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New York FY 2024-25 Enacted Budget

April 2024

Sachs Policy Group

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New York State Fiscal Year 2025 Enacted Budget Summary

OVERVIEW

Last weekend, New York State reached an agreement on a final Enacted Budget for Fiscal Year (FY) 2025, which runs from April 1, 2024 to March 31, 2025. The Budget is expected to propose total spending of $237 billion, a $4 billion increase from the Executive proposal of $232.7 billion, although not all documents have been published yet.

The final Enacted Budget does not include funding from a managed care organization (MCO) tax. The Legislature had sought to enact such a tax to add $4 billion of funding for Medicaid, but this will require federal approval. Instead, the Budget provides authority to the Executive to negotiate such a tax and hold the funds in a special Healthcare Stability Fund. Despite this, the Budget modestly increases Medicaid spending over the Executive Budget proposal.

Some of the most notable health care items in the Budget include:

- **Aggregate Medicaid reimbursement increases** on top of across-the-board increases in the last two years, for hospitals ($525 million all funds), nursing homes ($285 million all funds), and Assisted Living Programs ($15 million all funds).
- **A Cost of Living Adjustment (COLA)** for human services agencies of 2.84% (up from the Executive's proposed 1.5%), with the additional provision that salaries for frontline staff must increase by at least 1.7%. As in the Executive Budget, the same entities are eligible who received last year's COLA, except for Care Coordination Organizations (CCOs).
- **The establishment of a single Statewide Fiscal Intermediary (FI)** in the Consumer Directed Personal Assistance Services (CDPAS) program. The Statewide FI must be an entity that is currently serving as statewide FI for another state. It will employ several subcontractors, including at least one per rate-setting region, which must be entities with existing FI experience. Other than these entities, no other FIs will be allowed to continue operating after April 2025.
- **The Governor's Healthcare Safety Net Transformation program** for partnerships to stabilize distressed safety net hospitals, with an anticipated $300 million in funding.
- **Creation of a Community Advisory Board for SUNY Downstate** and postponement of any reduction in capacity there until at least April 2025.
- **Most of the Governor's proposed consumer protections**, including:
  - An expanded, mandatory uniform hospital financial assistance policy, with a new clarification that immigration status may not be considered in the process.
  - Requirement that separate patient consent must be obtained for treatment and payment.
  - Limits on medical financial products, such as medical credit cards.
- **Implementation support for the State's new 1115 Medicaid waiver amendment**.

The below summary provides further detail on these and other highlights from the Budget. Where available, legislative sources are marked in [brackets]. The Governor's press release on the Budget is available here.

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MEDICAID

Medicaid Global Cap

As proposed in the Executive Budget, the Medicaid Global Cap will be extended 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 has previously projected that the Global Cap will increase by a total of $15.6 billion between FY 2024 and 2028.

1115 Waiver Implementation

The Budget includes the Executive's proposed allocation of state funds to support New York's new 1115 Medicaid waiver, New York Health Equity Reform. According to the 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 [Scorecard].

The Enacted Budget also includes the new authority proposed in the Governor's 30-day amendments to allow the Department of Health (DOH) to have contracting flexibility (such as the ability to make awards without a competitive bid) for waiver-related projects [HMH, Part GG].

Telehealth Payment Parity Extension

The Enacted Budget includes the extension of the current requirement, first passed in the FY 2023 Budget, for telehealth payment parity for both Medicaid and commercial plans, by two years, through April 1, 2026 [HMH, Part B, Section 5]. This is an increase from the Executive proposal of one year.

Children's Continuous Eligibility Expansions

The Enacted Budget includes the Governor's proposed expansion of 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 is 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) [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) [Scorecard].

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 [Scorecard].

Discontinuation of Managed Care Quality Pool Supplemental Funding

The Budget includes savings from the reduction of the managed care and managed long-term care (MLTC) quality pool supplemental funding. However, the pools are not eliminated as proposed by the Executive. The reductions are:

- $33.8 million state share from the mainstream quality pool, where the Executive Budget proposed to save $60 million state share, leaving a total of $52.4 million (all funds); and

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- $29.6 million state share from the MLTC quality pool, where the Executive Budget proposed to save $51.8 million state share, leaving a total of $44.4 million (all funds) [Scorecard].

Increased Medicaid Audit Target

The Budget continues to forecast an increased recovery of $100 million in Medicaid audits due to the increased volume of Medicaid claims [Scorecard].

