BROWN | WEINRAUB

50 State Street • Albany, New York 12207
Telephone (518) 427-7350 • Facsimile (518) 427-7792
Website: www.brownweinraub.com

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

SFY 2017-2018 NYS Budget

FINAL HMH Article VII

Selected Healthcare Sector Related Provisions[1]

[1] This Matrix is not intended to represent a complete summary of the status of the current budget legislation or of all the provisions contained therein related to healthcare. For specific questions, please contact Carolyn Kerr (ckerr@brownweinraub.com) or John Tauriello (jtauriello@brownweinraub.com) at 518-427-7350.

- **Effective Date of Provisions = Call us to verify if not noted.**
- **Health & Mental Hygiene Article VII Bills (One House versions) = S.2007B, A.3007B**

Part, Section	Subject	Proposed	Senate	Assembly	FINAL
CAPITAL FOR DELIVERY SYSTEM INFRASTRUCTURE					
K	***Health care facility Transformation Program***	-$500M for protecting access to care through capital $, debt relief, or non-capital projects -$50M of this for Montefiore -$30M minimum for community based health care providers (D&TC, OASAS clinic, primary care provider, home care provider, Article 31 clinic). Must fulfill a need for services in the community, but includes "acute inpatient"?? - purposes: mergers, consolidations, acquisition, expanding essential services, creating financially sustainable systems of care -can't be used for general operating expenses -jointly administered by DOH and DASNY. Bonded projects must be approved by Public Authorities Control Board -eligible entities: hospitals, nursing homes, D&TCs, clinics licensed under the MHL -priority given to previously unfunded projects. Projects already funded are not eligible	***Language OMITTED ($800M in funding included in appropriations for essential provider transformation)***	-$700M for protecting access to care through capital $, debt relief, or non-capital projects - $50M for Montefiore -eligible entities: hospitals, nursing homes, D&TCs, clinics licensed under the MHL -- purposes: mergers, consolidations, acquisition, expanding essential services, creating financially sustainable systems of care -jointly administered by DOH and DASNY. Bonded projects must be approved by Public Authorities Control Board --$125M minimum for community based health care providers (D&TC, OASAS clinic, primary care provider, home care provider, Article 31 clinic). Must fulfill a need for services in the community, but includes "acute inpatient" -priority given to previously unfunded projects. Projects already funded are not eligible	***Included in the Revenue Article VII (S.2009-C/A.3009-C) and the Capital appropriations bill (*S.2004D/A.3004D*):*** $500M for protecting access to care through capital $, debt relief, or non-capital projects • $50M for Montefiore • up to $75M for community providers (D&TC, OASAS clinic, primary care provider, home care provider, Article 31 clinic). • $200M bonded • up to $300M can be used toward the RFP issued in the fall -- purposes: mergers, consolidations, acquisition, expanding essential services, creating financially sustainable systems of care (not for general operating expenses) -jointly administered by DOH and DASNY. Bonded projects must be approved by Public Authorities Control Board -Department must announce the awards of last year's $195M no later than May 1, 2017. - new RFA would be issued for any remaining dollars; and the legislation allows that the new RFA will reflect legislative and stakeholder input, including on whether the eligibility requirements for community based providers be expanded.

Part, Section	Subject	Proposed	Senate	Assembly	FINAL
		-DOH can use funds to fund projects not funded under earlier RFA -criteria: (1) contribution to integration of services, establishing long term sustainability of services, or preserve essential services in the community; (2) alignment w/ DSRIP; (3) geographic distribution; (4) meets community need; (5) applicant's access to alternative funding; (6) extent to which project furthers primary care and OP; (7) extent to which project benefits Medicaid beneficiaries and uninsured; (8) extent to which community has been engaged in planning project; (9) risk to patient safety. -successful applicants must meet metrics/milestones -doh to report quarterly to legislature		**Does NOT include language to allow DOH the discretion to use the funds to make awards under the previously issued RFA** Rest of language is same as Governor's	
			DOH OPERATIONS		
G, Sec. 2	***OHIP employees***	Would give OHIP authority to hire various positions and trainees outside of civil service requirements	***OMITTED***	***OMITTED***	***OMITTED***

