BROWN & WEINRAUB, PLLC

ATTORNEYS AT LAW

50 State Street, 4th Floor • Albany, New York 12210
Telephone (518) 427-7350 • Facsimile (518) 427-7792
Website: www.brownandweinraub.com

233 Broadway, Suite 2070 • New York, New York 10279
Telephone (212) 566-4600 • Facsimile (212) 566-4063

Executive NYS Budget Proposal SFY 2015-2016 Matrix

HMH Article VII

Selected Healthcare Sector Related Provisions[1]

[1] This Matrix is not intended to represent a complete summary of the Governor's State Budget Proposal, or of all the provisions contained therein related to healthcare. For specific questions, please contact Carolyn Kerr (ckerr@brownweinraub.com) or Dennis Norton (dnorton@brownweinraub.com) at 518-427-7350.

HEALTH CARE FINANCING AND RATES 3
HOSPITALS 5
CERTIFICATE OF NEED REFORM 6
MEDICAL MALPRACTICE/PROFESSIONAL MEDICAL CONDUCT 7
PRIMARY & PREVENTIVE CARE 8
HEALTH INFORMATION TECHNOLOGY 8
PROCUREMENT OPPORTUNITIES/ISSUES 8
FEDERAL HEALTH CARE REFORM/HEALTH BENEFIT EXCHANGE 8
MEDICAID/MEDICAID REDESIGN/WAIVER 9
HEALTH HOMES 10
CHILD HEALTH PLUS 11
BEHAVIORAL HEALTH & SUBSTANCE ABUSE 11
DEVELOPMENTAL DISABILITIES 11
Rx 12
LONG TERM CARE SERVICES & PROVIDERS 12

- **Effective Date of Provisions = Call us to verify if not noted.**
- **Health & Mental Hygiene Article VII Bill = HERE**

Part, Section	Subject	Proposed
HEALTH CARE FINANCING AND RATES		
B, Sec. 14	***VAP – Rural/Isolated Areas***	Would create new VAP allocation for essential community providers offering servicers in a defined and isolated geographic region. Eligible providers include hospitals, D&TCs, NHs, ambulatory surgery centers and clinics. ($290M new dollars are in the appropriation.)
B, Sec. 24	***Notification of Rate changes (Hospitals & D&TCs)***	Would eliminate provisions requiring DOH notification to Hospitals and D&TCs of rate changes
D, Sec. 16	***Medical Care Facilities Financing Act***	Would permanently authorize provisions of this program
D, Sec. 18	***HEAL***	Would extend for 2 years authorization for HEAL funding for HCRA pools

Part Q	***Private Equity***	• Comm'r to establish pilot program
		• PHHPC to approve up to 5 "business corporations formed under the" Bus. Corp. Law
		• Requires corporations to affiliate w/ at least one academic medical center or teaching hospital
		• No publicly traded corps
		• Eligible to participate in debt financing provided by DASNY, local development corps and economic development corps
		• Exemption from rules against hospitals being owned by corporate entities, certain character and competence requirements, and certain disposition of stock rules
		• Shareholders' identities may required to be disclosed
		• Powers of corp limited to ownership and operation or ownership of specific hospital(s) and specific designations; but can also include ownership and operation or ownership of CHHAs or hospices
		• Board of corp must consider (w/o violation of fiduciary duty to shareholders) impact of corporate action on
		    ○ Corporation and shareholders
		    ○ Employees and workforce
		    ○ Patients
		    ○ Community
		    ○ Short and long term interests of the corporation

Part, Section	Subject	Proposed

		• PHHPC to consider and balance various factors in considering approval, but, in consultation with the Comm'r, shall specifically consider the extent to which the bus. corporation does the following – however, none of the following shall be dispositive in any decision (i.e., discretionary factors):
		  ○ Provides for either equal or majority governance rights of the NFP hospital partner, regardless of equity stakes, through weighted class voting structure or rotherwise
		  ○ Incorporates a representative governance model that
		    ▪ Clearly delineates authority and responsibility for the hospital's operations
		    ▪ Defines mechanisms for approval of designated shareholders or investors, and
		    ▪ Reserves powers granted to a local governing authority to assure access and quality
		  ○ Is incorporated as a benefit corporation
		  ○ Commits to maintaining or enhancing existing levels of services, charity care and core community benefits
		  ○ Identifies actionable strategy to monitor and improve quality of care
		  ○ Explains the level of capital commitment and how it will be infused into the system
		  ○ Addresses the development of a foundation to address community public health needs
		  ○ Addresses workforce issues – including retaining and/or retraining the existing workforce and addressing pension and benefit obligations
		  ○ Addresses distribution of profits without compromising core community benefits and quality of care
		• Prohibits approval of any business entity unless it
		  ○ Creates a local advisory board that will make recommendations on issues such as
		    ▪ Mission, vision
		    ▪ Quality
		    ▪ Board member recommendation and CEO approval
		    ▪ Strategic planning
		    ▪ Policies relating to core community benefits and charity care
		  ○ Attest that it will allow its NFP hospital partner to retain exclusive authority over

