

S T A T E O F N E W Y O R K

S. 6407--A

A. 9007--A

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

January 14, 2016

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 -- committee discharged, bill amended, ordered reprinted as amended and recommitted to said committee

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 -- committee discharged, bill amended, ordered reprinted as amended and recommitted to said committee

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

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

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provisions of the social services law relating to the authorization of prescriber prevails in the managed care program (Part B); to amend chapter 266 of the laws of 1986, amending the civil practice law and rules and other laws relating to malpractice and professional medical conduct, in relation to apportioning premium for certain policies; and to amend part J of chapter 63 of the laws of 2001 amending chapter 266 of the laws of 1986, amending the civil practice law and rules and other laws relating to malpractice and professional medical conduct, in relation to extending certain provisions concerning the hospital excess liability pool (Part C); to amend chapter 474 of the laws of 1996, amending the education law and other laws relating to rates for residential healthcare facilities, in relation to extending the authority of the department of health to make disproportionate share payments to public hospitals outside of New York City; to amend chapter 649 of the laws of 1996, amending the public health law, the mental hygiene law and the social services law relating to authorizing the establishment of special needs plans, in relation to the effectiveness thereof; to repeal subdivision 8 of section 84 of part A of chapter 56 of the laws of 2013, amending the public health law and other laws relating to general hospital reimbursement for annual rates, relating to the effectiveness thereof; to repeal subdivision (f) of section 129 of part C of chapter 58 of the laws of 2009, amending the public health law relating to payment by governmental agencies for general hospital inpatient services, relating to the effectiveness thereof; and to repeal subdivision (c) of section 122 of part E of chapter 56 of the laws of 2013, amending the public health law relating to the general public health work program, relating to the effectiveness thereof (Part D); to amend the public health law and the insurance law, in relation to the early intervention program for infants and toddlers with disabilities and their families (Part E); to amend the public health law, in relation to the health care facility transformation program (Part F); to amend the public health law, in relation to authorizing the establishment of limited service clinics (Part G); to amend part D of chapter 111 of the laws of 2010 relating to the recovery of exempt income by the office of mental health for community residences and family-based treatment programs, in relation to the effectiveness thereof (Part H); to amend chapter 723 of the laws of 1989 amending the mental hygiene law and other laws relating to comprehensive psychiatric emergency programs, in relation to the effectiveness of certain provisions thereof (Part I); to amend chapter 420 of the laws of 2002 amending the education law relating to the profession of social work, in relation to extending the expiration of certain provisions thereof; to amend chapter 676 of the laws of 2002 amending the education law relating to the practice of psychology, in relation to extending the expiration of certain provisions; and to amend chapter 130 of the laws of 2010 amending the education law and other laws relating to registration of entities providing certain professional services and licensure of certain professions, in relation to extending certain provisions thereof (Part J); to amend the criminal procedure law, in relation to authorizing restorations to competency within correctional facility based residential settings (Part K); to amend the mental hygiene law, in relation to the appointment of temporary operators for the continued operation of programs and the provision of services for persons with serious mental illness and/or developmental disabilities; and to amend the social services law, in relation to the powers and duties of the commissioner of

social services (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, including
7 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, subdivision
23 (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] chapter
45 58 of the laws of 2010 [which amended this subdivision], and amounts

1 paid to managed care providers pursuant to section 3-d of part B of
2 [the] chapter 58 of the laws of 2010 [which amended this subdivision],
3 shall be excluded from all calculations made pursuant to this section.

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

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

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

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

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

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

35 (c-1) Notwithstanding any provisions of subdivision (c) of this
36 section to the contrary, effective April 1, 2013, for the period January
37 1, 2013 through December 31, 2013 and for each calendar year thereafter,
38 the medical assistance expenditure amount for the social services
39 district for such period shall be equal to the previous calendar year's
40 medical assistance expenditure amount, except that:

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

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

47 (C-2) NOTWITHSTANDING ANY PROVISIONS OF SUBDIVISION (C-1) OF THIS
48 SECTION TO THE CONTRARY, EFFECTIVE APRIL 1, 2016, FOR THE PERIOD JANUARY
49 1, 2016 THROUGH DECEMBER 31, 2016 AND FOR EACH CALENDAR YEAR THEREAFTER,
50 THE MEDICAL ASSISTANCE EXPENDITURE AMOUNT FOR A SOCIAL SERVICES DISTRICT
51 HAVING A POPULATION OF MORE THAN FIVE MILLION SHALL BE EQUAL TO THE
52 AMOUNT CALCULATED PURSUANT TO SUBDIVISIONS (B) AND (C) OF THIS SECTION.

53 (d) The base year expenditure amounts calculated pursuant to paragraph
54 (b) of this section and the calendar year social services district
55 expenditure amounts calculated pursuant to paragraph (c) of this section
56 shall be converted into state fiscal year social services district

1 expenditure cap amounts for each social services district such that each
2 such state fiscal year amount is proportional to the portions of the two
3 calendar years within each fiscal year, as follows:

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

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

9 (iii) each succeeding fiscal year: 75% of the first calendar year
10 within that fiscal year's amount plus 25% of the second calendar year
11 within that fiscal year's amount.

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

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

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

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

35 (f) Subject to paragraph (g) of this section, the state fiscal year
36 social services district expenditure cap amount calculated for each
37 social services district pursuant to paragraph (d) of this section shall
38 be allotted to each district during that fiscal year and paid to the
39 department in equal weekly amounts in a manner to be determined by the
40 commissioner and communicated to such districts and, subject to the
41 provisions of subdivision four of section six of this part, shall repre-
42 sent each district's maximum responsibility for medical assistance
43 expenditures governed by this section. HOWEVER, FOR FISCAL YEAR
44 2016-2017, THE EXPENDITURE CAP AMOUNT CALCULATED FOR A SOCIAL SERVICES
45 DISTRICT HAVING A POPULATION OF MORE THAN FIVE MILLION SHALL BE PAID TO
46 THE DEPARTMENT IN WEEKLY AMOUNTS IN A MANNER TO BE DETERMINED BY THE
47 COMMISSIONER, IN CONSULTATION WITH THE DIRECTOR OF THE DIVISION OF THE
48 BUDGET, AND COMMUNICATED TO SUCH DISTRICT.

49 (g) (i) No allotment pursuant to paragraph (f) of this section shall
50 be applied against a social services district during the period April 1,
51 2005 through December 31, 2005. Social services district medical
52 assistance shares shall be determined for such period pursuant to shares
53 provisions in effect on January 1, 2005.

54 (ii) For the period January 1, 2006 through June 30, 2006, the commis-
55 sioner is authorized to allot against each district an amount based on
56 the commissioner's best estimate of the final base year expenditure

1 calculation required by paragraph (b) of this section. Upon completion
2 of such calculation, the commissioner shall, no later than December 31,
3 2006, reconcile such estimated allotments with the fiscal year social
4 services district expenditure cap amounts calculated pursuant to subpar-
5 agraphs (i) and (ii) of paragraph (d) of this section.

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

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

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

44 PART B

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

48 4. The commissioner of health is authorized to assume responsibility
49 from a local social services official for the provision and reimburse-
50 ment of transportation costs under this section. If the commissioner
51 elects to assume such responsibility, the commissioner shall notify the
52 local social services official in writing as to the election, the date
53 upon which the election shall be effective and such information as to
54 transition of responsibilities as the commissioner deems prudent. The

1 commissioner is authorized to contract with a transportation manager or
2 managers to manage transportation services in any local social services
3 district[, other than transportation services provided or arranged for
4 enrollees of managed long term care plans issued certificates of author-
5 ity under section forty-four hundred three-f of the public health law].
6 Any transportation manager or managers selected by the commissioner to
7 manage transportation services shall have proven experience in coordi-
8 nating transportation services in a geographic and demographic area
9 similar to the area in New York state within which the contractor would
10 manage the provision of services under this section. Such a contract or
11 contracts may include responsibility for: review, approval and process-
12 ing of transportation orders; management of the appropriate level of
13 transportation based on documented patient medical need; and development
14 of new technologies leading to efficient transportation services. If the
15 commissioner elects to assume such responsibility from a local social
16 services district, the commissioner shall examine and, if appropriate,
17 adopt quality assurance measures that may include, but are not limited
18 to, global positioning tracking system reporting requirements and
19 service verification mechanisms. Any and all reimbursement rates devel-
20 oped by transportation managers under this subdivision shall be subject
21 to the review and approval of the commissioner.

22 S 2. Subparagraph (i) of paragraph (b) of subdivision 7 of section
23 4403-f of the public health law, as amended by section 41-b of part H of
24 chapter 59 of the laws of 2011, is amended to read as follows:

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

1 health care programs that comply with such guidelines. Copies of such
2 original waiver applications and amendments thereto shall be provided to
3 the chairs of the senate finance committee, the assembly ways and means
4 committee and the senate and assembly health committees simultaneously
5 with their submission to the federal government.

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

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

20 S 4. Subparagraph (i) of paragraph (d) of subdivision 2 of section
21 366-c of the social services law is amended by adding a new clause (C)
22 to read as follows:

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

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

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

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

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

44 (B) RESEARCH AND DEVELOPMENT COSTS OF THE DRUG INCLUDING PAYMENTS TO
45 PREDECESSOR ENTITIES CONDUCTING RESEARCH AND DEVELOPMENT, INCLUDING BUT
46 NOT LIMITED TO BIOTECHNOLOGY COMPANIES, UNIVERSITIES AND MEDICAL
47 SCHOOLS, AND PRIVATE RESEARCH INSTITUTIONS;

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

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

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

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

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

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

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

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

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

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

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

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

48 15. NOTWITHSTANDING ANY INCONSISTENT PROVISION OF THIS SECTION, THE
49 COMMISSIONER MAY REQUIRE PRIOR AUTHORIZATION FOR ANY DRUG AFTER EVALUAT-
50 ING THE FACTORS SET FORTH IN SUBDIVISION THREE OF THIS SECTION AND PRIOR
51 TO OBTAINING THE BOARD'S EVALUATION AND RECOMMENDATION REQUIRED BY
52 SUBDIVISION FOUR OF THIS SECTION. THE BOARD MAY RECOMMEND TO THE COMMIS-
53 SIONER, PURSUANT TO SUBDIVISION SIX OF THIS SECTION, THAT ANY SUCH PRIOR
54 AUTHORIZATION REQUIREMENT BE MODIFIED, CONTINUED OR REMOVED.

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

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

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

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

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

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

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

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

55 During the period from April first, two thousand fifteen through March
56 thirty-first, two thousand seventeen, the commissioner may, in lieu of a

1 managed care provider, negotiate directly and enter into an agreement
2 with a pharmaceutical manufacturer for the provision of supplemental
3 rebates relating to pharmaceutical utilization by enrollees of managed
4 care providers pursuant to section three hundred sixty-four-j of this
5 title AND, NOTWITHSTANDING THE PROVISIONS OF SECTION TWO HUNDRED SEVEN-
6 TY-TWO OF THE PUBLIC HEALTH LAW OR ANY OTHER INCONSISTENT PROVISION OF
7 LAW, MAY ALSO NEGOTIATE DIRECTLY AND ENTER INTO SUCH AN AGREEMENT RELAT-
8 ING TO PHARMACEUTICAL UTILIZATION BY MEDICAL ASSISTANCE RECIPIENTS NOT
9 SO ENROLLED. Such rebates shall be limited to drug utilization in the
10 following classes: antiretrovirals approved by the FDA for the treatment
11 of HIV/AIDS and hepatitis C agents for which the pharmaceutical manufac-
12 turer has in effect a rebate agreement with the federal secretary of
13 health and human services pursuant to 42 U.S.C. S 1396r-8, and for which
14 the state has established standard clinical criteria. No agreement
15 entered into pursuant to this paragraph shall have an initial term or be
16 extended beyond March thirty-first, two thousand twenty.

17 S 13. Subparagraph (iv) of paragraph (e) of subdivision 7 of section
18 367-a of the social services law, as added by section 1 of part B of
19 chapter 57 of the laws of 2015, is amended to read as follows:

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

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

28 26-A. MANAGED CARE PROVIDERS SHALL REQUIRE PRIOR AUTHORIZATION OF
29 PRESCRIPTIONS OF OPIOID ANALGESICS IN EXCESS OF FOUR PRESCRIPTIONS IN A
30 THIRTY-DAY PERIOD.

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

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

41 (B) SUCH PENALTIES SHALL BE AS FOLLOWS:

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

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

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

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

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

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

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

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

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

52 1. For state fiscal years 2011-12 through [2016-17] 2017-18, the
53 director of the budget, in consultation with the commissioner of health
54 referenced as "commissioner" for purposes of this section, shall assess
55 on a monthly basis, as reflected in monthly reports pursuant to subdivi-
56 sion five of this section known and projected department of health state

1 funds medicaid expenditures by category of service and by geographic
2 regions, as defined by the commissioner, and if the director of the
3 budget determines that such expenditures are expected to cause medicaid
4 disbursements for such period to exceed the projected department of
5 health medicaid state funds disbursements in the enacted budget finan-
6 cial plan pursuant to subdivision 3 of section 23 of the state finance
7 law, the commissioner of health, in consultation with the director of
8 the budget, shall develop a medicaid savings allocation plan to limit
9 such spending to the aggregate limit level specified in the enacted
10 budget financial plan, provided, however, such projections may be
11 adjusted by the director of the budget to account for any changes in the
12 New York state federal medical assistance percentage amount established
13 pursuant to the federal social security act, changes in provider reven-
14 ues, reductions to local social services district medical assistance
15 administration, and beginning April 1, 2012 the operational costs of the
16 New York state medical indemnity fund and state costs or savings from
17 the basic health plan. Such projections may be adjusted by the director
18 of the budget to account for increased or expedited department of health
19 state funds medicaid expenditures as a result of a natural or other type
20 of disaster, including a governmental declaration of emergency.