Part, Section	Subject	Proposed	Senate	Assembly	FINAL
			HEALTH CARE FINANCING		
AA	***Enhanced Safety Net Hospital Program***	NA	NA	Would provide add'l Medicaid payments to enhanced safety net hospitals, defined as: (1) a public hospital; (2) a sole community hospital or CAH; or (3) not less than 50% of patients are Medicaid or uninsured; 40% of IP discharges are Medicaid; 25% or less of patients are commercially insured; not less than 3% of patients are uninsured; and the hospital provides care to the uninsured in ER, clinics, etc. Enhanced payment would be passed through managed care plans. Comm'r to develop a formula. No local share permitted. Funds would be additive to other funding streams.	***Language OMITTED from HMH Article VII but the appropriations*** (Aid to Localities) bill would have $10M appropriated annually for this program (plus potential FFP).
V, Sec. 2	***Enhanced Payment to Critical Access Hospitals***	NA	Would require Medicaid payments to rural CAHs to = 101% of Medicaid	NA	***Language OMITTED from HMH Article VII but the appropriations*** (Aid to Localities) bill would have $10M appropriated annually for this program (plus a potential federal match).

Part, Section	Subject	Proposed	Senate	Assembly	FINAL
			COMMERCIAL INSURANCE		
C, Sec. 2-12	***Small Group Definition***	NA	NA	Would amend definition of small group from 1-100 to 1-50, and allow for sales of stop loss insurance to groups with 51+ members.	***OMITTED***
			HEALTH CARE REGULATION MODERNIZATION TEAM		
L	***Streamlining regulations and statutes***	Would establish a 25-person team to advise on the restructuring of statutes, regulations and policies relating to governance and oversight of health care facilities and home care. Members would include: state officers/employees, PHHPC chair & co-chair, 2 NYS Assembly members, 1 assembly nominee, 2 senators, 1 senate nominee, stakeholders with relevant experience. Authority is very broad and will encompass a wide array of issues relating to improving and modernizing care delivery, including facility licensure procedures, alternative models of care delivery, etc. ***Notable: would allow for implementation with 30-day prior notice and comment period of time limited pilots***	*Modified:* Would establish a 12-person team; limit the scope of the work to CoN and surveillance issues; and eliminate the ability to implement pilots notwithstanding statute or regulation.	***OMITTED***	***OMITTED***

Part, Section	Subject	Proposed	Senate	Assembly	FINAL
		notwithstanding any statute prohibiting the practice/program/project. Public participation opportunities envisioned. To begin July 1, 2017.			
MEDICAID/MEDICAID REDESIGN/WAIVER					
Revenue Bill, Part XXX, Sec. 22-e	***Superpowers language***	*Throughout appropriations bill*	OMITTED	OMITTED	***Compromise language:*** if there are federal budget (including through continuing resolutions), statutory or regulatory changes that result in a reduction of federal financial participation greater than $850M, the Division of Budget can develop a plan to reduce Medicaid appropriations, which it will then deliver to the Legislature. -The plan must (a) specify the total amount of the reduction in federal financial participation in Medicaid, (b) itemize the specific programs and activities that will be affected by the reduction in federal financial participation in Medicaid, and (c) identify the general fund and state special revenue fund appropriations and related disbursements that shall be reduced. -The reductions must "be applied equally and proportionally" to the affected programs. -The legislature will then have 90 days to prepare its own plan (which may be adopted by concurrent resolution passed by both houses). -If it fails to do adopt a different plan within the 90 day time period, the Administration's plan automatically take effect.