Continuation of School-Based Health Center Carveout

The Enacted Budget includes the Senate and Assembly proposals to specify in statute that school-based health centers must remain carved out of Medicaid managed care until April 1, 2025 [HMH, Part JJ].

Omitted Proposals

The Enacted Budget omitted the Executive's proposals to:

- Seek an "unallocated savings" target of $200 million from the Medicaid program;
- "Restructure" Health Homes for a savings of $125 million; and
- Remove the Medicaid program from being subject to the independent dispute resolution (IDR) process for surprise out-of-network bills.

HOSPITALS

Aggregate Medicaid Rate Increase for Hospitals

The Enacted Budget includes a new provision to provide a one-year (FY 2025 only) aggregate increase to "Medicaid payments made for hospital services." This may be up to $525 million all funds [HMH, Part NN, Section 1]. The Budget Scorecard allocates $200 million state share (i.e., $400 million all funds) for this purpose; it is currently unclear where the remaining $125 million is budgeted.

The Budget does not specifiy how these increases will be distributed. It only states that they "may take the form of increased rates of payment in Medicaid FFS and/or MMC, lump sum payments, or state-directed payments" [HMH, Part NN, Section 4].

Safety Net Transformation Program

The Enacted Budget includes, with modifications, the Governor's proposal to establish a new Healthcare Safety Net Transformation Program to support safety net hospitals to improve care and achieve sustainability through clinical partnerships. The Program will offer participants aligned capital funding and regulatory flexibility. Notable changes include:

- The Executive Budget had proposed to transfer $500 million of the funding from Phases IV and V of the Statewide Health Care Facility Transformation Program (SHCFTP) for this purpose.

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Under the Enacted Budget, both SHCFTP funds are made available for this purpose, but the amount of funding to be transferred is not specified. An additional $300 million in operating funds is also available for this program [AtL 865].

- The statute now contains additional specifications for applications:
  - Applications must demonstrate why the funding and regulatory flexibilities are necessary to achieve the program goals;
  - Applications must include:
    - Key organizational information;
    - The type of collaborative model proposed;
    - A description of the five-year transformation plan;
    - A timeline of key metrics and goals;
    - A description of requested regulatory flexibilities; and
    - The amount of funding requested.
- The statute places certain restrictions on DOH's administration of the program, as noted below.

Under this program, 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.

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 another type of health care entity. However, DOH may not "deem" any entity to be eligible as proposed by the Executive. The partnership may, but is not required to, culminate in a merger, acquisition, management services contract, or clinical integration.

DOH is authorized to waive regulations to allow participants in this program to more efficiently implement projects awarded funding through this program. In the Executive proposal, this excluded 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.

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The Enacted Budget further excludes regulations related to:

- Quality of care;
- Safe staffing;
- Adverse event reporting;
- Infection control; and
- Character and competence.

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. The Enacted Budget also includes a requirement for DOH to report to the Legislature on all participants in this program [HMH, Part S].

Inpatient Capital Add-on Reduction

As proposed, the Budget makes 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 increases this reduction to a total of 20%, effective October 2024 [HMH, Part D, Section 1].

New Hospital Financial Assistance Law Requirements

The Enacted Budget includes a slightly modified version of the Executive proposal for new consumer protections as part of the State's Hospital Financial Assistance Law. Under the new policy:

- 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. Previously, hospitals could 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 will:
    - 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.

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- 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.
- 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 1-3].

Modifications in the Enacted Budget include:

- Clarification that all hospitals (not only those participating in the Indigent Care Pool) must establish a financial assistance policy in compliance with this statute [HMH, Part O, Section 2].
- Specification that immigration status is not a consideration for eligibility for financial assistance. While hospitals may continue to require patients to apply for public insurance as part of the process, they may not require people who lack appropriate immigration status to apply for such programs [HMH, Part O, Section 3].
- Expansion of reporting requirements to include that hospitals must report on the number of financial assistance requests that they approve and deny [HMH, Part O, Section 3].

SUNY Downstate Community Advisory Board

The Enacted Budget includes a new provision to establish a SUNY Downstate Community Advisory Board to consider options for its viability. The Board will conduct a study with the goal of developing a "reasonable, scalable, and fiscally responsible plan for the financial health, viability, and sustainability of SUNY Downstate." The Board's plan is directed to "incorporate utilization of all available state and federally available appropriated amounts, and shall not exceed more than two hundred fifty percent of such amounts." The plan must be submitted by April 1, 2025. Until that date, the Public Health and Health Planning Council (PHHPC) may not review or approve any Certificate of Need application that would reduce inpatient services at SUNY Downstate [Part MM].