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

24 (a) sections one, two and six of this act shall take effect October 1,
25 2016;

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

30 (c) the amendments to subparagraph (i) of paragraph (b) of subdivision
31 7 of section 4403-f of the public health law, made by section two of
32 this act, shall not affect the expiration of such subdivision or the
33 repeal of such section, and shall expire or be deemed repealed there-
34 with;

35 (d) sections four and sixteen of this act shall take effect July 1,
36 2016;

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

40 (f) sections eight, nine and ten of this act shall take effect June 1,
41 2016;

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

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

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

1 Section 1. Subdivision 1 of section 18 of chapter 266 of the laws of
2 1986, amending the civil practice law and rules and other laws relating
3 to malpractice and professional medical conduct, is amended by adding a
4 new paragraph (c) to read as follows:

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

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

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

1 1, 1993 and June 30, 1994, between July 1, 1994 and June 30, 1995,
2 between July 1, 1995 and June 30, 1996, between July 1, 1996 and June
3 30, 1997, between July 1, 1997 and June 30, 1998, between July 1, 1998
4 and June 30, 1999, between July 1, 1999 and June 30, 2000, between July
5 1, 2000 and June 30, 2001, between July 1, 2001 and June 30, 2002,
6 between July 1, 2002 and June 30, 2003, between July 1, 2003 and June
7 30, 2004, between July 1, 2004 and June 30, 2005, between July 1, 2005
8 and June 30, 2006, between July 1, 2006 and June 30, 2007, between July
9 1, 2007 and June 30, 2008, between July 1, 2008 and June 30, 2009,
10 between July 1, 2009 and June 30, 2010, between July 1, 2010 and June
11 30, 2011, between July 1, 2011 and June 30, 2012, between July 1, 2012
12 and June 30, 2013, between July 1, 2013 and June 30, 2014, between July
13 1, 2014 and June 30, 2015, [and] between July 1, 2015 and June 30, 2016,
14 AND BETWEEN JULY 1, 2016 AND JUNE 30, 2017 or reimburse the hospital
15 where the hospital purchases equivalent excess coverage as defined in
16 subparagraph (i) of paragraph (a) of subdivision 1-a of this section for
17 medical or dental malpractice occurrences between July 1, 1987 and June
18 30, 1988, between July 1, 1988 and June 30, 1989, between July 1, 1989
19 and June 30, 1990, between July 1, 1990 and June 30, 1991, between July
20 1, 1991 and June 30, 1992, between July 1, 1992 and June 30, 1993,
21 between July 1, 1993 and June 30, 1994, between July 1, 1994 and June
22 30, 1995, between July 1, 1995 and June 30, 1996, between July 1, 1996
23 and June 30, 1997, between July 1, 1997 and June 30, 1998, between July
24 1, 1998 and June 30, 1999, between July 1, 1999 and June 30, 2000,
25 between July 1, 2000 and June 30, 2001, between July 1, 2001 and June
26 30, 2002, between July 1, 2002 and June 30, 2003, between July 1, 2003
27 and June 30, 2004, between July 1, 2004 and June 30, 2005, between July
28 1, 2005 and June 30, 2006, between July 1, 2006 and June 30, 2007,
29 between July 1, 2007 and June 30, 2008, between July 1, 2008 and June
30 30, 2009, between July 1, 2009 and June 30, 2010, between July 1, 2010
31 and June 30, 2011, between July 1, 2011 and June 30, 2012, between July
32 1, 2012 and June 30, 2013, between July 1, 2013 and June 30, 2014,
33 between July 1, 2014 and June 30, 2015, [and] between July 1, 2015 and
34 June 30, 2016, AND BETWEEN JULY 1, 2016 AND JUNE 30, 2017 for physicians
35 or dentists certified as eligible for each such period or periods pursu-
36 ant to subdivision 2 of this section by a general hospital licensed
37 pursuant to article 28 of the public health law; provided that no single
38 insurer shall write more than fifty percent of the total excess premium
39 for a given policy year; and provided, however, that such eligible
40 physicians or dentists must have in force an individual policy, from an
41 insurer licensed in this state of primary malpractice insurance coverage
42 in amounts of no less than one million three hundred thousand dollars
43 for each claimant and three million nine hundred thousand dollars for
44 all claimants under that policy during the period of such excess cover-
45 age for such occurrences or be endorsed as additional insureds under a
46 hospital professional liability policy which is offered through a volun-
47 tary attending physician ("channeling") program previously permitted by
48 the superintendent of financial services during the period of such
49 excess coverage for such occurrences. During such period, such policy
50 for excess coverage or such equivalent excess coverage shall, when
51 combined with the physician's or dentist's primary malpractice insurance
52 coverage or coverage provided through a voluntary attending physician
53 ("channeling") program, total an aggregate level of two million three
54 hundred thousand dollars for each claimant and six million nine hundred
55 thousand dollars for all claimants from all such policies with respect
56 to occurrences in each of such years provided, however, if the cost of

1 primary malpractice insurance coverage in excess of one million dollars,
2 but below the excess medical malpractice insurance coverage provided
3 pursuant to this act, exceeds the rate of nine percent per annum, then
4 the required level of primary malpractice insurance coverage in excess
5 of one million dollars for each claimant shall be in an amount of not
6 less than the dollar amount of such coverage available at nine percent
7 per annum; the required level of such coverage for all claimants under
8 that policy shall be in an amount not less than three times the dollar
9 amount of coverage for each claimant; and excess coverage, when combined
10 with such primary malpractice insurance coverage, shall increase the
11 aggregate level for each claimant by one million dollars and three
12 million dollars for all claimants; and provided further, that, with
13 respect to policies of primary medical malpractice coverage that include
14 occurrences between April 1, 2002 and June 30, 2002, such requirement
15 that coverage be in amounts no less than one million three hundred thou-
16 sand dollars for each claimant and three million nine hundred thousand
17 dollars for all claimants for such occurrences shall be effective April
18 1, 2002.

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

23 (3)(a) The superintendent of financial services shall determine and
24 certify to each general hospital and to the commissioner of health the
25 cost of excess malpractice insurance for medical or dental malpractice
26 occurrences between July 1, 1986 and June 30, 1987, between July 1, 1988
27 and June 30, 1989, between July 1, 1989 and June 30, 1990, between July
28 1, 1990 and June 30, 1991, between July 1, 1991 and June 30, 1992,
29 between July 1, 1992 and June 30, 1993, between July 1, 1993 and June
30 30, 1994, between July 1, 1994 and June 30, 1995, between July 1, 1995
31 and June 30, 1996, between July 1, 1996 and June 30, 1997, between July
32 1, 1997 and June 30, 1998, between July 1, 1998 and June 30, 1999,
33 between July 1, 1999 and June 30, 2000, between July 1, 2000 and June
34 30, 2001, between July 1, 2001 and June 30, 2002, between July 1, 2002
35 and June 30, 2003, between July 1, 2003 and June 30, 2004, between July
36 1, 2004 and June 30, 2005, between July 1, 2005 and June 30, 2006,
37 between July 1, 2006 and June 30, 2007, between July 1, 2007 and June
38 30, 2008, between July 1, 2008 and June 30, 2009, between July 1, 2009
39 and June 30, 2010, between July 1, 2010 and June 30, 2011, between July
40 1, 2011 and June 30, 2012, between July 1, 2012 and June 30, 2013, and
41 between July 1, 2013 and June 30, 2014, between July 1, 2014 and June
42 30, 2015, [and] between July 1, 2015 and June 30, 2016, AND BETWEEN JULY
43 1, 2016 AND JUNE 30, 2017 allocable to each general hospital for physi-
44 cians or dentists certified as eligible for purchase of a policy for
45 excess insurance coverage by such general hospital in accordance with
46 subdivision 2 of this section, and may amend such determination and
47 certification as necessary.

48 (b) The superintendent of financial services shall determine and
49 certify to each general hospital and to the commissioner of health the
50 cost of excess malpractice insurance or equivalent excess coverage for
51 medical or dental malpractice occurrences between July 1, 1987 and June
52 30, 1988, between July 1, 1988 and June 30, 1989, between July 1, 1989
53 and June 30, 1990, between July 1, 1990 and June 30, 1991, between July
54 1, 1991 and June 30, 1992, between July 1, 1992 and June 30, 1993,
55 between July 1, 1993 and June 30, 1994, between July 1, 1994 and June
56 30, 1995, between July 1, 1995 and June 30, 1996, between July 1, 1996

1 and June 30, 1997, between July 1, 1997 and June 30, 1998, between July
2 1, 1998 and June 30, 1999, between July 1, 1999 and June 30, 2000,
3 between July 1, 2000 and June 30, 2001, between July 1, 2001 and June
4 30, 2002, between July 1, 2002 and June 30, 2003, between July 1, 2003
5 and June 30, 2004, between July 1, 2004 and June 30, 2005, between July
6 1, 2005 and June 30, 2006, between July 1, 2006 and June 30, 2007,
7 between July 1, 2007 and June 30, 2008, between July 1, 2008 and June
8 30, 2009, between July 1, 2009 and June 30, 2010, between July 1, 2010
9 and June 30, 2011, between July 1, 2011 and June 30, 2012, between July
10 1, 2012 and June 30, 2013, between July 1, 2013 and June 30, 2014,
11 between July 1, 2014 and June 30, 2015, [and] between July 1, 2015 and
12 June 30, 2016, AND BETWEEN JULY 1, 2016 AND JUNE 30, 2017 allocable to
13 each general hospital for physicians or dentists certified as eligible
14 for purchase of a policy for excess insurance coverage or equivalent
15 excess coverage by such general hospital in accordance with subdivision
16 2 of this section, and may amend such determination and certification as
17 necessary. The superintendent of financial services shall determine and
18 certify to each general hospital and to the commissioner of health the
19 ratable share of such cost allocable to the period July 1, 1987 to
20 December 31, 1987, to the period January 1, 1988 to June 30, 1988, to
21 the period July 1, 1988 to December 31, 1988, to the period January 1,
22 1989 to June 30, 1989, to the period July 1, 1989 to December 31, 1989,
23 to the period January 1, 1990 to June 30, 1990, to the period July 1,
24 1990 to December 31, 1990, to the period January 1, 1991 to June 30,
25 1991, to the period July 1, 1991 to December 31, 1991, to the period
26 January 1, 1992 to June 30, 1992, to the period July 1, 1992 to December
27 31, 1992, to the period January 1, 1993 to June 30, 1993, to the period
28 July 1, 1993 to December 31, 1993, to the period January 1, 1994 to June
29 30, 1994, to the period July 1, 1994 to December 31, 1994, to the period
30 January 1, 1995 to June 30, 1995, to the period July 1, 1995 to December
31 31, 1995, to the period January 1, 1996 to June 30, 1996, to the period
32 July 1, 1996 to December 31, 1996, to the period January 1, 1997 to June
33 30, 1997, to the period July 1, 1997 to December 31, 1997, to the period
34 January 1, 1998 to June 30, 1998, to the period July 1, 1998 to December
35 31, 1998, to the period January 1, 1999 to June 30, 1999, to the period
36 July 1, 1999 to December 31, 1999, to the period January 1, 2000 to June
37 30, 2000, to the period July 1, 2000 to December 31, 2000, to the period
38 January 1, 2001 to June 30, 2001, to the period July 1, 2001 to June 30,
39 2002, to the period July 1, 2002 to June 30, 2003, to the period July 1,
40 2003 to June 30, 2004, to the period July 1, 2004 to June 30, 2005, to
41 the period July 1, 2005 and June 30, 2006, to the period July 1, 2006
42 and June 30, 2007, to the period July 1, 2007 and June 30, 2008, to the
43 period July 1, 2008 and June 30, 2009, to the period July 1, 2009 and
44 June 30, 2010, to the period July 1, 2010 and June 30, 2011, to the
45 period July 1, 2011 and June 30, 2012, to the period July 1, 2012 and
46 June 30, 2013, to the period July 1, 2013 and June 30, 2014, to the
47 period July 1, 2014 and June 30, 2015, [and] to the period July 1, 2015
48 and June 30, 2016, AND BETWEEN JULY 1, 2016 AND JUNE 30, 2017.

49 S 4. Paragraphs (a), (b), (c), (d) and (e) of subdivision 8 of section
50 18 of chapter 266 of the laws of 1986, amending the civil practice law
51 and rules and other laws relating to malpractice and professional
52 medical conduct, as amended by section 3 of part Y of chapter 57 of the
53 laws of 2015, are amended to read as follows:

54 (a) To the extent funds available to the hospital excess liability
55 pool pursuant to subdivision 5 of this section as amended, and pursuant
56 to section 6 of part J of chapter 63 of the laws of 2001, as may from

1 time to time be amended, which amended this subdivision, are insuffi-
2 cient to meet the costs of excess insurance coverage or equivalent
3 excess coverage for coverage periods during the period July 1, 1992 to
4 June 30, 1993, during the period July 1, 1993 to June 30, 1994, during
5 the period July 1, 1994 to June 30, 1995, during the period July 1, 1995
6 to June 30, 1996, during the period July 1, 1996 to June 30, 1997,
7 during the period July 1, 1997 to June 30, 1998, during the period July
8 1, 1998 to June 30, 1999, during the period July 1, 1999 to June 30,
9 2000, during the period July 1, 2000 to June 30, 2001, during the period
10 July 1, 2001 to October 29, 2001, during the period April 1, 2002 to
11 June 30, 2002, during the period July 1, 2002 to June 30, 2003, during
12 the period July 1, 2003 to June 30, 2004, during the period July 1, 2004
13 to June 30, 2005, during the period July 1, 2005 to June 30, 2006,
14 during the period July 1, 2006 to June 30, 2007, during the period July
15 1, 2007 to June 30, 2008, during the period July 1, 2008 to June 30,
16 2009, during the period July 1, 2009 to June 30, 2010, during the period
17 July 1, 2010 to June 30, 2011, during the period July 1, 2011 to June
18 30, 2012, during the period July 1, 2012 to June 30, 2013, during the
19 period July 1, 2013 to June 30, 2014, during the period July 1, 2014 to
20 June 30, 2015, [and] during the period July 1, 2015 and June 30, 2016,
21 AND BETWEEN JULY 1, 2016 AND JUNE 30, 2017 allocated or reallocated in
22 accordance with paragraph (a) of subdivision 4-a of this section to
23 rates of payment applicable to state governmental agencies, each physi-
24 cian or dentist for whom a policy for excess insurance coverage or
25 equivalent excess coverage is purchased for such period shall be respon-
26 sible for payment to the provider of excess insurance coverage or equiv-
27 alent excess coverage of an allocable share of such insufficiency, based
28 on the ratio of the total cost of such coverage for such physician to
29 the sum of the total cost of such coverage for all physicians applied to
30 such insufficiency.

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

1 such provider of excess insurance coverage or equivalent excess coverage
2 in a time and manner determined by the superintendent of financial
3 services.

4 (c) If a physician or dentist liable for payment of a portion of the
5 costs of excess insurance coverage or equivalent excess coverage cover-
6 ing the period July 1, 1992 to June 30, 1993, or covering the period
7 July 1, 1993 to June 30, 1994, or covering the period July 1, 1994 to
8 June 30, 1995, or covering the period July 1, 1995 to June 30, 1996, or
9 covering the period July 1, 1996 to June 30, 1997, or covering the peri-
10 od July 1, 1997 to June 30, 1998, or covering the period July 1, 1998 to
11 June 30, 1999, or covering the period July 1, 1999 to June 30, 2000, or
12 covering the period July 1, 2000 to June 30, 2001, or covering the peri-
13 od July 1, 2001 to October 29, 2001, or covering the period April 1,
14 2002 to June 30, 2002, or covering the period July 1, 2002 to June 30,
15 2003, or covering the period July 1, 2003 to June 30, 2004, or covering
16 the period July 1, 2004 to June 30, 2005, or covering the period July 1,
17 2005 to June 30, 2006, or covering the period July 1, 2006 to June 30,
18 2007, or covering the period July 1, 2007 to June 30, 2008, or covering
19 the period July 1, 2008 to June 30, 2009, or covering the period July 1,
20 2009 to June 30, 2010, or covering the period July 1, 2010 to June 30,
21 2011, or covering the period July 1, 2011 to June 30, 2012, or covering
22 the period July 1, 2012 to June 30, 2013, or covering the period July 1,
23 2013 to June 30, 2014, or covering the period July 1, 2014 to June 30,
24 2015, or covering the period July 1, 2015 to June 30, 2016, OR COVERING
25 THE PERIOD JULY 1, 2016 TO JUNE 30, 2017 determined in accordance with
26 paragraph (a) of this subdivision fails, refuses or neglects to make
27 payment to the provider of excess insurance coverage or equivalent
28 excess coverage in such time and manner as determined by the superinten-
29 dent of financial services pursuant to paragraph (b) of this subdivi-
30 sion, excess insurance coverage or equivalent excess coverage purchased
31 for such physician or dentist in accordance with this section for such
32 coverage period shall be cancelled and shall be null and void as of the
33 first day on or after the commencement of a policy period where the
34 liability for payment pursuant to this subdivision has not been met.

