

2016-17 NEW YORK STATE EXECUTIVE BUDGET

**HEALTH AND MENTAL HYGIENE
ARTICLE VII LEGISLATION**

MEMORANDUM IN SUPPORT

2016-17 NEW YORK STATE EXECUTIVE BUDGET

HEALTH AND MENTAL HYGIENE ARTICLE VII LEGISLATION

MEMORANDUM IN SUPPORT

CONTENTS

PART	DESCRIPTION	STARTING PAGE NUMBER
A	This bill modifies New York City's local funding contribution under the Medical Assistance Program	5
B	This bill makes statutory changes necessary to continue implementation of Medicaid Redesign Team recommendations	6
C	This bill would extend the Physicians Excess Medical Malpractice Program and amends its distribution methodology	8
D	This bill extends the authorization to make Disproportionate Share Payments, to operate certain Special Needs Plans, to continue the current reimbursement methodology for general hospitals regarding behavioral rates, to operate the Patient Centered Medical Home Program, and to authorize temporary operators of adult homes	9
E	Reform the Early Intervention program	10
F	Modify the Health Care Facility Transformation program	12
G	This bill makes statutory changes necessary to allow retail business operations to operate limited services clinics	13
H	Authorizes the Office of Mental Health to continue to recover Medicaid exempt income from providers of community residences	14
I	Extend authorization for the Comprehensive Psychiatric Emergency Program (CPEP)	15

PART	DESCRIPTION	STARTING PAGE NUMBER
J	Extends for five years the long-time exemption from licensure for individuals working in certain programs and services that are regulated, operated, funded or approved by the Office of Mental Health (OMH), the Office for People with Developmental Disabilities (OPWDD), the Office for Alcoholism and Substance Abuse Services (OASAS), the Department of Health (DOH), the State Office for the Aging (SOFA), the Office of Children and Family Services (OCFS), the Department of Corrections and Community Services (DOCCS), the Office of Temporary and Disability Assistance (OTDA) and/or local governmental units or social service districts	15
K	Authorizes the Office of Mental Health to work with volunteering counties to establish jail-based restoration to competency programs for individuals awaiting trial	17
L	Provides authority for OMH and OPWDD to appoint temporary operators for the continued operation of programs and the provision of services for persons with serious mental illness and/or developmental disabilities	18
M	This would permit State operated facilities to share clinical records with managed care organizations	19
N	This bill would authorize an OASAS licensed treatment facility that provides alcohol and/or substance abuse services to also operate a traditional physical health care clinic, while remaining eligible for DASNY financing	20

MEMORANDUM IN SUPPORT

A BUDGET BILL submitted by the Governor in
Accordance with Article VII of the Constitution

AN ACT to amend chapter 58 of the laws of 2005, relating to authorizing reimbursements for expenditures made by or on behalf of social services districts for medical assistance for needy persons and the administration thereof, in relation to the expenditure cap for the medical assistance program for needy persons (Part A); to amend the social services law, in relation to provisions relating to transportation in the managed long term care program; to amend the public health law, in relation to restricting the managed long term care benefit to those who are nursing home eligible; to amend the social services law, in relation to conforming with federal law provisions relating to spousal contributions, community spouse resource budgeting; to amend the social services law, in relation to authorizing price ceilings on blockbuster drugs and reducing reimbursement rates for specialty drugs; to amend the public health law, in relation to expanding prior authorization for the clinical drug review program and eliminating prescriber prevails; to amend the social services law, in relation to authorizing the commissioner of health to apply federally established consumer price index penalties for generic drugs, to facilitate supplemental rebates for fee-for-service pharmaceuticals, to apply prior authorization requirements for opioid drugs, to impose penalties on managed care plans for reporting late or incorrect encounter data, to apply cost sharing limits to medicare Part C claims and to authorize funding for the criminal justice pilot program within health home rates; to amend chapter 59 of the laws of 2011, amending the public health law and other laws relating to known and projected department of health state fund Medicaid expenditures, in relation to extending the expiration of certain provisions thereof; and to repeal certain provisions of the social services law relating to the authorization of prescriber prevails in the managed care program (Part B); to amend chapter 266 of the laws of 1986, amending the civil