Incentives to Reduce Unnecessary C-Sections

No further details are available yet on the Executive proposal to create new Medicaid financial incentives to reduce unnecessary C-sections.

Omitted Proposals

The Enacted Budget omits the Executive proposals to:

- Rename and expand the Hospital-Home Care-Physician Collaboration demonstration program to a wider variety of providers.
- Modify the definition of "licensed home care services agency" (LHCSA) to clarify that Article 28 hospitals may be exempted from the definition under certain conditions.

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LONG TERM CARE

Aggregate Medicaid Rate Increase for Nursing Homes and ALPs

The Enacted Budget includes a new provision to provide a one-year (FY 2025 only) aggregate increase to "Medicaid payments made for nursing home services" and "assisted living programs" (ALPs). The nursing home increase is up to $285 million all funds, while the ALP increase is up to $15 million all funds. The Budget Scorecard allocates $150 million state share to cover these increases [HMH, Part NN, Sections 2-3].

The Budget does not specify how these increases will be distributed. It only states that they "may take the form of increased rates of payment in Medicaid FFS and/or MMC, lump sum payments, or state-directed payments" [HMH, Part NN, Section 4].

Single Statewide Fiscal Intermediary for CDPAS

The final budget replaces the Governor's proposals related to consumer-directed personal aide services (CDPAS) wage parity with the implementation of a single Statewide Fiscal Intermediary (FI) by April 2025. It accordingly repeals the previous procurement of FIs [HMH, Part HH, Sections 4 and 6].

Under this initiative, the State will contract with a single Statewide FI to oversee the delivery of FI services related to CDPAS. Once selected, all MLTC plans and other payers of CDPAS services must contract with the statewide FI [HMH, Part HH, Section 2].

The State will review all offers that meet the following minimum criteria:

- Demonstrate capability to perform statewide FI services with cultural and language competencies appropriate for consumers and CDPAS workers;
- Have experience serving individuals with disabilities; and
- As of April 1, 2024, serve as a statewide FI for another state [HMH, Part HH, Section 1].

The Statewide FI will be required to subcontract with certain entities with existing FI experience:

- At least one entity per rate setting region with a record of serving "individuals with disabilities and the senior population," that has been an FI since at least January 1, 2012. Like the statewide FI, subcontractors must demonstrate cultural and language competency.
- A service center for independent living that has been an FI since at least January 1, 2024 [HMH, Part HH, Section 1].

DOH will promulgate regulations for the FI registration process, standards and timeframes, and regulations to ensure adequate access. DOH may revoke, suspend, or limit an FI's registration if it fails to comply with such regulations, and may take actions necessary to prohibit unregistered entities from providing FI services. The selected subcontractors must register as FIs within 30 days of being selected. After April 1, 2025, no other entities other than the statewide FI and its subcontractors may serve as FIs [HMH, Part HH, Section 3, 5, and 7].

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The statute also specifies that DOH has authority to establish regulations for "minimum safety, health, and immunization criteria and training requirements" for CDPAS assistants [HMH, Part HH, Section 7].

This proposal is projected to save $200 million in FY 2025 and $504 million per year afterwards [Scorecard].

Nursing Home Rate Freeze and Capital Reduction

As proposed in the Executive Budget, the operating component of skilled nursing facility (SNF) rates will be frozen "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%. The Budget includes the Executive proposal to implement an additional reduction of 10%, effective April 2024. However, the Enacted Budget version includes an exemption for pediatric nursing homes for medically fragile children [HMH, Part E, Section 2].

Safety Net ALR Program

The Enacted Budget includes the proposal to remove the cap on the number of participants in the pilot Safety Net Assisted Living Residence (ALR) program. This program offers vouchers to subsidize up to 75% of the private pay rate for people who are not eligible for Medicaid.

Previously, only 200 vouchers were available. Under the Budget, the number of vouchers is subject to the available appropriations. The statute also clarifies that the program is only available to people who 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].

Omitted Proposals

The Enacted Budget omits the Executive proposals to:

- Set a target of $200 million in annual savings from long-term care programs (outside of community-based services).
- Create new quality and performance reporting requirements for ALRs.
- Establish a new interagency Elder Justice Coordinating Council.

