S. 2007-B HEALTH & MENTAL HYGIENE FACT SHEET

Article VII Proposals (S. 2007-B)

- PART A – The Legislature modifies the Executive proposal to achieve savings reflected in the FY 2016 budget:
  - The Legislature denies the proposals to eliminate:
    - The Enhancing the Quality of Adult Living (EQUAL) program; and
    - The New York State Physician's Profile Website.
  - The Legislature includes legislation to:
    - Amend the Physician's Profile Website by adjusting the existing reporting timeframes and requiring DOH to study the feasibility of incorporating health insurance network participation information on the website.
    - Amend the EQUAL program to provide guidelines related to program expenditures;
    - Authorize mail order pharmacies to obtain consent to the delivery of mail order prescription drugs;
    - Add an umbilical cord blood banking awareness program to the Wellness and Outreach Program;
    - Extend the Enriched Social Adult Day Services project for two years;
    - Require a quarterly report on the use of Statewide Health Innovations Network of New York (SHIN-NY) funds and clarifies that recent report issued by the Health Information Technology workgroup was an interim report; and
    - Require a report on the implementation of the State Health Innovation Plan (SHIP).
- PART B – The Legislature modifies the Executive proposal to implement Medicaid Redesign Team recommendations:
  - The Legislature denies the proposals that would:
    - Increase the current Average Wholesale Price (AWP) from 17 percent to 24 percent for brand name drugs in the fee for service program;
    - Increase dispensing fees from $3.50 to $8.00 for brand name drugs in the fee for service program;
    - Authorize DOH to require prior authorization for fee for service drugs prior to obtaining the Drug Utilization Review Board's evaluation and recommendation;
    - Authorize the Commissioner to require manufacturers of brand name drugs utilized in the Medicaid fee for service pharmacy program that are eligible for reimbursement to provide a minimum supplemental rebate to the State;
    - Eliminate "prescriber prevails" provisions in Medicaid fee-for-service;
    - Require providers participating in the federal 340B drug program to bill managed care plans at the actual acquisition cost of such drugs;
    - Reduce the assessment on inpatient obstetrical services;
    - Carve out family planning services from the Ambulatory Patient Group (APG) rates and hospital inpatient reimbursement methodology;

- Limit Medicaid reimbursement to providers for services provided to individuals dually enrolled in Medicaid and Medicare PART C;
- Require spousal support for the costs of community-based long-term care;
- Transfer recruitment, training and retention for managed long term care to the base rate;
- Authorize up to 300 term appointments within the Office of Health Insurance Programs; and
- Carve out long term care transportation from Medicaid managed care.

- The Legislature modifies the proposals to:
  - Authorize DOH to negotiate supplemental rebate agreements directly with the pharmaceutical manufacturer by:
    - requiring the State to impose evidenced based standard clinical criteria;
    - limiting rebate authority to antiretroviral and hepatitis C drug classes;
    - ensuring rebate agreements do not diminish rights currently afforded to patients; and
    - ensuring adequacy of reimbursement rates for managed care plans for such drugs.
  - Codify and extend the State Medicaid Global Cap and related provisions by keeping global cap provisions in unconsolidated law;
  - Establish an inpatient hospital quality pool by adding requirements to report on the distribution of funds thirty days prior to awards and to report quarterly on the disbursement of funds;
  - Provide enhanced payments for inpatient and outpatient services at sole community hospitals by adding requirements to report on the distribution of funds thirty days prior to awards and to report quarterly on the disbursement of funds;
  - Increase the Critical Access Hospital carve-out within the Vital Access Provider (VAP) program from $5 million to $7.5 million by adding reporting requirements;
  - Carve-out $10 million in VAP funding for providers serving rural areas and isolated geographic regions of the state, and for essential community providers, by adding requirements to report on the distribution of funds thirty days prior to awards and to report quarterly on the disbursement of funds;
  - Require co-payments for certain individuals enrolled in Medicaid Managed Care by requiring the state to apply for a federal waiver from the Centers for Medicare and Medicaid Services to continue the current co-payment exemption, and stipulate the proposal will take effect if the waiver is denied;
  - Reinvest any State savings associated with the Community First Choice Option Program into the State's Olmstead plan by requiring DOH to submit a spending plan to the Legislature and to report annually on the amount of savings generated and expenditures;
  - Discontinue notice periods for approved inpatient rates of payment to hospitals by requiring that at least 30 days notice be given;
  - Authorize DOH to establish rates of payment to insurers in the Basic Health Program by requiring the independent actuary selected by the department to set the rates to also provide the legislature with a comprehensive annual report related to the establishment of the rates; and

    - Establish a nursing home energy efficiency demonstration program by clarifying the parameters of the program and establishing reporting requirements to the Legislature.

