STATE OF NEW YORK

S. 7507 A. 9507

SENATE - ASSEMBLY

January 18, 2018

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

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

AN ACT to amend the public health law, in relation to establishing a temporary workgroup on capital rate methodology for capital expenditures to hospitals and residential nursing facilities; and to amend the social services law, in relation to standard coverage for physical therapy services under medical assistance for needy persons programs (Part A); to amend the public health law, in relation to payments to residential health care facilities; to amend the social services law and the public health law, in relation to assisted living program providers licensed in the state; to amend the social services law, in relation to payments for certain medical assistance provided to eligible persons participating in the New York traumatic brain injury waiver program; and to repeal certain provisions of section 366 of the social services law relating to furnishing medical assistance (Part B); to amend the social services law and the public health law, in relation to health homes and penalties for managed care providers (Part C); to amend the social services law and the public health law, in relation to drug coverage, updating the professional dispensing fee, copayments, pharmacist physician collaboration and comprehensive medication management; and to repeal certain provisions of the social services law relating thereto (Part D); to amend the social services law, in relation to reimbursement of transportation costs, reimbursement of emergency transportation services and supplemental transportation payments; and repealing certain provisions of such law relating thereto (Part E); providing for not-for-profit and tax exempt corporations' Medicaid capitation rates (Part F); to amend the public health law, in relation to authorizing certain retail practices to offer health services (Part G); to amend the education law, in relation to the practice of nursing by certified registered nurse anesthetists (Part H); to amend the social services law and the public health law, in relation to managed care organizations (Part I); to

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

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amend the state finance law, in relation to the false claims act (Part J); authorizing the department of health to require certain health care providers to report on costs incurred; and 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 medicaid global cap (Part K); to amend the social services law and the public health law, in relation to the child health insurance program (Part L); 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; 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, relating to the effectiveness of certain provisions of such chapter, in relation to extending certain provisions concerning the hospital excess liability pool; and to amend part H of chapter 57 of the laws of 2017, amending the New York Health Care Reform Act of 1996 and other laws relating to extending certain provisions relating thereto, in relation to extending provisions relating to excess coverage (Part M); to amend part C of chapter 57 of the laws of 2006, establishing a cost of living adjustment for designated human services, in relation to the determination thereof; and to repeal certain provisions thereof relating to eligible programs (Part N); 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 O); to amend the public health law, in relation to the empire clinical research investigator program and hospital resident hour audits; and to repeal certain provisions of the public health law relating thereto (Part P); to amend the public health law, in relation to the health care facility transformation program (Part Q); to amend the public health law, the executive law, and the real property law, in relation to lead abatement and enforcement (Part R); to amend the public health law and the social services law, in relation to the establishment of community paramedicine collaboratives (Subpart A); to amend the public health law and the mental hygiene law, in relation to integrated services (Subpart B); and to amend the public health law, in relation to the definitions of telehealth provider, originating site and remote patient monitoring (Subpart C)(Part S); to amend chapter 59 of the laws of 2016, amending the social services law and other laws relating to authorizing the commissioner of health to apply federally established consumer price index penalties for generic drugs, and authorizing the commissioner of health to impose penalties on managed care plans for reporting late or incorrect encounter data, in relation to the effectiveness of certain provisions of such chapter; to amend chapter 58 of the laws of 2007, amending the social services law and other laws relating to adjustments of rates, in relation to the effectiveness of certain provisions of such chapter; to amend chapter 54 of the laws of 2016, amending part C of chapter 58 of the laws of 2005, authorizing reimbursements for expenditures made by or on behalf of social services districts for medical assistance for needy persons and administration thereof, in relation to the effectiveness thereof; to amend chapter 906 of the laws of 1984, amending the social services law relating to expanding medical assistance eligibility and the scope of services available to certain persons with disabilities, in relation to the effectiveness thereof; and to amend chapter 56 of the

laws of 2013, amending chapter 59 of the laws of 2011 amending the public health law and other laws relating to general hospital reimbursement for annual rates relating to the cap on local Medicaid expenditures, in relation to rates of payments (Part T); to amend part NN of chapter 58 of the laws of 2015 amending the mental hygiene law relating to clarifying the authority of the commissioners in the department of mental hygiene to design and implement time-limited demonstration programs, in relation to the effectiveness thereof (Part U); to amend chapter 62 of the laws of 2003, amending the mental hygiene law and the state finance law relating to the community mental health support and workforce reinvestment program, the membership of subcommittees for mental health of community services boards and the duties of such subcommittees and creating the community mental health and workforce reinvestment account, in relation to extending such provisions relating thereto (Part V); to amend the criminal procedure law, in relation to amending the definition of appropriate institution; and providing for the repeal of such provisions upon expiration thereof (Part W); to amend chapter 111 of the laws of 2010 amending the mental hygiene law relating to the receipt of federal and state benefits received by individuals receiving care in facilities operated by an office of the department of mental hygiene, in relation to the effectiveness thereof (Part X); to amend the education law, in relation to persons practicing in certain licensed programs or services who are exempt from practice requirements of professionals licensed by the department of education; 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 the registration of entities providing certain professional services and licensure of certain professions, in relation to extending certain provisions thereof (Part Y); to amend the social services law, in relation to adding demonstration waivers to waivers allowable for home and community-based services; to amend the social services law, in relation to adding successor federal waivers to waivers granted under subsection (c) of section 1915 of the federal social security law, in relation to nursing facility services; to amend the social services law, in relation to waivers for high quality and integrated care; to amend part C of chapter 58 of the laws of 2007, amending the social services law and other laws relating to enacting the major components of legislation necessary to implement the health and mental hygiene budget for the 2007-2008 fiscal year, in relation to the effectiveness thereof; to amend the mental hygiene law, in relation to adding new and successor federal waivers to waivers in relation to home and community-based services; to amend part A of chapter 56 of the laws of 2013, amending the social services law and other laws relating to enacting the major components of legislation necessary to implement the health and mental hygiene budget for the 2013-2014 state fiscal year, in relation to the effectiveness of certain provisions thereof; to amend the public health law, in relation to expansion of comprehensive health services plans; to amend chapter 659 of the laws of 1997, amending the public health law and other laws relating to creation of continuing care retirement communities, in relation to extending provisions thereof; to amend the public

health law, in relation to managed long term care plans, health and long term care services and developmental disability individual support and care coordination organizations; to amend chapter 165 of the laws of 1991, amending the public health law and other laws relating to establishing payments for medical assistance, in relation to extending the provisions thereof; to amend the mental hygiene law, in relation to reimbursement rates; and to amend chapter 710 of the laws of 1988, amending the social services law and the education law relating to medical assistance eligibility of certain persons and providing for managed medical care demonstration programs, in relation to extending the provisions thereof (Part Z); and to amend part C of chapter 57 of the laws of 2006, relating to establishing a cost of living adjustment for designated human services programs, in relation to the inclusion and development of certain cost of living adjustments (Part AA)

The People of the State of New York, represented in Senate and Assembly, do enact as follows:

Section 1. This act enacts into law major components of legislation which are necessary to implement the state fiscal plan for the 2018-2019 state fiscal year. Each component is wholly contained within a Part identified as Parts A through AA. The effective date for each particular provision contained within such Part is set forth in the last section of such Part. Any provision in any section contained within a Part, including the effective date of the Part, which makes a reference to a section "of this act", when used in connection with that particular component, shall be deemed to mean and refer to the corresponding section of the Part in which it is found. Section three of this act sets forth the general effective date of this act.

PART A

Section 1. The public health law is amended by adding a new section 2827 to read as follows:

§ 2827. Temporary workgroup on capital rate methodology. (a) The commissioner shall convene a temporary workgroup comprised of representatives of hospitals and residential nursing facilities, as well as representatives from the department, to develop recommendations for streamlining the capital reimbursement methodology to achieve a one percent reduction in capital expenditures to hospitals and residential nursing facilities, including associated specialty and adult day health care units. Pending the development of the workgroup's recommendations and the implementation of any such recommendations accepted by the commissioner, the commissioner shall be authorized to reduce the overall amount of capital reimbursement as necessary to achieve a one percent reduction in capital expenditures beginning with state fiscal year two thousand eighteen--two thousand nineteen.

(b) The commissioner may promulgate regulations to effectuate the provisions of this section.

§ 2. Subdivision 5-d of section 2807-k of the public health law, as amended by section 1 of part E of chapter 57 of the laws of 2015, is amended to read as follows:

5-d. (a) Notwithstanding any inconsistent provision of this section, section twenty-eight hundred seven-w of this article or any other

contrary provision of law, and subject to the availability of federal financial participation, for periods on and after January first, two thousand thirteen, through December thirty-first, two thousand [~~eighteen~~] nineteen, all funds available for distribution pursuant to this section, except for funds distributed pursuant to subparagraph (v) of paragraph (b) of subdivision five-b of this section, and all funds available for distribution pursuant to section twenty-eight hundred seven-w of this article, shall be reserved and set aside and distributed in accordance with the provisions of this subdivision.

(b) The commissioner shall promulgate regulations, and may promulgate emergency regulations, establishing methodologies for the distribution of funds as described in paragraph (a) of this subdivision and such regulations shall include, but not be limited to, the following:

(i) Such regulations shall establish methodologies for determining each facility's relative uncompensated care need amount based on uninsured inpatient and outpatient units of service from the cost reporting year two years prior to the distribution year, multiplied by the applicable medicaid rates in effect January first of the distribution year, as summed and adjusted by a statewide cost adjustment factor and reduced by the sum of all payment amounts collected from such uninsured patients, and as further adjusted by application of a nominal need computation that shall take into account each facility's medicaid inpatient share.

(ii) Annual distributions pursuant to such regulations for the two thousand thirteen through two thousand [~~eighteen~~] nineteen calendar years shall be in accord with the following:

(A) one hundred thirty-nine million four hundred thousand dollars shall be distributed as Medicaid Disproportionate Share Hospital ("DSH") payments to major public general hospitals; and

(B) nine hundred ninety-four million nine hundred thousand dollars as Medicaid DSH payments to eligible general hospitals, other than major public general hospitals.

(iii)(A) Such regulations shall establish transition adjustments to the distributions made pursuant to clauses (A) and (B) of subparagraph (ii) of this paragraph such that no facility experiences a reduction in indigent care pool payments pursuant to this subdivision that is greater than the percentages, as specified in clause (C) of this subparagraph as compared to the average distribution that each such facility received for the three calendar years prior to two thousand thirteen pursuant to this section and section twenty-eight hundred seven-w of this article.

(B) Such regulations shall also establish adjustments limiting the increases in indigent care pool payments experienced by facilities pursuant to this subdivision by an amount that will be, as determined by the commissioner and in conjunction with such other funding as may be available for this purpose, sufficient to ensure full funding for the transition adjustment payments authorized by clause (A) of this subparagraph.

(C) No facility shall experience a reduction in indigent care pool payments pursuant to this subdivision that: for the calendar year beginning January first, two thousand thirteen, is greater than two and one-half percent; for the calendar year beginning January first, two thousand fourteen, is greater than five percent; and, for the calendar year beginning on January first, two thousand fifteen[~~,~~]; is greater than seven and one-half percent, and for the calendar year beginning on January first, two thousand sixteen, is greater than ten percent; and for the calendar year beginning on January first, two thousand seventeen, is

greater than twelve and one-half percent; and for the calendar year beginning on January first, two thousand eighteen, is greater than fifteen percent**; and for the calendar year beginning on January first, two thousand nineteen, is greater than seventeen and one-half percent**.

(iv) Such regulations shall reserve one percent of the funds available for distribution in the two thousand fourteen and two thousand fifteen calendar years, and for calendar years thereafter, pursuant to this subdivision, subdivision fourteen-f of section twenty-eight hundred seven-c of this article, and sections two hundred eleven and two hundred twelve of chapter four hundred seventy-four of the laws of nineteen hundred ninety-six, in a "financial assistance compliance pool" and shall establish methodologies for the distribution of such pool funds to facilities based on their level of compliance, as determined by the commissioner, with the provisions of subdivision nine-a of this section.

(c) The commissioner shall annually report to the governor and the legislature on the distribution of funds under this subdivision including, but not limited to:

(i) the impact on safety net providers, including community providers, rural general hospitals and major public general hospitals;

(ii) the provision of indigent care by units of services and funds distributed by general hospitals; and

(iii) the extent to which access to care has been enhanced.

§ 3. Subdivision 14-a of section 2807 of the public health law, as added by section 11 of part B of chapter 57 of the laws of 2015, is amended to read as follows:

14-a. **(a)** Notwithstanding any provision of law to the contrary, and subject to federal financial participation, the commissioner is authorized to establish, pursuant to regulations, a statewide general hospital quality pool for the purpose of incentivizing and facilitating quality improvements in general hospitals.

(b) Such regulations shall include provisions:

(i) to create a performance target to reduce potentially preventable emergency department visits;

(ii) to reduce or eliminate the payment of the rates, published by the department on the hospital inpatient publication schedules and hospital ambulatory patient group schedules, which are paid by contractors to hospitals, based on the quality and safety scores of a hospital as determined by the department; and

(iii) to facilitate necessary quality improvements in hospitals, as determined by the commissioner.

(c) Awards from such pool shall be subject to approval by the director of budget. If federal financial participation is unavailable, then the non-federal share of awards made pursuant to this subdivision may be made as state grants.

[~~(a)~~] **(d)** Thirty days prior to adopting or applying a methodology or procedure for making an allocation or modification to an allocation made pursuant to this subdivision, the commissioner shall provide written notice to the chairs of the senate finance committee, the assembly ways and means committee, and the senate and assembly health committees with regard to the intent to adopt or apply the methodology or procedure, including a detailed explanation of the methodology or procedure.

[~~(b)~~] **(e)** Thirty days prior to executing an allocation or modification to an allocation made pursuant to this subdivision, the commissioner shall provide written notice to the chairs of the senate finance committee, the assembly ways and means committee, and the senate and assembly health committees with regard to the intent to distribute such funds.

Such notice shall include, but not be limited to, information on the methodology used to distribute the funds, the facility specific allocations of the funds, any facility specific project descriptions or requirements for receiving such funds, the multi-year impacts of these allocations, and the availability of federal matching funds. The commissioner shall provide quarterly reports to the chair of the senate finance committee and the chair of the assembly ways and means committee on the distribution and disbursement of such funds.

(f) Notwithstanding any inconsistent provision of law or regulation to the contrary, the hospital quality pool shall allocate ten million dollars annually to expand preventative services as the commissioner may determine in regulation. Such preventative services may include but not be limited to mental health counseling provided by a licensed clinical social worker or a licensed master social worker, physical therapy, diabetes prevention, or treatment by an applied behavior analyst.

§ 4. Subparagraph (ii) of paragraph (f) of subdivision 2-a of section 2807 of the public health law, as amended by section 43 of part B of chapter 58 of the laws of 2010, is amended to read as follows:

(ii) notwithstanding the provisions of paragraphs (a) and (b) of this subdivision, for periods on and after January first, two thousand nine, the following services provided by general hospital outpatient departments and diagnostic and treatment centers shall be reimbursed with rates of payment based entirely upon the ambulatory patient group methodology as described in paragraph (e) of this subdivision, provided, however, that the commissioner may utilize existing payment methodologies or may promulgate regulations establishing alternative payment methodologies for one or more of the services specified in this subparagraph, effective for periods on and after March first, two thousand nine:

(A) services provided in accordance with the provisions of paragraphs (q) and (r) of subdivision two of section three hundred sixty-five-a of the social services law; and

(B) all services, but only with regard to additional payment amounts, as determined in accordance with regulations issued in accordance with paragraph (e) of this subdivision, for the provision of such services during times outside the facility's normal hours of operation, as determined in accordance with criteria set forth in such regulations; and

(C) individual psychotherapy services provided by licensed social workers, in accordance with licensing criteria set forth in applicable regulations[~~, to persons under the age of twenty-one and to persons requiring such services as a result of or related to pregnancy or giving birth~~]; and

(D) individual psychotherapy services provided by licensed social workers, in accordance with licensing criteria set forth in applicable regulations, at diagnostic and treatment centers that provided, billed for, and received payment for these services between January first, two thousand seven and December thirty-first, two thousand seven;

(E) services provided to pregnant women pursuant to paragraph (s) of subdivision two of section three hundred sixty-five-a of the social services law and, for periods on and after January first, two thousand ten, all other services provided pursuant to such paragraph (s) and services provided pursuant to paragraph (t) of subdivision two of section three hundred sixty-five-a of the social services law;

(F) wheelchair evaluation services and eyeglass dispensing services; and

(G) immunization services, effective for services rendered on and after June tenth, two thousand nine.

§ 5. Paragraph (h) of subdivision 2 of section 365-a of the social services law, as amended by chapter 220 of the laws of 2011, is amended to read as follows:

(h) speech therapy, and when provided at the direction of a physician or nurse practitioner, physical therapy including related rehabilitative services and occupational therapy; provided, however, that speech therapy[~~, physical therapy~~] and occupational therapy [~~each~~] shall be limited to coverage of twenty visits per year; **physical therapy shall be limited to coverage of forty visits per year;** such limitation shall not apply to persons with developmental disabilities or, notwithstanding any other provision of law to the contrary, to persons with traumatic brain injury;

§ 6. This act shall take effect immediately.

PART B

Section 1. Subdivision 2-c of section 2808 of the public health law is amended by adding a new paragraph (g) to read as follows:

(g) The commissioner shall reduce Medicaid revenue to a residential health care facility in a payment year by two percent if in each of the two most recent payment years for which New York state nursing home quality initiative data is available, the facility was ranked in the lowest two quintiles of facilities based on its nursing home quality initiative performance, and was ranked in the lowest quintile in the most recent payment year. The commissioner may waive the application of this paragraph to a facility if the commissioner determines that the facility is in extreme financial distress.

§ 2. Subdivision 3 of section 461-l of the social services law is amended by adding four new paragraphs (k), (l), (m) and (n) to read as follows:

(k)(i) Existing assisted living program providers licensed on or before April first, two thousand eighteen may apply to the department for up to nine additional assisted living program beds, by a deadline to be determined by the department. The department may utilize an expedited review process to allow eligible applicants in good standing the ability to be licensed for the additional beds within ninety days of the department's receipt of a satisfactory application. Eligible applicants are those that: do not require major renovation or construction; serve only public pay individuals; and are in substantial compliance with appropriate state and local requirements as determined by the department.

