposals (RFP) to re-select all Medicaid MCOs, except for HIV Special Needs Plans (HIV SNPs). Programs of All-Inclusive Care for the Elderly (PACE) programs are also presumed to be exempted due to the PACE application process established in Article 29-EE of the Public Health Law [HMH, Part H, Sections 3-7].

The procurement would be expected to include:

- Mainstream plans;
- Health and Recovery Plans (HARPs);
- Managed long-term care (MLTC) plans; and
- Medicaid Advantage Plans (MAPs).

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The State would seek to establish a minimum of two plans per region, with regions to be defined by DOH in the RFP. Unlike the 2023 proposal, this Budget would not place a maximum limit on the number of plans operating in each region.

DOH will evaluate applications in consultation with OMH, OPWDD, OASAS, and OCFS. The agencies will consider a variety of factors in awarding contracts, some of which include:

- Inclusion of major public hospitals in the plan's network;
- Not-for-profit status;
- Ability to offer plans in multiple regions;
- Operation of different types of plans, including CHIP, the Essential Plan, and MLTC;
- Participation in products offering integrated care for dual eligible;
- Participation in value-base arrangements, including "the delegation of significant financial risk to clinically integrated provider networks"; and
- Commitment to community reinvestment spending.

Although these considerations are listed in the proposed statute, they do not define a methodology by which bids must be awarded, and other factors could be considered.

DOH would also be authorized to re-procure these bids in the future as needed, after the end of a contract term. Unlike the 2023 proposal, this Budget would not require MCOs to notify DOH of their intent respond to the RFP within a limited timeframe.

Until the RFP is released, DOH would not process or approve any further requests to establish MCOs, exempting the following:

- Applications submitted before January 1, 2024;
- Applications seeking approval to transfer ownership/control of an existing MCO;
- Applications seeking authorization to expand an existing MCO's approved service area;
- Applications to operate an HIV SNP plan or Developmental Disability Individual Support and Care Coordination Organization (DISCO); and
- Applications that would be appropriate to address a serious concern with care delivery, such as a lack of adequate access to MCOs in a geographic area or a lack of adequate and appropriate care, language, and cultural competence or special needs services [HMH, Part H, Section 2].

The current moratorium on establishing new MLTC plans would also be extended through the date of the issuance of the procurement. However, the current cap on MLTC enrollment would end as of March 31, 2024 [HMH, Part H, Section 7].

Repeal of 1% Across-the-Board Increase

Effective April 1, 2024, the Budget would remove Medicaid managed care organizations from the 1% across-the-board increase passed as part of the FY 2023 Budget [HMH, Part H, Section 8].

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Authority to Impose Liquidated Damages on Plans

The Budget proposes to establish authority for DOH to recover liquidated damages from MCOs (defined as any Article 44 plan, including MLTC plans) related to failures to meet their contractual obligations, as established in the MCO's Model Contract or other state or federal regulations. The amount of liquidated damages may vary from $250 to $25,000 per violation, as determined by DOH based on the severity of noncompliance, and each day of noncompliance may be counted as a separate violation. Each instance or day of failing to furnish required medical services to an enrollee may also be counted as a violation.

Damages would be owed within 60 days, and DOH could collect through withholds of capitation payments as needed. Plans would be able to appeal within 30 days in a format to be prescribed by DOH. Liquidated damages may not be "passed through" to any network provider or subcontractor [HMH, Part H, Section 9].

Reporting on Prenatal and Postpartum Care

The Budget proposes to impose new reporting requirements on plans regarding prenatal and postpartum care. Further details do not yet appear to be available [Briefing Book].

ESSENTIAL PLAN AND MARKETPLACE

Cost-Sharing Subsidies and Conforming Amendments in Case of 1332 Transition

Previous Budgets have authorized DOH to seek to move the authority for New York's Essential Plan (EP), which is currently 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."