Part, Section	Subject	Proposed
		functions relating to its tax-exempt status ○ Commit to ongoing reporting to the Dept's on quality, workforce, etc. • Any approved entity must articulate intent around exist strategies including ○ Anticipated timeframe for investment ○ Whether it will allow buy back by the hospital ○ Safeguards to protect services and quality during transition and how the hospital will be involved in those discussions • Sale, lease, conveyance or other disposition of all or substantially all of assets of corp must be approved by DOH, but cannot occur within 3 years of start of demonstration project, and in approving such transaction, DOH must consider impact on quality, core community benefits and charity care; whether there are minimum capital obligations post-transaction; impact on governance structure; and obligations of transferee to guarantee/retain transferor's obligations to the hospital • DOH to report to legislature and governor 2 years after initiation of pilot on efficacy/impact, etc. • Purpose of corp: acquisition, construction, reconstruction, rehabilitation and improvement, furnishing and/or equipping of hospital(s)
	HOSPITALS	
B, Sec. 10	***Assessment on IP Obstetrics***	Would reduce assessment by $15M annually
B, Sec. 11	***General Hosp. Quality Pool***	Would establish pool to "incentive and facilitate quality improvements". DOB to award. If no FFP, then state share will be provided.
B, Sec. 12	***Enhanced Rates for IP and OP Services (Sole Community Hospitals)***	Would allow general hospitals designated as sole community hospitals to be eligible for enhanced payments for IP and/or OP services up to $12M. DOH to administer. If no FFP, then State share will be provided.
B, Sec. 13	***Critical Access Hospitals -- VAP***	Would extend CAH VAP carve out and increase funding from $5.5M to $7.5M, and also examine "permanent Medicaid rate methodology changes"
B, Sec. 16-23	***HHC & Upper Payment Limits***	Would modify existing UPL distribution to NYC HHC as required by CMS, including retroactive application to 2011

Part, Section	Subject	Proposed
D, Sec. 5	***Trend Factors***	Would permanently extend exclusions of 1996-97 trend factor and the .25% trend factor reduction
D, Sec. 13	***Contracts with Managed Care Organizations***	Would permanently extend requirement that MCOs and hospitals abide by terms of a contract two months from effective date of termination
E	***General Hospital Indigent Care Pool***	Would extend through 12/31/18 and allow DOH to adjust (on an annual basis) DSH payments reductions to be capped up to 15% (by 2018) unless otherwise required by federal funding
CERTIFICATE OF NEED REFORM		

H, Sec. 1	***Limited Services Clinics***	Would regulate entities such as "Minute Clinics"
		• define LSCs as D&TCs operating w/in a retail business operation (e.g., a pharmacy)
		• allow legal entities (i.e, not natural persons) to own/operate
		• subject to PHHPC review/approval
		• PHHPC to adopt rules/regs for review, including governing
		  ○ Direct or indirect transfers of ownership/voting rights
		  ○ Local governance and oversight of owner
		  ○ Character and competence requirements
		• Exempt LSCs from rules against Art. 28's being owned by corporate entities, certain character and competence requirements, and certain disposition of stock rules
		• Define LSCs as health care provider; clarify employment status of dispensing pharmacist
		• Allow for DOH to issue regulations on physical plant requirements, including how they may be different from other D&TCs (accreditation requirements, limiting services allowed, limiting age of patients that can be served, marketing rules, and linking to primary care services)
		Requires regulations to promote primary care through integrating LSCs w/ PCPs and referring patients to appropriate providers (including PCPs) and record transmission requirements

H, Sec. 2	***Urgent Care Centers***	Would establish definition of urgent care provider as one providing treatment on an unscheduled basis for acute illness or minor traumas that are not life-threatening, disabling or require ongoing monitoring. Would impose marketing/signage rules. • PHHPC to adopt regulations/rules (w/ DOH approval), including on integration of services and referral of patients to other appropriate providers Most provisions eff 7/1/2015