practice law and rules and other laws relating to malpractice and professional medical conduct, in relation to apportioning premium for certain policies and to amend part J of chapter 63 of the laws of 2001 amending chapter 266 of the laws of 1986, amending the civil practice law and rules and other laws relating to malpractice and professional medical conduct, in relation to extending certain provisions concerning the hospital excess liability pool (Part C); to amend chapter 474 of the laws of 1996, amending the education law and other laws relating to rates for residential healthcare facilities, in relation to extending the authority of the department of health to make disproportionate share payments to public hospitals outside of New York City; to amend chapter 649 of the laws of 1996, amending the public health law, the mental hygiene law and the social services law relating to authorizing the establishment of special needs plans, in relation to the effectiveness thereof; to repeal subdivision 8 of section 84 of part A of chapter 56 of the laws of 2013, amending the public health law and other laws relating to general hospital reimbursement for annual rates, relating to the effectiveness thereof; to repeal subdivision (f) of section 129 of part C of chapter 58 of the laws of 2009, amending the public health law relating to payment by governmental agencies for general hospital inpatient services, relating to the effectiveness thereof; and to repeal subdivision (c) of section 122 of part E of chapter 56 of the laws of 2013, amending the public health law relating to the general public health work program, relating to the effectiveness thereof (Part D); to amend the public health law and the insurance law, in relation to the early intervention program for infants and toddlers with disabilities and their families (Part E); to amend the public health law, in relation to the health care facility transformation program (Part F); to amend the public health law, in relation to authorizing the establishment of limited service clinics (Part G); to amend part D of chapter 111 of the laws of 2010 relating to the recovery of exempt income by the office of mental health for community residences and family-based treatment programs, in relation to the effectiveness thereof (Part H); to amend chapter 723

of the laws of 1989 amending the mental hygiene law and other laws relating to comprehensive psychiatric emergency programs, in relation to the effectiveness of certain provisions thereof (Part I); to amend chapter 420 of the laws of 2002 amending the education law relating to the profession of social work, in relation to extending the expiration of certain provisions thereof; to amend chapter 676 of the laws of 2002 amending the education law relating to the practice of psychology, in relation to extending the expiration of certain provisions; and to amend chapter 130 of the laws of 2010 amending the education law and other laws relating to registration of entities providing certain professional services and licensure of certain professions, in relation to extending certain provisions thereof (Part J); to amend the criminal procedure law, in relation to authorizing restorations to competency within correctional facility based residential settings (Part K); to amend the mental hygiene law, in relation to the appointment of temporary operators for the continued operation of programs and the provision of services for persons with serious mental illness and/or developmental disabilities (Part L); to amend the mental hygiene law, in relation to sharing clinical records with managed care organizations (Part M); and to amend the facilities development corporation act, in relation to the definition of mental hygiene facility (Part N)

PURPOSE: This bill contains provisions needed to implement the Health and Mental Hygiene portions of the 2016-17 Executive Budget.

This memorandum describes Parts A through N of the bill which are described wholly within the parts listed below.

Part A – This bill modifies New York City’s local funding contribution under the Medical Assistance Program

Purpose:

This bill would re-institute the New York City contribution toward financing growth in Medicaid expenses.

Summary of Provisions and Statement in Support:

This bill would re-institute the New York City contribution toward financing growth in Medicaid expenses. The contribution level would be increased by \$180 million in FY 2017 and would grow to \$476 million in FY 2018, after reflecting its increased share of enhanced Federal Medicaid funding, as required under the ACA.

Budget Implications:

This bill would amend Section 1 of part C of Chapter 58 of the Laws of 2005 to increase New York City's contribution towards Medicaid by approximately 3.6 percent (\$180 million). The contribution would increase to \$476 million in FY 2018 and increase by \$129 million annually thereafter.

Effective Date:

The provisions of this bill would take effect April 1, 2016.

Part B – This bill makes statutory changes necessary to continue implementation of Medicaid Redesign Team recommendations

Purpose:

This bill makes statutory changes necessary to continue implementation of Medicaid Redesign Team recommendations.

Summary of Provisions and Statement in Support:

Section one of this bill amends Social Services Law §365-h to remove Medicaid transportation reimbursement from the Managed Long Term Care capitated rates (excluding the Program of All-inclusive Care for the Elderly) to fee-for-service management. The management of trips will be performed by a professional transportation management contractor procured by the State.

Section two of this bill amends Public Health Law §4403-f to restrict enrollees of Managed Long Term Care (MLTC) Plans to enrollees who require nursing home level of care. Existing MLTC members will be allowed to continue accessing services through the MLTC program.

Section three of this bill amends Social Services Law §366 to conform with Federal law in regard to spousal contributions and responsibilities for spouses residing together in the community.

Section four of this bill amends Social Services Law §366-c to change the threshold of spousal budgeting for community spouse resources, consistent with Federal law.