35 (d) Each provider of excess insurance coverage or equivalent excess
36 coverage shall notify the superintendent of financial services and the
37 commissioner of health or their designee of each physician and dentist
38 eligible for purchase of a policy for excess insurance coverage or
39 equivalent excess coverage covering the period July 1, 1992 to June 30,
40 1993, or covering the period July 1, 1993 to June 30, 1994, or covering
41 the period July 1, 1994 to June 30, 1995, or covering the period July 1,
42 1995 to June 30, 1996, or covering the period July 1, 1996 to June 30,
43 1997, or covering the period July 1, 1997 to June 30, 1998, or covering
44 the period July 1, 1998 to June 30, 1999, or covering the period July 1,
45 1999 to June 30, 2000, or covering the period July 1, 2000 to June 30,
46 2001, or covering the period July 1, 2001 to October 29, 2001, or cover-
47 ing the period April 1, 2002 to June 30, 2002, or covering the period
48 July 1, 2002 to June 30, 2003, or covering the period July 1, 2003 to
49 June 30, 2004, or covering the period July 1, 2004 to June 30, 2005, or
50 covering the period July 1, 2005 to June 30, 2006, or covering the peri-
51 od July 1, 2006 to June 30, 2007, or covering the period July 1, 2007 to
52 June 30, 2008, or covering the period July 1, 2008 to June 30, 2009, or
53 covering the period July 1, 2009 to June 30, 2010, or covering the peri-
54 od July 1, 2010 to June 30, 2011, or covering the period July 1, 2011 to
55 June 30, 2012, or covering the period July 1, 2012 to June 30, 2013, or
56 covering the period July 1, 2013 to June 30, 2014, or covering the peri-

od July 1, 2014 to June 30, 2015, or covering the period July 1, 2015 to June 30, 2016, OR COVERING THE PERIOD JULY 1, 2016 TO JUNE 30, 2017 that has made payment to such provider of excess insurance coverage or equivalent excess coverage in accordance with paragraph (b) of this subdivision and of each physician and dentist who has failed, refused or neglected to make such payment.

(e) A provider of excess insurance coverage or equivalent excess coverage shall refund to the hospital excess liability pool any amount allocable to the period July 1, 1992 to June 30, 1993, and to the period July 1, 1993 to June 30, 1994, and to the period July 1, 1994 to June 30, 1995, and to the period July 1, 1995 to June 30, 1996, and to the period July 1, 1996 to June 30, 1997, and to the period July 1, 1997 to June 30, 1998, and to the period July 1, 1998 to June 30, 1999, and to the period July 1, 1999 to June 30, 2000, and to the period July 1, 2000 to June 30, 2001, and to the period July 1, 2001 to October 29, 2001, and to the period April 1, 2002 to June 30, 2002, and to the period July 1, 2002 to June 30, 2003, and to the period July 1, 2003 to June 30, 2004, and to the period July 1, 2004 to June 30, 2005, and to the period July 1, 2005 to June 30, 2006, and to the period July 1, 2006 to June 30, 2007, and to the period July 1, 2007 to June 30, 2008, and to the period July 1, 2008 to June 30, 2009, and to the period July 1, 2009 to June 30, 2010, and to the period July 1, 2010 to June 30, 2011, and to the period July 1, 2011 to June 30, 2012, and to the period July 1, 2012 to June 30, 2013, and to the period July 1, 2013 to June 30, 2014, and to the period July 1, 2014 to June 30, 2015, and to the period July 1, 2015 to June 30, 2016, AND TO THE PERIOD JULY 1, 2016 TO JUNE 30, 2017 received from the hospital excess liability pool for purchase of excess insurance coverage or equivalent excess coverage covering the period July 1, 1992 to June 30, 1993, and covering the period July 1, 1993 to June 30, 1994, and covering the period July 1, 1994 to June 30, 1995, and covering the period July 1, 1995 to June 30, 1996, and covering the period July 1, 1996 to June 30, 1997, and covering the period July 1, 1997 to June 30, 1998, and covering the period July 1, 1998 to June 30, 1999, and covering the period July 1, 1999 to June 30, 2000, and covering the period July 1, 2000 to June 30, 2001, and covering the period July 1, 2001 to October 29, 2001, and covering the period April 1, 2002 to June 30, 2002, and covering the period July 1, 2002 to June 30, 2003, and covering the period July 1, 2003 to June 30, 2004, and covering the period July 1, 2004 to June 30, 2005, and covering the period July 1, 2005 to June 30, 2006, and covering the period July 1, 2006 to June 30, 2007, and covering the period July 1, 2007 to June 30, 2008, and covering the period July 1, 2008 to June 30, 2009, and covering the period July 1, 2009 to June 30, 2010, and covering the period July 1, 2010 to June 30, 2011, and covering the period July 1, 2011 to June 30, 2012, and covering the period July 1, 2012 to June 30, 2013, and covering the period July 1, 2013 to June 30, 2014, and covering the period July 1, 2014 to June 30, 2015, and covering the period July 1, 2015 to June 30, 2016, AND COVERING THE PERIOD JULY 1, 2016 TO JUNE 30, 2017 for a physician or dentist where such excess insurance coverage or equivalent excess coverage is cancelled in accordance with paragraph (c) of this subdivision.

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

1 S 40. The superintendent of financial services shall establish rates
2 for policies providing coverage for physicians and surgeons medical
3 malpractice for the periods commencing July 1, 1985 and ending June 30,
4 [2016] 2017; provided, however, that notwithstanding any other provision
5 of law, the superintendent shall not establish or approve any increase
6 in rates for the period commencing July 1, 2009 and ending June 30,
7 2010. The superintendent shall direct insurers to establish segregated
8 accounts for premiums, payments, reserves and investment income attrib-
9 utable to such premium periods and shall require periodic reports by the
10 insurers regarding claims and expenses attributable to such periods to
11 monitor whether such accounts will be sufficient to meet incurred claims
12 and expenses. On or after July 1, 1989, the superintendent shall impose
13 a surcharge on premiums to satisfy a projected deficiency that is
14 attributable to the premium levels established pursuant to this section
15 for such periods; provided, however, that such annual surcharge shall
16 not exceed eight percent of the established rate until July 1, [2016]
17 2017, at which time and thereafter such surcharge shall not exceed twen-
18 ty-five percent of the approved adequate rate, and that such annual
19 surcharges shall continue for such period of time as shall be sufficient
20 to satisfy such deficiency. The superintendent shall not impose such
21 surcharge during the period commencing July 1, 2009 and ending June 30,
22 2010. On and after July 1, 1989, the surcharge prescribed by this
23 section shall be retained by insurers to the extent that they insured
24 physicians and surgeons during the July 1, 1985 through June 30, [2016]
25 2017 policy periods; in the event and to the extent physicians and
26 surgeons were insured by another insurer during such periods, all or a
27 pro rata share of the surcharge, as the case may be, shall be remitted
28 to such other insurer in accordance with rules and regulations to be
29 promulgated by the superintendent. Surcharges collected from physicians
30 and surgeons who were not insured during such policy periods shall be
31 apportioned among all insurers in proportion to the premium written by
32 each insurer during such policy periods; if a physician or surgeon was
33 insured by an insurer subject to rates established by the superintendent
34 during such policy periods, and at any time thereafter a hospital,
35 health maintenance organization, employer or institution is responsible
36 for responding in damages for liability arising out of such physician's
37 or surgeon's practice of medicine, such responsible entity shall also
38 remit to such prior insurer the equivalent amount that would then be
39 collected as a surcharge if the physician or surgeon had continued to
40 remain insured by such prior insurer. In the event any insurer that
41 provided coverage during such policy periods is in liquidation, the
42 property/casualty insurance security fund shall receive the portion of
43 surcharges to which the insurer in liquidation would have been entitled.
44 The surcharges authorized herein shall be deemed to be income earned for
45 the purposes of section 2303 of the insurance law. The superintendent,
46 in establishing adequate rates and in determining any projected defi-
47 ciency pursuant to the requirements of this section and the insurance
48 law, shall give substantial weight, determined in his discretion and
49 judgment, to the prospective anticipated effect of any regulations
50 promulgated and laws enacted and the public benefit of stabilizing
51 malpractice rates and minimizing rate level fluctuation during the peri-
52 od of time necessary for the development of more reliable statistical
53 experience as to the efficacy of such laws and regulations affecting
54 medical, dental or podiatric malpractice enacted or promulgated in 1985,
55 1986, by this act and at any other time. Notwithstanding any provision
56 of the insurance law, rates already established and to be established by

1 the superintendent pursuant to this section are deemed adequate if such
2 rates would be adequate when taken together with the maximum authorized
3 annual surcharges to be imposed for a reasonable period of time whether
4 or not any such annual surcharge has been actually imposed as of the
5 establishment of such rates.

6 S 6. Section 5 and subdivisions (a) and (e) of section 6 of part J of
7 chapter 63 of the laws of 2001, amending chapter 266 of the laws of
8 1986, amending the civil practice law and rules and other laws relating
9 to malpractice and professional medical conduct, as amended by section 5
10 of part Y of chapter 57 of the laws of 2015, are amended to read as
11 follows:

12 S 5. The superintendent of financial services and the commissioner of
13 health shall determine, no later than June 15, 2002, June 15, 2003, June
14 15, 2004, June 15, 2005, June 15, 2006, June 15, 2007, June 15, 2008,
15 June 15, 2009, June 15, 2010, June 15, 2011, June 15, 2012, June 15,
16 2013, June 15, 2014, June 15, 2015, [and] June 15, 2016, AND JUNE 15,
17 2017 the amount of funds available in the hospital excess liability
18 pool, created pursuant to section 18 of chapter 266 of the laws of 1986,
19 and whether such funds are sufficient for purposes of purchasing excess
20 insurance coverage for eligible participating physicians and dentists
21 during the period July 1, 2001 to June 30, 2002, or July 1, 2002 to June
22 30, 2003, or July 1, 2003 to June 30, 2004, or July 1, 2004 to June 30,
23 2005, or July 1, 2005 to June 30, 2006, or July 1, 2006 to June 30,
24 2007, or July 1, 2007 to June 30, 2008, or July 1, 2008 to June 30,
25 2009, or July 1, 2009 to June 30, 2010, or July 1, 2010 to June 30,
26 2011, or July 1, 2011 to June 30, 2012, or July 1, 2012 to June 30,
27 2013, or July 1, 2013 to June 30, 2014, or July 1, 2014 to June 30,
28 2015, or July 1, 2015 to June 30, 2016, OR JULY 1, 2016 TO JUNE 30, 2017
29 as applicable.

30 (a) This section shall be effective only upon a determination, pursu-
31 ant to section five of this act, by the superintendent of financial
32 services and the commissioner of health, and a certification of such
33 determination to the state director of the budget, the chair of the
34 senate committee on finance and the chair of the assembly committee on
35 ways and means, that the amount of funds in the hospital excess liabil-
36 ity pool, created pursuant to section 18 of chapter 266 of the laws of
37 1986, is insufficient for purposes of purchasing excess insurance cover-
38 age for eligible participating physicians and dentists during the period
39 July 1, 2001 to June 30, 2002, or July 1, 2002 to June 30, 2003, or July
40 1, 2003 to June 30, 2004, or July 1, 2004 to June 30, 2005, or July 1,
41 2005 to June 30, 2006, or July 1, 2006 to June 30, 2007, or July 1, 2007
42 to June 30, 2008, or July 1, 2008 to June 30, 2009, or July 1, 2009 to
43 June 30, 2010, or July 1, 2010 to June 30, 2011, or July 1, 2011 to June
44 30, 2012, or July 1, 2012 to June 30, 2013, or July 1, 2013 to June 30,
45 2014, or July 1, 2014 to June 30, 2015, or July 1, 2015 to June 30,
46 2016, OR JULY 1, 2016 TO JUNE 30, 2017 as applicable.

47 (e) The commissioner of health shall transfer for deposit to the
48 hospital excess liability pool created pursuant to section 18 of chapter
49 266 of the laws of 1986 such amounts as directed by the superintendent
50 of financial services for the purchase of excess liability insurance
51 coverage for eligible participating physicians and dentists for the
52 policy year July 1, 2001 to June 30, 2002, or July 1, 2002 to June 30,
53 2003, or July 1, 2003 to June 30, 2004, or July 1, 2004 to June 30,
54 2005, or July 1, 2005 to June 30, 2006, or July 1, 2006 to June 30,
55 2007, as applicable, and the cost of administering the hospital excess
56 liability pool for such applicable policy year, pursuant to the program

1 established in chapter 266 of the laws of 1986, as amended, no later
2 than June 15, 2002, June 15, 2003, June 15, 2004, June 15, 2005, June
3 15, 2006, June 15, 2007, June 15, 2008, June 15, 2009, June 15, 2010,
4 June 15, 2011, June 15, 2012, June 15, 2013, June 15, 2014, June 15,
5 2015, [and] June 15, 2016, AND JUNE 15, 2017 as applicable.

6 S 7. Notwithstanding any law, rule or regulation to the contrary, only
7 physicians or dentists who were eligible, and for whom the superinten-
8 dent of financial services and the commissioner of health, or their
9 designee, purchased, with funds available in the hospital excess liabil-
10 ity pool, a full or partial policy for excess coverage or equivalent
11 excess coverage for the coverage period ending the thirtieth of June,
12 two thousand sixteen, shall be eligible to apply for such coverage for
13 the coverage period beginning the first of July, two thousand sixteen;
14 provided, however, if the total number of physicians or dentists for
15 whom such excess coverage or equivalent excess coverage was purchased
16 for the policy year ending the thirtieth of June, two thousand sixteen
17 exceeds the total number of physicians or dentists certified as eligible
18 for the coverage period beginning the first of July, two thousand
19 sixteen, then the general hospitals may certify additional eligible
20 physicians or dentists in a number equal to such general hospital's
21 proportional share of the total number of physicians or dentists for
22 whom excess coverage or equivalent excess coverage was purchased with
23 funds available in the hospital excess liability pool as of the thirti-
24 eth of June, two thousand sixteen, as applied to the difference between
25 the number of eligible physicians or dentists for whom a policy for
26 excess coverage or equivalent excess coverage was purchased for the
27 coverage period ending the thirtieth of June, two thousand sixteen and
28 the number of such eligible physicians or dentists who have applied for
29 excess coverage or equivalent excess coverage for the coverage period
30 beginning the first of July, two thousand sixteen.