Part, Section	Subject	Proposed
H, Sec. 3-4	***Upgraded D&TCs***	Would repeal authorizing language as unnecessary/duplicative. Eff: One year after becoming law
K, Sec. 2-3	***Primary care facilities/services***	Would exempt hospitals and D&TCs from public need and financial review requirements for applications to (1) construct primary care services facility; or (2) undertake construction that does not involve a change in capacity, the types of services provided, major medical equipment, facility replacement or the geographic location of services.
K, Sec. 4	***Character & competence***	Would reduce look-back period from 10 to 7 years for character & competence reviews & would include stockholders in review process. Would also allow for person to show that any violations were not attributable to that person/operator.
K, Sec. 5-6	***Disposition of Stock***	Would streamline reviews of dispositions of 10% more of stock/ownership interests by PHHPC, and would allow for revocation or suspension of operating certificate if hospital does not comply
Part L and Part H, Sec. 5	***Office-Based Anesthesia & Office-Based surgery***	Would amend the PHL to • require reporting of ED visit or assignment to an observation bed within 72 hours of office-based surgery • require DOH registration • amend definition of office-based surgery to include office-based anesthesia, including nerve blocks, neuraxial anesthesia and general anesthesia; and require registration w/ the DOH • requires reporting of adverse events w/in 3 (versus 1) days of occurrence • limit OBS or OBA to operations with expected duration of no more than 6 six hours and appropriate/safe discharge w/in 6 hours. • Utilize American Board of Medical Specialties certification and other rules in investigating/reviewing OBS Eff: One year after becoming law Part H would allow PHHPC review of OP anesthesia/sedation practices.
MEDICAL MALPRACTICE/PROFESSIONAL MEDICAL CONDUCT		
A, Sec. 3	***Dissemination of findings by the Office of Professional Medical Conduct***	Would eliminate the requirement that findings and conclusions of OPMC be published in physician profiles (which the executive would eliminate in his budget proposal), but would now require dissemination of that information to other licensed physicians with whom licensee shares a group practice and any health plan with whom the licensee contracts or has other affiliations (in addition to his/her primary practice setting and hospitals with whom he/she has privileges).

Part, Section	Subject	Proposed
		PRIMARY & PREVENTIVE CARE
B, Sec. 26 & 27	***Family Planning***	Would carve out family planning services from APGs in order to ensure maximizing federal funds
	Limited Service clinics	See CON Reform, above
		HEALTH INFORMATION TECHNOLOGY
D, Sec. 28	***SHIN-NY and SPARCS***	Would permanently extend provisions relating to these programs
		PROCUREMENT OPPORTUNITIES/ISSUES
B, Sec. 26		See Basic Health Plan Rates, below
B, Sec. 34		See Developmental Disabilities, ***Assessment of Mobility and Transportation Needs, below***
		FEDERAL HEALTH CARE REFORM/HEALTH BENEFIT EXCHANGE
B, Sec. 26	***Basic Health Plan rates***	Would require DOH to contract w/ an independent actuary to study and recommend appropriate reimbursement methodologies for the cost of health care service coverage, and after consultation w/ plans, the comm'r would be required to develop methodologies and fee schedules for determining rates of payment; may include capitation. Emergency regulatory authority provided.
B, Sec. 45-46	***Basic Health Plan – Non-Citizens***	Would amend Basic Health Plan language to allow for coverage of non-citizens in a valid nonimmigrant status

G	***Assessment to Fund Operating Expenses of Health Benefit Exchange***	Beginning 4/1/15, Superintendent of DFS to assess domestic accident and health insurers (individual, small group, large group markets) for the Exchange direct and indirect operating expenses.
		• Assessments shall be pro rata, in proportion to gross direct premiums
		    ○ exclusive of federal tax credits and returned premiums
		    ○ written in NYS for the previous calendar year
		    ○ for Exchange operational expenses attributable to qualified health plan coverage in

