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Leading Age

FROM: Hinman Straub P.C.

RE: 2016-17 Executive Health & Medicaid Budget Overview

DATE: January 14, 2016

NATURE OF THIS INFORMATION: This is general information you might find helpful or informative.

DATE FOR RESPONSE OR IMPLEMENTATION: None – this is for your information.

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On Wednesday, January 13, 2016, Governor Andrew Cuomo released his proposed budget for State Fiscal Year (SFY) 2016-17. The following is a summary of the Executive Budget presentation and a high-level review of the pertinent health care related items. Additional analysis and memoranda will be forthcoming as briefings take place and additional information becomes available.

Budget Overview

The Governor's "Built to Lead" budget proposal totals \$145.3 billion, an increase of 1.7 percent (state funds) over the 2015-16 enacted Budget. The Governor's budget also includes an additional \$2.3 billion in "one-shot" funding resulting from monetary settlements with financial institutions that will be used for various investments, including \$900 million for transportation, \$640 million for homeless and affordable housing, and \$255 million for economic development.

As has been his practice in previous years, the Governor announced major policy proposals in the days leading up the budget release, each of which will be subject to debate and negotiation with the Legislature. In a wide-ranging speech highlighting his Administration's accomplishments and goals over five years in office, the Governor advanced a package of actions aimed to foster economic growth, social progress, large-scale infrastructure improvements and spending increases across state government.

Below is an outline of the Governor's proposed SFY 2016-17 Executive Budget impacting the health care sector:

General Health Highlights

- **Medicaid Program Funding.** The Executive Budget proposes to increase Medicaid funding by \$1.4 billion, growing from \$62 billion in 2015-16 to \$63.4 billion (inclusive of the Federal and State share).
- **Health Benefit Exchange Funding.** The Executive Budget proposes to allocate approximately \$120 million of new funds in 2016-17 to fund the New York Health Benefit Exchange. The Exchange was funded in 2015-16 with \$69 million in state funds. When combined with re-appropriations of funds from prior years, total funding for the Exchange is in excess of \$300 million.
- **SHIN-NY Funding.** The Executive Budget includes an appropriation of \$30 million for the continued funding of the SHIN-NY. The allocation provides that no expenditure shall be made without a plan, prepared by the Commissioner of Health and approved by the Director of Budget, detailing sufficient resources available to support the expenditure.
- **All Payers Database.** The Executive Budget proposes to provide \$10 million in funding to support the establishment and operation of the All Payers Database (APD).
- **State Health Innovation Plan (SHIP).** The Governor's briefing book pledges to continue its implementation of the State Health Innovation Plan (SHIP) under the terms

of a \$100 million Federal grant. Implemented over four years, this plan will provide statewide access to high quality and coordinated care. The intent is to build upon Medicaid reform efforts and translate these efforts to achieve similar outcomes across New York's entire health care system.

- **Medical Marijuana Program.** The Executive Budget proposes to provide \$6.74 million to support the State's Medical Marijuana program.
- **Minimum Wage Increase.** The Executive Budget proposes to raise the minimum wage to \$15 an hour in New York City by 2018 and for the rest of the State by 2021. Under the proposal, the minimum wage increase phased-in as follows:
 - In New York City, the minimum wage would increase from \$9/hour to:
 - \$10.50 on July 31, 2016 (to catch up to the current minimum for fast food workers & State employees, which took effect 12/31/2015);
 - \$12 on December 31, 2016 (consistent with the next hike for fast food workers & State employees);
 - \$13.50 on December 31, 2017; and
 - \$15 on December 31, 2018.
 - In the rest of the State, the minimum wage would increase from \$9/hour to:
 - \$9.75 on July 31, 2016 (to catch up to the current minimum for fast food workers & State employees, which took effect 12/31/2015);
 - \$10.75 on December 31, 2016 (consistent with the next hike for fast food workers & State employees);
 - \$11.75 on December 31, 2017;
 - \$12.75 on December 31, 2018;
 - \$13.75 on December 31, 2019;
 - \$14.50 on December 31, 2020; and
 - \$15 on July 1, 2021.

Paid Family Leave. The Executive Budget proposes to provide 12 weeks per year of, job-protected, employee-funded paid leave for purposes of caring for a newborn child, to care for a seriously-ill family member or as a result of another qualifying exigency under the Family Medical Leave Act (FMLA) (i.e. spouse, domestic partner, child, or parent of the employee's call to military service). All employees eligible for NYS Short Term Disability Benefits would be eligible for benefits under the proposed Paid Family Leave Act. The proposal would go into effect on January 1, 2018.

The proposed paid leave benefit would start at 35% of the employee's average weekly wage capped at 35% of the State's average weekly wage. The proposed paid leave benefit would increase yearly and be fully phased-in at 50% of the employee's average weekly wage capped at 50% of the State's average weekly wage on January 1, 2021.