- The Legislature includes legislation to:
    - Require lead entities of a system established under the Medicaid Delivery System Reform Incentive Payment (DSRIP) program to establish a project advisory committee;
    - Authorize grants to coordinate care between health homes and the criminal justice system by adding funding to assist Medicaid enrollment of high risk populations discharged from state and local correctional facilities;
    - Require DOH to create and implement a contingency plan in the event federal reimbursement or eligibility rules change federal reimbursement to the state; and to require the department to report to the legislature annually on the fiscal impact of the Basic Health Program, its impact on the State's uninsured population, and demographic information of enrollees in the program;
    - Require managed care plans to adopt expedited procedures for approving personal care services for a medical assistance recipient who requires immediate personal care;
    - Require DOH to develop expedited procedures for determining medical assistance eligibility for any medical assistance applicant with an immediate need for personal care;
    - Require DOH to ensure rate adequacy in establishing rates for Medicaid managed long term care plans;
    - Establish a Medicaid evidence based review advisory committee to provide advice and make recommendations to the department related to coverage of health technology or services;
    - Establish up to three young adult special populations demonstration programs for individuals with severe and chronic medical or health challenges, or multiple disabling conditions;
    - Establish a hospital-home care-physician collaboration program to facilitate innovation in hospital, home care agency and physician collaboration to improve community health care needs;
    - Establish universal codes for payment of medical assistance claims to long term care providers, and to require the use of electronic transfers in paying claims to providers;
    - Codify the criteria DOH must consider when reviewing applications for Vital Access Provider funding, including the extent to which the applicant is geographically isolated in relation to other providers;
    - Establish a shared savings program for nursing homes that choose to refinance their mortgage loans;
    - Provide supplemental medical assistance payments for emergency medical transportation services;
    - Repeal the 28 percent rate reduction for Child Health Plus plans above the 2010 statewide average;

    - Require DOH to provide appropriate actuarial data to managed care providers 30 days prior to submission of the rates to the federal government for approval and to provide the annual Medicaid managed care operating reports to the Legislature; and
    - Authorize a capital reimbursement cap for the Jewish Home of Rochester to ensure completion of the construction of the facility.
- PART B – Section 34 - INTENTIONALLY OMITTED: Includes language authorizing the Office for People with Developmental Disabilities to contract with outside entities to conduct an assessment of the mobility and transportation needs of persons with disabilities and other special needs populations.
- PART C – The Legislature modifies the Executive proposal to extend ambulatory behavioral health fees paid by managed care organizations for patients enrolled in the Child Health Plus (CHP) program until December 31, 2017, and to extend the fee for service ambulatory patient group (APG) rate-setting methodology for behavioral health services until June 30, 2017 for New York City, and December 31, 2017 for the rest of the state and for individuals under the age of 21.
- PART D – The Legislature modifies the Executive proposal to permanently extend various provisions of the Public Health, Social Services and Mental Hygiene Laws:
  - The Legislature denies the proposal that would extend the collaborative drug therapy management program for teaching hospitals for three years.
  - The Legislature modifies the Executive proposals to permanently extend certain programs or initiatives by extending authorization for two years:
    - Authorize for bad debt and charity care allowances for certified home health agencies (CHHA's);
    - Provide provisions relating to Medicaid capital cost reimbursement;
    - Provide the Nursing Home reimbursable cash assessment program;
    - Provide for the exclusion of the 1996-97 trend factor projections or adjustments from nursing home and inpatient rates;
    - Provide for the .025 percent trend factor reduction for hospitals and nursing homes;
    - Require that nursing homes, hospitals certified home health care agencies, and long-term home care providers maximize Medicare revenues;
    - Eliminate a $1.5 mission reconciliation limit for the certified home health care agency and long term home care health care program administrative and general caps;
    - Require that parties to a contract between a hospital and a managed care organization continue to abide by the terms of the contract for two months from the effective date of contract termination or nonrenewal, unless certain circumstances are met;
    - Limit the reimbursement of long term home health care program administrative and general costs to not exceed a Statewide average;
    - Authorize the Commissioner to contract for Medicaid transportation management;
    - Provide provisions related to the Statewide Planning and Research Cooperative System (SPARCS) and the Statewide Health Information Network of New York (SHIN-NY); and
    - Extend for two years the elimination of a trend factor for nursing homes, hospitals and other various long-term care provider.
  - The Legislature modifies the Executive proposals to permanently extend certain programs or initiatives by extending authorization for four years:

        - Authorize certain provisions related to the New York State Medical Care Facilities Financing Act, which relate to the financing of certain health care capital improvements;
    - Provide provisions related to Medicaid co-payments;
    - Provide provisions related to managed long-term care plans, including those related to increased certificates of operation, the authorization of the Commissioner to submit waivers necessary to continue Medicaid managed- long term care, and guidelines for patient assessment timeframes;
    - Authorize the managed long-term care program;
    - Authorize the episodic payment per 60 days period of care for certified home health agencies;
    - Authorize for emergency services personnel in certain areas of the State to be certified or recertified without a written examination if they meet certain requirements; and
    - Provide provisions related to the New York State Medical Care Facilities Financing Act, which permits flexibility in contracting for goods and services by State-operated hospitals.
- PART E – The Legislature modifies the Executive proposal to extend the Indigent Care Pool for three years by:
    - Eliminating the Department of Health's authority to make adjustments to the distribution methodology without Legislative approval; and
    - Authorizing the Commissioner to adjust voluntary hospital inpatient Upper Payment Limit (UPL) payments in the event the cap is reached by seeking a waiver from CMS to authorize voluntary hospital outpatient UPL to provide relief to the inpatient UPL cap.
- PART F – The Legislature denies the Executive proposal to require Value Based Payments within the Delivery System Reform Incentive Program (DSRIP) or in the commercial marketplace.
- PART G – The Legislature denies the Executive proposal to tax all health insurers to fund operations of the state health benefit exchange, New York State of Health.
- PART H – The Legislature denies the Executive proposal to:
    - Authorize Limited Services Clinics;
    - Establish urgent care clinic regulatory oversight;
    - Repeal the establishment of upgraded diagnostic and treatment centers; and
    - Authorize the Public Health and Health Planning Council to review certain procedures.
- PART I – The Legislature modifies the Executive proposal to make statutory changes related an End of AIDS initiative by denying provisions that would:
    - Exempt hypodermic syringes and needles obtained and possessed from the state's syringe exchange and pharmacy and medical provider-based expanded syringe access programs from the prohibition in General Business Law;
    - Remove the limit on the number of syringes that a pharmacy can sell; and
    - Discontinue the ban on advertising the availability of syringes without a prescription.
- PART J – The Legislature denies the Executive proposal to provide an exemption to the Nurse Practice Act for advanced home health aides.
- PART K – The Legislature denies the Executive proposal to implement various provisions related to the Certificate of Need (CON) process and includes language to add "improper delegation of

authority to a management consultant by the governing authority or operator" to the list of reasons DOH may initiate the appointment of a temporary operator to a facility.

- PART L – The Legislature modifies the Executive proposal to expand the regulation of office based surgery by excluding office-based anesthesia in the definition of office-based procedures and to eliminate a requirement to register with DOH.
- PART M – The Legislature concurs with Executive proposal related to water fluoridation.
- PART N – The Legislature modifies the Executive proposal to authorize the Office to seek input from the public regarding the establishment of an Office of Community Living by requiring statewide input from stakeholders and requiring specific reporting requirements.
- PART O – INTENTIONALLY OMITTED: Concurs with the Executive proposal to extend the authority for the recovery of Medicaid exempt income from community residence providers by the Office of Mental Health through June 30, 2016.
- PART P – INTENTIONALLY OMITTED: Modifies the Executive proposal to extend the pilot program restructuring educational services for children and youth residing in Office of Mental Health hospitals through June 30, 2018.
- PART Q – The Legislature denies the Executive proposal to allow up to five business corporations to invest in hospitals.
- PART R – INTENTIONALLY OMITTED: Concurs with the Executive proposal to extend a facility director's authority to apply a patient's personal funds for care and treatment without violating the director's fiduciary obligation, through June 30, 2018.
- PART S – INTENTIONALLY OMITTED: Modifies the Executive proposal in relation to providing professional services in non-certified settings.
- PART T – INTENTIONALLY OMITTED: Modifies the Executive proposal to exempt time-limited mental hygiene demonstration programs from the Office of the State Comptroller's contract procurement requirements until March 31, 2018.
- PART U – INTENTIONALLY OMITTED: Modifies the Executive proposal in relation to the consolidation of the Office for People with Developmental Disabilities rate setting functions and related authority to the Department of Health.
- PART V – The Legislature includes legislation to authorize school districts, schools and their employees to administer opiod antagonists on school grounds in emergency situations and to authorize licensed medical professionals to administer opiod antagonists in emergency situations.
- PART W – The Legislature includes legislation to:
  - Require the Department to provide an annual report on all Health Care Reform Act (HCRA) revenues and disbursements;
  - Establish a HCRA Modernization Task Force to evaluate and make recommendations regarding the efficacy and transparency of the HCRA statute and HCRA fund; and
  - Increase funding for the Doctors Across New York Program by $2 million annually.
- PART X – The Legislature includes language to extend risk-based capital exemptions for medical malpractice insurance carriers for an additional three years.
- PART Y – The Legislature modifies the Executive proposal to extend the excess medical malpractice insurance pool by removing the requirement of a physician to receive a tax clearance from the Department of Tax and Finance before being eligible for coverage. The Legislature extends the excess pool for one year.