Part, Section	Subject	Proposed	Senate	Assembly	FINAL
C	***Essential Plan changes***	Sec. 1 – increases populations that would require $20 monthly payment from families at 150% to 138% FPL, to be increased annually based on CPI in 2018 and after. (No payment for 138% FPL and lower)	Same as Executive	Different version: Would require cost-sharing provisions for those at 138-150%FPL to maintain an actuarial value of 99.68%, and for 151-200%FPL, an actuarial value of 90.02%	***OMITTED***
F	***Transportation services***	Would carve transportation benefit out of MLTC and eliminate payment to rural transportation networks	*Modified: Would* only carve out transportation for adult day services	Same as Executive	***OMITTED***
G, Sec. 1	***Global Cap***	-Would extend to SFY 18-19 -Would allow adjustments of Medicaid expenditures based on changes in federal financial participation and/or federal eligibility requirement changes	*Modified:* Would require any savings plan under the Cap to be approved by the Legislature. Would also change cap calculation based on 10 year average of medical CPI. (Sec. 1-a)	***OMITTED***	-Would extend to SFY 18-19 -Would allow adjustments of Medicaid expenditures based on changes in federal financial participation and/or federal eligibility requirement changes
G, Sec. 3	***School supportive Health in NYC***	Would cut $50M from NYC school supportive health services unless city agrees to commit an additional $100M to preschool and school supportive health services	Appears to be same as Executive's	***OMITTED***	***OMITTED***
G, Sec. 3-b	***Reduction of Managed care rates***	NA	Would prohibit administrative reduction of managed care rates where medical costs exceed rate paid by State, the plan MLR is 90+%, or the reduction is retroactive. Rates defined to include quality pool payment	NA	***OMITTED***
E, Secs. 6-g-6-h	***Managed Care Rates***	NA	Would establish a new process for ensuring development of actuarially	NA	***OMITTED***

Part, Section	Subject	Proposed	Senate	Assembly	FINAL
			sound rates, including consideration of geographic factors for MLTC plans, wages, needs for provider technology, delivery system infrastructure needs.		
Part V	***School Based Health Center – Managed care carve out***	NA	Similar to Assembly (Part V, Sec. 5-6)	Would carve services provided by school based health centers out of medicaid managed care, and specifies reimbursement methodologies	***Language not included in the budget, but there has been agreement to administratively delay the carve-in until July 2018***
Part V, Sec. 4	***AIDS Rate add-on***	NA	Would require rate add-on to managed care payment for AIDS related services	NA	***OMITTED***
Part V, Sec. 7	***Health Homes and Care managers***	NA	Would allow, among other things, MCOs to operate as HH care managers.	NA	***OMITTED***
Part S, Sec. 1	***Additional payments to Health Homes***	NA	NA	NA	Would allow additional payments to health homes that meet process/outcome measures (dependent on FFP)
Part S, Sec. 3	***Human Breast Milk***	NA	NA	NA	Adds donor breast milk to Medicaid benefit. **This was also included in the Extender (language) bill.**
Part S, Sec. 4	***IVF treatments***	NA	NA	NA	Adds certain IVF treatments to Medicaid benefit. **This was also included in the Extender (language) bill.**
Part X	***Reporting of rate adjustments***	NA	NA	Would require DOH to report planned rate changes to Senate and Assembly and explain the purpose, methodology and impact of the change.	***OMITTED***

Part, Section	Subject	Proposed	Senate	Assembly	FINAL
			WORKFORCE		
Q	***Defer COLA***	COLAs for all behavioral health (and all human services) agencies are eliminated for FY 2017- 18. However, the sunset date on the statutory authority permitting such COLAs is extended from March 31, 2019 until March 31, 2021.		***OMITTED***	COLAs are eliminated all DD and behavioral health agencies for 2 fiscal years, and sunset date on statutory authority permitting COLAs is extended two years until March 31, 2020. **Direct Support staff (CFR 100 series) and Direct Care staff (200) series: 3.25% increase Jan 1, 2018 plus 3.25% on April 1, 2018.** **Clinical Staff (CFR 300 series): 3.25% increase on April 1, 2018.** **This was also included in the Extender (language) bill.**
W, Sec. 13	***Community Paramedicine***	NA	Would include community paramedicine in hospital-home care-physician collaboration program	NA	***OMITTED***
Y	***Worker OT***	NA	NA	Would require any state agency with 25 percent or more of their workforce accruing overtime in a calendar year to maintain all FTE positions and to fill vacancies; report to the Legislature annually the total number of workers and the total number of workers accruing overtime, and how many positions filled and efforts to reduce OT.	***OMITTED***