MANAGED CARE

MCO Tax

The Enacted Budget authorizes DOH to seek to implement an MCO Provider Tax to raise funds to finance the Medicaid program. This proposal is modeled on California's MCO tax, which has existed for many years but was expanded significantly in 2023. California engaged with the federal government on

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structuring the tax, with the understanding that "CMS has declared intention to change federal regulations associated with Health Care Related Taxes" and that "this proposed model may not be approvable in the future […] beyond calendar year 2026."

The Senate and Assembly sought to use an additional $4 billion per year in funding for three years from the MCO Provider Tax. However, the Enacted Budget does not assume any immediate budgetary impact. Instead, it directs DOH to:

- Apply for a waiver of federal regulations to secure federal financial participation;
- Issue regulations to implement the MCO provider tax; and
- Impose the MCO provider tax as an assessment on Medicaid, CHIP, Essential Plan, Marketplace, and other comprehensive plans offered by Article 32, 42, and 43 insurers or Article 44 health maintenance organizations.

Funds from the tax would be placed in a "Healthcare Stability Fund" under the joint custody of the Comptroller and the Commissioner of Taxation and Finance. The funds would not be included in the calculation of the Medicaid Global Cap. Subject to approval by the Division of the Budget, the Healthcare Stability Fund could be used to:

- Provide state share of increased capitation payments for Medicaid MCOs;
- Provide state share for Medicaid expenditures such as supplemental payments and quality incentive programs;
- Reimburse the General Fund for Medicaid expenditures that accrue to it; or
- Fund capital projects to support the delivery of health care services [HMH, Part II].

The Enacted Scorecard projects $350 million in offsets from the fund for this fiscal year.

Repeal of 1% Across-the-Board Increase for MCOs

As proposed in the Executive Budget, effective April 1, 2024, Medicaid MCOs will be removed from the 1% across-the-board increase to Medicaid rates that was passed as part of the FY 2023 Budget [HMH, Part H].

Omitted Proposals

The Enacted Budget does not include the Executive's proposals to:

- Authorize DOH to conduct a procurement to reselect Medicaid MCOs;
- Authorize DOH to recover liquidated damages from MCOs related to failures to meet their contractual obligations.

No further details are available yet on the proposal described in the Executive Budget Briefing Book to establish new reporting requirements on plans regarding prenatal and postpartum care.

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SAFETY NET

The Governor announced that the Budget includes a total of $3.9 billion in funding for safety net hospitals. This includes an increase of $500 million in Vital Access Provider Assurance Program (VAPAP) funding from the $344 million proposed in the Executive Budget [AtL 865].

ESSENTIAL PLAN AND MARKETPLACE

Essential Plan Transition to 1332 Waiver

As proposed in the Executive Budget, the Enacted Budget provides authority to make changes to New York's Essential Plan (EP) to conform with its transition to a Section 1332 State Innovation Waiver. As the federal government approved New York's 1332 waiver application on March 1st, these changes are now being implemented.

In particular, the Budget establishes the 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].

This program is enacted in the Section 1332 waiver as the Insurer Reimbursement Implementation Plan (IRIP), which will provide about $44 million to insurers to keep premiums for individuals purchasing QHPs at the same level they would be without the waiver.

Delay of LTSS Coverage Extension to All EP Populations

As proposed in the Executive Budget, the planned extension of coverage of long-term services and supports (LTSS) to all current EP populations is delayed by one year, until 2026.

In the FY 2023 Budget, the State expanded the EP 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 Enacted Budget is expected to include the Executive's proposed benefit expansions in the EP, including:

- Eliminating all premiums for EP coverage (which was approved in the Section 1332 Waiver);
- Eliminating cost sharing for individuals with certain chronic conditions;
- Eliminating all cost-sharing for pregnancy-related benefits;
- Adding coverage of doula services;

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- Increasing funding for substance use disorder treatment (a related program was included in the Section 1332 waiver); 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). A related program was included in the Section 1332 waiver.

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

BEHAVIORAL HEALTH

Mandate for Commercial Plans to Reimburse Licensed Clinics at Medicaid Rates

The Enacted Budget includes the Executive proposal 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.

The Enacted version specifies that the rate in question must be not less than the Medicaid rate as of April 1st of the previous year, as established by October 1st of that year. The rates must then remain unchanged for the remainder of the year. Insurers may submit adjustments to their rate filings in future years if needed to account for the fiscal impact of the lag. This requirement applies 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].

Time-Limited Demonstration Authority

The Enacted Budget did not, as proposed by the Executive, 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." Instead, it enacted a one-year extension of the authority, through the end of FY 2025 [HMH, Part Z].