<table>
<tr><th>Part, Section</th><th>Subject</th><th>Proposed</th></tr>
<tr><td></td><td></td><td>State
○ Due by 2/15/16
○ If more is collected than needed, it will be applied to the next quarterly bill
○ If less is collected than needed, DFS “may require full payment” to be made
○ DFS to reconcile with actual premium data
• Payments subject to DOH audit (up to 6 years back)
○ Requires keeping monthly records of source records generated by information systems, financial accounting records, etc.
○ If Plan fails to produce data in an audit, DFS can estimate amounts due for a quarter
○ Allows DFS to waive interest and penalties in resolving a DOH audit
• Medicare, Medicaid, CHP, Basic Health Plan plans excluded
• Beginning 4/1/16, quarterly payments begin to be due (March 15, June 15, etc.)
• Penalties of up to $10K for every instance of failing to produce required data w/in 30 days (unless good cause is shown)
• HCRA assessment
• Mechanism to allow DOH to receive payments from DFS-regulated insurers</td></tr>
<tr><td colspan="3">MEDICAID/MEDICAID REDESIGN/WAIVER</td></tr>
<tr><td>B, Sec. 33</td><td>Elimination of Spousal Refusal</td><td>Old chestnut.</td></tr>
<tr><td>B, Sec. 8</td><td>Medicaid Growth Cap</td><td>Would codify Medicaid cap as: “not exceed[ing] the 10 year rolling average of the medical component of the consumer price index for the preceding 10 years; provided, however, that for SFY13-14 or any fiscal year thereafter, the maximum allowable annual increase in the amount of . . . shall be calculated by multiplying the” previous year spending minus state operations spending by the 10 year rolling average; would require monthly reporting and establishment of allocation plan, including allowing the Comm’r to cut if the State exceeds the cap. Also allows for distribution of savings (dividend) at discretion of Comm’r. Budget documents indicate this proposal is codification of Medicaid Global Cap previously annually enacted in the Budget.</td></tr>
<tr><td>B, Sec. 31-32</td><td>Medicare Parts B&C and Medicaid rates</td><td>Would ensure that if provider receives payments under Medicare B and/or C, Medicaid payment will be adjusted to ensure that total payment will not be greater than that allowed under Medicaid</td></tr>
</table>

Part, Section	Subject	Proposed
B, Sec. 35-36	***Presumptive Eligibility***	Would clarify state law to comply with a court decision limiting scope of what Medicaid can pay for in period of presumptive eligibility
B, Sec. 41	***OHIP Staffing***	Would authorize temporary (up to 5 year) appointments without regard to Civil service requirements for those possessing "highly specialized expertise." Up to 300 persons; term cannot be extended beyond 60 months. Notice provisions apply.
D, Sec. 2	***Medicaid Capital Cost reimbursement***	Would extend certain provisions relating to this
D, Sec. 17	***Co-payments***	Would permanently extend copayment provisions
D, Sec. 19	***Managed LTC***	Would permanently extend provisions relating to MLTCs

F	***Value Based Payments***	• Allows Comm'r to authorize
		  o Article 44 MCOs to contract for value based payments and
		  o The Department to utilize methodologies for reimbursement that are value-based
		• Authority to use VBP **not** limited to DSRIP PPSs or subsets of PPS providers, and allows continuation of VBP beyond 5-yr DSRIP period
		• Allow extension of VBP to all Article 44 MCOs and any provider receiving Medicaid payment
		• Authorizes PPS (or subset of PPS providers) to use VBP
		• DOH to work with DFS in developing regulations (but regulations not necessary to implementation). Regulations (if enacted) would address
		  o Authorizing discrete levels of VBP that account for level of risk and placing conditions on these levels of risk
		  o Requiring or adjusting reserves for MCOs participating in VBP
		  o Authorizing Comm'r to establish a reinsurance pool
		  o Ensuring the VBP methodologies/payments conform to the terms and conditions of the DSRIP waiver
		Eff. 4/1/15

	HEALTH HOMES	
B, Sec. 24	***Criminal Justice Health Homes***	Would authorize up to $5M in grants to coordinate services b/w HHs and the criminal justice system

Part, Section	Subject	Proposed
CHILD HEALTH PLUS		
		See Behavioral Health & Substance Abuse, below
BEHAVIORAL HEALTH & SUBSTANCE ABUSE		
C	***Rate Parity Between CHP and Medicaid Managed Care***	Would require fee paid under CHP for ambulatory behavioral health services be equivalent to the Medicaid APG rates for the same services through 12/13/16 (NYC) or 6/30/17 (non-NYC), but plans and providers can negotiate different rates, subject to DOH approval (in consultation w/ OASAS and OMH).
Part O	***OMH recovery of "exempt income" from CRs***	Extends the ability for OMH to recover "exempt income" from community residence providers for a one-year period, through June 30, 2016.
Part P	***Education Pilot - BOCES OMH Facilities***	Authorizes BOCES programs to educate OMH patients and extends local school district education pilot program for a three-year period until June, 2018.
Part R	***Representative Payees by OMH and OPWDD Facility Directors***	Extends the authority of facility directors of OMH and OPWDD facilities to act as representative payees, as permitted under Federal law, for a three-year period (until June 2018)
DEVELOPMENTAL DISABILITIES		
B, Sec. 34	***Assessment of Mobility and Transportation Needs***	Would authorize DOH to contract with one or more entities to assess mobility and transportation needs of the disabled and other special populations. Purpose – to develop a pilot program to coordinate medical and non-medical transportation services, maximize funding sources and enhance community integration.
B, Sec. 37	***Olmstead Plan***	Would direct enhanced FMAP monies available as a result of NYS participation in the community first choice state plan option (1915 waiver) to be used to implement Olmstead Plan (in consultation with stakeholders)