Section five of this bill amends Social Services Law §367-a by adding a new paragraph (g) to authorize the Commissioner to set a ceiling price for new high cost blockbuster drugs as determined by the State's actuary and to potentially require drug manufacturers to provide rebates to the Department of Health for certain critical prescription drugs.

Section six of this bill amends Social Services Law §367-a by adding a new paragraph (iv) to reduce reimbursement rates for certain specialty drugs to align with rates achieved by managed care plans.

Section seven of this bill amends Public Health Law §274 by adding a new subdivision 15 to authorize the Commissioner of Health to require prior authorization for fee-for-service drugs meeting the Clinical Drug Review Program criteria prior to obtaining the Drug Utilization Review Board's evaluation and recommendation.

Sections eight through ten of this bill amend Public Health Law §273 and Social Services Law §364-j to eliminate the prescriber's right of final determination, excluding mental health medications, when the justification for use is not clinically supported.

Section eleven of this bill amends Social Services Law §367-a by adding a new paragraph (f) to authorize the Commissioner to apply the Federally established Consumer Price Index (CPI) penalty for generic drugs.

Sections twelve and thirteen of this bill amend Social Services Law §367-a to make a technical correction to allow the Commissioner to negotiate directly with pharmaceutical manufacturers for supplemental rebates outside of the Preferred Drug Program on fee-for-service utilization for antiretrovirals and hepatitis C agents.

Section fourteen of this bill amends Social Services Law §364-j by adding a new subdivision 26-a to require managed care organizations to implement prior authorization of opioid analgesic refills exceeding four prescriptions in thirty days, consistent with existing fee for service policy.

Section fifteen of this bill amends Social Services Law §364-j by adding a new subdivision 32 to institute tiered penalties for the submission of late and/or inaccurate encounter data for Managed Care Organizations to ensure the collection of pharmacy rebates and timely rate setting.

Section sixteen of this bill amends Social Services Law §367-a to ensure that the Medicaid program will not pay any portion of costs associated with Medicare Part C claims when the total payment to the provider would be greater than the Medicaid rate of payment.

Section seventeen of this bill amends Social Services Law §365-l to make a technical change to the distribution of payments under the criminal justice pilot program within health homes.

Section eighteen of this bill amends the Laws of 2011 to extend the Medicaid Global Cap for State Fiscal Year 2018.

Budget Implications:

Enactment of this bill is necessary to implement the FY 2017 Executive Budget by keeping overall Medicaid spending within capped levels, which are indexed to the ten-year rolling average of the medical component of the Consumer Price Index as proscribed in current statute.

Effective Date:

This bill would take effect April 1, 2016 except that:

- Sections eight through ten shall take effect June 1, 2016;
- Sections four and sixteen shall take effect July 1, 2016; and
- Sections one, two and six shall take effect October 1, 2016.

Part C – This bill would extend the Physicians Excess Medical Malpractice Program and amends its distribution methodology

Purpose:

This bill would extend the Physicians Excess Medical Malpractice Program and amend its distribution methodology.

Summary of Provisions and Statement in Support:

Section one of this bill would amend subdivision 1 of section 18 of chapter 266 of the laws of 1986 to allow the Superintendent of the Department of Financial Services 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.

Sections two through six would amend chapter 266 of the laws of 1986 to extend the hospital excess liability pool by one year through June 30, 2017.

Budget Implications:

Enactment of this bill is necessary to implement the FY 2017 Executive Budget and generate \$25 million in annual State savings.

Effective Date:

This bill would take effect April 1, 2016 except that section two shall take effect July 1, 2017.

Part D – This bill extends the authorization to make Disproportionate Share Payments, to operate certain Special Needs Plans, to continue the current reimbursement methodology for general hospitals regarding behavioral rates, to operate the Patient Centered Medical Home Program, and to authorize temporary operators of adult homes

Purpose:

This bill extends the authorization to make Disproportionate Share Payments, to operate certain Special Needs Plans, to continue the current reimbursement methodology for general hospitals regarding behavioral rates, to operate the Patient Centered Medical Home Program, and to authorize temporary operators of adult homes.

Summary of Provisions and Statement in Support:

Section one of this bill amends chapter 474 of the Laws of 1996 to permanently extend the authority of the Department of Health to make Disproportionate Share/Inter-governmental Transfers (DSH/IGT) payments to public hospitals outside of New York City.

Section two of this bill amends chapter 649 of the Laws of 1996 to authorize the continued operation of Special Needs Plans serving persons with mental illness or the Human Immunodeficiency Virus. There are currently three Special Needs Plans statewide serving approximately 14,540 recipients.