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

34 PART D

35 Section 1. Paragraph (a) of subdivision 1 of section 212 of chapter
36 474 of the laws of 1996, amending the education law and other laws
37 relating to rates for residential healthcare facilities, as amended by
38 section 2 of part B of chapter 56 of the laws of 2013, is amended to
39 read as follows:

40 (a) Notwithstanding any inconsistent provision of law or regulation to
41 the contrary, effective beginning August 1, 1996, for the period April
42 1, 1997 through March 31, 1998, April 1, 1998 for the period April 1,
43 1998 through March 31, 1999, August 1, 1999, for the period April 1,
44 1999 through March 31, 2000, April 1, 2000, for the period April 1, 2000
45 through March 31, 2001, April 1, 2001, for the period April 1, 2001
46 through March 31, 2002, April 1, 2002, for the period April 1, 2002
47 through March 31, 2003, and for the state fiscal year beginning April 1,
48 2005 through March 31, 2006, and for the state fiscal year beginning
49 April 1, 2006 through March 31, 2007, and for the state fiscal year
50 beginning April 1, 2007 through March 31, 2008, and for the state fiscal
51 year beginning April 1, 2008 through March 31, 2009, and for the state
52 fiscal year beginning April 1, 2009 through March 31, 2010, and for the
53 state fiscal year beginning April 1, 2010 through March 31, 2016, AND
54 ANNUALLY THEREAFTER, the department of health is authorized to pay

1 public general hospitals, as defined in subdivision 10 of section 2801
2 of the public health law, operated by the state of New York or by the
3 state university of New York or by a county, which shall not include a
4 city with a population of over one million, of the state of New York,
5 and those public general hospitals located in the county of Westchester,
6 the county of Erie or the county of Nassau, additional payments for
7 inpatient hospital services as medical assistance payments pursuant to
8 title 11 of article 5 of the social services law for patients eligible
9 for federal financial participation under title XIX of the federal
10 social security act in medical assistance pursuant to the federal laws
11 and regulations governing disproportionate share payments to hospitals
12 up to one hundred percent of each such public general hospital's medical
13 assistance and uninsured patient losses after all other medical assist-
14 ance, including disproportionate share payments to such public general
15 hospital for 1996, 1997, 1998, and 1999, based initially for 1996 on
16 reported 1994 reconciled data as further reconciled to actual reported
17 1996 reconciled data, and for 1997 based initially on reported 1995
18 reconciled data as further reconciled to actual reported 1997 reconciled
19 data, for 1998 based initially on reported 1995 reconciled data as
20 further reconciled to actual reported 1998 reconciled data, for 1999
21 based initially on reported 1995 reconciled data as further reconciled
22 to actual reported 1999 reconciled data, for 2000 based initially on
23 reported 1995 reconciled data as further reconciled to actual reported
24 2000 data, for 2001 based initially on reported 1995 reconciled data as
25 further reconciled to actual reported 2001 data, for 2002 based initial-
26 ly on reported 2000 reconciled data as further reconciled to actual
27 reported 2002 data, and for state fiscal years beginning on April 1,
28 2005, based initially on reported 2000 reconciled data as further recon-
29 ciled to actual reported data for 2005, and for state fiscal years
30 beginning on April 1, 2006, based initially on reported 2000 reconciled
31 data as further reconciled to actual reported data for 2006, for state
32 fiscal years beginning on and after April 1, 2007 through March 31,
33 2009, based initially on reported 2000 reconciled data as further recon-
34 ciled to actual reported data for 2007 and 2008, respectively, for state
35 fiscal years beginning on and after April 1, 2009, based initially on
36 reported 2007 reconciled data, adjusted for authorized Medicaid rate
37 changes applicable to the state fiscal year, and as further reconciled
38 to actual reported data for 2009, for state fiscal years beginning on
39 and after April 1, 2010, based initially on reported reconciled data
40 from the base year two years prior to the payment year, adjusted for
41 authorized Medicaid rate changes applicable to the state fiscal year,
42 and further reconciled to actual reported data from such payment year,
43 and to actual reported data for each respective succeeding year. The
44 payments may be added to rates of payment or made as aggregate payments
45 to an eligible public general hospital.

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

51 S 10. This act shall take effect immediately and shall be deemed to
52 have been in full force and effect on and after July 1, 1996[; provided,
53 however, that sections one, two and three of this act shall expire and
54 be deemed repealed on March 31, 2016 provided, however that the amend-
55 ments to section 364-j of the social services law made by section four
56 of this act shall not affect the expiration of such section and shall be

1 deemed to expire therewith and provided, further, that the provisions of
2 subdivisions 8, 9 and 10 of section 4401 of the public health law, as
3 added by section one of this act; section 4403-d of the public health
4 law as added by section two of this act and the provisions of section
5 seven of this act, except for the provisions relating to the establish-
6 ment of no more than twelve comprehensive HIV special needs plans, shall
7 expire and be deemed repealed on July 1, 2000].

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

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

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

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

20 PART E

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

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

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

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

33 12-A. "MULTIDISCIPLINARY" MEANS THE INVOLVEMENT OF TWO OR MORE SEPA-
34 RATE DISCIPLINES OR PROFESSIONS, WHICH MAY MEAN THE INVOLVEMENT OF ONE
35 INDIVIDUAL WHO MEETS THE DEFINITION OF QUALIFIED PERSONNEL AS DEFINED IN
36 SUBDIVISION FIFTEEN OF THIS SECTION AND WHO IS QUALIFIED, IN ACCORDANCE
37 WITH STATE LICENSURE, CERTIFICATION OR OTHER COMPARABLE STANDARDS, TO
38 EVALUATE ALL FIVE DEVELOPMENTAL DOMAINS.

39 15-A. "SCREENING" MEANS THE PROCEDURES USED BY QUALIFIED PERSONNEL, AS
40 DEFINED IN SUBDIVISION FIFTEEN OF THIS SECTION, TO DETERMINE WHETHER A
41 CHILD IS SUSPECTED OF HAVING A DISABILITY AND IN NEED OF EARLY INTER-
42 VENTION SERVICES, AND SHALL INCLUDE, WHERE AVAILABLE AND APPROPRIATE FOR
43 THE CHILD, THE ADMINISTRATION OF A STANDARDIZED INSTRUMENT OR INSTRU-
44 MENTS APPROVED BY THE DEPARTMENT, IN ACCORDANCE WITH SUBDIVISION THREE
45 OF SECTION TWENTY-FIVE HUNDRED FORTY-FOUR OF THIS TITLE.

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

49 3. [The following persons and entities, within] (A) UNLESS THE PARENT
50 OBJECTS, WITHIN two working days of identifying an infant or toddler
51 suspected of having a disability or at risk of having a disability, THE
52 FOLLOWING PERSONS AND ENTITIES shall refer such infant or toddler to the
53 early intervention official or the health officer [of the public health
54 district in which the infant or toddler resides, as designated by the

1 municipality, but in no event over the objection of the parent made in
2 accordance with procedures established by the department for use by such
3 primary referral sources, unless the child has already been referred] OF
4 THE PUBLIC HEALTH DISTRICT DESIGNATED BY THE MUNICIPALITY IN WHICH THE
5 INFANT OR TODDLER RESIDES: hospitals, child health care providers, day
6 care programs, local school districts, public health facilities, early
7 childhood direction centers and such other social service and health
8 care agencies and providers as the commissioner shall specify in regu-
9 lation[; provided, however, that the]. THIS SHALL NOT APPLY IF THE
10 INFANT OR TODDLER HAS ALREADY BEEN REFERRED TO SUCH EARLY INTERVENTION
11 OFFICIAL OR HEALTH OFFICER. THE department shall establish procedures,
12 including regulations if required, to ensure that primary referral
13 sources adequately inform the parent or guardian about the early inter-
14 vention program, including through brochures and written materials
15 created or approved by the department.

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

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

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

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

52 (b) [the evaluator shall designate an individual as the principal
53 contact for the multidisciplinary team] INITIAL SERVICE COORDINATORS
54 SHALL INFORM THE PARENT OF THE APPLICABLE SCREENING OR EVALUATION PROCE-
55 DURES THAT MAY BE PERFORMED. FOR A CHILD REFERRED TO THE EARLY INTER-
56 VENTION OFFICIAL WHO HAS A DIAGNOSED PHYSICAL OR MENTAL CONDITION THAT

1 HAS A HIGH PROBABILITY OF RESULTING IN DEVELOPMENTAL DELAY, THE INITIAL
2 SERVICE COORDINATOR SHALL INFORM THE PARENT THAT THE EVALUATION OF THE
3 CHILD SHALL BE CONDUCTED IN ACCORDANCE WITH THE PROCEDURES SET FORTH IN
4 SUBDIVISION FIVE OF THIS SECTION.

5 (c) If, in consultation with the evaluator, the service coordinator
6 identifies a child that is potentially eligible for programs or services
7 offered by or under the auspices of the office for people with develop-
8 mental disabilities, the service coordinator shall, with parent consent,
9 notify the office for people with developmental disabilities' regional
10 developmental disabilities services office of the potential eligibility
11 of such child for said programs or services.

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

18 (b)] SCREENINGS FOR CHILDREN REFERRED TO THE EARLY INTERVENTION
19 PROGRAM TO DETERMINE WHETHER THEY ARE SUSPECTED OF HAVING A DISABILITY.
20 (A) FOR A CHILD REFERRED TO THE EARLY INTERVENTION PROGRAM, THE EVALU-
21 ATOR SHALL FIRST PERFORM A SCREENING OF THE CHILD, WITH PARENTAL
22 CONSENT, TO DETERMINE WHETHER THE CHILD IS SUSPECTED OF HAVING A DISA-
23 BILITY.

24 (B) THE EVALUATOR SHALL UTILIZE A STANDARDIZED INSTRUMENT OR INSTRU-
25 MENTS APPROVED BY THE DEPARTMENT TO CONDUCT THE SCREENING. IF THE EVALU-
26 ATOR DOES NOT UTILIZE A STANDARDIZED INSTRUMENT OR INSTRUMENTS APPROVED
27 BY THE DEPARTMENT FOR THE SCREENING, THE EVALUATOR SHALL DOCUMENT IN
28 WRITING WHY SUCH STANDARDIZED INSTRUMENT OR INSTRUMENTS ARE UNAVAILABLE
29 OR INAPPROPRIATE FOR THE CHILD.

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

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

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

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

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

50 (a) INCLUDE THE ADMINISTRATION OF AN EVALUATION STANDARDIZED INSTRU-
51 MENT OR INSTRUMENTS APPROVED BY THE DEPARTMENT. IF THE EVALUATOR DOES
52 NOT UTILIZE A STANDARDIZED INSTRUMENT OR INSTRUMENTS APPROVED BY THE
53 DEPARTMENT AS PART OF THE EVALUATION OF THE CHILD, THE EVALUATOR SHALL
54 DOCUMENT IN WRITING WHY SUCH STANDARDIZED INSTRUMENT OR INSTRUMENTS ARE
55 NOT APPROPRIATE OR AVAILABLE FOR THE CHILD;

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

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

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

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

(i) a review of pertinent records related to the child's current 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)

1 CONSIST OF A REVIEW OF THE RESULTS OF THE MEDICAL OR OTHER RECORDS THAT
2 ESTABLISHED THE CHILD'S ELIGIBILITY, AND ANY OTHER PERTINENT EVALUATIONS
3 OR RECORDS AVAILABLE AND (II) COMPLY WITH THE PROCEDURES SET FORTH IN
4 PARAGRAPH (F) OF SUBDIVISION FOUR OF THIS SECTION. THE EVALUATION PROCE-
5 DURES SET FORTH IN PARAGRAPHS (A) AND (E) OF SUBDIVISION FOUR SHALL NOT
6 BE REQUIRED OR CONDUCTED.

7 6. An evaluation shall not include a reference to any specific provid-
8 er of early intervention services.

9 [6.] 7. Nothing in this section shall restrict an evaluator from
10 utilizing, in addition to findings from his or her personal examination,
11 other examinations, evaluations or assessments conducted for such child,
12 including those conducted prior to the evaluation under this section, if
13 such examinations, evaluations or assessments are consistent with the
14 coordinated standards and procedures.

15 [7.] 8. Following completion of the evaluation, the evaluator shall
16 provide the parent and service coordinator with a copy of a summary of
17 the full evaluation. To the extent practicable, the summary shall be
18 provided in the native language of the parent. Upon request of the
19 parent, early intervention official or service coordinator, the evalu-
20 ator shall provide a copy of the full evaluation to such parent, early
21 intervention official or service coordinator.

22 [8.] 9. A parent who disagrees with the results of an evaluation may
23 obtain an additional evaluation or partial evaluation at public expense
24 to the extent authorized by federal law or regulation.

25 [9.] 10. Upon receipt of the results of an evaluation, a service coor-
26 dinator may, with parental consent, require additional diagnostic infor-
27 mation regarding the condition of the child, provided, however, that
28 such evaluation or assessment is not unnecessarily duplicative or inva-
29 sive to the child, and provided further, that:

30 (a) where the evaluation has established the child's eligibility, such
31 additional diagnostic information shall be used solely to provide addi-
32 tional information to the parent and service coordinator regarding the
33 child's need for services and cannot be a basis for refuting eligibil-
34 ity;

35 (b) the service coordinator provides the parent with a written expla-
36 nation of the basis for requiring additional diagnostic information;

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

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

42 [10.] 11. (a) If the screening indicates that the infant or toddler is
43 not an eligible child and the parent elects not to have an evaluation,
44 or if the evaluation indicates that the infant or toddler is not an
45 eligible child, the service coordinator shall inform the parent of other
46 programs or services that may benefit such child, and the child's family
47 and, with parental consent, refer such child to such programs or
48 services.

49 (b) A parent may appeal a determination that a child is ineligible
50 pursuant to the provisions of section twenty-five hundred forty-nine of
51 this title, provided, however, that a parent may not initiate such
52 appeal until all evaluations are completed. IN ADDITION, FOR A CHILD
53 REFERRED TO THE EARLY INTERVENTION OFFICIAL WHO HAS A DIAGNOSED PHYSICAL
54 OR MENTAL CONDITION THAT ESTABLISHES THE CHILD'S ELIGIBILITY FOR THE
55 PROGRAM IN ACCORDANCE WITH SUBDIVISION FIVE OF THIS SECTION, THE PARENT
56 MAY REQUEST, AND SUCH REQUEST SHALL BE GRANTED, THAT THE EVALUATOR

1 CONDUCT THE EVALUATION PROCEDURES SET FORTH IN PARAGRAPHS (A) THROUGH
2 (E) OF SUBDIVISION FOUR OF THIS SECTION, PROVIDED, HOWEVER, THAT THE
3 PARENT MAY NOT MAKE SUCH REQUEST UNTIL THE EVALUATION CONDUCTED IN
4 ACCORDANCE WITH SUBDIVISION FIVE OF THIS SECTION IS COMPLETED.