Part, Section	Subject	Proposed	Senate	Assembly	FINAL
			GENERAL PUBLIC HEALTH WORK PROGRAM		
B	***GPHWP – NYC Reimbursement***	Would reduce DOH reimbursement for this program, which reimburses local health departments for core public health services. Reimbursement for non-emergency claims would be reduced 7% (from 36% to 29%)	***OMITTED***	***OMITTED***	***OMITTED***
			PUBLIC HEALTH		
T	***Regulation of e-cigarettes***	NA	Senate bill includes legislation to impose tighter regulations on e-cigarettes	NA	***OMITTED***
			HCRA		
H	***HCRA Extension***	Extends HCRA for 3 years. Would also continue $500M in additional payments to hospitals.	*Modified version*. Provides for specific allocations for various programs as well as extensions	Appears to be the same	3-year HCRA extensions with legislative additions.
I	***Additional HCRA and other Extensions***	NA	See above	Would extend additional HCRA programs (e.g., CHHA bad debt & charity care, 6% NH tax, no trend factor for NH payments, Medicaid rates, ACOs, etc.)	See above

Part, Section	Subject	Proposed	Senate	Assembly	FINAL
			EARLY INTERVENTION		
A	***Enhance 3d party payer responsibility for early intervention services***	Sec. 1 – require EI claims be submitted in accordance with prompt pay law Sec. 2 – referral from PCP would satisfy preauth requirements; coverage of services regardless of site of where they are provided or duration of services; require payment for EI services covered by commercial insurance policy; timelines on subrogation notification Sec. 3 – require service coordinators to collect 3d party insurance information Sec. 4 – allows counties to conduct audits Secs. 5&6 – relate to provider authorization	***OMITTED***	Appears to only include a portion of the Governor's proposal (sections 1 and 2)	***OMITTED***
			DEVELOPMENTALLY DISABLED		
Part S	***Report to Legislature***	NA	NA	Would require OPWDD to report to the Assembly and the Senate on or before 10/1/17 on housing issues relating to the DD community and to update the Legislature on the work of the Transformation Panel	***OMITTED***

Part, Section	Subject	Proposed	Senate	Assembly	FINAL
			BEHAVIORAL HEALTH & SUBSTANCE ABUSE		
Part O	***Permits OMH to authorize prisons and local jails to restore competency to persons in order to stand trial for criminal actions. (Sunsets in five years.)***	Amends Section 730.10 of the Criminal Procedure Law (CPL) to authorize for a 5 year demonstration, until March 31, 2022, for restoration to competency of felony defendants awaiting criminal trials within consenting local jails and State prisons. $850,000 would be appropriated for this project.	***OMITTED***	***OMITTED***	***OMITTED***
P	***Extension of APG rates (AKA "Government Rates") paid by MCOs for Medicaid behavioral health licensed clinics; extends such APG rates to all other behavioral health providers except inpatient; and requires annual VBP targets.***	● Extends APG rates paid by MCOs for Medicaid clinic service providers (includes CHIP) licensed by OMH and OASAS, from June 2018 until March 31, 2020; ● Expands to non-inpatient behavioral health services; and ● Authorizes DOH, in consultation with OMH and OASAS to make APG payments contingent on value-based payment, aggregate spending targets, as follows: - FY 2017, at least 10% Level 1	● Extends APG rates paid by MCOs for Medicaid clinic service providers (includes CHIP) licensed by OMH and OASAS, from June 2018 until March 31, 2020; ● Expands to include all behavioral health services in Medicaid redesign waiver, except inpatient; ● Does not include VBP contingency authorization.	● Extends such APG rates until March 31, 2021; ● Expands to include all behavioral health services in Medicaid redesign waiver, except inpatient; ● Includes all of the Executive's VBP contingencies for APG fees, but delays each by a one-year period	● Extends such APG rates until March 31, 2020; ● Expands to include all behavioral health services in Medicaid redesign waiver, except inpatient; ● Authorizes DOH, in consultation with OMH and OASAS to make APG payments contingent on providers meeting "alternative payment methodology requirements" set forth in Attachment I of the 1115 waiver, unless such condition is waived. Waivers shall occur if a "sufficient number of providers suffer financial hardship" as a result of these requirements, or if APGs threaten access to ambulatory BH services. Waivers can be provider specific or industrywide.