(ii) Existing assisted living program providers licensed on or before April first, two thousand twenty may submit additional applications for up to nine additional assisted living program beds on June thirtieth, two thousand twenty, and by a deadline to be determined by the department. Every two years thereafter, existing providers licensed on or before April first of such year may submit such applications on June thirtieth of such year, and by a deadline to be determined by the department. The number of additional assisted living program beds shall be based on the total number of previously awarded beds either withdrawn by the applicant or denied by the department.

(l) The commissioner of health is authorized to solicit and award applications for up to a total of five hundred new assisted living program beds in those counties where there is one or no assisted living

program providers, pursuant to criteria to be determined by the commissioner.

(m) The commissioner of health is authorized to solicit and award applications for up to five hundred new assisted living program beds in counties where utilization of existing assisted living program beds exceeds eighty-five percent. All applicants shall comply with federal home and community-based settings requirements, as set forth in 42 CFR Part 441 Subpart G. To be eligible for an award, an applicant must agree to:

(i) Serve only public pay individuals;

(ii) Develop and execute collaborative agreements within twenty-four months of an application being made to the department, in accordance with guidance to be published by the department, between at least one of each of the following entities: an adult care facility; a residential health care facility; and a general hospital;

(iii) Enter into an agreement with an existing managed care entity; and

(iv) Participate in value based payment models, where such models are available for participation.

(n) The commissioner of health is authorized to create a program to subsidize the cost of assisted living for those individuals living with Alzheimer's disease and dementia who are not eligible for medical assistance pursuant to title eleven of article five of this chapter. The program shall authorize up to two hundred vouchers to individuals through an application process and pay for up to seventy-five percent of the average private pay rate in the respective region. The commissioner may propose rules and regulations to effectuate this provision.

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

(i) The commissioner shall, to the extent necessary, submit the appropriate waivers, including, but not limited to, those authorized pursuant to sections eleven hundred fifteen and nineteen hundred fifteen of the federal social security act, or successor provisions, and any other waivers necessary to achieve the purposes of high quality, integrated, and cost effective care and integrated financial eligibility policies under the medical assistance program or pursuant to title XVIII of the federal social security act. In addition, the commissioner is authorized to submit the appropriate waivers, including but not limited to those authorized pursuant to sections eleven hundred fifteen and nineteen hundred fifteen of the federal social security act or successor provisions, and any other waivers necessary to require on or after April first, two thousand twelve, medical assistance recipients who are twenty-one years of age or older and who require community-based long term care services, as specified by the commissioner, for more than one hundred and twenty days, to receive such services through an available plan certified pursuant to this section or other program model that meets guidelines specified by the commissioner that support coordination and integration of services. Such guidelines shall address the requirements of paragraphs (a), (b), (c), (d), (e), (f), (g), (h), and (i) of subdivision three of this section as well as payment methods that ensure provider accountability for cost effective quality outcomes. Such other program models may include long term home health care programs that comply with such guidelines. Copies of such original waiver applications and amendments thereto shall be provided to the chairs of the senate finance committee, the assembly ways and means committee and the senate

and assembly health committees simultaneously with their submission to the federal government.

On or after October first, two thousand eighteen, the commissioner may, through such an approved waiver, limit enrollment in a plan certified under this section to individuals who achieve a score of nine or above when assessed using the Uniform Assessment System for New York assessment tool and who require community-based long term care services for a continuous period of more than one hundred twenty days from the date of enrollment and from the dates when continuing enrollment is reauthorized; however, medical assistance recipients enrolled in a managed long term care plan on October first, two thousand eighteen may continue to be eligible for such plans, irrespective of whether the enrollee meets these level of care requirements, provided that once such recipients are disenrolled from their managed long term care plan, any applicable level of care requirements would apply to future eligibility determinations.

§ 4. Subparagraphs (vii) and (viii) of paragraph (b) of subdivision 7 of section 4403-f of the public health law are redesignated as subparagraphs (viii) and (ix) and a new subparagraph (vii) is added to read as follows:

(vii) If another managed long term care plan certified under this section is available, medical assistance recipients required to enroll in such plans pursuant to this section may change plans without cause within thirty days of notification of enrollment or the effective date of enrollment into a plan, whichever is later, by making a request of the local social services district or entity designated by the department, except that such period shall be forty-five days for recipients who have been assigned to a provider by the commissioner. However, after such thirty or forty-five day period, whichever is applicable, a recipient may be prohibited from changing plans more frequently than once every twelve months, as permitted by federal law, except for good cause as determined by the commissioner.

§ 5. Clauses 11 and 12 of subparagraph (v) of paragraph (b) of subdivision 7 of section 4403-f of the public health law, as amended by section 48 of part A of chapter 56 of the laws of 2013, are amended to read as follows:

(11) a person who is eligible for medical assistance pursuant to paragraph (b) of subdivision four of section three hundred sixty-six of the social services law; [~~and~~]

(12) Native Americans; and

(13) a person who is permanently placed in a nursing home for a consecutive period of six months or more.

§ 6. Paragraph (a) of subdivision 3 of section 366 of the social services law is REPEALED and a new paragraph (a) is added to read as follows:

(a) Medical assistance shall be furnished without consideration of the income and resources of an applicant's legally responsible relative if the applicant's eligibility would normally be determined by comparing the amount of available income and/or resources of the applicant, including amounts deemed available to the applicant from legally responsible relatives, to an applicable eligibility standard, and:

(1) (i) the legally responsible relative is a community spouse, as defined in section three hundred sixty-six-c of this title;

(ii) such relative is refusing to make his or her income and/or resources available to meet the cost of necessary medical care, services, and supplies; and

(iii) the applicant executes an assignment of support from the community spouse in favor of the social services district and the department, unless the applicant is unable to execute such assignment due to physical or mental impairment or to deny assistance would create an undue hardship, as defined by the commissioner; or

(2) the legally responsible relative is absent from the applicant's household, and fails or refuses to make his or her income and/or resources available to meet the cost of necessary medical care, services, and supplies.

In such cases, however, the furnishing of such assistance shall create an implied contract with such relative, and the cost thereof may be recovered from such relative in accordance with title six of article three of this chapter and other applicable provisions of law.

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

(C) on and after July first, two thousand eighteen, twenty-four thousand one hundred eighty dollars or such greater amount as may be required under federal law;

§ 8. Subdivision 1 of section 367-a of the social services law is amended by adding a new paragraph (h) to read as follows:

(h) Amounts payable under this title for medical assistance in the form of freestanding clinic services pursuant to article twenty-eight of the public health law provided to eligible persons participating in the New York traumatic brain injury waiver program who are also beneficiaries under part B of title XVIII of the federal social security act or who are qualified medicare beneficiaries under part B of title XVIII of such act shall not be less than the approved medical assistance payment level less the amount payable under part B.

§ 9. The commissioner of health shall conduct a study of home and community based services available to recipients of the Medicaid program in rural areas of the state. Such study shall include a review and analysis of factors affecting such availability, including but not limited to transportation costs, costs of direct care personnel including home health aides, personal care attendants and other direct service personnel, opportunities for telehealth services, and technological advances to improve efficiencies. Consistent with the results of the study, the commissioner of health is authorized to provide a targeted Medicaid rate enhancement to fee-for-service personal care rates and rates under Medicaid waiver programs such as the nursing home transition and diversion waiver and the traumatic brain injury program waiver, in an aggregate amount of three million dollars minus the cost of conducting the study; provided further, that nothing in this section shall be deemed to affect payment for the costs of the study and any related Medicaid rate enhancement if federal participation is not available for such costs.

§ 10. This act shall take effect immediately; provided, however, that the amendments made to paragraph (b) of subdivision 7 of section 4403-f of the public health law made by sections three, four and five of this act shall not affect the expiration of such paragraph pursuant to subdivision (i) of section 111 of part H of chapter 59 of the laws of 2011, as amended, and shall be deemed to expire therewith; provided, further, that the amendments to paragraph (b) of subdivision 7 of section 4403-f of the public health law made by sections three, four and five of this act shall not affect the repeal of such section pursuant to chapter 659 of the laws of 1997, as amended, and shall be deemed repealed therewith;

provided, further, that section four of this act shall take effect on October 1, 2018.

PART C

Section 1. Subdivision 2 of section 365-l of the social services law, as amended by section 1 of part S of chapter 57 of the laws of 2017, is amended to read as follows:

2. In addition to payments made for health home services pursuant to subdivision one of this section, the commissioner is authorized to pay additional amounts**: (a)** to providers of health home services that meet process or outcome standards specified by the commissioner**; and (b) to Medicaid managed care enrollees who are members of health homes in the form of incentive payments to reward such enrollees for participating in wellness activities and for avoiding unnecessary hospitalizations and unnecessary utilization of hospital emergency department services**. Such additional amounts may be paid with state funds only if federal financial participation for such payments is unavailable.

§ 2. Section 365-l of the social services law is amended by adding a new subdivision 2-d to read as follows:

2-d. The commissioner shall establish targets for health home participation by enrollees of special needs managed care plans designated pursuant to subdivision four of section three hundred sixty-five-m of this title and by high-risk enrollees of other Medicaid managed care plans operating pursuant to section three hundred sixty-four-j of this title, and shall require the managed care providers to work collaboratively with health homes to achieve such targets. The commissioner may assess penalties under this subdivision against managed care providers that fail to meet the participation targets established pursuant to this subdivision, except that managed care providers shall not be penalized for the failure of a health home to work collaboratively toward meeting the participation targets.

§ 3. Subdivision 6 of section 2899 of the public health law, as amended by chapter 471 of the laws of 2016, is amended to read as follows:

6. "Provider" shall mean **(a)** any residential health care facility licensed under article twenty-eight of this chapter; or any certified home health agency, licensed home care services agency or long term home health care program certified under article thirty-six of this chapter; any hospice program certified pursuant to article forty of this chapter; or any adult home, enriched housing program or residence for adults licensed under article seven of the social services law**; or (b) a health home, or any subcontractor of such health home, who contracts with or is approved or otherwise authorized by the department to provide health home services to all those enrolled pursuant to a diagnosis of a developmental disability as defined in subdivision twenty-two of section 1.03 of the mental hygiene law and enrollees who are under twenty-one years of age under section three hundred sixty-five-l of the social services law, or any entity that provides home and community based services to enrollees who are under twenty-one years of age under a demonstration program pursuant to section eleven hundred fifteen of the federal social security act**.

§ 4. Paragraph (b) of subdivision 9 of section 2899-a of the public health law, as added by chapter 331 of the laws of 2006, is amended to read as follows:

(b) Residential health care facilities licensed pursuant to article twenty-eight of this chapter and certified home health care agencies and long-term home health care programs certified or approved pursuant to article thirty-six of this chapter **or a health home, or any subcontractor of such health home, who contracts with or is approved or otherwise authorized by the department to provide health home services to all those enrolled pursuant to a diagnosis of a developmental disability as defined in subdivision twenty-two of section 1.03 of the mental hygiene law and enrollees who are under twenty-one years of age under section three hundred sixty-five-l of the social services law, or any entity that provides home and community based services to enrollees who are under twenty-one years of age under a demonstration program pursuant to section eleven hundred fifteen of the federal social security act**, may, subject to the availability of federal financial participation, claim as reimbursable costs under the medical assistance program, costs reflecting the fee established pursuant to law by the division of criminal justice services for processing a criminal history information check, the fee imposed by the federal bureau of investigation for a national criminal history check, and costs associated with obtaining the fingerprints, provided, however, that for the purposes of determining rates of payment pursuant to article twenty-eight of this chapter for residential health care facilities, such reimbursable fees and costs shall be reflected as timely as practicable in such rates within the applicable rate period.

§ 5. Subdivision 10 of section 2899-a of the public health law, as amended by chapter 206 of the laws of 2017, is amended to read as follows:

10. Notwithstanding subdivision eleven of section eight hundred forty-five-b of the executive law, a certified home health agency, licensed home care services agency or long term home health care program certified, licensed or approved under article thirty-six of this chapter or a home care services agency exempt from certification or licensure under article thirty-six of this chapter, a hospice program under article forty of this chapter, or an adult home, enriched housing program or residence for adults licensed under article seven of the social services law, **or a health home, or any subcontractor of such health home, who contracts with or is approved or otherwise authorized by the department to provide health home services to all enrollees enrolled pursuant to a diagnosis of a developmental disability as defined in subdivision twenty-two of section 1.03 of the mental hygiene law and enrollees who are under twenty-one years of age under section three hundred sixty-five-l of the social services law, or any entity that provides home and community based services to enrollees who are under twenty-one years of age under a demonstration program pursuant to section eleven hundred fifteen of the federal social security act** may temporarily approve a prospective employee while the results of the criminal history information check and the determination are pending, upon the condition that the provider conducts appropriate direct observation and evaluation of the temporary employee, while he or she is temporarily employed, and the care recipient. The results of such observations shall be documented in the temporary employee's personnel file and shall be maintained. For purposes of providing such appropriate direct observation and evaluation, the provider shall utilize an individual employed by such provider with a minimum of one year's experience working in an agency certified, licensed or approved under article thirty-six of this chapter or an adult home, enriched housing program or residence for adults licensed

under article seven of the social services law, a health home, or any subcontractor of such health home, who contracts with or is approved or otherwise authorized by the department to provide health home services to those enrolled pursuant to a diagnosis of a developmental disability as defined in subdivision twenty-two of section 1.03 of the mental hygiene law and enrollees who are under twenty-one years of age under section three hundred sixty-five-l of the social services law, or any entity that provides home and community based services to enrollees who are under twenty-one years of age under a demonstration program pursuant to section eleven hundred fifteen of the federal social security act. If the temporary employee is working under contract with another provider certified, licensed or approved under article thirty-six of this chapter, such contract provider's appropriate direct observation and evaluation of the temporary employee, shall be considered sufficient for the purposes of complying with this subdivision.

§ 6. Subdivision 3 of section 424-a of the social services law, as amended by section 3 of part Q of chapter 56 of the laws of 2017, is amended to read as follows:

3. For purposes of this section, the term "provider" or "provider agency" shall mean: an authorized agency; the office of children and family services; juvenile detention facilities subject to the certification of the office of children and family services; programs established pursuant to article nineteen-H of the executive law; non-residential or residential programs or facilities licensed or operated by the office of mental health or the office for people with developmental disabilities except family care homes; licensed child day care centers, including head start programs which are funded pursuant to title V of the federal economic opportunity act of nineteen hundred sixty-four, as amended; early intervention service established pursuant to section twenty-five hundred forty of the public health law; preschool services established pursuant to section forty-four hundred ten of the education law; school-age child care programs; special act school districts as enumerated in chapter five hundred sixty-six of the laws of nineteen hundred sixty-seven, as amended; programs and facilities licensed by the office of alcoholism and substance abuse services; residential schools which are operated, supervised or approved by the education department; health homes, or any subcontract or of such health homes, who contracts with or is approved or otherwise authorized by the department of health to provide health home services to all those enrolled pursuant to a diagnosis of a developmental disability as defined in subdivision twenty-two of section 1.03 of the mental hygiene law and enrollees who are under twenty-one years of age under section three hundred sixty-five-l of this chapter, or any entity that provides home and community based services to enrollees who are under twenty-one years of age under a demonstration program pursuant to section eleven hundred fifteen of the federal social security act; publicly-funded emergency shelters for families with children, provided, however, for purposes of this section, when the provider or provider agency is a publicly-funded emergency shelter for families with children, then all references in this section to the "potential for regular and substantial contact with individuals who are cared for by the agency" shall mean the potential for regular and substantial contact with children who are served by such shelter; and any other facility or provider agency, as defined in subdivision four of section four hundred eighty-eight of this chapter, in regard to the employment of staff, or use of providers of goods and services and staff of such providers, consultants, interns and volunteers.

§ 7. Paragraph (a) of subdivision 1 of section 413 of the social services law, as amended by section 2 of part Q of chapter 56 of the laws of 2017, is amended to read as follows:

(a) The following persons and officials are required to report or cause a report to be made in accordance with this title when they have reasonable cause to suspect that a child coming before them in their professional or official capacity is an abused or maltreated child, or when they have reasonable cause to suspect that a child is an abused or maltreated child where the parent, guardian, custodian or other person legally responsible for such child comes before them in their professional or official capacity and states from personal knowledge facts, conditions or circumstances which, if correct, would render the child an abused or maltreated child: any physician; registered physician assistant; surgeon; medical examiner; coroner; dentist; dental hygienist; osteopath; optometrist; chiropractor; podiatrist; resident; intern; psychologist; registered nurse; social worker; emergency medical technician; licensed creative arts therapist; licensed marriage and family therapist; licensed mental health counselor; licensed psychoanalyst; licensed behavior analyst; certified behavior analyst assistant; hospital personnel engaged in the admission, examination, care or treatment of persons; a Christian Science practitioner; school official, which includes but is not limited to school teacher, school guidance counselor, school psychologist, school social worker, school nurse, school administrator or other school personnel required to hold a teaching or administrative license or certificate; full or part-time compensated school employee required to hold a temporary coaching license or professional coaching certificate; social services worker; employee of a publicly-funded emergency shelter for families with children; director of a children's overnight camp, summer day camp or traveling summer day camp, as such camps are defined in section thirteen hundred ninety-two of the public health law; day care center worker; school-age child care worker; provider of family or group family day care; employee or volunteer in a residential care facility for children that is licensed, certified or operated by the office of children and family services; or any other child care or foster care worker; mental health professional; substance abuse counselor; alcoholism counselor; all persons credentialed by the office of alcoholism and substance abuse services; **employees of a health home or health home care management agency contracting with a health home as designated by the department of health and authorized under section three hundred sixty-five-l of this chapter or such employees who provide home and community based services under a demonstration program pursuant to section eleven hundred fifteen of the federal social security act;** peace officer; police officer; district attorney or assistant district attorney; investigator employed in the office of a district attorney; or other law enforcement official.