This Budget would make various conforming changes to legislation to incorporate references to the Section 1332 waiver authority where applicable. In particular, it would establish authority to use Section 1332 waiver funds for a "program to provide subsidies for the payment of premium or cost-sharing or both" to help individuals seeking to purchase Qualified Health Plans (QHPs) through the marketplace [HMH, Part J, Sections 4-7].

These subsidies would be available to individuals with incomes of up to 350% of the FPL [DOH Agency Appropriations Report]. This would help address the likelihood that the EP transition to 1332 authority, if enacted, would increase premiums for QHPs. However, it remains uncertain if the federal government can or will approve the state's 1332 request.

Delay of LTSS Coverage Extension to All EP Populations

The Budget would delay the planned extension of coverage of long-term services and supports (LTSS) to all current EP populations by one year, until 2026. In the FY 2023 Budget, the State expanded the EP

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benefit to include certain long-term services and supports (LTSS) for individuals who have "functional limitations and/or chronic illnesses." Such benefits are currently available only to EP 3 and 4 populations, who are individuals who are lawfully present and would be Medicaid-eligible, i.e., who have incomes between 0-138% of FPL, if not for immigration status. This availability will be extended accordingly [HMH, Part J, Section 3].

EP and QHP Benefit Expansions

The Budget describes several planned benefit expansions in the Essential Plan, including:

- Eliminating all premiums for EP coverage[1];
- Eliminating cost sharing for individuals with certain chronic conditions;
- Eliminating all cost-sharing for pregnancy-related benefits;
- Adding coverage of doula services;
- Increasing funding for substance use disorder treatment; and
- Expanding coverage for services for persons with asthma to address health risks related to climate change (e.g., home modifications to install air filtration or air conditioners) [DOH Agency Appropriations Report].

The Budget also proposes to eliminate non-hospital cost sharing for pregnancy and postpartum care for QHP-eligible individuals.

BEHAVIORAL HEALTH

Increased Fines for Parity Violations

The Budget proposes to increase DFS's authority to levy fines for violations of behavioral health parity requirements. DFS currently has the general authorization to issue fines of up to $1,000 per offense for willful violations of the Insurance Law to insurers. This legislation would add a specific clause for violations of state or federal behavioral health parity requirements, under which DFS could levy fines of up to $2,000 per offense [TED, Part HH].

Mandate for Commercial Plans to Reimburse Licensed Clinics at Medicaid Rates

The Budget proposes to require commercial insurers to reimburse OMH and OASAS-licensed clinics for outpatient treatment at the Medicaid rate (at minimum). This policy builds on last year's initiative that implemented a similar requirement to cover school-based mental health clinics at the Medicaid rate.

[1] Since the EP already does not charge premiums to current enrollees, this likely refers to the proposed $15 per month premium for individuals with incomes between 200% and 250% of the FPL, if the 1332 waiver is approved.

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The new requirement would apply effective January 1, 2025 to individual and group policies issued by Article 32 accident and health insurers and all coverage provided by Article 43 not-for-profit insurers [HMH, Part AA].

Reinvestment of State Inpatient Savings into the BH System

The Budget proposes to make permanent the Community Mental Health Support and Workforce Reinvestment Program, which allocates funds from State Psychiatric Center inpatient bed closures to support community-based mental health programs [HMH, Part Y].

CPEP Authority

The Budget proposes to make permanent the authorization for OMH to designate Comprehensive Psychiatric Emergency Programs (CPEP). This authority was last extended in the FY 2021 Enacted Budget [HMH, Part BB].

Time-Limited Demonstration Authority

The Budget proposes to make permanent the longstanding broad authorization under Section 41.35 of the Mental Hygiene Law for OMH, OASAS, and OPWDD to conduct "time-limited demonstration programs." This authority was last extended in the FY 2022 Enacted Budget [HMH, Part Z].

