

S. 6407

A. 9007

S E N A T E - A S S E M B L Y

January 14, 2016

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IN SENATE -- A BUDGET BILL, submitted by the Governor pursuant to article seven of the Constitution -- read twice and ordered printed, and when printed to be committed to the Committee on Finance

IN ASSEMBLY -- A BUDGET BILL, submitted by the Governor pursuant to article seven of the Constitution -- read once and referred to the Committee on Ways and Means

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

EXPLANATION--Matter in *ITALICS* (underscored) is new; matter in brackets [ ] is old law to be omitted.

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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)

THE PEOPLE OF THE STATE OF NEW YORK, REPRESENTED IN SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

1 Section 1. This act enacts into law major components of legislation  
2 which are necessary to implement the state fiscal plan for the 2016-2017  
3 state fiscal year. Each component is wholly contained within a Part  
4 identified as Parts A through N. The effective date for each particular  
5 provision contained within such Part is set forth in the last section of  
6 such Part. Any provision in any section contained within a Part, includ-  
7 ing the effective date of the Part, which makes a reference to a section  
8 "of this act", when used in connection with that particular component,  
9 shall be deemed to mean and refer to the corresponding section of the  
10 Part in which it is found. Section three of this act sets forth the  
11 general effective date of this act.

12 PART A

13 Section 1. Section 1 of part C of chapter 58 of the laws of 2005,  
14 relating to authorizing reimbursements for expenditures made by or on  
15 behalf of social services districts for medical assistance for needy  
16 persons and the administration thereof, subdivision (a) as amended by  
17 section 3-e of part B of chapter 58 of the laws of 2010, subdivision (b)  
18 as amended by section 24 of part B of chapter 109 of the laws of 2010,  
19 subdivision (c-1) as added by section 1 of part F of chapter 56 of the  
20 laws of 2012, subdivision (f) as amended by section 23 of part B of  
21 chapter 109 of the laws of 2010, paragraph (iii) of subdivision (g) as  
22 amended by section 2 of part F of chapter 56 of the laws of 2012, subdi-  
23 vision (h) as added by section 61 of part D of chapter 56 of the laws of  
24 2012, is amended to read as follows:

25 Section 1. (a) Notwithstanding the provisions of section 368-a of the  
26 social services law, or any other provision of law, the department of  
27 health shall provide reimbursement for expenditures made by or on behalf  
28 of social services districts for medical assistance for needy persons,  
29 and the administration thereof, in accordance with the provisions of  
30 this section; provided, however, that this section shall not apply to  
31 amounts expended for health care services under FORMER section 369-ee of  
32 the social services law, which amounts shall be reimbursed in accordance  
33 with paragraph (t) of subdivision 1 of section 368-a of such law and  
34 shall be excluded from all calculations made pursuant to this section;  
35 and provided further that amounts paid to the public hospitals pursuant  
36 to subdivision 14-f of section 2807-c of the public health law and  
37 amounts expended pursuant to: subdivision 12 of section 2808 of the  
38 public health law; sections 211 and 212 of chapter 474 of the laws of  
39 1996, as amended; and sections 11 through 14 of part A and sections 13  
40 and 14 of part B of chapter 1 of the laws of 2002; and amounts paid to  
41 public diagnostic and treatment centers as provided in sections 3-a and  
42 3-b of part B of [the] chapter 58 of the laws of 2010 [which amended  
43 this subdivision], amounts paid to public general hospitals as certified  
44 public expenditures as provided in section 3-c of part B of [the] chap-  
45 ter 58 of the laws of 2010 [which amended this subdivision], and amounts  
46 paid to managed care providers pursuant to section 3-d of part B of  
47 [the] chapter 58 of the laws of 2010 [which amended this subdivision],  
48 shall be excluded from all calculations made pursuant to this section.

49 (b) Commencing with the period April 1, 2005 through March 31, 2006, a  
50 social services district's yearly net share of medical assistance  
51 expenditures shall be calculated in relation to a reimbursement base

1 year which, for purposes of this section, is defined as January 1, 2005  
2 through December 31, 2005. The final base year expenditure calculation  
3 for each social services district shall be made by the commissioner of  
4 health, and approved by the director of the division of the budget, no  
5 later than June 30, 2006. Such calculations shall be based on actual  
6 expenditures made by or on behalf of social services districts, and  
7 revenues received by social services districts, during the base year and  
8 shall be made without regard to expenditures made, and revenues  
9 received, outside the base year that are related to services provided  
10 during, or prior to, the base year. Such base year calculations shall be  
11 based on the social services district medical assistance shares  
12 provisions in effect on January 1, 2005. Subject to the provisions of  
13 subdivision four of section six of this part, the state/local social  
14 services district relative percentages of the non-federal share of  
15 medical assistance expenditures incurred prior to January 1, 2006 shall  
16 not be subject to adjustment on and after July 1, 2006.

17 (c) Commencing with the calendar year beginning January 1, 2006,  
18 calendar year social services district medical assistance expenditure  
19 amounts for each social services district shall be calculated by multi-  
20 plying the results of the calculations performed pursuant to paragraph  
21 (b) of this section by a non-compounded trend factor, as follows:

22 (i) 2006 (January 1, 2006 through December 31, 2006): 3.5%;

23 (ii) 2007 (January 1, 2007 through December 31, 2007): 6.75% (3.25%  
24 plus the prior year's 3.5%);

25 (iii) 2008 (January 1, 2008 through December 31, 2008): 9.75% (3%  
26 plus the prior year's 6.75%);

27 (iv) 2009 (January 1, 2009 through December 31, 2009), and each  
28 succeeding calendar year: prior year's trend factor percentage plus 3%.

29 (c-1) Notwithstanding any provisions of subdivision (c) of this  
30 section to the contrary, effective April 1, 2013, for the period January  
31 1, 2013 through December 31, 2013 and for each calendar year thereafter,  
32 the medical assistance expenditure amount for the social services  
33 district for such period shall be equal to the previous calendar year's  
34 medical assistance expenditure amount, except that:

35 (1) for the period January 1, 2013 through December 31, 2013, the  
36 previous calendar year medical assistance expenditure amount will be  
37 increased by 2%;

38 (2) for the period January 1, 2014 through December 31, 2014, the  
39 previous calendar year medical assistance expenditure amount will be  
40 increased by 1%.

41 (C-2) NOTWITHSTANDING ANY PROVISIONS OF SUBDIVISION (C-1) OF THIS  
42 SECTION TO THE CONTRARY, EFFECTIVE APRIL 1, 2016, FOR THE PERIOD JANUARY  
43 1, 2016 THROUGH DECEMBER 31, 2016 AND FOR EACH CALENDAR YEAR THEREAFTER,  
44 THE MEDICAL ASSISTANCE EXPENDITURE AMOUNT FOR A SOCIAL SERVICES DISTRICT  
45 HAVING A POPULATION OF MORE THAN FIVE MILLION SHALL BE EQUAL TO THE  
46 AMOUNT CALCULATED PURSUANT TO SUBDIVISIONS (B) AND (C) OF THIS SECTION.

47 (d) The base year expenditure amounts calculated pursuant to paragraph  
48 (b) of this section and the calendar year social services district  
49 expenditure amounts calculated pursuant to paragraph (c) of this section  
50 shall be converted into state fiscal year social services district  
51 expenditure cap amounts for each social services district such that each  
52 such state fiscal year amount is proportional to the portions of the two  
53 calendar years within each fiscal year, as follows:

54 (i) fiscal year 2005-2006 (April 1, 2005 through March 31, 2006): 75%  
55 of the base year amount plus 25% of the 2006 calendar year amount;

1 (ii) fiscal year 2006-2007 (April 1, 2006 through March 31, 2007): 75%  
2 of the 2006 year calendar amount plus 25% of the 2007 calendar year  
3 amount;

4 (iii) each succeeding fiscal year: 75% of the first calendar year  
5 within that fiscal year's amount plus 25% of the second calendar year  
6 within that fiscal year's amount.

7 (D-1) NOTWITHSTANDING ANY PROVISIONS OF SUBDIVISION (D) OF THIS  
8 SECTION TO THE CONTRARY, FOR FISCAL YEARS 2015-2016 AND 2016-2017, THE  
9 BASE YEAR EXPENDITURE AMOUNT CALCULATED PURSUANT TO PARAGRAPH (B) OF  
10 THIS SECTION AND THE CALENDAR YEAR SOCIAL SERVICES DISTRICT EXPENDITURE  
11 AMOUNT CALCULATED PURSUANT TO PARAGRAPH (C) OF THIS SECTION SHALL BE  
12 CONVERTED INTO A STATE FISCAL YEAR SOCIAL SERVICES DISTRICT EXPENDITURE  
13 CAP AMOUNT FOR A SOCIAL SERVICES DISTRICT HAVING A POPULATION OF MORE  
14 THAN FIVE MILLION AS FOLLOWS:

15 (I) FISCAL YEAR 2015-2016 (APRIL 1, 2015 THROUGH MARCH 31, 2016): 75%  
16 OF THE 2015 BASE YEAR AMOUNT PLUS 25% OF THE 2016 CALENDAR YEAR AMOUNT,  
17 IF SUCH 2016 CALENDAR YEAR AMOUNT WERE CALCULATED WITHOUT REGARD TO THE  
18 PROVISIONS OF SUBDIVISION (C-2) OF THIS SECTION;

19 (II) FISCAL YEAR 2016-2017 (APRIL 1, 2016 THROUGH MARCH 31, 2017): 75%  
20 OF THE 2016 BASE YEAR AMOUNT PLUS 25% OF THE 2017 CALENDAR YEAR AMOUNT;  
21 THIS CAP AMOUNT SHALL BE REDUCED BY ONE-HALF OF THE DIFFERENCE BETWEEN  
22 THIS AMOUNT AND THE CAP AMOUNT FOR THIS PERIOD THAT WOULD RESULT IF  
23 CALCULATED WITHOUT REGARD TO THE PROVISIONS OF SUBDIVISION (C-2) OF THIS  
24 SECTION.

25 (e) No later than April 1, 2007, the commissioner of health shall  
26 certify the 2006-2007 fiscal year social services district expenditure  
27 cap amounts for each social services district calculated pursuant to  
28 subparagraph (ii) of paragraph (d) of this section and shall communicate  
29 such amounts to the commissioner of taxation and finance.

30 (f) Subject to paragraph (g) of this section, the state fiscal year  
31 social services district expenditure cap amount calculated for each  
32 social services district pursuant to paragraph (d) of this section shall  
33 be allotted to each district during that fiscal year and paid to the  
34 department in equal weekly amounts in a manner to be determined by the  
35 commissioner and communicated to such districts and, subject to the  
36 provisions of subdivision four of section six of this part, shall repre-  
37 sent each district's maximum responsibility for medical assistance  
38 expenditures governed by this section. HOWEVER, FOR FISCAL YEAR  
39 2016-2017, THE EXPENDITURE CAP AMOUNT CALCULATED FOR A SOCIAL SERVICES  
40 DISTRICT HAVING A POPULATION OF MORE THAN FIVE MILLION SHALL BE PAID TO  
41 THE DEPARTMENT IN WEEKLY AMOUNTS IN A MANNER TO BE DETERMINED BY THE  
42 COMMISSIONER, IN CONSULTATION WITH THE DIRECTOR OF THE DIVISION OF THE  
43 BUDGET, AND COMMUNICATED TO SUCH DISTRICT.

44 (g) (i) No allotment pursuant to paragraph (f) of this section shall  
45 be applied against a social services district during the period April 1,  
46 2005 through December 31, 2005. Social services district medical  
47 assistance shares shall be determined for such period pursuant to shares  
48 provisions in effect on January 1, 2005.

49 (ii) For the period January 1, 2006 through June 30, 2006, the commis-  
50 sioner is authorized to allot against each district an amount based on  
51 the commissioner's best estimate of the final base year expenditure  
52 calculation required by paragraph (b) of this section. Upon completion  
53 of such calculation, the commissioner shall, no later than December 31,  
54 2006, reconcile such estimated allotments with the fiscal year social  
55 services district expenditure cap amounts calculated pursuant to subpar-  
56 agraphs (i) and (ii) of paragraph (d) of this section.

(iii) During each state fiscal year subject to the provisions of this section and prior to state fiscal year 2015-16, the commissioner shall maintain an accounting, for each social services district, of the net amounts that would have been expended by, or on behalf of, such district had the social services district medical assistance shares provisions in effect on January 1, 2005 been applied to such district. For purposes of this paragraph, fifty percent of the payments made by New York State to the secretary of the federal department of health and human services pursuant to section 1935(c) of the social security act shall be deemed to be payments made on behalf of social services districts; such fifty percent share shall be apportioned to each district in the same ratio as the number of "full-benefit dual eligible individuals," as that term is defined in section 1935(c)(6) of such act, for whom such district has fiscal responsibility pursuant to section 365 of the social services law, relates to the total of such individuals for whom districts have fiscal responsibility. As soon as practicable after the conclusion of each such fiscal year, but in no event later than six months after the conclusion of each such fiscal year, the commissioner shall reconcile such net amounts with such fiscal year's social services district expenditure cap amount. Such reconciliation shall be based on actual expenditures made by or on behalf of social services districts, and revenues received by social services districts, during such fiscal year and shall be made without regard to expenditures made, and revenues received, outside such fiscal year that are related to services provided during, or prior to, such fiscal year. The commissioner shall pay to each social services district the amount, if any, by which such district's expenditure cap amount exceeds such net amount.

(h) Notwithstanding the provisions of section 368-a of the social services law or any other contrary provision of law, no reimbursement shall be made for social services districts' claims submitted on and after the effective date of this paragraph, for district expenditures incurred prior to January 1, 2006, including, but not limited to, expenditures for services provided to individuals who were eligible for medical assistance pursuant to section three hundred sixty-six of the social services law as a result of a mental disability, formerly referred to as human services overburden aid to counties.

S 2. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2016.

39

## PART B

Section 1. Subdivision 4 of section 365-h of the social services law, as separately amended by section 50 of part B and section 24 of part D of chapter 57 of the laws of 2015, is amended to read as follows:

4. The commissioner of health is authorized to assume responsibility from a local social services official for the provision and reimbursement of transportation costs under this section. If the commissioner elects to assume such responsibility, the commissioner shall notify the local social services official in writing as to the election, the date upon which the election shall be effective and such information as to transition of responsibilities as the commissioner deems prudent. The commissioner is authorized to contract with a transportation manager or managers to manage transportation services in any local social services district[, other than transportation services provided or arranged for enrollees of managed long term care plans issued certificates of authority under section forty-four hundred three-f of the public health law].

1 Any transportation manager or managers selected by the commissioner to  
2 manage transportation services shall have proven experience in coordi-  
3 nating transportation services in a geographic and demographic area  
4 similar to the area in New York state within which the contractor would  
5 manage the provision of services under this section. Such a contract or  
6 contracts may include responsibility for: review, approval and process-  
7 ing of transportation orders; management of the appropriate level of  
8 transportation based on documented patient medical need; and development  
9 of new technologies leading to efficient transportation services. If the  
10 commissioner elects to assume such responsibility from a local social  
11 services district, the commissioner shall examine and, if appropriate,  
12 adopt quality assurance measures that may include, but are not limited  
13 to, global positioning tracking system reporting requirements and  
14 service verification mechanisms. Any and all reimbursement rates devel-  
15 oped by transportation managers under this subdivision shall be subject  
16 to the review and approval of the commissioner.

17 S 2. Subparagraph (i) of paragraph (b) of subdivision 7 of section  
18 4403-f of the public health law, as amended by section 41-b of part H of  
19 chapter 59 of the laws of 2011, is amended to read as follows:

20 (i) The commissioner shall, to the extent necessary, submit the appro-  
21 priate waivers, including, but not limited to, those authorized pursuant  
22 to sections eleven hundred fifteen and nineteen hundred fifteen of the  
23 federal social security act, or successor provisions, and any other  
24 waivers necessary to achieve the purposes of high quality, integrated,  
25 and cost effective care and integrated financial eligibility policies  
26 under the medical assistance program or pursuant to title XVIII of the  
27 federal social security act. In addition, the commissioner is authorized  
28 to submit the appropriate waivers, including but not limited to those  
29 authorized pursuant to sections eleven hundred fifteen and nineteen  
30 hundred fifteen of the federal social security act or successor  
31 provisions, and any other waivers necessary to require on or after April  
32 first, two thousand twelve, medical assistance recipients who are twen-  
33 ty-one years of age or older and who require community-based long term  
34 care services, as specified by the commissioner, for more than one  
35 hundred and twenty days, to receive such services through an available  
36 plan certified pursuant to this section or other program model that  
37 meets guidelines specified by the commissioner that support coordination  
38 and integration of services; PROVIDED, HOWEVER, THAT THE COMMISSIONER  
39 MAY, THROUGH SUCH WAIVERS, LIMIT ELIGIBILITY TO AVAILABLE PLANS TO  
40 ENROLLEES THAT REQUIRE NURSING FACILITY LEVEL OF CARE. NOTWITHSTANDING  
41 THE FOREGOING, MEDICAL ASSISTANCE RECIPIENTS ENROLLED IN A MANAGED LONG  
42 TERM CARE PLAN ON APRIL FIRST, TWO THOUSAND SIXTEEN MAY CONTINUE TO BE  
43 ELIGIBLE FOR SUCH PLANS, IRRESPECTIVE OF WHETHER THE ENROLLEE MEETS ANY  
44 APPLICABLE NURSING FACILITY LEVEL OF CARE REQUIREMENTS, PROVIDED, HOWEV-  
45 ER, THAT ONCE SUCH RECIPIENTS ARE DISENROLLED FROM THEIR MANAGED LONG  
46 TERM CARE PLAN, ANY APPLICABLE NURSING FACILITY LEVEL OF CARE REQUIRE-  
47 MENTS WOULD APPLY TO FUTURE ELIGIBILITY DETERMINATIONS. Such guidelines  
48 shall address the requirements of paragraphs (a), (b), (c), (d), (e),  
49 (f), (g), (h), and (i) of subdivision three of this section as well as  
50 payment methods that ensure provider accountability for cost effective  
51 quality outcomes. Such other program models may include long term home  
52 health care programs that comply with such guidelines. Copies of such  
53 original waiver applications and amendments thereto shall be provided to  
54 the chairs of the senate finance committee, the assembly ways and means  
55 committee and the senate and assembly health committees simultaneously  
56 with their submission to the federal government.

1 S 3. Paragraph (a) of subdivision 3 of section 366 of the social  
2 services law, as amended by chapter 110 of the laws of 1971, is amended  
3 to read as follows:

4 (a) Medical assistance shall be furnished to applicants in cases  
5 where, although such applicant has a responsible relative with suffi-  
6 cient income and resources to provide medical assistance as determined  
7 by the regulations of the department, the income and resources of the  
8 responsible relative are not available to such applicant because of the  
9 absence of such relative [or] AND the refusal or failure of such ABSENT  
10 relative to provide the necessary care and assistance. In such cases,  
11 however, the furnishing of such assistance shall create an implied  
12 contract with such relative, and the cost thereof may be recovered from  
13 such relative in accordance with title six of article three OF THIS  
14 CHAPTER and other applicable provisions of law.

15 S 4. Subparagraph (i) of paragraph (d) of subdivision 2 of section  
16 366-c of the social services law is amended by adding a new clause (C)  
17 to read as follows:

18 (C) ON AND AFTER JULY FIRST, TWO THOUSAND SIXTEEN, TWENTY-THREE THOU-  
19 SAND EIGHT HUNDRED FORTY-FOUR DOLLARS OR SUCH GREATER AMOUNT AS MAY BE  
20 REQUIRED UNDER FEDERAL LAW;

21 S 5. Subdivision 7 of section 367-a of the social services law is  
22 amended by adding a new paragraph (g) to read as follows:

23 (G)(I) THE DEPARTMENT SHALL DEVELOP A LIST OF CRITICAL PRESCRIPTION  
24 DRUGS FOR WHICH THERE IS A SIGNIFICANT PUBLIC INTEREST IN ENSURING  
25 RATIONAL PRICING BY DRUG MANUFACTURERS. IN SELECTING DRUGS FOR POSSIBLE  
26 INCLUSION IN SUCH LIST, FACTORS TO BE CONSIDERED BY THE DEPARTMENT SHALL  
27 INCLUDE, BUT NOT BE LIMITED TO: THE SERIOUSNESS AND PREVALENCE OF THE  
28 DISEASE OR CONDITION THAT IS TREATED BY THE DRUG; THE EXTENT OF UTILIZA-  
29 TION OF THE DRUG; THE AVERAGE WHOLESALE PRICE AND RETAIL PRICE OF THE  
30 DRUG; THE NUMBER OF PHARMACEUTICAL MANUFACTURERS THAT PRODUCE THE DRUG;  
31 WHETHER THERE ARE PHARMACEUTICAL EQUIVALENTS TO THE DRUG; AND THE POTEN-  
32 TIAL IMPACT OF THE COST OF THE DRUG ON PUBLIC HEALTH CARE PROGRAMS,  
33 INCLUDING MEDICAID.

34 (II) FOR EACH PRESCRIPTION DRUG INCLUDED ON THE CRITICAL PRESCRIPTION  
35 DRUG LIST, THE DEPARTMENT SHALL REQUIRE THE MANUFACTURERS OF SAID  
36 PRESCRIPTION DRUG TO REPORT THE FOLLOWING INFORMATION:

37 (A) THE ACTUAL COST OF DEVELOPING, MANUFACTURING, PRODUCING (INCLUDING  
38 THE COST PER DOSE OF PRODUCTION), AND DISTRIBUTING SUCH DRUG;

39 (B) RESEARCH AND DEVELOPMENT COSTS OF THE DRUG INCLUDING PAYMENTS TO  
40 PREDECESSOR ENTITIES CONDUCTING RESEARCH AND DEVELOPMENT, INCLUDING BUT  
41 NOT LIMITED TO BIOTECHNOLOGY COMPANIES, UNIVERSITIES AND MEDICAL  
42 SCHOOLS, AND PRIVATE RESEARCH INSTITUTIONS;

43 (C) ADMINISTRATIVE, MARKETING, AND ADVERTISING COSTS FOR THE DRUG,  
44 APPORTIONED BY MARKETING ACTIVITIES THAT ARE DIRECTED TO CONSUMERS,  
45 MARKETING ACTIVITIES THAT ARE DIRECTED TO PRESCRIBERS, AND THE TOTAL  
46 COST OF ALL MARKETING AND ADVERTISING THAT IS DIRECTED PRIMARILY TO  
47 CONSUMERS AND PRESCRIBERS IN NEW YORK, INCLUDING BUT NOT LIMITED TO  
48 PRESCRIBER DETAILING, COPAYMENT DISCOUNT PROGRAMS AND DIRECT TO CONSUMER  
49 MARKETING;

50 (D) PRICES FOR THE DRUG THAT ARE CHARGED TO PURCHASERS OUTSIDE THE  
51 UNITED STATES;

52 (E) PRICES CHARGED TO TYPICAL PURCHASERS IN NEW YORK, INCLUDING BUT  
53 NOT LIMITED TO PHARMACIES, PHARMACY CHAINS, PHARMACY WHOLESALERS OR  
54 OTHER DIRECT PURCHASERS;

55 (F) THE AVERAGE REBATES AND DISCOUNTS PROVIDED PER PAYOR TYPE;



(G) THE AVERAGE PROFIT MARGIN OF EACH DRUG OVER THE PRIOR FIVE YEAR PERIOD AND THE PROJECTED PROFIT MARGIN ANTICIPATED FOR SUCH DRUG; AND

(H) CLINICAL INFORMATION INCLUDING BUT NOT LIMITED TO CLINICAL TRIALS AND CLINICAL OUTCOMES RESEARCH.

(III) THE DEPARTMENT SHALL DEVELOP A STANDARD REPORTING FORM THAT SATISFIES THE REQUIREMENTS OF SUBPARAGRAPH (II) OF THIS PARAGRAPH. MANUFACTURERS SHALL PROVIDE THE REQUIRED INFORMATION WITHIN NINETY DAYS OF THE DEPARTMENT'S REQUEST. ALL INFORMATION DISCLOSED PURSUANT TO SUBPARAGRAPH (II) OF THIS PARAGRAPH IS CONFIDENTIAL AND SHALL NOT BE DISCLOSED BY THE DEPARTMENT OR ITS ACTUARY IN A FORM THAT DISCLOSES THE IDENTITY OF A SPECIFIC MANUFACTURER, OR PRICES CHARGED FOR DRUGS BY SUCH MANUFACTURER, EXCEPT AS THE COMMISSIONER DETERMINES IS NECESSARY TO CARRY OUT THE PROVISIONS OF THIS SECTION, OR TO ALLOW THE DEPARTMENT, THE ATTORNEY GENERAL, THE STATE COMPTROLLER, OR THE CENTERS FOR MEDICARE AND MEDICAID SERVICES TO PERFORM AUDITS OR INVESTIGATIONS AUTHORIZED BY LAW.

(IV) FOR EACH CRITICAL PRESCRIPTION DRUG IDENTIFIED BY THE DEPARTMENT, THE DEPARTMENT SHALL DIRECT ITS ACTUARY TO UTILIZE THE INFORMATION PROVIDED PURSUANT TO SUBPARAGRAPH (II) OF THIS PARAGRAPH TO CONDUCT A VALUE-BASED ASSESSMENT OF SUCH DRUG AND ESTABLISH A REASONABLE CEILING PRICE.