CPEP Authority

The Enacted Budget did not, as proposed by the Executive, make permanent the authorization for OMH to designate Comprehensive Psychiatric Emergency Programs (CPEP). Instead, it enacts a further three-year extension of the authority through July 1, 2027 [HMH, Part BB].

Omitted Proposals

The Enacted Budget omits the following behavioral health proposals from the Executive Budget:

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- Making 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.
- Increasing DFS's authority to levy fines for violation of behavioral health parity requirements.

PHARMACY

Prohibition on Cost Sharing for Insulin

As proposed by the Executive, the Enacted Budget expands the FY 2021 Budget's limits on cost-sharing for insulin by prohibiting cost-sharing entirely.

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

Replacement of Medicaid Drug Cap with Prescription Rebate Negotiations

The Enacted Budget includes, with modifications, the Executive proposal to replace the current Medicaid Prescription Drug Cap program, which sets a growth target for pharmacy expenditures, with a supplemental rebate negotiation system.

Under this system, DOH will review all Medicaid drug expenditures at least annually. DOH will examine drugs in the 80th percentile or higher of total spending or cost per claim, net of rebates. The Executive had proposed to allow DOH to consider other drugs as well, but this was not included in the Enacted version.

Following this review, DOH will 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 has 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 will be considered confidential by the State.

After review, DOH may choose to take a variety of actions with respect to drugs referred to DURB, if the manufacturer has not agreed to an appropriate supplemental rebate arrangement that meets the DURB target rebate amount. These may include, but are not limited to:

- Subjecting the drug to prior approval requirements;
- Directing MCOs to limit or reduce physician reimbursement for the drug, if it is a physician-administered drug;
- Directing MCOs to remove such drugs from their Medicaid formularies; or
- Promoting the use of other cost-effective, clinically appropriate drugs.

Additionally, DOH may allow manufacturers to accelerate rebate payments under existing contracts and may undertake other actions as authorized by law.

The Enacted version of this proposal requires that DOH provide 30 days' written notice to the legislature before taking such actions [HMH, Part I, Section 4].

Negotiation on Accelerated Approval Drugs

As proposed in the Executive Budget (with technical modifications), the Enacted Budget provides 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.

Medicaid Reimbursement for Physician-Administered Drugs

As proposed in the Executive Budget, the Enacted Budget replaces current statute that directs Medicaid to reimburse physicians for drugs they administer at their "actual cost." Medicaid will instead pay the lowest of:

- The National Average Drug Acquisition Cost (NADAC) or the wholesale acquisition cost (WAC) based on the package size;
- The federal upper limit;
- A State Maximum Acquisition Cost (SMAC), if such exists for the drug; or
- The physician's actual cost.

The Executive Budget proposed that, if such drugs are purchased through the 340B program, Medicaid will pay at the 340B actual cost. The Enacted Budget expands on this to require that:

- Practitioners submitting 340B claims should notify the department of their 340B eligibility; and
- Regardless of the above, a medical practitioner must be reimbursed an amount that is at least equal to the SMAC or, if that does not exist for the drug, the WAC based on the package size [HMH, Part I, Section 6].

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Medicaid Reimbursement for Pharmacy Dispensed Drugs

The Enacted Budget removes the 3.3% reduction to Medicaid reimbursement for brand-name prescription drugs dispensed by pharmacies that has previously applied when that reimbursement is the NADAC or WAC [HMH, Part I, Section 6].

DOH Authority to Modify the OTC Formulary

The Enacted Budget includes, with modifications, the Executive's proposal to give DOH the authority to remove coverage of over-the-counter drugs that are reimbursable by Medicaid. Under current law, DOH only has the authority to add new drugs.

In the Enacted version, DOH must provide 60 days' notice to enrollees of any removals and must refer proposed eliminations to the DURB [HMH, Part I, Sections 1-3].

Omitted Proposals

The Enacted Budget does not include the Executive proposals to:

- End the "prescriber prevails" requirements;
- Expand the definition of items eligible for procurement under DOH's Preferred Diabetic Supply Program;
- Implement a new cost reporting system for Medicaid-participating pharmacies; and
- Modify regulations around prescription drug monitoring to extend the data retention period and enable disclosure for public health surveillance purposes.

OVERSIGHT OF HEALTH CARE TRANSACTIONS

CON Reforms

The Enacted Budget is expected to include the Governor's non-legislative 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.