§ 8. Section 364-j of the social services law is amended by adding a new subdivision 34 to read as follows:

34. (a) The commissioner may, in his or her discretion, apply penalties to managed care providers that do not submit a performing provider system partnership plan by July first, two thousand eighteen, in accordance with any submission guidelines issued by the department prior thereto. For purposes of this subdivision, "performing provider system partnership plan" shall mean a plan submitted by such managed care providers to the department that includes both short and long term approaches for effective collaboration with each performing provider system within its service area.

(b) Such penalties shall be as follows: for managed care providers that do not submit a performing provider system partnership plan in accordance with this subdivision, Medicaid premiums shall be reduced by eighty-five one-hundredths of one percent for the rate period from April first, two thousand eighteen through March thirty-first, two thousand nineteen.

§ 9. This act shall take effect immediately; provided, however, that the amendments made to subdivision 6 of section 2899 of the public health law made by section three of this act shall take effect on the same date and in the same manner as section 8 of chapter 471 of the laws of 2016, as amended, takes effect and shall not affect the expiration of such subdivision and shall be deemed expired therewith; provided further, however, that the amendments made to section 364-j of the social services law made by section eight of this act shall not affect the repeal of such section and shall be deemed repealed therewith.

PART D

Section 1. Paragraph (d) of subdivision 9 of section 367-a of the social services law, as amended by section 7 of part D of chapter 57 of the laws of 2017, is amended to read as follows:

(d) In addition to the amounts paid pursuant to paragraph (b) of this subdivision, the department shall pay a professional pharmacy dispensing fee for each such drug dispensed in the amount of ten dollars **and eight cents** per prescription or written order of a practitioner; provided, however that this professional dispensing fee will not apply to drugs that are available without a prescription as required by section sixty-eight hundred ten of the education law but do not meet the definition of a covered outpatient drug pursuant to Section 1927K of the Social Security Act.

§ 2. Paragraph (a) of subdivision 4 of section 365-a of the social services law, as amended by chapter 493 of the laws of 2010, is amended to read as follows:

(a) drugs which may be dispensed without a prescription as required by section sixty-eight hundred ten of the education law; provided, however, that the state commissioner of health may by regulation specify certain of such drugs which may be reimbursed as an item of medical assistance in accordance with the price schedule established by such commissioner. Notwithstanding any other provision of law, [~~additions~~] **modifications** to the list of drugs reimbursable under this paragraph may be filed as regulations by the commissioner of health without prior notice and comment;

§ 3. Paragraph (c) of subdivision 6 of section 367-a of the social services law is amended by adding a new subparagraph (v) to read as follows:

(v) Notwithstanding any other provision of this paragraph, co-payments charged for drugs dispensed without a prescription as required by section sixty-eight hundred ten of the education law but which are reimbursed as an item of medical assistance pursuant to paragraph (a) of subdivision four of section three hundred sixty-five-a of this title shall be one dollar.

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

(b) In the event that the patient does not meet the criteria in paragraph (a) of this subdivision, the prescriber may provide additional

information to the program to justify the use of a prescription drug that is not on the preferred drug list. The program shall provide a reasonable opportunity for a prescriber to reasonably present his or her justification of prior authorization. [~~If, after consultation with the program, the prescriber, in his or her reasonable professional judgment, determines that the use of a prescription drug that is not on the preferred drug list is warranted, the prescriber's determination shall be final.~~] The program will consider the additional information and the justification presented to determine whether the use of a prescription drug that is not on the preferred drug list is warranted.

§ 5. Subdivisions 25 and 25-a of section 364-j of the social services law are REPEALED.

§ 6. The public health law is amended by adding a new section 280-c to read as follows:

§ 280-c. Comprehensive medication management. 1. Definitions. For purposes of this section:

(a) Qualified pharmacist. The term "qualified pharmacist" shall mean a pharmacist who maintains a current unrestricted license pursuant to article one hundred thirty-seven of the education law, who has a minimum of two years of experience in patient care as a practicing pharmacist within the last five years, and who has demonstrated competency in the medication management of patients with a chronic disease or diseases, including but not limited to, the completion of one or more programs which are accredited by the accreditation council for pharmacy education, recognized by the education department and acceptable to the patient's treating physician.

(b) Comprehensive medication management. The term "comprehensive medication management" shall mean a program conducted by a qualified pharmacist that ensures a patient's medications, whether prescription or nonprescription, are individually assessed to determine that each medication is appropriate for the patient, effective for the medical condition, safe given comorbidities and other medications being taken, and able to be taken by the patient as intended. Comprehensive medication management conducted by a qualified pharmacist shall include sharing of applicable patient clinical information with the treating physician as specified in the comprehensive medication management protocol.

(c) Comprehensive medication management protocol. The term "comprehensive medication management protocol" means a written document pursuant to and consistent with any applicable state and federal requirements, that is entered into voluntarily by either a physician licensed pursuant to article one hundred thirty-one of the education law or a nurse practitioner certified pursuant to section sixty-nine hundred ten of the education law, and a qualified pharmacist which addresses a chronic disease or diseases as determined by the treating physician or nurse practitioner and that describes the nature and scope of the comprehensive medication management services to be performed by the qualified pharmacist, in accordance with the provisions of this section. Comprehensive medication management protocols between licensed physicians or nurse practitioners and qualified pharmacists shall be made available to the department for review and to ensure compliance with this article, upon request.

2. Authorization to establish comprehensive medication management protocols. A physician licensed pursuant to article one hundred thirty-one of the education law or a nurse practitioner certified pursuant to section sixty-nine hundred ten of the education law shall be authorized to voluntarily establish a comprehensive medication management protocol

with a qualified pharmacist to provide comprehensive medication management services for a patient who has not met clinical goals of therapy, is at risk for hospitalization, or for whom the physician or nurse practitioner deems it is necessary to receive comprehensive medication management services. Participation by the patient in comprehensive medication management services shall be voluntary.

3. Scope of comprehensive medication management protocols. (a) Under a comprehensive medication management protocol, a qualified pharmacist shall be permitted to:

(i) adjust or manage a drug regimen for the patient, pursuant to the patient specific order or protocol established by the patient's treating physician or nurse practitioner, which may include adjusting drug strength, frequency of administration or route of administration. Adjusting the drug regimen shall not include substituting or selecting a different drug which differs from that initially prescribed by the patient's treating physician or nurse practitioner unless such substitution is expressly authorized in the written order or protocol. The qualified pharmacist shall be required to immediately document in the patient's medical record changes made to the drug therapy. The patient's treating physician or nurse practitioner may prohibit, by written instruction, any adjustment or change in the patient's drug regimen by the qualified pharmacist;

(ii) evaluate and only if specifically authorized by the protocol, and only to the extent necessary to discharge the responsibility set forth in this section, order or perform routine patient monitoring functions or disease state laboratory tests related to the drug therapy comprehensive medication management for the specific chronic disease or diseases specified within the written agreement or comprehensive medication management protocol;

(iii) only if specifically authorized by the written order or protocol and only to the extent necessary to discharge the responsibilities set forth in this section, order or perform routine patient monitoring functions as may be necessary in the drug therapy management, including the collecting and reviewing of patient histories, and ordering or checking patient vital signs, including pulse, temperature, blood pressure, weight and respiration; and

(iv) access the complete patient medical record maintained by the treating physician or nurse practitioner with whom the qualified pharmacist has the comprehensive medication management protocol and shall document any adjustments made pursuant to the protocol in the patient's medical record and shall notify the patient's treating physician or nurse practitioner of any adjustments in a timely manner electronically or by other means.

(b) Under no circumstances shall the qualified pharmacist be permitted to delegate comprehensive medication management services to any other licensed pharmacist or other pharmacy personnel.

4. Medication adjustments. Any medication adjustments made by the qualified pharmacist pursuant to the comprehensive medication management protocol, including adjustments in drug strength, frequency or route of administration, or initiation of a drug which differs from that initially prescribed and as documented in the patient medical record, shall be deemed an oral prescription authorized by an agent of the patient's treating physician or nurse practitioner and shall be dispensed consistent with section sixty-eight hundred ten of the education law. For the purposes of this section, a pharmacist who is not an employee of the

physician or nurse practitioner may be authorized to serve as an agent of the physician or nurse practitioner.

5. Referrals. A physician licensed pursuant to article one hundred thirty-one of the education law or a nurse practitioner certified pursuant to section sixty-nine hundred ten of the education law, who has responsibility for the treatment and care of a patient for a chronic disease or diseases as determined by the physician or nurse practitioner may refer the patient to a qualified pharmacist for comprehensive medication management services, pursuant to the comprehensive medication management protocol that the physician or nurse practitioner has established with the qualified pharmacist. The protocol agreement shall authorize the pharmacist to serve as an agent of the physician or nurse practitioner as defined by the protocol. Such referral shall be documented in the patient's medical record.

6. Patient participation. Participation in comprehensive medication management services shall be voluntary, and no patient, physician, nurse practitioner or pharmacist shall be required to participate. The referral of a patient for comprehensive medication management services and the patient's right to choose not to participate shall be disclosed to the patient. Comprehensive medication management services shall not be utilized unless the patient or the patient's authorized representative consents, in writing, to such services. Such consent shall be noted in the patient's medical record. If the patient or the patient's authorized representative who consented chooses to no longer participate in such services, at any time, the services shall be discontinued and it shall be noted in the patient's medical record.

§ 7. Subdivision 4 of section 365-a of the social services law is amended by adding a new paragraph (h) to read as follows:

(h) opioids prescribed to a patient initiating or being maintained on opioid treatment for pain which has lasted more than three months or past the time of normal tissue healing, unless the medical record contains a written treatment plan that includes: goals for pain management and functional improvement based on diagnosis; information on whether non-opioid therapies have been tried and optimized or are contraindicated; a statement that the prescriber has explained to the patient the risks of and alternatives to opioid treatment; an evaluation of the patient for risk factors of harm and misuse of opioids; an assessment of the patient's adherence to treatment with respect to other conditions treated by the same provider; the signature of the patient and/or an attestation by the prescriber that the patient verbally agreed to the treatment plan; and any other information required by the department. Such treatment plan shall be updated twice within the year immediately following its initiation and annually thereafter. The requirements of this paragraph shall not apply in the case of patients who are being treated for cancer that is not in remission, who are in hospice or other end-of-life care, or whose pain is being treated as part of palliative care practices.

§ 8. Subdivision 2 of section 280 of the public health law, as amended by section 1 of part D of chapter 57 of the laws of 2017, is amended to read as follows:

2. The commissioner shall establish a year to year department of health state-funds Medicaid drug spending growth target as follows:

(a) for state fiscal year two thousand seventeen--two thousand eighteen, be limited to the ten-year rolling average of the medical component of the consumer price index plus five percent and minus a pharmacy savings target of fifty-five million dollars; [~~and~~]

(b) for state fiscal year two thousand eighteen--two thousand nineteen, be limited to the ten-year rolling average of the medical component of the consumer price index plus four percent and minus a pharmacy savings target of eighty-five million dollars[~~.~~]; and

(c) for state fiscal year two thousand nineteen--two thousand twenty, be limited to the ten-year rolling average of the medical component of the consumer price index plus four percent and minus a pharmacy savings target of eighty-five million dollars.

§ 9. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2018; provided, however, that sections two and three of this act shall take effect July 1, 2018; and provided further, however, that the amendments to paragraph (d) of subdivision 9 and paragraph (c) of subdivision 6 of section 367-a of the social services law made by sections one and three, respectively, of this act shall not affect the expiration or repeal of such provisions and shall expire or be deemed repealed therewith.

PART E

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

4. The commissioner of health is authorized to assume responsibility from a local social services official for the provision and reimbursement of transportation costs under this section. If the commissioner elects to assume such responsibility, the commissioner shall notify the local social services official in writing as to the election, the date upon which the election shall be effective and such information as to transition of responsibilities as the commissioner deems prudent. The commissioner is authorized to contract with a transportation manager or managers to manage transportation services in any local social services district, other than transportation services provided or arranged for enrollees of [~~managed long term care plans issued certificates of authority under section forty-four hundred three-f of the public health law~~] a program designated as a Program of All-Inclusive Care for the Elderly (PACE) as authorized by Federal Public law 1053-33, subtitle 1 of title IV of the Balanced Budget Act of 1997. Any transportation manager or managers selected by the commissioner to manage transportation services shall have proven experience in coordinating transportation services in a geographic and demographic area similar to the area in New York state within which the contractor would manage the provision of services under this section. Such a contract or contracts may include responsibility for: review, approval and processing of transportation orders; management of the appropriate level of transportation based on documented patient medical need; and development of new technologies leading to efficient transportation services. If the commissioner elects to assume such responsibility from a local social services district, the commissioner shall examine and, if appropriate, adopt quality assurance measures that may include, but are not limited to, global positioning tracking system reporting requirements and service verification mechanisms. Any and all reimbursement rates developed by transportation managers under this subdivision shall be subject to the review and approval of the commissioner.

§ 2. The opening paragraph of subdivision 1 and subdivision 3 of section 367-s of the social services law, as amended by section 53 of

part B of chapter 57 of the laws of 2015, are amended to read as follows:

Notwithstanding any provision of law to the contrary, a supplemental medical assistance payment shall be made on an annual basis to providers of emergency medical transportation services in an aggregate amount not to exceed four million dollars for two thousand six, six million dollars for two thousand seven, six million dollars for two thousand eight, six million dollars for the period May first, two thousand fourteen through March thirty-first, two thousand fifteen, and six million dollars [~~annually beginning with~~] **on an annual basis for** the period April first, two thousand fifteen through March thirty-first, two thousand [~~sixteen~~] **eighteen** pursuant to the following methodology:

3. If all necessary approvals under federal law and regulation are not obtained to receive federal financial participation in the payments authorized by this section, payments under this section shall be made in an aggregate amount not to exceed two million dollars for two thousand six, three million dollars for two thousand seven, three million dollars for two thousand eight, three million dollars for the period May first, two thousand fourteen through March thirty-first, two thousand fifteen, and three million dollars [~~annually beginning with~~] **on an annual basis for** the period April first, two thousand fifteen through March thirty-first, two thousand [~~sixteen~~] **eighteen**. In such case, the multiplier set forth in paragraph (b) of subdivision one of this section shall be deemed to be two million dollars or three million dollars as applicable to the annual period.

§ 3. Subdivision 5 of section 365-h of the social services law is REPEALED.

§ 4. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2018; provided, however, that section one of this act shall take effect October 1, 2018; provided, further that the amendments to subdivision 4 of section 365-h of the social services law made by section one of this act shall not affect the repeal of such section and shall expire and be deemed repealed therewith.

PART F

Section 1. Notwithstanding any inconsistent provision of law, rule or regulation to the contrary, if a Medicaid managed care plan or managed long term care plan that has been issued a certificate of authority pursuant to article 44 of the public health law and that satisfies the definition of corporation in subparagraph 5 of paragraph (a) of section 102 of the not-for-profit corporation law or is exempt from taxation under section 501 of the Internal Revenue Code of 1986 has an aggregate accumulated contingent reserve, across all of its Medicaid lines of business, in an amount that exceeds the minimum contingent reserve amount required by regulations of the department of health, the commissioner of health shall be authorized to make prospective adjustments to the Medicaid capitation rates of such plan and shall apply any relevant criteria as determined necessary in his or her discretion, in order to achieve a reduction in Medicaid reimbursement to the plan equal to the amount of the excess, or such lesser amount as determined by the commissioner of health.

§ 2. This act shall take effect April 1, 2018.

PART G

Section 1. The public health law is amended by adding a new article 29-J to read as follows:

ARTICLE 29-J

HEALTH SERVICES OFFERED BY RETAIL PRACTICES

Section 2999-hh. Definitions.

2999-ii. Retail practice sponsors.

2999-jj. Retail practices.

2999-kk. Accreditation.

2999-ll. Other laws.

§ 2999-hh. Definitions. For purposes of this article:

1. "Reportable event" shall mean:

(a) the transfer of an individual who visits a retail practice to a hospital or emergency department during such visit; or

(b) the death of an individual who visits a retail practice during such visit.

2. "Collaborative relationship" shall mean an arrangement between a retail practice and one or more of the following entities located within the same geographic region as the retail practice, designed to facilitate development and implementation of strategies that support the provision of coordinated care within the population served by the parties to such relationship:

(a) a hospital licensed pursuant to article twenty-eight of this chapter;

(b) a physician practice;

(c) an accountable care organization certified pursuant to article twenty-nine-E of this chapter; or

(d) a performing provider system under the delivery system reform incentive payment program.

3. "Retail health services" shall mean the services offered and provided by a retail practice.

(a) Retail health services shall include:

(i) the provision of treatment and services to patients for minor acute episodic illnesses or conditions;

(ii) episodic preventive and wellness treatments and services such as immunizations, except as otherwise specified in paragraph (c) of this subdivision;

(iii) treatment and services for minor traumas that are not reasonably likely to be life threatening or potentially disabling if ambulatory care within the capacity of the retail practice is provided;

(iv) administration of an opioid antagonist in the event of an emergency; and

(v) limited screening and referral for behavioral health conditions.

(b) Retail health services may include laboratory tests at the option of the retail practice, provided that:

(i) such tests are administered solely as an adjunct to treatment of patients visiting the retail practice, with all specimens collected and testing performed on-site;

(ii) such tests are "waived tests", meaning a clinical laboratory test that has been designated as a waived test or is otherwise subject to certificate of waiver requirements pursuant to the federal clinical laboratory improvement act of nineteen hundred eighty-eight, as amended; and

(iii) the retail practice obtains approval from the department pursuant to section five hundred seventy-nine of this chapter.

(c) Retail health services shall not include:

(i) the performance of procedures involving the provision of sedation or anesthesia;

(ii) the provision of services to patients twenty-four months of age or younger;

(iii) the provision of immunizations to patients between twenty-four months and eighteen years of age, other than immunizations against influenza;

(iv) services provided by pharmacists pursuant to article one hundred thirty-seven of the education law;

(v) health services provided on-site by an employer to its employees in a retail business operation;

(v) health services provided on a time-limited basis such as flu clinics or health fairs; or

(vi) educational courses offered to individuals on health topics, including instruction in self-management of medical conditions.