(V) THE COMMISSIONER MAY REQUIRE A DRUG MANUFACTURER TO PROVIDE REBATES TO THE DEPARTMENT FOR A CRITICAL PRESCRIPTION DRUG WHOSE PRICE EXCEEDS THE CEILING PRICE FOR THE DRUG ESTABLISHED BY THE DEPARTMENT'S ACTUARY PURSUANT TO SUBPARAGRAPH (IV) OF THIS PARAGRAPH. SUCH REBATES SHALL BE IN ADDITION TO ANY REBATES PAYABLE TO THE DEPARTMENT PURSUANT TO ANY OTHER PROVISION OF FEDERAL OR STATE LAW. THE ADDITIONAL REBATES AUTHORIZED PURSUANT TO THIS SUBPARAGRAPH SHALL APPLY TO CRITICAL PRESCRIPTION DRUGS DISPENSED TO ENROLLEES OF MANAGED CARE PROVIDERS PURSUANT TO SECTION THREE HUNDRED SIXTY-FOUR-J OF THIS TITLE AND TO CRITICAL PRESCRIPTION DRUGS DISPENSED TO MEDICAID RECIPIENTS WHO ARE NOT ENROLLEES OF SUCH PROVIDERS.

S 6. Paragraph (b) of subdivision 9 of section 367-a of the social services law is amended by adding a new subparagraph (iv) to read as follows:

(IV) NOTWITHSTANDING SUBPARAGRAPHS (I) AND (II) OF THIS PARAGRAPH, IF THE DRUG DISPENSED IS A DRUG THAT ONE OR MORE MANAGED CARE PROVIDERS OPERATING PURSUANT TO SECTION THREE HUNDRED SIXTY-FOUR-J OF THIS TITLE HAVE DESIGNATED AS A SPECIALTY DRUG, AN AMOUNT THAT DOES NOT EXCEED THE AMOUNT SUCH PROVIDERS PAY FOR THE DRUG, AS DETERMINED BY THE COMMISSIONER BASED ON MANAGED CARE PROVIDERS' ENCOUNTER DATA FOR THE DRUG.

S 7. Section 274 of the public health law is amended by adding a new subdivision 15 to read as follows:

15. NOTWITHSTANDING ANY INCONSISTENT PROVISION OF THIS SECTION, THE COMMISSIONER MAY REQUIRE PRIOR AUTHORIZATION FOR ANY DRUG AFTER EVALUATING THE FACTORS SET FORTH IN SUBDIVISION THREE OF THIS SECTION AND PRIOR TO OBTAINING THE BOARD'S EVALUATION AND RECOMMENDATION REQUIRED BY SUBDIVISION FOUR OF THIS SECTION. THE BOARD MAY RECOMMEND TO THE COMMISSIONER, PURSUANT TO SUBDIVISION SIX OF THIS SECTION, THAT ANY SUCH PRIOR AUTHORIZATION REQUIREMENT BE MODIFIED, CONTINUED OR REMOVED.

S 8. Paragraph (b) of subdivision 3 of section 273 of the public health law, as added by section 10 of part C of chapter 58 of the laws of 2005, is amended to read as follows:

(b) In the event that the patient does not meet the criteria in paragraph (a) of this subdivision, the prescriber may provide additional information to the program to justify the use of a prescription drug

1 that is not on the preferred drug list. The program shall provide a  
2 reasonable opportunity for a prescriber to reasonably present his or her  
3 justification of prior authorization. [If, after consultation with the  
4 program, the prescriber, in his or her reasonable professional judgment,  
5 determines that the use of a prescription drug that is not on the  
6 preferred drug list is warranted, the prescriber's determination shall  
7 be final.] THE PROGRAM WILL CONSIDER THE ADDITIONAL INFORMATION AND THE  
8 JUSTIFICATION PRESENTED TO DETERMINE WHETHER THE USE OF A PRESCRIPTION  
9 DRUG THAT IS NOT ON THE PREFERRED DRUG LIST IS WARRANTED. IN THE CASE OF  
10 ATYPICAL ANTIPSYCHOTICS AND ANTIDEPRESSANTS, IF AFTER CONSULTATION WITH  
11 THE PROGRAM, THE PRESCRIBER, IN HIS OR HER REASONABLE PROFESSIONAL JUDG-  
12 MENT, DETERMINES THAT THE USE OF A PRESCRIPTION DRUG THAT IS NOT ON THE  
13 PREFERRED DRUG LIST IS WARRANTED, THE PRESCRIBER'S DETERMINATION SHALL  
14 BE FINAL.

15 S 9. Subdivision 25 of section 364-j of the social services law, as  
16 added by section 55 of part D of chapter 56 of the laws of 2012, is  
17 amended to read as follows:

18 25. [Effective January first, two thousand thirteen, notwithstanding]  
19 NOTWITHSTANDING any provision of law to the contrary, managed care  
20 providers shall cover medically necessary prescription drugs in the  
21 atypical antipsychotic AND ANTIDEPRESSANT therapeutic [class] CLASSES,  
22 including non-formulary drugs, upon demonstration by the prescriber,  
23 after consulting with the managed care provider, that such drugs, in the  
24 prescriber's reasonable professional judgment, are medically necessary  
25 and warranted.

26 S 10. Subdivision 25-a of section 364-j of the social services law is  
27 REPEALED.

28 S 11. Subdivision 7 of section 367-a of the social services law is  
29 amended by adding a new paragraph (f) to read as follows:

30 (F) THE COMMISSIONER MAY REQUIRE MANUFACTURERS OF DRUGS OTHER THAN  
31 SINGLE SOURCE DRUGS AND INNOVATOR MULTIPLE SOURCE DRUGS, AS SUCH TERMS  
32 ARE DEFINED IN 42 U.S.C. S 1396R-8(K), TO PROVIDE REBATES TO THE DEPART-  
33 MENT FOR GENERIC DRUGS WHOSE PRICES INCREASE AT A RATE GREATER THAN THE  
34 RATE OF INFLATION. SUCH REBATES SHALL BE IN ADDITION TO ANY REBATES  
35 PAYABLE TO THE DEPARTMENT PURSUANT TO ANY OTHER PROVISION OF FEDERAL OR  
36 STATE LAW. IN DETERMINING THE AMOUNT OF SUCH ADDITIONAL REBATES FOR  
37 GENERIC DRUGS, THE COMMISSIONER MAY USE A METHODOLOGY SIMILAR TO THAT  
38 USED BY THE CENTERS FOR MEDICARE & MEDICAID SERVICES IN DETERMINING THE  
39 AMOUNT OF ANY ADDITIONAL REBATES FOR SINGLE SOURCE AND INNOVATOR MULTI-  
40 PLE SOURCE DRUGS, AS SET FORTH IN 42 U.S.C. S 1396R-8(C)(2). THE ADDI-  
41 TIONAL REBATES AUTHORIZED PURSUANT TO THIS PARAGRAPH SHALL APPLY TO  
42 GENERIC PRESCRIPTION DRUGS DISPENSED TO ENROLLEES OF MANAGED CARE  
43 PROVIDERS PURSUANT TO SECTION THREE HUNDRED SIXTY-FOUR-J OF THIS TITLE  
44 AND TO GENERIC PRESCRIPTION DRUGS DISPENSED TO MEDICAID RECIPIENTS WHO  
45 ARE NOT ENROLLEES OF SUCH PROVIDERS.

46 S 12. The opening paragraph of paragraph (e) of subdivision 7 of  
47 section 367-a of the social services law, as added by section 1 of part  
48 B of chapter 57 of the laws of 2015, is amended to read as follows:

49 During the period from April first, two thousand fifteen through March  
50 thirty-first, two thousand seventeen, the commissioner may, in lieu of a  
51 managed care provider, negotiate directly and enter into an agreement  
52 with a pharmaceutical manufacturer for the provision of supplemental  
53 rebates relating to pharmaceutical utilization by enrollees of managed  
54 care providers pursuant to section three hundred sixty-four-j of this  
55 title AND, NOTWITHSTANDING THE PROVISIONS OF SECTION TWO HUNDRED SEVEN-  
56 TY-TWO OF THE PUBLIC HEALTH LAW OR ANY OTHER INCONSISTENT PROVISION OF

LAW, MAY ALSO NEGOTIATE DIRECTLY AND ENTER INTO SUCH AN AGREEMENT RELATING TO PHARMACEUTICAL UTILIZATION BY MEDICAL ASSISTANCE RECIPIENTS NOT SO ENROLLED. Such rebates shall be limited to drug utilization in the following classes: antiretrovirals approved by the FDA for the treatment of HIV/AIDS and hepatitis C agents for which the pharmaceutical manufacturer has in effect a rebate agreement with the federal secretary of health and human services pursuant to 42 U.S.C. S 1396r-8, and for which the state has established standard clinical criteria. No agreement entered into pursuant to this paragraph shall have an initial term or be extended beyond March thirty-first, two thousand twenty.

S 13. Subparagraph (iv) of paragraph (e) of subdivision 7 of section 367-a of the social services law, as added by section 1 of part B of chapter 57 of the laws of 2015, is amended to read as follows:

(iv) Nothing in this paragraph shall be construed to require a pharmaceutical manufacturer to enter into a supplemental rebate agreement with the commissioner relating to pharmaceutical utilization by enrollees of managed care providers pursuant to section three hundred sixty-four-j of this title OR RELATING TO PHARMACEUTICAL UTILIZATION BY MEDICAL ASSISTANCE RECIPIENTS NOT SO ENROLLED.

S 14. Section 364-j of the social services law is amended by adding a new subdivision 26-a to read as follows:

26-A. MANAGED CARE PROVIDERS SHALL REQUIRE PRIOR AUTHORIZATION OF PRESCRIPTIONS OF OPIOID ANALGESICS IN EXCESS OF FOUR PRESCRIPTIONS IN A THIRTY-DAY PERIOD.

S 15. Section 364-j of the social services law is amended by adding a new subdivision 32 to read as follows:

32. (A) THE COMMISSIONER MAY, IN HIS OR HER DISCRETION, APPLY PENALTIES TO MANAGED CARE ORGANIZATIONS SUBJECT TO THIS SECTION AND ARTICLE FORTY-FOUR OF THE PUBLIC HEALTH LAW FOR UNTIMELY OR INACCURATE SUBMISSION OF ENCOUNTER DATA. FOR PURPOSES OF THIS SECTION, "ENCOUNTER DATA" SHALL MEAN THE TRANSACTIONS REQUIRED TO BE REPORTED UNDER THE MODEL CONTRACT. ANY PENALTY ASSESSED UNDER THIS SUBDIVISION SHALL BE CALCULATED AS A PERCENTAGE OF THE ADMINISTRATIVE COMPONENT OF THE MEDICAID PREMIUM CALCULATED BY THE DEPARTMENT.

(B) SUCH PENALTIES SHALL BE AS FOLLOWS:

(I) FOR ENCOUNTER DATA SUBMITTED OR RESUBMITTED PAST THE DEADLINES SET FORTH IN THE MODEL CONTRACT, MEDICAID PREMIUMS SHALL BE REDUCED BY ONE AND ONE-HALF PERCENT; AND

(II) FOR INCOMPLETE OR INACCURATE ENCOUNTER DATA THAT FAILS TO CONFORM TO DEPARTMENT DEVELOPED BENCHMARKS FOR COMPLETENESS AND ACCURACY, MEDICAID PREMIUMS SHALL BE REDUCED BY ONE-HALF PERCENT; AND

(III) FOR SUBMITTED DATA THAT RESULTS IN A REJECTION RATE IN EXCESS OF TEN PERCENT OF DEPARTMENT DEVELOPED VOLUME BENCHMARKS, MEDICAID PREMIUMS SHALL BE REDUCED BY ONE HALF-PERCENT.

(C) PENALTIES UNDER THIS SUBDIVISION MAY BE APPLIED TO ANY AND ALL CIRCUMSTANCES DESCRIBED IN PARAGRAPH (B) OF THIS SUBDIVISION AT A FREQUENCY DETERMINED BY THE COMMISSIONER. THE COMMISSIONER MAY, IN HIS OR HER DISCRETION, WAIVE SUCH PENALTY.

S 16. Paragraph (d) of subdivision 1 of section 367-a of the social services law is amended by adding a new subparagraph (iv) to read as follows:

(IV) IF A HEALTH PLAN PARTICIPATING IN PART C OF TITLE XVIII OF THE FEDERAL SOCIAL SECURITY ACT PAYS FOR ITEMS AND SERVICES PROVIDED TO ELIGIBLE PERSONS WHO ARE ALSO BENEFICIARIES UNDER PART B OF TITLE XVIII OF THE FEDERAL SOCIAL SECURITY ACT OR TO QUALIFIED MEDICARE BENEFICIARIES, THE AMOUNT PAYABLE FOR SERVICES UNDER THIS TITLE SHALL BE THE

1 AMOUNT OF ANY CO-INSURANCE LIABILITY OF SUCH ELIGIBLE PERSONS PURSUANT  
2 TO FEDERAL LAW IF THEY WERE NOT ELIGIBLE FOR MEDICAL ASSISTANCE OR WERE  
3 NOT QUALIFIED MEDICARE BENEFICIARIES WITH RESPECT TO SUCH BENEFITS UNDER  
4 SUCH PART B, BUT SHALL NOT EXCEED THE AMOUNT THAT OTHERWISE WOULD BE  
5 MADE UNDER THIS TITLE IF PROVIDED TO AN ELIGIBLE PERSON WHO IS NOT A  
6 BENEFICIARY UNDER PART B OR A QUALIFIED MEDICARE BENEFICIARY, LESS THE  
7 AMOUNT PAYABLE BY THE PART C HEALTH PLAN; PROVIDED, HOWEVER, AMOUNTS  
8 PAYABLE UNDER THIS TITLE FOR ITEMS AND SERVICES PROVIDED TO ELIGIBLE  
9 PERSONS WHO ARE ALSO BENEFICIARIES UNDER PART B OR TO QUALIFIED MEDICARE  
10 BENEFICIARIES BY AN AMBULANCE SERVICE UNDER THE AUTHORITY OF AN OPERAT-  
11 ING CERTIFICATE ISSUED PURSUANT TO ARTICLE THIRTY OF THE PUBLIC HEALTH  
12 LAW, A PSYCHOLOGIST LICENSED UNDER ARTICLE ONE HUNDRED FIFTY-THREE OF  
13 THE EDUCATION LAW, OR A FACILITY UNDER THE AUTHORITY OF AN OPERATING  
14 CERTIFICATE ISSUED PURSUANT TO ARTICLE SIXTEEN, THIRTY-ONE OR THIRTY-TWO  
15 OF THE MENTAL HYGIENE LAW AND WITH RESPECT TO OUTPATIENT HOSPITAL AND  
16 CLINIC ITEMS AND SERVICES PROVIDED BY A FACILITY UNDER THE AUTHORITY OF  
17 AN OPERATING CERTIFICATE ISSUED PURSUANT TO ARTICLE TWENTY-EIGHT OF THE  
18 PUBLIC HEALTH LAW, SHALL NOT BE LESS THAN THE AMOUNT OF ANY CO-INSURANCE  
19 LIABILITY OF SUCH ELIGIBLE PERSONS OR SUCH QUALIFIED MEDICARE BENEFICI-  
20 ARIES, OR FOR WHICH SUCH ELIGIBLE PERSONS OR SUCH QUALIFIED MEDICARE  
21 BENEFICIARIES WOULD BE LIABLE UNDER FEDERAL LAW WERE THEY NOT ELIGIBLE  
22 FOR MEDICAL ASSISTANCE OR WERE THEY NOT QUALIFIED MEDICARE BENEFICIARIES  
23 WITH RESPECT TO SUCH BENEFITS UNDER PART B.

24 S 17. Subdivision 2-b of section 365-1 of the social services law, as  
25 added by section 25 of part B of chapter 57 of the laws of 2015, is  
26 amended to read as follows:

27 2-b. The commissioner is authorized to make [grants] LUMP SUM  
28 PAYMENTS OR ADJUST RATES OF PAYMENT TO PROVIDERS up to a gross amount of  
29 five million dollars, to establish coordination between the health homes  
30 and the criminal justice system and for the integration of information  
31 of health homes with state and local correctional facilities, to the  
32 extent permitted by law. SUCH RATE ADJUSTMENTS MAY BE MADE TO HEALTH  
33 HOMES PARTICIPATING IN A CRIMINAL JUSTICE PILOT PROGRAM WITH THE PURPOSE  
34 OF ENROLLING INCARCERATED INDIVIDUALS WITH SERIOUS MENTAL ILLNESS, TWO  
35 OR MORE CHRONIC CONDITIONS, INCLUDING SUBSTANCE ABUSE DISORDERS, OR  
36 HIV/AIDS, INTO SUCH HEALTH HOME. Health homes receiving funds under this  
37 subdivision shall be required to document and demonstrate the effective  
38 use of funds distributed herein.

39 S 18. Subdivision 1 of section 92 of part H of chapter 59 of the laws  
40 of 2011, amending the public health law and other laws relating to known  
41 and projected department of health state fund medicaid expenditures, as  
42 amended by section 8 of part B of chapter 57 of the laws of 2015, is  
43 amended to read as follows:

44 1. For state fiscal years 2011-12 through [2016-17] 2017-18, the  
45 director of the budget, in consultation with the commissioner of health  
46 referenced as "commissioner" for purposes of this section, shall assess  
47 on a monthly basis, as reflected in monthly reports pursuant to subdivi-  
48 sion five of this section known and projected department of health state  
49 funds medicaid expenditures by category of service and by geographic  
50 regions, as defined by the commissioner, and if the director of the  
51 budget determines that such expenditures are expected to cause medicaid  
52 disbursements for such period to exceed the projected department of  
53 health medicaid state funds disbursements in the enacted budget finan-  
54 cial plan pursuant to subdivision 3 of section 23 of the state finance  
55 law, the commissioner of health, in consultation with the director of  
56 the budget, shall develop a medicaid savings allocation plan to limit

1 such spending to the aggregate limit level specified in the enacted  
2 budget financial plan, provided, however, such projections may be  
3 adjusted by the director of the budget to account for any changes in the  
4 New York state federal medical assistance percentage amount established  
5 pursuant to the federal social security act, changes in provider reven-  
6 ues, reductions to local social services district medical assistance  
7 administration, and beginning April 1, 2012 the operational costs of the  
8 New York state medical indemnity fund and state costs or savings from  
9 the basic health plan. Such projections may be adjusted by the director  
10 of the budget to account for increased or expedited department of health  
11 state funds medicaid expenditures as a result of a natural or other type  
12 of disaster, including a governmental declaration of emergency.

13 S 19. This act shall take effect immediately and shall be deemed to  
14 have been in full force and effect on and after April 1, 2016; provided  
15 that:

16 (a) sections one, two and six of this act shall take effect October 1,  
17 2016;

18 (b) the amendments to subdivision 4 of section 365-h of the social  
19 services law, made by section one of this act, shall not affect the  
20 expiration and repeal of certain provisions of such section, and shall  
21 expire and be deemed repealed therewith;

22 (c) the amendments to subparagraph (i) of paragraph (b) of subdivision  
23 7 of section 4403-f of the public health law, made by section two of  
24 this act, shall not affect the expiration of such subdivision or the  
25 repeal of such section, and shall expire or be deemed repealed there-  
26 with;

27 (d) sections four and sixteen of this act shall take effect July 1,  
28 2016;

29 (e) the amendments to subdivision 9 of section 367-a of the social  
30 services law, made by section six of this act, shall not affect the  
31 expiration of such subdivision and shall expire therewith;

32 (f) sections eight, nine and ten of this act shall take effect June 1,  
33 2016;

34 (g) the amendments to subdivision 25 of section 364-j of the social  
35 services law, made by section nine of this act, shall not affect the  
36 repeal of such section, and shall be deemed repealed therewith;

37 (h) the amendments to paragraph (e) of subdivision 7 of section 367-a  
38 of the social services law, made by sections twelve and thirteen of this  
39 act shall not affect the repeal of such paragraph and shall be deemed  
40 repealed therewith; and

41 (i) subdivisions 26-a and 32 of section 364-j of the social services  
42 law, as added by sections fourteen and fifteen of this act shall be  
43 deemed repealed on the same date and in the same manner as such section  
44 is repealed.

45 PART C

46 Section 1. Subdivision 1 of section 18 of chapter 266 of the laws of  
47 1986, amending the civil practice law and rules and other laws relating  
48 to malpractice and professional medical conduct, is amended by adding a  
49 new paragraph (c) to read as follows:

50 (C) STARTING WITH THE POLICY YEAR BEGINNING JULY FIRST, TWO THOUSAND  
51 SIXTEEN, AND AT LEAST ONCE EVERY FIVE YEARS THEREAFTER, THE SUPERINTEN-  
52 DENT OF FINANCIAL SERVICES SHALL RANK FROM HIGHEST TO LOWEST EACH CLASS  
53 AND TERRITORY COMBINATION USED FOR THE PURPOSE OF APPORTIONING PREMIUM  
54 FOR POLICIES PURCHASED FROM FUNDS AVAILABLE IN THE HOSPITAL EXCESS

1 LIABILITY POOL ACCORDING TO RELATIVITIES DERIVED FROM THE MEDICAL MALP-  
2 RACTICE INSURANCE POOL'S PRIMARY RATES AND THE APPLICABLE EXCESS TIER  
3 FACTORS. ANNUALLY, THE SUPERINTENDENT SHALL DETERMINE THE CLASS AND  
4 TERRITORY COMBINATIONS FOR WHICH A POLICY OR POLICIES FOR EXCESS INSUR-  
5 ANCE COVERAGE, OR FOR EQUIVALENT EXCESS INSURANCE COVERAGE, MAY BE  
6 PURCHASED FOR ELIGIBLE PHYSICIANS OR DENTISTS WITHIN THE LIMITS OF THE  
7 APPROPRIATION FOR THE HOSPITAL EXCESS LIABILITY POOL. THE SUPERINTENDENT  
8 SHALL GRANT PRIORITY FOR PURCHASING POLICIES IN EACH POLICY YEAR IN  
9 DESCENDING ORDER BEGINNING WITH THE HIGHEST RISK CLASS AND TERRITORY  
10 COMBINATION. THE SUPERINTENDENT AND COMMISSIONER OF HEALTH SHALL NOT BE  
11 OBLIGATED TO PURCHASE ANY MORE POLICIES THAN THE NUMBER OF POLICIES THAT  
12 CAN BE PURCHASED AT THE RATES PROMULGATED ANNUALLY BY THE SUPERINTENDENT  
13 WITHIN THE LIMITS OF THE APPROPRIATION. ONCE THE BALANCE OF THE APPRO-  
14 PRIATION BECOMES INSUFFICIENT TO COVER ALL PHYSICIANS AND DENTISTS WITH-  
15 IN A PARTICULAR CLASS AND TERRITORY COMBINATION, THE REMAINING FUNDS FOR  
16 THAT COMBINATION SHALL BE ALLOCATED, FOR THE PURPOSE OF PURCHASING POLI-  
17 CIES FOR SELECTED ADDITIONAL PHYSICIANS AND DENTISTS WITHIN THAT COMBI-  
18 NATION TO GENERAL HOSPITALS IN PROPORTION TO THEIR SHARE OF THE TOTAL  
19 NUMBER OF PHYSICIANS OR DENTISTS PRACTICING IN SUCH CLASS AND TERRITORY  
20 COMBINATION WHO WERE CERTIFIED BY THE GENERAL HOSPITALS, AND FOR WHOM  
21 POLICIES WERE PURCHASED, IN THE PRIOR YEAR, PROVIDED THAT ANY SHARE OF  
22 LESS THAN ONE PHYSICIAN OR DENTIST SHALL BE DEEMED TO EQUAL ZERO. FOR  
23 THE PURPOSES OF THIS PARAGRAPH, WITH REGARD TO POLICIES ISSUED FOR THE  
24 COVERAGE PERIOD BEGINNING JULY FIRST, TWO THOUSAND SIXTEEN, "PRIOR YEAR"  
25 SHALL MEAN THE POLICY YEAR THAT BEGAN ON JULY FIRST, TWO THOUSAND  
26 FIFTEEN.