CSE Residential Placement Funding Formula

The Budget proposes to make permanent the FY 2021 Budget's provisions that changed the allocation of payment for residential placements made by school district Committees on Special Education (CSEs) outside of New York City. Previously, the State paid 18.424% of the costs for such placements, but the FY 2021 Budget transferred the responsibility for the state share to the school district [ELFA, Part G].

PHARMACY

Prohibition on Cost Sharing for Insulin

The Budget proposes to expand on the FY 2021 Budget's limits on cost-sharing for insulin by prohibiting cost-sharing entirely.

Specifically, effective January 1, 2025, the Budget would prohibit regulated Article 32 accident and health insurers and Article 43 not-for-profit insurers from applying a deductible, copayment, coinsurance, or any other cost sharing for covered prescription insulin drugs. These regulations would apply to individual and group policies [TED, Part EE].

Replacement of Medicaid Drug Cap with Prescription Rebate Negotiations

The Budget proposes to replace the current Medicaid Prescription Drug Cap program, which sets a growth target for pharmacy expenditures, with a system in which DOH would perform an annual review

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of all Medicaid drug expenditures. DOH would particularly focus on drugs in the 80th percentile or higher of total spending or cost per claim, net of rebates, but may examine others as well.

DOH would identify drugs to refer to the existing Drug Utilization Review Board (DURB) for negotiations over a rebate agreement. If DOH fails to reach a rebate agreement with the drug manufacturer, it would have the authority to require that manufacturer to report a variety of cost and profit information related to the drug, including:

- Actual cost of development, manufacture, production, and distribution of the drug;
- Research and development costs associated with the drug;
- Administrative, marketing, and advertising costs for the drug;
- The drug's overall utilization;
- Prices charged to purchasers outside the United States;
- Prices charged to typical purchasers in New York, such as wholesalers and pharmacies;
- Average rebates and discounts provided to other payers; and
- The average profit margin for the drug over the last five years and projected future profit margins.

This cost information would be considered confidential by the State [HMH, Part I, Section 4].

Negotiation on Accelerated Approval Drugs

The Budget would provide DOH with the authority to directly negotiate supplemental rebates with manufacturers of drugs identified by the federal Food and Drug Administration (FDA) for accelerated approval [HMH, Part I, Section 5]. Drugs approved through this pathway have recently drawn attention due to the potential costs of covering such drugs for the treatment of Alzheimer's disease and skepticism around their effectiveness.

Expanded Scope of Preferred Diabetic Supply Program

The Budget proposes to expand the definition of items eligible for procurement under DOH's Preferred Diabetic Supply Program beyond current statute, which specifies that the program encompasses glucometers and test strips. Under the proposed language, the program may consider supplies that "include but are not limited to" those items [HMH, Part I, Section 6].

Pharmacy Cost Reporting

Effective October 1, 2024, the Budget would direct DOH to implement a new cost reporting system for Medicaid-participating pharmacies. Similar to other existing cost reporting systems for hospitals and nursing homes, pharmacies would be required to submit an annual cost report. Information on the report would include, but not be limited to, costs incurred for procuring and dispensing prescription drugs. Pharmacies not in compliance could be removed from the Medicaid pharmacy program [HMH, Part I, Section 7].

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Medicaid Reimbursement for Physician-Administered Drugs

The Budget would replace current statute that directs Medicaid to reimburse physicians for drugs they administer at their "actual cost." Medicaid would instead pay the lowest of: the National Drug Acquisition Cost or wholesale acquisition cost; federal upper limit; a State Maximum Acquisition Cost, if applicable; or the physician's actual cost. If the drug has been purchased through the 340B program, Medicaid would pay at the 340B actual cost [HMH, Part I, Section 8].

Prescription Drug Monitoring

The Budget proposes to modify regulations around prescription drug monitoring to:

- Extend the data retention period for the Prescription Drug Monitoring program from five years to ten years; and
- Clarify rules around disclosure of patient-identifying information to enable disclosure for certain public health surveillance purposes. It also establishes a formal definition of "public health surveillance" in the Public Health Law.