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 Enacted Budget extends for two years, through July 1, 2026, the following scope of practice expansions that were passed in the FY 2023 Budget:

- The addition of pharmacists to the definition of "qualified health care professional" for the purposes of directing laboratory testing for Covid and influenza tests. The Executive Budget had proposed to make this permanent.
- 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. The Executive Budget had proposed to extend this through April 2026.
- 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. The Executive Budget had proposed to make this permanent [HMH, Part P].

The Budget did not include the Executive's proposals to:

- Allow pharmacists to execute non-patient specific orders for the dispensing of HIV PrEP medication.
- Allow pharmacists to administer mpox immunizations.

Scope of Practice: Certified Registered Nurses

The Enacted Budget extends for two years, through July 1, 2026, the authority for physicians and NPs to issue non-patient specific regimens that allow registered nurses to order Covid and influenza tests [HMH, Part P].

The Budget did not include the Executive's proposals to:

- Make the above authority permanent; or
- Expand the process to hepatitis B testing.

Scope of Practice: School Psychologists

As proposed in the Executive Budget, 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, is eliminated. School psychologists may still conduct evaluations of children aged 3 to 5 years old for preschool special education services [HMH, Part C].

Scope of Practice: EMS

Although the Executive's legislative proposals around EMS were all removed from the Enacted Budget, the Governor is expected to proceed with her 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.

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Omitted Proposals

The Enacted Budget omitted the Executive's proposals to:

- Allow for independent practice by experienced physician assistants;
- Allow certified medication aides to administer routine and prefilled medications in residential health care facilities;
- Allow a physician or physician assistant to directly assign and supervise a medical assistant to draw and administer immunizations to patients;
- Enable dentists to administer vaccines and conduct HIV and hepatitis C tests;
- Expand the scope of practice of dental hygienists;
- Create a process to allow experienced dental hygienists to practice independently with a collaborative agreement with a licensed dentist;
- Develop an expanded definition of emergency medical services (EMS);
- Create a new Article 30-D defining EMS as "essential services" and requiring every medical dispatch agency to be licensed by DOH;
- Authorize EMS demonstration programs, including collaborations with other health care organizations;
- Create a licensure process under DOH for EMS practitioners;
- Establish a rural Paramedic Urgent Care program;
- Extend the authority for the community paramedicine demonstration passed in last year's legislative session (S.6749/A.6683);
- Join the Interstate Medical Licensure Compact and Nurse Licensure Compact; or
- Clarify that direct support professionals working in Office for People with Developmental Disabilities (OPWDD) programs may perform support services in self-directed settings.

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, 2025 [ELFA, Part M]. This is a one-year delay from the Executive proposal to end the requirement on July 31st this year, but the legislative proposal to retain the requirement for certain health care providers was rejected.

COLA FOR HUMAN SERVICES AGENCIES

The Enacted Budget includes a 2.84% COLA for FY 2025 for eligible human services programs. This is an increase from the Governor's proposal of a 1.5% COLA. 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).

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The COLA will 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).

The Enacted Budget includes a new provision that each provider receiving the COLA must provide a targeted salary increase of 1.7% to support staff, direct care staff, clinical staff, and non-executive administrative staff in targeted programs. This includes a specific set of fiscal report codes.

Unlike previous COLAs, OPWDD Care Coordination Organizations (CCOs) are not included, either for Health Home services or Basic HCBS Plan support [HMH, Part FF].

CAPITAL FUNDING

Modification of SHCFTP Funding

The Budget does not contain new major capital funding allocations or a new round of the SHCFTP program. Instead, it reallocates the appropriation of current SHCFTP Phase IV and V funding, as follows:

- As mentioned above, the Budget proposes to allocate "a portion" of these funds to the Healthcare Safety Net Transformation program.
- As proposed by the Executive, it allocates $20 million from SHCFTP V funding to support capital grants for the "research and treatment of ALS and other rare diseases."
- It allocates $300 million from SHCFTP V to support SUNY Downstate [Capital 428].

After the three recent SHCFTP Requests for Applications (RFAs) released by the State, this leaves approximately $920 million in funds not yet allocated or released for applications, which may be eligible to be used for either the Healthcare Safety Net Transformation program or for future SHCFTP RFAs.

Artificial Intelligence (AI)

As proposed by the Governor in her State of the State address, the Enacted Budget includes legislation to establish the Empire AI Research Program. Empire AI's centerpiece is the establishment of an AI computing facility based at the SUNY Buffalo campus in upstate New York. The Empire AI Center's resources will be available collectively to the participating institutions, which include Columbia University, Cornell University, CUNY, New York University, Rensselaer Polytechnic Institute, SUNY, and the Simons Foundation.