27 S 2. Paragraph (a) of subdivision 1 of section 18 of chapter 266 of  
28 the laws of 1986, amending the civil practice law and rules and other  
29 laws relating to malpractice and professional medical conduct, as  
30 amended by section 1 of part Y of chapter 57 of the laws of 2015, is  
31 amended to read as follows:

32 (a) The superintendent of financial services and the commissioner of  
33 health or their designee shall, from funds available in the hospital  
34 excess liability pool created pursuant to subdivision 5 of this section,  
35 purchase a policy or policies for excess insurance coverage, as author-  
36 ized by paragraph 1 of subsection (e) of section 5502 of the insurance  
37 law; or from an insurer, other than an insurer described in section 5502  
38 of the insurance law, duly authorized to write such coverage and actual-  
39 ly writing medical malpractice insurance in this state; or shall  
40 purchase equivalent excess coverage in a form previously approved by the  
41 superintendent of financial services for purposes of providing equiv-  
42 alent excess coverage in accordance with section 19 of chapter 294 of  
43 the laws of 1985, for medical or dental malpractice occurrences between  
44 July 1, 1986 and June 30, 1987, between July 1, 1987 and June 30, 1988,  
45 between July 1, 1988 and June 30, 1989, between July 1, 1989 and June  
46 30, 1990, between July 1, 1990 and June 30, 1991, between July 1, 1991  
47 and June 30, 1992, between July 1, 1992 and June 30, 1993, between July  
48 1, 1993 and June 30, 1994, between July 1, 1994 and June 30, 1995,  
49 between July 1, 1995 and June 30, 1996, between July 1, 1996 and June  
50 30, 1997, between July 1, 1997 and June 30, 1998, between July 1, 1998  
51 and June 30, 1999, between July 1, 1999 and June 30, 2000, between July  
52 1, 2000 and June 30, 2001, between July 1, 2001 and June 30, 2002,  
53 between July 1, 2002 and June 30, 2003, between July 1, 2003 and June  
54 30, 2004, between July 1, 2004 and June 30, 2005, between July 1, 2005  
55 and June 30, 2006, between July 1, 2006 and June 30, 2007, between July  
56 1, 2007 and June 30, 2008, between July 1, 2008 and June 30, 2009,

1 between July 1, 2009 and June 30, 2010, between July 1, 2010 and June  
2 30, 2011, between July 1, 2011 and June 30, 2012, between July 1, 2012  
3 and June 30, 2013, between July 1, 2013 and June 30, 2014, between July  
4 1, 2014 and June 30, 2015, [and] between July 1, 2015 and June 30, 2016,  
5 AND BETWEEN JULY 1, 2016 AND JUNE 30, 2017 or reimburse the hospital  
6 where the hospital purchases equivalent excess coverage as defined in  
7 subparagraph (i) of paragraph (a) of subdivision 1-a of this section for  
8 medical or dental malpractice occurrences between July 1, 1987 and June  
9 30, 1988, between July 1, 1988 and June 30, 1989, between July 1, 1989  
10 and June 30, 1990, between July 1, 1990 and June 30, 1991, between July  
11 1, 1991 and June 30, 1992, between July 1, 1992 and June 30, 1993,  
12 between July 1, 1993 and June 30, 1994, between July 1, 1994 and June  
13 30, 1995, between July 1, 1995 and June 30, 1996, between July 1, 1996  
14 and June 30, 1997, between July 1, 1997 and June 30, 1998, between July  
15 1, 1998 and June 30, 1999, between July 1, 1999 and June 30, 2000,  
16 between July 1, 2000 and June 30, 2001, between July 1, 2001 and June  
17 30, 2002, between July 1, 2002 and June 30, 2003, between July 1, 2003  
18 and June 30, 2004, between July 1, 2004 and June 30, 2005, between July  
19 1, 2005 and June 30, 2006, between July 1, 2006 and June 30, 2007,  
20 between July 1, 2007 and June 30, 2008, between July 1, 2008 and June  
21 30, 2009, between July 1, 2009 and June 30, 2010, between July 1, 2010  
22 and June 30, 2011, between July 1, 2011 and June 30, 2012, between July  
23 1, 2012 and June 30, 2013, between July 1, 2013 and June 30, 2014,  
24 between July 1, 2014 and June 30, 2015, [and] between July 1, 2015 and  
25 June 30, 2016, AND BETWEEN JULY 1, 2016 AND JUNE 30, 2017 for physicians  
26 or dentists certified as eligible for each such period or periods pursu-  
27 ant to subdivision 2 of this section by a general hospital licensed  
28 pursuant to article 28 of the public health law; provided that no single  
29 insurer shall write more than fifty percent of the total excess premium  
30 for a given policy year; and provided, however, that such eligible  
31 physicians or dentists must have in force an individual policy, from an  
32 insurer licensed in this state of primary malpractice insurance coverage  
33 in amounts of no less than one million three hundred thousand dollars  
34 for each claimant and three million nine hundred thousand dollars for  
35 all claimants under that policy during the period of such excess cover-  
36 age for such occurrences or be endorsed as additional insureds under a  
37 hospital professional liability policy which is offered through a volun-  
38 tary attending physician ("channeling") program previously permitted by  
39 the superintendent of financial services during the period of such  
40 excess coverage for such occurrences. During such period, such policy  
41 for excess coverage or such equivalent excess coverage shall, when  
42 combined with the physician's or dentist's primary malpractice insurance  
43 coverage or coverage provided through a voluntary attending physician  
44 ("channeling") program, total an aggregate level of two million three  
45 hundred thousand dollars for each claimant and six million nine hundred  
46 thousand dollars for all claimants from all such policies with respect  
47 to occurrences in each of such years provided, however, if the cost of  
48 primary malpractice insurance coverage in excess of one million dollars,  
49 but below the excess medical malpractice insurance coverage provided  
50 pursuant to this act, exceeds the rate of nine percent per annum, then  
51 the required level of primary malpractice insurance coverage in excess  
52 of one million dollars for each claimant shall be in an amount of not  
53 less than the dollar amount of such coverage available at nine percent  
54 per annum; the required level of such coverage for all claimants under  
55 that policy shall be in an amount not less than three times the dollar  
56 amount of coverage for each claimant; and excess coverage, when combined

1 with such primary malpractice insurance coverage, shall increase the  
2 aggregate level for each claimant by one million dollars and three  
3 million dollars for all claimants; and provided further, that, with  
4 respect to policies of primary medical malpractice coverage that include  
5 occurrences between April 1, 2002 and June 30, 2002, such requirement  
6 that coverage be in amounts no less than one million three hundred thou-  
7 sand dollars for each claimant and three million nine hundred thousand  
8 dollars for all claimants for such occurrences shall be effective April  
9 1, 2002.

10 S 3. Subdivision 3 of section 18 of chapter 266 of the laws of 1986,  
11 amending the civil practice law and rules and other laws relating to  
12 malpractice and professional medical conduct, as amended by section 2 of  
13 part Y of chapter 57 of the laws of 2015, is amended to read as follows:

14 (3)(a) The superintendent of financial services shall determine and  
15 certify to each general hospital and to the commissioner of health the  
16 cost of excess malpractice insurance for medical or dental malpractice  
17 occurrences between July 1, 1986 and June 30, 1987, between July 1, 1988  
18 and June 30, 1989, between July 1, 1989 and June 30, 1990, between July  
19 1, 1990 and June 30, 1991, between July 1, 1991 and June 30, 1992,  
20 between July 1, 1992 and June 30, 1993, between July 1, 1993 and June  
21 30, 1994, between July 1, 1994 and June 30, 1995, between July 1, 1995  
22 and June 30, 1996, between July 1, 1996 and June 30, 1997, between July  
23 1, 1997 and June 30, 1998, between July 1, 1998 and June 30, 1999,  
24 between July 1, 1999 and June 30, 2000, between July 1, 2000 and June  
25 30, 2001, between July 1, 2001 and June 30, 2002, between July 1, 2002  
26 and June 30, 2003, between July 1, 2003 and June 30, 2004, between July  
27 1, 2004 and June 30, 2005, between July 1, 2005 and June 30, 2006,  
28 between July 1, 2006 and June 30, 2007, between July 1, 2007 and June  
29 30, 2008, between July 1, 2008 and June 30, 2009, between July 1, 2009  
30 and June 30, 2010, between July 1, 2010 and June 30, 2011, between July  
31 1, 2011 and June 30, 2012, between July 1, 2012 and June 30, 2013, and  
32 between July 1, 2013 and June 30, 2014, between July 1, 2014 and June  
33 30, 2015, [and] between July 1, 2015 and June 30, 2016, AND BETWEEN JULY  
34 1, 2016 AND JUNE 30, 2017 allocable to each general hospital for physi-  
35 cians or dentists certified as eligible for purchase of a policy for  
36 excess insurance coverage by such general hospital in accordance with  
37 subdivision 2 of this section, and may amend such determination and  
38 certification as necessary.

39 (b) The superintendent of financial services shall determine and  
40 certify to each general hospital and to the commissioner of health the  
41 cost of excess malpractice insurance or equivalent excess coverage for  
42 medical or dental malpractice occurrences between July 1, 1987 and June  
43 30, 1988, between July 1, 1988 and June 30, 1989, between July 1, 1989  
44 and June 30, 1990, between July 1, 1990 and June 30, 1991, between July  
45 1, 1991 and June 30, 1992, between July 1, 1992 and June 30, 1993,  
46 between July 1, 1993 and June 30, 1994, between July 1, 1994 and June  
47 30, 1995, between July 1, 1995 and June 30, 1996, between July 1, 1996  
48 and June 30, 1997, between July 1, 1997 and June 30, 1998, between July  
49 1, 1998 and June 30, 1999, between July 1, 1999 and June 30, 2000,  
50 between July 1, 2000 and June 30, 2001, between July 1, 2001 and June  
51 30, 2002, between July 1, 2002 and June 30, 2003, between July 1, 2003  
52 and June 30, 2004, between July 1, 2004 and June 30, 2005, between July  
53 1, 2005 and June 30, 2006, between July 1, 2006 and June 30, 2007,  
54 between July 1, 2007 and June 30, 2008, between July 1, 2008 and June  
55 30, 2009, between July 1, 2009 and June 30, 2010, between July 1, 2010  
56 and June 30, 2011, between July 1, 2011 and June 30, 2012, between July



1 1, 2012 and June 30, 2013, between July 1, 2013 and June 30, 2014,  
2 between July 1, 2014 and June 30, 2015, [and] between July 1, 2015 and  
3 June 30, 2016, AND BETWEEN JULY 1, 2016 AND JUNE 30, 2017 allocable to  
4 each general hospital for physicians or dentists certified as eligible  
5 for purchase of a policy for excess insurance coverage or equivalent  
6 excess coverage by such general hospital in accordance with subdivision  
7 2 of this section, and may amend such determination and certification as  
8 necessary. The superintendent of financial services shall determine and  
9 certify to each general hospital and to the commissioner of health the  
10 ratable share of such cost allocable to the period July 1, 1987 to  
11 December 31, 1987, to the period January 1, 1988 to June 30, 1988, to  
12 the period July 1, 1988 to December 31, 1988, to the period January 1,  
13 1989 to June 30, 1989, to the period July 1, 1989 to December 31, 1989,  
14 to the period January 1, 1990 to June 30, 1990, to the period July 1,  
15 1990 to December 31, 1990, to the period January 1, 1991 to June 30,  
16 1991, to the period July 1, 1991 to December 31, 1991, to the period  
17 January 1, 1992 to June 30, 1992, to the period July 1, 1992 to December  
18 31, 1992, to the period January 1, 1993 to June 30, 1993, to the period  
19 July 1, 1993 to December 31, 1993, to the period January 1, 1994 to June  
20 30, 1994, to the period July 1, 1994 to December 31, 1994, to the period  
21 January 1, 1995 to June 30, 1995, to the period July 1, 1995 to December  
22 31, 1995, to the period January 1, 1996 to June 30, 1996, to the period  
23 July 1, 1996 to December 31, 1996, to the period January 1, 1997 to June  
24 30, 1997, to the period July 1, 1997 to December 31, 1997, to the period  
25 January 1, 1998 to June 30, 1998, to the period July 1, 1998 to December  
26 31, 1998, to the period January 1, 1999 to June 30, 1999, to the period  
27 July 1, 1999 to December 31, 1999, to the period January 1, 2000 to June  
28 30, 2000, to the period July 1, 2000 to December 31, 2000, to the period  
29 January 1, 2001 to June 30, 2001, to the period July 1, 2001 to June 30,  
30 2002, to the period July 1, 2002 to June 30, 2003, to the period July 1,  
31 2003 to June 30, 2004, to the period July 1, 2004 to June 30, 2005, to  
32 the period July 1, 2005 and June 30, 2006, to the period July 1, 2006  
33 and June 30, 2007, to the period July 1, 2007 and June 30, 2008, to the  
34 period July 1, 2008 and June 30, 2009, to the period July 1, 2009 and  
35 June 30, 2010, to the period July 1, 2010 and June 30, 2011, to the  
36 period July 1, 2011 and June 30, 2012, to the period July 1, 2012 and  
37 June 30, 2013, to the period July 1, 2013 and June 30, 2014, to the  
38 period July 1, 2014 and June 30, 2015, [and] to the period July 1, 2015  
39 and June 30, 2016, AND BETWEEN JULY 1, 2016 AND JUNE 30, 2017.

40 S 4. Paragraphs (a), (b), (c), (d) and (e) of subdivision 8 of section  
41 18 of chapter 266 of the laws of 1986, amending the civil practice law  
42 and rules and other laws relating to malpractice and professional  
43 medical conduct, as amended by section 3 of part Y of chapter 57 of the  
44 laws of 2015, are amended to read as follows:

45 (a) To the extent funds available to the hospital excess liability  
46 pool pursuant to subdivision 5 of this section as amended, and pursuant  
47 to section 6 of part J of chapter 63 of the laws of 2001, as may from  
48 time to time be amended, which amended this subdivision, are insuffi-  
49 cient to meet the costs of excess insurance coverage or equivalent  
50 excess coverage for coverage periods during the period July 1, 1992 to  
51 June 30, 1993, during the period July 1, 1993 to June 30, 1994, during  
52 the period July 1, 1994 to June 30, 1995, during the period July 1, 1995  
53 to June 30, 1996, during the period July 1, 1996 to June 30, 1997,  
54 during the period July 1, 1997 to June 30, 1998, during the period July  
55 1, 1998 to June 30, 1999, during the period July 1, 1999 to June 30,  
56 2000, during the period July 1, 2000 to June 30, 2001, during the period

1 July 1, 2001 to October 29, 2001, during the period April 1, 2002 to  
2 June 30, 2002, during the period July 1, 2002 to June 30, 2003, during  
3 the period July 1, 2003 to June 30, 2004, during the period July 1, 2004  
4 to June 30, 2005, during the period July 1, 2005 to June 30, 2006,  
5 during the period July 1, 2006 to June 30, 2007, during the period July  
6 1, 2007 to June 30, 2008, during the period July 1, 2008 to June 30,  
7 2009, during the period July 1, 2009 to June 30, 2010, during the period  
8 July 1, 2010 to June 30, 2011, during the period July 1, 2011 to June  
9 30, 2012, during the period July 1, 2012 to June 30, 2013, during the  
10 period July 1, 2013 to June 30, 2014, during the period July 1, 2014 to  
11 June 30, 2015, [and] during the period July 1, 2015 and June 30, 2016,  
12 AND BETWEEN JULY 1, 2016 AND JUNE 30, 2017 allocated or reallocated in  
13 accordance with paragraph (a) of subdivision 4-a of this section to  
14 rates of payment applicable to state governmental agencies, each physi-  
15 cian or dentist for whom a policy for excess insurance coverage or  
16 equivalent excess coverage is purchased for such period shall be respon-  
17 sible for payment to the provider of excess insurance coverage or equiv-  
18 alent excess coverage of an allocable share of such insufficiency, based  
19 on the ratio of the total cost of such coverage for such physician to  
20 the sum of the total cost of such coverage for all physicians applied to  
21 such insufficiency.

22 (b) Each provider of excess insurance coverage or equivalent excess  
23 coverage covering the period July 1, 1992 to June 30, 1993, or covering  
24 the period July 1, 1993 to June 30, 1994, or covering the period July 1,  
25 1994 to June 30, 1995, or covering the period July 1, 1995 to June 30,  
26 1996, or covering the period July 1, 1996 to June 30, 1997, or covering  
27 the period July 1, 1997 to June 30, 1998, or covering the period July 1,  
28 1998 to June 30, 1999, or covering the period July 1, 1999 to June 30,  
29 2000, or covering the period July 1, 2000 to June 30, 2001, or covering  
30 the period July 1, 2001 to October 29, 2001, or covering the period  
31 April 1, 2002 to June 30, 2002, or covering the period July 1, 2002 to  
32 June 30, 2003, or covering the period July 1, 2003 to June 30, 2004, or  
33 covering the period July 1, 2004 to June 30, 2005, or covering the peri-  
34 od July 1, 2005 to June 30, 2006, or covering the period July 1, 2006 to  
35 June 30, 2007, or covering the period July 1, 2007 to June 30, 2008, or  
36 covering the period July 1, 2008 to June 30, 2009, or covering the peri-  
37 od July 1, 2009 to June 30, 2010, or covering the period July 1, 2010 to  
38 June 30, 2011, or covering the period July 1, 2011 to June 30, 2012, or  
39 covering the period July 1, 2012 to June 30, 2013, or covering the peri-  
40 od July 1, 2013 to June 30, 2014, or covering the period July 1, 2014 to  
41 June 30, 2015, or covering the period July 1, 2015 to June 30, 2016, OR  
42 COVERING THE PERIOD JULY 1, 2016 TO JUNE 30, 2017 shall notify a covered  
43 physician or dentist by mail, mailed to the address shown on the last  
44 application for excess insurance coverage or equivalent excess coverage,  
45 of the amount due to such provider from such physician or dentist for  
46 such coverage period determined in accordance with paragraph (a) of this  
47 subdivision. Such amount shall be due from such physician or dentist to  
48 such provider of excess insurance coverage or equivalent excess coverage  
49 in a time and manner determined by the superintendent of financial  
50 services.

51 (c) If a physician or dentist liable for payment of a portion of the  
52 costs of excess insurance coverage or equivalent excess coverage cover-  
53 ing the period July 1, 1992 to June 30, 1993, or covering the period  
54 July 1, 1993 to June 30, 1994, or covering the period July 1, 1994 to  
55 June 30, 1995, or covering the period July 1, 1995 to June 30, 1996, or  
56 covering the period July 1, 1996 to June 30, 1997, or covering the peri-

1 od July 1, 1997 to June 30, 1998, or covering the period July 1, 1998 to  
2 June 30, 1999, or covering the period July 1, 1999 to June 30, 2000, or  
3 covering the period July 1, 2000 to June 30, 2001, or covering the peri-  
4 od July 1, 2001 to October 29, 2001, or covering the period April 1,  
5 2002 to June 30, 2002, or covering the period July 1, 2002 to June 30,  
6 2003, or covering the period July 1, 2003 to June 30, 2004, or covering  
7 the period July 1, 2004 to June 30, 2005, or covering the period July 1,  
8 2005 to June 30, 2006, or covering the period July 1, 2006 to June 30,  
9 2007, or covering the period July 1, 2007 to June 30, 2008, or covering  
10 the period July 1, 2008 to June 30, 2009, or covering the period July 1,  
11 2009 to June 30, 2010, or covering the period July 1, 2010 to June 30,  
12 2011, or covering the period July 1, 2011 to June 30, 2012, or covering  
13 the period July 1, 2012 to June 30, 2013, or covering the period July 1,  
14 2013 to June 30, 2014, or covering the period July 1, 2014 to June 30,  
15 2015, or covering the period July 1, 2015 to June 30, 2016, OR COVERING  
16 THE PERIOD JULY 1, 2016 TO JUNE 30, 2017 determined in accordance with  
17 paragraph (a) of this subdivision fails, refuses or neglects to make  
18 payment to the provider of excess insurance coverage or equivalent  
19 excess coverage in such time and manner as determined by the superinten-  
20 dent of financial services pursuant to paragraph (b) of this subdivi-  
21 sion, excess insurance coverage or equivalent excess coverage purchased  
22 for such physician or dentist in accordance with this section for such  
23 coverage period shall be cancelled and shall be null and void as of the  
24 first day on or after the commencement of a policy period where the  
25 liability for payment pursuant to this subdivision has not been met.

26 (d) Each provider of excess insurance coverage or equivalent excess  
27 coverage shall notify the superintendent of financial services and the  
28 commissioner of health or their designee of each physician and dentist  
29 eligible for purchase of a policy for excess insurance coverage or  
30 equivalent excess coverage covering the period July 1, 1992 to June 30,  
31 1993, or covering the period July 1, 1993 to June 30, 1994, or covering  
32 the period July 1, 1994 to June 30, 1995, or covering the period July 1,  
33 1995 to June 30, 1996, or covering the period July 1, 1996 to June 30,  
34 1997, or covering the period July 1, 1997 to June 30, 1998, or covering  
35 the period July 1, 1998 to June 30, 1999, or covering the period July 1,  
36 1999 to June 30, 2000, or covering the period July 1, 2000 to June 30,  
37 2001, or covering the period July 1, 2001 to October 29, 2001, or cover-  
38 ing the period April 1, 2002 to June 30, 2002, or covering the period  
39 July 1, 2002 to June 30, 2003, or covering the period July 1, 2003 to  
40 June 30, 2004, or covering the period July 1, 2004 to June 30, 2005, or  
41 covering the period July 1, 2005 to June 30, 2006, or covering the peri-  
42 od July 1, 2006 to June 30, 2007, or covering the period July 1, 2007 to  
43 June 30, 2008, or covering the period July 1, 2008 to June 30, 2009, or  
44 covering the period July 1, 2009 to June 30, 2010, or covering the peri-  
45 od July 1, 2010 to June 30, 2011, or covering the period July 1, 2011 to  
46 June 30, 2012, or covering the period July 1, 2012 to June 30, 2013, or  
47 covering the period July 1, 2013 to June 30, 2014, or covering the peri-  
48 od July 1, 2014 to June 30, 2015, or covering the period July 1, 2015 to  
49 June 30, 2016, OR COVERING THE PERIOD JULY 1, 2016 TO JUNE 30, 2017 that  
50 has made payment to such provider of excess insurance coverage or equiv-  
51 alent excess coverage in accordance with paragraph (b) of this subdivi-  
52 sion and of each physician and dentist who has failed, refused or  
53 neglected to make such payment.

54 (e) A provider of excess insurance coverage or equivalent excess  
55 coverage shall refund to the hospital excess liability pool any amount  
56 allocable to the period July 1, 1992 to June 30, 1993, and to the period

1 July 1, 1993 to June 30, 1994, and to the period July 1, 1994 to June  
2 30, 1995, and to the period July 1, 1995 to June 30, 1996, and to the  
3 period July 1, 1996 to June 30, 1997, and to the period July 1, 1997 to  
4 June 30, 1998, and to the period July 1, 1998 to June 30, 1999, and to  
5 the period July 1, 1999 to June 30, 2000, and to the period July 1, 2000  
6 to June 30, 2001, and to the period July 1, 2001 to October 29, 2001,  
7 and to the period April 1, 2002 to June 30, 2002, and to the period July  
8 1, 2002 to June 30, 2003, and to the period July 1, 2003 to June 30,  
9 2004, and to the period July 1, 2004 to June 30, 2005, and to the period  
10 July 1, 2005 to June 30, 2006, and to the period July 1, 2006 to June  
11 30, 2007, and to the period July 1, 2007 to June 30, 2008, and to the  
12 period July 1, 2008 to June 30, 2009, and to the period July 1, 2009 to  
13 June 30, 2010, and to the period July 1, 2010 to June 30, 2011, and to  
14 the period July 1, 2011 to June 30, 2012, and to the period July 1, 2012  
15 to June 30, 2013, and to the period July 1, 2013 to June 30, 2014, and  
16 to the period July 1, 2014 to June 30, 2015, and to the period July 1,  
17 2015 to June 30, 2016, AND TO THE PERIOD JULY 1, 2016 TO JUNE 30, 2017  
18 received from the hospital excess liability pool for purchase of excess  
19 insurance coverage or equivalent excess coverage covering the period  
20 July 1, 1992 to June 30, 1993, and covering the period July 1, 1993 to  
21 June 30, 1994, and covering the period July 1, 1994 to June 30, 1995,  
22 and covering the period July 1, 1995 to June 30, 1996, and covering the  
23 period July 1, 1996 to June 30, 1997, and covering the period July 1,  
24 1997 to June 30, 1998, and covering the period July 1, 1998 to June 30,  
25 1999, and covering the period July 1, 1999 to June 30, 2000, and cover-  
26 ing the period July 1, 2000 to June 30, 2001, and covering the period  
27 July 1, 2001 to October 29, 2001, and covering the period April 1, 2002  
28 to June 30, 2002, and covering the period July 1, 2002 to June 30, 2003,  
29 and covering the period July 1, 2003 to June 30, 2004, and covering the  
30 period July 1, 2004 to June 30, 2005, and covering the period July 1,  
31 2005 to June 30, 2006, and covering the period July 1, 2006 to June 30,  
32 2007, and covering the period July 1, 2007 to June 30, 2008, and cover-  
33 ing the period July 1, 2008 to June 30, 2009, and covering the period  
34 July 1, 2009 to June 30, 2010, and covering the period July 1, 2010 to  
35 June 30, 2011, and covering the period July 1, 2011 to June 30, 2012,  
36 and covering the period July 1, 2012 to June 30, 2013, and covering the  
37 period July 1, 2013 to June 30, 2014, and covering the period July 1,  
38 2014 to June 30, 2015, and covering the period July 1, 2015 to June 30,  
39 2016, AND COVERING THE PERIOD JULY 1, 2016 TO JUNE 30, 2017 for a physi-  
40 cian or dentist where such excess insurance coverage or equivalent  
41 excess coverage is cancelled in accordance with paragraph (c) of this  
42 subdivision.