Paid Family Leave coverage will be provided by Article 42 accident and health insurers and workers' compensation disability carriers, the State Insurance Fund (SIF), or self-insured employers. In order to limit premium volatility, the Superintendent of Financial Services will determine whether coverage provided by carriers and SIF will be experience rated or community

rated. Premiums for Paid Family Leave policies would be supported through a minimal payroll deduction on all covered employees effective January 1, 2018 and will be established by the Superintendent of Financial Services on an annual basis.

Nursing Homes

- **Spousal Support.** The Executive Budget once again proposes to require spousal support for the costs of community-based long term care and all managed long term care enrollees. In addition, the Executive changes the threshold, as of July 1, 2016, of spousal budgeting for community spouse resources to be \$23,844 or such greater amount as required under Federal law.
- **Vital Access Provider (VAP) Funding.** The Executive Budget includes \$212 million for VAP, incorporating any VAP funds previously allocated that were not distributed, rather than through a separate re-appropriation.
- **Health Care Facility Transformation Program.** *For more information on this proposal, please see the “Health Care Facility Transformation Program” section of the memorandum*
- **Miscellaneous Appropriations.** The Executive proposes the following appropriations impacting the Nursing Home sector:
 - Continuing Care Retirement Community Account = \$248,000
 - (SFY 15-16 = \$248,000)
 - Quality of Care Improvement Account = \$2,018,000
 - (SFY 15-16 = \$2,018,000)
 - Nursing Home Receivership Account = \$2,000,000 (re.)
 - (SFY 14-15 = \$2,000,000)
 - Program for background checks on patient contact personnel in Long-term care facilities = \$3,000,000
 - (SFY 15-16 = \$2,000,000)
 - Administration of the housing subsidies = \$2,303,000

Adult Home/Assisted Living

- **EQUAL.** The Executive proposes to maintain funding for the EQUAL program at \$6,532,000.
- **Temporary Operator of Adult Homes.** The Executive proposes to permanently extend the statutory authority enacted in 2013 for DOH to appoint a “temporary operator” when there are conditions seriously endangering the life, health or safety of residents (when enacted in 2013, this statutory authority was only made effective for three years and is now set to expire).

- **Transition of Mentally Ill Adult Home Residents.** The Executive proposes to include \$38 million for the provision of education, assessments, training, care coordination, supported housing and the services needed by mentally ill residents of adult homes and persons with mental illness who are discharged from adult homes. An additional \$7 million is provided to the Research Foundation of Mental Hygiene, Inc. for a contract with OMH to conduct 2 demonstration programs, 1 of which is for persons with mental illness who are discharged from impacted adult homes in New York City.
- **ACF Criminal History Record Check.** The Executive proposes to maintain funding at \$1.3 million for the administration of the criminal history record check system for staff at ACFs.
- **Supplemental Social Security (SSI).** The Executive proposal contains the traditional statutory authority to pass-through any Federal COLA that becomes effective on or after January 1, 2017.
- **Minimum Wage Increase.** *For more information on this proposal, please see the “General Health Highlights” section of the memorandum.*
- **Miscellaneous Appropriations.**
 - Adult Homes Advocacy Program: \$170,000
 - Adult Home Resident Council Support Project: \$60,000
 - Assisted Living Residence Quality Oversight Account \$2,110,000
 - Adult Home Quality Enhancement Account = \$500,000
- **Miscellaneous Re-Appropriations.**
 - EnAble: \$1.7M from SFY 2009-10.

Investment in Health Care Facilities

- **Capital Restructuring Financing Program.** The Executive budget contains a reappropriation for the \$1.2 billion in funding for the Capital Restructuring Financing Program (CRFP).
- **Health Care Facility Transformation Program.** This proposal would amend last year’s allocation of \$300 million to create an integrated health care delivery system in Oneida County. The proposal removes the program limitation to Oneida County; instead making the program available statewide. It would also reduce the allocation to \$200 million for the replacement of inefficient and outdated facilities as part of a merger, consolidation, acquisition or other restructuring activity that is part of an overall transformation plan to create a financially sustainable system. Facilities eligible for these funds include general hospitals, residential health care facilities, diagnostic and treatment centers, clinics, primary care providers, and home care providers. The proposal would also add to the factors to be considered by DOH and DASNY in awarding funds: the geographic distribution of funds, and the extent to which the applicant has access to alternative financing. Awardees would be required to meet certain process and

performance metrics to receive funding. For the remaining \$100 million that was originally allocated to Oneida County, the Executive proposes to:

- Allocate \$5 million for the purchase of mammography equipped vehicles; and
 - Allocate up to \$100 million for economic development at Nano Utica.
- **VAP Funding for Behavioral Health.** The Executive Budget proposes to provide \$50 million in vital access provider (VAP) funding to preserve behavioral health services. This VAP funding amount is separate from the general VAP funding pool and is available solely for behavioral health providers.
 - **Health Homes Funding.** The Executive Budget proposes to allocate \$105 million for services and expenses for health homes, including grants for expenses associated with health homes establishment and infrastructure costs. The appropriation reallocates \$82.5 million in funding for health homes in 2015-16, thus provides \$32.5 million in new funding.