Section three of this bill amends chapter 56 of the Laws of 2013 to permanently extend the annual reimbursement method for general hospitals regarding behavioral rates.

Section four of this bill amends chapter 58 of the Laws of 2009 to permanently extend the Patient Centered Medical Home program.

Section five of this bill amends chapter 56 of the Laws of 2013 to permanently extend authorization for temporary operators of adult homes.

Budget Implications:

Enactment of this bill is necessary to implement the FY 2017 Executive Budget. These proposals do not result in an increased State cost.

Effective Date:

This bill would take effect immediately.

Part E – Reform the Early Intervention program

Purpose:

This bill would reform the Early Intervention (EI) program by streamlining the eligibility process and ensuring appropriate health insurance reimbursement for covered EI services.

Summary of Provisions and Statement in Support:

EI provides a comprehensive array of therapeutic and support services to children under age three with confirmed disabilities (e.g., autism, cerebral palsy, Down Syndrome) or developmental delays in physical, cognitive, communication, social-emotional, or adaptive development. Services are provided at no cost to families participating in the program. The program is financed by a combination of State, local government, Medicaid, and commercial insurance dollars.

Currently, a child may be referred to EI when the child's parent or a "primary referral source" – such as a health care provider – believes that the child is suspected of having a developmental delay or certain diagnosed conditions. A multidisciplinary evaluation and assessment is conducted to determine the child's eligibility for EI. If the evaluator determines that the child is eligible, an Individualized Family Services Plan (IFSP) is developed, setting forth the services plan for the child and identifying the providers who would provide those services.

Sections 1 through 4 streamline the eligibility process and tailor the evaluation to the child in order to decrease the time from referral to the provision of services, and reduce unnecessary testing, or evaluations.

Sections 1 and 2 would amend PHL § 2541 to revise the definitions of "evaluation" and "evaluator" and to define the terms "multidisciplinary" and "screening."

Section 3 would amend PHL § 2542(3) to require persons who refer children to EI to inform parents that, for children with a diagnosed physical or mental condition, eligibility would be established through a records review.

Section 4 would amend PHL § 2544 to:

- Require service coordinators to inform parents of the screening, evaluation, and review procedures;
- Require screenings for children referred to EI to determine if they are suspected of having a disability; if, based on the screening, a child is suspected of having a disability, then an evaluation will be conducted;
- Establish that for children with a diagnosed physical or mental condition eligibility would be established using the child's medical or other records;

- Establish that if a child is found eligible, he or she will receive: an assessment to identify the services appropriate to meet his or her needs, a voluntary family-directed assessment, and an assessment of any transportation needs; and
- Require that, following a request by a parent, a full evaluation be conducted for a child who has a diagnosed physical or mental condition who was found ineligible following a records review.

Providers are required to seek reimbursement from third party payers in the first instance, including health insurers and Medicaid. Health insurers deny the majority of EI claims submitted, with one of the most common reasons being that the claim was not submitted timely. EI services not covered by third party payers are reimbursed by the municipality in which the child resides. Municipal governments are subsequently reimbursed by the State for 49 percent of the amount they reimburse providers.

Reforms enacted in Fiscal Year (FY) 2013 established a direct relationship between third party payers and a State Fiscal Agent to manage EI claims. However, in FY 2015 nearly 85 percent of claims submitted to private insurers were denied; insurers received \$80 million in claim submissions, of which they paid \$13 million. This is only 2 percent of total EI expenditures (\$591 million), compared with 38 percent (\$244 million) paid by Medicaid, 28 percent (\$160 million) by the State, and 32 percent (\$175 million) by municipalities.

The most common reasons for denials are:

- Lack of prior authorization;
- Location where the services are provided;
- Services provided are habilitative rather than rehabilitative;
- Provider is not in the insurer's network; and
- Claims were not submitted in a timely fashion.

Amending the Insurance Law to improve insurer reimbursement will yield savings to the State and municipalities.

Sections 5 through 7 improve the timeliness of health insurer payments, streamline the claims adjudication process, and improve insurer reimbursement by addressing the most common reasons for insurer denials; this will also provide savings to municipalities and the State.

Section 5 would amend PHL § 2559(3) to require providers to:

- Submit all claims within ninety days of the date of service; claims not submitted within ninety days would be ineligible for reimbursement from the municipality; and
- Enroll in one or more health care clearinghouses and agreements with insurers.