It also modernizes an array of regulations around drug monitoring and reporting [HMH, Part U].

Prescriber Prevails and DOH Authority to Modify the OTC Formulary

The Budget renews the Executive's longstanding proposal to end the current "prescriber prevails" requirements. It also renews last year's proposal 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 I, Sections 1-3].

OVERSIGHT OF HEALTH CARE TRANSACTIONS

CON Reforms

The Governor plans to modify the Certificate of Need (CON) program to reduce the burden of CON applications. Specifically, the State will increase the monetary thresholds under which an Article 28 facility's project may qualify for less intensive review. The State also plans to streamline application and approval processes, particularly for services now considered routine [DOH Agency Appropriations Report]. It is anticipated that this will not require legislation.

Currently, Limited Review (the lowest tier) is available for hospital projects that are $15 million or less and other projects that are $6 million or less, and Administrative Review (the second tier) is available for hospital projects that are between $15 million and $30 million and other projects that are between $6 and $15 million. Projects in these tiers do not need to go before the Public Health and Health Planning Council (PHHPC) for approval.

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WORKFORCE

Scope of Practice: NPs and Pharmacists

The Executive Budget would extend and build on the following scope of practice expansions that were passed in the FY 2023 Budget:

- Permanently adding pharmacists to the definition of "qualified health care professional" for the purposes of directing laboratory testing for Covid and influenza tests;
- Extending for two years, through FY 2026, the amendments to the Nurse Practitioner (NP) Modernization Act that enable NPs more than 3,600 hours of experience to practice independently without a collaborative agreement with a physician; and
- Permanently extending the Collaborative Drug Therapy Management 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 [HMH, Part P].

Additionally, the Budget proposes the following new expansions for pharmacists:

- Permanently allowing pharmacists to execute non-patient specific orders for the dispensing of HIV PrEP medication as ordered by DOH, a physician, or an NP. Pharmacists will be required to receive appropriate training and ensure that the patient is HIV negative [HMH, Part T, Section 7].
- Permanently allowing pharmacists to administer mpox immunizations.

Scope of Practice: Certified Registered Nurses

The Budget renews the previous proposal to permanently authorize physicians and NPs to issue non-patient specific regimens that allow registered nurses to order Covid and influenza tests [HMH, Part P]. It would also expand this to permit the same process for registered nurses to order hepatitis B testing [HMH, Part T, Sections 5-6].

Scope of Practice: Physician Assistants

The Budget renews last year's proposal to 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 [HMH, Part Q, Sections 1-7]

Scope of Practice: Certified Medication Aides

The Budget renews the proposal from the 2023 and 2024 Executive Budgets to expand 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 Q, Sections 8-10]

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Scope of Practice: Medical Assistants

The Budget proposes to allow a physician or a physician assistant to directly assign and supervise a medical assistant in an outpatient setting to draw and administer immunizations to patients. The physician maintains responsibility for the assistant's actions [HMH, Part Q, Sections 11-12].

Scope of Practice: Dentists and Dental Hygienists

The Budget renews previous proposals to permanently enable dentists to administer vaccines for influenza, Covid, HPV, and others in response to a public health emergency. Dentists would also be permitted to conduct HIV and hepatitis C tests [HMH, Part Q, Section 13].

The Budget would also expand the scope of practice of dental hygienists to include a variety of new activities, including placing pre-fit orthodontic bands and adjusting removable appliances [HMH, Part Q, Sections 14-15].

The Budget proposes to create a process to allow registered dental hygienists with more than 4,500 hours of practice and three years' experience to practice independently with a collaborative agreement with a licensed dentist, as is currently the case for NPs and physicians. The dental hygienist would be able to perform any services not requiring prior evaluation or supervision from a dentist or medical professional. Dentists may have collaborative agreements with up to six hygienists [HMH, Part Q, Section 16].