43 S 5. Section 40 of chapter 266 of the laws of 1986, amending the civil  
44 practice law and rules and other laws relating to malpractice and  
45 professional medical conduct, as amended by section 4 of part Y of chap-  
46 ter 57 of the laws of 2015, is amended to read as follows:

47 S 40. The superintendent of financial services shall establish rates  
48 for policies providing coverage for physicians and surgeons medical  
49 malpractice for the periods commencing July 1, 1985 and ending June 30,  
50 [2016] 2017; provided, however, that notwithstanding any other provision  
51 of law, the superintendent shall not establish or approve any increase  
52 in rates for the period commencing July 1, 2009 and ending June 30,  
53 2010. The superintendent shall direct insurers to establish segregated  
54 accounts for premiums, payments, reserves and investment income attrib-  
55 utable to such premium periods and shall require periodic reports by the  
56 insurers regarding claims and expenses attributable to such periods to

1 monitor whether such accounts will be sufficient to meet incurred claims  
2 and expenses. On or after July 1, 1989, the superintendent shall impose  
3 a surcharge on premiums to satisfy a projected deficiency that is  
4 attributable to the premium levels established pursuant to this section  
5 for such periods; provided, however, that such annual surcharge shall  
6 not exceed eight percent of the established rate until July 1, [2016]  
7 2017, at which time and thereafter such surcharge shall not exceed twen-  
8 ty-five percent of the approved adequate rate, and that such annual  
9 surcharges shall continue for such period of time as shall be sufficient  
10 to satisfy such deficiency. The superintendent shall not impose such  
11 surcharge during the period commencing July 1, 2009 and ending June 30,  
12 2010. On and after July 1, 1989, the surcharge prescribed by this  
13 section shall be retained by insurers to the extent that they insured  
14 physicians and surgeons during the July 1, 1985 through June 30, [2016]  
15 2017 policy periods; in the event and to the extent physicians and  
16 surgeons were insured by another insurer during such periods, all or a  
17 pro rata share of the surcharge, as the case may be, shall be remitted  
18 to such other insurer in accordance with rules and regulations to be  
19 promulgated by the superintendent. Surcharges collected from physicians  
20 and surgeons who were not insured during such policy periods shall be  
21 apportioned among all insurers in proportion to the premium written by  
22 each insurer during such policy periods; if a physician or surgeon was  
23 insured by an insurer subject to rates established by the superintendent  
24 during such policy periods, and at any time thereafter a hospital,  
25 health maintenance organization, employer or institution is responsible  
26 for responding in damages for liability arising out of such physician's  
27 or surgeon's practice of medicine, such responsible entity shall also  
28 remit to such prior insurer the equivalent amount that would then be  
29 collected as a surcharge if the physician or surgeon had continued to  
30 remain insured by such prior insurer. In the event any insurer that  
31 provided coverage during such policy periods is in liquidation, the  
32 property/casualty insurance security fund shall receive the portion of  
33 surcharges to which the insurer in liquidation would have been entitled.  
34 The surcharges authorized herein shall be deemed to be income earned for  
35 the purposes of section 2303 of the insurance law. The superintendent,  
36 in establishing adequate rates and in determining any projected defi-  
37 ciency pursuant to the requirements of this section and the insurance  
38 law, shall give substantial weight, determined in his discretion and  
39 judgment, to the prospective anticipated effect of any regulations  
40 promulgated and laws enacted and the public benefit of stabilizing  
41 malpractice rates and minimizing rate level fluctuation during the peri-  
42 od of time necessary for the development of more reliable statistical  
43 experience as to the efficacy of such laws and regulations affecting  
44 medical, dental or podiatric malpractice enacted or promulgated in 1985,  
45 1986, by this act and at any other time. Notwithstanding any provision  
46 of the insurance law, rates already established and to be established by  
47 the superintendent pursuant to this section are deemed adequate if such  
48 rates would be adequate when taken together with the maximum authorized  
49 annual surcharges to be imposed for a reasonable period of time whether  
50 or not any such annual surcharge has been actually imposed as of the  
51 establishment of such rates.

52 S 6. Section 5 and subdivisions (a) and (e) of section 6 of part J of  
53 chapter 63 of the laws of 2001, amending chapter 266 of the laws of  
54 1986, amending the civil practice law and rules and other laws relating  
55 to malpractice and professional medical conduct, as amended by section 5

1 of part Y of chapter 57 of the laws of 2015, are amended to read as  
2 follows:

3 S 5. The superintendent of financial services and the commissioner of  
4 health shall determine, no later than June 15, 2002, June 15, 2003, June  
5 15, 2004, June 15, 2005, June 15, 2006, June 15, 2007, June 15, 2008,  
6 June 15, 2009, June 15, 2010, June 15, 2011, June 15, 2012, June 15,  
7 2013, June 15, 2014, June 15, 2015, [and] June 15, 2016, AND JUNE 15,  
8 2017 the amount of funds available in the hospital excess liability  
9 pool, created pursuant to section 18 of chapter 266 of the laws of 1986,  
10 and whether such funds are sufficient for purposes of purchasing excess  
11 insurance coverage for eligible participating physicians and dentists  
12 during the period July 1, 2001 to June 30, 2002, or July 1, 2002 to June  
13 30, 2003, or July 1, 2003 to June 30, 2004, or July 1, 2004 to June 30,  
14 2005, or July 1, 2005 to June 30, 2006, or July 1, 2006 to June 30,  
15 2007, or July 1, 2007 to June 30, 2008, or July 1, 2008 to June 30,  
16 2009, or July 1, 2009 to June 30, 2010, or July 1, 2010 to June 30,  
17 2011, or July 1, 2011 to June 30, 2012, or July 1, 2012 to June 30,  
18 2013, or July 1, 2013 to June 30, 2014, or July 1, 2014 to June 30,  
19 2015, or July 1, 2015 to June 30, 2016, OR JULY 1, 2016 TO JUNE 30, 2017  
20 as applicable.

21 (a) This section shall be effective only upon a determination, pursu-  
22 ant to section five of this act, by the superintendent of financial  
23 services and the commissioner of health, and a certification of such  
24 determination to the state director of the budget, the chair of the  
25 senate committee on finance and the chair of the assembly committee on  
26 ways and means, that the amount of funds in the hospital excess liabil-  
27 ity pool, created pursuant to section 18 of chapter 266 of the laws of  
28 1986, is insufficient for purposes of purchasing excess insurance cover-  
29 age for eligible participating physicians and dentists during the period  
30 July 1, 2001 to June 30, 2002, or July 1, 2002 to June 30, 2003, or July  
31 1, 2003 to June 30, 2004, or July 1, 2004 to June 30, 2005, or July 1,  
32 2005 to June 30, 2006, or July 1, 2006 to June 30, 2007, or July 1, 2007  
33 to June 30, 2008, or July 1, 2008 to June 30, 2009, or July 1, 2009 to  
34 June 30, 2010, or July 1, 2010 to June 30, 2011, or July 1, 2011 to June  
35 30, 2012, or July 1, 2012 to June 30, 2013, or July 1, 2013 to June 30,  
36 2014, or July 1, 2014 to June 30, 2015, or July 1, 2015 to June 30,  
37 2016, OR JULY 1, 2016 TO JUNE 30, 2017 as applicable.

38 (e) The commissioner of health shall transfer for deposit to the  
39 hospital excess liability pool created pursuant to section 18 of chapter  
40 266 of the laws of 1986 such amounts as directed by the superintendent  
41 of financial services for the purchase of excess liability insurance  
42 coverage for eligible participating physicians and dentists for the  
43 policy year July 1, 2001 to June 30, 2002, or July 1, 2002 to June 30,  
44 2003, or July 1, 2003 to June 30, 2004, or July 1, 2004 to June 30,  
45 2005, or July 1, 2005 to June 30, 2006, or July 1, 2006 to June 30,  
46 2007, as applicable, and the cost of administering the hospital excess  
47 liability pool for such applicable policy year, pursuant to the program  
48 established in chapter 266 of the laws of 1986, as amended, no later  
49 than June 15, 2002, June 15, 2003, June 15, 2004, June 15, 2005, June  
50 15, 2006, June 15, 2007, June 15, 2008, June 15, 2009, June 15, 2010,  
51 June 15, 2011, June 15, 2012, June 15, 2013, June 15, 2014, June 15,  
52 2015, [and] June 15, 2016, AND JUNE 15, 2017 as applicable.

53 S 7. Notwithstanding any law, rule or regulation to the contrary, only  
54 physicians or dentists who were eligible, and for whom the superinten-  
55 dent of financial services and the commissioner of health, or their  
56 designee, purchased, with funds available in the hospital excess liabil-

ity pool, a full or partial policy for excess coverage or equivalent excess coverage for the coverage period ending the thirtieth of June, two thousand sixteen, shall be eligible to apply for such coverage for the coverage period beginning the first of July, two thousand sixteen; provided, however, if the total number of physicians or dentists for whom such excess coverage or equivalent excess coverage was purchased for the policy year ending the thirtieth of June, two thousand sixteen exceeds the total number of physicians or dentists certified as eligible for the coverage period beginning the first of July, two thousand sixteen, then the general hospitals may certify additional eligible physicians or dentists in a number equal to such general hospital's proportional share of the total number of physicians or dentists for whom excess coverage or equivalent excess coverage was purchased with funds available in the hospital excess liability pool as of the thirtieth of June, two thousand sixteen, as applied to the difference between the number of eligible physicians or dentists for whom a policy for excess coverage or equivalent excess coverage was purchased for the coverage period ending the thirtieth of June, two thousand sixteen and the number of such eligible physicians or dentists who have applied for excess coverage or equivalent excess coverage for the coverage period beginning the first of July, two thousand sixteen.

S 8. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2016, provided, however, section two of this act shall take effect July 1, 2016.

25

## PART D

Section 1. Paragraph (a) of subdivision 1 of section 212 of chapter 474 of the laws of 1996, amending the education law and other laws relating to rates for residential healthcare facilities, as amended by section 2 of part B of chapter 56 of the laws of 2013, is amended to read as follows:

(a) Notwithstanding any inconsistent provision of law or regulation to the contrary, effective beginning August 1, 1996, for the period April 1, 1997 through March 31, 1998, April 1, 1998 for the period April 1, 1998 through March 31, 1999, August 1, 1999, for the period April 1, 1999 through March 31, 2000, April 1, 2000, for the period April 1, 2000 through March 31, 2001, April 1, 2001, for the period April 1, 2001 through March 31, 2002, April 1, 2002, for the period April 1, 2002 through March 31, 2003, and for the state fiscal year beginning April 1, 2005 through March 31, 2006, and for the state fiscal year beginning April 1, 2006 through March 31, 2007, and for the state fiscal year beginning April 1, 2007 through March 31, 2008, and for the state fiscal year beginning April 1, 2008 through March 31, 2009, and for the state fiscal year beginning April 1, 2009 through March 31, 2010, and for the state fiscal year beginning April 1, 2010 through March 31, 2016, AND ANNUALLY THEREAFTER, the department of health is authorized to pay public general hospitals, as defined in subdivision 10 of section 2801 of the public health law, operated by the state of New York or by the state university of New York or by a county, which shall not include a city with a population of over one million, of the state of New York, and those public general hospitals located in the county of Westchester, the county of Erie or the county of Nassau, additional payments for inpatient hospital services as medical assistance payments pursuant to title 11 of article 5 of the social services law for patients eligible for federal financial participation under title XIX of the federal

1 social security act in medical assistance pursuant to the federal laws  
2 and regulations governing disproportionate share payments to hospitals  
3 up to one hundred percent of each such public general hospital's medical  
4 assistance and uninsured patient losses after all other medical assist-  
5 ance, including disproportionate share payments to such public general  
6 hospital for 1996, 1997, 1998, and 1999, based initially for 1996 on  
7 reported 1994 reconciled data as further reconciled to actual reported  
8 1996 reconciled data, and for 1997 based initially on reported 1995  
9 reconciled data as further reconciled to actual reported 1997 reconciled  
10 data, for 1998 based initially on reported 1995 reconciled data as  
11 further reconciled to actual reported 1998 reconciled data, for 1999  
12 based initially on reported 1995 reconciled data as further reconciled  
13 to actual reported 1999 reconciled data, for 2000 based initially on  
14 reported 1995 reconciled data as further reconciled to actual reported  
15 2000 data, for 2001 based initially on reported 1995 reconciled data as  
16 further reconciled to actual reported 2001 data, for 2002 based initial-  
17 ly on reported 2000 reconciled data as further reconciled to actual  
18 reported 2002 data, and for state fiscal years beginning on April 1,  
19 2005, based initially on reported 2000 reconciled data as further recon-  
20 ciled to actual reported data for 2005, and for state fiscal years  
21 beginning on April 1, 2006, based initially on reported 2000 reconciled  
22 data as further reconciled to actual reported data for 2006, for state  
23 fiscal years beginning on and after April 1, 2007 through March 31,  
24 2009, based initially on reported 2000 reconciled data as further recon-  
25 ciled to actual reported data for 2007 and 2008, respectively, for state  
26 fiscal years beginning on and after April 1, 2009, based initially on  
27 reported 2007 reconciled data, adjusted for authorized Medicaid rate  
28 changes applicable to the state fiscal year, and as further reconciled  
29 to actual reported data for 2009, for state fiscal years beginning on  
30 and after April 1, 2010, based initially on reported reconciled data  
31 from the base year two years prior to the payment year, adjusted for  
32 authorized Medicaid rate changes applicable to the state fiscal year,  
33 and further reconciled to actual reported data from such payment year,  
34 and to actual reported data for each respective succeeding year. The  
35 payments may be added to rates of payment or made as aggregate payments  
36 to an eligible public general hospital.

37 S 2. Section 10 of chapter 649 of the laws of 1996, amending the  
38 public health law, the mental hygiene law and the social services law  
39 relating to authorizing the establishment of special needs plans, as  
40 amended by section 20 of part D of chapter 59 of the laws of 2011, is  
41 amended to read as follows:

42 S 10. This act shall take effect immediately and shall be deemed to  
43 have been in full force and effect on and after July 1, 1996[; provided,  
44 however, that sections one, two and three of this act shall expire and  
45 be deemed repealed on March 31, 2016 provided, however that the amend-  
46 ments to section 364-j of the social services law made by section four  
47 of this act shall not affect the expiration of such section and shall be  
48 deemed to expire therewith and provided, further, that the provisions of  
49 subdivisions 8, 9 and 10 of section 4401 of the public health law, as  
50 added by section one of this act; section 4403-d of the public health  
51 law as added by section two of this act and the provisions of section  
52 seven of this act, except for the provisions relating to the establish-  
53 ment of no more than twelve comprehensive HIV special needs plans, shall  
54 expire and be deemed repealed on July 1, 2000].



1 S 3. Subdivision 8 of section 84 of part A of chapter 56 of the laws  
2 of 2013, amending the public health law and other laws relating to  
3 general hospital reimbursement for annual rates is REPEALED.

4 S 4. Subdivision (f) of section 129 of part C of chapter 58 of the  
5 laws of 2009, amending the public health law relating to payment by  
6 governmental agencies for general hospital inpatient services, is  
7 REPEALED.

8 S 5. Subdivision (c) of section 122 of part E of chapter 56 of the  
9 laws of 2013 amending the public health law relating to the general  
10 public health work program is REPEALED.

11 S 6. This act shall take effect immediately and shall be deemed to  
12 have been in full force and effect on and after April 1, 2016.

13 PART E

14 Section 1. Subdivisions 9 and 10 of section 2541 of the public health  
15 law, as added by chapter 428 of the laws of 1992, are amended to read as  
16 follows:

17 9. "Evaluation" means a multidisciplinary professional, objective  
18 [assessment] EXAMINATION conducted by appropriately qualified personnel  
19 and conducted pursuant to section twenty-five hundred forty-four of this  
20 title to determine a child's eligibility under this title.

21 10. "Evaluator" means a [team of two or more professionals approved  
22 pursuant to section twenty-five hundred fifty-one of this title] PROVID-  
23 ER APPROVED BY THE DEPARTMENT to conduct screenings and evaluations.

24 S 2. Section 2541 of the public health law is amended by adding two  
25 new subdivisions 12-a and 15-a to read as follows:

26 12-A. "MULTIDISCIPLINARY" MEANS THE INVOLVEMENT OF TWO OR MORE SEPA-  
27 RATE DISCIPLINES OR PROFESSIONS, WHICH MAY MEAN THE INVOLVEMENT OF ONE  
28 INDIVIDUAL WHO MEETS THE DEFINITION OF QUALIFIED PERSONNEL AS DEFINED IN  
29 SUBDIVISION FIFTEEN OF THIS SECTION AND WHO IS QUALIFIED, IN ACCORDANCE  
30 WITH STATE LICENSURE, CERTIFICATION OR OTHER COMPARABLE STANDARDS, TO  
31 EVALUATE ALL FIVE DEVELOPMENTAL DOMAINS.

32 15-A. "SCREENING" MEANS THE PROCEDURES USED BY QUALIFIED PERSONNEL, AS  
33 DEFINED IN SUBDIVISION FIFTEEN OF THIS SECTION, TO DETERMINE WHETHER A  
34 CHILD IS SUSPECTED OF HAVING A DISABILITY AND IN NEED OF EARLY INTER-  
35 VENTION SERVICES, AND SHALL INCLUDE, WHERE AVAILABLE AND APPROPRIATE FOR  
36 THE CHILD, THE ADMINISTRATION OF A STANDARDIZED INSTRUMENT OR INSTRU-  
37 MENTS APPROVED BY THE DEPARTMENT, IN ACCORDANCE WITH SUBDIVISION THREE  
38 OF SECTION TWENTY-FIVE HUNDRED FORTY-FOUR OF THIS TITLE.

39 S 3. Subdivision 3 of section 2542 of the public health law, as  
40 amended by chapter 231 of the laws of 1993, is amended to read as  
41 follows:

42 3. [The following persons and entities, within] (A) UNLESS THE PARENT  
43 OBJECTS, WITHIN two working days of identifying an infant or toddler  
44 suspected of having a disability or at risk of having a disability, THE  
45 FOLLOWING PERSONS AND ENTITIES shall refer such infant or toddler to the  
46 early intervention official or the health officer [of the public health  
47 district in which the infant or toddler resides, as designated by the  
48 municipality, but in no event over the objection of the parent made in  
49 accordance with procedures established by the department for use by such  
50 primary referral sources, unless the child has already been referred] OF  
51 THE PUBLIC HEALTH DISTRICT DESIGNATED BY THE MUNICIPALITY IN WHICH THE  
52 INFANT OR TODDLER RESIDES: hospitals, child health care providers, day  
53 care programs, local school districts, public health facilities, early  
54 childhood direction centers and such other social service and health

1 care agencies and providers as the commissioner shall specify in regu-  
2 lation[; provided, however, that the]. THIS SHALL NOT APPLY IF THE  
3 INFANT OR TODDLER HAS ALREADY BEEN REFERRED TO SUCH EARLY INTERVENTION  
4 OFFICIAL OR HEALTH OFFICER. THE department shall establish procedures,  
5 including regulations if required, to ensure that primary referral  
6 sources adequately inform the parent or guardian about the early inter-  
7 vention program, including through brochures and written materials  
8 created or approved by the department.

9 (B) THE PRIMARY REFERRAL SOURCES IDENTIFIED IN PARAGRAPH (A) OF THIS  
10 SUBDIVISION SHALL, WITH PARENTAL CONSENT, COMPLETE AND TRANSMIT AT THE  
11 TIME OF REFERRAL, A REFERRAL FORM DEVELOPED BY THE DEPARTMENT WHICH  
12 CONTAINS INFORMATION SUFFICIENT TO DOCUMENT THE PRIMARY REFERRAL  
13 SOURCE'S CONCERN OR BASIS FOR SUSPECTING THE CHILD HAS A DISABILITY OR  
14 IS AT RISK OF HAVING A DISABILITY, AND WHERE APPLICABLE, SPECIFIES THE  
15 CHILD'S DIAGNOSED CONDITION THAT ESTABLISHES THE CHILD'S ELIGIBILITY FOR  
16 THE EARLY INTERVENTION PROGRAM. THE PRIMARY REFERRAL SOURCE SHALL INFORM  
17 THE PARENT OF A CHILD WITH A DIAGNOSED CONDITION THAT HAS A HIGH PROBA-  
18 BILITY OF RESULTING IN DEVELOPMENTAL DELAY, THAT (I) ELIGIBILITY FOR THE  
19 PROGRAM MAY BE ESTABLISHED BY MEDICAL OR OTHER RECORDS AND (II) OF THE  
20 IMPORTANCE OF PROVIDING CONSENT FOR THE PRIMARY REFERRAL SOURCE TO TRAN-  
21 SMIT RECORDS OR REPORTS NECESSARY TO SUPPORT THE DIAGNOSIS, OR, FOR  
22 PARENTS OR GUARDIANS OF CHILDREN WHO DO NOT HAVE A DIAGNOSED CONDITION,  
23 RECORDS OR REPORTS THAT WOULD ASSIST IN DETERMINING ELIGIBILITY FOR THE  
24 PROGRAM.

25 S 4. Section 2544 of the public health law, as added by chapter 428 of  
26 the laws of 1992, paragraph (c) of subdivision 2 as added by section 1  
27 of part A of chapter 56 of the laws of 2012 and subdivision 11 as added  
28 by section 3 of part B3 of chapter 62 of the laws of 2003, is amended to  
29 read as follows:

30 S 2544. Screening and evaluations. 1. Each child thought to be an  
31 eligible child is entitled to [a multidisciplinary] AN evaluation  
32 CONDUCTED IN ACCORDANCE WITH THIS SECTION, and the early intervention  
33 official shall ensure such evaluation, with parental consent.

34 2. (a) The parent may select an evaluator from the list of approved  
35 evaluators as described in section twenty-five hundred forty-two of this  
36 title to conduct the APPLICABLE SCREENING AND/OR evaluation IN ACCORD-  
37 ANCE WITH THIS SECTION. The parent or evaluator shall immediately noti-  
38 fy the early intervention official of such selection. THE EVALUATOR  
39 SHALL REVIEW THE INFORMATION AND DOCUMENTATION PROVIDED WITH THE REFER-  
40 RAL TO DETERMINE THE APPROPRIATE SCREENING OR EVALUATION PROCESS TO  
41 FOLLOW IN ACCORDANCE WITH THIS SECTION. The evaluator may begin the  
42 SCREENING OR evaluation no sooner than four working days after such  
43 notification, unless otherwise approved by the initial service coordina-  
44 tor.

45 (b) [the evaluator shall designate an individual as the principal  
46 contact for the multidisciplinary team] INITIAL SERVICE COORDINATORS  
47 SHALL INFORM THE PARENT OF THE APPLICABLE SCREENING OR EVALUATION PROCE-  
48 DURES THAT MAY BE PERFORMED. FOR A CHILD REFERRED TO THE EARLY INTER-  
49 VENTION OFFICIAL WHO HAS A DIAGNOSED PHYSICAL OR MENTAL CONDITION THAT  
50 HAS A HIGH PROBABILITY OF RESULTING IN DEVELOPMENTAL DELAY, THE INITIAL  
51 SERVICE COORDINATOR SHALL INFORM THE PARENT THAT THE EVALUATION OF THE  
52 CHILD SHALL BE CONDUCTED IN ACCORDANCE WITH THE PROCEDURES SET FORTH IN  
53 SUBDIVISION FIVE OF THIS SECTION.

54 (c) If, in consultation with the evaluator, the service coordinator  
55 identifies a child that is potentially eligible for programs or services  
56 offered by or under the auspices of the office for people with develop-

1 mental disabilities, the service coordinator shall, with parent consent,  
2 notify the office for people with developmental disabilities' regional  
3 developmental disabilities services office of the potential eligibility  
4 of such child for said programs or services.

5 3. [(a) To determine eligibility, an evaluator shall, with parental  
6 consent, either (i) screen a child to determine what type of evaluation,  
7 if any, is warranted, or (ii) provide a multidisciplinary evaluation. In  
8 making the determination whether to provide an evaluation, the evaluator  
9 may rely on a recommendation from a physician or other qualified person  
10 as designated by the commissioner.

11 (b)] SCREENINGS FOR CHILDREN REFERRED TO THE EARLY INTERVENTION  
12 PROGRAM TO DETERMINE WHETHER THEY ARE SUSPECTED OF HAVING A DISABILITY.  
13 (A) FOR A CHILD REFERRED TO THE EARLY INTERVENTION PROGRAM, THE EVALU-  
14 ATOR SHALL FIRST PERFORM A SCREENING OF THE CHILD, WITH PARENTAL  
15 CONSENT, TO DETERMINE WHETHER THE CHILD IS SUSPECTED OF HAVING A DISA-  
16 BILITY.

17 (B) THE EVALUATOR SHALL UTILIZE A STANDARDIZED INSTRUMENT OR INSTRU-  
18 MENTS APPROVED BY THE DEPARTMENT TO CONDUCT THE SCREENING. IF THE EVALU-  
19 ATOR DOES NOT UTILIZE A STANDARDIZED INSTRUMENT OR INSTRUMENTS APPROVED  
20 BY THE DEPARTMENT FOR THE SCREENING, THE EVALUATOR SHALL DOCUMENT IN  
21 WRITING WHY SUCH STANDARDIZED INSTRUMENT OR INSTRUMENTS ARE UNAVAILABLE  
22 OR INAPPROPRIATE FOR THE CHILD.

23 (C) THE EVALUATOR SHALL EXPLAIN THE RESULTS OF THE SCREENING TO THE  
24 PARENT AND SHALL FULLY DOCUMENT THE RESULTS IN WRITING.

25 (D) If, based upon the screening, a child is [believed to be eligible,  
26 or if otherwise elected by the parent] SUSPECTED OF HAVING A DISABILITY,  
27 the child shall, with [the consent of a parent] PARENTAL CONSENT,  
28 receive [a multidisciplinary evaluation. All evaluations shall be  
29 conducted in accordance with] AN EVALUATION TO BE CONDUCTED IN ACCORD-  
30 ANCE WITH THE PROCEDURES SET FORTH IN SUBDIVISION FOUR OF THIS SECTION,  
31 the coordinated standards and procedures and with regulations promulgat-  
32 ed by the commissioner.

33 (E) IF, BASED UPON THE SCREENING, A CHILD IS NOT SUSPECTED OF HAVING A  
34 DISABILITY, AN EVALUATION SHALL NOT BE PROVIDED, UNLESS REQUESTED BY THE  
35 PARENT. THE EARLY INTERVENTION OFFICIAL SHALL PROVIDE THE PARENT WITH  
36 WRITTEN NOTICE OF THE SCREENING RESULTS, WHICH SHALL INCLUDE INFORMATION  
37 ON THE PARENT'S RIGHT TO REQUEST AN EVALUATION.

38 (F) A SCREENING SHALL NOT BE PROVIDED TO CHILDREN WHO ARE REFERRED TO  
39 THE EARLY INTERVENTION PROGRAM WHO HAVE A DIAGNOSED PHYSICAL OR MENTAL  
40 CONDITION WITH A HIGH PROBABILITY OF RESULTING IN DEVELOPMENTAL DELAY  
41 THAT ESTABLISHES ELIGIBILITY FOR THE PROGRAM.