Section 6 would amend Insurance Law § 3224-a to:

- Require insurers to notify providers through DOH's fiscal agent within fifteen business days of receipt of a claim whether the health insurance policy covering the child is regulated by the State;
- Require insurers to request any additional information needed to determine liability to pay an EI claim within fifteen business days of receipt of the claim;
- Deem payable claims where the insurer has failed to adhere to its legal obligations under the Prompt Pay Law and require insurers to pay such claims at the higher of either rates established by DOH or rates negotiated by the insurer in accordance with regulation; and
- Add EI providers to the definition of "health care provider" in the Prompt Pay Law.

Section 7 would amend Insurance Law § 3235-a to require health insurers to, with respect to EI services:

- Accept a written order, referral, recommendation for diagnostic services to determine program eligibility, or IFSP as sufficient to meet any precertification, preauthorization, and/or medical necessity requirements;
- Reimburse at the higher of either a rate established by DOH or a negotiated rate;
- Cover services regardless of the location where the services are provided, the habilitative nature of the services, or whether the provider participates in the insurer's network;
- Cover services that are not covered under the child's policy but are considered essential health benefits under the Affordable Care Act; and
- Remit payment to the provider who submitted the claim and not to the child, the child's family, or the professional who delivered the service.

Section 8 would establish the effective date.

Budget Implications:

Enactment of this bill is necessary to implement the 2016-17 Executive Budget to achieve total net savings of \$5 million in FY 2017 and \$20.3 million in FY 2018.

Effective Date:

This bill would take effect April 1, 2016.

Part F – Modify the Health Care Facility Transformation program

Purpose:

This bill modifies the Health Care Facility Transformation program.

Summary of Provisions and Statement in Support:

The FY 2017 Executive Budget continues funding through the Health Care Facility Transformation Program enacted in 2016. Funding is financed through bonds issued by the Dormitory Authority of the State of New York (DASNY).

This bill modifies the program, without impacting funding for Brooklyn hospitals, to make funds available statewide and:

- Specifies that funding may be used to replace inefficient and outdated facilities as part of a merger, consolidation, acquisition or other significant corporate restructuring activity that is part of an overall transformation plan intended to create a financially sustainable system of care;
- Includes residential health care facilities, diagnostic and treatment centers, primary care providers, and home care providers as eligible applicants for funding;
- Requires applicants be deemed by the Commission of Health as a provider that fulfills or will fulfill a health care need for acute inpatient, outpatient, primary or residential health care services in a community; and
- Includes geographic distribution of funds and the extent to which the applicant has access to alternative financing as part of award criteria.

Budget Implications:

\$200 million in funding is maintained through this program to support the needs of health care facilities throughout the state under the terms of the proposed amendments.

Effective Date:

This bill would take effect April 1, 2016.

Part G – This bill makes statutory changes necessary to allow retail business operations to operate limited services clinics

Purpose:

This bill would make statutory changes necessary to allow retail business operations to operate limited services clinics.

Summary of Provisions and Statement in Support:

This bill would amend Section 2801-a of the Public Health Law to add a new section that allows retail business operations (i.e., pharmacies) to operate accredited Diagnostic and Treatment Centers known as Limited Services Clinics within their retail spaces, thus giving the Department of Health oversight over their physical property, scope of services, and quality of care.

Budget Implications:

Enactment of this bill is necessary to increase access to economical primary care services for Medicaid recipients and reduce unnecessary emergency room and inpatient visits. This bill is also necessary to implement the FY 2016-2017 Executive Budget and generate \$5 million in annual State savings.

Effective Date:

This bill would take effect on April 1, 2016.

Part H – Authorizes the Office of Mental Health to continue to recover Medicaid exempt income from providers of community residences

Purpose:

This bill would extend the Office of Mental Health's (OMH) authority to recover Medicaid exempt income from providers consistent with legislation enacted in prior years.

Summary of Provisions and Statement in Support:

This bill would amend unconsolidated law by extending the relevant fiscal period through to June 30, 2019, during which OMH may seek to recover excess income. Specifically, the bill validates the Commissioner of OMH's authority to recoup Medicaid exempt income from providers of community residences licensed by OMH. Legislation enacted in prior years extended and confirmed OMH's statutory authority to recoup exempt income for specific time periods.

This bill would allow OMH to continue its practice and permit it to recover an amount equal to fifty percent of the Medicaid revenue received by providers that exceeds the fixed amount of annual budgeted Medicaid revenue, as established by OMH. This authority is consistent with contractual agreements between OMH and residential providers. This bill is necessary to continue existing practice and avoid a loss of \$3 million in annual exempt income recoveries.