5 [11.] 12. Notwithstanding any other provision of law to the contrary,
6 where a request has been made to review an IFSP prior to the six-month
7 interval provided in subdivision seven of section twenty-five hundred
8 forty-five of this title for purposes of increasing frequency or dura-
9 tion of an approved service, including service coordination, the early
10 intervention official may require an additional evaluation or partial
11 evaluation at public expense by an approved evaluator other than the
12 current provider of service, with parent consent.

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

16 (IV) PROVIDERS SHALL SUBMIT ALL CLAIMS, IN ACCORDANCE WITH SUBPARA-
17 GRAPH (III) OF THIS PARAGRAPH AND WITHIN NINETY DAYS OF THE DATE OF
18 SERVICE, UNLESS THE SUBMISSION IS DELAYED DUE TO EXTRAORDINARY CIRCUM-
19 STANCES DOCUMENTED BY THE PROVIDER. ALL CLAIMS SUBMITTED AFTER NINETY
20 DAYS SHALL BE SUBMITTED WITHIN THIRTY DAYS FROM THE TIME THE PROVIDER
21 WAS RELIEVED FROM THE EXTRAORDINARY CIRCUMSTANCES THAT PREVIOUSLY
22 DELAYED A TIMELY SUBMISSION. CLAIMS THAT ARE NOT SUBMITTED WITHIN TIME-
23 FRAMES SET FORTH WILL NOT BE REIMBURSED BY THE DEPARTMENT'S FISCAL AGENT
24 FROM THE ESCROW ACCOUNT FUNDED BY MUNICIPAL GOVERNMENTAL PAYERS.

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

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

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

50 (a) Except in a case where the obligation of an insurer or an organ-
51 ization or corporation licensed or certified pursuant to article forty-
52 three or forty-seven of this chapter or article forty-four of the public
53 health law to pay a claim submitted by a policyholder or person covered
54 under such policy ("covered person") or make a payment to a health care
55 provider is not reasonably clear, or when there is a reasonable basis
56 supported by specific information available for review by the super-

intendent 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

1 of the greater of the rate equal to the rate set by the commissioner of
2 taxation and finance for corporate taxes pursuant to paragraph one of
3 subsection (e) of section one thousand ninety-six of the tax law or
4 twelve percent per annum, to be computed from the date the claim or
5 health care payment was required to be made. When the amount of interest
6 due on such a claim is less [then] THAN two dollars, and insurer or
7 organization or corporation shall not be required to pay interest on
8 such claim.

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

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

35 (d) For the purposes of this section:

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

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

49 (e) Nothing in this section shall in any way be deemed to impair any
50 right available to the state to adjust the timing of its payments for
51 medical assistance pursuant to title eleven of article five of the
52 social services law, or for child health insurance plan benefits pursu-
53 ant to title one-a of article twenty-five of the public health law or
54 otherwise be deemed to require adjustment of payments by the state for
55 such medical assistance or child health insurance.

1 (f) In any action brought by the superintendent pursuant to this
2 section or article twenty-four of this chapter relating to this section
3 regarding payments for medical assistance pursuant to title eleven of
4 article five of the social services law, child health insurance plan
5 benefits pursuant to title one-a of article twenty-five of the public
6 health law, benefits under the voucher insurance program pursuant to
7 section one thousand one hundred twenty-one of this chapter, and bene-
8 fits under the New York state small business health insurance partner-
9 ship program pursuant to article nine-A of the public health law, it
10 shall be a mitigating factor that the insurer, corporation or organiza-
11 tion is owed any premium amounts, premium adjustments, stop-loss recov-
12 eries or other payments from the state or one of its fiscal interme-
13 diaries under any such program.

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

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

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

50 (2) An insurer or organization or corporation licensed or certified
51 pursuant to article forty-three or article forty-seven of this chapter
52 or article forty-four of the public health law may reduce the reimburse-
53 ment due to a health care provider for an untimely claim that otherwise
54 meets the requirements of paragraph one of this subsection by an amount
55 not to exceed twenty-five percent of the amount that would have been
56 paid had the claim been submitted in a timely manner; provided, however,

1 that nothing in this subsection shall preclude a health care provider
2 and an insurer or organization or corporation from agreeing to a lesser
3 reduction. The provisions of this subsection shall not apply to any
4 claim submitted three hundred sixty-five days after the date of service,
5 in which case the insurer or organization or corporation may deny the
6 claim in full.

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

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

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

53 S 3235-a. Payment for early intervention services. (a) No policy of
54 accident and health insurance, including contracts issued pursuant to
55 article forty-three of this chapter, shall exclude coverage for other-
56 wise covered services solely on the basis that the services constitute

1 early intervention program services under title two-A of article twen-
2 ty-five of the public health law.

3 (b) Where a policy of accident and health insurance, including a
4 contract issued pursuant to article forty-three of this chapter,
5 provides coverage for an early intervention program service, such cover-
6 age shall not be applied against any maximum annual or lifetime monetary
7 limits set forth in such policy or contract. Visit limitations [and
8 other terms and conditions of the policy] will continue to apply to
9 early intervention services. However, any visits used for early inter-
10 vention program services shall not reduce the number of visits otherwise
11 available under the policy or contract for such services. WHEN SUCH
12 POLICY OF ACCIDENT AND HEALTH INSURANCE, INCLUDING A CONTRACT ISSUED
13 PURSUANT TO ARTICLE FORTY-THREE AND SECTION ELEVEN HUNDRED TWENTY OF
14 THIS CHAPTER, PROVIDES COVERAGE FOR ESSENTIAL HEALTH BENEFITS, AS
15 DEFINED IN SECTION 1302(B) OF THE AFFORDABLE CARE ACT, 42 U.S.C. S
16 18022(B), AND CONSTITUTES EARLY INTERVENTION SERVICES AS SET FORTH IN
17 PARAGRAPH (H) OF SUBDIVISION SEVEN OF SECTION TWENTY-FIVE HUNDRED
18 FORTY-ONE OF THE PUBLIC HEALTH LAW, OR EARLY INTERVENTION EVALUATION
19 SERVICES AS SET FORTH IN SUBDIVISION NINE OF SECTION TWENTY-FIVE HUNDRED
20 FORTY-ONE OF THE PUBLIC HEALTH LAW, A WRITTEN ORDER, REFERRAL, RECOMMEN-
21 DATION FOR DIAGNOSTIC SERVICES TO DETERMINE PROGRAM ELIGIBILITY, OR THE
22 INDIVIDUALIZED FAMILY SERVICES PLAN CERTIFIED BY THE EARLY INTERVENTION
23 OFFICIAL, AS DEFINED IN SECTION TWENTY-FIVE HUNDRED FORTY-ONE OF THE
24 PUBLIC HEALTH LAW OR SUCH OFFICIAL'S DESIGNEE, SHALL BE SUFFICIENT TO
25 MEET PRECERTIFICATION, PREAUTHORIZATION AND/OR MEDICAL NECESSITY
26 REQUIREMENTS IMPOSED UNDER SUCH POLICY.

27 (C) REIMBURSEMENT FOR ANY EARLY INTERVENTION PROGRAM SERVICE, AS SET
28 FORTH IN PARAGRAPH (H) OF SUBDIVISION SEVEN OF SECTION TWENTY-FIVE
29 HUNDRED FORTY-ONE OF THE PUBLIC HEALTH LAW, OR EARLY INTERVENTION EVALU-
30 ATION SERVICE, AS SET FORTH IN SUBDIVISION NINE OF SECTION TWENTY-FIVE
31 HUNDRED FORTY-ONE OF THE PUBLIC HEALTH LAW, THAT IS A COVERED SERVICE
32 UNDER THE POLICY OF ACCIDENT AND HEALTH INSURANCE, INCLUDING A CONTRACT
33 ISSUED PURSUANT TO ARTICLE FORTY-THREE OF THIS CHAPTER, SHALL BE AT THE
34 HIGHER OF EITHER A RATE ESTABLISHED BY THE COMMISSIONER OF HEALTH OR A
35 RATE NEGOTIATED BY THE INSURER IN ACCORDANCE WITH REGULATION.

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

39 (I) THE LOCATION WHERE SERVICES ARE PROVIDED;

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

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

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

48 [(c)] (E) Any right of subrogation to benefits which a municipality or
49 provider is entitled in accordance with paragraph (d) of subdivision
50 three of section twenty-five hundred fifty-nine of the public health law
51 shall be valid and enforceable to the extent benefits are available
52 under any accident and health insurance policy. The right of subrogation
53 does not attach to insurance benefits paid or provided under any acci-
54 dent and health insurance policy prior to receipt by the insurer of
55 written notice from the municipality or provider, as applicable. IF AN
56 INSURER MAKES PAYMENT IN WHOLE OR IN PART FOR A CLAIM OR BILL FOR

1 SERVICES RENDERED UNDER THE EARLY INTERVENTION PROGRAM ESTABLISHED IN
2 TITLE TWO-A OF ARTICLE TWENTY-FIVE OF THE PUBLIC HEALTH LAW, SUCH
3 PAYMENT SHALL BE MADE TO THE PROVIDER WHO SUBMITTED THE CLAIM AND NOT TO
4 THE RENDERING PROFESSIONAL WHO DELIVERED THE SERVICE OR THE COVERED
5 PERSON REGARDLESS OF WHETHER SUCH PROVIDER IS IN THE INSURER'S NETWORK.
6 The insurer shall provide the municipality and service coordinator with
7 information on the extent of benefits available to the covered person
8 under such policy within fifteen days of the insurer's receipt of writ-
9 ten request and notice authorizing such release. The service coordinator
10 shall provide such information to the rendering provider assigned to
11 provide services to the child.

12 [(d)] (F) No insurer, including a health maintenance organization
13 issued a certificate of authority under article forty-four of the public
14 health law and a corporation organized under article forty-three of this
15 chapter, shall refuse to issue an accident and health insurance policy
16 or contract or refuse to renew an accident and health insurance policy
17 or contract solely because the applicant or insured is receiving
18 services under the early intervention program.

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

26

PART F

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

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

48 2. The commissioner and the president of the authority shall enter
49 into an agreement, subject to approval by the director of the budget,
50 and subject to section sixteen hundred eighty-r of the public authori-
51 ties law, for the purposes of awarding, distributing, and administering
52 the funds made available pursuant to this section. Such funds may be
53 distributed by the commissioner and the president of the authority for
54 capital grants to general hospitals [for the purposes of consolidating

1 multiple licensed health care facilities into an integrated system of
2 care], RESIDENTIAL HEALTH CARE FACILITIES, DIAGNOSTIC AND TREATMENT
3 CENTERS AND CLINICS LICENSED PURSUANT TO THIS CHAPTER OR THE MENTAL
4 HYGIENE LAW, PRIMARY CARE PROVIDERS, AND HOME CARE PROVIDERS CERTIFIED
5 OR LICENSED PURSUANT TO ARTICLE THIRTY-SIX OF THIS CHAPTER, for capital
6 non-operational works or purposes that support the purposes set forth in
7 this section. A copy of such agreement, and any amendments thereto,
8 shall be provided to the chair of the senate finance committee, the
9 chair of the assembly ways and means committee, and the director of the
10 division of budget no later than thirty days prior to the release of a
11 request for applications for funding under this program. Projects
12 awarded, IN WHOLE OR PART, under section twenty-eight hundred twenty-
13 five of this article shall not be eligible for grants or awards made
14 available under this section.

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

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

27 (a) the extent to which the proposed capital project will contribute
28 to the integration of health care services and long term sustainability
29 of the applicant or preservation of essential health services in the
30 community or communities served by the applicant;

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

34 (c) CONSIDERATION OF GEOGRAPHIC DISTRIBUTION OF FUNDS;

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

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

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

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

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

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

48 5. DISBURSEMENT OF AWARDS MADE PURSUANT TO THIS SECTION SHALL BE
49 CONDITIONED ON THE AWARDEE ACHIEVING CERTAIN PROCESS AND PERFORMANCE
50 METRICS AND MILESTONES AS DETERMINED IN THE SOLE DISCRETION OF THE
51 COMMISSIONER. SUCH METRICS AND MILESTONES SHALL BE STRUCTURED TO ENSURE
52 THAT THE HEALTH CARE TRANSFORMATION AND PROVIDER SUSTAINABILITY GOALS OF
53 THE PROJECT ARE ACHIEVED, AND SUCH METRICS AND MILESTONES SHALL BE
54 INCLUDED IN GRANT DISBURSEMENT AGREEMENTS OR OTHER CONTRACTUAL DOCUMENTS
55 AS REQUIRED BY THE COMMISSIONER.

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

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

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

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

8 (D) A LIMITED SERVICES CLINIC SHALL BE DEEMED TO BE A "HEALTH CARE
9 PROVIDER" FOR THE PURPOSES OF TITLE TWO-D OF ARTICLE TWO OF THIS CHAP-
10 TER. A PRESCRIBER PRACTICING IN A LIMITED SERVICES CLINIC SHALL NOT BE
11 DEEMED TO BE IN THE EMPLOY OF A PHARMACY OR PRACTICING IN A HOSPITAL FOR
12 PURPOSES OF SUBDIVISION TWO OF SECTION SIXTY-EIGHT HUNDRED SEVEN OF THE
13 EDUCATION LAW.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

54 (II) MAINTAIN AND REGULARLY UPDATE A LIST OF LOCAL PRIMARY CARE
55 PROVIDERS AND PROVIDE SUCH LIST TO EACH PATIENT WHO INDICATES THAT HE OR
56 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 this act shall revert to its text as it existed prior to the effective date of this act.

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 J

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

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

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

a. In relation to activities and services provided under article 153 of the education law, nothing in this act shall prohibit or limit such activities or services on the part of any person in the employ of a program or service operated, regulated, funded, or approved by the department of mental hygiene or the office of children and family services, or a local governmental unit as that term is defined in article 41 of the mental hygiene law or a social services district as defined in section 61 of the social services law. In relation to activities and services provided under article 163 of the education law, nothing in this act shall prohibit or limit such activities or services on the part of any person in the employ of a program or service operated, regulated, funded, or approved by the department of mental hygiene, the office of children and family services, the department of corrections and community supervision, the office of temporary and disability assistance, the state office for the aging and the department of health or a local governmental unit as that term is defined in article 41 of the mental hygiene law or a social services district as defined in section 61 of the social services law, pursuant to authority granted by law. This section shall not authorize the use of any title authorized

pursuant to article 153 or 163 of the education law by any such employed person, except as otherwise provided by such articles respectively. This section shall be deemed repealed July 1, [2016] 2021.

S 3. Section 16 of chapter 130 of the laws of 2010 amending the education law and other laws relating to the registration of entities providing certain professional services and the licensure of certain professions, as amended by section 3 of part AA of chapter 57 of the laws of 2013, is amended to read as follows:

S 16. This act shall take effect immediately; provided that sections thirteen, fourteen and fifteen of this act shall take effect immediately and shall be deemed to have been in full force and effect on and after June 1, 2010 and such sections shall be deemed repealed July 1, [2016] 2021; provided further that the amendments to section 9 of chapter 420 of the laws of 2002 amending the education law relating to the profession of social work made by section thirteen of this act shall repeal on the same date as such section repeals; provided further that the amendments to section 17-a of chapter 676 of the laws of 2002 amending the education law relating to the practice of psychology made by section fourteen of this act shall repeal on the same date as such section repeals.