42 4. The evaluation of [each] A child shall:

43 (a) INCLUDE THE ADMINISTRATION OF AN EVALUATION STANDARDIZED INSTRU-  
44 MENT OR INSTRUMENTS APPROVED BY THE DEPARTMENT. IF THE EVALUATOR DOES  
45 NOT UTILIZE A STANDARDIZED INSTRUMENT OR INSTRUMENTS APPROVED BY THE  
46 DEPARTMENT AS PART OF THE EVALUATION OF THE CHILD, THE EVALUATOR SHALL  
47 DOCUMENT IN WRITING WHY SUCH STANDARDIZED INSTRUMENT OR INSTRUMENTS ARE  
48 NOT APPROPRIATE OR AVAILABLE FOR THE CHILD;

49 (B) be conducted by personnel trained to utilize appropriate methods  
50 and procedures;

51 [(b)] (C) be based on informed clinical opinion;

52 [(c)] (D) be made without regard to the availability of services in  
53 the municipality or who might provide such services; [and

54 (d)] (E) with parental consent, include the following:

55 (i) a review of pertinent records related to the child's current  
56 health status and medical history; AND

(ii) an evaluation of the child's level of functioning in each of the developmental areas set forth in paragraph (c) of subdivision seven of section twenty-five hundred forty-one of this title[;] TO DETERMINE WHETHER THE CHILD HAS A DISABILITY AS DEFINED IN THIS TITLE THAT ESTABLISHES THE CHILD'S ELIGIBILITY FOR THE PROGRAM; AND

(F) IF THE CHILD HAS BEEN DETERMINED ELIGIBLE BY THE EVALUATOR AFTER CONDUCTING THE PROCEDURES SET FORTH IN PARAGRAPHS (A) THROUGH (E) OF THIS SUBDIVISION, THE EVALUATION SHALL ALSO INCLUDE:

[(iii)] (I) an assessment [of the unique needs of the child in terms of] FOR THE PURPOSES OF IDENTIFYING THE CHILD'S UNIQUE STRENGTHS AND NEEDS IN each of the developmental areas [set forth in paragraph (c) of subdivision seven of section twenty-five hundred forty-one of this title, including the identification of] AND THE EARLY INTERVENTION services appropriate to meet those needs;

[(iv)] (II) A FAMILY-DIRECTED ASSESSMENT, IF CONSENTED TO BY THE FAMILY, IN ORDER TO IDENTIFY THE FAMILY'S RESOURCES, PRIORITIES, AND CONCERNS AND THE SUPPORTS NECESSARY TO ENHANCE THE FAMILY'S CAPACITY TO MEET THE DEVELOPMENTAL NEEDS OF THE CHILD. THE FAMILY ASSESSMENT SHALL BE VOLUNTARY ON THE PART OF EACH FAMILY MEMBER PARTICIPATING IN THE ASSESSMENT;

(III) an [evaluation] ASSESSMENT of the transportation needs of the child, if any; and

[(v)] (IV) such other matters as the commissioner may prescribe in regulation.

5. EVALUATIONS FOR CHILDREN WHO ARE REFERRED TO THE EARLY INTERVENTION OFFICIAL WITH DIAGNOSED PHYSICAL OR MENTAL CONDITIONS THAT HAVE A HIGH PROBABILITY OF RESULTING IN DEVELOPMENTAL DELAY. (A) IF A CHILD HAS A DIAGNOSED PHYSICAL OR MENTAL CONDITION THAT HAS A HIGH PROBABILITY OF RESULTING IN DEVELOPMENTAL DELAY, THE CHILD'S MEDICAL OR OTHER RECORDS SHALL BE USED, WHEN AVAILABLE, TO ESTABLISH THE CHILD'S ELIGIBILITY FOR THE PROGRAM.

(B) THE EVALUATOR SHALL, UPON REVIEW OF THE REFERRAL FORM PROVIDED IN ACCORDANCE WITH SECTION TWENTY-FIVE HUNDRED FORTY-TWO OF THIS TITLE OR ANY MEDICAL OR OTHER RECORDS, OR AT THE TIME OF INITIAL CONTACT WITH THE CHILD'S FAMILY, DETERMINE WHETHER THE CHILD HAS A DIAGNOSED CONDITION THAT ESTABLISHES THE CHILD'S ELIGIBILITY FOR THE PROGRAM. IF THE EVALUATOR HAS REASON TO BELIEVE, AFTER SPEAKING WITH THE CHILD'S FAMILY, THAT THE CHILD MAY HAVE A DIAGNOSED CONDITION THAT ESTABLISHES THE CHILD'S ELIGIBILITY BUT THE EVALUATOR HAS NOT BEEN PROVIDED WITH MEDICAL OR OTHER DOCUMENTATION OF SUCH DIAGNOSIS, THE EVALUATOR SHALL, WITH PARENTAL CONSENT, OBTAIN SUCH DOCUMENTATION, WHEN AVAILABLE, PRIOR TO PROCEEDING WITH THE EVALUATION OF THE CHILD.

(C) THE EVALUATOR SHALL REVIEW ALL RECORDS RECEIVED TO DOCUMENT THAT THE CHILD'S DIAGNOSIS AS SET FORTH IN SUCH RECORDS ESTABLISHES THE CHILD'S ELIGIBILITY FOR THE EARLY INTERVENTION PROGRAM.

(D) NOTWITHSTANDING SUBDIVISION FOUR OF THIS SECTION, IF THE CHILD'S ELIGIBILITY FOR THE EARLY INTERVENTION PROGRAM IS ESTABLISHED IN ACCORDANCE WITH THIS SUBDIVISION, THE EVALUATION OF THE CHILD SHALL (I) CONSIST OF A REVIEW OF THE RESULTS OF THE MEDICAL OR OTHER RECORDS THAT ESTABLISHED THE CHILD'S ELIGIBILITY, AND ANY OTHER PERTINENT EVALUATIONS OR RECORDS AVAILABLE AND (II) COMPLY WITH THE PROCEDURES SET FORTH IN PARAGRAPH (F) OF SUBDIVISION FOUR OF THIS SECTION. THE EVALUATION PROCEDURES SET FORTH IN PARAGRAPHS (A) AND (E) OF SUBDIVISION FOUR SHALL NOT BE REQUIRED OR CONDUCTED.

6. An evaluation shall not include a reference to any specific provider of early intervention services.

[6.] 7. Nothing in this section shall restrict an evaluator from utilizing, in addition to findings from his or her personal examination, other examinations, evaluations or assessments conducted for such child, including those conducted prior to the evaluation under this section, if such examinations, evaluations or assessments are consistent with the coordinated standards and procedures.

[7.] 8. Following completion of the evaluation, the evaluator shall provide the parent and service coordinator with a copy of a summary of the full evaluation. To the extent practicable, the summary shall be provided in the native language of the parent. Upon request of the parent, early intervention official or service coordinator, the evaluator shall provide a copy of the full evaluation to such parent, early intervention official or service coordinator.

[8.] 9. A parent who disagrees with the results of an evaluation may obtain an additional evaluation or partial evaluation at public expense to the extent authorized by federal law or regulation.

[9.] 10. Upon receipt of the results of an evaluation, a service coordinator may, with parental consent, require additional diagnostic information regarding the condition of the child, provided, however, that such evaluation or assessment is not unnecessarily duplicative or invasive to the child, and provided further, that:

(a) where the evaluation has established the child's eligibility, such additional diagnostic information shall be used solely to provide additional information to the parent and service coordinator regarding the child's need for services and cannot be a basis for refuting eligibility;

(b) the service coordinator provides the parent with a written explanation of the basis for requiring additional diagnostic information;

(c) the additional diagnostic procedures are at no expense to the parent; and

(d) the evaluation is completed and a meeting to develop an IFSP is held within the time prescribed in subdivision one of section twenty-five hundred forty-five of this title.

[10.] 11. (a) If the screening indicates that the infant or toddler is not an eligible child and the parent elects not to have an evaluation, or if the evaluation indicates that the infant or toddler is not an eligible child, the service coordinator shall inform the parent of other programs or services that may benefit such child, and the child's family and, with parental consent, refer such child to such programs or services.

(b) A parent may appeal a determination that a child is ineligible pursuant to the provisions of section twenty-five hundred forty-nine of this title, provided, however, that a parent may not initiate such appeal until all evaluations are completed. IN ADDITION, FOR A CHILD REFERRED TO THE EARLY INTERVENTION OFFICIAL WHO HAS A DIAGNOSED PHYSICAL OR MENTAL CONDITION THAT ESTABLISHES THE CHILD'S ELIGIBILITY FOR THE PROGRAM IN ACCORDANCE WITH SUBDIVISION FIVE OF THIS SECTION, THE PARENT MAY REQUEST, AND SUCH REQUEST SHALL BE GRANTED, THAT THE EVALUATOR CONDUCT THE EVALUATION PROCEDURES SET FORTH IN PARAGRAPHS (A) THROUGH (E) OF SUBDIVISION FOUR OF THIS SECTION, PROVIDED, HOWEVER, THAT THE PARENT MAY NOT MAKE SUCH REQUEST UNTIL THE EVALUATION CONDUCTED IN ACCORDANCE WITH SUBDIVISION FIVE OF THIS SECTION IS COMPLETED.

[11.] 12. Notwithstanding any other provision of law to the contrary, where a request has been made to review an IFSP prior to the six-month interval provided in subdivision seven of section twenty-five hundred forty-five of this title for purposes of increasing frequency or dura-

tion of an approved service, including service coordination, the early intervention official may require an additional evaluation or partial evaluation at public expense by an approved evaluator other than the current provider of service, with parent consent.

S 5. Paragraph (a) of subdivision 3 of section 2559 of the public health law, is amended by adding two new subparagraphs (iv) and (v) to read as follows:

(IV) PROVIDERS SHALL SUBMIT ALL CLAIMS, IN ACCORDANCE WITH SUBPARAGRAPH (III) OF THIS PARAGRAPH AND WITHIN NINETY DAYS OF THE DATE OF SERVICE, UNLESS THE SUBMISSION IS DELAYED DUE TO EXTRAORDINARY CIRCUMSTANCES DOCUMENTED BY THE PROVIDER. ALL CLAIMS SUBMITTED AFTER NINETY DAYS SHALL BE SUBMITTED WITHIN THIRTY DAYS FROM THE TIME THE PROVIDER WAS RELIEVED FROM THE EXTRAORDINARY CIRCUMSTANCES THAT PREVIOUSLY DELAYED A TIMELY SUBMISSION. CLAIMS THAT ARE NOT SUBMITTED WITHIN TIMEFRAMES SET FORTH WILL NOT BE REIMBURSED BY THE DEPARTMENT'S FISCAL AGENT FROM THE ESCROW ACCOUNT FUNDED BY MUNICIPAL GOVERNMENTAL PAYERS.

(V) PROVIDERS SHALL ENROLL, ON REQUEST OF THE DEPARTMENT OR THE DEPARTMENT'S FISCAL AGENT, WITH ONE OR MORE HEALTH CARE CLEARINGHOUSES, AS NECESSARY, FOR PROCESSING OF CLAIMS TO THIRD PARTY PAYORS AND FOR RECEIPT OF REMITTANCE ADVICES IN STANDARD ELECTRONIC FORMAT AND IN COMPLIANCE WITH ANY APPLICABLE FEDERAL OR STATE REGULATIONS WITH RESPECT TO ELECTRONIC CLAIMS TRANSACTIONS.

S 6. Section 3224-a of the insurance law, as amended by chapter 666 of the laws of 1997, the opening paragraph and subsections (a), (b) and (c) as amended and subsections (g) and (h) as added by chapter 237 of the laws of 2009, paragraph 2 of subsection (d) as amended by section 57-b of part A of chapter 56 of the laws of 2013, subsection (i) as added by chapter 297 of the laws of 2012 and subsection (j) as added by section 5 of part H of chapter 60 of the laws of 2014, is amended to read as follows:

S 3224-a. Standards for prompt, fair and equitable settlement of claims for health care and payments for health care services. In the processing of all health care claims submitted under contracts or agreements issued or entered into pursuant to this article and articles forty-two, forty-three and forty-seven of this chapter and article forty-four of the public health law and all bills for health care services rendered by health care providers pursuant to such contracts or agreements, any insurer or organization or corporation licensed or certified pursuant to article forty-three or forty-seven of this chapter or article forty-four of the public health law shall adhere to the following standards:

(a) Except in a case where the obligation of an insurer or an organization or corporation licensed or certified pursuant to article forty-three or forty-seven of this chapter or article forty-four of the public health law to pay a claim submitted by a policyholder or person covered under such policy ("covered person") or make a payment to a health care provider is not reasonably clear, or when there is a reasonable basis supported by specific information available for review by the superintendent that such claim or bill for health care services rendered was submitted fraudulently, such insurer or organization or corporation shall pay the claim to a policyholder or covered person or make a payment to a health care provider within thirty days of receipt of a claim or bill for services rendered that is transmitted via the internet or electronic mail, or forty-five days of receipt of a claim or bill for services rendered that is submitted by other means, such as paper or facsimile.

(A-1) AN INSURER, ORGANIZATION, INCLUDING AN APPROVED ORGANIZATION AS DEFINED IN SUBDIVISION TWO OF SECTION TWENTY-FIVE HUNDRED TEN OF THE PUBLIC HEALTH LAW, OR CORPORATION SHALL, WITHIN FIFTEEN BUSINESS DAYS OF RECEIPT OF A CLAIM OR BILL FOR SERVICES RENDERED UNDER THE EARLY INTERVENTION PROGRAM, ESTABLISHED IN TITLE TWO-A OF ARTICLE TWENTY-FIVE OF THE PUBLIC HEALTH LAW, NOTIFY THE HEALTH CARE PROVIDER, IN A MANNER AND FORMAT DETERMINED BY THE DEPARTMENT OF HEALTH, THROUGH THE DEPARTMENT OF HEALTH'S DESIGNATED FISCAL AGENT, WHETHER THE CONTRACT OR AGREEMENT IS SUBJECT TO THE PROVISIONS OF THIS CHAPTER.

(b) In a case where the obligation of an insurer or an organization or corporation licensed or certified pursuant to article forty-three or forty-seven of this chapter or article forty-four of the public health law to pay a claim or make a payment for health care services rendered is not reasonably clear due to a good faith dispute regarding the eligibility of a person for coverage, the liability of another insurer or corporation or organization for all or part of the claim, the amount of the claim, the benefits covered under a contract or agreement, or the manner in which services were accessed or provided, an insurer or organization or corporation shall pay any undisputed portion of the claim in accordance with this subsection and notify the policyholder, covered person or health care provider in writing within thirty calendar days of the receipt of the claim:

(1) that it is not obligated to pay the claim or make the medical payment, stating the specific reasons why it is not liable; or

(2) to request all additional information needed to determine liability to pay the claim or make the health care payment, EXCEPT THAT WITH RESPECT TO A CLAIM OR BILL FOR SERVICES RENDERED UNDER THE EARLY INTERVENTION PROGRAM ESTABLISHED IN TITLE TWO-A OF ARTICLE TWENTY-FIVE OF THE PUBLIC HEALTH LAW, THE INSURER OR CORPORATION OR ORGANIZATION, INCLUDING AN APPROVED ORGANIZATION AS DEFINED IN SUBDIVISION TWO OF SECTION TWENTY-FIVE HUNDRED TEN OF THE PUBLIC HEALTH LAW, SHALL REQUEST SUCH ADDITIONAL INFORMATION FROM THE HEALTH CARE PROVIDER WITHIN FIFTEEN BUSINESS DAYS OF RECEIPT OF THE CLAIM.

Upon receipt of the information requested in paragraph two of this subsection or an appeal of a claim or bill for health care services denied pursuant to paragraph one of this subsection, an insurer or organization or corporation licensed or certified pursuant to article forty-three or forty-seven of this chapter or article forty-four of the public health law shall comply with subsection (a) of this section.

(c) (1) Except as provided in [paragraph] PARAGRAPHS two AND THREE of this subsection, each claim or bill for health care services processed in violation of this section shall constitute a separate violation. In addition to the penalties provided in this chapter, any insurer or organization or corporation that fails to adhere to the standards contained in this section shall be obligated to pay to the health care provider or person submitting the claim, in full settlement of the claim or bill for health care services, the amount of the claim or health care payment plus interest on the amount of such claim or health care payment of the greater of the rate equal to the rate set by the commissioner of taxation and finance for corporate taxes pursuant to paragraph one of subsection (e) of section one thousand ninety-six of the tax law or twelve percent per annum, to be computed from the date the claim or health care payment was required to be made. When the amount of interest due on such a claim is less [then] THAN two dollars, and insurer or organization or corporation shall not be required to pay interest on such claim.

1 (2) Where a violation of this section is determined by the superinten-  
2 dent as a result of the superintendent's own investigation, examination,  
3 audit or inquiry, an insurer or organization or corporation licensed or  
4 certified pursuant to article forty-three or forty-seven of this chapter  
5 or article forty-four of the public health law shall not be subject to a  
6 civil penalty prescribed in paragraph one of this subsection, if the  
7 superintendent determines that the insurer or organization or corpo-  
8 ration has otherwise processed at least ninety-eight percent of the  
9 claims submitted in a calendar year in compliance with this section;  
10 provided, however, nothing in this paragraph shall limit, preclude or  
11 exempt an insurer or organization or corporation from payment of a claim  
12 and payment of interest pursuant to this section. This paragraph shall  
13 not apply to violations of this section determined by the superintendent  
14 resulting from individual complaints submitted to the superintendent by  
15 health care providers or policyholders.

16 (3) WHERE AN INSURER OR ORGANIZATION, INCLUDING AN APPROVED ORGANIZA-  
17 TION AS DEFINED IN SUBDIVISION TWO OF SECTION TWENTY-FIVE HUNDRED TEN OF  
18 THE PUBLIC HEALTH LAW, OR CORPORATION FAILS TO ADHERE TO THE STANDARDS  
19 CONTAINED IN THIS SECTION IN RELATION TO A CLAIM OR BILL FOR SERVICES  
20 SUBMITTED FOR A SERVICE RENDERED UNDER THE EARLY INTERVENTION PROGRAM  
21 ESTABLISHED IN TITLE TWO-A OF ARTICLE TWENTY-FIVE OF THE PUBLIC HEALTH  
22 LAW, THE CLAIM OR BILL FOR SERVICES SHALL BE DEEMED COVERED OR PAYABLE  
23 UNDER THE CONTRACT OR AGREEMENT, AND THE INSURER OR ORGANIZATION OR  
24 CORPORATION SHALL BE OBLIGATED TO PAY SUCH CLAIM OR BILL FOR SERVICES AT  
25 THE HIGHER OF EITHER A RATE ESTABLISHED BY THE COMMISSIONER OF HEALTH OR  
26 A RATE NEGOTIATED BY THE INSURER IN ACCORDANCE WITH REGULATION.

27 (d) For the purposes of this section:

28 (1) "policyholder" shall mean a person covered under such policy or a  
29 representative designated by such person; and

30 (2) "health care provider" shall mean an entity licensed or certified  
31 pursuant to article twenty-eight, thirty-six or forty of the public  
32 health law, a facility licensed pursuant to article nineteen or thirty-  
33 one of the mental hygiene law, a fiscal intermediary operating under  
34 section three hundred sixty five-f of the social services law, AN INDI-  
35 VIDUAL OR AGENCY APPROVED BY THE DEPARTMENT OF HEALTH PURSUANT TO TITLE  
36 TWO-A OF ARTICLE TWENTY-FIVE OF THE PUBLIC HEALTH LAW, a health care  
37 professional licensed, registered or certified pursuant to title eight  
38 of the education law, a dispenser or provider of pharmaceutical  
39 products, services or durable medical equipment, or a representative  
40 designated by such entity or person.

41 (e) Nothing in this section shall in any way be deemed to impair any  
42 right available to the state to adjust the timing of its payments for  
43 medical assistance pursuant to title eleven of article five of the  
44 social services law, or for child health insurance plan benefits pursu-  
45 ant to title one-a of article twenty-five of the public health law or  
46 otherwise be deemed to require adjustment of payments by the state for  
47 such medical assistance or child health insurance.

48 (f) In any action brought by the superintendent pursuant to this  
49 section or article twenty-four of this chapter relating to this section  
50 regarding payments for medical assistance pursuant to title eleven of  
51 article five of the social services law, child health insurance plan  
52 benefits pursuant to title one-a of article twenty-five of the public  
53 health law, benefits under the voucher insurance program pursuant to  
54 section one thousand one hundred twenty-one of this chapter, and bene-  
55 fits under the New York state small business health insurance partner-  
56 ship program pursuant to article nine-A of the public health law, it



1 shall be a mitigating factor that the insurer, corporation or organiza-  
2 tion is owed any premium amounts, premium adjustments, stop-loss recov-  
3 eries or other payments from the state or one of its fiscal interme-  
4 diaries under any such program.

5 (g) Time period for submission of claims. (1) Except as otherwise  
6 provided by law, health care claims must be initially submitted by  
7 health care providers within one hundred twenty days after the date of  
8 service to be valid and enforceable against an insurer or organization  
9 or corporation licensed or certified pursuant to article forty-three or  
10 article forty-seven of this chapter or article forty-four of the public  
11 health law. Provided, however, that nothing in this subsection shall  
12 preclude the parties from agreeing to a time period or other terms which  
13 are more favorable to the health care provider. Provided further that,  
14 in connection with contracts between organizations or corporations  
15 licensed or certified pursuant to article forty-three of this chapter or  
16 article forty-four of the public health law and health care providers  
17 for the provision of services pursuant to section three hundred sixty-  
18 four-j or three hundred sixty-nine-ee of the social services law or  
19 title I-A of article twenty-five of the public health law, nothing here-  
20 in shall be deemed: (i) to preclude the parties from agreeing to a  
21 different time period but in no event less than ninety days; or (ii) to  
22 supersede contract provisions in existence at the time this subsection  
23 takes effect except to the extent that such contracts impose a time  
24 period of less than ninety days.

25 (2) This subsection shall not abrogate any right or reduce or limit  
26 any additional time period for claim submission provided by law or regu-  
27 lation specifically applicable to coordination of benefits in effect  
28 prior to the effective date of this subsection.

29 (h) (1) An insurer or organization or corporation licensed or certi-  
30 fied pursuant to article forty-three or article forty-seven of this  
31 chapter or article forty-four of the public health law shall permit a  
32 participating health care provider to request reconsideration of a claim  
33 that is denied exclusively because it was untimely submitted pursuant to  
34 subsection (g) of this section. The insurer or organization or corpo-  
35 ration shall pay such claim pursuant to the provisions of paragraph two  
36 of this subsection if the health care provider can demonstrate both  
37 that: (i) the health care provider's non-compliance was a result of an  
38 unusual occurrence; and (ii) the health care provider has a pattern or  
39 practice of timely submitting claims in compliance with [subdivision]  
40 SUBSECTION (g) of this section.

41 (2) An insurer or organization or corporation licensed or certified  
42 pursuant to article forty-three or article forty-seven of this chapter  
43 or article forty-four of the public health law may reduce the reimburse-  
44 ment due to a health care provider for an untimely claim that otherwise  
45 meets the requirements of paragraph one of this subsection by an amount  
46 not to exceed twenty-five percent of the amount that would have been  
47 paid had the claim been submitted in a timely manner; provided, however,  
48 that nothing in this subsection shall preclude a health care provider  
49 and an insurer or organization or corporation from agreeing to a lesser  
50 reduction. The provisions of this subsection shall not apply to any  
51 claim submitted three hundred sixty-five days after the date of service,  
52 in which case the insurer or organization or corporation may deny the  
53 claim in full.

54 (i) Except where the parties have developed a mutually agreed upon  
55 process for the reconciliation of coding disputes that includes a review  
56 of submitted medical records to ascertain the correct coding for

1 payment, a general hospital certified pursuant to article twenty-eight  
2 of the public health law shall, upon receipt of payment of a claim for  
3 which payment has been adjusted based on a particular coding to a  
4 patient including the assignment of diagnosis and procedure, have the  
5 opportunity to submit the affected claim with medical records supporting  
6 the hospital's initial coding of the claim within thirty days of receipt  
7 of payment. Upon receipt of such medical records, an insurer or an  
8 organization or corporation licensed or certified pursuant to article  
9 forty-three or forty-seven of this chapter or article forty-four of the  
10 public health law shall review such information to ascertain the correct  
11 coding for payment and process the claim in accordance with the time-  
12 frames set forth in subsection (a) of this section. In the event the  
13 insurer, organization, or corporation processes the claim consistent  
14 with its initial determination, such decision shall be accompanied by a  
15 statement of the insurer, organization or corporation setting forth the  
16 specific reasons why the initial adjustment was appropriate. An insurer,  
17 organization, or corporation that increases the payment based on the  
18 information submitted by the general hospital, but fails to do so in  
19 accordance with the timeframes set forth in subsection (a) of this  
20 section, shall pay to the general hospital interest on the amount of  
21 such increase at the rate set by the commissioner of taxation and  
22 finance for corporate taxes pursuant to paragraph one of subdivision (e)  
23 of section one thousand ninety-six of the tax law, to be computed from  
24 the end of the forty-five day period after resubmission of the addi-  
25 tional medical record information. Provided, however, a failure to remit  
26 timely payment shall not constitute a violation of this section.  
27 Neither the initial or subsequent processing of the claim by the insur-  
28 er, organization, or corporation shall be deemed an adverse determi-  
29 nation as defined in section four thousand nine hundred of this chapter  
30 if based solely on a coding determination. Nothing in this subsection  
31 shall apply to those instances in which the insurer or organization, or  
32 corporation has a reasonable suspicion of fraud or abuse.