4. "Retail practice" shall mean an entity which:

(a) is located within the space of a retail business operation open to the general public, such that customer access to the retail practice location is available within the main premises of the retail operation;

(b) provides retail health services, as defined in subdivision three of this section;

(c) is established and overseen by a retail practice sponsor, as defined in subdivision five of this section;

(d) is staffed at all times by, at a minimum, one or more of the following: a physician licensed pursuant to article one hundred thirty-one of the education law, a physician assistant licensed pursuant to article one hundred thirty-one-A of the education law, and/or a nurse practitioner licensed pursuant to article one hundred thirty-nine of the education law; provided that no more than four physician assistants employed by a retail practice sponsor shall be supervised by a single physician; and

(e) is accredited as set forth in section twenty-nine hundred ninety-nine-kk of this article.

5. "Retail practice sponsor" shall mean an entity formed under the laws of the state of New York, which may include stockholders or members which are not natural persons, and which operates one or more retail practices. Retail practice sponsors may include business corporations, and general hospitals, nursing homes, and diagnostic and treatment centers licensed pursuant to article twenty-eight of this chapter.

§ 2999-ii. Retail practice sponsors. 1. Notwithstanding any law to the contrary, a retail practice sponsor may operate one or more retail practices to provide retail health services in accordance with this article.

2. A retail practice sponsor shall:

(a) employ or otherwise retain the services of a medical director who is licensed and currently registered to practice medicine in the state of New York to oversee the development of and adherence to medical policies and procedures used in the retail practices operated by the retail practice sponsor;

(b) establish and maintain policies and procedures requiring retail practices to comply with the provisions of section twenty-nine hundred ninety-nine-jj of this article;

(c) notify the department when it is prepared to commence operation of a retail practice by:

(i) identifying the corporate name of the retail practice sponsor, providing documentation of its organization under the laws of the state

of New York, and identifying the individual who will serve as the point of contact between the retail practice sponsor and the department;

(ii) identifying the location of the retail practice, the services to be offered by the retail practice, the name of the individual employed with the overall responsibility for the on-site management of the retail practice, and the staffing plan for the retail practice;

(iii) identifying the entities with which the retail practice will collaborate pursuant to subdivision two of section twenty-nine hundred ninety-nine-hh of this article; and

(iv) identifying the date on which it anticipates that the retail practice will be open for business;

(d) promptly update the department as to any changes in the information required under subdivision three of this section; and

(e) provide information to the department at a frequency and in a manner determined by the department, which at a minimum shall include an annual report that provides data, for each retail practice operated by the retail practice, on:

(i) the number of visits that occurred during the timeframe identified by the department;

(ii) the services provided to patients;

(iii) the source of payment for services provided;

(iv) the number of referrals to primary care practitioners made; and

(v) the number of reportable events that occurred.

3. (a) In discharging the duties of their respective positions, the board of directors, committees of the board, and individual directors and officers of a retail practice sponsor that operates three or more retail practices shall consider the effects of any action upon:

(i) the ability of the business corporation to accomplish its purpose;

(ii) the shareholders of the business corporation;

(iii) the interests of patients of the retail practices;

(iv) community and societal considerations, including those of the communities in which retail practices are located.

(b) The consideration of interests and factors in the manner required in paragraph (a) of this subdivision:

(i) shall not constitute a violation of the provisions of section seven hundred fifteen or seven hundred seventeen of the business corporation law; and

(ii) is in addition to the ability of directors to consider interests and factors as provided in section seven hundred seventeen of the business corporation law.

(c) A retail practice sponsor that operates three or more retail practices shall publish on a publicly available website a description of how its operation of existing and planned retail practices:

(i) will improve access to services in the communities where they are located;

(ii) supports a commitment to offer assistance to individuals who do not have health care coverage;

(iii) supports an overall commitment by the retail practice sponsor to operate some of its retail practices in medically underserved areas of the state as defined by the commissioner; and

(iv) will otherwise benefit the communities where they are located.

§ 2999-jj. Retail practices. 1. Retail health services shall not be provided in a retail business operation open to the public except in accordance with this article.

2. Notwithstanding any law to the contrary, a retail practice shall:

(a) provide retail health services and only retail health services;

(b) provide treatment without discrimination as to source of payment;

(c) maintain a policy offering a sliding scale for payment for patients who do not have health care coverage and publish such policy on a publicly available website;

(d) provide to patients who indicate that they do not have health care coverage information on the state health benefit exchange, including the website address for the exchange and contact information for local navigators offering in-person enrollment assistance;

(e) accept walk-in patients without previously scheduled appointments;

(f) offer business hours for a minimum of twelve hours per day and six days per week or, if the retail business in which the retail practice is located is open for less than twelve hours per day and six days per week, then the retail practice shall offer the same business hours as the retail business;

(g) publish a list of the retail health services it offers on a publicly available website together with the prices of such services;

(h) post signs in a conspicuous location in large type stating that prescriptions and over-the-counter supplies may be purchased by a patient from any business and do not need to be purchased on-site;

(i) enter into and maintain at least one collaborative relationship as defined in subdivision two of section twenty-nine hundred ninety-nine-hh of this article;

(j) inquire of each patient whether he or she has a primary care provider;

(k) maintain and regularly update a list of local primary care providers and provide such list to each patient who indicates that he or she does not have a primary care provider;

(l) refer patients to their primary care providers or other health care providers as appropriate;

(m) transmit, by electronic means whenever possible, records of services to patients' primary care providers and maintain records of services for a minimum of six years;

(n) execute participation agreements with health information organizations, also known as qualified entities, pursuant to which the retail practice shall agree to participate in the statewide health information network for New York (SHIN-NY);

(o) attain and maintain accreditation pursuant to section twenty-nine hundred ninety-nine-kk of this section; and

(p) report reportable events to the accrediting entity within three business days of the occurrence of such reportable event.

3. Entities meeting the definition of a retail practice as set forth in this article and providing services on or before the effective date of this article shall have one hundred twenty days after such effective date to notify the department of compliance therewith.

§ 2999-kk. Accreditation. 1. A retail practice shall be required to attain and maintain accreditation by a nationally recognized accrediting entity as determined by the department.

2. The accrediting entity shall be required to notify the department promptly if a retail practice loses its accreditation.

3. The accrediting entity shall be required to report data on all retail practices accredited by such entity to the commissioner.

§ 2999-ll. Other laws. 1. Nothing in this article shall be deemed to alter the scope of practice of any practitioner licensed or certified under title eight of the education law.

2. Nothing in this article shall be deemed to mitigate the responsibility of any individual practitioner licensed or certified under title

eight of the education law from accountability for his or her actions under applicable provisions of law.

3. A retail practice shall be deemed to be a "health care provider" for the purposes of title two-D of article two of this chapter.

4. A prescriber practicing in a retail practice shall not be deemed to be in the employ of a pharmacy or practicing in a hospital for purposes of subdivision two of section sixty-eight hundred seven of the education law.

§ 2. This act shall take effect immediately.

PART H

Section 1. Section 6902 of the education law is amended by adding a new subdivision 4 to read as follows:

4. (a) The practice of registered professional nursing by a certified registered nurse anesthetist, certified under section sixty-nine hundred twelve of this article may include the practice of nurse anesthesia.

(i) Subject to the provisions of paragraph (e) of this subdivision, nurse anesthesia includes: the administration of anesthesia and anesthesia related care to patients; pre-anesthesia evaluation and preparation; anesthetic induction, maintenance and emergence; post anesthesia care; perianesthesia nursing and clinical support functions; and pain management.

(ii) Nurse anesthesia must be provided in collaboration with a licensed physician qualified to determine the need for anesthesia services, provided such services are performed in accordance with a written practice agreement and written practice protocols as set forth in paragraph (b) of this subdivision or pursuant to collaborative relationships as set forth in paragraph (c) of this subdivision, whichever is applicable.

(iii) Prescriptions for drugs, devices, and anesthetic agents, anesthesia related agents, and pain management agents may be issued by a certified registered nurse anesthetist, in accordance with the written practice agreement and written practice protocols described in paragraph (b) of this subdivision if applicable. The certified registered nurse anesthetist shall obtain a certificate from the department upon successfully completing a program including an appropriate pharmacology component, or its equivalent, as established by the commissioner's regulations, prior to prescribing under this subparagraph. The certificate issued under section sixty-nine hundred twelve of this article shall state whether the certified registered nurse anesthetist has successfully completed such a program or equivalent and is authorized to prescribe under this subdivision.

(b) A certified registered nurse anesthetist certified under section sixty-nine hundred twelve of this article and practicing for thirty-six hundred hours or less shall do so in accordance with a written practice agreement and written practice protocols agreed upon by a licensed physician qualified by education and experience to determine the need for anesthesia.

(i) The written practice agreement shall include explicit provisions for the resolution of any disagreement between the collaborating physician and the certified registered nurse anesthetist regarding a matter of anesthesia or pain management treatment that is within the scope of practice of both. To the extent the practice agreement does not so provide, then the collaborating physician's treatment shall prevail.

(ii) Each practice agreement shall provide for patient records review by the collaborating physician in a timely fashion but in no event less often than every three months. The names of the certified registered nurse anesthetist and the collaborating physician shall be clearly posted in the practice setting of the certified registered nurse anesthetist.

(iii) The practice protocol shall reflect current accepted medical and nursing practice. The protocols shall be filed with the department within ninety days of the commencement of the practice and may be updated periodically. The commissioner shall make regulations establishing the procedure for the review of protocols and the disposition of any issues arising from such review.

(c) A certified registered nurse anesthetist certified under section sixty-nine hundred twelve of this article and practicing for more than thirty-six hundred hours shall have collaborative relationships with one or more licensed physicians qualified to determine the need for anesthesia services or a hospital, licensed under article twenty-eight of the public health law, that provides services through licensed physicians qualified to determine the need for anesthesia services and having privileges at such institution.

(i) For purposes of this paragraph, "collaborative relationships" shall mean that the certified registered nurse anesthetist shall communicate, whether in person, by telephone or through written (including electronic) means, with a licensed physician qualified to determine the need for anesthesia services or, in the case of a hospital, communicate with a licensed physician qualified to determine the need for anesthesia services and having privileges at such hospital, for the purposes of exchanging information, as needed, in order to provide comprehensive patient care and to make referrals as necessary.

(ii) As evidence that the certified registered nurse anesthetist maintains collaborative relationships, the certified registered nurse anesthetist shall complete and maintain a form, created by the department, to which the certified registered nurse anesthetist shall attest, that describes such collaborative relationships. Such form shall also reflect the certified registered nurse anesthetist's acknowledgement that if reasonable efforts to resolve any dispute that may arise with the collaborating physician or, in the case of a collaboration with a hospital, with a licensed physician qualified to determine the need for anesthesia services and having privileges at such hospital, about a patient's care are not successful, the recommendation of the physician shall prevail. Such form shall be updated as needed and may be subject to review by the department. The certified registered nurse anesthetist shall maintain documentation that supports such collaborative relationships.

(d) Nothing in this subdivision shall be deemed to limit or diminish the practice of the profession of nursing as a registered professional nurse under this article or any other law, rule, regulation or certification, nor to deny any registered professional nurse the right to do any act or engage in any practice authorized by this article or any other law, rule, regulation or certification.

(e)(i) Anesthesia services may be provided by certified registered nurse anesthetists only in the following settings:

(A) general hospitals, hospital outpatient surgical departments, and diagnostic and treatment centers licensed by the department of health pursuant to article twenty-eight of the public health law and authorized

to provide sedation, anesthesia services, and/or pain management services in connection with such licensure;

(B) practices where office-based surgery, as defined by section two hundred-thirty-d of the public health law, is performed and/or pain management services are provided; and

(C) dentists' and periodontists' offices where sedation and/or anesthesia services are provided.

(ii) Anesthesia services offered in such settings, including services provided by certified registered nurse anesthetists, shall be directed by a physician, dentist, or periodontist, as applicable, who is responsible for the clinical aspects of all anesthesia services offered by the provider and is qualified to determine the need for and administer anesthesia. Such physician shall have the discretion to establish parameters for supervision of certified registered nurse anesthetists where he or she makes a reasonable determination that the circumstances of a particular case or type of cases, although within the scope of practice of a certified registered nurse anesthetist as set forth in paragraph (a) of this subdivision, are of such complexity that they should be conducted under supervision. In such cases, such supervision shall be provided by an anesthesiologist who is immediately available as needed or by the operating physician who is qualified to determine the need for anesthesia services and supervise the administration of anesthesia.

§ 2. The education law is amended by adding a new section 6912 to read as follows:

§ 6912. Certificates for nurse anesthesia practice. 1. For issuance of a certificate to practice as a certified registered nurse anesthetist under subdivision four of section sixty-nine hundred two of this article, the applicant shall fulfill the following requirements:

(a) Application: file an application with the department;

(b) License: be licensed as a registered professional nurse in the state;

(c) Education: (i) have satisfactorily completed educational preparation for provision of these services in a program registered by the department or in a program accredited by a national body recognized by the department or determined by the department to be the equivalent; and (ii) submit evidence of current certification or recertification by a national certifying body, recognized by the department;

(d) Fees: pay a fee to the department of fifty dollars for an initial certificate authorizing nurse anesthesia practice and a triennial registration fee of thirty dollars; and

(e) Information and documentation: in conjunction with and as a condition of each triennial registration, provide to the department, and the department shall collect, such information and documentation required by the department, in consultation with the department of health, as is necessary to enable the department of health to evaluate access to needed services in this state, including, but not limited to, the location and type of setting wherein the certified registered nurse anesthetist practices and other information the department, in consultation with the department of health, deems relevant. The department of health, in consultation with the department, shall make such data available in aggregate, de-identified form on a publicly accessible website. Additionally, in conjunction with each triennial registration, the department, in consultation with the department of health, shall provide information on registering in the donate life registry for organ and tissue donation, including the website address for such registry.

After a certified registered nurse anesthetist's initial registration, registration under this section shall be coterminous with the certified registered nurse anesthetist's registration as a professional nurse.

2. Only a person certified under this section shall use the title "certified registered nurse anesthetist," except as set forth in subdivision three of this section.

3. Nothing in this section shall be deemed from preventing any other professional licensed or certified under this chapter or the public health law from carrying out any responsibilities established by relevant sections of such chapters.

4. An individual who meets the requirements for certification as a certified registered nurse anesthetist and who has been performing the duties of a certified registered nurse anesthetist for two of the five years prior to the effective date of this article may be certified without meeting additional requirements, provided that such individual submits an application, including an attestation from the applicant's supervising physician as to the applicant's experience and competence, to the department within two years of the effective date of this section. Such individual may use the title "certified registered nurse anesthetist" in connection with that practice while such application is pending.

5. (a) A registered professional nurse licensed under section sixty-nine hundred five of this article who has satisfactorily completed a program of educational preparation as provided in subdivision one of this section may, for a period not to exceed twenty-four months immediately following the completion of such educational program, practice nurse anesthesia under subdivision four of section sixty-nine hundred two of this article as a graduate nurse anesthetist in the same manner as a certified registered nurse anesthetist under that subdivision.

(b) A registered professional nurse licensed under section sixty-nine hundred five of this article who is duly enrolled in a program of educational preparation may practice nurse anesthesia as a student nurse anesthetist under the supervision of an anesthesiologist or a certified registered nurse anesthetist, who is immediately available as needed.

§ 3. This act shall take effect immediately.

PART I

Section 1. Section 364-j of the social services law is amended by adding a new subdivision 34 to read as follows:

34. Monies paid by the department to managed care organizations are public funds and retain their status as public funds regardless of any payments made by the managed care organization to subcontractors or providers.

§ 2. Section 364-j of the social services law is amended by adding a new subdivision 35 to read as follows:

35. Recovery of overpayments from network providers. (a) Where the Medicaid inspector general, during the course of an audit or investigation, identifies improper medical assistance payments made by a managed care organization to its subcontractor or subcontractors or provider or providers, the state shall have the right to recover the improper payment from the subcontractor or subcontractors, provider or providers, or the managed care organization.

(b) Where the state is unsuccessful in recovering the improper payment from the subcontractor or subcontractors or provider or providers, the Medicaid inspector general may require the managed care organization to

recover the improper medical assistance payments identified in paragraph (a) of this subdivision. The managed care organization shall remit to the state the full amount of the identified improper payment no later than six months after receiving notice of the overpayment.

(c) The managed care organization may charge its subcontractor or subcontractors or provider or providers a collection fee to account for the reasonable costs incurred by the managed care organization to collect the debt. Any collection fee imposed shall not exceed five percent of the total amount owed.

§ 3. Section 364-j of the social services law is amended by adding a new subdivision 36 to read as follows:

36. Reporting acts of fraud. (a) All managed care organizations shall promptly refer to the office of the Medicaid inspector general all cases of potential fraud, waste, or abuse.

(b) Any managed care organization making a complaint or furnishing a report, referral, information or records in good faith pursuant to this section shall be immune from civil liability for making such complaint, referral, or report to the office of the Medicaid inspector general.

(c) A managed care organization that willfully fails to promptly make a referral to the Medicaid inspector general when there is actual knowledge that an act of fraud is being or has been committed may be fined in an amount not exceeding one hundred thousand dollars for each determination.

§ 4. The public health law is amended by adding a new section 37 to read as follows:

§ 37. Violations of medical assistance program laws, regulations or directives; fines. 1. (a) Any individual or entity participating in the medical assistance program that fails to comply with or violates any statute, rule, regulation, or directive of the medical assistance program, may be fined in an amount not exceeding the sum of five thousand dollars for each violation.

(b) Every failure to comply with or violation of any statute, rule, regulation, or directive of the medical assistance program shall be a separate and distinct offense and, in the case of a continuing violation, every day's continuance thereof shall be a separate and distinct offense.

2. (a) Any entity authorized to operate under article forty-four of this chapter or article forty-three of the insurance law, including any subcontractor or provider thereof, and participating in the medical assistance program that fails to comply with or violates any statute, rule, regulation, or directive of the medical assistance program, or any term of its contract with the department, may be fined in an amount not exceeding the sum of five thousand dollars for each violation.

(b) Every failure to comply with or violation of any statute, rule, regulation, or directive of the medical assistance program, or term of the entity's contract with the department shall be a separate and distinct offense and, in the case of a continuing violation, every day's continuance thereof shall be a separate and distinct offense.