Housing

- **Affordable Housing.** The Governor proposes to commit \$640 million in settlement funds towards the \$20 billion multi-year investment in affordable housing and services for individuals who are homeless or at risk of homelessness. The plan calls for \$9.7 billion to establish 94,000 units of affordable housing and \$2.6 billion for 6,000 units of supportive housing and will also establish 1,000 new emergency shelter beds. Over 15 years, the plan will result in 20,000 units or shelter beds, including 18,000 new supportive housing units.
- **Expanded Affordable Housing.** In FY 2017, OPWDD will provide an additional \$10 million in capital funding (\$15 million in total) to support the development of affordable housing

Long Term Care

- **Naturally Occurring Retirement Communities.** The Governor proposes to limit state aid grants for Naturally Occuring Retirement Communities (NORCs) and Neighborhood Naturally Occuring Retirement Communities (NNORCs) to those NORC/NNORC programs that continue to meet statutory requirements. The Executive proposal includes an appropriation of \$2,027,500 million for state aid grants for NORCs and \$2,027,500 million for state aid grants for NNORCs. The budget briefing book provides that the State expects \$951,000 in savings annually as a result of the policy change.
- **Investment in Caregiver Supports.** The Executive Budget allocates \$25 million to caregiver support services for persons with Alzheimer's and other dementias including additional respite and expansion of the Department of Health caregiver support services programs.

Home Health Care

- **Minimum Wage Increase.** *For more information on this proposal, please see the “General Health Highlights” section of the memorandum.*
- **Health Care Facility Transformation Program.** *For more information on this proposal, please see the “Health Care Facility Transformation Program” section of the memorandum*

Medicaid-General

- **Medicaid Global Spending Cap.** The Governor proposes to extend the Global Spending Cap through 2017-2018 (expiring March 31, 2018) and allow for continued growth within the Global Cap at the indexed rate of 3.4%, for a total cap of \$18,540,445 for the 2016-17 fiscal year. The Governor proposes to increase the cap for the 2017-18 fiscal year to \$18,995,139,000. .
- **NYC Share of Medicaid Funding.** The Governor proposes to reinstitute New York City’s contribution to the annual growth in Medicaid costs in recognition of the financial capacity derived from the City’s exemption from the Property Tax Cap. The contribution level would be increased by \$180 million in FY 2017 and would grow to \$476 million in FY 2018 and increase by \$129 million annually thereafter, after reflecting its increased share of enhanced Federal Medicaid funding, as required under the ACA. The city currently spends about \$5.4 billion helping the state finance Medicaid. The other 57 counties contribute about \$2.2 billion.
- **Medicare Part C Co-Insurance.** This proposal would limit the amount Medicaid would pay for Medicare Part C co-Insurance to the amount Medicaid would have paid if it was the primary payer minus the amount Medicare Part C already paid for the service except such limit does not apply to services provided by ambulance providers or psychologists, or outpatient services provided by OMH Article 16, 31, and 32 facilities and Article 28 clinics.
- **Electronic Medicaid Systems Account.** The Executive Budget would provide \$404 million for contractual services to operate an electronic Medicaid eligibility verification system, Medicaid override application system, and Medicaid management information system. Part of this allocation would also be used for contractual services to develop and operate a replacement electronic Medicaid system.

Medicaid Managed Care (MMC), Managed Long Term Care (MLTC), and Child Health Plus (CHP)

- **MLTC Eligibility.** The Governor proposes to reinstate the requirement that MLTC eligibility be limited to enrollees who require a nursing facility level of care. Current MLTC enrollees would be grandfathered in unless disenrolled from MLTC at which time the new requirements would apply.
- **MLTC Transportation Carve-Out.** This proposal provides for the Department of Health to contract with a transportation manager for the provision of transportation that is currently provided by MLTC plans.
- **Encounter Data Submission Penalties.** The Executive Budget proposes to give the Department the authority to impose penalties on Plans related to untimely or incomplete submission of encounter data that Plans are required to report under the model contract. OHIP had indicated its intention to pursue this approach at recent Monthly Meetings. Any penalty imposed would be calculated as a percentage of the administrative component of the Medicaid premium calculated by the Department. Encounter data submitted or resubmitted past the deadline in the model contract would result in a 1.5% reduction. Incomplete or inaccurate encounter data that does not conform to Department-developed benchmarks for completeness and accuracy would result in a 0.5% reduction. Submitted data that results in a rejection rate in excess of 10% of Department-developed volume benchmarks would result in a 0.5% reduction. Penalties could be cumulative. The proposed language gives the Department the authority to waive the penalties.