S 4. This act shall take effect immediately.

PART K

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

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

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 L

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

S 16.25 TEMPORARY OPERATOR.

(A) FOR THE PURPOSES OF THIS SECTION:

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

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

(3) "SERIOUS FINANCIAL INSTABILITY" SHALL INCLUDE BUT NOT BE LIMITED TO DEFAULTING OR VIOLATING MATERIAL COVENANTS OF BOND ISSUES, MISSED MORTGAGE PAYMENTS, MISSED RENT PAYMENTS, A PATTERN OF UNTIMELY PAYMENT OF DEBTS, FAILURE TO PAY ITS EMPLOYEES OR VENDORS, INSUFFICIENT FUNDS TO MEET THE GENERAL OPERATING EXPENSES OF THE PROGRAM, FAILURE TO MAINTAIN REQUIRED DEBT SERVICE COVERAGE RATIOS AND/OR, AS APPLICABLE, FACTORS THAT HAVE TRIGGERED A WRITTEN EVENT OF DEFAULT NOTICE TO THE OFFICE BY THE DORMITORY AUTHORITY OF THE STATE OF NEW YORK.

(4) "OFFICE" SHALL MEAN THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES.

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

A. AGREES TO PROVIDE SERVICES CERTIFIED PURSUANT TO THIS ARTICLE ON A TEMPORARY BASIS IN THE BEST INTERESTS OF ITS INDIVIDUALS 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 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 PROVIDER OF SERVICES' 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 INDIVIDUALS UNTIL THE ESTABLISHED OPERATOR CAN RESUME OPERATIONS WITHIN THE DESIGNATED TIME PERIOD OR OTHER ACTION IS TAKEN AS DESCRIBED IN SECTION 16.17 OF THIS ARTICLE.

(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 PROGRAM

1 AND TO PROMOTE THE QUALITY AND ACCESSIBILITY OF SERVICES IN THE COMMUNI-
2 TY SERVED BY THE PROVIDER OF SERVICES.

3 (2) DURING THE TERM OF APPOINTMENT, THE TEMPORARY OPERATOR SHALL HAVE
4 THE AUTHORITY TO DIRECT THE STAFF OF THE ESTABLISHED OPERATOR AS NECES-
5 SARY TO APPROPRIATELY PROVIDE SERVICES FOR INDIVIDUALS. THE TEMPORARY
6 OPERATOR SHALL, DURING THIS PERIOD, PROVIDE SERVICES IN SUCH A MANNER AS
7 TO PROMOTE SAFETY AND THE QUALITY AND ACCESSIBILITY OF SERVICES IN THE
8 COMMUNITY SERVED BY THE ESTABLISHED OPERATOR UNTIL EITHER THE ESTAB-
9 LISHED OPERATOR CAN RESUME OPERATIONS OR UNTIL THE OFFICE REVOKES THE
10 OPERATING CERTIFICATE FOR THE SERVICES ISSUED UNDER THIS ARTICLE.

11 (3) THE ESTABLISHED OPERATOR SHALL GRANT ACCESS TO THE TEMPORARY OPER-
12 ATOR TO THE ESTABLISHED OPERATOR'S ACCOUNTS AND RECORDS IN ORDER TO
13 ADDRESS ANY DEFICIENCIES RELATED TO THE PROGRAM EXPERIENCING SERIOUS
14 FINANCIAL INSTABILITY OR AN ESTABLISHED OPERATOR REQUESTING FINANCIAL
15 ASSISTANCE IN ACCORDANCE WITH THIS SECTION. THE TEMPORARY OPERATOR SHALL
16 APPROVE ANY FINANCIAL DECISION RELATED TO AN ESTABLISHED PROVIDER'S DAY
17 TO DAY OPERATIONS OR THE ESTABLISHED PROVIDER'S ABILITY TO PROVIDE
18 SERVICES.

19 (4) THE TEMPORARY OPERATOR SHALL NOT BE REQUIRED TO FILE ANY BOND. NO
20 SECURITY INTEREST IN ANY REAL OR PERSONAL PROPERTY COMPRISING THE ESTAB-
21 LISHED OPERATOR OR CONTAINED WITHIN THE ESTABLISHED OPERATOR OR IN ANY
22 FIXTURE OF THE PROGRAM, SHALL BE IMPAIRED OR DIMINISHED IN PRIORITY BY
23 THE TEMPORARY OPERATOR. NEITHER THE TEMPORARY OPERATOR NOR THE OFFICE
24 SHALL ENGAGE IN ANY ACTIVITY THAT CONSTITUTES A CONFISCATION OF PROPER-
25 TY.

26 (D) THE TEMPORARY OPERATOR SHALL BE ENTITLED TO A REASONABLE FEE, AS
27 DETERMINED BY THE COMMISSIONER AND SUBJECT TO THE APPROVAL OF THE DIREC-
28 TOR OF THE DIVISION OF THE BUDGET, AND NECESSARY EXPENSES INCURRED WHILE
29 SERVING AS A TEMPORARY OPERATOR. THE TEMPORARY OPERATOR SHALL BE LIABLE
30 ONLY IN ITS CAPACITY AS TEMPORARY OPERATOR FOR INJURY TO PERSON AND
31 PROPERTY BY REASON OF ITS OPERATION OF SUCH PROGRAM; NO LIABILITY SHALL
32 INCUR IN THE TEMPORARY OPERATOR'S PERSONAL CAPACITY, EXCEPT FOR GROSS
33 NEGLIGENCE AND INTENTIONAL ACTS.

34 (E) (1) THE INITIAL TERM OF THE APPOINTMENT OF THE TEMPORARY OPERATOR
35 SHALL NOT EXCEED NINETY DAYS. AFTER NINETY DAYS, IF THE COMMISSIONER
36 DETERMINES THAT TERMINATION OF THE TEMPORARY OPERATOR WOULD CAUSE
37 SIGNIFICANT DETERIORATION OF THE QUALITY OF, OR ACCESS TO, CARE IN THE
38 COMMUNITY OR THAT REAPPOINTMENT IS NECESSARY TO CORRECT THE DEFICIENCIES
39 THAT REQUIRED THE APPOINTMENT OF THE TEMPORARY OPERATOR, THE COMMISSION-
40 ER MAY AUTHORIZE AN ADDITIONAL NINETY-DAY TERM. HOWEVER, SUCH AUTHORI-
41 ZATION SHALL INCLUDE THE COMMISSIONER'S REQUIREMENTS FOR CONCLUSION OF
42 THE TEMPORARY OPERATORSHIP TO BE SATISFIED WITHIN THE ADDITIONAL TERM.

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

47 A. THE ACTIONS TAKEN DURING THE APPOINTMENT TO ADDRESS THE IDENTIFIED
48 PROGRAM DEFICIENCIES, THE RESUMPTION OF PROGRAM OPERATIONS BY THE ESTAB-
49 LISHED OPERATOR, OR THE REVOCATION OF AN OPERATING CERTIFICATE ISSUED BY
50 THE OFFICE;

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

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

55 (3) THE TERM OF THE INITIAL APPOINTMENT AND OF ANY SUBSEQUENT REAP-
56 POINTMENT MAY BE TERMINATED PRIOR TO THE EXPIRATION OF THE DESIGNATED

1 TERM, IF THE ESTABLISHED OPERATOR AND THE COMMISSIONER AGREE ON A PLAN
2 OF CORRECTION AND THE IMPLEMENTATION OF SUCH PLAN.

3 (F) (1) THE COMMISSIONER SHALL, UPON MAKING A DETERMINATION OF AN
4 INTENTION TO APPOINT A TEMPORARY OPERATOR PURSUANT TO PARAGRAPH ONE OF
5 SUBDIVISION (B) OF THIS SECTION, CAUSE THE ESTABLISHED OPERATOR TO BE
6 NOTIFIED OF THE INTENTION BY REGISTERED OR CERTIFIED MAIL ADDRESSED TO
7 THE PRINCIPAL OFFICE OF THE ESTABLISHED OPERATOR. SUCH NOTIFICATION
8 SHALL INCLUDE A DETAILED DESCRIPTION OF THE FINDINGS UNDERLYING THE
9 INTENTION TO APPOINT A TEMPORARY OPERATOR, AND THE DATE AND TIME OF A
10 REQUIRED MEETING WITH THE COMMISSIONER AND/OR HIS OR HER DESIGNEE WITHIN
11 TEN BUSINESS DAYS OF THE RECEIPT OF SUCH NOTICE. AT SUCH MEETING, THE
12 ESTABLISHED OPERATOR SHALL HAVE THE OPPORTUNITY TO REVIEW AND DISCUSS
13 ALL RELEVANT FINDINGS. AT SUCH MEETING, THE COMMISSIONER AND THE ESTAB-
14 LISHED OPERATOR SHALL ATTEMPT TO DEVELOP A MUTUALLY SATISFACTORY PLAN OF
15 CORRECTION AND SCHEDULE FOR IMPLEMENTATION. IN SUCH EVENT, THE COMMIS-
16 SIONER SHALL NOTIFY THE ESTABLISHED OPERATOR THAT THE COMMISSIONER WILL
17 ABSTAIN FROM APPOINTING A TEMPORARY OPERATOR CONTINGENT UPON THE ESTAB-
18 LISHED OPERATOR REMEDIATING THE IDENTIFIED DEFICIENCIES WITHIN THE
19 AGREED UPON TIMEFRAME.

20 (2) SHOULD THE COMMISSIONER AND THE ESTABLISHED OPERATOR BE UNABLE TO
21 ESTABLISH A PLAN OF CORRECTION PURSUANT TO PARAGRAPH ONE OF THIS SUBDI-
22 VISION, OR SHOULD THE ESTABLISHED OPERATOR FAIL TO RESPOND TO THE
23 COMMISSIONER'S INITIAL NOTIFICATION, THERE SHALL BE AN ADMINISTRATIVE
24 HEARING ON THE COMMISSIONER'S DETERMINATION TO APPOINT A TEMPORARY OPER-
25 ATOR TO BEGIN NO LATER THAN THIRTY DAYS FROM THE DATE OF THE NOTICE TO
26 THE ESTABLISHED OPERATOR. ANY SUCH HEARING SHALL BE STRICTLY LIMITED TO
27 THE ISSUE OF WHETHER THE DETERMINATION OF THE COMMISSIONER TO APPOINT A
28 TEMPORARY OPERATOR IS SUPPORTED BY SUBSTANTIAL EVIDENCE. A COPY OF THE
29 DECISION SHALL BE SENT TO THE ESTABLISHED OPERATOR.

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

33 (G) NOTWITHSTANDING THE APPOINTMENT OF A TEMPORARY OPERATOR, THE
34 ESTABLISHED OPERATOR SHALL REMAIN OBLIGATED FOR THE CONTINUED PROVISION
35 OF SERVICES. NO PROVISION CONTAINED IN THIS SECTION SHALL BE DEEMED TO
36 RELIEVE THE ESTABLISHED OPERATOR OR ANY OTHER PERSON OF ANY CIVIL OR
37 CRIMINAL LIABILITY INCURRED, OR ANY DUTY IMPOSED BY LAW, BY REASON OF
38 ACTS OR OMISSIONS OF THE ESTABLISHED OPERATOR OR ANY OTHER PERSON PRIOR
39 TO THE APPOINTMENT OF ANY TEMPORARY OPERATOR OF THE PROGRAM HEREUNDER;
40 NOR SHALL ANYTHING CONTAINED IN THIS SECTION BE CONSTRUED TO SUSPEND
41 DURING THE TERM OF THE APPOINTMENT OF THE TEMPORARY OPERATOR OF THE
42 PROGRAM ANY OBLIGATION OF THE ESTABLISHED OPERATOR OR ANY OTHER PERSON
43 FOR THE MAINTENANCE AND REPAIR OF THE FACILITY, PROVISION OF UTILITY
44 SERVICES, PAYMENT OF TAXES OR OTHER OPERATING AND MAINTENANCE EXPENSES
45 OF THE FACILITY, NOR OF THE ESTABLISHED OPERATOR OR ANY OTHER PERSON FOR
46 THE PAYMENT OF MORTGAGES OR LIENS.

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

49 S 31.20 TEMPORARY OPERATOR.

50 (A) FOR THE PURPOSES OF THIS SECTION:

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

54 (2) "EXTRAORDINARY FINANCIAL ASSISTANCE" SHALL MEAN STATE FUNDS
55 PROVIDED TO, OR REQUESTED BY, A PROGRAM FOR THE EXPRESS PURPOSE OF

1 PREVENTING THE CLOSURE OF THE PROGRAM THAT THE COMMISSIONER FINDS
2 PROVIDES ESSENTIAL AND NECESSARY SERVICES WITHIN THE COMMUNITY.

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

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

8 (5) "SERIOUS FINANCIAL INSTABILITY" SHALL INCLUDE BUT NOT BE LIMITED
9 TO DEFAULTING OR VIOLATING MATERIAL COVENANTS OF BOND ISSUES, MISSED
10 MORTGAGE PAYMENTS, A PATTERN OF UNTIMELY PAYMENT OF DEBTS, FAILURE TO
11 PAY ITS EMPLOYEES OR VENDORS, INSUFFICIENT FUNDS TO MEET THE GENERAL
12 OPERATING EXPENSES OF THE PROGRAM, FAILURE TO MAINTAIN REQUIRED DEBT
13 SERVICE COVERAGE RATIOS AND/OR, AS APPLICABLE, FACTORS THAT HAVE TRIG-
14 GERED A WRITTEN EVENT OF DEFAULT NOTICE TO THE OFFICE BY THE DORMITORY
15 AUTHORITY OF THE STATE OF NEW YORK.

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

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

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

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

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

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

52 (C) (1) A TEMPORARY OPERATOR APPOINTED PURSUANT TO THIS SECTION SHALL
53 USE HIS OR HER BEST EFFORTS TO IMPLEMENT THE PLAN DEEMED SATISFACTORY BY
54 THE COMMISSIONER TO CORRECT OR ELIMINATE ANY DEFICIENCIES IN THE MENTAL
55 HEALTH PROGRAM AND TO PROMOTE THE QUALITY AND ACCESSIBILITY OF MENTAL
56 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

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

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

7 (F) (1) THE COMMISSIONER SHALL, UPON MAKING A DETERMINATION OF AN
8 INTENTION TO APPOINT A TEMPORARY OPERATOR PURSUANT TO PARAGRAPH ONE OF
9 SUBDIVISION (B) OF THIS SECTION CAUSE THE ESTABLISHED OPERATOR TO BE
10 NOTIFIED OF THE INTENTION BY REGISTERED OR CERTIFIED MAIL ADDRESSED TO
11 THE PRINCIPAL OFFICE OF THE ESTABLISHED OPERATOR. SUCH NOTIFICATION
12 SHALL INCLUDE A DETAILED DESCRIPTION OF THE FINDINGS UNDERLYING THE
13 INTENTION TO APPOINT A TEMPORARY OPERATOR, AND THE DATE AND TIME OF A
14 REQUIRED MEETING WITH THE COMMISSIONER AND/OR HIS OR HER DESIGNEE WITHIN
15 TEN BUSINESS DAYS OF THE RECEIPT OF SUCH NOTICE. AT SUCH MEETING, THE
16 ESTABLISHED OPERATOR SHALL HAVE THE OPPORTUNITY TO REVIEW AND DISCUSS
17 ALL RELEVANT FINDINGS. AT SUCH MEETING, THE COMMISSIONER AND THE ESTAB-
18 LISHED OPERATOR SHALL ATTEMPT TO DEVELOP A MUTUALLY SATISFACTORY PLAN OF
19 CORRECTION AND SCHEDULE FOR IMPLEMENTATION. IN SUCH EVENT, THE COMMIS-
20 SIONER SHALL NOTIFY THE ESTABLISHED OPERATOR THAT THE COMMISSIONER WILL
21 ABSTAIN FROM APPOINTING A TEMPORARY OPERATOR CONTINGENT UPON THE ESTAB-
22 LISHED OPERATOR REMEDIATING THE IDENTIFIED DEFICIENCIES WITHIN THE
23 AGREED UPON TIMEFRAME.