3. Any entity participating in the medical assistance program and authorized to operate under article forty-four of this chapter or article forty-three of the insurance law that submits a cost report to the medical assistance program that contains data which is intentionally or systematically inaccurate or improper, may be fined in an amount not exceeding one hundred thousand dollars for each determination.

4. Any entity authorized to operate under article forty-four of this chapter or article forty-three of the insurance law, and participating

in the medical assistance program that intentionally or systematically submits inaccurate encounter data to the state may be fined in an amount not exceeding one hundred thousand dollars for each determination.

5. The Medicaid inspector general shall, in consultation with the commissioner, consider the following prior to assessing a fine against an individual or entity under this section and have the discretion to reduce or eliminate a fine under this section:

(a) the effect, if any, on the quality of medical care provided to or arranged for recipients of medical assistance as a result of the acts of the individual or entity;

(b) the amount of damages to the program;

(c) the degree of culpability of the individual or entity in committing the proscribed actions and any mitigating circumstances;

(d) any prior violations committed by the individual or entity relating to the medical assistance program, Medicare or any other social services programs which resulted in either criminal or administrative sanction, penalty, or fine;

(e) the degree to which factors giving rise to the proscribed actions were out of the control of the individual or entity;

(f) the number and nature of the violations or other related offenses;

(g) any other facts relating to the nature and seriousness of the violations including any exculpatory facts; and/or

(h) any other relevant factors.

6. The Medicaid inspector general shall, in consultation with the commissioner, promulgate regulations enumerating those violations which may result in a fine pursuant to subdivisions one and two of this section, the amounts of any fines which may be assessed under this section, and the appeal rights afforded to individuals or entities subject to a fine.

§ 5. Paragraph (d) of subdivision 32 of section 364-j of the social services law, as added by section 15 of part B of chapter 59 of the laws of 2016, is amended to read as follows:

(d) (i) Penalties under this subdivision may be applied to any and all circumstances described in paragraph (b) of this subdivision until the managed care organization complies with the requirements for submission of encounter data. (ii) No penalties for late, incomplete or inaccurate encounter data shall be assessed against managed care organizations in addition to those provided for in this subdivision, provided, however, that nothing in this paragraph shall prohibit the imposition of penalties, in cases of fraud or abuse, otherwise authorized by law.

§ 6. This act shall take effect on the ninetieth day after it shall have become a law; provided, however, that the amendments to section 364-j of the social services law made by sections one, two, three and five of this act shall not affect the repeal of such section and shall be deemed repealed therewith.

PART J

Section 1. Paragraph (h) of subdivision 1 of section 189 of the state finance law, as amended by section 8 of part A of chapter 56 of the laws of 2013, is amended to read as follows:

(h) knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the state or a local government, or conspires to do the same; shall be liable to the state or a local government, as applicable, for a civil penalty of not less than six thousand dollars and not more than twelve thousand

dollars, **as adjusted to be equal to the civil penalty allowed under the federal False Claims Act, 31 U.S.C. sec. 3729, et seq., as amended, as adjusted for inflation by the Federal Civil Penalties Inflation Adjustment Act of 1990, as amended (28 U.S.C. 2461 note; Pub. L. No. 101-410),** plus three times the amount of all damages, including consequential damages, which the state or local government sustains because of the act of that person.

§ 2. This act shall take effect immediately.

PART K

Section 1. Notwithstanding any contrary provision of law, the department of health is authorized to require any Medicaid-enrolled provider, and any health care provider that is part of a network of providers of a managed care organization operating pursuant to section 364-j of the social services law or section 4403-f of the public health law, to report on costs incurred by the provider in rendering health care services to Medicaid beneficiaries. The department of health may specify the frequency and format of such reports, determine the type and amount of information to be submitted, and require the submission of supporting documentation. In the case of a provider in a managed care network, the department of health may require the managed care organization to obtain the required information from the network provider on behalf of the department.

§ 2. Subdivision 1 of section 92 of part H of 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, as amended by section 1 of part G of chapter 57 of the laws of 2017, is amended to read as follows:

1. For state fiscal years 2011-12 through [~~2018-19~~] **2019-20**, the director of the budget, in consultation with the commissioner of health referenced as "commissioner" for purposes of this section, shall assess on a monthly basis, as reflected in monthly reports pursuant to subdivision five of this section known and projected department of health state funds medicaid expenditures by category of service and by geographic regions, as defined by the commissioner, and if the director of the budget determines that such expenditures are expected to cause medicaid disbursements for such period to exceed the projected department of health medicaid state funds disbursements in the enacted budget financial plan pursuant to subdivision 3 of section 23 of the state finance law, the commissioner of health, in consultation with the director of the budget, shall develop a medicaid savings allocation plan to limit such spending to the aggregate limit level specified in the enacted budget financial plan, provided, however, such projections may be adjusted by the director of the budget to account for any changes in the New York state federal medical assistance percentage amount established pursuant to the federal social security act, changes in provider revenues, reductions to local social services district medical assistance administration, minimum wage increases, and beginning April 1, 2012 the operational costs of the New York state medical indemnity fund and state costs or savings from the basic health plan. Such projections may be adjusted by the director of the budget to account for increased or expedited department of health state funds medicaid expenditures as a result of a natural or other type of disaster, including a governmental declaration of emergency.

§ 3. This act shall take effect immediately.

PART L

Section 1. Subdivision 7 of section 369 of the social services law, as amended by section 7 of part F of chapter 56 of the laws of 2012, is amended to read as follows:

7. Notwithstanding any provision of law to the contrary, the department shall, when it determines necessary program features are in place, assume sole responsibility for commencing actions or proceedings in accordance with the provisions of this section, sections one hundred one, one hundred four, one hundred four-b, paragraph (a) of subdivision three of section three hundred sixty-six, subparagraph one of paragraph (h) of subdivision four of section three hundred sixty-six, and paragraph (b) of subdivision two of section three hundred sixty-seven-a of this chapter, to recover the cost of medical assistance furnished pursuant to this title and title eleven-D of this article. The department is authorized to contract with an entity that shall conduct activities on behalf of the department pursuant to this subdivision**, and may contract with an entity to conduct similar activities on behalf of the child health insurance program established pursuant to title one-A of article twenty-five of the public health law to the extent allowed by law**. Prior to assuming such responsibility from a social services district, the department of health shall, in consultation with the district, define the scope of the services the district will be required to perform on behalf of the department of health pursuant to this subdivision.

§ 2. Section 2511 of the public health law is amended by adding a new subdivision 22 to read as follows:

22. Notwithstanding the provisions of this section, section twenty-five hundred ten of this title, and any other inconsistent provision of law, in the event federal funding pursuant to Title XXI of the federal social security act is reduced or eliminated on and after October first, two thousand seventeen:

(a) The director of the division of the budget, in consultation with the commissioner, shall identify the amount of such reduction or elimination and notify the temporary president of the senate and the speaker of the assembly in writing that the federal actions will reduce or eliminate expected funding to New York state by such amount.

(b) The director of the division of the budget, in consultation with the commissioner, shall determine if programmatic changes are necessary to continue covering eligible children within state-only funding levels, identify available resources or actions, identify specific changes needed to align the program with current funding levels, and establish a plan for implementing such changes which may include emergency regulations promulgated by the commissioner. Such plan shall be submitted to the legislature prior to its implementation.

§ 3. This act shall take effect immediately.

PART M

Section 1. Paragraph (a) of subdivision 1 of section 18 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 15 of part H of chapter 57 of the laws of 2017, is amended to read as follows:

(a) The superintendent of financial services and the commissioner of health or their designee shall, from funds available in the hospital

excess liability pool created pursuant to subdivision 5 of this section, purchase a policy or policies for excess insurance coverage, as authorized by paragraph 1 of subsection (e) of section 5502 of the insurance law; or from an insurer, other than an insurer described in section 5502 of the insurance law, duly authorized to write such coverage and actually writing medical malpractice insurance in this state; or shall purchase equivalent excess coverage in a form previously approved by the superintendent of financial services for purposes of providing equivalent excess coverage in accordance with section 19 of chapter 294 of the laws of 1985, for medical or dental malpractice occurrences between July 1, 1986 and June 30, 1987, between July 1, 1987 and June 30, 1988, between July 1, 1988 and June 30, 1989, between July 1, 1989 and June 30, 1990, between July 1, 1990 and June 30, 1991, between July 1, 1991 and June 30, 1992, between July 1, 1992 and June 30, 1993, between July 1, 1993 and June 30, 1994, between July 1, 1994 and June 30, 1995, between July 1, 1995 and June 30, 1996, between July 1, 1996 and June 30, 1997, between July 1, 1997 and June 30, 1998, between July 1, 1998 and June 30, 1999, between July 1, 1999 and June 30, 2000, between July 1, 2000 and June 30, 2001, between July 1, 2001 and June 30, 2002, between July 1, 2002 and June 30, 2003, between July 1, 2003 and June 30, 2004, between July 1, 2004 and June 30, 2005, between July 1, 2005 and June 30, 2006, between July 1, 2006 and June 30, 2007, between July 1, 2007 and June 30, 2008, between July 1, 2008 and June 30, 2009, between July 1, 2009 and June 30, 2010, between July 1, 2010 and June 30, 2011, between July 1, 2011 and June 30, 2012, between July 1, 2012 and June 30, 2013, between July 1, 2013 and June 30, 2014, between July 1, 2014 and June 30, 2015, between July 1, 2015 and June 30, 2016, between July 1, 2016 and June 30, 2017, [~~and~~] between July 1, 2017 and June 30, 2018**, and between July 1, 2018 and June 30, 2019** or reimburse the hospital where the hospital purchases equivalent excess coverage as defined in subparagraph (i) of paragraph (a) of subdivision 1-a of this section for medical or dental malpractice occurrences between July 1, 1987 and June 30, 1988, between July 1, 1988 and June 30, 1989, between July 1, 1989 and June 30, 1990, between July 1, 1990 and June 30, 1991, between July 1, 1991 and June 30, 1992, between July 1, 1992 and June 30, 1993, between July 1, 1993 and June 30, 1994, between July 1, 1994 and June 30, 1995, between July 1, 1995 and June 30, 1996, between July 1, 1996 and June 30, 1997, between July 1, 1997 and June 30, 1998, between July 1, 1998 and June 30, 1999, between July 1, 1999 and June 30, 2000, between July 1, 2000 and June 30, 2001, between July 1, 2001 and June 30, 2002, between July 1, 2002 and June 30, 2003, between July 1, 2003 and June 30, 2004, between July 1, 2004 and June 30, 2005, between July 1, 2005 and June 30, 2006, between July 1, 2006 and June 30, 2007, between July 1, 2007 and June 30, 2008, between July 1, 2008 and June 30, 2009, between July 1, 2009 and June 30, 2010, between July 1, 2010 and June 30, 2011, between July 1, 2011 and June 30, 2012, between July 1, 2012 and June 30, 2013, between July 1, 2013 and June 30, 2014, between July 1, 2014 and June 30, 2015, between July 1, 2015 and June 30, 2016, between July 1, 2016 and June 30, 2017, [~~and~~] between July 1, 2017 and June 30, 2018**, and between July 1, 2018 and June 30, 2019** for physicians or dentists certified as eligible for each such period or periods pursuant to subdivision 2 of this section by a general hospital licensed pursuant to article 28 of the public health law; provided that no single insurer shall write more than fifty percent of the total excess premium for a given policy year; and provided, however, that such eligible physicians or dentists must have in force an individ-

ual policy, from an insurer licensed in this state of primary malpractice insurance coverage in amounts of no less than one million three hundred thousand dollars for each claimant and three million nine hundred thousand dollars for all claimants under that policy during the period of such excess coverage for such occurrences or be endorsed as additional insureds under a hospital professional liability policy which is offered through a voluntary attending physician ("channeling") program previously permitted by the superintendent of financial services during the period of such excess coverage for such occurrences. During such period, such policy for excess coverage or such equivalent excess coverage shall, when combined with the physician's or dentist's primary malpractice insurance coverage or coverage provided through a voluntary attending physician ("channeling") program, total an aggregate level of two million three hundred thousand dollars for each claimant and six million nine hundred thousand dollars for all claimants from all such policies with respect to occurrences in each of such years provided, however, if the cost of primary malpractice insurance coverage in excess of one million dollars, but below the excess medical malpractice insurance coverage provided pursuant to this act, exceeds the rate of nine percent per annum, then the required level of primary malpractice insurance coverage in excess of one million dollars for each claimant shall be in an amount of not less than the dollar amount of such coverage available at nine percent per annum; the required level of such coverage for all claimants under that policy shall be in an amount not less than three times the dollar amount of coverage for each claimant; and excess coverage, when combined with such primary malpractice insurance coverage, shall increase the aggregate level for each claimant by one million dollars and three million dollars for all claimants; and provided further, that, with respect to policies of primary medical malpractice coverage that include occurrences between April 1, 2002 and June 30, 2002, such requirement that coverage be in amounts no less than one million three hundred thousand dollars for each claimant and three million nine hundred thousand dollars for all claimants for such occurrences shall be effective April 1, 2002.

§ 2. Subdivision 3 of section 18 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 16 of part H of chapter 57 of the laws of 2017, is amended to read as follows:

(3)(a) The superintendent of financial services shall determine and certify to each general hospital and to the commissioner of health the cost of excess malpractice insurance for medical or dental malpractice occurrences between July 1, 1986 and June 30, 1987, between July 1, 1988 and June 30, 1989, between July 1, 1989 and June 30, 1990, between July 1, 1990 and June 30, 1991, between July 1, 1991 and June 30, 1992, between July 1, 1992 and June 30, 1993, between July 1, 1993 and June 30, 1994, between July 1, 1994 and June 30, 1995, between July 1, 1995 and June 30, 1996, between July 1, 1996 and June 30, 1997, between July 1, 1997 and June 30, 1998, between July 1, 1998 and June 30, 1999, between July 1, 1999 and June 30, 2000, between July 1, 2000 and June 30, 2001, between July 1, 2001 and June 30, 2002, between July 1, 2002 and June 30, 2003, between July 1, 2003 and June 30, 2004, between July 1, 2004 and June 30, 2005, between July 1, 2005 and June 30, 2006, between July 1, 2006 and June 30, 2007, between July 1, 2007 and June 30, 2008, between July 1, 2008 and June 30, 2009, between July 1, 2009 and June 30, 2010, between July 1, 2010 and June 30, 2011, between July

1, 2011 and June 30, 2012, between July 1, 2012 and June 30, 2013, and between July 1, 2013 and June 30, 2014, between July 1, 2014 and June 30, 2015, between July 1, 2015 and June 30, 2016, and between July 1, 2016 and June 30, 2017, [~~and~~] between July 1, 2017 and June 30, 2018**, and between July 1, 2018 and June 30, 2019** allocable to each general hospital for physicians or dentists certified as eligible for purchase of a policy for excess insurance coverage by such general hospital in accordance with subdivision 2 of this section, and may amend such determination and certification as necessary.

(b) The superintendent of financial services shall determine and certify to each general hospital and to the commissioner of health the cost of excess malpractice insurance or equivalent excess coverage for medical or dental malpractice occurrences between July 1, 1987 and June 30, 1988, between July 1, 1988 and June 30, 1989, between July 1, 1989 and June 30, 1990, between July 1, 1990 and June 30, 1991, between July 1, 1991 and June 30, 1992, between July 1, 1992 and June 30, 1993, between July 1, 1993 and June 30, 1994, between July 1, 1994 and June 30, 1995, between July 1, 1995 and June 30, 1996, between July 1, 1996 and June 30, 1997, between July 1, 1997 and June 30, 1998, between July 1, 1998 and June 30, 1999, between July 1, 1999 and June 30, 2000, between July 1, 2000 and June 30, 2001, between July 1, 2001 and June 30, 2002, between July 1, 2002 and June 30, 2003, between July 1, 2003 and June 30, 2004, between July 1, 2004 and June 30, 2005, between July 1, 2005 and June 30, 2006, between July 1, 2006 and June 30, 2007, between July 1, 2007 and June 30, 2008, between July 1, 2008 and June 30, 2009, between July 1, 2009 and June 30, 2010, between July 1, 2010 and June 30, 2011, between July 1, 2011 and June 30, 2012, between July 1, 2012 and June 30, 2013, between July 1, 2013 and June 30, 2014, between July 1, 2014 and June 30, 2015, between July 1, 2015 and June 30, 2016, [~~and~~] between July 1, 2016 and June 30, 2017, [~~and~~] between July 1, 2017 and June 30, 2018**, and between July 1, 2018 and June 30, 2019** allocable to each general hospital for physicians or dentists certified as eligible for purchase of a policy for excess insurance coverage or equivalent excess coverage by such general hospital in accordance with subdivision 2 of this section, and may amend such determination and certification as necessary. The superintendent of financial services shall determine and certify to each general hospital and to the commissioner of health the ratable share of such cost allocable to the period July 1, 1987 to December 31, 1987, to the period January 1, 1988 to June 30, 1988, to the period July 1, 1988 to December 31, 1988, to the period January 1, 1989 to June 30, 1989, to the period July 1, 1989 to December 31, 1989, to the period January 1, 1990 to June 30, 1990, to the period July 1, 1990 to December 31, 1990, to the period January 1, 1991 to June 30, 1991, to the period July 1, 1991 to December 31, 1991, to the period January 1, 1992 to June 30, 1992, to the period July 1, 1992 to December 31, 1992, to the period January 1, 1993 to June 30, 1993, to the period July 1, 1993 to December 31, 1993, to the period January 1, 1994 to June 30, 1994, to the period July 1, 1994 to December 31, 1994, to the period January 1, 1995 to June 30, 1995, to the period July 1, 1995 to December 31, 1995, to the period January 1, 1996 to June 30, 1996, to the period July 1, 1996 to December 31, 1996, to the period January 1, 1997 to June 30, 1997, to the period July 1, 1997 to December 31, 1997, to the period January 1, 1998 to June 30, 1998, to the period July 1, 1998 to December 31, 1998, to the period January 1, 1999 to June 30, 1999, to the period July 1, 1999 to December 31, 1999, to the period January 1, 2000 to June 30, 2000, to the period July 1, 2000 to December

31, 2000, to the period January 1, 2001 to June 30, 2001, to the period July 1, 2001 to June 30, 2002, to the period July 1, 2002 to June 30, 2003, to the period July 1, 2003 to June 30, 2004, to the period July 1, 2004 to June 30, 2005, to the period July 1, 2005 and June 30, 2006, to the period July 1, 2006 and June 30, 2007, to the period July 1, 2007 and June 30, 2008, to the period July 1, 2008 and June 30, 2009, to the period July 1, 2009 and June 30, 2010, to the period July 1, 2010 and June 30, 2011, to the period July 1, 2011 and June 30, 2012, to the period July 1, 2012 and June 30, 2013, to the period July 1, 2013 and June 30, 2014, to the period July 1, 2014 and June 30, 2015, to the period July 1, 2015 and June 30, 2016, and between July 1, 2016 and June 30, 2017, and to the period July 1, 2017 [~~and~~] **to** June 30, 2018**, and to the period July 1, 2018 to June 30, 2019**.