Plans have raised concerns about this approach in multiple venues, citing an apparent disconnect between OHIP requirements and APD/Encounter Reporting efforts that are evolving and occasionally causing submission challenges beyond Plans' control. While the mainstream managed care model contract already includes the authority for the Department to impose penalties for failing to submit or correct encounter data, this language takes a different approach by expanding the issues that could trigger penalties and using the rate reduction instead of the per-day penalty included in the model contract.

- **Health Home Coordination with the Criminal Justice System.** The Executive Budget proposes to modify language enacted in 2015-16 that established funding for a Health Homes criminal justice initiative. The Governor adds language expanding participation in the program to include health homes participating in a criminal justice pilot program with the purpose of enrolling incarcerated individuals with serious mental illness, two or more chronic conditions, or HIV/AIDS into such health home.
- **Patient Centered Medical Homes.** This proposal would permanently extend the authority for the Department of Health to designate and pay enhanced rates to Patient Centered Medical Homes.
- **OMH Clinical Records.** This proposal would provide the authority for OMH licensed facilities to share clinical records with managed care organizations, behavioral health

organizations, Health Homes, and other entities identified by the Department of Health for clients enrolled in or receiving services from such organizations. Today such records may only be shared with managed care organizations for payment purposes.

- **HIV SNP Extender.** The Governor proposes to permanently extend the statutory authority for HIV Special Needs Plans.
- **Transition Behavioral Health to Managed Care.** The Executive Budget provides \$7 million in new Medicaid rate enhancements to provide financial stability to providers as they transition to managed care, including those that operate Free Standing Inpatient Alcohol Rehabilitation, Residential Rehabilitation Services for Youth, Residential Detox and Outpatient Detox services.

Delivery System Reform Incentive Payment Program (DSRIP)

- **DSRIP Funding.** The Executive Budget contains a re-appropriation of the State Share for DSRIP, a total of \$4 billion. According to the Governor, in the first two years, \$1.7 billion has been awarded under the waiver. This includes \$963 million to 25 Performing Provider Systems (PPSs) statewide so that these consortiums of regional providers can implement approved Delivery System Reform Incentive Payments (DSRIP) program transformation projects; \$280 million for Health Homes and other reform initiatives; and \$500 million for financially distressed safety net hospitals whose viability is critical to achieving ongoing reforms.

Pharmacy

The Executive Budget includes a number of changes to the Medicaid prescription drug program, including:

- **Prescriber Prevails.** The Executive Budget proposes to eliminate “prescriber prevails” in both the Fee-For-Service and the Medicaid Managed Care programs for all drug classes with the exception of atypical antipsychotics and antidepressants. Currently, prescriber prevails applies to all drug classes in the FFS program and to nine drug classes (atypical antipsychotic, anti-depressant, anti-retroviral, anti-rejection, seizure, epilepsy, endocrine, hematologic and immunologic) in the MMC program.
- **Transparency and Cost Controls.** The Executive Budget proposes a new program by which the Department would identify certain “Critical Prescription Drugs” which would be subject to certain reporting requirements and increased rebates. The proposal identifies a number of criteria to be considered by the Department when identifying drugs to be included, such as the seriousness and prevalence of the disease or condition that is treated by the drug, the extent of utilization of the drug, the average wholesale and retail price of the drug, and the cost impact on public health programs. Once a drug is included on the “Critical Prescription Drug List,” manufacturers of the drug would be required to report a wide range of information to the Department on a prescribed form. Reporting would include:

- The actual cost of developing, manufacturing, producing (including the cost of per dose production), and distributing such drug;
- Research and development costs of the drug including payments to predecessor entities conducting research and development, including but not limited to biotechnology companies, universities and medical schools, and private research institutions;
- Administrative, marketing and advertising costs for the drug, apportioned by marketing activities that are directed to consumers, marketing activities that are directed to prescribers, and the total cost of all marketing and advertising that is directed primarily to consumers and prescribers in New York, including but not limited to prescriber detailing, copayment discount programs and direct to consumer marketing;
- Prices for the drug that are charged to purchasers outside the US;
- Prices charged to typical purchasers in New York, including but not limited to pharmacies, pharmacy chains, pharmacy wholesalers or other direct purchasers;
- The average rebates and discounts provided per payor type;
- The average profit margin of each drug over the prior five year period and the projected profit margin anticipated for such drug; and
- Clinical information including but not limited to clinical trials and clinical outcomes research.

The proposal includes protections from public disclosure so that the identity of a specific manufacturer or prices charged by the manufactures are not released except as the Commissioner determines is necessary to carry out the provisions or the program or to allow the Department, the Attorney General, the Office of State Comptroller or CMS to perform audits or investigations.

The information provided to the Department by manufacturers will be provided to the Department's actuary so that the actuary may conduct a value-based assessment of the drug and establish a reasonable ceiling price. The proposal then empowers the Department to require a manufacturer to provide rebates to the Department at a level that ensures the price of such drug does not exceed the ceiling price when dispensed to Medicaid enrollees in both the FFS and the MMC programs.