24 (2) SHOULD THE COMMISSIONER AND THE ESTABLISHED OPERATOR BE UNABLE TO
25 ESTABLISH A PLAN OF CORRECTION PURSUANT TO PARAGRAPH ONE OF THIS SUBDI-
26 VISION, OR SHOULD THE ESTABLISHED OPERATOR FAIL TO RESPOND TO THE
27 COMMISSIONER'S INITIAL NOTIFICATION, THERE SHALL BE AN ADMINISTRATIVE
28 HEARING ON THE COMMISSIONER'S DETERMINATION TO APPOINT A TEMPORARY OPER-
29 ATOR TO BEGIN NO LATER THAN THIRTY DAYS FROM THE DATE OF THE NOTICE TO
30 THE ESTABLISHED OPERATOR. ANY SUCH HEARING SHALL BE STRICTLY LIMITED TO
31 THE ISSUE OF WHETHER THE DETERMINATION OF THE COMMISSIONER TO APPOINT A
32 TEMPORARY OPERATOR IS SUPPORTED BY SUBSTANTIAL EVIDENCE. A COPY OF THE
33 DECISION SHALL BE SENT TO THE ESTABLISHED OPERATOR.

34 (3) IF THE DECISION TO APPOINT A TEMPORARY OPERATOR IS UPHELD SUCH
35 TEMPORARY OPERATOR SHALL BE APPOINTED AS SOON AS IS PRACTICABLE AND
36 SHALL OPERATE THE MENTAL HEALTH PROGRAM PURSUANT TO THE PROVISIONS OF
37 THIS SECTION.

38 (G) NOTWITHSTANDING THE APPOINTMENT OF A TEMPORARY OPERATOR, THE
39 ESTABLISHED OPERATOR SHALL REMAIN OBLIGATED FOR THE CONTINUED OPERATION
40 OF THE MENTAL HEALTH PROGRAM SO THAT SUCH PROGRAM CAN FUNCTION IN A
41 NORMAL MANNER. NO PROVISION CONTAINED IN THIS SECTION SHALL BE DEEMED TO
42 RELIEVE THE ESTABLISHED OPERATOR OR ANY OTHER PERSON OF ANY CIVIL OR
43 CRIMINAL LIABILITY INCURRED, OR ANY DUTY IMPOSED BY LAW, BY REASON OF
44 ACTS OR OMISSIONS OF THE ESTABLISHED OPERATOR OR ANY OTHER PERSON PRIOR
45 TO THE APPOINTMENT OF ANY TEMPORARY OPERATOR OF THE PROGRAM HEREUNDER;
46 NOR SHALL ANYTHING CONTAINED IN THIS SECTION BE CONSTRUED TO SUSPEND
47 DURING THE TERM OF THE APPOINTMENT OF THE TEMPORARY OPERATOR OF THE
48 PROGRAM ANY OBLIGATION OF THE ESTABLISHED OPERATOR OR ANY OTHER PERSON
49 FOR THE MAINTENANCE AND REPAIR OF THE FACILITY, PROVISION OF UTILITY
50 SERVICES, PAYMENT OF TAXES OR OTHER OPERATING AND MAINTENANCE EXPENSES
51 OF THE FACILITY, NOR OF THE ESTABLISHED OPERATOR OR ANY OTHER PERSON FOR
52 THE PAYMENT OF MORTGAGES OR LIENS.

53 S 3. Subdivision (i) of section 17 of the social services law, as
54 relettered by section 1 of part K3 of chapter 57 of the laws of 2007, is
55 relettered subdivision (j).

1 S 4. Section 17 of the social services law is amended by adding a new
2 subdivision (i) to read as follows:

3 (I) HAVE THE AUTHORITY TO UNDERTAKE, OR AUTHORIZE A DESIGNEE TO UNDER-
4 TAKE, AN INVESTIGATION OF THE FINANCIAL MATTERS, THE AFFAIRS AND THE
5 MANAGEMENT OF ANY EMERGENCY SHELTER, OR OF ANY PERSON, CORPORATION,
6 SOCIETY, ASSOCIATION OR ORGANIZATION WHICH OPERATES OR HOLDS ITSELF OUT
7 AS BEING AUTHORIZED TO OPERATE ANY SUCH EMERGENCY SHELTER, OR OF THE
8 CONDUCT OF ANY OFFICERS OR EMPLOYERS OF ANY SUCH EMERGENCY SHELTER.
9 PERSONS EMPOWERED BY THE COMMISSIONER OR BY A DESIGNEE TO CONDUCT ANY
10 SUCH INVESTIGATION ARE HEREBY EMPOWERED TO ISSUE COMPULSORY PROCESS FOR
11 THE ATTENDANCE OF WITNESSES AND THE PRODUCTION OF PAPERS, TO ADMINISTER
12 OATHS AND TO EXAMINE PERSONS UNDER OATH, AND TO EXERCISE THE SAME POWERS
13 IN RESPECT TO THE CONDUCT OF SUCH AN INVESTIGATION AS THOSE BELONGING TO
14 REFEREES APPOINTED BY THE SUPREME COURT, CONSISTENT WITH, BUT NOT LIMIT-
15 ED BY, THE AUTHORITY CONFERRED PURSUANT TO PARAGRAPHS (A) AND (B) OF
16 SUBDIVISION FIVE OF SECTION THIRTY-FOUR OF THIS ARTICLE.

17 WHENEVER THE COMMISSIONER OR A DESIGNEE HAS DETERMINED AN EMERGENCY
18 SHELTER DESCRIBED IN THIS SUBDIVISION HAS FAILED TO COMPLY WITH THE
19 REQUIREMENTS OF STATE OR LOCAL LAWS OR REGULATIONS APPLICABLE TO THE
20 OPERATION OF SUCH EMERGENCY SHELTER, THEN THE FOLLOWING PROVISIONS
21 APPLY:

22 (1) FOR THE PURPOSES OF THIS SECTION:

23 (I) "BUILDING" SHALL MEAN AN ENTIRE BUILDING OR A UNIT WITHIN THAT
24 PROVIDES EMERGENCY SHELTER TO HOMELESS PERSONS.

25 (II) "COMMISSIONER" SHALL MEAN THE COMMISSIONER OF THE OFFICE OR HIS
26 OR HER DESIGNEE.

27 (III) "DATA" SHALL MEAN WRITTEN DOCUMENTATION OR KNOWLEDGE OBTAINED
28 VIA ANNOUNCED OR UNANNOUNCED INSPECTIONS, AUDITS, OR OTHER METHODS MADE
29 BY ANY STATE OR LOCAL ENTITY AUTHORIZED TO CONDUCT INSPECTIONS OR
30 AUDITS, INCLUDING STATE OR LOCAL COMPTROLLERS.

31 (IV) "EMERGENCY SHELTER" MEANS ANY BUILDING WITH OVERNIGHT SLEEPING
32 ACCOMMODATIONS, THE PRIMARY PURPOSE OF WHICH IS TO PROVIDE TEMPORARY
33 SHELTER FOR THE HOMELESS IN GENERAL OR FOR SPECIFIC POPULATIONS OF THE
34 HOMELESS, INCLUDING RESIDENTIAL PROGRAMS FOR VICTIMS OF DOMESTIC
35 VIOLENCE AND RUNAWAY AND HOMELESS YOUTH PROGRAMS CERTIFIED BY THE OFFICE
36 OF CHILDREN AND FAMILY SERVICES.

37 (V) "ESTABLISHED OPERATOR" SHALL MEAN A PROVIDER OF EMERGENCY SHELTER.

38 (VI) "SERIOUS FINANCIAL, HEALTH OR SAFETY DEFICIENCY" SHALL INCLUDE,
39 BUT NOT BE LIMITED TO, MISSED MORTGAGE PAYMENTS, MISSED RENT PAYMENTS, A
40 PATTERN OF UNTIMELY PAYMENT OF DEBTS, FAILURE TO PAY ITS EMPLOYEES OR
41 VENDORS, INSUFFICIENT FUNDS TO MEET THE GENERAL OPERATING EXPENSES OF
42 THE PROGRAM, OR A VIOLATION OF LAW, REGULATION, OR CODE WITH RESPECT TO
43 A BUILDING THAT PROVIDES EMERGENCY SHELTER TO HOMELESS PERSONS, IN WHICH
44 THERE ARE CONDITIONS THAT ARE DANGEROUS, HAZARDOUS, IMMINENTLY DETRI-
45 MENTAL TO LIFE OR HEALTH, OR OTHERWISE RENDER THE BUILDING NOT FIT FOR
46 HUMAN HABITATION.

47 (VII) "TEMPORARY OPERATOR" SHALL MEAN ANY PROVIDER OF EMERGENCY SHEL-
48 TER THAT:

49 (A) AGREES TO PROVIDE EMERGENCY SHELTER PURSUANT TO THIS CHAPTER ON A
50 TEMPORARY BASIS IN THE BEST INTERESTS OF ITS HOMELESS INDIVIDUALS AND
51 FAMILIES SERVED BY THE BUILDING;

52 (B) HAS A HISTORY OF COMPLIANCE WITH APPLICABLE LAWS, RULES, AND REGU-
53 LATIONS AND A RECORD OF PROVIDING EMERGENCY SHELTER OF GOOD QUALITY, AS
54 DETERMINED BY THE COMMISSIONER; AND

1 (C) PRIOR TO APPOINTMENT AS TEMPORARY OPERATOR, DEVELOPS A PLAN DETER-
2 MINED TO BE SATISFACTORY BY THE COMMISSIONER TO ADDRESS THE BUILDING'S
3 DEFICIENCIES.

4 (2) (I) IN THE EVENT THAT: (A) DATA DEMONSTRATES THAT THE BUILDING IS
5 EXHIBITING A SERIOUS FINANCIAL, HEALTH, OR SAFETY DEFICIENCY; (B) DATA
6 DEMONSTRATES THAT THE ESTABLISHED OPERATOR IS UNABLE OR UNWILLING TO
7 ENSURE THE PROPER OPERATION OF THE BUILDING; OR (C) DATA INDICATES THERE
8 EXIST CONDITIONS THAT SERIOUSLY ENDANGER OR JEOPARDIZE EMERGENCY SHELTER
9 RESIDENTS, THE COMMISSIONER MAY NOTIFY THE ESTABLISHED OPERATOR OF HIS
10 OR HER INTENTION TO APPOINT A TEMPORARY OPERATOR TO ASSUME SOLE RESPON-
11 SIBILITY FOR THE PROVIDER OF THE EMERGENCY SHELTER'S OPERATIONS FOR A
12 LIMITED PERIOD OF TIME. THE APPOINTMENT OF A TEMPORARY OPERATOR SHALL BE
13 EFFECTUATED PURSUANT TO THIS SECTION, AND SHALL BE IN ADDITION TO ANY
14 OTHER REMEDIES PROVIDED BY LAW.

15 (II) THE ESTABLISHED OPERATOR MAY AT ANY TIME REQUEST THE COMMISSIONER
16 TO APPOINT A TEMPORARY OPERATOR. UPON RECEIVING SUCH A REQUEST, THE
17 COMMISSIONER MAY, IF HE OR SHE DETERMINES THAT SUCH AN ACTION IS NECES-
18 SARY, ENTER INTO AN AGREEMENT WITH THE ESTABLISHED OPERATOR FOR THE
19 APPOINTMENT OF A TEMPORARY OPERATOR TO RESTORE OR MAINTAIN THE PROVISION
20 OF QUALITY EMERGENCY SHELTER TO THE EMERGENCY SHELTER RESIDENTS UNTIL
21 THE ESTABLISHED OPERATOR CAN RESUME OPERATIONS WITHIN THE DESIGNATED
22 TIME PERIOD OR OTHER ACTION IS TAKEN TO SUSPEND, REVOKE, OR LIMIT THE
23 AUTHORITY OF THE ESTABLISHED OPERATOR.

24 (3) (I) A TEMPORARY OPERATOR APPOINTED PURSUANT TO THIS SECTION SHALL
25 USE HIS OR HER BEST EFFORTS TO IMPLEMENT THE PLAN DEEMED SATISFACTORY BY
26 THE COMMISSIONER TO CORRECT OR ELIMINATE ANY DEFICIENCIES IN THE BUILD-
27 ING AND TO PROMOTE THE QUALITY AND ACCESSIBILITY OF THE EMERGENCY SHEL-
28 TER IN THE COMMUNITY SERVED BY THE PROVIDER OF EMERGENCY SHELTER.

29 (II) DURING THE TERM OF APPOINTMENT, THE TEMPORARY OPERATOR SHALL HAVE
30 THE AUTHORITY TO DIRECT THE STAFF OF THE ESTABLISHED OPERATOR AS NECES-
31 SARY TO APPROPRIATELY PROVIDE EMERGENCY SHELTER FOR HOMELESS INDIVIDUALS
32 AND FAMILIES. THE TEMPORARY OPERATOR SHALL, DURING THIS PERIOD, PROVIDE
33 EMERGENCY SHELTER IN SUCH A MANNER AS TO PROMOTE SAFETY AND THE QUALITY
34 AND ACCESSIBILITY OF EMERGENCY SHELTER IN THE COMMUNITY SERVED BY THE
35 ESTABLISHED OPERATOR UNTIL EITHER THE ESTABLISHED OPERATOR CAN RESUME
36 OPERATIONS OR UNTIL THE OFFICE REVOKES THE AUTHORITY OF THE EMERGENCY
37 SHELTER TO OPERATE UNDER THIS CHAPTER.

38 (III) THE ESTABLISHED OPERATOR SHALL GRANT ACCESS TO THE TEMPORARY
39 OPERATOR TO THE ESTABLISHED OPERATOR'S ACCOUNTS AND RECORDS IN ORDER TO
40 ADDRESS ANY SERIOUS FINANCIAL, HEALTH OR SAFETY DEFICIENCY. THE TEMPO-
41 RARY OPERATOR SHALL APPROVE ANY DECISION RELATED TO AN ESTABLISHED
42 PROVIDER'S DAY TO DAY OPERATIONS OR THE ESTABLISHED PROVIDER'S ABILITY
43 TO PROVIDE EMERGENCY SHELTER.