Part, Section	Subject	Proposed	Senate	Assembly	FINAL
		- FY 2018, at least 50% Level 1 and 15% Level 2 FY 2019, at least 80% Level 1 and 35% Level 2			
Q	***Cost of Living Adjustment (COLA)***	COLAs for all behavioral health (and all human services) agencies are eliminated for FY 2017- 18. However, the sunset date on the statutory authority permitting such COLAs is extended from March 31, 2019 until March 31, 2021.	Same as Governor.	Intentionally Omitted.	COLAs are eliminated all DD and behavioral health agencies for 2 fiscal years, and sunset date on statutory authority permitting COLAs is extended two years until March 31, 2020. **Direct Support staff (CFR 100 series) and Direct Care staff (200) series: 3.25% increase Jan 1, 2018 plus 3.25% on April 1, 2018.** **Clinical Staff (CFR 300 series): 3.25% increase on April 1, 2018. This was also included in the Extender (language) bill.**
R (Assembly Part U)	***Western NY Children's Psychiatric Center in Erie Co. to remain open***	NA	WNYCPC shall remain open and not be merged or co-located with any other facility.	WNYCPC shall remain open and not be merged or co-located with any other adult facility and shall operate 46 beds serving exclusively children and adolescents.	***OMITTED***
T	***Drug related Paraphernalia re crimes for possession of drugs***	NA	NA	Possession of residual amounts of controlled substances in hypodermic needles, syringes or other objects used for injections shall not be considered criminal possession of a controlled substance.	***OMITTED***

Part, Section	Subject	Proposed	Senate	Assembly	FINAL
Z	***Limits OMH ability to transfer State-operated inpatient services to article 28s***	NA	NA	Prevents reduction of services and staff, and requires reinvestment of any savings.	***OMITTED***
D, Sec. 8	***Opioid prescribing in the Medicaid program***	Would prohibit prescribing of opioids in violation of the requirements limiting prescribing of opioids, and/or contrary to recommendations issued by the drug utilization review board	Similar to Executive, but requires an Order before the exclusion of a provider under PHL section 12-a.	Same (Sec. 13)	Includes Governor's proposal to prohibit prescribing of opioids in violation of the requirements limiting prescribing of opioids, and/or contrary to recommendations issued by the drug utilization review board, but includes due process provisions. **This was also included in the Extender (language) bill.**
D, Sec. 9	***7-day limit for controlled substances***	Would require prior auth for more than a7-day prescription of a controlled substance in the Medicaid program	Same as Executive	Same (Sec. 14)	Includes Governor's proposal to require prior authorization for more than a 7-day prescription of a controlled substance in the Medicaid program. **This was also included in the Extender (language) bill.**
			Rx		
D	***Tackling High Cost Drugs***	-Purpose is for State (through DOH & Drug Utilization Review Bd) to collect info on drug prices to establish benchmark price for drugs. If these drugs are paid for by Medicaid, will be subject to rebate and a tax surcharge -"High priced drugs" defined as: (1) priced disproportionately given ltd therapeutic benefit; (2) when first introduced are prohibitively expensive to	Different proposal: Would allow state to "limit sudden and unjustifiable" price increases on (1) existing drugs via current law; (2) existing brand drugs through federal provisions; and (3) impose and "overall limit on the amount the state spends on drugs that fail to generate a corresponding health care offsets" or taxpayer savings.	Different proposal: - for State (through DOH & Drug Utilization Review Bd) to collect info on drug prices to establish benchmark price for drugs. If these drugs are paid for by Medicaid, will be subject to rebate and a tax surcharge -"High priced drugs" defined as: (1) priced disproportionately given ltd therapeutic benefit; (2)	Sec 1, 3, 17. The language contained in the final bill represents a compromise between the Legislature and the Executive. Under the agreed upon on language, Medicaid will establish a pharmacy cap as a separate component within the Medicaid Global Cap: • SFY17-18: 10 year rolling average of medical CPI + 5% - $55M • SFY18-19: 10 year rolling average of medical CPI + 4% - $85M DOH and DOB will make quarterly assessments of drug expenditures (FFS + managed care, minus rebates and