Recent legislation ratified OMH's authority to recoup exempt income during established timeframes, however, some providers maintained that OMH lacked sufficient legal authority to continue this action. Litigation brought against the State on this issue resulted in a favorable outcome and supported the agency's practice of recouping exempt income.

Budget Implications:

Enactment of this bill is necessary to implement the 2016-17 Executive Budget and will avoid a potential loss of \$3 million in recoveries on an annual basis.

Effective Date:

This bill would take effect immediately.

Part I – Extend authorization for the Comprehensive Psychiatric Emergency Program (CPEP)

Purpose:

This bill would extend the statutory authority for the Comprehensive Psychiatric Emergency Program (CPEP) until July 1, 2020.

Summary of Provisions and Statement in Support:

This bill would extend until July 1, 2020, the authority of the Commissioner of Mental Health to administer certificates for a CPEP. This section also extends to July 1, 2020, sections 1, 2 and 4 through 20 of Chapter 723 of the Laws of 1989, which explain the implementation and operation of the CPEP model.

The statutory authority for the CPEP program as established by Chapter 723 of the Laws of 1989, as amended, currently expires on July 1, 2016.

Budget Implications:

Enactment of this bill is necessary to continue essential services to at-risk individuals and this Executive Budget provides funding for the continued operation of 22 hospitals in New York State licensed to provide these services in accordance with the CPEP model.

Effective Date:

This bill would take effect immediately.

Part J – Extends for five years the long-time exemption from licensure for individuals working in certain programs and services that are regulated, operated, funded or approved by the Office of Mental Health (OMH), the Office for People with Developmental Disabilities (OPWDD), the Office for Alcoholism and Substance Abuse Services (OASAS), the Department of Health (DOH), the State Office for the Aging (SOFA), the Office of Children and Family Services (OCFS), the Department of Corrections and Community Services (DOCCS), the Office of Temporary and Disability Assistance (OTDA) and/or local governmental units or social service districts

Purpose:

This bill would extend for five years the current exemption for certain social work and mental health professional licensure requirements of persons employed by a program or service operated, regulated, funded or approved by OMH, OPWDD, OASAS, DOH, SOFA, OCFS, OTDA, DOCCS, and/or local governmental units or social services districts.

Summary of Provisions and Statement in Support:

This bill would amend Chapter 420 of the Laws of 2002, as amended by Chapter 57 of the Laws of 2013, in relation to the licensure of social workers and other mental health professionals, amends subdivision a of section 17-a of Chapter 676 of the Laws of 2002, as amended by Chapter 57 of the Laws of 2013, and amends section 16 of Chapter 130 of the Laws of 2010, as amended by Chapter 57 of the Laws of 2013. These laws include provisions that exempt from licensure individuals working in programs that are regulated, operated, funded or approved by OMH, DOH, SOFA, OCFS, DOCCS, OTDA, OASAS, OPWDD, and/or local governmental units or social services districts. Chapter 57 of the Laws of 2013 extended the exemption to July 1, 2016.

The existing licensure exemption has been in place since 2002. There has been no evidence to show that the added cost associated with eliminating the exemption would improve outcomes. Programs licensed, regulated, funded or approved by State agencies and/or local government units or social services districts are subject to State oversight, monitoring and regulation. These programs must comply with detailed State regulations, and, if funded by Medicaid, applicable Medicaid regulations and standards established by the Centers for Medicare and Medicaid Services. Other State and federal agencies that provide oversight of these programs include the DOH, U.S. Department of Health and Human Services, U.S. Department of Justice, New York State Office of the Medicaid Inspector General, New York State Office of the State Comptroller, New York State Justice Center for the Protection of People with Special Needs, The Joint Commission and the Commission on the Accreditation of Rehabilitation Facilities and New York State Family Court.

The purpose of the current exemption is to allow for greater State and local government flexibility in the delivery of services. Since many State-operated and local programs rely on social workers, psychologists, clinical coordinators, and other professionals to perform counseling, psychotherapy, and case management, failure to make the exemption permanent would have a significant negative impact on the delivery of services and may require the State and local governments to lay off professionals who do not meet current licensing standards, and replace them with licensed individuals.

This proposal compliments and supports the on-going Medicaid Redesign Team (MRT) initiative establishing Behavioral Health Homes as the current fee-for-service Behavioral Health benefits transition to managed care. Extending the current exemption will avoid

the adverse impact on the MRT Health Home initiative. The MRT team concluded that the impact on the quality of care would be profound, including the loss of culturally competent staff, and loss of certain master's level professionals. It would also cause disruptions in client care and loss of services.