§ 3. Paragraphs (a), (b), (c), (d) and (e) of subdivision 8 of section 18 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 17 of part H of chapter 57 of the laws of 2017, are amended to read as follows:

(a) To the extent funds available to the hospital excess liability pool pursuant to subdivision 5 of this section as amended, and pursuant to section 6 of part J of chapter 63 of the laws of 2001, as may from time to time be amended, which amended this subdivision, are insufficient to meet the costs of excess insurance coverage or equivalent excess coverage for coverage periods during the period July 1, 1992 to June 30, 1993, during the period July 1, 1993 to June 30, 1994, during the period July 1, 1994 to June 30, 1995, during the period July 1, 1995 to June 30, 1996, during the period July 1, 1996 to June 30, 1997, during the period July 1, 1997 to June 30, 1998, during the period July 1, 1998 to June 30, 1999, during the period July 1, 1999 to June 30, 2000, during the period July 1, 2000 to June 30, 2001, during the period July 1, 2001 to October 29, 2001, during the period April 1, 2002 to June 30, 2002, during the period July 1, 2002 to June 30, 2003, during the period July 1, 2003 to June 30, 2004, during the period July 1, 2004 to June 30, 2005, during the period July 1, 2005 to June 30, 2006, during the period July 1, 2006 to June 30, 2007, during the period July 1, 2007 to June 30, 2008, during the period July 1, 2008 to June 30, 2009, during the period July 1, 2009 to June 30, 2010, during the period July 1, 2010 to June 30, 2011, during the period July 1, 2011 to June 30, 2012, during the period July 1, 2012 to June 30, 2013, during the period July 1, 2013 to June 30, 2014, during the period July 1, 2014 to June 30, 2015, during the period July 1, 2015 [~~and~~] **to** June 30, 2016, during the period July 1, 2016 [~~and~~] **to** June 30, 2017, [~~and~~] during the period July 1, 2017 [~~and~~] **to** June 30, 2018**, and during the period July 1, 2018 to June 30, 2019** allocated or reallocated in accordance with paragraph (a) of subdivision 4-a of this section to rates of payment applicable to state governmental agencies, each physician or dentist for whom a policy for excess insurance coverage or equivalent excess coverage is purchased for such period shall be responsible for payment to the provider of excess insurance coverage or equivalent excess coverage of an allocable share of such insufficiency, based on the ratio of the total cost of such coverage for such physician to the sum of the total cost of such coverage for all physicians applied to such insufficiency.

(b) Each provider of excess insurance coverage or equivalent excess coverage covering the period July 1, 1992 to June 30, 1993, or covering the period July 1, 1993 to June 30, 1994, or covering the period July 1, 1994 to June 30, 1995, or covering the period July 1, 1995 to June 30,

1996, or covering the period July 1, 1996 to June 30, 1997, or covering the period July 1, 1997 to June 30, 1998, or covering the period July 1, 1998 to June 30, 1999, or covering the period July 1, 1999 to June 30, 2000, or covering the period July 1, 2000 to June 30, 2001, or covering the period July 1, 2001 to October 29, 2001, or covering the period April 1, 2002 to June 30, 2002, or covering the period July 1, 2002 to June 30, 2003, or covering the period July 1, 2003 to June 30, 2004, or covering the period July 1, 2004 to June 30, 2005, or covering the period July 1, 2005 to June 30, 2006, or covering the period July 1, 2006 to June 30, 2007, or covering the period July 1, 2007 to June 30, 2008, or covering the period July 1, 2008 to June 30, 2009, or covering the period July 1, 2009 to June 30, 2010, or covering the period July 1, 2010 to June 30, 2011, or covering the period July 1, 2011 to June 30, 2012, or covering the period July 1, 2012 to June 30, 2013, or covering the period July 1, 2013 to June 30, 2014, or covering the period 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, or covering the period July 1, 2017 to June 30, 2018**, or covering the period July 1, 2018 to June 30, 2019** shall notify a covered physician or dentist by mail, mailed to the address shown on the last application for excess insurance coverage or equivalent excess coverage, of the amount due to such provider from such physician or dentist for such coverage period determined in accordance with paragraph (a) of this subdivision. Such amount shall be due from such physician or dentist to such provider of excess insurance coverage or equivalent excess coverage in a time and manner determined by the superintendent of financial services.

(c) If a physician or dentist liable for payment of a portion of the costs of excess insurance coverage or equivalent excess coverage covering the period July 1, 1992 to June 30, 1993, or covering the period July 1, 1993 to June 30, 1994, or covering the period July 1, 1994 to June 30, 1995, or covering the period July 1, 1995 to June 30, 1996, or covering the period July 1, 1996 to June 30, 1997, or covering the period July 1, 1997 to June 30, 1998, or covering the period July 1, 1998 to June 30, 1999, or covering the period July 1, 1999 to June 30, 2000, or covering the period July 1, 2000 to June 30, 2001, or covering the period July 1, 2001 to October 29, 2001, or covering the period April 1, 2002 to June 30, 2002, or covering the period July 1, 2002 to June 30, 2003, or covering the period July 1, 2003 to June 30, 2004, or covering the period July 1, 2004 to June 30, 2005, or covering the period July 1, 2005 to June 30, 2006, or covering the period July 1, 2006 to June 30, 2007, or covering the period July 1, 2007 to June 30, 2008, or covering the period July 1, 2008 to June 30, 2009, or covering the period July 1, 2009 to June 30, 2010, or covering the period July 1, 2010 to June 30, 2011, or covering the period July 1, 2011 to June 30, 2012, or covering the period July 1, 2012 to June 30, 2013, or covering the period July 1, 2013 to June 30, 2014, or covering the period 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, or covering the period July 1, 2017 to June 30, 2018**, or covering the period July 1, 2018 to June 30, 2019** determined in accordance with paragraph (a) of this subdivision fails, refuses or neglects to make payment to the provider of excess insurance coverage or equivalent excess coverage in such time and manner as determined by the superintendent of financial services pursuant to paragraph (b) of this subdivision, excess insurance coverage or equivalent excess coverage purchased for such physician or dentist in accordance with this section for such coverage period shall be cancelled and

shall be null and void as of the first day on or after the commencement of a policy period where the liability for payment pursuant to this subdivision has not been met.

(d) Each provider of excess insurance coverage or equivalent excess coverage shall notify the superintendent of financial services and the commissioner of health or their designee of each physician and dentist eligible for purchase of a policy for excess insurance coverage or equivalent excess coverage covering the period July 1, 1992 to June 30, 1993, or covering the period July 1, 1993 to June 30, 1994, or covering the period July 1, 1994 to June 30, 1995, or covering the period July 1, 1995 to June 30, 1996, or covering the period July 1, 1996 to June 30, 1997, or covering the period July 1, 1997 to June 30, 1998, or covering the period July 1, 1998 to June 30, 1999, or covering the period July 1, 1999 to June 30, 2000, or covering the period July 1, 2000 to June 30, 2001, or covering the period July 1, 2001 to October 29, 2001, or covering the period April 1, 2002 to June 30, 2002, or covering the period July 1, 2002 to June 30, 2003, or covering the period July 1, 2003 to June 30, 2004, or covering the period July 1, 2004 to June 30, 2005, or covering the period July 1, 2005 to June 30, 2006, or covering the period July 1, 2006 to June 30, 2007, or covering the period July 1, 2007 to June 30, 2008, or covering the period July 1, 2008 to June 30, 2009, or covering the period July 1, 2009 to June 30, 2010, or covering the period July 1, 2010 to June 30, 2011, or covering the period July 1, 2011 to June 30, 2012, or covering the period July 1, 2012 to June 30, 2013, or covering the period July 1, 2013 to June 30, 2014, or covering the period 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, or covering the period July 1, 2017 to June 30, 2018**, or covering the period July 1, 2018 to June 30, 2019** 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, to the period July 1, 2016 to June 30, 2017, and to the period July 1, 2017 to June 30, 2018**, and to the period July 1, 2018 to June 30, 2019** 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, and covering the period July 1, 2017 to June 30, 2018**, and covering the period July 1, 2018 to June 30, 2019** for a physician or dentist where such excess insurance coverage or equivalent excess coverage is cancelled in accordance with paragraph (c) of this subdivision.

§ 4. 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 18 of part H of chapter 57 of the laws of 2017, is amended to read as follows:

§ 40. The superintendent of financial services shall establish rates for policies providing coverage for physicians and surgeons medical malpractice for the periods commencing July 1, 1985 and ending June 30, [~~2018~~] **2019**; provided, however, that notwithstanding any other provision of law, the superintendent shall not establish or approve any increase in rates for the period commencing July 1, 2009 and ending June 30, 2010. The superintendent shall direct insurers to establish segregated accounts for premiums, payments, reserves and investment income attributable to such premium periods and shall require periodic reports by the insurers regarding claims and expenses attributable to such periods to monitor whether such accounts will be sufficient to meet incurred claims and expenses. On or after July 1, 1989, the superintendent shall impose a surcharge on premiums to satisfy a projected deficiency that is attributable to the premium levels established pursuant to this section for such periods; provided, however, that such annual surcharge shall not exceed eight percent of the established rate until July 1, [~~2018~~] **2019**, at which time and thereafter such surcharge shall not exceed twenty-five percent of the approved adequate rate, and that such annual surcharges shall continue for such period of time as shall be sufficient to satisfy such deficiency. The superintendent shall not impose such surcharge during the period commencing July 1, 2009 and ending June 30, 2010. On and after July 1, 1989, the surcharge prescribed by this section shall be retained by insurers to the extent that they insured physicians and surgeons during the July 1, 1985 through June 30, [~~2018~~] **2019** policy periods; in the event and to the extent physicians and surgeons were insured by another insurer during such periods, all or a pro rata share of the surcharge, as the case may be, shall be remitted to such other insurer in accordance with rules and regulations to be

promulgated by the superintendent. Surcharges collected from physicians and surgeons who were not insured during such policy periods shall be apportioned among all insurers in proportion to the premium written by each insurer during such policy periods; if a physician or surgeon was insured by an insurer subject to rates established by the superintendent during such policy periods, and at any time thereafter a hospital, health maintenance organization, employer or institution is responsible for responding in damages for liability arising out of such physician's or surgeon's practice of medicine, such responsible entity shall also remit to such prior insurer the equivalent amount that would then be collected as a surcharge if the physician or surgeon had continued to remain insured by such prior insurer. In the event any insurer that provided coverage during such policy periods is in liquidation, the property/casualty insurance security fund shall receive the portion of surcharges to which the insurer in liquidation would have been entitled. The surcharges authorized herein shall be deemed to be income earned for the purposes of section 2303 of the insurance law. The superintendent, in establishing adequate rates and in determining any projected deficiency pursuant to the requirements of this section and the insurance law, shall give substantial weight, determined in his discretion and judgment, to the prospective anticipated effect of any regulations promulgated and laws enacted and the public benefit of stabilizing malpractice rates and minimizing rate level fluctuation during the period of time necessary for the development of more reliable statistical experience as to the efficacy of such laws and regulations affecting medical, dental or podiatric malpractice enacted or promulgated in 1985, 1986, by this act and at any other time. Notwithstanding any provision of the insurance law, rates already established and to be established by the superintendent pursuant to this section are deemed adequate if such rates would be adequate when taken together with the maximum authorized annual surcharges to be imposed for a reasonable period of time whether or not any such annual surcharge has been actually imposed as of the establishment of such rates.

§ 5. Section 5 and subdivisions (a) and (e) of section 6 of 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, relating to the effectiveness of certain provisions of such chapter, as amended by section 19 of part H of chapter 57 of the laws of 2017, are amended to read as follows:

§ 5. The superintendent of financial services and the commissioner of health shall determine, no later than June 15, 2002, June 15, 2003, June 15, 2004, June 15, 2005, June 15, 2006, June 15, 2007, June 15, 2008, June 15, 2009, June 15, 2010, June 15, 2011, June 15, 2012, June 15, 2013, June 15, 2014, June 15, 2015, June 15, 2016, June 15, 2017, [~~and~~] June 15, 2018**, and June 15, 2019** the amount of funds available in the hospital excess liability pool, created pursuant to section 18 of chapter 266 of the laws of 1986, and whether such funds are sufficient for purposes of purchasing excess insurance coverage for eligible participating physicians and dentists during the period July 1, 2001 to June 30, 2002, or July 1, 2002 to June 30, 2003, or July 1, 2003 to June 30, 2004, or July 1, 2004 to June 30, 2005, or July 1, 2005 to June 30, 2006, or July 1, 2006 to June 30, 2007, or July 1, 2007 to June 30, 2008, or July 1, 2008 to June 30, 2009, or July 1, 2009 to June 30, 2010, or July 1, 2010 to June 30, 2011, or July 1, 2011 to June 30, 2012, or July 1, 2012 to June 30, 2013, or July 1, 2013 to June 30,

2014, or July 1, 2014 to June 30, 2015, or July 1, 2015 to June 30, 2016, or July 1, 2016 to June 30, 2017, or [~~to~~] July 1, 2017 to June 30, 2018**, or July 1, 2018 to June 30, 2019** as applicable.

(a) This section shall be effective only upon a determination, pursuant to section five of this act, by the superintendent of financial services and the commissioner of health, and a certification of such determination to the state director of the budget, the chair of the senate committee on finance and the chair of the assembly committee on ways and means, that the amount of funds in the hospital excess liability pool, created pursuant to section 18 of chapter 266 of the laws of 1986, is insufficient for purposes of purchasing excess insurance coverage for eligible participating physicians and dentists during the period July 1, 2001 to June 30, 2002, or July 1, 2002 to June 30, 2003, or July 1, 2003 to June 30, 2004, or July 1, 2004 to June 30, 2005, or July 1, 2005 to June 30, 2006, or July 1, 2006 to June 30, 2007, or July 1, 2007 to June 30, 2008, or July 1, 2008 to June 30, 2009, or July 1, 2009 to June 30, 2010, or July 1, 2010 to June 30, 2011, or July 1, 2011 to June 30, 2012, or July 1, 2012 to June 30, 2013, or July 1, 2013 to June 30, 2014, or July 1, 2014 to June 30, 2015, or July 1, 2015 to June 30, 2016, or July 1, 2016 to June 30, 2017, or July 1, 2017 to June 30, 2018**, or July 1, 2018 to June 30, 2019** as applicable.

(e) The commissioner of health shall transfer for deposit to the hospital excess liability pool created pursuant to section 18 of chapter 266 of the laws of 1986 such amounts as directed by the superintendent of financial services for the purchase of excess liability insurance coverage for eligible participating physicians and dentists for the policy year July 1, 2001 to June 30, 2002, or July 1, 2002 to June 30, 2003, or July 1, 2003 to June 30, 2004, or July 1, 2004 to June 30, 2005, or July 1, 2005 to June 30, 2006, or July 1, 2006 to June 30, 2007, as applicable, and the cost of administering the hospital excess liability pool for such applicable policy year, pursuant to the program established in chapter 266 of the laws of 1986, as amended, no later than June 15, 2002, June 15, 2003, June 15, 2004, June 15, 2005, June 15, 2006, June 15, 2007, June 15, 2008, June 15, 2009, June 15, 2010, June 15, 2011, June 15, 2012, June 15, 2013, June 15, 2014, June 15, 2015, June 15, 2016, June 15, 2017, [~~and~~] June 15, 2018**, and June 15, 2019** as applicable.

§ 6. Section 20 of part H of chapter 57 of the laws of 2017, amending the New York Health Care Reform Act of 1996 and other laws relating to extending certain provisions thereto, is amended to read as follows:

§ 20. Notwithstanding any law, rule or regulation to the contrary, only physicians or dentists who were eligible, and for whom the superintendent of financial services and the commissioner of health, or their designee, purchased, with funds available in the hospital excess liability pool, a full or partial policy for excess coverage or equivalent excess coverage for the coverage period ending the thirtieth of June, two thousand [~~seventeen~~] **eighteen**, shall be eligible to apply for such coverage for the coverage period beginning the first of July, two thousand [~~seventeen~~] **eighteen**; provided, however, if the total number of physicians or dentists for whom such excess coverage or equivalent excess coverage was purchased for the policy year ending the thirtieth of June, two thousand [~~seventeen~~] **eighteen** exceeds the total number of physicians or dentists certified as eligible for the coverage period beginning the first of July, two thousand [~~seventeen~~] **eighteen**, then the general hospitals may certify additional eligible physicians or dentists in a number equal to such general hospital's proportional share of the

total number of physicians or dentists for whom excess coverage or equivalent excess coverage was purchased with funds available in the hospital excess liability pool as of the thirtieth of June, two thousand [~~seventeen~~] **eighteen**, as applied to the difference between the number of eligible physicians or dentists for whom a policy for excess coverage or equivalent excess coverage was purchased for the coverage period ending the thirtieth of June, two thousand [~~seventeen~~] **eighteen** and the number of such eligible physicians or dentists who have applied for excess coverage or equivalent excess coverage for the coverage period beginning the first of July, two thousand [~~seventeen~~] **eighteen**.

§ 7. This act shall take effect immediately.