Part, Section	Subject	Proposed	Senate	Assembly	FINAL
		consumers; (3) suddenly experience an unexplained increased cost. -All drugs included (generic and brand, multiple makers or single source, reimbursed by commercial or public payers, prescription *and non-prescription*) -Requires drug manufacturers to provide info on actual R&D costs, advertising costs, utilization data, prices charged for the drug outside of the US, prices charged to in-state purchasers, average rebates, average profit margins. Information shall generally be kept confidential, but with many exceptions -Info will be given to DURB, and DURB will recommend a value based, per unit benchmark cost of the drug, utilizing certain criteria -Medicaid can require rebate for high-cost drugs (in addition to other rebates) -tax: would impose surcharge of 60% on high cost drugs -taxes would go into a Reimbursement Fund to credit Medicaid program and commercial premiums -increase DURB membership to include health care	-Would limit Medicaid Rx spending (FFS and MMC, separately accounted for in global cap) to 5% + 10 yr rolling average of medical CPI OR more than 2X the annual Medicaid growth, whichever is greater. DOH can impose supplemental rebate on drugs that cause growth outside of these limits. Annual drug expenditure would be defined to have several exclusions (rebates, outbreaks and epidemics, etc.). Independent actuary to be used for this process, and process established for notifying drug manufacturer. Would establish DURB process for examination of sudden increases in drugs (100% or more increase in WAC at once or over a 12-month period) and allow prior authorization of such drugs. -Allows for role of AG upon referral from DURB for price gouging, who can litigate the matter; factors for unconscionable increases set in the bill -No tax, no DURB membership changes	when first introduced are prohibitively expensive to consumers; (3) suddenly experience an unexplained increased cost. Only includes prescription drugs -Requires drug manufacturers to provide info, but with more safeguards to ensure tax and proprietary information is kept confidential - Medicaid can require rebate for high-cost drugs (in addition to other rebates) -tax: would impose surcharge of 60% on high cost drugs – more detailed than Governor's proposal -increase DURB membership to include health care economists, an actuary and a representative of DFS	supplemental rebates). If the expenditure is projected to exceed the cap, DOH can identify and refer drugs to Drug Utilization and Review Board on whether a targeted supplemental rebate should be paid by the manufacturer to the State. The law establishes a process for this review and for determining the amount of the rebate (including looking at whether there has been an unjustified price increase, and whether the cost outweighs the therapeutic benefits). If DOH cannot negotiate a rebate with the manufacturer at least 75% of the target rebate amount, the law authorizes DOH direct managed care plans to remove the drug from formularies and to subject the drug to prior authorization (if such action does not pose a harm to the patient). Additionally, where no agreement on a rebate is reached, the Department would be able to request information from the manufacturer regarding the actual cost of the drug. DOH would only have this authority during the period that the pharmacy cap is exceeded. Sec. 2: Includes the Governor's proposal to expand the membership of the DURB to include health care economists, an actuary and a representative of DFS. **This was also included in the Extender (language) bill.**

Part, Section	Subject	Proposed	Senate	Assembly	FINAL
		economists, an actuary and a representative of DFS -also establishes test for non-prescription drugs - eff. 4/1/17			
D, Sec. 7-9	***Carve Rx Benefit out of managed care***	NA	NA	Would require DURB/CDRP to provide and price drugs provided through managed care plans. Costs to be included in capitation. State to contract with PBM to manage the benefit for the state	***OMITTED***
D, Sec. 7	***Dispensing fee***	Pharmacy dispensing fee would be increased from 3.50 to $10	Similar to Assembly version, and adds $12 dispensing fee	Sec. 12 – proposes a different scheme for dispensing fees based on national drug acquisition cost or WAC; the usual and customary cost of the pharmacy; CMS federal upper limit; state maximum acquisition cost	Sec. 7. Appears to combine Governor's proposal to raise dispensing fee to $10 with legislature's proposal to base certain fees on national drug acquisition cost or WAC; the usual and customary cost of the pharmacy; CMS federal upper limit; state maximum acquisition cost. **This was also included in the Extender (language) bill.**
D, Sec. 10-12	***Prescriber prevails***	Eliminates prescriber prevails in Medicaid program except for atypical antipsychotics and antidepressants	***OMITTED***	***Rejected. Would reinstate prescriber prevails***	***OMITTED***
D, Sec. 13	***Comprehensive Medication management***	Would allow physicians/nurse practitioners and pharmacists to establish written protocols to provide comprehensive medication management to patients with a chronic disease or diseases who have not met clinical goals of therapy, are at risk for hospitalization, or whom	***OMITTED***	***OMITTED***	***OMITTED***