The Center will be operated and managed by a not-for-profit organization known as the "Empire AI Consortium." It will be responsible for "research and development to advance the ethical and public interest uses of artificial intelligence technology in the state" [TED, Part TT].

The Budget appropriates $250 million in capital funding and $2.5 million in state operations funding to support this initiative [Capital 1027; State Ops 740]. An additional $25 million contribution is anticipated from the SUNY budget. Empire AI also includes $125 million of committed donations from

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private donors. Publicly announced donations include $25 million from the Simons Foundation to support the participation of the Flatiron Institute (its in-house computational research division) and CUNY and $5 million from the Secunda Family Foundation for SUNY Binghamton.

STATE AGENCIES

Please note that investments noted in the Executive Appropriations Reports and Briefing Book are not included below.

SHIN-NY Expansion and Technology

The Budget continues 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 424-5].

The Budget also proposes to renew the usual $10 million allocation for the All-Payer Claims Database (APCD) [Capital 421].

OMH

The Budget allocates $5.9 billion in all funds appropriations for OMH, a decrease of about $510 million from last year, owing to the removal of one-time capital investments from last year. This includes:

- $2.98 billion in aid to localities, an increase of $288 million from last year [AtL 1167]
- $596 million in capital projects, a decrease of $864 million from last year [Capital 513]
- $2.31 billion in state operations, an increase of $66 million from last year [State Ops 604].

As proposed, the Budget includes $55 million to establish 200 new inpatient psychiatric beds at State-run facilities, as well as additional funding for crisis services. It also 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 1172].

The Budget adds a new $4 million (on top of last year's $14 million allocation) for the OMH Loan Forgiveness program [AtL 1169]. 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 in OMH and OCFS licensed settings."

For children's services, the Budget 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);

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- $10 million (an increase of $5 million) for high fidelity wraparound services for children; and
- 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 1183].

OASAS

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

- $961 million in aid to localities, a $109 million decrease from last year [AtL 1135].
- $92 million for capital projects, the same as last year [Capital 490].
- $173 million for state operations, a decrease of about $7 million from last year [State Ops 594].

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

OPWDD

The Budget provides $7.7 billion in all funds for OPWDD:

- $5.17 billion in aid to localities, up about $181 million from last year [AtL 1208].
- $139 million in capital projects, up about $20 million from last year [Capital Projects 559].
- $2.36 billion in state operations, up $ million from last year [State Ops 617].

Omitted Proposals

The Enacted Budget does not include the Executive proposal intending to 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 once these reports are no longer subject to amendment or appeal.

REPRODUCTIVE AND MATERNAL HEALTH

Reproductive Freedom and Equity Grants

The Enacted Budget establishes a new “Reproductive Freedom and Equity” grant program in DOH for abortion providers and not-for-profit organizations that provide or facilitate access to abortions. Grants are intended to increase access and capacity, fund uncompensated health care costs related to abortion, and address practical support needs of individuals seeking abortions [ELFA, Part PP].

The Budget allocates $25 million for this program this year [AtL 821].

Prohibiting Referral Requirements for Doula Services

The Enacted Budget includes the Executive proposal allowing DOH to issue a statewide, non-patient specific standing order for the provision of doula services for pregnant, birthing, and postpartum women

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for up to 12 months postpartum. This standing order would supersede any requirements to obtain a referral to access doula services [HMH, Part KK].

Community Doula Expansion Grant Program

The Enacted Budget also includes the Senate proposal for $250,000 for a new Community Doula Expansion Grant Program, allowing eligible providers to receive funding for recruitment, training, certification, supporting, and/or mentoring of community-based doulas. Funding will be prioritized for providers that train, recruit, and employ bilingual doulas and doulas from historically vulnerable communities [HMH, Part KK; AtL 828].

Capital Funding for At-Risk Reproductive Health Centers

As proposed by the Executive, the Budget makes a new $18.3 million capital appropriation for safety and security grants for at-risk reproductive health centers [Capital 424]. 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.

Omitted Proposals

The Enacted Budget omits the Executive's proposals to:

- Allow any licensed health care practitioner to "prescribe or distribute a contraceptive device or medication" based on their professional judgment; and
- Clarify that any pregnant person, including minors, may consent to "any and all" reproductive health care services, including termination of pregnancies.