33 (j) An insurer or an organization or corporation licensed or certified  
34 pursuant to article forty-three or forty-seven of this chapter or arti-  
35 cle forty-four of the public health law or a student health plan estab-  
36 lished or maintained pursuant to section one thousand one hundred twen-  
37 ty-four of this chapter shall accept claims submitted by a policyholder  
38 or covered person, in writing, including through the internet, by elec-  
39 tronic mail or by facsimile.

40 S 7. Section 3235-a of the insurance law, as added by section 3 of  
41 part C of chapter 1 of the laws of 2002, subsection (c) as amended by  
42 section 17 of part A of chapter 56 of the laws of 2012, is amended to  
43 read as follows:

44 S 3235-a. Payment for early intervention services. (a) No policy of  
45 accident and health insurance, including contracts issued pursuant to  
46 article forty-three of this chapter, shall exclude coverage for other-  
47 wise covered services solely on the basis that the services constitute  
48 early intervention program services under title two-A of article twen-  
49 ty-five of the public health law.

50 (b) Where a policy of accident and health insurance, including a  
51 contract issued pursuant to article forty-three of this chapter,  
52 provides coverage for an early intervention program service, such cover-  
53 age shall not be applied against any maximum annual or lifetime monetary  
54 limits set forth in such policy or contract. Visit limitations [and  
55 other terms and conditions of the policy] will continue to apply to  
56 early intervention services. However, any visits used for early inter-

1 vention program services shall not reduce the number of visits otherwise  
2 available under the policy or contract for such services. WHEN SUCH  
3 POLICY OF ACCIDENT AND HEALTH INSURANCE, INCLUDING A CONTRACT ISSUED  
4 PURSUANT TO ARTICLE FORTY-THREE AND SECTION ELEVEN HUNDRED TWENTY OF  
5 THIS CHAPTER, PROVIDES COVERAGE FOR ESSENTIAL HEALTH BENEFITS, AS  
6 DEFINED IN SECTION 1302(B) OF THE AFFORDABLE CARE ACT, 42 U.S.C. S  
7 18022(B), AND CONSTITUTES EARLY INTERVENTION SERVICES AS SET FORTH IN  
8 PARAGRAPH (H) OF SUBDIVISION SEVEN OF SECTION TWENTY-FIVE HUNDRED  
9 FORTY-ONE OF THE PUBLIC HEALTH LAW, OR EARLY INTERVENTION EVALUATION  
10 SERVICES AS SET FORTH IN SUBDIVISION NINE OF SECTION TWENTY-FIVE HUNDRED  
11 FORTY-ONE OF THE PUBLIC HEALTH LAW, A WRITTEN ORDER, REFERRAL, RECOMMEN-  
12 DATION FOR DIAGNOSTIC SERVICES TO DETERMINE PROGRAM ELIGIBILITY, OR THE  
13 INDIVIDUALIZED FAMILY SERVICES PLAN CERTIFIED BY THE EARLY INTERVENTION  
14 OFFICIAL, AS DEFINED IN SECTION TWENTY-FIVE HUNDRED FORTY-ONE OF THE  
15 PUBLIC HEALTH LAW OR SUCH OFFICIAL'S DESIGNEE, SHALL BE SUFFICIENT TO  
16 MEET PRECERTIFICATION, PREAUTHORIZATION AND/OR MEDICAL NECESSITY  
17 REQUIREMENTS IMPOSED UNDER SUCH POLICY.

18 (C) REIMBURSEMENT FOR ANY EARLY INTERVENTION PROGRAM SERVICE, AS SET  
19 FORTH IN PARAGRAPH (H) OF SUBDIVISION SEVEN OF SECTION TWENTY-FIVE  
20 HUNDRED FORTY-ONE OF THE PUBLIC HEALTH LAW, OR EARLY INTERVENTION EVALU-  
21 ATION SERVICE, AS SET FORTH IN SUBDIVISION NINE OF SECTION TWENTY-FIVE  
22 HUNDRED FORTY-ONE OF THE PUBLIC HEALTH LAW, THAT IS A COVERED SERVICE  
23 UNDER THE POLICY OF ACCIDENT AND HEALTH INSURANCE, INCLUDING A CONTRACT  
24 ISSUED PURSUANT TO ARTICLE FORTY-THREE OF THIS CHAPTER, SHALL BE AT THE  
25 HIGHER OF EITHER A RATE ESTABLISHED BY THE COMMISSIONER OF HEALTH OR A  
26 RATE NEGOTIATED BY THE INSURER IN ACCORDANCE WITH REGULATION.

27 (D) A POLICY OF ACCIDENT AND HEALTH INSURANCE, INCLUDING A CONTRACT  
28 ISSUED PURSUANT TO ARTICLE FORTY-THREE AND SECTION ELEVEN HUNDRED TWENTY  
29 OF THIS CHAPTER, SHALL NOT DENY COVERAGE BASED ON THE FOLLOWING:

30 (I) THE LOCATION WHERE SERVICES ARE PROVIDED;

31 (II) THE DURATION OF THE CHILD'S CONDITION AND/OR THAT THE CHILD'S  
32 CONDITION IS NOT AMENABLE TO SIGNIFICANT IMPROVEMENT WITHIN A CERTAIN  
33 PERIOD OF TIME AS SPECIFIED IN THE POLICY;

34 (III) THE SERVICE IS NOT A COVERED BENEFIT BUT IS AN ESSENTIAL HEALTH  
35 BENEFIT AS DEFINED IN SECTION 1302(B) OF THE AFFORDABLE CARE ACT, 42  
36 U.S.C. S 18022(B); OR

37 (IV) THE PROVIDER OF SERVICES IS NOT A PARTICIPATING PROVIDER IN THE  
38 INSURER'S NETWORK.

39 [(c)] (E) Any right of subrogation to benefits which a municipality or  
40 provider is entitled in accordance with paragraph (d) of subdivision  
41 three of section twenty-five hundred fifty-nine of the public health law  
42 shall be valid and enforceable to the extent benefits are available  
43 under any accident and health insurance policy. The right of subrogation  
44 does not attach to insurance benefits paid or provided under any acci-  
45 dent and health insurance policy prior to receipt by the insurer of  
46 written notice from the municipality or provider, as applicable. IF AN  
47 INSURER MAKES PAYMENT IN WHOLE OR IN PART FOR A CLAIM OR BILL FOR  
48 SERVICES RENDERED UNDER THE EARLY INTERVENTION PROGRAM ESTABLISHED IN  
49 TITLE TWO-A OF ARTICLE TWENTY-FIVE OF THE PUBLIC HEALTH LAW, SUCH  
50 PAYMENT SHALL BE MADE TO THE PROVIDER WHO SUBMITTED THE CLAIM AND NOT TO  
51 THE RENDERING PROFESSIONAL WHO DELIVERED THE SERVICE OR THE COVERED  
52 PERSON REGARDLESS OF WHETHER SUCH PROVIDER IS IN THE INSURER'S NETWORK.  
53 The insurer shall provide the municipality and service coordinator with  
54 information on the extent of benefits available to the covered person  
55 under such policy within fifteen days of the insurer's receipt of writ-  
56 ten request and notice authorizing such release. The service coordinator

1 shall provide such information to the rendering provider assigned to  
2 provide services to the child.

3 [(d)] (F) No insurer, including a health maintenance organization  
4 issued a certificate of authority under article forty-four of the public  
5 health law and a corporation organized under article forty-three of this  
6 chapter, shall refuse to issue an accident and health insurance policy  
7 or contract or refuse to renew an accident and health insurance policy  
8 or contract solely because the applicant or insured is receiving  
9 services under the early intervention program.

10 S 8. This act shall take effect immediately and shall be deemed to  
11 have been in full force and effect on and after April 1, 2016; provided  
12 however, that the amendments to section 3224-a of the insurance law as  
13 made by section six of this act and the amendments to section 3235-a of  
14 the insurance law as made by section seven of this act shall apply only  
15 to policies, benefit packages, and contracts issued, renewed, modified,  
16 altered or amended on or after such date.

17 PART F

18 Section 1. Section 2825-b of the public health law, as added by  
19 section 2 of part J of chapter 60 of the laws of 2015, is amended to  
20 read as follows:

21 S 2825-b. [Oneida county health] HEALTH care facility transformation  
22 program: [Oneida county project] STATEWIDE. 1. [An Oneida county] A  
23 STATEWIDE health care facility transformation program is hereby estab-  
24 lished under the joint administration of the commissioner and the presi-  
25 dent of the dormitory authority of the state of New York for the purpose  
26 of strengthening and protecting continued access to health care services  
27 in communities. The program shall provide capital funding in support of  
28 projects [located in the largest population center in Oneida county that  
29 consolidate multiple licensed health care facilities into an integrated  
30 system of care] THAT REPLACE INEFFICIENT AND OUTDATED FACILITIES AS PART  
31 OF A MERGER, CONSOLIDATION, ACQUISITION OR OTHER SIGNIFICANT CORPORATE  
32 RESTRUCTURING ACTIVITY THAT IS PART OF AN OVERALL TRANSFORMATION PLAN  
33 INTENDED TO CREATE A FINANCIALLY SUSTAINABLE SYSTEM OF CARE. The issu-  
34 ance of any bonds or notes hereunder shall be subject to the approval of  
35 the director of the division of the budget, and any projects funded  
36 through the issuance of bonds or notes hereunder shall be approved by  
37 the New York state public authorities control board, as required under  
38 section fifty-one of the public authorities law.

39 2. The commissioner and the president of the authority shall enter  
40 into an agreement, subject to approval by the director of the budget,  
41 and subject to section sixteen hundred eighty-r of the public authori-  
42 ties law, for the purposes of awarding, distributing, and administering  
43 the funds made available pursuant to this section. Such funds may be  
44 distributed by the commissioner and the president of the authority for  
45 capital grants to general hospitals [for the purposes of consolidating  
46 multiple licensed health care facilities into an integrated system of  
47 care], RESIDENTIAL HEALTH CARE FACILITIES, DIAGNOSTIC AND TREATMENT  
48 CENTERS AND CLINICS LICENSED PURSUANT TO THIS CHAPTER OR THE MENTAL  
49 HYGIENE LAW, PRIMARY CARE PROVIDERS, AND HOME CARE PROVIDERS CERTIFIED  
50 OR LICENSED PURSUANT TO ARTICLE THIRTY-SIX OF THIS CHAPTER, for capital  
51 non-operational works or purposes that support the purposes set forth in  
52 this section. A copy of such agreement, and any amendments thereto,  
53 shall be provided to the chair of the senate finance committee, the  
54 chair of the assembly ways and means committee, and the director of the

1 division of budget no later than thirty days prior to the release of a  
2 request for applications for funding under this program. Projects  
3 awarded, IN WHOLE OR PART, under section twenty-eight hundred twenty-  
4 five of this article shall not be eligible for grants or awards made  
5 available under this section.

6 3. Notwithstanding section one hundred sixty-three of the state  
7 finance law or any inconsistent provision of law to the contrary, up to  
8 [three] TWO hundred million dollars of the funds appropriated for this  
9 program shall be awarded without a competitive bid or request for  
10 proposal process for capital grants to health care providers (hereafter  
11 "applicants") [located in the county of Oneida]. ELIGIBLE APPLICANTS  
12 SHALL BE THOSE DEEMED BY THE COMMISSIONER TO BE A PROVIDER THAT FULFILLS  
13 OR WILL FULFILL A HEALTH CARE NEED FOR ACUTE INPATIENT, OUTPATIENT,  
14 PRIMARY, HOME CARE OR RESIDENTIAL HEALTH CARE SERVICES IN A COMMUNITY.

15 4. In determining awards for eligible applicants under this section,  
16 the commissioner and the president of the authority shall consider  
17 criteria including, but not limited to:

18 (a) the extent to which the proposed capital project will contribute  
19 to the integration of health care services and long term sustainability  
20 of the applicant or preservation of essential health services in the  
21 community or communities served by the applicant;

22 (b) the extent to which the proposed project or purpose is aligned  
23 with delivery system reform incentive payment ("DSRIP") program goals  
24 and objectives;

25 (c) CONSIDERATION OF GEOGRAPHIC DISTRIBUTION OF FUNDS;

26 (D) the relationship between the proposed capital project and identi-  
27 fied community need;

28 [(d)] (E) THE EXTENT TO WHICH THE APPLICANT HAS ACCESS TO ALTERNATIVE  
29 FINANCING;

30 (F) the extent that the proposed capital project furthers the develop-  
31 ment of primary care and other outpatient services;

32 [(e)] (G) the extent to which the proposed capital project benefits  
33 Medicaid enrollees and uninsured individuals;

34 [(f)] (H) the extent to which the applicant has engaged the community  
35 affected by the proposed capital project and the manner in which commu-  
36 nity engagement has shaped such capital project; and

37 [(g)] (I) the extent to which the proposed capital project addresses  
38 potential risk to patient safety and welfare.

39 5. DISBURSEMENT OF AWARDS MADE PURSUANT TO THIS SECTION SHALL BE  
40 CONDITIONED ON THE AWARDEE ACHIEVING CERTAIN PROCESS AND PERFORMANCE  
41 METRICS AND MILESTONES AS DETERMINED IN THE SOLE DISCRETION OF THE  
42 COMMISSIONER. SUCH METRICS AND MILESTONES SHALL BE STRUCTURED TO ENSURE  
43 THAT THE HEALTH CARE TRANSFORMATION AND PROVIDER SUSTAINABILITY GOALS OF  
44 THE PROJECT ARE ACHIEVED, AND SUCH METRICS AND MILESTONES SHALL BE  
45 INCLUDED IN GRANT DISBURSEMENT AGREEMENTS OR OTHER CONTRACTUAL DOCUMENTS  
46 AS REQUIRED BY THE COMMISSIONER.

47 6. The department shall provide a report on a quarterly basis to the  
48 chairs of the senate finance, assembly ways and means, senate health and  
49 assembly health committees. Such reports shall be submitted no later  
50 than sixty days after the close of the quarter, and shall [conform to  
51 the reporting requirements of subdivision twenty of section twenty-eight  
52 hundred seven of this article, as applicable] INCLUDE, FOR EACH AWARD,  
53 THE NAME OF THE APPLICANT, A DESCRIPTION OF THE PROJECT OR PURPOSE, THE  
54 AMOUNT OF THE AWARD, DISBURSEMENT DATE, AND STATUS OF ACHIEVEMENT OF  
55 PROCESS AND PERFORMANCE METRICS AND MILESTONES PURSUANT TO SUBDIVISION  
56 FIVE OF THIS SECTION.

S 2. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2016.

## PART G

Section 1. Section 2801-a of the public health law is amended by adding a new subdivision 17 to read as follows:

17. (A) DIAGNOSTIC OR TREATMENT CENTERS ESTABLISHED TO PROVIDE HEALTH CARE SERVICES WITHIN THE SPACE OF A RETAIL BUSINESS OPERATION, SUCH AS A PHARMACY OR A STORE OPEN TO THE GENERAL PUBLIC, OR WITHIN SPACE USED BY AN EMPLOYER FOR PROVIDING HEALTH CARE SERVICES TO ITS EMPLOYEES, MAY BE OPERATED BY LEGAL ENTITIES FORMED UNDER THE LAWS OF THE STATE OF NEW YORK:

(I) WHOSE STOCKHOLDERS OR MEMBERS, AS APPLICABLE, ARE NOT NATURAL PERSONS;

(II) WHOSE PRINCIPAL STOCKHOLDERS AND MEMBERS, AS APPLICABLE, AND CONTROLLING PERSONS COMPLY WITH ALL APPLICABLE REQUIREMENTS OF THIS SECTION; AND

(III) THAT DEMONSTRATE, TO THE SATISFACTION OF THE PUBLIC HEALTH AND HEALTH PLANNING COUNCIL, SUFFICIENT EXPERIENCE AND EXPERTISE IN DELIVERING HIGH QUALITY HEALTH CARE SERVICES, AND FURTHER DEMONSTRATE A COMMITMENT TO OPERATE LIMITED SERVICES CLINICS IN MEDICALLY UNDERSERVED AREAS OF THE STATE. SUCH DIAGNOSTIC AND TREATMENT CENTERS SHALL BE REFERRED TO IN THIS SECTION AS "LIMITED SERVICES CLINICS".

(B) FOR PURPOSES OF PARAGRAPH (A) OF THIS SUBDIVISION, THE PUBLIC HEALTH AND HEALTH PLANNING COUNCIL SHALL ADOPT AND AMEND RULES AND REGULATIONS, NOTWITHSTANDING ANY INCONSISTENT PROVISION OF THIS SECTION, TO ADDRESS ANY MATTER IT DEEMS PERTINENT TO THE ESTABLISHMENT OF LIMITED SERVICES CLINICS. SUCH RULES AND REGULATIONS SHALL INCLUDE, BUT NOT BE LIMITED TO, PROVISIONS GOVERNING OR RELATING TO:

(I) ANY DIRECT OR INDIRECT CHANGES OR TRANSFERS OF OWNERSHIP INTERESTS OR VOTING RIGHTS IN SUCH ENTITIES OR THEIR STOCKHOLDERS OR MEMBERS, AS APPLICABLE;

(II) PUBLIC HEALTH AND HEALTH PLANNING COUNCIL APPROVAL OF ANY CHANGE IN CONTROLLING INTERESTS, PRINCIPAL STOCKHOLDERS, CONTROLLING PERSONS, PARENT COMPANY OR SPONSORS;

(III) OVERSIGHT OF THE OPERATOR AND ITS SHAREHOLDERS OR MEMBERS, AS APPLICABLE, INCLUDING LOCAL GOVERNANCE OF THE LIMITED SERVICES CLINICS; AND

(IV) THE CHARACTER AND COMPETENCE AND QUALIFICATIONS OF, AND CHANGES RELATING TO, THE DIRECTORS AND OFFICERS OF THE OPERATOR AND ITS PRINCIPAL STOCKHOLDERS, CONTROLLING PERSONS, PARENT COMPANY OR SPONSORS.

(C) THE FOLLOWING PROVISIONS OF THIS SECTION SHALL NOT APPLY TO LIMITED SERVICES CLINICS:

(I) PARAGRAPH (A) OF SUBDIVISION THREE OF THIS SECTION;

(II) PARAGRAPH (B) OF SUBDIVISION THREE OF THIS SECTION, RELATING TO STOCKHOLDERS AND MEMBERS OTHER THAN PRINCIPAL STOCKHOLDERS AND PRINCIPAL MEMBERS;

(III) PARAGRAPH (C) OF SUBDIVISION FOUR OF THIS SECTION, RELATING TO THE DISPOSITION OF STOCK OR VOTING RIGHTS; AND

(IV) PARAGRAPH (E) OF SUBDIVISION FOUR OF THIS SECTION, RELATING TO THE OWNERSHIP OF STOCK OR MEMBERSHIP.

(D) A LIMITED SERVICES CLINIC SHALL BE DEEMED TO BE A "HEALTH CARE PROVIDER" FOR THE PURPOSES OF TITLE TWO-D OF ARTICLE TWO OF THIS CHAPTER. A PRESCRIBER PRACTICING IN A LIMITED SERVICES CLINIC SHALL NOT BE DEEMED TO BE IN THE EMPLOY OF A PHARMACY OR PRACTICING IN A HOSPITAL FOR

PURPOSES OF SUBDIVISION TWO OF SECTION SIXTY-EIGHT HUNDRED SEVEN OF THE EDUCATION LAW.

(E) THE COMMISSIONER SHALL PROMULGATE REGULATIONS SETTING FORTH OPERATIONAL AND PHYSICAL PLANT STANDARDS FOR LIMITED SERVICES CLINICS, WHICH MAY BE DIFFERENT FROM THE REGULATIONS OTHERWISE APPLICABLE TO DIAGNOSTIC OR TREATMENT CENTERS, INCLUDING, BUT NOT LIMITED TO:

(I) REQUIRING THAT LIMITED SERVICES CLINICS ATTAIN AND MAINTAIN ACCREDITATION AND REQUIRING TIMELY REPORTING TO THE DEPARTMENT IF A LIMITED SERVICES CLINIC LOSES ITS ACCREDITATION;

(II) DESIGNATING OR LIMITING THE TREATMENTS AND SERVICES THAT MAY BE PROVIDED, INCLUDING:

(A) LIMITING THE SCOPE OF SERVICES TO THE FOLLOWING, PROVIDED THAT SUCH SERVICES SHALL NOT INCLUDE MONITORING OR TREATMENT AND SERVICES OVER PROLONGED PERIODS:

(1) THE PROVISION OF TREATMENT AND SERVICES TO PATIENTS FOR MINOR ACUTE EPISODIC ILLNESSES OR CONDITIONS;

(2) EPISODIC PREVENTIVE AND WELLNESS TREATMENTS AND SERVICES SUCH AS IMMUNIZATIONS; AND

(3) TREATMENT AND SERVICES FOR MINOR TRAUMAS THAT ARE NOT REASONABLY LIKELY TO BE LIFE THREATENING OR POTENTIALLY DISABLING IF AMBULATORY CARE WITHIN THE CAPACITY OF THE LIMITED SERVICES CLINIC IS PROVIDED;

(B) PROHIBITING THE PROVISION OF SERVICES TO PATIENTS TWENTY-FOUR MONTHS OF AGE OR YOUNGER;

(C) THE PROVISION OF SPECIFIC IMMUNIZATIONS TO PATIENTS YOUNGER THAN EIGHTEEN YEARS OF AGE;

(III) REQUIRING LIMITED SERVICES CLINICS TO ACCEPT WALK-INS AND OFFER EXTENDED BUSINESS HOURS;

(IV) SETTING FORTH GUIDELINES FOR ADVERTISING AND SIGNAGE, WHICH SHALL INCLUDE SIGNAGE INDICATING THAT PRESCRIPTIONS AND OVER-THE-COUNTER SUPPLIES MAY BE PURCHASED BY A PATIENT FROM ANY BUSINESS AND DO NOT NEED TO BE PURCHASED ON-SITE;

(V) SETTING FORTH GUIDELINES FOR DISCLOSURE OF OWNERSHIP INTERESTS, INFORMED CONSENT, RECORD KEEPING, REFERRAL FOR TREATMENT AND CONTINUITY OF CARE, CASE REPORTING TO THE PATIENT'S PRIMARY CARE OR OTHER HEALTH CARE PROVIDERS, DESIGN, CONSTRUCTION, FIXTURES, AND EQUIPMENT; AND

(VI) REQUIRING THE OPERATOR TO DIRECTLY EMPLOY A MEDICAL DIRECTOR WHO IS LICENSED AND CURRENTLY REGISTERED TO PRACTICE MEDICINE IN THE STATE OF NEW YORK.

(F) SUCH REGULATIONS ALSO SHALL PROMOTE AND STRENGTHEN PRIMARY CARE BY REQUIRING LIMITED SERVICES CLINICS TO:

(I) INQUIRE OF EACH PATIENT WHETHER HE OR SHE HAS A PRIMARY CARE PROVIDER;

(II) MAINTAIN AND REGULARLY UPDATE A LIST OF LOCAL PRIMARY CARE PROVIDERS AND PROVIDE SUCH LIST TO EACH PATIENT WHO INDICATES THAT HE OR SHE DOES NOT HAVE A PRIMARY CARE PROVIDER;

(III) REFER PATIENTS TO THEIR PRIMARY CARE PROVIDERS OR OTHER HEALTH CARE PROVIDERS AS APPROPRIATE;

(IV) TRANSMIT, BY ELECTRONIC MEANS WHENEVER POSSIBLE, RECORDS OF SERVICES TO PATIENTS' PRIMARY CARE PROVIDERS;

(V) EXECUTE PARTICIPATION AGREEMENTS WITH HEALTH INFORMATION ORGANIZATIONS, ALSO KNOWN AS QUALIFIED ENTITIES, PURSUANT TO WHICH LIMITED SERVICES CLINICS AGREE TO PARTICIPATE IN THE STATEWIDE HEALTH INFORMATION NETWORK FOR NEW YORK (SHIN-NY); AND

(VI) DECLINE TO TREAT ANY PATIENT FOR THE SAME CONDITION OR ILLNESS MORE THAN THREE TIMES IN A YEAR.

(G) A LIMITED SERVICES CLINIC SHALL PROVIDE TREATMENT WITHOUT DISCRIMINATION AS TO SOURCE OF PAYMENT.

(H) NOTWITHSTANDING THIS SUBDIVISION AND OTHER LAW OR REGULATION TO THE CONTRARY AND SUBJECT TO THE PROVISIONS OF SECTION TWENTY-EIGHT HUNDRED TWO OF THIS ARTICLE, A DIAGNOSTIC AND TREATMENT CENTER, COMMUNITY HEALTH CENTER OR FEDERALLY QUALIFIED HEALTH CENTER MAY OPERATE A LIMITED SERVICES CLINIC WHICH MEETS THE REGULATION PROMULGATED PURSUANT TO PARAGRAPH (E) OF THIS SUBDIVISION REGARDING OPERATIONAL PHYSICAL PLANT STANDARDS.

(I) IN DETERMINING WHETHER TO APPROVE ADDITIONAL LIMITED SERVICES CLINIC LOCATIONS, THE DEPARTMENT SHALL CONSIDER WHETHER THE OPERATOR HAS FULFILLED ITS COMMITMENT TO OPERATE LIMITED SERVICES CLINICS IN MEDICALLY UNDERSERVED AREAS OF THE STATE.

S 2. This act shall take effect immediately.

