RM&S Communication. Teamwork. Results.
One Commerce Plaza
Suite 402
Albany, NY 12210
Phone: 518.465.7330
Fax: 518.465.0273
ROBERT REID | SHAUNEEN MCNALLY | MARCY SAVAGE | PADRAIC BAMBRICK | KELLY KEAYS

# SFY 2017-18 Executive Budget
# Health/Mental Hygiene Summary
# January 19, 2017

| SECTOR | INITIATIVE | DESCRIPTION |
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| **Multiple-Sectors** | | |
| | Medicaid Funding | Increases the State share of Medicaid by $567 M, from $17.7 billion to $18.3 billion. Total funding (federal, state & local) in SFY 2017-18 is $65 billion, a $2 billion increase. |
| | Global Spending Cap | Extends the Medicaid Global Cap through FY 2019 and allows for an adjustment in the event of changes to federal financial participation (FFP). |
| | Health Care Reform Act Extension (HCRA) | Extends HCRA three years until December 31, 2020. |
| | SHIN-NY | $30M is made allocated for the SHIN-NY. The total allocation of up to $65M is extended through 12/31/20. |
| | Statewide Planning and Research Cooperative System (SPARCS) | Authority to operate SPARCS in extended until March 31, 2020. |
| | Trend Factor Elimination | Extends the elimination of trend factors for general hospitals, nursing homes, hospital-based and free-standing clinic services, certified home health agencies, personal care, adult day health care services, assisted living programs, and hospice services for three years until 2020. |

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| | All Payer Database (APD) | Provides $10M for the APD. |
| | Health Care Capital Support for Essential Health Care Providers | Funding of up to $500 million is provided and would be financed through a combination of bonds issued by the Dormitory Authority of the State of New York (DASNY) and hard dollar capital funding for a second Health Care Facility Transformation Program.<br><br>The program would provide funding to support capital projects, debt retirement, working capital, and other non-capital projects that facilitate health care transformation and expand access to health care services. Projects that received awards through the Brooklyn Health Care Facility Transformation Program or the Oneida Health Care Facility Transformation Program would not be eligible for funding.<br><br>Of this amount, $50 million would be specifically awarded to Montefiore Medical Center, and a minimum of $30 million would be made available to community based health care providers who demonstrate that they would fulfill a health care need for acute inpatient, outpatient, primary, home care, or residential health care services in a community. These providers include diagnostic and treatment centers, mental health clinics, alcohol and substance abuse treatment clinics, primary care providers, and home care providers. |
| | Minimum Wage for Health Care Providers | Provides $255 million in Medicaid Spending above Cap to support minimum wage increases. |
| | Human Service “COLA” | Eliminates the Human Service Cost of Living Adjustment for SFY 2017-18 and restores it beginning April 1, 2018 for three years. |
| | NYC GPHW | Reduces the NYS Department of Health (DOH)’s General Public Health Work (GPHW) program reimbursement rate for non- |

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| | | emergency expenditures above the base grant for New York City from 36% to 29%. |
| **Hospitals/Healthcare Facilities** | | |
| | Health Care Facility Transformation Program | Funding of up to $500 million is provided and would be financed through a combination of bonds issued by the Dormitory Authority of the State of New York (DASNY) and hard dollar capital funding for a second Health Care Facility Transformation Program.<br><br>The program would provide funding to support capital projects, debt retirement, working capital, and other non-capital projects that facilitate health care transformation and expand access to health care services. Projects that received awards through the Brooklyn Health Care Facility Transformation Program or the Oneida Health Care Facility Transformation Program would not be eligible for funding.<br><br>Of this amount, $50 million would be specifically awarded to Montefiore Medical Center, and a minimum of $30 million would be made available to community based health care providers who demonstrate that they would fulfill a health care need for acute inpatient, outpatient, primary, home care, or residential health care services in a community. These providers include diagnostic and treatment centers, mental health clinics, alcohol and substance abuse treatment clinics, primary care providers, and home care providers. |
| | Health Care Regulation Modernization Team | A 25-member Health Care Regulation Modernization Team would be established to provide advice to the Governor on a fundamental restructuring of statutes, policies, and regulations governing oversight and licensure of health care facilities and home care in order to increase quality, reduce costs, and improve health outcomes. |