CHILDREN'S SERVICES

New Rate Methodology for Medically Fragile Pediatric Facilities

The Enacted Budget includes a new provision that directs DOH to establish a new reimbursement methodology for pediatric facilities for medically fragile children. Specifically:

- Effective April 1, 2024, DOH will modify rates for pediatric Article 28 diagnostic and treatment centers (D&TCs) to "reflect the costs necessary" to treat medically fragile children. These are defined as D&TCs participating in the Section 2808-e demonstration and associated with a pediatric residential health facility for which at least 80% of total Medicaid fee-for-service reimbursements derive services for children under 21 with medical fragility.
- For the period April 1, 2024 to December 31, 2024, operating reimbursement will be provided based on budgeted costs. Upon verification of the cost report, the operating component will be adjusted to reflect actual costs for calendar year 2024, subject to appropriate adjustments. Afterwards, the base period reported operating costs will be updated at least every two years.

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- Medicaid managed care plans will also eb required to reimburse pediatric D&TCs at this rate.

This statute will expire in three years, at the end of FY 2027, if not renewed [HMH, Part LL].

OCFS After-School Programming Study

The Enacted Budget includes a provision requiring OCFS, within the next eighteen months, to complete a study evaluating the feasibility of providing after-school programming during the academic year to every school-aged child in New York. The study will examine:

- The costs of implementing an after-school programming, including transportation and labor costs;
- Per-child pay rates for current after-school providers;
- Current accessibility to subsidized after-school programming during the academic year; and
- Opportunities for inter- and intra-agency collaboration in delivering after school programming, including provider agencies [ELFA, Part VV].

CSE Residential Placement Funding Formula

The Enacted Budget extends through 2025 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. The Executive Budget had proposed to make these provisions permanent [ELFA, Part G].

OTHER HEALTH CARE PROVISIONS

Continuation of Local Tax Intercept for Distressed Providers Assistance

The Budget includes the Executive's proposed extension of 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; AtL 899].

Requiring Separate and Post-Treatment Consent to Pay

The Budget includes the Executive's proposal to 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 4].

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Prohibitions on Requiring and Offering Credit Cards

The Budget includes, with technical modifications, the Executive proposals to prohibit hospitals and health care 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 also requires 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 5].

Extenders

The Enacted Budget includes most of the proposed extenders for various existing provisions. However, policies that the Executive proposed to make permanent were only extended by several years instead.

- As proposed:
  - The Medicaid program's additional eligibility category for children aged 19 or 20 and living with their parents are 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 are extended, including:
    - Authorization for Mental Health Special Needs Plans is 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 is 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 are extended, including:
    - Authorization for DOH to issue certificates of authority for Medicaid accountable care organizations (ACOs) and Certificates of Public Advantage (COPAs) is 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 is extended by two years, through FY 2026 [HMH, Part B, Section 10].
  - The Statewide Medicaid Integrity and Efficiency Initiative is 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 is extended by three years, through July 1, 2027 [HMH, Part B, Section 9].

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- Modified:
  - The Opioid Stewardship Act of 2018 is extended by five years, through June 2029 [HMH, Part B, Section 7]. This is an increase from the proposed three years.
  - 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 is extended by three years [HMH, Part DD]. The Executive had proposed to make this permanent.
  - Authorization for DASNY to establish subsidiaries to take title from Article 28 hospitals that default on their obligations is extended by two years, through July 1, 2026 [TED, Part V]. This is a decrease from the proposed two years.
- New:
  - The requirement for OPWDD to provide 90 days' notice before closure or transfer of a state-operated Individualized Residential Alternative (IRA) is extended by two years [HMH, Part B, Section 11].
  - The OPWDD Care Demonstration Program is now an option for OPWDD to implement "at their discretion," instead of a mandated program. The authorization for the program is extended by two years, through 2026 [HMH, Part B, Sections 12-13].
  - The Cystic Fibrosis Assistance Program is extended by one year, through April 1, 2025 [HMH, Part B, Section 14].

Omitted Proposals

The Enacted Budget rejected the Executive's proposals to:

- Modify the premium payment structure of the Physician Excess Medical Malpractice Program to require practitioners to contribute 50% of the cost.
- Require physicians and laboratories to report to DOH all results, both positive and negative, of tests for HIV, hepatitis B and C, and syphilis, and repeal communicable disease-related offenses.
- Repeal the following programs:
  - The 405.4 Hospital Audit Program;
  - The Enhanced Quality of Adult Living (EQUAL) program;
  - The Empire Clinical Research Investigator Program (ECRIP);
  - The operating assistance sub-program for enriched housing;
  - The Tick-Borne Disease Institute; and
  - 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."