Budget Implications:

Enactment of this bill is necessary to implement the 2016-17 Executive Budget because the additional costs resulting from new licensure requirements for the State and entities licensed and regulated by the State would be \$325 million annually. These additional costs primarily result from replacing current non-licensed staff with more expensive licensed staff, and re-classifying existing titles to higher grade levels. This does not include unemployment costs resulting from layoffs that may occur if the existing exemption is not extended. Extending this exemption would enable the State and those programs and services that it regulates, operates, funds or approves to continue providing quality services in the most cost effective manner.

Effective Date:

This bill would take effect immediately.

Part K – Authorizes the Office of Mental Health to work with volunteering counties to establish jail-based restoration to competency programs for individuals awaiting trial

Purpose:

This bill would authorize the Office of Mental Health (OMH) to permit restoration to competency within jail-based residential settings.

Summary of Provisions and Statement in Support:

This bill would amend Section 730.10 of the Criminal Procedure Law (CPL) to permit restoration to competency within a jail-based residential setting. Restorations are currently only authorized at OMH psychiatric centers, Office for People With Developmental Disabilities (OPWDD) development centers, psychiatric units at Article 28 hospitals, or on an outpatient basis in the community.

OMH currently supports approximately 300 inpatient forensic beds that are used to serve an estimated 620 annual admissions of felony defendants deemed incompetent to stand trial. The cost per restoration is approximately \$128,000 for a total of \$78 million in State Fiscal Year 2014-15 (the State and counties each pay 50 percent). By contrast, it is estimated that the per bed costs to restore these defendants in a local jail-based setting is roughly one-third of the cost at a state facility (about \$40,000 per bed annually). It is anticipated that several counties may soon advance proposals to develop residential mental health pod unit(s) within county jails. Since counties

reimburse OMH for the costs of any restorations that occur at state hospitals, this proposal would save participating counties 33 percent of what they spend for such services.

Restorations to competency in jail-based residential settings have been implemented in ten other states (including California, Florida and Texas) with well-documented success. Jail-based restoration was identified as a “best practice” by the National Judicial College. The California Legislative Analyst Office favorably evaluated pilot projects in that state and recommended expansion statewide. The California program also received the “Best Practice” award by the California Council on Mentally Ill Offenders.

Budget Implications:

Enactment of this bill is necessary to implement the 2016-17 Executive Budget and will generate savings of \$4.2 million when fully annualized.

Effective Date:

This bill would take effect immediately.

Part L – Provides authority for OMH and OPWDD to appoint temporary operators for the continued operation of programs and the provision of services for persons with serious mental illness and/or developmental disabilities

Purpose:

This bill would amend the Mental Hygiene Law (MHL) by adding two new sections in relation to the appointment and duties of temporary operators for mental health programs and for services certified by the Office for People With Developmental Disabilities (OPWDD).

Summary of Provisions and Statement in Support:

This bill would amend the MHL to add two new sections, 16.25 and 31.20, to allow OPWDD and the Office of Mental Health (OMH) to appoint temporary operators in certain circumstances.

The bill would articulate that the goal of imposing a temporary operator would be to: preserve limited resources; protect the health and safety of patients and individuals; and protect the State’s investment in such programs, services and facilities. Other legal options would remain available to OPWDD and OMH, such as revocation of an operating certificate or the creation of a receivership, when the program or provider of services appears unable to stabilize operations.

The bill would also:

- Identify the factors used to evaluate circumstances when a temporary operator may be necessary to maintain a program’s viability and protect the health and safety of patients and individuals;
- List the duties of a temporary operator;
- Identify the limitations on a temporary operator’s liability;
- Provide the duration of a temporary operator’s appointment;
- Establish provisions for notice to the existing operator of a temporary operator’s appointment;
- Provide the review available to the established operator who disagrees with the relevant commissioner’s intent to appoint a temporary operator; and
- Identify the continuing obligations of the established operator during the tenure of a temporary operator.

This proposal is modeled after the authority provided to the Office of Alcoholism and Substance Abuse Services (OASAS) in Chapter 56 of the Laws of 2013, which provided OASAS with the authority to appoint a temporary operator for chemical dependency treatment programs. The MHL currently does not provide the authority to OMH and OPWDD to appoint a temporary operator.

Budget Implications:

Enactment of this bill is necessary to implement the 2016-17 Executive Budget because it would provide OMH and OPWDD with the authority to ensure the appropriate use of funding for mental health and developmental disability programs.

Effective Date:

This bill would take effect immediately.