PART N

Section 1. The opening paragraph of subdivision 1 of section 1 of part C of chapter 57 of the laws of 2006, establishing a cost of living adjustment for designated human services, is amended to read as follows:

Subject to available appropriations, the commissioners of the office of mental health, office of mental retardation and developmental disabilities, office of alcoholism and substance abuse services, [~~department of health,~~] office of children and family services and the state office for the aging shall establish an annual cost of living adjustment (COLA), subject to the approval of the director of the budget, effective April first of each state fiscal year, provided, however, that in state fiscal year 2006-07, the cost of living adjustment will be effective October first, to project for the effects of inflation, for rates of payments, contracts or any other form of reimbursement for the programs listed in paragraphs (i), (ii), (iii), (iv)[~~,~~] **and** (v) [~~and (vi)~~] of subdivision four of this section. The COLA shall be applied to the appropriate portion of reimbursable costs or contract amounts.

§ 2. Paragraph (iv) of subdivision 4 of section 1 of part C of chapter 57 of the laws of 2006, establishing a cost of living adjustment for designated human services, is REPEALED and paragraphs (v) and (vi) are renumbered paragraphs (iv) and (v).

§ 3. This act shall take effect immediately.

PART O

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

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

10. "Evaluator" means a [~~team of two or more professionals approved pursuant to section twenty-five hundred fifty-one of this title~~] **provider approved by the department** to conduct screenings and evaluations.

§ 2. Section 2541 of the public health law is amended by adding three new subdivisions 12-a, 14-a and 15-a to read as follows:

12-a. "Multidisciplinary" means the involvement of two or more separate disciplines or professions, which may mean the involvement of one individual who meets the definition of qualified personnel as defined in subdivision fifteen of this section and who is qualified, in accordance with state licensure, certification or other comparable standards, to evaluate all five developmental domains.

14-a. A "partial evaluation" shall mean an evaluation in a single developmental area for purposes of determining eligibility, and may also mean an examination of the child to determine the need for a modification to the child's individualized family service plan.

15-a. "Screening" means the procedures used by qualified personnel, as defined in subdivision fifteen of this section, to determine whether a child is suspected of having a disability and in need of early intervention services, and shall include, where available and appropriate for the child, the administration of a standardized instrument or instruments approved by the department, in accordance with subdivision three of section twenty-five hundred forty-four of this title.

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

3. [~~The~~] (a) Unless an infant or toddler has already been referred to the early intervention program or the health officer of the public health district in which the infant or toddler resides, as designated by the municipality, the following persons and entities, within two working days of identifying an infant or toddler suspected of having a disability or at risk of having a disability, shall refer such infant or toddler to the early intervention official or the health officer [~~of the public health district in which the infant or toddler resides, as designated by the municipality~~], as applicable, but in no event over the objection of the parent made in accordance with procedures established by the department for use by such primary referral sources[~~, unless the child has already been referred~~]: hospitals, child health care providers, day care programs, local school districts, public health facilities, early childhood direction centers and such other social service and health care agencies and providers as the commissioner shall specify in regulation; provided, however, that the department shall establish procedures, including regulations if required, to ensure that primary referral sources adequately inform the parent or guardian about the early intervention program, including through brochures and written materials created or approved by the department.

(b) The primary referral sources identified in paragraph (a) of this subdivision shall, with parental consent, complete and transmit at the time of referral, a referral form developed by the department which contains information sufficient to document the primary referral source's concern or basis for suspecting the child has a disability or is at risk of having a disability, and where applicable, specifies the child's diagnosed condition that establishes the child's eligibility for the early intervention program. The primary referral source shall inform the parent of a child with a diagnosed condition that has a high probability of resulting in developmental delay, that (i) eligibility for the program may be established by medical or other records and (ii) of the importance of providing consent for the primary referral source to transmit records or reports necessary to support the diagnosis, or, for parents or guardians of children who do not have a diagnosed condition, records or reports that would assist in determining eligibility for the program.

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

§ 2544. Screening and evaluations. 1. Each child thought to be an eligible child is entitled to [~~a multidisciplinary~~] an evaluation conducted in accordance with this section, and the early intervention official shall ensure such evaluation, with parental consent.

2. (a) [~~The~~] Subject to the provisions of this title, the parent may select an evaluator from the list of approved evaluators as described in section twenty-five hundred forty-two of this title to conduct the applicable screening and/or evaluation in accordance with this section. The parent or evaluator shall immediately notify the early intervention official of such selection. The evaluator shall review the information and documentation provided with the referral to determine the appropriate screening or evaluation process to follow in accordance with this section. The evaluator may begin the screening or evaluation no sooner than four working days after such notification, unless otherwise approved by the initial service coordinator.

(b) [~~the evaluator shall designate an individual as the principal contact for the multidisciplinary team~~] Initial service coordinators shall inform the parent of the applicable screening or evaluation procedures that may be performed. For a child referred to the early intervention official who has a diagnosed physical or mental condition that has a high probability of resulting in developmental delay, the initial service coordinator shall inform the parent that the evaluation of the child shall be conducted in accordance with the procedures set forth in subdivision five of this section.

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

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

~~(b)~~] Screenings for children referred to the early intervention program to determine whether they are suspected of having a disability. (a) For a child referred to the early intervention program, the evaluator shall first perform a screening of the child, with parental consent, to determine whether the child is suspected of having a disability.

(b) The evaluator shall utilize a standardized instrument or instruments approved by the department to conduct the screening. If the evaluator does not utilize a standardized instrument or instruments approved by the department for the screening, the evaluator shall document in writing why such standardized instrument or instruments are unavailable or inappropriate for the child.

(c) The evaluator shall explain the results of the screening to the parent and shall fully document the results in writing.

(d) If, based upon the screening, a child is [~~believed to be eligible, or if otherwise elected by the parent~~] suspected of having a disability, the child shall, with [~~the consent of a parent~~] parental consent, receive [~~a multidisciplinary evaluation. All evaluations shall be conducted in accordance with~~] an evaluation to be conducted in accord-

ance with the procedures set forth in subdivision four of this section, the coordinated standards and procedures, and [~~with~~] regulations promulgated by the commissioner.

(e) If, based upon the screening, a child is not suspected of having a disability, an evaluation shall not be provided, unless requested by the parent. The early intervention official shall provide the parent with written notice of the screening results, which shall include information on the parent's right to request an evaluation.

(f) A screening shall not be provided to children who are referred to the early intervention program who have a diagnosed physical or mental condition with a high probability of resulting in developmental delay that establishes eligibility for the program or for children who have previously received an evaluation under the early intervention program.

4. The evaluation of [~~each~~] a child shall:

(a) include the administration of an evaluation instrument or instruments approved by the department. If the evaluator does not utilize an instrument or instruments approved by the department as part of the evaluation of the child, the evaluator shall document in writing why such instrument or instruments are 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) consist of a review of the results of the medical or other records that established the child's eligibility, and any other pertinent evaluations or records available and (ii) comply with the procedures set forth in paragraph (f) of subdivision four of this section. The evaluation procedures set forth in paragraphs (a) through (e) of subdivision four of this section shall not be required or conducted.

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

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

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

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

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

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

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

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

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

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

(b) A parent may appeal a determination that a child is ineligible pursuant to the provisions of section twenty-five hundred forty-nine of this title, provided, however, that a parent may not initiate such appeal until all evaluations are completed**. In addition, for a child referred to the early intervention official who has a diagnosed physical or mental condition that establishes the child's eligibility for the program in accordance with subdivision five of this section, the parent may appeal the denial of a request to have the evaluator conduct the evaluation procedures set forth in paragraphs (a) through (e) of subdivision four of this section, provided, however, that the parent may not initiate the appeal until the evaluation conducted in accordance with subdivision five of this section is completed**.

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

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

§ 3235-a. Payment for early intervention services. (a) No policy of accident and health insurance, including contracts issued pursuant to article forty-three of this chapter, shall exclude coverage for otherwise covered services solely on the basis that the services constitute early intervention program services under title two-A of article twenty-five of the public health law**; provided, however, the insurer, including a health maintenance organization issued a certificate of authority under article forty-four of the public health law and a corporation organized under article forty-three of this chapter shall pay for such services to the extent that the services are a covered benefit under the policy**.

(b) Where a policy of accident and health insurance, including a contract issued pursuant to article forty-three of this chapter, provides coverage for an early intervention program service, such coverage shall not be applied against any maximum annual or lifetime monetary limits set forth in such policy or contract. **Any documentation obtained pursuant to subparagraph (ii) of paragraph (a) of subdivision three of section twenty-five hundred fifty-nine of the public health law and submitted to the insurer shall be considered as part of precertification, preauthorization and/or medical necessity review imposed under**

such policy of accident and health insurance, including a contract issued pursuant to article forty-three of this chapter. Visit limitations and other terms and conditions of the policy will continue to apply to early intervention services. However, any visits used for early intervention program services shall not reduce the number of visits otherwise available under the policy or contract for such services.

(c) Any right of subrogation to benefits which a municipality or provider is entitled in accordance with paragraph (d) of subdivision three of section twenty-five hundred fifty-nine of the public health law shall be valid and enforceable to the extent benefits are available under any accident and health insurance policy. The right of subrogation does not attach to insurance benefits paid or provided under any accident and health insurance policy prior to receipt by the insurer of written notice from the municipality or provider, as applicable. The insurer shall provide [~~the~~] such municipality and service coordinator with information on the extent of benefits available to the covered person under such policy within fifteen days of the insurer's receipt of written request and notice authorizing such release. The service coordinator shall provide such information to the rendering provider assigned to provide services to the child.

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

§ 6. Paragraph (a) of subdivision 3 of section 2559 of the public health law, as amended by section 11 of part A of chapter 56 of the laws of 2012, is amended to read as follows:

(a) Providers of evaluations and early intervention services, hereinafter collectively referred to in this subdivision as "provider" or "providers", shall in the first instance and where applicable, seek payment from all third party payors including governmental agencies prior to claiming payment from a given municipality for evaluations conducted under the program and for services rendered to eligible children, provided that, the obligation to seek payment shall not apply to a payment from a third party payor who is not prohibited from applying such payment, and will apply such payment, to an annual or lifetime limit specified in the insured's policy. If such a claim is denied by a third party payor, the provider shall request an appeal of such denial, in a manner prescribed by the department, in accordance with article forty-nine of this chapter and article forty-nine of the insurance law, and shall receive a determination of such appeal prior to submitting a claim for payment from another third party payor or from the municipality. A provider shall not delay or discontinue services to eligible children pending payment of the claim or pending a determination of any denial for payment that has been appealed.

(i) [~~Parents~~] In a form prescribed by the department, parents shall provide the municipality [~~and~~], service coordinator and provider information on any insurance policy, plan or contract under which an eligible child has coverage.

(ii) [~~Parents~~] In a timeline and format as prescribed by the department, the municipality shall request from the parent, and the parent shall provide the municipality [~~and the service coordinator~~], who shall provide such documentation to the service coordinator and provider,

with: (A) a written order, referral [~~from a primary care provider as documentation, for eligible children, of~~] or recommendation, signed by a physician, physician assistant or nurse practitioner, for the medical necessity of early intervention evaluation services to determine program eligibility for early intervention services;

(B) a copy of an individualized family service plan agreed upon pursuant to section twenty-five hundred forty-five of this title that contains documentation, signed by a physician, physician assistant or nurse practitioner on the medical necessity of early intervention services included in the individualized family service plan;

(C) written consent to contact the child's physician, physician assistant or nurse practitioner for purposes of obtaining a signed written order, referral, or recommendation as documentation for the medical necessity of early intervention evaluation services to determine program eligibility for early intervention services; or

(D) written consent to contact the child's physician, physician assistant or nurse practitioner for purposes of obtaining signed documentation of the medical necessity of early intervention services contained within the individualized family service plan agreed upon pursuant to section twenty-five hundred forty-five of this title.

(iii) [~~providers~~] Providers shall utilize the department's fiscal agent and data system for claiming payment and for requesting appeals of claims denied by third party payors, for evaluations and services rendered under the early intervention program.

§ 7. Paragraph (d) of subdivision 3 of section 2559 of the public health law, as amended by section 11 of part A of chapter 56 of the laws of 2012, is amended to read as follows:

(d) A municipality, or its designee, and a provider shall be subrogated, to the extent of the expenditures by such municipality or for early intervention services furnished to persons eligible for benefits under this title, to any rights such person may have or be entitled to from third party reimbursement. The provider shall submit any documentation obtained pursuant to subparagraph (ii) of paragraph (a) of this subdivision and shall submit notice to the insurer or plan administrator of his or her exercise of such right of subrogation upon the provider's assignment as the early intervention service provider for the child. The right of subrogation does not attach to benefits paid or provided under any health insurance policy or health benefits plan prior to receipt of written notice of the exercise of subrogation rights by the insurer or plan administrator providing such benefits.

§ 8. Subdivision 7 of section 4900 of the public health law, as amended by chapter 558 of the laws of 1999, is amended to read as follows:

7. "Health care provider" means a health care professional or a facility licensed pursuant to articles twenty-eight, thirty-six, forty-four or forty-seven of this chapter [~~or~~], a facility licensed pursuant to article nineteen, twenty-three, thirty-one or thirty-two of the mental hygiene law, qualified personnel pursuant to title two-A of article twenty-five of this chapter or an agency as defined by the department of health in regulations promulgated pursuant to title two-A of article twenty-five of this chapter.

§ 9. Subdivision 1 of section 4904 of the public health law, as added by chapter 705 of the laws of 1996, is amended to read as follows:

1. An enrollee, the enrollee's designee and, in connection with retrospective adverse determinations or adverse determinations for services rendered in accordance title two-A of article twenty-five of this chap-

ter, an enrollee's health care provider, may appeal an adverse determination rendered by a utilization review agent.

§ 10. The opening paragraph of subdivision 2 of section 4910 of the public health law, as amended by chapter 237 of the laws of 2009, is amended to read as follows:

An enrollee, the enrollee's designee and, in connection with concurrent and retrospective adverse determinations or adverse determinations for services rendered in accordance with title two-A of article twenty-five of this chapter, an enrollee's health care provider, shall have the right to request an external appeal when:

§ 11. Paragraph (a) of subdivision 4 of section 4914 of the public health law, as amended by chapter 237 of the laws of 2009, is amended to read as follows:

(a) Except as provided in paragraphs (b) and (c) of this subdivision, payment for an external appeal, including an appeal for services rendered in accordance with title two-A of article twenty-five of this chapter, shall be the responsibility of the health care plan. The health care plan shall make payment to the external appeal agent within forty-five days from the date the appeal determination is received by the health care plan, and the health care plan shall be obligated to pay such amount together with interest thereon calculated at a rate which is the greater of the rate set by the commissioner of taxation and finance for corporate taxes pursuant to paragraph one of subsection (e) of section one thousand ninety-six of the tax law or twelve percent per annum, to be computed from the date the bill was required to be paid, in the event that payment is not made within such forty-five days.

§ 12. Subsection (g) of section 4900 of the insurance law, as amended by chapter 558 of the laws of 1999, is amended to read as follows:

(g) "Health care provider" means a health care professional or a facility licensed pursuant to article twenty-eight, thirty-six, forty-four or forty-seven of the public health law [~~or~~], a facility licensed pursuant to article nineteen, twenty-three, thirty-one or thirty-two of the mental hygiene law, qualified personnel pursuant to title two-A of article twenty-five of the public health law, or an agency as defined by the department of health in regulations promulgated pursuant to title two-A of article twenty-five of the public health law.

§ 13. Subsection (a) of section 4904 of the insurance law, as added by chapter 705 of the laws of 1996, is amended to read as follows:

(a) An insured, the insured's designee and, in connection with retrospective adverse determinations or adverse determinations for services rendered in accordance with title two-A of article twenty-five of the public health law, an insured's health care provider, may appeal an adverse determination rendered by a utilization review agent.

§ 14. The opening paragraph of subsection (b) of section 4910 of the insurance law, as amended by chapter 237 of the laws of 2009, is amended to read as follows:

An insured, the insured's designee and, in connection with concurrent and retrospective adverse determinations or adverse determinations for services rendered in accordance with title two-A of article twenty-five of the public health law, an insured's health care provider, shall have the right to request an external appeal when:

§ 15. Paragraph 1 of subsection (d) of section 4914 of the insurance law, as amended by chapter 237 of the laws of 2009, is amended to read as follows:

(1) Except as provided in paragraphs two and three of this subsection, payment for an external appeal, including an appeal for services

rendered in accordance with title two-A of article twenty-five of the public health law, shall be the responsibility of the health care plan. The health care plan shall make payment to the external appeal agent within forty-five days, from the date the appeal determination is received by the health care plan, and the health care plan shall be obligated to pay such amount together with interest thereon calculated at a rate which is the greater of the rate set by the commissioner of taxation and finance for corporate taxes pursuant to paragraph one of subsection (e) of section one thousand ninety-six of the tax law or twelve percent per annum, to be computed from the date the bill was required to be paid, in the event that payment is not made within such forty-five days.

§ 16. Paragraph 1 of subsection (c) of section 109 of the insurance law, as amended by section 55 of part A of chapter 62 of the laws of 2011, is amended to read as follows:

(1) If the superintendent finds after notice and hearing that any [~~authorized~~] insurer, representative of the insurer, [~~licensed~~] insurance agent, [~~licensed~~] insurance broker, [~~licensed~~] adjuster, or any other person or entity [~~licensed, certified, registered, or authorized pursuant~~] subject to this chapter, has wilfully violated the provisions of this chapter or any regulation promulgated thereunder, then the superintendent may order the person or entity to pay to the people of this state a penalty in a sum not exceeding the greater of: (i) one thousand dollars for each offense; or (ii) where the violation relates to either the failure to pay a claim or making a false statement to the superintendent or the department, the greater of (A) ten thousand dollars for each offense, or (B) a multiple of two times the aggregate damages attributable to the violation, or (C) a multiple of two times the aggregate economic gain attributable to the violation.

§ 17. Upon enactment of the amendments to paragraph (a) of subdivision 3 of section 2559 of the public health law made by section six of this act, providers of early intervention services shall receive a two percent increase in rates of reimbursement for early intervention services provided that for payments made for early intervention services to persons eligible for medical assistance pursuant to title eleven of article five of the social services law, the two percent increase shall be subject to the availability of federal financial participation.