Scope of Practice: School Psychologists

The Budget would end the current temporary exemption for school psychologists to participate as Early Intervention (EI) program providers, which allows them to conduct evaluations of children aged 0 to 2 years old. However, the Budget would continue to allow school psychologists to conduct evaluations of children aged 3 to 5 years old for preschool special education services [HMH, Part C].

A bill (S.8802) extending this exemption for both populations was last passed in FY 2022, and has been reproposed this year. However, the Executive notes that it believes ending the EI exemption is required to achieve compliance with federal requirements.

Scope of Practice: EMS

The Budget repeats, with some modifications, previous proposals from the 2023 and 2024 Executive Budgets around emergency medical services (EMS). Specifically, it seeks to:

- Develop an expanded definition of emergency medical services that includes certain non-emergency care, community education and prevention programs, and other services [HMH, Part V, Section 6].
- Create a new Article 30-D defining EMS as "essential services," and requiring every medical dispatch agency to be licensed by DOH. Every county (except those part of New York City) would also be responsible for ensuring that it has adequate EMS capacity. The counties would be

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required to develop a comprehensive EMS plan that would be approved by DOH [HMH, Part V, Section 9].
- Authorize EMS demonstration programs, including collaboration with other health care organizations as part of the Health Care Delivery Collaboratives program (see above). DOH would be authorized to provide regulatory waivers and funding within existing resources to support such demonstrations [HMH, Part V, Section 10].
- Create a licensure process under DOH for EMS practitioners, including emergency medical technicians (EMTs) and advanced EMTs [HMH, Part V, Section 11].
- Establish a rural Paramedic Urgent Care Program. Under this program, EMS agencies would be able to deploy advanced EMTs to provide certain urgent care services (within the scope of practice of EMS) under the supervision of a physician, including through telehealth. Any such programs would need to be integrated with a hospital or other appropriate health care organization [HMH, Part V, Section 12].

The Governor also plans to direct the EMS task force established in last year's Budget to create five "EMS zones" across the state. Each zone would maintain its own EMS workforce to augment areas where local EMS capacity is insufficient [DOH Agency Appropriations Report].

Additionally, the Budget proposes to allow physicians and NPs to issue non-patient specific regimens to allow licensed EMS practitioners to administer immunizations [HMH, Part V, Sections 7-8].

Scope of Practice: OPWDD DSPs

The Budget would amend the Education Law to clarify that unlicensed persons may perform support services in self-directed settings, even if they might otherwise be considered nursing or home health.

Specifically, it would state that the scope of practice of nursing services does not include tasks performed by direct support professionals (DSPs) working in OPWDD-licensed or otherwise approved settings, when:

- Such tasks are directed by the service recipient or their family member; and
- A registered professional nurse (RN) has determined that that person is capable of providing instructions.

The 2014 Enacted Budget previously created a related exemption for tasks performed by DSPs under the supervision of an RN. If the RN does not determine that the individual or family member is capable of providing instructions, the DSP may still be able to provide services under the RN's supervision per the 2014 exemption [HMH, Part EE].

Community Paramedicine

The Budget proposes to build on the community-based paramedicine demonstration passed in last year's legislative session (S.6749/A.6683), which authorized community paramedicine programs that were

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operating under Covid-related flexibilities to continue operating in the same way for two years (through June 2025). The Governor's Budget proposes to:

- Extend the authority for this program by almost six years, through FY 2031; and
- Enable DOH to expand the program by allowing new applicants to apply to participate and existing participants to modify their current operations, and selecting up to 200 such applicants [HMH, Part V, Sections 4-5].

Interstate Licensure Compacts

The Budget repeats the proposal from the 2023 and 2024 Executive Budgets to join the Interstate Medical Licensure Compact and Nurse Licensure Compact, which would simplify the process for physicians and nurses to use another state licensure to practice in New York [HMH, Part R].