- **Generic Rebate Parity.** The Executive Budget contains a provision that would permit the Department to require rebates on generic drugs when the price of such a drug increases at a rate greater than the rate of inflation. These rebates would be in addition to any other rebate required by federal or state law. The Department would determine the amount of the rebate in a manner similar to that applied to brand rebates under the ACA. Under that approach, the additional rebate is calculated by multiplying the number of units dispensed by the amount the Average Manufacturer Price ("AMP") for the period in question exceeds a baseline AMP adjusted for inflation.
- **Pharmacy Reimbursement for Specialty Drugs.** The Executive Budget proposes to supersede existing FFS pharmacy reimbursement rules (e.g. AWP-25%, AWP-17%,

SMAC) when a drug is designated a “specialty drug” by one or more managed care providers. Under such circumstances, the reimbursement to the pharmacy cannot exceed the amount managed care providers pay for the drug, as determined by the Department using managed care plan encounter data. If enacted as proposed, this provision would be effective on October 1, 2016.

- **Clinical Drug Review Program.** The Executive Budget once again includes a proposal to expand the Commissioner’s authority to require prior authorization of a prescription drug under the Clinical Drug Review Program (“CDRP”), which is applicable in the Fee-For-Service program. Current law requires the Drug Utilization Board to consider various factors such as the potential for abuse and a history of inappropriate or overuse, and recommend the imposition of prior authorization for particular drugs. The Executive Budget would permit the Commissioner to add drugs to the CDRP prior to the evaluation and recommendation of the Drug Utilization Board and then empowers the Board to adjust or remove such requirements after the fact. The proposal has been rejected by the Legislature in previous budget cycles.
- **Direct Negotiation.** The Executive Budget proposes a technical modification to language included in the 2015-16 Enacted Budget that gave the Department the authority to directly negotiate supplemental rebates for Managed Care utilization with respect to antiretrovirals and hepatitis C agents. The language clarifies that the Department also has the authority to include FFS utilization in negotiations under this provision. This is consistent with the original intent of the language which simply sought to add managed care utilization to the Department’s existing authority to negotiate supplemental rebates related to the FFS program.
- **Opioid Prescribing.** The Executive Budget proposes to require MMC plans to require prior authorization of any prescription for an opioid analgesic in excess of four prescriptions in a 30-day period. This policy has been adopted in the FFS program at the recommendation of the DUR Board.

Health Planning and Public Health Promotion

- **Limited Services Clinics (Retail Clinics).** The Executive Budget would authorize a corporation (including a publicly-traded corporation) to establish and operate diagnostic or treatment centers to provide health care services within the space of a retail business operation, such as a pharmacy. Such operations would be operated as “Limited Services Clinics.” The proposal would require DOH, in consultation with the PHHPC, to promulgate regulations regarding the establishment and operation of limited service clinics, such as accreditation and limiting the scope of services that may be provided. The proposal provides that operators would be exempt from statutory requirements regarding a determination of public need.

This proposal was also included in the Executive 2015-16 proposed budget, however, this year’s proposal further limits retail clinic activities scope of services to treatment for minor acute episodic conditions; episodic preventative and wellness treatments; and

treatments for minor non-life threatening traumas. This year's proposal also includes provisions which emphasize the communication and collaboration with patients' primary care physicians. Also, the proposal would allow diagnostic and treatment centers, community health centers, and FQHCs to operate retail clinics. The Department would consider whether an operator has fulfilled its commitment to operate retail clinics in medically underserved areas before approving additional retail clinic locations.

- **DASNY Financing for OASAS Integrated Service Providers.** The Governor proposes to amend the Facilities Development Corporation (FDC) Act to allow any OASAS treatment facility that also operates as an "associated health care facility" to access DASNY financing for infrastructure projects. Co-licensed OASAS and OMH facilities are already eligible for DASNY financing under the statute. The amendment is required because current law does not allow OASAS clinics that operate as a health care facility to access State supported debt through the FDC. The integrated health services that would be eligible under the proposal are broadly defined to include not just Article 28 clinics but presumably any facility licensed by DOH or OMH that provide treatment or health care services, regardless of whether those individuals are receiving treatment for alcohol, substance abuse, or chemical dependency, expanding the eligibility pool to include OASAS licensed clinics that do not provide OASAS services.
- **Expanded Resources to Combat Breast Cancer.** The Governor proposes to allocate \$19 million to enhance breast cancer screening operations in New York by making screening more accessible. This includes expanded hours for clinics offering screenings, additional screening locations, and mobile screening efforts. In conjunction with this initiative, the Governor has directed DFS to ensure that health insurers provide coverage for breast cancer screening.
- **Funding for Heroin Epidemic.** The Executive Budget provides \$141 million, an increase of \$6 million from FY 2016, to address the growing heroin and opiate epidemic in communities across the State. These funds will continue to support prevention, treatment and recovery programs targeted toward chemical dependency, residential service opportunities, and public awareness and education activities.
- **Public Service Education Activities.** The Executive Budget proposes to continue to finance public service education activities with revenues generated from an assessment on cable television companies. The budget allocates \$454,000.
- **Family Planning Grant Funding.** This provision proposes to maintain funding for family planning services grants at \$23,701,700.
- **Roswell Park Cancer Institute Funding.** This provision consolidates existing appropriations for Roswell, but maintains state support at \$87.1 million. An additional \$15.5 million has been allocated to support capital expenses.
- **Indian Health Care Services.** This budget allocates \$22.5 million in program spending to support Indian health care services.