Part, Section	Subject	Proposed	Senate	Assembly	FINAL
		the physician or nurse practitioner deems to need comprehensive medication management services. Participation by the patient in comprehensive medication management is voluntary.			
D, Secs 14-16	***Co-pays for over the counter prescriptions***	Would increase Medicaid co-pay from .50 to $1.00, and reduce copays for prescription drugs from $3 to $2.50	*Modified:* Would reduce copays for prescription drugs from $3 to $2.50	*Modified*: Would reduce copays for prescription drugs from $3 to $2.50	*Includes Legislature's proposal:* just accepts the piece to reduce copays for prescription drugs from $3 to $2.50. **This was also included in the Extender (language) bill.**
D, Sec. 18	***Medicaid Drug Remittance Program***	NA	Would establish program where DOH would work with a 3d party vendor to validate existing Medicaid drug rebate claims. Requires vendor to meet certain specifications, and requires DOH to submit information to the vendor to validate rebate claims	NA	NA
D, Sec. 19	***Bi-Annual Assessment of non-Preferred drugs***	NA	Would require bi-annual assessment of non-preferred drugs and would require non-preferred drug to be classified as preferred if it meets certain criteria	NA	NA

Part, Section	Subject	Proposed	Senate	Assembly	FINAL
J	***Pharmacy Benefit Manager Regulation***	Would require PBMs to register w/ DFS (eff. 1/1/2019), with penalties for non-compliance, although that all PBMs have to register effective July 2017. Registration fee = $1K. Requires PBMs to report on matters as directed by DFS (seemingly without limitation). Quarterly statements will also be required separately, with fines for lateness. All information shall be deemed confidential unless exceptions apply. Penalties for acting without a license. DFS to set standards for registration, although the legislation requires minimum standards, including eliminating deceptive practices, conflicts of interest, anti-competitive and unfair practices, however those terms may be defined. $1K license fee. Allows DFS to issue regulations to implement. Identifies circumstances for license revocation. Would establish a tax on PBMs.	*Modified:* Would require contracts b/w PBMs and an insurer, municipal health plan, higher ed entity or NYSHIP to have provisions that require disclosure of information upon request within 60 days; provide for annual audit rights; allows for PBM to require NDA. Would require PBM to ensure that consumers do not pay a rate higher than the negotiated rate for the drug, less the rebate.	*Modified:* Would require PBMs to register with DFS, with penalties for non-compliance. Registration fee = $1K. Requires PBMs to report on matters as directed by DFS (seemingly without limitation). Quarterly statements may also be required separately, with fines for lateness. Penalties for acting without a license. $1K license fee DFS to set standards for registration, although the legislation requires minimum standards, including eliminating deceptive practices, conflicts of interest, anti-competitive and unfair practices, however those terms may be defined. Allows DFS to issue regulations to implement. *Allows DFS to refuse a license if, in its discretion, it finds the applicant "untrustworthy." Identifies circumstances and process for license revocation, including but not limited to fraud, incompetence, failure to pay taxes, improperly withheld monies. Imposes restrictions in the case of an entity that has had the*	***OMITTED***

Part, Section	Subject	Proposed	Senate	Assembly	FINAL
				license revoked (hiring of persons, etc.). Would establish a tax on PBMs. *-Would require mail order pharmacies to be reimbursed at the same level as non-mail order pharmacies in the network, and would remove obligations for retail pharmacies to comply with same contractual terms and conditions as mail order pharmacies. -Would repeal existing PBM law and replace it with new law the places transparency requirements and fund restrictions on arrangement b/w PBM and MCO; limits substitution of Rxs.*	
LONG TERM CARE SERVICES & PROVIDERS					
E, Sec. 1	***Eligibility for MLTCs***	Would restrict eligibility for MLTC enrollment to persons requiring nursing home level of care. Current enrollees would be grandfathered. Excluded persons would receive comparable services through mainstream plan. Eff. 10/2017	***OMITTED***	***OMITTED***	***OMITTED***
E, Sec. 2	***NH Medicaid rates – bed stay***	Eliminates vacancy rate from Medicaid rate calculation	***OMITTED***	***OMITTED***	*A compromise version of the Governor's proposal:* limiting payments for bed hold payments to those related to therapeutic