COLA for Human Services Agencies

The Budget proposes a new 1.5% COLA for FY 2025 for eligible human services programs, which would build on the 5.4% COLA enacted in FY 2023 and the 4% COLA enacted in FY 2024. As in previous years, eligible programs include most programs certified, licensed, or funded by:

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

Unlike previous COLAs, OPWDD Care Coordination Organizations (CCOs) would not be included for Health Home services (Basic HCBS Plan support for individuals refusing Health Home still is included).

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) [HMH, Part FF].

End of the Covid-19 Sick Leave Requirement

The Budget proposes to end the State's requirement for employers to offer paid sick leave and other benefits to individuals under a quarantine due to Covid-19, effective July 31, 2024 [ELFA, Part M].

CAPITAL FUNDING

The Budget does not contain new major capital funding allocations or a new round of the SHCFTP program. As discussed above, it proposes to allocate $500 million of the current SHCFTP Phase IV and V funding to support partnerships between safety net hospitals and other health care providers under the Healthcare Safety Net Transformation program. Additionally, it plans to allocate $20 million from SHCFTP V funding to support capital grants for the "research and treatment of ALS and other rare diseases" [DOH Agency Appropriations Report].

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Together with the three recent SHCFTP Requests for Applications (RFAs) released by the State, this would leave approximately $720 million in funds not yet allocated or released for applications.

STATE AGENCIES

SHIN-NY Expansion and Technology

The Budget proposes to continue last year's investment in modernizing health care data systems with a total investment of $35 million in capital funding for the Statewide Health Information Network (SHIN-NY), up from $32.5 million provided last year [Capital 353-4]. This reflects a new supplemental investment of $2.5 million in FY 2025 "to support the SHIN-NY Expansion" [DOH Agency Appropriations Report].

The Budget also proposes to renew the usual $10 million allocation for the All-Payer Claims Database (APCD) [Capital 351].

OMH

The Budget would recommend $5.8 billion in all funds appropriations for OMH, a decrease of about $560 million from last year, owing to the removal of one-time capital investments from last year. This includes:

- $2.93 billion in aid to localities, an increase of $240 million from last year [AtL 855]
- $596 million in capital projects, a decrease of about $860 million from last year [Capital 425]
- $2.31 billion in state operations, an increase of $60 million from last year [State Ops 520].

In operating funds, the Budget would allocate:

- $43 million to increase stipends for OMH Supported Housing Units;
- New initiatives to address recruitment and retention in the mental health workforce, including job marketing, a job bank, and a Behavioral Health Fellowship Program; and
- $1.5 million for the Project TEACH initiative to support maternal mental health [OMH Agency Appropriations Report].

It continues last year's funding allocations for various programs, including the Individual Placement and Supports program, the Intensive and Sustained Engagement Treatment (INSET) program, and expanded access to eating disorder treatment [AtL 858-861].

It adds a new $4 million (on top of last year's $14 million allocation) for the OMH Loan Forgiveness program [AtL 857]. This program incentivizes the recruitment and retention of psychiatrists, psychiatric NPs, and other licensed clinicians in mental health programs deemed to have critical capacity shortages. The new $4 million will be specifically for "mental health clinicians serving children and families OMH and OCFS licensed settings" [OMH Agency Appropriations Report].

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For children's services, it funds the following programs:

- Up to $5 million (the same as last year) 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 (the same as last year);
- $10 million (an increase of $5 million) for high fidelity wraparound services for children;
- An increase of approximately $13.5 million to expand the Healthy Steps program for children, the home-based crisis intervention program for children, and school-based clinics [AtL 865-866].

Additionally, the Budget proposes $9.6 million to establish 12 new youth Assertive Community Treatment (ACT) teams [OMH Agency Appropriations Report].

OASAS

The Budget would appropriate $1.2 billion in all funds for OASAS, which includes:

- $898 million in aid to localities, a $110 million decrease from last year [AtL 803].
- $92 million for capital projects, the same as last year [Capital 406].
- $171 million for state operations, a decrease of about $8 million from last year [State Ops 512].

The decrease is primarily attributable to lower anticipated deposits into the Opioid Stewardship Fund.