Hospitals

- **Intergovernmental Transfers and DSH Payments (extender).** The Governor proposes to permanently extend the authority of the Department of Health to make IGT/DSH payments to public hospitals outside of New York City, Nassau, Westchester, and Erie County. The current statutory authority is set to expire at the end of the 2015-16 SFY (March 31, 2016).
- **General Hospital Safety-Net Providers.** The Governor proposes to allocate \$137 million for general hospitals that are safety-net providers that evince severe financial distress.

Health Insurance

- **Commercial Coverage for Early Intervention Services.** The Executive Budget resurrects a number of coverage related proposals from prior Budgets which are designed to shift the cost of EI services from the state and counties to commercial insurance. Currently, most EI claims for such services as speech and physical therapy are denied as being developmental and not medically necessary. To ensure coverage, the Governor proposes the following:

Medical Necessity

- For services that are both Essential Health Benefits and Early Intervention services or evaluation services, a written order or referral for services to determine program eligibility or an Individualized Family Services Plan shall be deemed to meet any medical necessity requirements, including prior authorization. Thus, an insurer's ability to conduct medical necessity or medical management will be severely curtailed.

Payment

- Covered Early Intervention claims must be paid at the greater of the DOH rate or the negotiated rate.
- Payment must be made to the provider submitting the claim, rather than to the rendering provider or to the member, regardless of whether the provider is participating in the insurer's network.

Covered Claims

- Early Intervention claims cannot be denied based on any of the following: location of services, whether the child's condition is amenable to significant improvement in a short period of time, the services are not a covered services but is an Essential Health Benefit, or the provider is not a participating provider.

- **Prompt Payment for EI Services.** The Executive budget proposes to add new provisions to the existing health insurer prompt pay law to include specific requirements for EI services. Under the proposal:
 - All insurers would be required to notify EI providers through DOH's fiscal agent (PCG) within 15 business days of receipt of a claim whether the claim is fully insured and therefore subject to the prompt pay provisions.
 - Within the 15-day period, the insurer must also request any additional information needed to determine liability to pay an EI claim (this is in contrast to the 30 calendar days required for requests of additional information for all other claims).
 - The insurer must pay all claims submitted by the EI service provider within 30 days of receipt of the original claim, or the requested information, if submitted electronically or 45 days by paper. The exception to this would be if a claim is not “reasonably clear” or there is a “reasonable basis” for fraud, in which case the plans would not need to comply.

In the event the insurer fails to comply with the provisions of the prompt pay law, the claim for services will be deemed covered and payable, with the insurer obligated to pay the claim at the higher of either a rate established by the Commissioner or the rate negotiated by the insurer.

For additional changes to the Early Intervention Program, See the section below on Early Intervention

Department of Financial Services (“DFS”) Funding.

The DFS is funded entirely by assessments on insurers and banks. Proposed funding for SFY 2016-17 increased by \$4 million from 2015-16 funding to \$345,046,963 (re-appropriation is \$3,106,000), with \$66,794,000 earmarked for the Administration Program; \$78,155,000 earmarked for the Banking Program, and \$200,097,963 earmarked for the Insurance Program.

DFS Sub-Appropriations include:

- To DOH for enhanced newborn screening = \$11,900,000
- To DOH for forge-proof pharmaceutical prescription program = \$14,500,000
- To Criminal Justice for TraCS program = \$1,950,000
- To Department of Law for investigating broker/insurance practices = \$1,789,451
- To DOH for Center for Community Health Program = \$13,230,000
- To DOL for appointing AG as special prosecutor for no-fault insurance litigation = \$5,253,413
- To division of homeland security and emergency services for expenses related to fire inspections and fire safety training programs at privately operated colleges and universities in New York State = \$1,169,765
- To division of homeland security and emergency services for expenses related to the repair and rehabilitation of the state fire training academy = \$500,000
- To division of homeland security and emergency services for expenses related to developing and promulgating fire safety standards for cigarettes pursuant to section 156-c of the executive law = \$1,019,781