Part, Section	Subject	Proposed	Senate	Assembly	FINAL
		(eliminate reimbursement for bed hold days)			leaves (but eliminating payments for hospital leaves). **This was also included in the Extender (language) bill.**
E, Sec. 4	***Per Diem for NHs with Under-21 population***	NA	***NA***	***NA***	*Requires DOH to establish prospective per diem for NHs with predominantly under 21 population, to achieve a savings of $18M in each SFY*
E, Sec. 5	***Spousal refusal***	Old chestnut. Proposed for the 25th? Year?	***OMITTED***	***OMITTED***	***OMITTED***
E. Sec. 6	***Hospice***	Hospice services covered by Medicare would not be covered by Medicaid	Same as Executive	***OMITTED***	***OMITTED***
E, Sec. 6-a	***Family members as Home Health Aides***	NA	Would allow family members to be included in the definition of Home Health Aide	NA	***OMITTED***
E, Sec. 6-c	***NH rates***	NA	Would require State to fund NHs the State share of FMAP until SPA is approved	NA	***OMITTED***
E, Sec. 6-e	***Assisted Living Program Expansion***	NA	Would remove limitations on program and allow expansion of existing ALP programs upon demonstration of public need	NA	***OMITTED***
E, Sec. 6-f	***TBI/NHTD Carve out***	NA	Would carve TBI & NHTD waiver population out of Medicaid managed care	NA	***Language not included in the budget, but we understand there has been agreement to administratively delay the carve in through December 2018***
E, Sec. 6-j	***Out of State Placements***	NA	Would require DOH to report to Legislature on repatriation of complex needs Medicaid patients currently placed on OOS facilities	NA	***OMITTED***

Part, Section	Subject	Proposed	Senate	Assembly	FINAL
Part U	***Elder Abuse***	NA	Would establish multi-disciplinary team to investigate incidences of elder abuse and establish central register of elder abuse reporting	NA	***OMITTED***
Part W, Sec. 1	***Fiscal Intermediaries***	NA	Would define, establish role and set parameters around responsibilities of, and other regulatory rules relating to, fiscal intermediaries (Part E, Sec. 6-b)	Would define, establish role and set parameters around responsibilities of, and other regulatory rules relating to, fiscal intermediaries	Legislature's proposal included in the final bill (Part E, Sec. 1)
Part W, Sec. 2	***Universal Assessment***	NA	NA	Would require evaluation of existing assessment tool for ability to accurately determine cognitive impairment, among other things.	***OMITTED***
Part W, Sec. 3-5	***High Needs Rate Cell***	NA	Substantially similar proposal (Part E, Sec. 6-i)	Would require the establishment of a high needs rate cell for certain individuals (NH, 12-24 hours personal, community services or home care/day). Dollars to support WRR	***OMITTED***
Part W, Sec. 6	***NH Benchmark rates***	NA	Similar language included in Part E, Sec. 6-i	Would require MCOs to continue to reimburse NHs at benchmark rates, defined as the FFS rate	*Included: Part S, Sec. 2*
Part W, Sec. 7	***Reporting of home care wage parity information***	NA	Similar to Assembly version, plus would require plans to distribute funds using a reasonable methodology (Part E, Sec. 6-d)	Would require plans to report how wage parity dollars have been distributed to providers	***OMITTED***

Part, Section	Subject	Proposed	Senate	Assembly	FINAL
Part W, Sec 8	***CDPC inclusion in home care wage parity***	NA	NA	Would include personal assistant performing services under consumer directed personal care program as home care worker for purposes of wage parity	*Assembly proposal Included (Part S, Sec. 5)*