Part, Section	Subject	Proposed
Part S	***Home and Community-based waiver services in OPWDD settings***	Authorizes OPWDD to apply for a 1915 (c) Waiver to provide Home and Community-Based Services for Medicaid eligible persons with developmental disabilities. OPWDD shall establish criteria to oversee such services, consistent with recently-enacted Federal regulatory requirements.
	Rx	
B, Sec. 6	***Prescriber Prevails***	Would eliminate prescriber prevails for brand name drugs not on a preferred drug list (FFS). Would include new language that the DOH would consider add'l information and the prescriber's justification; would also state clarify that this new process would not limit a recipient's rights.
B, Sec. 4	***Prior authorization***	Would allow commissioner to require prior authorization for FFS drugs meeting clinical drug reviewer program until Drug Utilization Review Board (proposed last year)
B, Sec. 1	***Supplemental Rebates – OP managed care drugs***	Would allow Comm'r to negotiate directly with an Rx manufacturer for supplemental rebates, including supplemental rebates relating to Rx utilization by enrollees of managed care providers – but only for OP drugs for which the manufacturer has in effect a rebate agreement with the federal Sec'y of HHS
B, Sec. 2	***AWP***	Would change AWP from wholesale acquisition cost minus 17% to minus 24% minus 9% (v. 0.41%)
B, Sec. 3	***Dispensing subsidies to providers***	Would increase from $3.50 to $8 per prescription.
B, Sec. 5	***Supplemental Rebates***	Would allow Comm'r to require pharmaceutical manufacturers to provide a minimum supplemental rebate for drugs eligible for State public health plan reimbursement; and allow Comm'r to require prior authorization if such supplemental rebate is not provided. (proposed last year)
B, Sec. 7	***340B Drugs***	Would require that Claims for payment of OP drugs submitted to managed care shall be at actual acquisition cost, defined to mean the invoice price minus "all discounts and other cost-reductions attributable to the drug."
	LONG TERM CARE SERVICES & PROVIDERS	
A, Sec. 6	***Enhancing Quality of Adult Living Program***	Would repeal this program

Part, Section	Subject	Proposed
B, Sec. 38	***Energy Efficiency/Disaster Preparedness for NHs***	Would establish "an energy efficiency and/or disaster preparedness demonstration program" for NHs that is limited to real property capital costs. Provides regulatory authority.
D, Sec. 1	***CHHA Bad Debt & Charity Care***	Would permanently extend authorization for this program
D, Sec. 3	***NH Reimbursable Cash Assessment Program***	Would permanently extend program
D, Sec. 4	***Project Eldercare***	Would permanently extend this long term care program
D, Sec. 5-6	***Trend Factors***	Would permanently extend exclusions of 1996-97 trend factor and the .25% trend factor reduction
D, Sec. 7-10	***Maximizing Medicare Revenue***	Would permanently extend this requirement
D, Sec. 11-12	***Reconciliation Limit***	Would permanently remove a $1.5M reconciliation limit for CHHAs and LTCCP administrative and general caps
D, Sec. 14	***LTHCCP Cost Limits***	Would permanently extend a limitation on LTHHCP admin and general costs not to exceed a statewide average
D, Sec. 15	***Licensed Home Care in Adult Homes or Enriched Housing***	Would extend for two years the requirement establishing Lic. Home care service agencies in adult homes or enriched housing programs as providers of personal care and limited medical services
D, Sec. 21	***Nursing Home Appeals***	Would extend for four years the limit on payment ($80M/yr)
D, Sec. 22	***CHHA Episodic Payment***	Would permanently extend authorization of episodic payment for 60 day period for CHHAs
J	***Advanced Home Health Aides***	Would establish this level of certification for home health aides with an expanded scope of practice.