- To the division of homeland security and emergency services for services and expenses related to the fire prevention and control program and the state fire reporting system = \$22,881,739
- To the division of homeland security and emergency services for expenses related to the urban search and rescue program = \$497,301
- To DOH for expenses incurred in the approval of managed care implementation plans = \$300,000
- To DOH for expenses incurred in the certification of managed care programs = \$300,000
- To the Department of State for expenses incurred in the enforcement, development and maintenance of the state building code = \$8,487,513
- To DOH for services and expenses related to the administration of the lead prevention program = \$677,000
- To DOH for expenses related to the administration of the childhood lead poisoning primary prevention program = \$9,891,300
- To DOH for services and expenses related to the administration of the lead poisoning prevention program = \$4,035,700
- To DOH for services and expenses related to the administration of the immunization program = \$7,520,000
- To the office of the inspector general for services and expenses = \$227,000
- To DOL or Department of Taxation for services and expenses related to the crime proceeds task force = \$938,000
- To the office of the inspector general for services and expenses = \$250,000
- To Department of Homeland Security for services related to fighting fires on state property = \$989,000
- For services and expenses related to the Healthy New York Program = \$35 million

State Employee Health Insurance

- **NYSHIP Retiree Health Insurance Premium Differential.** Under current law, the State reimburses retired former state employees for their health insurance costs if they had at least 10 years of state service. For State retirees with at least 10 years of service at grade 10 or higher, the State pays 84% of the cost of Individual Coverage and 69% of the cost of Dependent Coverage – the retiree pays 16% and 31% respectively. For State retirees with at least 10 years of service at grade 9 or lower, the State pays 88% of the cost of Individual Coverage and 73% of the cost of Dependent Coverage – the retiree pays 12% and 27% respectively.

The Governor's proposal seeks to establish a graduated health insurance reimbursement system for civilian State employees retiring on or after October 1, 2016 whereby retirees would contribute a greater share toward health insurance costs. The Governor's proposal does not apply to members of the NYS Local Police and Fire Retirement System, members of the uniformed personnel in the Department of Corrections and Community Supervision, and/or State employees who are determined to have retired with an ordinary, accidental, or performance of duty disability retirement.

The Governor's proposal seeks to enact the following contribution levels:

Years of Service	Grade 9 or lower		Grade 10 or higher	
	NYS Individual Contribution	NYS Dependent Contribution	NYS Individual Contribution	NYS Dependent Contribution
10	54%	39%	50%	35%
11	56%	41%	52%	37%
12	58%	43%	54%	39%
13	60%	45%	56%	41%
14	62%	47%	58%	43%
15	64%	49%	60%	45%
16	66%	51%	62%	47%
17	68%	53%	64%	49%
18	70%	55%	66%	51%
19	72%	57%	68%	53%
20	78%	63%	74%	59%
21	79%	64%	75%	60%
22	80%	65%	76%	61%
23	81%	66%	77%	62%
24	82%	67%	78%	63%
25	83%	68%	79%	64%
26	84%	69%	80%	65%
27	85%	70%	81%	66%
28	86%	71%	82%	67%
29	87%	72%	83%	68%
30	88%	73%	84%	69%

The Governor's proposal estimates the graduated reimbursement system will reduce NYSHIP costs by \$3 million and impact 2,815 retirees and dependents in SFY 2017. By 2020, the Governor's proposal projects annual savings of \$24.5 million.

- Medicare Part B Reimbursement Cap.** Under current law, the State provides full reimbursement of the Medicare Part B standard premium (\$104.90 per month) to all eligible state retirees. The Governor's proposal seeks to cap State reimbursement at the current monthly premium and eliminate State reimbursement for the federal Cost of Living Adjustment of 2% (\$17 per month) for all eligible retirees effective October 1, 2016. The Governor's proposal estimates that the Medicare Part B Cap will save \$942,000 dollars in SFY 2017 and result in annual savings of \$6.9 million by SFY 2020.
- Income Related Medicare Adjustment Amounts (IRMAA) Reimbursement.** The Governor's proposal would amend the Civil Service Law to cease reimbursement of additional Income Related Medicare Adjustment Amount premiums paid by higher-income state retirees retroactive to January 1, 2016.

To minimize employee health benefit costs, the State requires all retirees participating in the NYSHIP to enroll in Medicare Part B upon turning age 65. After enrolling in Medicare Part B, the federal government requires enrollees to pay a monthly premium (\$104.90 in 2016). State retirees pay this monthly premium to the federal government (typically taken as a Social Security check deduction), but are later reimbursed the full amount by the State as a credit in their monthly pension allowance.