Part M – This would permit State operated facilities to share clinical records with managed care organizations

Purpose:

This bill would amend Section 33.13 of the Mental Hygiene Law (MHL) to permit facilities, including facilities operated or licensed by the Department of Mental Hygiene (the Department), to share clinical records with managed care organizations, behavioral health organizations, health homes, and other entities authorized by the Department or Department of Health (DOH) to provide, arrange or coordinate health care services for Medicaid recipients for whom such entities are responsible.

Summary of Provisions and Statement in Support:

Under Section 33.13(c) of the MHL, the release of clinical information tending to identify patients or clients by facilities to any person or agency is prohibited except as provided in the subsequent subsections, including subsection 33.13(c)(9)(i), which permits the

release of information to government agencies, insurance companies, and other third parties “requiring information necessary for payments to be made to or on behalf of patients or clients.”

Under Section 33.13(d) of the MHL, the exchange of identifiable information concerning patients or clients is also permitted between and among: (i) facilities or others providing services for such patients or clients pursuant to an approved local services plan, as defined in article forty-one of the MHL, or pursuant to agreement with the Department; and (ii) the Department or any of its licensed or operated facilities, as well as between and among hospital emergency services licensed pursuant to Article 28 of the Public Health Law and hospitals operated or licensed by the Office of Mental Health.

By broadening the scope of allowable disclosures permitted by Section 33.13 of the MHL to include Medicaid Managed Care organizations, this bill would increase the ability of such entities to provide higher quality, coordinated and cost-effective care to Medicaid recipients. The bill would also partially align federal and State law confidentiality protections, thus reducing operational barriers to participation in such initiatives by State-operated facilities. It would also promote the best interests of Medicaid beneficiaries enrolled in the Medicaid Managed Care program or receiving services under the Health Home program.

Furthermore, current State law confidentiality provisions codified in Section 33.13(c) of the MHL regarding allowable disclosures to insurance companies and other entities do not permit State-operated facilities to share information with such entities in cases where State-operated facilities are not pursuing payment from Medicaid Managed Care payers. This jeopardizes the ability of Medicaid Managed Care companies to adequately perform the obligations imposed on them by the State. Moreover, in cases where no payment is sought, current State law prohibits facilities from sharing information necessary to engage Medicaid Managed Care companies and other entities authorized to provide or coordinate care for Medicaid enrollees, especially at the time of discharge from an inpatient facility, in order to reduce expensive inpatient readmissions. This bill would address those concerns.

Budget Implications:

Enactment of this bill is necessary to implement the SFY 2016-17 Executive Budget because it would facilitate the provision of integrated and coordinated care, which would result in more efficient use of governmental resources.

Effective Date:

This bill would take effect immediately.

Part N – This bill would authorize an OASAS licensed treatment facility that provides alcohol and/or substance abuse services to also operate a traditional physical health care clinic, while remaining eligible for DASNY financing

Purpose:

New York State's Delivery System Reform Incentive Payment (DSRIP) Program is designed to fundamentally restructure the health care delivery system and reduce avoidable hospitalizations, provide better clinical management and improve overall health.

Under current law, OASAS-sponsored DSRIP-like integrated health facilities are prohibited from receiving State supported bonds for infrastructure projects. This bill would authorize OASAS treatment facilities that provide alcohol, substance abuse and/or chemical dependency services to also operate as a traditional physical health care clinic (i.e. Article 28 hospital), while also remaining eligible for DASNY financing.

Summary of Provisions and Statement in Support:

Effective immediately, this bill would amend the definition of mental hygiene facility within the Facilities Development Corporation (FDC) Act to include any treatment facility that operates an alcoholism or substance abuse treatment program and also operates an associated health care facility.

This bill would define an associated health care facility as an Article 28 licensed health care facility that provides health care services and/or treatment to all persons, regardless of whether such persons receive treatment for alcohol and/or substance abuse.

Under current law, State supported bonds support OASAS facilities that exclusively provide behavioral health care services. However, as the State moves to a more integrated model of physical and behavioral health care, a DASNY financing vehicle is necessary. This proposal would authorize State supported debt in these circumstances.

Budget Implications:

This bill would allow integrated health care models to qualify for State supported debt. Although it expands eligibility, all integrated behavioral and physical health care models would be funded consistent with existing OASAS processes and within existing Financial Plan resources.

Effective Date:

This bill would take effect immediately.

The provisions of this act shall take effect immediately, provided, however, that the applicable effective date of each part of this act shall be as specifically set forth in the last section of such part.