This year, the Budget proposes $5 million to support existing recovery community centers whose federal grants will expire in October [OASAS Agency Appropriations Report].

OPWDD

The Budget would provide $7.6 billion in all funds for OPWDD:

- $5.13 billion in aid to localities, up about $140 million from last year [AtL 883].
- $139 million in capital projects, up about $20 million from last year [Capital Projects 464].
- $2.36 billion in state operations, unchanged from last year [State Ops 516].

New and expanded initiatives include:

- A new $6.7 million investment to support New Yorkers with IDD to join employment opportunities through a multi-agency collaboration led by OPWDD.
- $30 million for OPWDD "priority program reforms and new service opportunities," focused on individuals entering the OPWDD service system for the first time and those whose needs have changed. This amount will annualize to $60 million and will leverage federal match for a gross increase of $120 million per year [OPWDD Agency Appropriations Report].

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Justice Center

The Budget would clarify that the Justice Center will only forward reports of abuse and neglect to the Office of the Medicaid Inspector General (OMIG) to consider sanctions (such as excluding the culpable provider from the Medicaid program) once these reports are no longer subject to amendment or appeal [HMH, Part CC].

REPRODUCTIVE AND MATERNAL HEALTH

Plan to Improve Prenatal and Postpartum Care

The Budget says that it will advance a "comprehensive plan to further increase access to quality care during the pre- and post-natal period." This plan incorporates a variety of initiatives discussed below in this section and elsewhere in this document, including the maternal health benefit expansions for the EP and QHP populations, new requirements for managed care plans to report on prenatal and postnatal care, and new Medicaid incentives to discourage unnecessary caesarean sections [Briefing Book].

Expanding Consent for Reproductive Health Services

The Budget proposes to modify legislation to clarify that any pregnant person, including minors, may consent to "any and all" reproductive health care services, including termination of pregnancies [HMH, Part N, Sections 2-3].

Prohibiting Referral Requirements for Doula Services

The Budget proposes legislation that would allow DOH to issue a statewide, non-patient specific standing order for the provision of doula services for pregnant, birthing, and postpartum women for up to 12 months postpartum. This standing order would supersede any requirements to obtain a referral to access doula services [HMH, Part N, Section 1].

Authorization to Dispense Contraception

The Budget would create new statutory language that allows any licensed health care practitioner to "prescribe or distribute a contraceptive device or medication" based on their professional judgment [HMH, Part N, Section 4].

Capital Funding for At-Risk Reproductive Health Centers

The Budget proposes a new $18.3 million capital appropriation for safety and security grants for at-risk reproductive health centers [Capital 353].

This initiative builds on previous investments in reproductive health centers in the wake of the overturning of *Roe v. Wade*, including $10 million for the same purpose appropriated last year.

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OTHER HEALTH CARE PROVISIONS

Continuation of Local Tax Intercept for Distressed Providers Assistance

The Budget would extend the authority for the Distressed Provider Assistance Account, which uses a local tax intercept to fund safety net payments for hospitals and nursing homes, to last for an additional three years, through 2028. This program was last altered in the FY 2023 Enacted Budget, in which the program was extended through 2025 and the overall amount was reduced from $250 million to $150 million annually [HMH, Part D, Section 2].

Requiring Separate and Post-Treatment Consent to Pay

The Budget would require health care providers to obtain separate patient consent for treatment and payment. Under the proposed legislation, consent to pay for services "shall not be given prior to the patient receiving such services and discussing treatment costs" [HMH, Part O, Section 3].

Prohibitions on Requiring and Offering Credit Cards

The Budget would prohibit providers from:

- Requiring patients to have a credit card on file or a pre-authorization prior to providing "emergency or medically necessary medical services".
- Completing any part of an application for a medical financial product (medical credit card or third-party medical installment loan) on behalf of a patient.

It would also require providers to notify all patients about the risk of paying for medical services for a credit card, including that they are forgoing state and federal protections regarding medical debt [HMH, Part O, Section 4].