Hospital Excess Liability Pool

- **Hospital Excess Liability Pool:** The Excess Pool provides a secondary layer of medical malpractice coverage to qualified physicians and dentists, supplementing their primary individual coverage. The proposed budget would extend the Excess Pool as currently designed through June 30, 2017 and to authorize the Department of Financial Services to purchase coverage for eligible physicians and dentists for the period of July 1, 2016 to June 30, 2017; however, it contains substantial changes to the Pool that result in a reduction in funding. The proposal would extend for an additional year the provision contained in the 2013-14 final Budget that limits eligibility for enrollment in the Excess Pool to physicians and dentists who were provided coverage through the Excess Pool in the previous year, thus those covered from July 1, 2013 to June 30, 2014, subject to openings due to attrition. The budget appropriates \$102.4 million for the pool for 2016-17, a reduction of \$25 million in funding from 2015-16, through a Department of Health sub-appropriation to DFS. Beginning in July, 2017, DFS will be required to rank specialty and geographic location combinations by risk level to determine the allocation of funds from the hospital excess liability pool. This ranking would become the new basis for distributing funds under this program as DFS would be grant priority for purchasing policies in descending order beginning with the highest risk territory.

Mental Health & Human Services

- **Office of Mental Health (OMH) Recovery of Medicaid Exempt Provider Income.** The Governor proposes to extend until June 30, 2019, the authority of OMH to recoup Medicaid Exempt Income from community residence and family based treatment providers. Medicaid Exempt Income is defined as the amount of revenue received by providers that exceeds the fixed amount of annual budgeted Medicaid revenue as established by the Office. The proposal would authorize the OMH Commissioner to recover 50% of the Medicaid Exempt Income.
- **Extend Authorization for Comprehensive Psychiatric Emergency Program (CPEP).** The Governor's proposal would extend the statutory authority for CPEPs until July 1, 2020. CPEPs which were established in 1989 as an alternative to providing emergency psychiatric treatment in the emergency rooms of general hospitals. CPEPs provide specialized triage, assessment, intervention and community linkages for individuals experiencing a psychiatric crisis.
- **Nurse Practice Act Exemption.** The Governor proposes to extend for five years, statutory provisions which exempt from licensure requirements social workers and other

mental health clinicians who work in programs that are regulated, operated, funded or approved by OMH, DOH, SOFA, OCFS, DOCCS, OTDA, OASAS, OPWDD, and local governmental units or social services districts.

- **Establishment of Jail-based Restoration to Competence Programs.** When a defendant in a criminal trial is, after evaluation, determined to be incompetent to participate in his or her defense, the Court may order a period of treatment intended to restore competence. In New York this treatment is provided in forensic beds operated by OMH and/or OPWDD. The Governor's proposal would authorize OMH to work with volunteer Counties to establish jail-based restoration to competence programs. The Governor argues that jail-based restoration to competence programs can provide effective treatment for one third of the cost of providing the treatment in state operated beds thus accomplishing significant savings to both the State and the Counties.
- **Temporary Operators for OMH and OPWDD Facilities.** The Governor proposes to amend the Mental Hygiene Law to authorize the appointment of a temporary operator in mental health facilities, programs and services where the Office of Mental Health or the Office for People with Developmental Disabilities finds that: (1) the facility is experiencing serious financial instability, (2) the facility is unable or unwilling to ensure the proper operation of its program, (3) there are conditions that seriously endanger continued access to necessary services within the community, or (4) the established operator requests the appointment of a temporary operator. Temporary operators would carry out specified duties for a term of ninety (90) days, with the possibility of a term extension, until an approved succession plan is in place. The proposal includes an administrative review process for facilities who disagree with the decision to appoint a temporary operator.

Bioscience Funding

- **Stem Cell Funding.** The Governor proposes to maintain funding at \$44,800,000 for the Empire State Stem Cell Research Account, consistent with SFY 2015-16 levels.
- **Spinal Cord Injury Research Fund Account.** The Governor proposes to continue allocate \$8.5 million.

Early Intervention

The Executive Budget includes a number of significant changes to the Early Intervention ("EI") Program, including:

- **Eligibility and Evaluation.** This proposal would amend the Public Health Law to update the eligibility and evaluation process used to determine a child's eligibility for the Early Intervention (EI) Program. The eligibility determination process would include a mandatory primary referral to the EI program by a referral source, such as a healthcare provider or school using a referral form, followed by a disability screening by the EI program using the DOH approved "standard instrument". If a child is determined

eligible, he/she would undergo an evaluation to determine his/her needs; and the family would undergo a voluntary assessment to identify their capacity to meet the child's needs. Children diagnosed with a physical or mental condition with a high probability of resulting in developmental delay would not be required to undergo the screening process, and instead, eligibility would be determined by the child's medical or other records. The amendments also identify certain parental rights with respect to the provision of information, consent, and assessment requests.

- **Submission of Claims by EI Providers.** The Executive budget would require all EI providers to submit all claims within ninety days of the date of service, unless the delay is due to extraordinary circumstances documented by the provider. All claims submitted after 90 days must be submitted within 30 days from the time the extraordinary circumstance no longer applied. Claims not submitted within 90 days would be ineligible for reimbursement from the municipality or state fiscal agent. It would also require EI providers to enroll in one or more health care clearinghouses for processing claims to third party payors.

We will continue to analyze each of the above reference provisions and other provisions of the Budget and will, if necessary, provide a more detailed analysis. Please feel free to contact us if you have any questions.