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Legislative Response to Executive NYS Budget Proposal SFY 2017-2018 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 John Tauriello (jtauriello@brownweinraub.com) at 518-427-7350.

CAPITAL FOR DELIVERY SYSTEM INFRASTRUCTURE 3
DOH OPERATIONS 4
HEALTH CARE FINANCING 5
COMMERCIAL INSURANCE 5
HEALTH CARE REGULATION MODERNIZATION TEAM 6
MEDICAID/MEDICAID REDESIGN/WAIVER 7
WORKFORCE 8
GENERAL PUBLIC HEALTH WORK PROGRAM 9
PUBLIC HEALTH 10
HCRA 10
EARLY INTERVENTION 10
DEVELOPMENTALLY DISABLED 11
BEHAVIORAL HEALTH & SUBSTANCE ABUSE 11
Rx 14
LONG TERM CARE SERVICES & PROVIDERS 20

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

Part, Section	Subject	Proposed	Senate	Assembly
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 **Does NOT include language to allow DOH the discretion to use**

Part, Section	Subject	Proposed	Senate	Assembly
		-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		**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***

Part, Section	Subject	Proposed	Senate	Assembly
		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.
V, Sec. 2	***Enhanced Payment to Critical Access Hospitals***	NA	Would require Medicaid payments to rural CAHs to = 101% of Medicaid	NA
		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.

Part, Section	Subject	Proposed	Senate	Assembly
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 notwithstanding any statute prohibiting the practice/program/project.*** Public participation opportunities envisioned. To begin July 1, 2017.	*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***

Part, Section	Subject	Proposed	Senate	Assembly
		MEDICAID/MEDICAID REDESIGN/WAIVER		
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%
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
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***
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***
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	NA

Part, Section	Subject	Proposed	Senate	Assembly
			retroactive. Rates defined to include quality pool payment	
E, Secs. 6-g-6-h	***Managed Care Rates***	NA	Would establish a new process for ensuring development of actuarially sound rates, including consideration of geographic factors for MLTC plans, wages, needs for provider technology, delivery system infrastructure needs.	NA
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
Part V, Sec. 4	***AIDS Rate add-on***	NA	Would require rate add-on to managed care payment for AIDS related services	NA
Part V, Sec. 7	***Health Homes and Care managers***	NA	Would allow, among other things, MCOs to operate as HH care managers.	NA
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.
		WORKFORCE		
Q	***Defer COLA***	COLAs for all behavioral health (and all human services) agencies are eliminated for FY 2017- 18.		***OMITTED***

Part, Section	Subject	Proposed	Senate	Assembly
		However, the sunset date on the statutory authority permitting such COLAs is extended from March 31, 2019 until March 31, 2021.		
W, Sec. 13	***Community Paramedicine***	NA	Would include community paramedicine in hospital-home care-physician collaboration program	NA
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.
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***

Part, Section	Subject	Proposed	Senate	Assembly
		PUBLIC HEALTH		
T	***Regulation of e-cigarettes***	NA	Senate bill includes legislation to impose tighter regulations on e-cigarettes	NA
		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
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.)
		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	***OMITTED***	Appears to only include a portion of the Governor's proposal (sections 1 and 2)

Part, Section	Subject	Proposed	Senate	Assembly
		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		
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
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***

Part, Section	Subject	Proposed	Senate	Assembly
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 - FY 2018, at least 50% Level 1 and 15% Level 2 FY 2019, at least 80% Level 1 and 35% Level 2	● 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
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.
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.

Part, Section	Subject	Proposed	Senate	Assembly
S	***Special OPWDD provisions***	NA	OPWDD is required to establish Care Demonstration Programs to use the State workforce in community-based care.	By October 1, 2017 OPWDD shall report to the Legislature regarding progress on meeting housing needs of persons with DD, and report on the implementation of the Transformation Plan.
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.
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.
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)
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)

Part, Section	Subject	Proposed	Senate	Assembly
		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 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	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. -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	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) 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

Part, Section	Subject	Proposed	Senate	Assembly
		-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 economists, an actuary and a representative of DFS -also establishes test for non-prescription drugs - eff. 4/1/17	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	-increase DURB membership to include health care economists, an actuary and a representative of DFS
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
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

Part, Section	Subject	Proposed	Senate	Assembly
				limit; state maximum acquisition cost
D, Sec. 10-12	***Prescriber prevails***	Eliminates prescriber prevails in Medicaid program except for atypical antipsychotics and antidepressants	***OMITTED***	***Rejected. Would reinstate prescriber prevails***
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 the physician or nurse practitioner deems to need comprehensive medication management services. Participation by the patient in comprehensive medication management is voluntary.	***OMITTED***	***OMITTED***
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
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	NA

Part, Section	Subject	Proposed	Senate	Assembly
			DOH to submit information to the vendor to validate rebate claims	
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

Part, Section	Subject	Proposed	Senate	Assembly
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 license revoked (hiring of persons, etc.).* Would establish a tax on PBMs. *-Would require mail order pharmacies to be reimbursed at the*

Part, Section	Subject	Proposed	Senate	Assembly
				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.*

Part, Section	Subject	Proposed	Senate	Assembly
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***
E, Sec. 2-4	***NH Medicaid rates***	Eliminates vacancy rate from Medicaid rate calculation (eliminate reimbursement for bed hold days)	***OMITTED***	***OMITTED***
E, Sec. 5	***Spousal refusal***	Old chestnut. Proposed for the 25th? Year?	***OMITTED***	***OMITTED***
E. Sec. 6	***Hospice***	Hospice services covered by Medicare would not be covered by Medicaid	Same as Executive	***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
E, Sec. 6-c	***NH rates***	NA	Would require State to fund NHs the State share of FMAP until SPA is approved	NA
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

Part, Section	Subject	Proposed	Senate	Assembly
E, Sec. 6-f	***TBI/NHTD Carve out***	NA	Would carve TBI & NHTD waiver population out of Medicaid managed care	NA
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
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
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
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.
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

Part, Section	Subject	Proposed	Senate	Assembly
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
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
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