Physician Excess Medical Malpractice Program Modifications

The Budget would extend the Physicians Excess Medical Malpractice Program would be extended through June 30, 2025, but change its premium payment structure to require practitioners to contribute 50% of the cost, starting July 1, 2024. Payments by the pool to insurers would be converted to become two installments over two fiscal years, comprising the full premium for coverage purchased before July 2024 and the remaining 50% of the premium for coverage purchased afterwards [HMH, Part K].

The State projects that it will save approximately $39 million through this modification in FY 2025.

Communicable Disease

The Budget proposes to require physicians and laboratories to report to DOH all results, both positive and negative, of tests for HIV, hepatitis B and C, and syphilis [HMH, Part T, Sections 1-4].

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It also proposes to repeal Section 2307 of the Public Health Law, which makes it a misdemeanor for a person "knowing himself to be infected" with a venereal disease to have sexual intercourse [HMH, Part T, Section 9].

Extenders

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

- The Medicaid program's additional eligibility category for children aged 19 or 20 and living with their parents would be extended by five years, through October 2029 [HMH, Part B, Section 1].
- Various managed care provisions stemming from the Pataki Administration's original managed care initiatives in 1998 would be extended, including:
    - Authorization for Mental Health Special Needs Plans would be extended by five years, through FY 2030 [HMH, Part B, Section 2].
    - Authorization for MCOs to affiliate with not-for-profit-controlled entities to provide care coordination services would be extended by five years, through December 2029 [HMH, Part B, Section 6].
- Several provisions related to the previous Delivery System Reform Incentive Payment (DSRIP) Medicaid waiver would be extended, including:
    - Authorization for DOH to issue certificates of authority for Medicaid accountable care organizations (ACOs) and Certificates of Public Advantage (COPAs) would be extended by four years, through FY 2028 [HMH, Part B, Sections 3-4].
    - Authorization for DOH, OMH, OASAS, and OPWDD to waive regulatory requirements for DSRIP projects would be extended by two years, through FY 2026 [HMH, Part B, Section 10].
- Opioid stewardship programs, including:
    - The Opioid Stewardship Act of 2018 would be extended by three years, through June 2027 [HMH, Part B, Section 7].
    - The authorization for the Opioid Stewardship Fund would be made permanent [HMH, Part X].
- The Statewide Medicaid Integrity and Efficiency Initiative would be extended by two years, through FY 2026 [HMH, Part B, Section 8].
- Authorization for DOH to perform energy and disaster preparedness audits of nursing homes would be extended by three years, through July 1, 2027 [HMH, Part B, Section 9].
- Authorization for State mental hygiene facility directors to act as federally appointed representative payees to use funds for the cost of treatment for individuals at the facility would be made permanent [HMH, Part DD].
- Authorization for DASNY to establish subsidiaries to take title from Article 28 hospitals that default on their obligations would be extended by three years, through July 1, 2027 [TED, Part V].

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Repealers

The Budget would discontinue a variety of programs currently authorized under DOH, including:

- The 405.4 Hospital Audit Program, which conducts audits on working hours and conditions for postgraduate trainees and certain other staff [HMH, Part L, Section 1].
- The Enhanced Quality of Adult Living (EQUAL) program, which offers incentive payments to operators of Adult Homes and Enriched Housing Program based on their safety net populations [HMH, Part L, Section 2].
- The Empire Clinical Research Investigator Program (ECRIP) [HMH, Part L, Sections 3-5].
- The operating assistance sub-program for enriched housing [HMH, Part L, Section 6].
- The Tick-Borne Disease Institute [HMH Part L, Section 7].
- The contract with the Medical Society of the State of New York for a Committee on Physician Health to "confront and refer to treatment physicians who are thought to be suffering from alcoholism, drug abuse, or mental illness," which was established in 1980 and repeatedly extended [HMH, Part L, Sections 8-9].