44 (IV) THE TEMPORARY OPERATOR SHALL NOT BE REQUIRED TO FILE ANY BOND. NO
45 SECURITY INTEREST IN ANY REAL OR PERSONAL PROPERTY COMPRISING THE ESTAB-
46 LISHED OPERATOR OR CONTAINED WITHIN THE ESTABLISHED OPERATOR OR IN ANY
47 FIXTURE OF THE BUILDING, SHALL BE IMPAIRED OR DIMINISHED IN PRIORITY BY
48 THE TEMPORARY OPERATOR. NEITHER THE TEMPORARY OPERATOR NOR THE OFFICE
49 SHALL ENGAGE IN ANY ACTIVITY THAT CONSTITUTES A CONFISCATION OF PROPER-
50 TY.

51 (4) THE TEMPORARY OPERATOR SHALL BE ENTITLED TO A REASONABLE FEE, AS
52 DETERMINED BY THE COMMISSIONER AND SUBJECT TO THE APPROVAL OF THE DIREC-
53 TOR OF THE DIVISION OF THE BUDGET, AND NECESSARY EXPENSES INCURRED WHILE
54 SERVING AS A TEMPORARY OPERATOR. THE TEMPORARY OPERATOR SHALL BE LIABLE
55 ONLY IN ITS CAPACITY AS TEMPORARY OPERATOR FOR INJURY TO PERSON AND
56 PROPERTY BY REASON OF ITS OPERATION OF SUCH BUILDING; NO LIABILITY SHALL

1 INCUR IN THE TEMPORARY OPERATOR'S PERSONAL CAPACITY, EXCEPT FOR GROSS
2 NEGLIGENCE AND INTENTIONAL ACTS.

3 (5) (I) THE INITIAL TERM OF THE APPOINTMENT OF THE TEMPORARY OPERATOR
4 SHALL NOT EXCEED NINETY DAYS. AFTER NINETY DAYS, IF THE COMMISSIONER
5 DETERMINES THAT TERMINATION OF THE TEMPORARY OPERATOR WOULD CAUSE
6 SIGNIFICANT DETERIORATION OF THE QUALITY OF, OR ACCESS TO, EMERGENCY
7 SHELTER IN THE COMMUNITY OR THAT REAPPOINTMENT IS NECESSARY TO CORRECT
8 THE DEFICIENCIES THAT REQUIRED THE APPOINTMENT OF THE TEMPORARY OPERA-
9 TOR, THE COMMISSIONER MAY AUTHORIZE AN ADDITIONAL NINETY-DAY TERM.
10 HOWEVER, SUCH AUTHORIZATION SHALL INCLUDE THE COMMISSIONER'S REQUIRE-
11 MENTS FOR CONCLUSION OF THE TEMPORARY OPERATORSHIP TO BE SATISFIED WITH-
12 IN THE ADDITIONAL TERM.

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

17 (A) THE ACTIONS TAKEN DURING THE APPOINTMENT TO ADDRESS THE IDENTIFIED
18 BUILDING DEFICIENCIES, THE RESUMPTION OF BUILDING OPERATIONS BY THE
19 ESTABLISHED OPERATOR, OR THE REVOCATION OF AUTHORITY TO OPERATE AN EMER-
20 GENCY SHELTER;

21 (B) OBJECTIVES FOR THE CONTINUATION OF THE TEMPORARY OPERATORSHIP IF
22 NECESSARY AND A SCHEDULE FOR SATISFACTION OF SUCH OBJECTIVES; AND

23 (C) IF APPLICABLE, THE RECOMMENDED ACTIONS FOR THE ONGOING PROVISION
24 OF EMERGENCY SHELTER SUBSEQUENT TO THE TEMPORARY OPERATORSHIP.

25 (III) THE TERM OF THE INITIAL APPOINTMENT AND OF ANY SUBSEQUENT REAP-
26 POINTMENT MAY BE TERMINATED PRIOR TO THE EXPIRATION OF THE DESIGNATED
27 TERM, IF THE ESTABLISHED OPERATOR AND THE COMMISSIONER AGREE ON A PLAN
28 OF CORRECTION AND THE IMPLEMENTATION OF SUCH PLAN.

29 (6) (I) THE COMMISSIONER SHALL, UPON MAKING A DETERMINATION OF AN
30 INTENTION TO APPOINT A TEMPORARY OPERATOR PURSUANT TO SUBPARAGRAPH (I)
31 OF PARAGRAPH TWO OF THIS SUBDIVISION, CAUSE THE ESTABLISHED OPERATOR TO
32 BE NOTIFIED OF THE INTENTION BY REGISTERED OR CERTIFIED MAIL ADDRESSED
33 TO THE PRINCIPAL OFFICE OF THE ESTABLISHED OPERATOR. SUCH NOTIFICATION
34 SHALL INCLUDE A DETAILED DESCRIPTION OF THE FINDINGS UNDERLYING THE
35 INTENTION TO APPOINT A TEMPORARY OPERATOR, AND THE DATE AND TIME OF A
36 REQUIRED MEETING WITH THE COMMISSIONER WITHIN TEN BUSINESS DAYS OF THE
37 RECEIPT OF SUCH NOTICE. AT SUCH MEETING, THE ESTABLISHED OPERATOR SHALL
38 HAVE THE OPPORTUNITY TO REVIEW AND DISCUSS ALL RELEVANT FINDINGS. AT
39 SUCH MEETING, THE COMMISSIONER AND THE ESTABLISHED OPERATOR SHALL
40 ATTEMPT TO DEVELOP A MUTUALLY SATISFACTORY PLAN OF CORRECTION AND SCHED-
41 ULE FOR IMPLEMENTATION. IF A MUTUALLY SATISFACTORY PLAN OF CORRECTION
42 AND SCHEDULE FOR IMPLEMENTATION IS DEVELOPED, THE COMMISSIONER SHALL
43 NOTIFY THE ESTABLISHED OPERATOR THAT THE COMMISSIONER WILL ABSTAIN FROM
44 APPOINTING A TEMPORARY OPERATOR CONTINGENT UPON THE ESTABLISHED OPERATOR
45 REMEDIATING THE IDENTIFIED DEFICIENCIES WITHIN THE AGREED UPON TIME-
46 FRAME.

47 (II) SHOULD THE COMMISSIONER AND THE ESTABLISHED OPERATOR BE UNABLE TO
48 ESTABLISH A PLAN OF CORRECTION PURSUANT TO SUBPARAGRAPH (I) OF THIS
49 PARAGRAPH, OR SHOULD THE ESTABLISHED OPERATOR FAIL TO RESPOND TO THE
50 COMMISSIONER'S INITIAL NOTIFICATION, THERE SHALL BE AN ADMINISTRATIVE
51 HEARING ON THE COMMISSIONER'S DETERMINATION TO APPOINT A TEMPORARY OPER-
52 ATOR TO BEGIN NO LATER THAN THIRTY DAYS FROM THE DATE OF THE NOTICE TO
53 THE ESTABLISHED OPERATOR. ANY SUCH HEARING SHALL BE STRICTLY LIMITED TO
54 THE ISSUE OF WHETHER THE DETERMINATION OF THE COMMISSIONER TO APPOINT A
55 TEMPORARY OPERATOR IS SUPPORTED BY SUBSTANTIAL EVIDENCE. A COPY OF THE
56 DECISION SHALL BE SENT TO THE ESTABLISHED OPERATOR.

(III) IF THE DECISION TO APPOINT A TEMPORARY OPERATOR IS UPHOLD SUCH TEMPORARY OPERATOR SHALL BE APPOINTED AS SOON AS IS PRACTICABLE AND SHALL PROVIDE EMERGENCY SHELTER PURSUANT TO THE PROVISIONS OF THIS SECTION.

(7) NOTWITHSTANDING THE APPOINTMENT OF A TEMPORARY OPERATOR, THE ESTABLISHED OPERATOR SHALL REMAIN OBLIGATED FOR THE CONTINUED PROVISION OF EMERGENCY SHELTER. NO PROVISION CONTAINED IN THIS SECTION SHALL BE DEEMED TO RELIEVE THE ESTABLISHED OPERATOR OR ANY OTHER PERSON OF ANY CIVIL OR CRIMINAL LIABILITY INCURRED, OR ANY DUTY IMPOSED BY LAW, BY REASON OF ACTS OR OMISSIONS OF THE ESTABLISHED OPERATOR OR ANY OTHER PERSON PRIOR TO THE APPOINTMENT OF ANY TEMPORARY OPERATOR OF THE BUILDING HEREUNDER; NOR SHALL ANYTHING CONTAINED IN THIS SECTION BE CONSTRUED TO SUSPEND DURING THE TERM OF THE APPOINTMENT OF THE TEMPORARY OPERATOR OF THE BUILDING ANY OBLIGATION OF THE ESTABLISHED OPERATOR OR ANY OTHER PERSON FOR THE MAINTENANCE AND REPAIR OF THE BUILDING, PROVISION OF UTILITY SERVICES, PAYMENT OF TAXES OR OTHER OPERATING AND MAINTENANCE EXPENSES OF THE BUILDING, NOR OF THE ESTABLISHED OPERATOR OR ANY OTHER PERSON FOR THE PAYMENT OF MORTGAGES OR LIENS.

S 5. Nothing in section four of this act shall be deemed in any way to limit the authority of the commissioner of the office of temporary and disability assistance or the commissioner of the office of children and family services or his or her designee to take additional actions with respect to a building that provides emergency shelter, in which there are conditions that are dangerous, hazardous, imminently detrimental to life or health, or otherwise render the building not fit for human habitation.

S 6. 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 M

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

(d) Nothing in this section shall prevent the electronic or other exchange of information concerning patients or clients, including identification, between and among (i) facilities or others providing services for such patients or clients pursuant to an approved local services plan, as defined in article forty-one of this chapter, or pursuant to agreement with the department, and (ii) the department or any of its licensed or operated facilities. NEITHER SHALL ANYTHING IN THIS SECTION PREVENT THE EXCHANGE OF INFORMATION CONCERNING PATIENTS OR CLIENTS, INCLUDING IDENTIFICATION, BETWEEN FACILITIES AND MANAGED CARE ORGANIZATIONS, BEHAVIORAL HEALTH ORGANIZATIONS, HEALTH HOMES OR OTHER ENTITIES AUTHORIZED BY THE DEPARTMENT OR THE DEPARTMENT OF HEALTH TO PROVIDE, ARRANGE FOR OR COORDINATE HEALTH CARE SERVICES FOR SUCH PATIENTS OR CLIENTS WHO ARE ENROLLED IN OR RECEIVING SERVICES FROM SUCH ORGANIZATIONS OR ENTITIES. Furthermore, subject to the prior approval of the commissioner of mental health, hospital emergency services licensed pursuant to article twenty-eight of the public health law shall be authorized to exchange information concerning patients or clients electronically or otherwise with other hospital emergency services licensed pursuant to article twenty-eight of the public health law and/or hospitals licensed or operated by the office of mental health; provided that such exchange of information is consistent with standards, developed by the commissioner of mental health, which are designed to ensure confi-

1 dentiality of such information. Additionally, information so exchanged
2 shall be kept confidential and any limitations on the release of such
3 information imposed on the party giving the information shall apply to
4 the party receiving the information.

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

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

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

30 PART N

31 Section 1. Subdivision 10 of section 3 of section 1 of chapter 359 of
32 the laws of 1968, constituting the facilities development corporation
33 act, as amended by chapter 723 of the laws of 1993, is amended to read
34 as follows:

35 10. "Mental hygiene facility" shall mean a building, a unit within a
36 building, a laboratory, a classroom, a housing unit, a dining hall, an
37 activities center, a library, real property of any kind or description,
38 or any structure on or improvement to real property, or an interest in
39 real property, of any kind or description, owned by or under the juris-
40 diction of the corporation, including fixtures and equipment which are
41 an integral part of any such building, unit, structure or improvement, a
42 walkway, a roadway or a parking lot, and improvements and connections
43 for water, sewer, gas, electrical, telephone, heating, air conditioning
44 and other utility services, or a combination of any of the foregoing,
45 whether for patient care and treatment or staff, staff family or service
46 use, located at or related to any psychiatric center, any developmental
47 center, or any state psychiatric or research institute or other facility
48 now or hereafter established under the department. A mental hygiene
49 facility shall also mean and include a residential care center for
50 adults, a "community mental health and retardation facility" and a
51 treatment facility for use in the conduct of an alcoholism or substance
52 abuse treatment program as defined in the mental hygiene law unless such
53 residential care center for adults, community mental health and retarda-
54 tion facility or alcoholism or substance abuse facility is expressly

1 excepted, or the context clearly requires otherwise, AND SHALL ALSO MEAN
2 AND INCLUDE ANY TREATMENT FACILITY FOR USE IN THE CONDUCT OF AN ALCOHOL-
3 ISM OR SUBSTANCE ABUSE TREATMENT PROGRAM THAT IS ALSO OPERATED AS AN
4 ASSOCIATED HEALTH CARE FACILITY. The definition contained in this subdivi-
5 sion shall not be construed to exclude therefrom a facility owned or
6 leased by one or more voluntary agencies that is to be financed, refi-
7 nanced, designed, constructed, acquired, reconstructed, rehabilitated or
8 improved under any lease, sublease, loan or other financing agreement
9 entered into with such voluntary agencies, and shall not be construed to
10 exclude therefrom a facility to be made available from the corporation
11 to a voluntary agency at the request of the commissioners of the offices
12 of the department having jurisdiction thereof. The definition contained
13 in this subdivision shall not be construed to exclude therefrom a facil-
14 ity with respect to which a voluntary agency has an ownership interest
15 in, and proprietary lease from, an organization formed for the purpose
16 of the cooperative ownership of real estate.

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

20 20. "ASSOCIATED HEALTH CARE FACILITY" SHALL MEAN A FACILITY LICENSED
21 UNDER AND OPERATED PURSUANT TO ARTICLE 28 OF THE PUBLIC HEALTH LAW OR
22 ANY HEALTH CARE FACILITY LICENSED UNDER AND OPERATED IN ACCORDANCE WITH
23 ANY OTHER PROVISIONS OF THE PUBLIC HEALTH LAW OR THE MENTAL HYGIENE LAW
24 THAT PROVIDES HEALTH CARE SERVICES AND/OR TREATMENT TO ALL PERSONS,
25 REGARDLESS OF WHETHER SUCH PERSONS ARE PERSONS RECEIVING TREATMENT OR
26 SERVICES FOR ALCOHOL, SUBSTANCE ABUSE, OR CHEMICAL DEPENDENCY.

27 S 3. This act shall take effect immediately.

28 S 2. Severability clause. If any clause, sentence, paragraph, subdivi-
29 sion, section or part of this act shall be adjudged by any court of
30 competent jurisdiction to be invalid, such judgment shall not affect,
31 impair, or invalidate the remainder thereof, but shall be confined in
32 its operation to the clause, sentence, paragraph, subdivision, section
33 or part thereof directly involved in the controversy in which such judg-
34 ment shall have been rendered. It is hereby declared to be the intent of
35 the legislature that this act would have been enacted even if such
36 invalid provisions had not been included herein.

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