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| | | Work would begin no later than 7/1/17 with a report due 12/31/17. The Team is required to review and make recommendations in the following areas:<br><br>**CON Reform**. Streamline CON requirements and other licensure or construction approval processes.<br><br>**Scope of Practice and Licensing**. Create more flexible rules for licensing and scope of practice for clinicians and caregivers in collaboration with the Workforce Workgroup convened by DOH.<br><br>**Streamlining Statues and Regulations**. Streamlining duplicative laws, regulations and policies where there is duplication and inconsistency in federal and state standards for physical environment, quality of care, information technology, reporting, surveillance, and licensure.<br><br>**Streamlining and Simplifying provision of primary care, mental health and substance abuse disorder services in an integrated clinic setting.**<br><br>**Telehealth.** Integrating, standardizing, and increasing flexibility of state agency regulations governing delivery of and reimbursement for telehealth.<br><br>**Alternate Models of Care.** Allowing more flexible use of observation beds, ambulatory surgery centers, D&TCs, nursing homes, assisted living, home health, assisted living, off campus emergency departments, community paramedicine and other mode of delivering health care services. |

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| | | **Modernize licensing and regulation of home care and care management.**<br><br>**Aligning care models around home and community based services consistent with New York State's Olmstead report.**<br><br>**Exploring circumstances where statewide regulatory requirements may not be appropriate for regions or communities characterized by isolation, poverty, or other factors impacting access.**<br><br>**Calibrating facility and home care inspections and the scope of certificate of need reviews based on provider performance on quality and other outcome metrics.**<br><br>**Emergency Medical Services and Pre-hospital Care.** Evaluating changes in statue, regulation and policy to support timely and effective emergency medical services and pre-hospital care.<br><br>**Demonstration Program.** Provides wide sweeping authority to the commissioners of DOH, OMH, and OASAA to waive current statutes and regulations to implement demonstration programs to test and evaluate new models for organizing, financing, and delivering heath care services that are not permissible under laws and regulations. |
| **Long Term Care/ Home Care/Nursing Homes** | | |
| | Bad Debt & Charity Care for Certified Home Health Agencies (CHHAs) | Extends authorization of bad debt and charity care allowances for CHHAs through June 30, 2020. |

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| | Minimum Wage for Health Care Providers | Provides $255 million in Medicaid Spending above Cap. |
| | Spousal Impoverishment | Conform NY to Federal Spousal Impoverishment Provisions. |
| | Nursing Home Bed Holds | Eliminate Reimbursement for Bed Hold Days while preserving ability for residents to hold beds who temporarily leave NH. |
| | Restrict Enrollment in MLTCPs | Restrict enrollment to MLTCPs to enrollees who require nursing home level services, these enrollees would receive similar services through a mainstream managed care plan. |
| | Worker Recruitment and Retention | Continues funding for Home Care Workforce Recruitment and Retention ($272 million for personal care services in NYC; $22.4 million for personal care services outside of NYC). |
| | LTHHCP A&G Limit extender | Extends the LTHHCP A&G Limit to March 31, 2020. |
| | Hospice | Eliminates Medicaid coverage of hospice services that are covered by Medicare. |
| | Caregiver Supports | Continues $25 million for caregiver supports for individuals with Alzheimer's and other dementias. |
| **Housing/ Adult Homes** | | |
| | Transition of Mentally Adult Home Residents | Provides $38 million for education, assessment, training, care coordination, supported housing and other services for mentally ill residents of adult homes to transition to other care. |
| **Physicians/Health Care Providers** | | |
| | Excess Medical Malpractice Funding | Includes $127,400,000 in funding for the Excess Medical Malpractice Program. Also it extends the program for one year for eligible physicians and dentists for the policy year beginning July 1, 2017. The bill would maintain existing eligibility requirements, and would |