#### PART H

Section 1. Section 1 of 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, as amended by section 1 of part JJ of chapter 58 of the laws of 2015, is amended to read as follows:

Section 1. The office of mental health is authorized to recover funding from community residences and family-based treatment providers licensed by the office of mental health, consistent with contractual obligations of such providers, and notwithstanding any other inconsistent provision of law to the contrary, in an amount equal to 50 percent of the income received by such providers which exceeds the fixed amount of annual Medicaid revenue limitations, as established by the commissioner of mental health. Recovery of such excess income shall be for the following fiscal periods: for programs in counties located outside of the city of New York, the applicable fiscal periods shall be January 1, 2003 through December 31, 2009 and January 1, 2011 through December 31, [2016] 2019; and for programs located within the city of New York, the applicable fiscal periods shall be July 1, 2003 through June 30, 2010 and July 1, 2011 through June 30, [2016] 2019.

S 2. This act shall take effect immediately.

#### PART I

Section 1. Sections 19 and 21 of chapter 723 of the laws of 1989 amending the mental hygiene law and other laws relating to comprehensive psychiatric emergency programs, as amended by section 1 of part K of chapter 56 of the laws of 2012, are amended to read as follows:

S 19. Notwithstanding any other provision of law, the commissioner of mental health shall, until July 1, [2016] 2020, be solely authorized, in his or her discretion, to designate those general hospitals, local governmental units and voluntary agencies which may apply and be considered for the approval and issuance of an operating certificate pursuant to article 31 of the mental hygiene law for the operation of a comprehensive psychiatric emergency program.

S 21. This act shall take effect immediately, and sections one, two and four through twenty of this act shall remain in full force and effect, until July 1, [2016] 2020, at which time the amendments and additions made by such sections of this act shall be deemed to be repealed, and any provision of law amended by any of such sections of



1 this act shall revert to its text as it existed prior to the effective  
2 date of this act.

3 S 2. This act shall take effect immediately and shall be deemed to  
4 have been in full force and effect on and after April 1, 2016.

5 PART J

6 Section 1. Subdivision a of section 9 of chapter 420 of the laws of  
7 2002 amending the education law relating to the profession of social  
8 work, as amended by section 1 of part AA of chapter 57 of the laws of  
9 2013, is amended to read as follows:

10 a. Nothing in this act shall prohibit or limit the activities or  
11 services on the part of any person in the employ of a program or service  
12 operated, regulated, funded, or approved by the department of mental  
13 hygiene, the office of children and family services, the office of  
14 temporary and disability assistance, the department of corrections and  
15 community supervision, the state office for the aging, the department of  
16 health, or a local governmental unit as that term is defined in article  
17 41 of the mental hygiene law or a social services district as defined in  
18 section 61 of the social services law, provided, however, this section  
19 shall not authorize the use of any title authorized pursuant to article  
20 154 of the education law, except that this section shall be deemed  
21 repealed on July 1, [2016] 2021.

22 S 2. Subdivision a of section 17-a of chapter 676 of the laws of 2002  
23 amending the education law relating to the practice of psychology, as  
24 amended by section 2 of part AA of chapter 57 of the laws of 2013, is  
25 amended to read as follows:

26 a. In relation to activities and services provided under article 153  
27 of the education law, nothing in this act shall prohibit or limit such  
28 activities or services on the part of any person in the employ of a  
29 program or service operated, regulated, funded, or approved by the  
30 department of mental hygiene or the office of children and family  
31 services, or a local governmental unit as that term is defined in arti-  
32 cle 41 of the mental hygiene law or a social services district as  
33 defined in section 61 of the social services law. In relation to activ-  
34 ities and services provided under article 163 of the education law,  
35 nothing in this act shall prohibit or limit such activities or services  
36 on the part of any person in the employ of a program or service oper-  
37 ated, regulated, funded, or approved by the department of mental  
38 hygiene, the office of children and family services, the department of  
39 corrections and community supervision, the office of temporary and disa-  
40 bility assistance, the state office for the aging and the department of  
41 health or a local governmental unit as that term is defined in article  
42 41 of the mental hygiene law or a social services district as defined in  
43 section 61 of the social services law, pursuant to authority granted by  
44 law. This section shall not authorize the use of any title authorized  
45 pursuant to article 153 or 163 of the education law by any such employed  
46 person, except as otherwise provided by such articles respectively.  
47 This section shall be deemed repealed July 1, [2016] 2021.

48 S 3. Section 16 of chapter 130 of the laws of 2010 amending the educa-  
49 tion law and other laws relating to the registration of entities provid-  
50 ing certain professional services and the licensure of certain  
51 professions, as amended by section 3 of part AA of chapter 57 of the  
52 laws of 2013, is amended to read as follows:

53 S 16. This act shall take effect immediately; provided that sections  
54 thirteen, fourteen and fifteen of this act shall take effect immediately

1 and shall be deemed to have been in full force and effect on and after  
2 June 1, 2010 and such sections shall be deemed repealed July 1, [2016]  
3 2021; provided further that the amendments to section 9 of chapter 420  
4 of the laws of 2002 amending the education law relating to the profes-  
5 sion of social work made by section thirteen of this act shall repeal on  
6 the same date as such section repeals; provided further that the amend-  
7 ments to section 17-a of chapter 676 of the laws of 2002 amending the  
8 education law relating to the practice of psychology made by section  
9 fourteen of this act shall repeal on the same date as such section  
10 repeals.

11 S 4. This act shall take effect immediately.

12 PART K

13 Section 1. Subdivision 9 of section 730.10 of the criminal procedure  
14 law, as added by section 1 of part Q of chapter 56 of the laws of 2012,  
15 is amended to read as follows:

16 9. "Appropriate institution" means: (a) a hospital operated by the  
17 office of mental health or a developmental center operated by the office  
18 for people with developmental disabilities; [or] (b) a hospital licensed  
19 by the department of health which operates a psychiatric unit licensed  
20 by the office of mental health, as determined by the commissioner  
21 provided, however, that any such hospital that is not operated by the  
22 state shall qualify as an "appropriate institution" only pursuant to the  
23 terms of an agreement between the commissioner and the hospital; OR (C)  
24 A MENTAL HEALTH UNIT OPERATING WITHIN A CORRECTIONAL FACILITY OR LOCAL  
25 CORRECTIONAL FACILITY PROVIDED HOWEVER THAT ANY SUCH MENTAL HEALTH UNIT  
26 OPERATING WITHIN A LOCAL CORRECTIONAL FACILITY SHALL QUALIFY AS AN  
27 "APPROPRIATE INSTITUTION" ONLY PURSUANT TO THE TERMS OF AN AGREEMENT  
28 BETWEEN THE COMMISSIONER AND THE SHERIFF AND ANY SUCH MENTAL HEALTH UNIT  
29 OPERATING WITHIN A CORRECTIONAL FACILITY SHALL QUALIFY AS AN "APPROPRI-  
30 ATE INSTITUTION" ONLY PURSUANT TO THE TERMS OF AN AGREEMENT BETWEEN THE  
31 COMMISSIONER AND THE COMMISSIONER OF THE DEPARTMENT OF CORRECTIONS AND  
32 COMMUNITY SUPERVISION. Nothing in this article shall be construed as  
33 requiring a hospital, CORRECTIONAL FACILITY OR LOCAL CORRECTIONAL FACIL-  
34 ITY to consent to providing care and treatment to an incapacitated  
35 person at such hospital, CORRECTIONAL FACILITY OR LOCAL CORRECTIONAL  
36 FACILITY.

37 S 2. This act shall take effect immediately and shall be deemed to  
38 have been in full force and effect on and after April 1, 2016.

39 PART L

40 Section 1. The mental hygiene law is amended by adding a new section  
41 16.25 to read as follows:

42 S 16.25 TEMPORARY OPERATOR.

43 (A) FOR THE PURPOSES OF THIS SECTION:

44 (1) "ESTABLISHED OPERATOR" SHALL MEAN THE PROVIDER OF SERVICES THAT  
45 HAS BEEN ESTABLISHED AND ISSUED AN OPERATING CERTIFICATE PURSUANT TO  
46 THIS ARTICLE.

47 (2) "EXTRAORDINARY FINANCIAL ASSISTANCE" SHALL MEAN STATE FUNDS  
48 PROVIDED TO, OR REQUESTED BY, A PROGRAM FOR THE EXPRESS PURPOSE OF  
49 PREVENTING THE CLOSURE OF THE PROGRAM THAT THE COMMISSIONER FINDS  
50 PROVIDES ESSENTIAL AND NECESSARY SERVICES WITHIN THE COMMUNITY.

51 (3) "SERIOUS FINANCIAL INSTABILITY" SHALL INCLUDE BUT NOT BE LIMITED  
52 TO DEFAULTING OR VIOLATING MATERIAL COVENANTS OF BOND ISSUES, MISSED

1 MORTGAGE PAYMENTS, MISSED RENT PAYMENTS, A PATTERN OF UNTIMELY PAYMENT  
2 OF DEBTS, FAILURE TO PAY ITS EMPLOYEES OR VENDORS, INSUFFICIENT FUNDS TO  
3 MEET THE GENERAL OPERATING EXPENSES OF THE PROGRAM, FAILURE TO MAINTAIN  
4 REQUIRED DEBT SERVICE COVERAGE RATIOS AND/OR, AS APPLICABLE, FACTORS  
5 THAT HAVE TRIGGERED A WRITTEN EVENT OF DEFAULT NOTICE TO THE OFFICE BY  
6 THE DORMITORY AUTHORITY OF THE STATE OF NEW YORK.

7 (4) "TEMPORARY OPERATOR" SHALL MEAN ANY PROVIDER OF SERVICES THAT HAS  
8 BEEN ESTABLISHED AND ISSUED AN OPERATING CERTIFICATE PURSUANT TO THIS  
9 ARTICLE OR WHICH IS DIRECTLY OPERATED BY THE OFFICE, THAT:

10 A. AGREES TO PROVIDE SERVICES CERTIFIED PURSUANT TO THIS ARTICLE ON A  
11 TEMPORARY BASIS IN THE BEST INTERESTS OF ITS INDIVIDUALS SERVED BY THE  
12 PROGRAM; AND

13 B. HAS A HISTORY OF COMPLIANCE WITH APPLICABLE LAWS, RULES, AND REGU-  
14 LATIONS AND A RECORD OF PROVIDING CARE OF GOOD QUALITY, AS DETERMINED BY  
15 THE COMMISSIONER; AND

16 C. PRIOR TO APPOINTMENT AS TEMPORARY OPERATOR, DEVELOPS A PLAN DETER-  
17 MINED TO BE SATISFACTORY BY THE COMMISSIONER TO ADDRESS THE PROGRAM'S  
18 DEFICIENCIES.

19 (B) (1) IN THE EVENT THAT: (I) THE ESTABLISHED OPERATOR IS SEEKING  
20 EXTRAORDINARY FINANCIAL ASSISTANCE; (II) OFFICE COLLECTED DATA DEMON-  
21 STRATES THAT THE ESTABLISHED OPERATOR IS EXPERIENCING SERIOUS FINANCIAL  
22 INSTABILITY ISSUES; (III) OFFICE COLLECTED DATA DEMONSTRATES THAT THE  
23 ESTABLISHED OPERATOR'S BOARD OF DIRECTORS OR ADMINISTRATION IS UNABLE OR  
24 UNWILLING TO ENSURE THE PROPER OPERATION OF THE PROGRAM; OR (IV) OFFICE  
25 COLLECTED DATA INDICATES THERE ARE CONDITIONS THAT SERIOUSLY ENDANGER OR  
26 JEOPARDIZE CONTINUED ACCESS TO NECESSARY SERVICES WITHIN THE COMMUNITY,  
27 THE COMMISSIONER SHALL NOTIFY THE ESTABLISHED OPERATOR OF HIS OR HER  
28 INTENTION TO APPOINT A TEMPORARY OPERATOR TO ASSUME SOLE RESPONSIBILITY  
29 FOR THE PROVIDER OF SERVICES' OPERATIONS FOR A LIMITED PERIOD OF TIME.  
30 THE APPOINTMENT OF A TEMPORARY OPERATOR SHALL BE EFFECTUATED PURSUANT TO  
31 THIS SECTION, AND SHALL BE IN ADDITION TO ANY OTHER REMEDIES PROVIDED BY  
32 LAW.

33 (2) THE ESTABLISHED OPERATOR MAY AT ANY TIME REQUEST THE COMMISSIONER  
34 TO APPOINT A TEMPORARY OPERATOR. UPON RECEIVING SUCH A REQUEST, THE  
35 COMMISSIONER MAY, IF HE OR SHE DETERMINES THAT SUCH AN ACTION IS NECES-  
36 SARY, ENTER INTO AN AGREEMENT WITH THE ESTABLISHED OPERATOR FOR THE  
37 APPOINTMENT OF A TEMPORARY OPERATOR TO RESTORE OR MAINTAIN THE PROVISION  
38 OF QUALITY CARE TO THE INDIVIDUALS UNTIL THE ESTABLISHED OPERATOR CAN  
39 RESUME OPERATIONS WITHIN THE DESIGNATED TIME PERIOD OR OTHER ACTION IS  
40 TAKEN AS DESCRIBED IN SECTION 16.17 OF THIS ARTICLE.

41 (C) (1) A TEMPORARY OPERATOR APPOINTED PURSUANT TO THIS SECTION SHALL  
42 USE HIS OR HER BEST EFFORTS TO IMPLEMENT THE PLAN DEEMED SATISFACTORY BY  
43 THE COMMISSIONER TO CORRECT OR ELIMINATE ANY DEFICIENCIES IN THE PROGRAM  
44 AND TO PROMOTE THE QUALITY AND ACCESSIBILITY OF SERVICES IN THE COMMUNI-  
45 TY SERVED BY THE PROVIDER OF SERVICES.

46 (2) DURING THE TERM OF APPOINTMENT, THE TEMPORARY OPERATOR SHALL HAVE  
47 THE AUTHORITY TO DIRECT THE STAFF OF THE ESTABLISHED OPERATOR AS NECES-  
48 SARY TO APPROPRIATELY PROVIDE SERVICES FOR INDIVIDUALS. THE TEMPORARY  
49 OPERATOR SHALL, DURING THIS PERIOD, PROVIDE SERVICES IN SUCH A MANNER AS  
50 TO PROMOTE SAFETY AND THE QUALITY AND ACCESSIBILITY OF SERVICES IN THE  
51 COMMUNITY SERVED BY THE ESTABLISHED OPERATOR UNTIL EITHER THE ESTAB-  
52 LISHED OPERATOR CAN RESUME OPERATIONS OR UNTIL THE OFFICE REVOKES THE  
53 OPERATING CERTIFICATE FOR THE SERVICES ISSUED UNDER THIS ARTICLE.

54 (3) THE ESTABLISHED OPERATOR SHALL GRANT ACCESS TO THE TEMPORARY OPER-  
55 ATOR TO THE ESTABLISHED OPERATOR'S ACCOUNTS AND RECORDS IN ORDER TO  
56 ADDRESS ANY DEFICIENCIES RELATED TO THE PROGRAM EXPERIENCING SERIOUS

1 FINANCIAL INSTABILITY OR AN ESTABLISHED OPERATOR REQUESTING FINANCIAL  
2 ASSISTANCE IN ACCORDANCE WITH THIS SECTION. THE TEMPORARY OPERATOR SHALL  
3 APPROVE ANY FINANCIAL DECISION RELATED TO AN ESTABLISHED PROVIDER'S DAY  
4 TO DAY OPERATIONS OR THE ESTABLISHED PROVIDER'S ABILITY TO PROVIDE  
5 SERVICES.

6 (4) THE TEMPORARY OPERATOR SHALL NOT BE REQUIRED TO FILE ANY BOND. NO  
7 SECURITY INTEREST IN ANY REAL OR PERSONAL PROPERTY COMPRISING THE ESTAB-  
8 LISHED OPERATOR OR CONTAINED WITHIN THE ESTABLISHED OPERATOR OR IN ANY  
9 FIXTURE OF THE PROGRAM, SHALL BE IMPAIRED OR DIMINISHED IN PRIORITY BY  
10 THE TEMPORARY OPERATOR. NEITHER THE TEMPORARY OPERATOR NOR THE OFFICE  
11 SHALL ENGAGE IN ANY ACTIVITY THAT CONSTITUTES A CONFISCATION OF PROPER-  
12 TY.

13 (D) THE TEMPORARY OPERATOR SHALL BE ENTITLED TO A REASONABLE FEE, AS  
14 DETERMINED BY THE COMMISSIONER AND SUBJECT TO THE APPROVAL OF THE DIREC-  
15 TOR OF THE DIVISION OF THE BUDGET, AND NECESSARY EXPENSES INCURRED WHILE  
16 SERVING AS A TEMPORARY OPERATOR. THE TEMPORARY OPERATOR SHALL BE LIABLE  
17 ONLY IN ITS CAPACITY AS TEMPORARY OPERATOR FOR INJURY TO PERSON AND  
18 PROPERTY BY REASON OF ITS OPERATION OF SUCH PROGRAM; NO LIABILITY SHALL  
19 INCUR IN THE TEMPORARY OPERATOR'S PERSONAL CAPACITY, EXCEPT FOR GROSS  
20 NEGLIGENCE AND INTENTIONAL ACTS.

21 (E) (1) THE INITIAL TERM OF THE APPOINTMENT OF THE TEMPORARY OPERATOR  
22 SHALL NOT EXCEED NINETY DAYS. AFTER NINETY DAYS, IF THE COMMISSIONER  
23 DETERMINES THAT TERMINATION OF THE TEMPORARY OPERATOR WOULD CAUSE  
24 SIGNIFICANT DETERIORATION OF THE QUALITY OF, OR ACCESS TO, CARE IN THE  
25 COMMUNITY OR THAT REAPPOINTMENT IS NECESSARY TO CORRECT THE DEFICIENCIES  
26 THAT REQUIRED THE APPOINTMENT OF THE TEMPORARY OPERATOR, THE COMMISSION-  
27 ER MAY AUTHORIZE AN ADDITIONAL NINETY-DAY TERM. HOWEVER, SUCH AUTHORI-  
28 ZATION SHALL INCLUDE THE COMMISSIONER'S REQUIREMENTS FOR CONCLUSION OF  
29 THE TEMPORARY OPERATORSHIP TO BE SATISFIED WITHIN THE ADDITIONAL TERM.

30 (2) WITHIN FOURTEEN DAYS PRIOR TO THE TERMINATION OF EACH TERM OF THE  
31 APPOINTMENT OF THE TEMPORARY OPERATOR, THE TEMPORARY OPERATOR SHALL  
32 SUBMIT TO THE COMMISSIONER AND TO THE ESTABLISHED OPERATOR A REPORT  
33 DESCRIBING:

34 A. THE ACTIONS TAKEN DURING THE APPOINTMENT TO ADDRESS THE IDENTIFIED  
35 PROGRAM DEFICIENCIES, THE RESUMPTION OF PROGRAM OPERATIONS BY THE ESTAB-  
36 LISHED OPERATOR, OR THE REVOCATION OF AN OPERATING CERTIFICATE ISSUED BY  
37 THE OFFICE;

38 B. OBJECTIVES FOR THE CONTINUATION OF THE TEMPORARY OPERATORSHIP IF  
39 NECESSARY AND A SCHEDULE FOR SATISFACTION OF SUCH OBJECTIVES; AND

40 C. IF APPLICABLE, THE RECOMMENDED ACTIONS FOR THE ONGOING PROVISION OF  
41 SERVICES SUBSEQUENT TO THE TEMPORARY OPERATORSHIP.

42 (3) THE TERM OF THE INITIAL APPOINTMENT AND OF ANY SUBSEQUENT REAP-  
43 POINTMENT MAY BE TERMINATED PRIOR TO THE EXPIRATION OF THE DESIGNATED  
44 TERM, IF THE ESTABLISHED OPERATOR AND THE COMMISSIONER AGREE ON A PLAN  
45 OF CORRECTION AND THE IMPLEMENTATION OF SUCH PLAN.

46 (F) (1) THE COMMISSIONER SHALL, UPON MAKING A DETERMINATION OF AN  
47 INTENTION TO APPOINT A TEMPORARY OPERATOR PURSUANT TO PARAGRAPH ONE OF  
48 SUBDIVISION (B) OF THIS SECTION, CAUSE THE ESTABLISHED OPERATOR TO BE  
49 NOTIFIED OF THE INTENTION BY REGISTERED OR CERTIFIED MAIL ADDRESSED TO  
50 THE PRINCIPAL OFFICE OF THE ESTABLISHED OPERATOR. SUCH NOTIFICATION  
51 SHALL INCLUDE A DETAILED DESCRIPTION OF THE FINDINGS UNDERLYING THE  
52 INTENTION TO APPOINT A TEMPORARY OPERATOR, AND THE DATE AND TIME OF A  
53 REQUIRED MEETING WITH THE COMMISSIONER AND/OR HIS OR HER DESIGNEE WITHIN  
54 TEN BUSINESS DAYS OF THE RECEIPT OF SUCH NOTICE. AT SUCH MEETING, THE  
55 ESTABLISHED OPERATOR SHALL HAVE THE OPPORTUNITY TO REVIEW AND DISCUSS  
56 ALL RELEVANT FINDINGS. AT SUCH MEETING, THE COMMISSIONER AND THE ESTAB-

1 LISHED OPERATOR SHALL ATTEMPT TO DEVELOP A MUTUALLY SATISFACTORY PLAN OF  
2 CORRECTION AND SCHEDULE FOR IMPLEMENTATION. IN SUCH EVENT, THE COMMIS-  
3 SIONER SHALL NOTIFY THE ESTABLISHED OPERATOR THAT THE COMMISSIONER WILL  
4 ABSTAIN FROM APPOINTING A TEMPORARY OPERATOR CONTINGENT UPON THE ESTAB-  
5 LISHED OPERATOR REMEDIATING THE IDENTIFIED DEFICIENCIES WITHIN THE  
6 AGREED UPON TIMEFRAME.

7 (2) SHOULD THE COMMISSIONER AND THE ESTABLISHED OPERATOR BE UNABLE TO  
8 ESTABLISH A PLAN OF CORRECTION PURSUANT TO PARAGRAPH ONE OF THIS SUBDI-  
9 VISION, OR SHOULD THE ESTABLISHED OPERATOR FAIL TO RESPOND TO THE  
10 COMMISSIONER'S INITIAL NOTIFICATION, THERE SHALL BE AN ADMINISTRATIVE  
11 HEARING ON THE COMMISSIONER'S DETERMINATION TO APPOINT A TEMPORARY OPER-  
12 ATOR TO BEGIN NO LATER THAN THIRTY DAYS FROM THE DATE OF THE NOTICE TO  
13 THE ESTABLISHED OPERATOR. ANY SUCH HEARING SHALL BE STRICTLY LIMITED TO  
14 THE ISSUE OF WHETHER THE DETERMINATION OF THE COMMISSIONER TO APPOINT A  
15 TEMPORARY OPERATOR IS SUPPORTED BY SUBSTANTIAL EVIDENCE. A COPY OF THE  
16 DECISION SHALL BE SENT TO THE ESTABLISHED OPERATOR.

17 (3) IF THE DECISION TO APPOINT A TEMPORARY OPERATOR IS UPHELD SUCH  
18 TEMPORARY OPERATOR SHALL BE APPOINTED AS SOON AS IS PRACTICABLE AND  
19 SHALL PROVIDE SERVICES PURSUANT TO THE PROVISIONS OF THIS SECTION.

20 (G) NOTWITHSTANDING THE APPOINTMENT OF A TEMPORARY OPERATOR, THE  
21 ESTABLISHED OPERATOR SHALL REMAIN OBLIGATED FOR THE CONTINUED PROVISION  
22 OF SERVICES. NO PROVISION CONTAINED IN THIS SECTION SHALL BE DEEMED TO  
23 RELIEVE THE ESTABLISHED OPERATOR OR ANY OTHER PERSON OF ANY CIVIL OR  
24 CRIMINAL LIABILITY INCURRED, OR ANY DUTY IMPOSED BY LAW, BY REASON OF  
25 ACTS OR OMISSIONS OF THE ESTABLISHED OPERATOR OR ANY OTHER PERSON PRIOR  
26 TO THE APPOINTMENT OF ANY TEMPORARY OPERATOR OF THE PROGRAM HEREUNDER;  
27 NOR SHALL ANYTHING CONTAINED IN THIS SECTION BE CONSTRUED TO SUSPEND  
28 DURING THE TERM OF THE APPOINTMENT OF THE TEMPORARY OPERATOR OF THE  
29 PROGRAM ANY OBLIGATION OF THE ESTABLISHED OPERATOR OR ANY OTHER PERSON  
30 FOR THE MAINTENANCE AND REPAIR OF THE FACILITY, PROVISION OF UTILITY  
31 SERVICES, PAYMENT OF TAXES OR OTHER OPERATING AND MAINTENANCE EXPENSES  
32 OF THE FACILITY, NOR OF THE ESTABLISHED OPERATOR OR ANY OTHER PERSON FOR  
33 THE PAYMENT OF MORTGAGES OR LIENS.

34 S 2. The mental hygiene law is amended by adding a new section 31.20  
35 to read as follows:

36 S 31.20 TEMPORARY OPERATOR.

37 (A) FOR THE PURPOSES OF THIS SECTION:

38 (1) "ESTABLISHED OPERATOR" SHALL MEAN THE OPERATOR OF A MENTAL HEALTH  
39 PROGRAM THAT HAS BEEN ESTABLISHED AND ISSUED AN OPERATING CERTIFICATE  
40 PURSUANT TO THIS ARTICLE.

41 (2) "EXTRAORDINARY FINANCIAL ASSISTANCE" SHALL MEAN STATE FUNDS  
42 PROVIDED TO, OR REQUESTED BY, A PROGRAM FOR THE EXPRESS PURPOSE OF  
43 PREVENTING THE CLOSURE OF THE PROGRAM THAT THE COMMISSIONER FINDS  
44 PROVIDES ESSENTIAL AND NECESSARY SERVICES WITHIN THE COMMUNITY.