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| | | add a requirement that physicians and dentists applying for coverage receive a tax clearance from the Department of Taxation and Finance before receiving such coverage. |
| | Doctors Across New York | Includes $4,705,000 for the physician loan repayment program and $4,360,000 for the physician practice support program as part of Doctors Across New York. |
| | Prescriber Prevails | Limited prescriber prevails provisions under Medicaid FFS and Medicaid Managed Care to atypical antipsychotics and antidepressants. All other classes that are currently covered would be repealed. |
| | PA for Controlled Substances under FFS | Includes new prior authorization requirements on controlled substances prescribed in Medicaid Fee for Service (FFS) when more than a 7-day supply should remain if the drug was used as indicated. |
| | Opioid Prescribing | Deems it an "unacceptable practice" under Medicaid to prescribe opioids in violation of the 4-prescriptions per month prior approval requirements, the 7-day supply refill requirement being proposed in the Executive Budget or any other law limiting opioid prescribing or contrary to recommendations of the Drug Utilization Review Board (DURB). |
| | OPMC | Continues authorization for funds of the Office of Professional Medical Conduct (OPMC) for the Physician Profile website through 2020. |
| **Pharmacy/ Pharmaceuticals** | | |
| | Cap on Pharmaceutical Costs | Includes a series of proposals focused on capping pharmaceutical costs for certain drugs (including brand, generic and non-prescription) as selected by DOH based on having a "prohibitively high price," a large price increase in a short period of time, disproportionate pricing compared to benefits. The proposals include: |

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| | | • A manufacturer reporting requirement on their costs for development and distributing drugs, R&D, administrative and marketing costs, utilization of drug, prices charged for the drug in NY and outside the US, average rebates & discounts and average profit margin over a five year period.<br>• Information provided by manufacturers would be shared with the DOH Drug Utilization Review Board (DURB) which would recommend a "value-based, per-unit benchmark, price for the drug" based on a number of factors including seriousness of condition being treated, utilization of drug, effectiveness, likelihood of drug reducing other health services, the AWP/retail price of the drug, the number manufacturers that produce the drug and whether there are available equivalents.<br>• When a drug's price exceeds the benchmark price set by the DURB, it will be deemed a "high cost drug" and DOH will be authorized to collect an additional "supplemental" rebate in the amount determined by DOH for Fee for Service and Medicaid Managed Care.<br>• Membership on the DURB is increased to 23 and would include two health economists, an actuary and a rep from the Department of Financial Services.<br>• Creates a High Priced Drug Reimbursement Fund for the collection of a new surcharge on the drugs deemed "high cost drugs" by DOH and posted on the website. The surcharge would be imposed for the sale of these drugs as the difference between the cost of the drug sold by an establishment and the benchmark price set by DOH and a 60% surcharge would be applied to the difference. Such surcharge would be paid by the "establishment" making the first sale of the drug and cannot be passed on to its customers. Funds collected will be |

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| | | deposited into the new Fund and paid to health insurers and Medicaid for premium relief. |
| | Pharmacy Reimbursement | Changes Medicaid pharmacy reimbursement as required by the federal outpatient drug rule by proposing a new reimbursement methodology for pharmacies as follows:<br><br>• For Generic Drugs: The lower of NADAC or WAC-17.5% if no NADAC exists; or the Federal Upper Limit; or State Maximum Acquisition Cost (SMAC); or the dispensing pharmacy's usual and customary price charged to the general public<br>• For Brand Name Drugs: The lower of NADAC or WAC-3 & 3/10% if no NADAC exists; or the dispensing pharmacy's usual and customary price charged to the general public<br>• New Professional Fee: $10 per prescription or written order by a practitioner; Does not apply to OTCs that do not meet the definition of covered outpatient drug per section 1927K of the Social Security Act |
| | Regulation of Pharmacy Benefit Managers (PBMs) | Proposes to regulate PBMs in New York State by:<br><br>• Requiring initial registration of PBMs with DFS by June 1, 2017 and licensure of PBMs beginning January 1, 2019.<br>• Requiring detailed reporting by PBMs on financial incentives and benefits they offer for use of certain drugs or on other matters relating to PBM services.<br>• Establishment of minimum standards that PBMs must abide by including no conflicts of interest, anti-competitive practices or unfair claims practices. |

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| | | • Authorizing the DFS Superintendent to refuse to renew, revoke or suspend a PBM license or registration if the PBM violates any laws, provides false information, use of dishonest/fraudulent practices, ceased to meet requirements for registration or licensure or other practices. |
| | Comprehensive Medication Management | Creates a program for patients with a chronic disease or diseases who have not met clinical goals, are at risk for hospitalization, or are otherwise deemed in need of greater medication adherence services to be referred by a physician or nurse practitioner to a specially trained pharmacist to provide comprehensive medication management services, overseen by DOH and pursuant to a written service protocol. Participation by patients and providers is voluntary. This was a recommendation of the DOH Value Based Payment (VBP) Workgroup. |
| | Prescriber Prevails | Limited prescriber prevails provisions under Medicaid FFS and Medicaid Managed Care to atypical antipsychotics and antidepressants. All other classes that are currently covered would be repealed. |
| | PA for Controlled Substances under FFS | Includes new prior authorization requirements on controlled substances prescribed in Medicaid Fee for Service (FFS) when more than a 7-day supply should remain if the drug was used as indicated. |
| | Opioid Prescribing | Deems it an "unacceptable practice" under Medicaid to prescribe opioids in violation of the 4-prescriptions per month prior approval requirements, the 7-day supply refill requirement being proposed in the Executive Budget or any other law limiting opioid prescribing or contrary to recommendations of the Drug Utilization Review Board (DURB). |
| | Medicaid Co Pays | Includes new copay requirements under Medicaid. Specifically, $1 would be required for non-prescription drugs and the co-pay for non-preferred brands would be reduced to $2.50. |

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| | Medicaid OTCs | Allows for modifications to the list of non-prescription drugs that may be covered by Medicaid by filing a regulation without prior notice and comment. |
| | Generic Rebate | Changes the generic rebate requirements so additional rebates would be required when a generic price increases more than 75% of the State Maximum Acquisition Cost (SMAC) in 12 months (currently at 300% of SMAC). |
| **Behavioral Health** | | |
| | Behavioral Health APGs | Extends the payment of APGs to March 31, 2020 for BH Providers and includes new VBP requirements for BH Providers as follows:<br><br>• For period of April 1, 2017-March 31, 2018: 10% of managed care expenditures must be paid through level one VBP arrangements per Road Map<br>• For period April 1, 2018-March 31, 2019: 50% of managed care expenditures must be paid through level one VBP arrangements and 15% shall be paid through level 2 arrangements per Road Map<br>• For period April 1, 2019-March 31, 2020: 80% of managed care expenditures must be paid through level one VBP arrangements and 35% shall be paid through level 2 arrangements per Road Map<br><br>The Commissioners of DOH, OMH and OASAS may waive such VBP requirements if a sufficient number of BH providers suffer a financial hardship as a consequence of it or if the arrangements threaten an individuals' access to BH services |
| | Jail Restoration Programs | Includes $850,000 in funding to assist county jails in developing specialized residential treatment units within their jails. |

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| | VAP Behavioral Health | Includes $50 million in Vital Access Provider funding for Behavioral Health providers. |
| | Health Homes | Includes $105 million for services and expenses for Health Homes. |
| | OMH Community Services | Includes $11 million to expand community services based on regional needs and stakeholder input. |
| | Heroin Epidemic | Includes $30 million in new funding for a total of approximately $200 million to combat the heroin epidemic. Funding will be used for additional residential treatment beds, additional Opioid Treatment Program slots, new regional partnerships, support for navigator programs, additional peer engagement programs, new adolescent clubhouses, additional recovery community and outreach centers, 24/7 urgent access centers and a pilot program around recovery high schools. |
| | Minimum Wage | Provides $4.6 million for OASAS providers for assistance with implementing minimum wage increase and $3.5 million for OMH providers for this purpose. Funding can be used to support direct salary costs and related fringe benefits. |
| **Developmental Disabilities/ Early Intervention** | | |
| | Minimum Wage | Provides $14.9 million for minimum wage support for OPWDD providers. Funding can be used to support direct salary costs and related fringe benefits. |
| | OPWDD Supports & Services | Include $120 million (gross) in new funding for supports and services for individuals living at home or in residential schools transitioning to adult services. It will also support other programmatic reforms. |
| | Independent Living | Includes $15 million for the development of independent living housing capacity. These are in addition to the $20 million, give-year affordable and supportive housing plan. |