45 (3) "MENTAL HEALTH PROGRAM" SHALL MEAN A PROVIDER OF SERVICES FOR  
46 PERSONS WITH SERIOUS MENTAL ILLNESS, AS SUCH TERMS ARE DEFINED IN  
47 SECTION 1.03 OF THIS CHAPTER, WHICH IS LICENSED OR OPERATED BY THE  
48 OFFICE.

49 (4) "OFFICE" SHALL MEAN THE OFFICE OF MENTAL HEALTH.

50 (5) "SERIOUS FINANCIAL INSTABILITY" SHALL INCLUDE BUT NOT BE LIMITED  
51 TO DEFAULTING OR VIOLATING MATERIAL COVENANTS OF BOND ISSUES, MISSED  
52 MORTGAGE PAYMENTS, A PATTERN OF UNTIMELY PAYMENT OF DEBTS, FAILURE TO  
53 PAY ITS EMPLOYEES OR VENDORS, INSUFFICIENT FUNDS TO MEET THE GENERAL  
54 OPERATING EXPENSES OF THE PROGRAM, FAILURE TO MAINTAIN REQUIRED DEBT  
55 SERVICE COVERAGE RATIOS AND/OR, AS APPLICABLE, FACTORS THAT HAVE TRIG-

GERED A WRITTEN EVENT OF DEFAULT NOTICE TO THE OFFICE BY THE DORMITORY AUTHORITY OF THE STATE OF NEW YORK.

(6) "TEMPORARY OPERATOR" SHALL MEAN ANY OPERATOR OF A MENTAL HEALTH PROGRAM THAT HAS BEEN ESTABLISHED AND ISSUED AN OPERATING CERTIFICATE PURSUANT TO THIS ARTICLE OR WHICH IS DIRECTLY OPERATED BY THE OFFICE OF MENTAL HEALTH, THAT:

A. AGREES TO OPERATE A MENTAL HEALTH PROGRAM ON A TEMPORARY BASIS IN THE BEST INTERESTS OF ITS PATIENTS SERVED BY THE PROGRAM; AND

B. HAS A HISTORY OF COMPLIANCE WITH APPLICABLE LAWS, RULES, AND REGULATIONS AND A RECORD OF PROVIDING CARE OF GOOD QUALITY, AS DETERMINED BY THE COMMISSIONER; AND

C. PRIOR TO APPOINTMENT AS TEMPORARY OPERATOR, DEVELOPS A PLAN DETERMINED TO BE SATISFACTORY BY THE COMMISSIONER TO ADDRESS THE PROGRAM'S DEFICIENCIES.

(B) (1) IN THE EVENT THAT: (I) THE ESTABLISHED OPERATOR IS SEEKING EXTRAORDINARY FINANCIAL ASSISTANCE; (II) OFFICE COLLECTED DATA DEMONSTRATES THAT THE ESTABLISHED OPERATOR IS EXPERIENCING SERIOUS FINANCIAL INSTABILITY ISSUES; (III) OFFICE COLLECTED DATA DEMONSTRATES THAT THE ESTABLISHED OPERATOR'S BOARD OF DIRECTORS OR ADMINISTRATION IS UNABLE OR UNWILLING TO ENSURE THE PROPER OPERATION OF THE PROGRAM; OR (IV) OFFICE COLLECTED DATA INDICATES THERE ARE CONDITIONS THAT SERIOUSLY ENDANGER OR JEOPARDIZE CONTINUED ACCESS TO NECESSARY MENTAL HEALTH SERVICES WITHIN THE COMMUNITY, THE COMMISSIONER SHALL NOTIFY THE ESTABLISHED OPERATOR OF HIS OR HER INTENTION TO APPOINT A TEMPORARY OPERATOR TO ASSUME SOLE RESPONSIBILITY FOR THE PROGRAM'S TREATMENT OPERATIONS FOR A LIMITED PERIOD OF TIME. THE APPOINTMENT OF A TEMPORARY OPERATOR SHALL BE EFFECTUATED PURSUANT TO THIS SECTION, AND SHALL BE IN ADDITION TO ANY OTHER REMEDIES PROVIDED BY LAW.

(2) THE ESTABLISHED OPERATOR MAY AT ANY TIME REQUEST THE COMMISSIONER TO APPOINT A TEMPORARY OPERATOR. UPON RECEIVING SUCH A REQUEST, THE COMMISSIONER MAY, IF HE OR SHE DETERMINES THAT SUCH AN ACTION IS NECESSARY, ENTER INTO AN AGREEMENT WITH THE ESTABLISHED OPERATOR FOR THE APPOINTMENT OF A TEMPORARY OPERATOR TO RESTORE OR MAINTAIN THE PROVISION OF QUALITY CARE TO THE PATIENTS UNTIL THE ESTABLISHED OPERATOR CAN RESUME OPERATIONS WITHIN THE DESIGNATED TIME PERIOD; THE PATIENTS MAY BE TRANSFERRED TO OTHER MENTAL HEALTH PROGRAMS OPERATED OR LICENSED BY THE OFFICE; OR THE OPERATIONS OF THE MENTAL HEALTH PROGRAM SHOULD BE COMPLETELY DISCONTINUED.

(C) (1) A TEMPORARY OPERATOR APPOINTED PURSUANT TO THIS SECTION SHALL USE HIS OR HER BEST EFFORTS TO IMPLEMENT THE PLAN DEEMED SATISFACTORY BY THE COMMISSIONER TO CORRECT OR ELIMINATE ANY DEFICIENCIES IN THE MENTAL HEALTH PROGRAM AND TO PROMOTE THE QUALITY AND ACCESSIBILITY OF MENTAL HEALTH SERVICES IN THE COMMUNITY SERVED BY THE MENTAL HEALTH PROGRAM.

(2) IF THE IDENTIFIED DEFICIENCIES CANNOT BE ADDRESSED IN THE TIME PERIOD DESIGNATED IN THE PLAN, THE PATIENTS SHALL BE TRANSFERRED TO OTHER APPROPRIATE MENTAL HEALTH PROGRAMS LICENSED OR OPERATED BY THE OFFICE.

(3) DURING THE TERM OF APPOINTMENT, THE TEMPORARY OPERATOR SHALL HAVE THE AUTHORITY TO DIRECT THE STAFF OF THE ESTABLISHED OPERATOR AS NECESSARY TO APPROPRIATELY TREAT AND/OR TRANSFER THE PATIENTS. THE TEMPORARY OPERATOR SHALL, DURING THIS PERIOD, OPERATE THE MENTAL HEALTH PROGRAM IN SUCH A MANNER AS TO PROMOTE SAFETY AND THE QUALITY AND ACCESSIBILITY OF MENTAL HEALTH SERVICES IN THE COMMUNITY SERVED BY THE ESTABLISHED OPERATOR UNTIL EITHER THE ESTABLISHED OPERATOR CAN RESUME PROGRAM OPERATIONS OR UNTIL THE PATIENTS ARE APPROPRIATELY TRANSFERRED TO OTHER PROGRAMS LICENSED OR OPERATED BY THE OFFICE.

(4) THE ESTABLISHED OPERATOR SHALL GRANT ACCESS TO THE TEMPORARY OPERATOR TO THE ESTABLISHED OPERATOR'S ACCOUNTS AND RECORDS IN ORDER TO ADDRESS ANY DEFICIENCIES RELATED TO A MENTAL HEALTH PROGRAM EXPERIENCING SERIOUS FINANCIAL INSTABILITY OR AN ESTABLISHED OPERATOR REQUESTING FINANCIAL ASSISTANCE IN ACCORDANCE WITH THIS SECTION. THE TEMPORARY OPERATOR SHALL APPROVE ANY FINANCIAL DECISION RELATED TO A PROGRAM'S DAY TO DAY OPERATIONS OR PROGRAM'S ABILITY TO PROVIDE MENTAL HEALTH SERVICES.

(5) THE TEMPORARY OPERATOR SHALL NOT BE REQUIRED TO FILE ANY BOND. NO SECURITY INTEREST IN ANY REAL OR PERSONAL PROPERTY COMPRISING THE ESTABLISHED OPERATOR OR CONTAINED WITHIN THE ESTABLISHED OPERATOR OR IN ANY FIXTURE OF THE MENTAL HEALTH PROGRAM, SHALL BE IMPAIRED OR DIMINISHED IN PRIORITY BY THE TEMPORARY OPERATOR. NEITHER THE TEMPORARY OPERATOR NOR THE OFFICE SHALL ENGAGE IN ANY ACTIVITY THAT CONSTITUTES A CONFISCATION OF PROPERTY.

(D) THE TEMPORARY OPERATOR SHALL BE ENTITLED TO A REASONABLE FEE, AS DETERMINED BY THE COMMISSIONER AND SUBJECT TO THE APPROVAL OF THE DIRECTOR OF THE DIVISION OF THE BUDGET, AND NECESSARY EXPENSES INCURRED WHILE SERVING AS A TEMPORARY OPERATOR. THE TEMPORARY OPERATOR SHALL BE LIABLE ONLY IN ITS CAPACITY AS TEMPORARY OPERATOR OF THE MENTAL HEALTH PROGRAM FOR INJURY TO PERSON AND PROPERTY BY REASON OF ITS OPERATION OF SUCH PROGRAM; NO LIABILITY SHALL INCUR IN THE TEMPORARY OPERATOR'S PERSONAL CAPACITY, EXCEPT FOR GROSS NEGLIGENCE AND INTENTIONAL ACTS.

(E) (1) THE INITIAL TERM OF THE APPOINTMENT OF THE TEMPORARY OPERATOR SHALL NOT EXCEED NINETY DAYS. AFTER NINETY DAYS, IF THE COMMISSIONER DETERMINES THAT TERMINATION OF THE TEMPORARY OPERATOR WOULD CAUSE SIGNIFICANT DETERIORATION OF THE QUALITY OF, OR ACCESS TO, MENTAL HEALTH CARE IN THE COMMUNITY OR THAT REAPPOINTMENT IS NECESSARY TO CORRECT THE DEFICIENCIES THAT REQUIRED THE APPOINTMENT OF THE TEMPORARY OPERATOR, THE COMMISSIONER MAY AUTHORIZE AN ADDITIONAL NINETY-DAY TERM. HOWEVER, SUCH AUTHORIZATION SHALL INCLUDE THE COMMISSIONER'S REQUIREMENTS FOR CONCLUSION OF THE TEMPORARY OPERATORSHIP TO BE SATISFIED WITHIN THE ADDITIONAL TERM.

(2) WITHIN FOURTEEN DAYS PRIOR TO THE TERMINATION OF EACH TERM OF THE APPOINTMENT OF THE TEMPORARY OPERATOR, THE TEMPORARY OPERATOR SHALL SUBMIT TO THE COMMISSIONER AND TO THE ESTABLISHED OPERATOR A REPORT DESCRIBING:

A. THE ACTIONS TAKEN DURING THE APPOINTMENT TO ADDRESS THE IDENTIFIED MENTAL HEALTH PROGRAM DEFICIENCIES, THE RESUMPTION OF MENTAL HEALTH PROGRAM OPERATIONS BY THE ESTABLISHED OPERATOR, OR THE TRANSFER OF THE PATIENTS TO OTHER PROVIDERS LICENSED OR OPERATED BY THE OFFICE;

B. OBJECTIVES FOR THE CONTINUATION OF THE TEMPORARY OPERATORSHIP IF NECESSARY AND A SCHEDULE FOR SATISFACTION OF SUCH OBJECTIVES; AND

C. IF APPLICABLE, THE RECOMMENDED ACTIONS FOR THE ONGOING OPERATION OF THE MENTAL HEALTH PROGRAM SUBSEQUENT TO THE TEMPORARY OPERATORSHIP.

(3) THE TERM OF THE INITIAL APPOINTMENT AND OF ANY SUBSEQUENT REAPPOINTMENT MAY BE TERMINATED PRIOR TO THE EXPIRATION OF THE DESIGNATED TERM, IF THE ESTABLISHED OPERATOR AND THE COMMISSIONER AGREE ON A PLAN OF CORRECTION AND THE IMPLEMENTATION OF SUCH PLAN.

(F) (1) THE COMMISSIONER SHALL, UPON MAKING A DETERMINATION OF AN INTENTION TO APPOINT A TEMPORARY OPERATOR PURSUANT TO PARAGRAPH ONE OF SUBDIVISION (B) OF THIS SECTION CAUSE THE ESTABLISHED OPERATOR TO BE NOTIFIED OF THE INTENTION BY REGISTERED OR CERTIFIED MAIL ADDRESSED TO THE PRINCIPAL OFFICE OF THE ESTABLISHED OPERATOR. SUCH NOTIFICATION SHALL INCLUDE A DETAILED DESCRIPTION OF THE FINDINGS UNDERLYING THE INTENTION TO APPOINT A TEMPORARY OPERATOR, AND THE DATE AND TIME OF A

1 REQUIRED MEETING WITH THE COMMISSIONER AND/OR HIS OR HER DESIGNEE WITHIN  
2 TEN BUSINESS DAYS OF THE RECEIPT OF SUCH NOTICE. AT SUCH MEETING, THE  
3 ESTABLISHED OPERATOR SHALL HAVE THE OPPORTUNITY TO REVIEW AND DISCUSS  
4 ALL RELEVANT FINDINGS. AT SUCH MEETING, THE COMMISSIONER AND THE ESTAB-  
5 LISHED OPERATOR SHALL ATTEMPT TO DEVELOP A MUTUALLY SATISFACTORY PLAN OF  
6 CORRECTION AND SCHEDULE FOR IMPLEMENTATION. IN SUCH EVENT, THE COMMIS-  
7 SIONER SHALL NOTIFY THE ESTABLISHED OPERATOR THAT THE COMMISSIONER WILL  
8 ABSTAIN FROM APPOINTING A TEMPORARY OPERATOR CONTINGENT UPON THE ESTAB-  
9 LISHED OPERATOR REMEDIATING THE IDENTIFIED DEFICIENCIES WITHIN THE  
10 AGREED UPON TIMEFRAME.

11 (2) SHOULD THE COMMISSIONER AND THE ESTABLISHED OPERATOR BE UNABLE TO  
12 ESTABLISH A PLAN OF CORRECTION PURSUANT TO PARAGRAPH ONE OF THIS SUBDI-  
13 VISION, OR SHOULD THE ESTABLISHED OPERATOR FAIL TO RESPOND TO THE  
14 COMMISSIONER'S INITIAL NOTIFICATION, THERE SHALL BE AN ADMINISTRATIVE  
15 HEARING ON THE COMMISSIONER'S DETERMINATION TO APPOINT A TEMPORARY OPER-  
16 ATOR TO BEGIN NO LATER THAN THIRTY DAYS FROM THE DATE OF THE NOTICE TO  
17 THE ESTABLISHED OPERATOR. ANY SUCH HEARING SHALL BE STRICTLY LIMITED TO  
18 THE ISSUE OF WHETHER THE DETERMINATION OF THE COMMISSIONER TO APPOINT A  
19 TEMPORARY OPERATOR IS SUPPORTED BY SUBSTANTIAL EVIDENCE. A COPY OF THE  
20 DECISION SHALL BE SENT TO THE ESTABLISHED OPERATOR.

21 (3) IF THE DECISION TO APPOINT A TEMPORARY OPERATOR IS UPHELD SUCH  
22 TEMPORARY OPERATOR SHALL BE APPOINTED AS SOON AS IS PRACTICABLE AND  
23 SHALL OPERATE THE MENTAL HEALTH PROGRAM PURSUANT TO THE PROVISIONS OF  
24 THIS SECTION.

25 (G) NOTWITHSTANDING THE APPOINTMENT OF A TEMPORARY OPERATOR, THE  
26 ESTABLISHED OPERATOR SHALL REMAIN OBLIGATED FOR THE CONTINUED OPERATION  
27 OF THE MENTAL HEALTH PROGRAM SO THAT SUCH PROGRAM CAN FUNCTION IN A  
28 NORMAL MANNER. NO PROVISION CONTAINED IN THIS SECTION SHALL BE DEEMED TO  
29 RELIEVE THE ESTABLISHED OPERATOR OR ANY OTHER PERSON OF ANY CIVIL OR  
30 CRIMINAL LIABILITY INCURRED, OR ANY DUTY IMPOSED BY LAW, BY REASON OF  
31 ACTS OR OMISSIONS OF THE ESTABLISHED OPERATOR OR ANY OTHER PERSON PRIOR  
32 TO THE APPOINTMENT OF ANY TEMPORARY OPERATOR OF THE PROGRAM HEREUNDER;  
33 NOR SHALL ANYTHING CONTAINED IN THIS SECTION BE CONSTRUED TO SUSPEND  
34 DURING THE TERM OF THE APPOINTMENT OF THE TEMPORARY OPERATOR OF THE  
35 PROGRAM ANY OBLIGATION OF THE ESTABLISHED OPERATOR OR ANY OTHER PERSON  
36 FOR THE MAINTENANCE AND REPAIR OF THE FACILITY, PROVISION OF UTILITY  
37 SERVICES, PAYMENT OF TAXES OR OTHER OPERATING AND MAINTENANCE EXPENSES  
38 OF THE FACILITY, NOR OF THE ESTABLISHED OPERATOR OR ANY OTHER PERSON FOR  
39 THE PAYMENT OF MORTGAGES OR LIENS.

40 S 3. This act shall take effect immediately.

41 PART M

42 Section 1. Subdivision (d) of section 33.13 of the mental hygiene law,  
43 as amended by section 3 of part E of chapter 111 of the laws of 2010, is  
44 amended to read as follows:

45 (d) Nothing in this section shall prevent the electronic or other  
46 exchange of information concerning patients or clients, including iden-  
47 tification, between and among (i) facilities or others providing  
48 services for such patients or clients pursuant to an approved local  
49 services plan, as defined in article forty-one of this chapter, or  
50 pursuant to agreement with the department, and (ii) the department or  
51 any of its licensed or operated facilities. NEITHER SHALL ANYTHING IN  
52 THIS SECTION PREVENT THE EXCHANGE OF INFORMATION CONCERNING PATIENTS OR  
53 CLIENTS, INCLUDING IDENTIFICATION, BETWEEN FACILITIES AND MANAGED CARE  
54 ORGANIZATIONS, BEHAVIORAL HEALTH ORGANIZATIONS, HEALTH HOMES OR OTHER



1 ENTITIES AUTHORIZED BY THE DEPARTMENT OR THE DEPARTMENT OF HEALTH TO  
2 PROVIDE, ARRANGE FOR OR COORDINATE HEALTH CARE SERVICES FOR SUCH  
3 PATIENTS OR CLIENTS WHO ARE ENROLLED IN OR RECEIVING SERVICES FROM SUCH  
4 ORGANIZATIONS OR ENTITIES. Furthermore, subject to the prior approval of  
5 the commissioner of mental health, hospital emergency services licensed  
6 pursuant to article twenty-eight of the public health law shall be  
7 authorized to exchange information concerning patients or clients elec-  
8 tronically or otherwise with other hospital emergency services licensed  
9 pursuant to article twenty-eight of the public health law and/or hospi-  
10 tals licensed or operated by the office of mental health; provided that  
11 such exchange of information is consistent with standards, developed by  
12 the commissioner of mental health, which are designed to ensure confi-  
13 dentiality of such information. Additionally, information so exchanged  
14 shall be kept confidential and any limitations on the release of such  
15 information imposed on the party giving the information shall apply to  
16 the party receiving the information.

17 S 2. Subdivision (d) of section 33.13 of the mental hygiene law, as  
18 amended by section 4 of part E of chapter 111 of the laws of 2010, is  
19 amended to read as follows:

20 (d) Nothing in this section shall prevent the exchange of information  
21 concerning patients or clients, including identification, between (i)  
22 facilities or others providing services for such patients or clients  
23 pursuant to an approved local services plan, as defined in article  
24 forty-one, or pursuant to agreement with the department and (ii) the  
25 department or any of its facilities. NEITHER SHALL ANYTHING IN THIS  
26 SECTION PREVENT THE EXCHANGE OF INFORMATION CONCERNING PATIENTS OR  
27 CLIENTS, INCLUDING IDENTIFICATION, BETWEEN FACILITIES AND MANAGED CARE  
28 ORGANIZATIONS, BEHAVIORAL HEALTH ORGANIZATIONS, HEALTH HOMES OR OTHER  
29 ENTITIES AUTHORIZED BY THE DEPARTMENT OR THE DEPARTMENT OF HEALTH TO  
30 PROVIDE, ARRANGE FOR OR COORDINATE HEALTH CARE SERVICES FOR SUCH  
31 PATIENTS OR CLIENTS WHO ARE ENROLLED IN OR RECEIVING SERVICES FOR SUCH  
32 ORGANIZATIONS OR ENTITIES. Information so exchanged shall be kept confi-  
33 dential and any limitations on the release of such information imposed  
34 on the party giving the information shall apply to the party receiving  
35 the information.

36 S 3. This act shall take effect immediately; provided that the amend-  
37 ments to subdivision (d) of section 33.13 of the mental hygiene law made  
38 by section one of this act shall be subject to the expiration and rever-  
39 sion of such subdivision pursuant to section 18 of chapter 408 of the  
40 laws of 1999, as amended, when upon such date the provisions of section  
41 two of this act shall take effect.

## 42 PART N

43 Section 1. Subdivision 10 of section 3 of section 1 of chapter 359 of  
44 the laws of 1968, constituting the facilities development corporation  
45 act, as amended by chapter 723 of the laws of 1993, is amended to read  
46 as follows:

47 10. "Mental hygiene facility" shall mean a building, a unit within a  
48 building, a laboratory, a classroom, a housing unit, a dining hall, an  
49 activities center, a library, real property of any kind or description,  
50 or any structure on or improvement to real property, or an interest in  
51 real property, of any kind or description, owned by or under the juris-  
52 diction of the corporation, including fixtures and equipment which are  
53 an integral part of any such building, unit, structure or improvement, a  
54 walkway, a roadway or a parking lot, and improvements and connections

1 for water, sewer, gas, electrical, telephone, heating, air conditioning  
2 and other utility services, or a combination of any of the foregoing,  
3 whether for patient care and treatment or staff, staff family or service  
4 use, located at or related to any psychiatric center, any developmental  
5 center, or any state psychiatric or research institute or other facility  
6 now or hereafter established under the department. A mental hygiene  
7 facility shall also mean and include a residential care center for  
8 adults, a "community mental health and retardation facility" and a  
9 treatment facility for use in the conduct of an alcoholism or substance  
10 abuse treatment program as defined in the mental hygiene law unless such  
11 residential care center for adults, community mental health and retarda-  
12 tion facility or alcoholism or substance abuse facility is expressly  
13 excepted, or the context clearly requires otherwise, AND SHALL ALSO MEAN  
14 AND INCLUDE ANY TREATMENT FACILITY FOR USE IN THE CONDUCT OF AN ALCOHOL-  
15 ISM OR SUBSTANCE ABUSE TREATMENT PROGRAM THAT IS ALSO OPERATED AS AN  
16 ASSOCIATED HEALTH CARE FACILITY. The definition contained in this subdi-  
17 vision shall not be construed to exclude therefrom a facility owned or  
18 leased by one or more voluntary agencies that is to be financed, refi-  
19 nanced, designed, constructed, acquired, reconstructed, rehabilitated or  
20 improved under any lease, sublease, loan or other financing agreement  
21 entered into with such voluntary agencies, and shall not be construed to  
22 exclude therefrom a facility to be made available from the corporation  
23 to a voluntary agency at the request of the commissioners of the offices  
24 of the department having jurisdiction thereof. The definition contained  
25 in this subdivision shall not be construed to exclude therefrom a facil-  
26 ity with respect to which a voluntary agency has an ownership interest  
27 in, and proprietary lease from, an organization formed for the purpose  
28 of the cooperative ownership of real estate.

29 S 2. Section 3 of section 1 of chapter 359 of the laws of 1968,  
30 constituting the facilities development corporation act, is amended by  
31 adding a new subdivision 20 to read as follows:

32 20. "ASSOCIATED HEALTH CARE FACILITY" SHALL MEAN A FACILITY LICENSED  
33 UNDER AND OPERATED PURSUANT TO ARTICLE 28 OF THE PUBLIC HEALTH LAW OR  
34 ANY HEALTH CARE FACILITY LICENSED UNDER AND OPERATED IN ACCORDANCE WITH  
35 ANY OTHER PROVISIONS OF THE PUBLIC HEALTH LAW OR THE MENTAL HYGIENE LAW  
36 THAT PROVIDES HEALTH CARE SERVICES AND/OR TREATMENT TO ALL PERSONS,  
37 REGARDLESS OF WHETHER SUCH PERSONS ARE PERSONS RECEIVING TREATMENT OR  
38 SERVICES FOR ALCOHOL, SUBSTANCE ABUSE, OR CHEMICAL DEPENDENCY.

39 S 3. This act shall take effect immediately.

40 S 2. Severability clause. If any clause, sentence, paragraph, subdivi-  
41 sion, section or part of this act shall be adjudged by any court of  
42 competent jurisdiction to be invalid, such judgment shall not affect,  
43 impair, or invalidate the remainder thereof, but shall be confined in  
44 its operation to the clause, sentence, paragraph, subdivision, section  
45 or part thereof directly involved in the controversy in which such judg-  
46 ment shall have been rendered. It is hereby declared to be the intent of  
47 the legislature that this act would have been enacted even if such  
48 invalid provisions had not been included herein.

49 S 3. This act shall take effect immediately provided, however, that  
50 the applicable effective date of Parts A through N of this act shall be  
51 as specifically set forth in the last section of such Parts.