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| | START Services | Includes $12 million to continue expansion of the START crisis prevention program downstate. |
| | Transition to Managed Care | According to the Executive Budget Briefing Book, by late 2017, Regional Care Coordination Organizations (CCOs) are expected to begin operations and will be rolled-out on a regional basis. Enrollment on a voluntary basis in managed care is expected to begin in 2019, and the transition to managed care is planned to be completed within a five-year period. The Executive Budget proposes to apply ongoing DOH Global Cap resources to support the initial start-up costs of transitioning the OPWDD service delivery system from a fee-for-service payment structure to managed care. |
| | Early Intervention (EI) | Proposes amendments to the Insurance Law as outlined below.<br><br>Amends the prompt pay law to expressly include EI providers among those whose claims are required to be processed within specific time frames.<br><br>Requires insurers to:<br>• Accept a written order, referral, or recommendation for EI services, or an IFSP, signed by the child's primary health care provider, as sufficient to meet any precertification, preauthorization, and/or medical necessity requirements.<br><br>• Cover services regardless of the location where the services are provided or the habilitative nature of the services;<br>• Pay for EI services covered under the child's insurance policy, including services for autism spectrum disorder; and<br>• Notify the county, service coordinator, and provider whether the child's health insurance policy is regulated by the State |

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| | | within 15 business days of receipt of a subrogation notice or a request from a county or service coordinator.<br><br>Require service coordinators and providers to collect third party insurance information from parents. Currently this is the responsibility of the EIO.<br><br>Clarifies that counties can conduct audits and that audit results submitted to NYS DOH will include any recoveries by the county.<br><br>Require a parent to provide or to provide consent for others (the county, services coordinator, or provider) to obtain, the provider's signature on the written order, referral, recommendation, or IFSP.<br><br>Authorizes NYS DOH or the State Fiscal agent to require providers to appeal insurance denials for medical necessity, coordination of benefits, utilization review or other criteria prior to submitting claims to the county for payment.<br><br>These provisions are effective on April 1, 2017. |
| **Special Education/ Preschool** | | |
| | School District Waivers | Authorizes the Commissioner of SED to grant a waiver for any requirement imposed on a local school district, approved private school, or BOCES upon a finding that the waiver will result in implementation of an innovative special education program that is consistent with applicable federal requirements, and will enhance student achievement and/or opportunities for placement in regular classes and programs. |

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| **Public Health** | | |
| | Public Health Program "Buckets" | Consolidates 39 public health, advocacy and workforce programs into four buckets to compete for funding as follows:<br>• Disease Prevention & Control: $33,365,000<br>• Maternal & Children Health Care: $26,755,000<br>• Health Workforce: $33,713,000<br>• Health Access & Advocacy: $4,524,000<br><br>A total reduction of 20% will be applied to the buckets to save $24.6 million. |
| | Drinking Water Testing | Requires that public water systems throughout the State to test for the presence of emergency contaminants pursuant to a list developed by DOH at least once every three years. Results would be reported to DOH and property owners. |
| | Access to Healthy Food | The Governor's State of the State referenced approximately $1 million to address Food Deserts and bring healthy food to these areas as well as funding for the Fresh Connect program. The budget includes up to $625,000 to improve healthy food access for the Fresh Connect program. |
| | Medical Marijuana | Includes $4 million for the State Medical Marijuana program. |
| | Spinal Cord Injury | Includes $8.5 million for the Spinal Cord Injury Research Program (SCIRP). |
| | Funding for Cystic Fibrosis Program | $800,000 is provided for the CF Under 21 program. |
| | Tax Vapor (Electronic Cigarette) Products | Impose an Excise Tax of on vapor products (e-Cigs, Vaping Pens, hookah pens, etc.) of ten cents per fluid milliliter. |
| | Extend Clean Indoor Air Act(CIA) | Extends the CIA to Vapor Products (Electronic Cigarettes). |

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| | Packaging of Vapor Products | All Vapor Products must have "special packaging for the protection of children." |
| | Reform Cigar Tax | Change the Taxation from a Percentage to a tax of 45 cents per cigar. |
| | Tobacco Enforcement | Lowers Threshold from 25 cartons to 10 for presumption to evade.<br>Aligns Counterfeit tax stamps to the penalties for criminal possession of a forged instrument (Class E to Class C Felony).<br>Allow the issuance for Jeopardy Assessments for the collection of tobacco excise taxes. |
| **Insurance** | | |
| | Health Exchange | Includes $134 million in new funds and a total of $553 million for the State Health Exchange. |
| | Essential Plan | Increases patient cost sharing the Essential Plan. Those with incomes of between 138%-150% of the federal poverty level (FPL) would pay $20 per month beginning January 1, 2018. The premium would be adjusted annually by medical CPI for those with incomes between 138%-200% of FPL. |
| | Child Health Plus (CHP) | Proposes to extend CHP authorization through 2020. |