§ 18. This act shall take effect immediately and shall be deemed to have been in full force and effect on or after April 1, 2018; provided that the amendments to section 3235-a of the insurance law made by section five of this act shall apply only to policies and contracts issued, renewed, modified, altered or amended on or after such date.

PART P

Section 1. The opening paragraph of paragraph (b) of subdivision 5-a of section 2807-m of the public health law, as amended by section 6 of part H of chapter 57 of the laws of 2017, is amended to read as follows:

Nine million one hundred twenty thousand dollars annually for the period January first, two thousand nine through December thirty-first, two thousand ten, and two million two hundred eighty thousand dollars for the period January first, two thousand eleven, through March thirty-first, two thousand eleven, nine million one hundred twenty thousand dollars each state fiscal year for the period April first, two thousand eleven through March thirty-first, two thousand fourteen, up to eight million six hundred twelve thousand dollars each state fiscal year for

the period April first, two thousand fourteen through March thirty-first, two thousand seventeen, and up to eight million six hundred twelve thousand dollars each state fiscal year for the period April first, two thousand seventeen through March thirty-first, two thousand [~~twenty~~] **eighteen**, shall be set aside and reserved by the commissioner from the regional pools established pursuant to subdivision two of this section to be allocated regionally with two-thirds of the available funding going to New York city and one-third of the available funding going to the rest of the state and shall be available for distribution as follows:

§ 2. Subparagraph (xiii) of paragraph (a) of subdivision 7 of section 2807-s of the public health law, as amended by section 4 of part H of chapter 57 of the laws of 2017, is amended to read as follows:

(xiii) twenty-three million eight hundred thirty-six thousand dollars each state fiscal year for the period April first, two thousand twelve through March thirty-first, **two thousand eighteen, and fifteen million two hundred twenty-four thousand dollars for each state fiscal year for the period April first, two thousand eighteen through March thirty-first,** two thousand twenty;

§ 3. Subdivision 9 of section 2803 of the public health law is REPEALED.

§ 4. This act shall take effect immediately; provided, however, that the amendments to subparagraph (xiii) of paragraph (a) of subdivision 7 of section 2807-s of the public health law made by section two of this act shall not affect the expiration of such section and shall be deemed to expire therewith.

PART Q

Section 1. The public health law is amended by adding a new section 2825-f to read as follows:

§ 2825-f. Health care facility transformation program: statewide III. 1. A statewide health care facility transformation program is hereby established under the joint administration of the commissioner and the president of the dormitory authority of the state of New York for the purpose of strengthening and protecting continued access to health care services in communities. The program shall provide funding in support of capital projects, debt retirement, working capital or other non-capital projects that facilitate health care transformation activities including, but not limited to, merger, consolidation, acquisition or other activities intended to: (a) create financially sustainable systems of care; (b) preserve or expand essential health care services; (c) modernize obsolete facility physical plants and infrastructure; (d) foster participation in value based payments arrangements including, but not limited to, contracts with managed care plans and accountable care organizations; (e) for residential health care facilities, increase the quality of resident care or experience; or (f) improve health information technology infrastructure, including telehealth, to strengthen the acute, post-acute and long-term care continuum. Grants shall not be available to support general operating expenses. The issuance of any bonds or notes hereunder shall be subject to section sixteen hundred eighty-r of the public authorities law and the approval of the director of the division of the budget, and any projects funded through the issuance of bonds or notes hereunder shall be approved by the New York state public authorities control board, as required under section fifty-one of the public authorities law.

2. The commissioner and the president of the dormitory authority shall enter into an agreement, subject to approval by the director of the budget, and subject to section sixteen hundred eighty-r of the public authorities law, for the purposes of awarding, distributing, and administering the funds made available pursuant to this section. Such funds may be distributed by the commissioner for grants to general hospitals, residential health care facilities, diagnostic and treatment centers and clinics licensed pursuant to this chapter or the mental hygiene law, and community-based health care providers as defined in subdivision three of this section for grants in support of the purposes set forth in this section. A copy of such agreement, and any amendments thereto, shall be provided to the chair of the senate finance committee, the chair of the assembly ways and means committee, and the director of the division of the budget no later than thirty days prior to the release of a request for applications for funding under this program. Projects awarded, in whole or part, under sections twenty-eight hundred twenty-five-a and twenty-eight hundred twenty-five-b of this article shall not be eligible for grants or awards made available under this section.

3. Notwithstanding section one hundred sixty-three of the state finance law or any inconsistent provision of law to the contrary, up to four hundred and twenty-five million dollars of the funds appropriated for this program shall be awarded without a competitive bid or request for proposal process for grants to health care providers (hereafter "applicants"). Provided, however, that a minimum of: (a) sixty million dollars of total awarded funds shall be made to community-based health care providers, which for purposes of this section shall be defined as a diagnostic and treatment center licensed or granted an operating certificate under this article; a mental health clinic licensed or granted an operating certificate under article thirty-one of the mental hygiene law; a substance use disorder treatment clinic licensed or granted an operating certificate under article thirty-two of the mental hygiene law; a primary care provider; a home care provider certified or licensed pursuant to article thirty-six of this chapter; or an assisted living program approved by the department pursuant to subdivision one of section four hundred sixty one-1 of the social services law; and (b) forty-five million dollars of the total awarded funds shall be made to residential health care facilities.

4. Notwithstanding any inconsistent subdivision of this section or any other provision of law to the contrary, the commissioner, with the approval of the director of the budget, may expend up to twenty million dollars of the funds appropriated for this program and designated for community-based health care providers pursuant to subdivision three of this section for awards made pursuant to paragraph (l) of subdivision three of section four hundred sixty-one-l of the social services law.

5. In determining awards for eligible applicants under this section, the commissioner shall consider criteria including, but not limited to:

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

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

(c) the geographic distribution of funds;

(d) the relationship between the proposed project and identified community need;

(e) the extent to which the applicant has access to alternative financing;

(f) the extent to which the proposed project furthers the development of primary care and other outpatient services;

(g) the extent to which the proposed project benefits Medicaid enrollees and uninsured individuals;

(h) the extent to which the applicant has engaged the community affected by the proposed project and the manner in which community engagement has shaped such project; and

(i) the extent to which the proposed project addresses potential risk to patient safety and welfare.

6. Disbursement of awards made pursuant to this section shall be conditioned on the awardee achieving certain process and performance metrics and milestones as determined in the sole discretion of the commissioner. Such metrics and milestones shall be structured to ensure that the goals of the project are achieved, and such metrics and milestones shall be included in grant disbursement agreements or other contractual documents as required by the commissioner.

7. The department shall provide a report on a quarterly basis to the chairs of the senate finance, assembly ways and means, and senate and assembly health committees, until such time as the department determines that the projects that receive funding pursuant to this section are substantially complete. Such reports shall be submitted no later than sixty days after the close of the quarter, and shall 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 six of this section.

§ 2. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2018.

PART R

Section 1. Section 1373 of the public health law is amended by adding two new subdivisions 1-a and 1-b to read as follows:

1-a. Every municipality that administers the New York state uniform fire prevention and building code, and that contains an area designated as high risk by the commissioner pursuant to subdivision one of this section, shall submit to the department aggregate reports summarizing the outcomes of inspections and remediation conducted pursuant to subdivision seven of section three hundred eighty-one of the executive law, in a format to be determined by the commissioner in consultation with the secretary of state.

1-b. The commissioner shall have the authority to monitor each municipality's compliance with subdivision seven of section three hundred eighty-one of the executive law, including authority to perform inspections of residential and non-residential properties and to ensure implementation of lead remediation measures.

§ 2. Section 378 of the executive law is amended by adding a new subdivision 17 to read as follows:

17. For any area designated as high risk by the commissioner of health pursuant to subdivision one of section thirteen hundred seventy-three of the public health law:

a. A presumption that all paint on any residential building on which the original construction was completed prior to January first, nineteen hundred seventy-eight, and the exterior of any nonresidential structure

on which the original construction was completed prior to January first, nineteen hundred seventy-eight, is lead-based.

b. A requirement that the interior and exterior of any residential building on which the original construction was completed prior to January first, nineteen hundred seventy-eight, and the exterior of any nonresidential structure on which the original construction was completed prior to January first, nineteen hundred seventy-eight, be maintained in a condition such that the paint thereon does not become deteriorated paint, unless the deteriorated paint surfaces comprise a minimal surface area.

§ 3. Section 381 of the executive law is amended by adding a new subdivision 7 to read as follows:

7. Notwithstanding any other provision of law, the secretary shall promulgate rules and regulations with respect to areas designated as high risk by the commissioner of health pursuant to subdivision one of section thirteen hundred seventy-three of the public health law:

a. Requiring that local code enforcement officers conduct inspections of residential rental property periodically and at specified times including, but not limited to, as part of an application for a certificate of occupancy, a renewal of a certificate of occupancy, or based upon the filing of a complaint. Such inspections shall include at a minimum a visual assessment for deteriorated paint and bare soil present within the dripline of the building.

b. Establishing remedies for violations of uniform code provisions adopted pursuant to subdivision seventeen of section three hundred seventy-eight of this article, which shall include as appropriate:

(i) Certification by a lead-based paint inspector or risk assessor that the property has been determined through a lead-based paint inspection conducted in accordance with appropriate federal regulations not to contain lead-based paint.

(ii) Certification by a lead-based paint inspector or risk assessor that all cited violations have been abated, or interim controls implemented, and clearance has been achieved in accordance with the uniform code.

(iii) Where exterior deteriorated paint violations, including deteriorated paint violations on an open porch, and/or bare soil violations are cited, or where interior deteriorated paint violations are cited in a common area, clearance may be established through a visual assessment by a local code enforcement officer after reduction measures have been implemented.

c. Establishing standards for a clearance examination and report.

§ 4. Paragraphs b and c of subdivision 1 of section 223-b of the real property law, as amended by chapter 584 of the laws of 1991, is amended to read as follows:

b. Actions taken in good faith, by or in behalf of the tenant, to secure or enforce any rights under the lease or rental agreement, under section two hundred thirty-five-b of this chapter, or under any other law of the state of New York, or of its governmental subdivisions, or of the United States which has as its objective the regulation of premises used for dwelling purposes or which pertains to the offense of rent gouging in the third, second or first degree; [~~or~~]

c. The tenant's participation in the activities of a tenant's organization; or

d. The tenant's reporting of a suspected lead-based paint hazard to the owner or to any state or local agency.

§ 5. This act shall take effect on the one hundred eightieth day after it shall have become a law.

PART S

Section 1. This Part enacts into law major components of legislation which are necessary to effectuate recommendations made as part of the Regulatory Modernization Initiative undertaken by the Department of Health. Each component is wholly contained within a Subpart identified as Subparts A through C. The effective date for each particular provision contained within such Subpart is set forth in the last section of such Subpart. Any provision in any section contained within a Subpart, including the effective date of the Subpart, which makes a reference to a section "of this act," when used in connection with that particular component, shall be deemed to mean and refer to the corresponding section of the Subpart in which it is found. Section three of this Part sets forth the general effective date of this Part.

SUBPART A

Section 1. The public health law is amended by adding a new section 2805-z to read as follows:

§ 2805-z. Community paramedicine collaboratives. 1. For purposes of this section:

(a) A "community paramedicine collaborative" shall mean an initiative comprised of the participants set forth in subdivision two of this section and organized to carry out a community paramedicine program as defined in paragraph (b) of this subdivision.

(b) A "community paramedicine program" shall mean a program carried out by a community paramedicine collaborative for the purpose of achieving objectives identified by the collaborative, pursuant to which individuals who are certified under regulations issued pursuant to section three thousand two of this chapter shall perform community paramedicine services in residential settings other than the initial emergency medical care and transportation of sick and injured persons, provided that such individuals are:

(i) certified pursuant to article thirty of this chapter;

(ii) employees or volunteers of an emergency medical services provider that participates in the collaborative;

(iii) providing services that are within their education or training; and

(iv) working under medical control as defined by subdivision fifteen of section three thousand one of this title.

(c) "Community paramedicine services" shall mean services provided in residential settings by individuals who are certified under regulations issued pursuant to section three thousand two of this chapter and employees or volunteers of an emergency medical services provider, other than the initial emergency medical care and transportation of sick and injured persons.

(d) An "emergency medical services provider" shall mean an ambulance service or an advanced life support first response service that is certified under article thirty of this chapter to provide ambulance or advanced life support first response services and staffed by individuals who are certified under regulations issued pursuant to section three thousand two of this chapter to provide basic or advanced life support.

2. (a) At a minimum, a community paramedicine collaborative shall include the participation of at least one hospital licensed under this article, at least one physician who may but need not be employed or otherwise affiliated with a hospital participating in such collaborative, at least one emergency medical services provider and, if the community paramedicine services are to be provided in a private residence, at least one home care services agency licensed or certified under article thirty-six of this chapter.

(b) Where the collaborative's objectives include a focus on serving individuals with behavioral health conditions and/or individuals with developmental disabilities, the collaborative shall include the participation of providers operated, licensed, or certified by the office of mental health, the office of alcoholism and substance abuse services, and/or the office for people with developmental disabilities, as appropriate.

(c) Such collaborative may also include additional participants such as payors and local health departments.

3. A community paramedicine collaborative may establish a community paramedicine program to provide community paramedicine services to individuals living in residential settings for the purpose of achieving objectives identified by the collaborative such as: preventing emergencies, avoidable emergency room visits, avoidable medical transport, and potentially avoidable hospital admissions and readmissions; improving outcomes following discharge from a general hospital or other inpatient admission; and/or promoting self-management of health or behavioral health care conditions.

4. A community paramedicine collaborative shall be required to provide or arrange for appropriate orientation and training for staff participating in the community paramedicine program. In all cases, such orientation and training shall address the assessment of the needs of individuals with behavioral health conditions and individuals with developmental disabilities.

5. An emergency medical services provider participating in a community paramedicine collaborative shall: (a) ensure that the provision of community paramedicine services occurs within the provider's primary operating territory pursuant to article thirty of this chapter; and (b) make reasonable efforts to ensure that it has sufficiently staffed the provision of initial emergency medical care and transportation of sick and injured persons before making staff available to provide community paramedicine services.

6. (a) No community paramedicine collaborative shall begin providing services under a community paramedicine program until it has notified the department of the initiation of such collaborative by:

(i) identifying the participants of the collaborative and the individual who will serve as the point of contact;

(ii) describing the goals of the collaborative in carrying out a community paramedicine program;

(iii) describing the population to be served by the community paramedicine program and the geographic area in which the program will focus;

(iv) identifying the services to be offered under the community paramedicine program and the collaborative participants that will provide such services;

(v) describing the collaborative's plan to assure, to the extent possible, that care provided under the community paramedicine program is coordinated with other providers of the individuals served;

(vi) describing the quality assurance and improvement procedures that will be used by the collaborative in carrying out the community paramedicine program; and

(vii) identifying the date of the anticipated start of activities.

(b) A community paramedicine collaborative shall:

(i) promptly update the department as to any changes in the information required under paragraph (a) of this subdivision; and

(ii) provide information to the department about the collaborative's activities and outcomes at a frequency and in a manner determined by the department, which at a minimum shall include an annual report.

7. Nothing in this section shall be deemed to prohibit the performance of any tasks or responsibilities by any person licensed or certified under this chapter or under title VIII of the education law or by any entity licensed or certified under this article or under the mental hygiene law, provided such tasks or responsibilities are permitted pursuant to such statutory provisions.

§ 2. Subdivision 15 of section 3001 of the public health law, as amended by chapter 445 of the laws of 1993, is amended to read as follows:

15. "Medical control" means: (a) advice and direction provided by a physician or under the direction of a physician to certified first responders, emergency medical technicians or advanced emergency medical technicians who are providing medical care at the scene of an emergency or en route to a health care facility; [~~and~~] (b) indirect medical control including the written policies, procedures, and protocols for prehospital emergency medical care and transportation developed by the state emergency medical advisory committee, approved by the state emergency medical services council and the commissioner, and implemented by regional medical advisory committees; and (c) in a community paramedicine program established by a community paramedicine collaborative pursuant to section twenty-eight hundred five-z of this chapter, advice and direction provided and policies, procedures, and protocols issued by a physician within the collaborative who is responsible for the overall clinical supervision of the community paramedicine program.

§ 3. The public health law is amended by adding a new section 3001-a to read as follows:

§ 3001-a. Community paramedicine services. Notwithstanding any inconsistent provision of this article, an individual who is certified under regulations issued pursuant to section three thousand two of this article to provide basic or advanced life support may, in the course of his or her work as an employee or volunteer of an ambulance service or an advanced life support first response service certified under this article, also participate as an employee or volunteer of such service in a community paramedicine program established by a community paramedicine collaborative pursuant to section twenty-eight hundred five-z of this chapter.

§ 4. Subdivision 2 of section 365-a of the social services law is amended by adding a new paragraph (ff) to read as follows:

(ff) subject to the availability of federal financial participation, community paramedicine services provided in accordance with the requirements of section twenty-eight hundred five-z of the public health law.

§ 5. This act shall take effect immediately.

SUBPART B

Section 1. Subdivision 1 of section 2801 of the public health law, as amended by chapter 397 of the laws of 2016, is amended to read as follows:

1. "Hospital" means a facility or institution engaged principally in providing services by or under the supervision of a physician or, in the case of a dental clinic or dental dispensary, of a dentist, or, in the case of a midwifery birth center, of a midwife, for the prevention, diagnosis or treatment of human disease, pain, injury, deformity or physical condition, including, but not limited to, a general hospital, public health center, diagnostic center, treatment center, dental clinic, dental dispensary, rehabilitation center other than a facility used solely for vocational rehabilitation, nursing home, tuberculosis hospital, chronic disease hospital, maternity hospital, midwifery birth center, lying-in-asylum, out-patient department, out-patient lodge, dispensary and a laboratory or central service facility serving one or more such institutions, but the term hospital shall not include an institution, sanitarium or other facility engaged principally in providing services for the prevention, diagnosis or treatment of mental disability and which is subject to the powers of visitation, examination, inspection and investigation of the department of mental hygiene except for those distinct parts of such a facility which provide hospital service. The provisions of this article shall not apply to a facility or institution engaged principally in providing services by or under the supervision of the bona fide members and adherents of a recognized religious organization whose teachings include reliance on spiritual means through prayer alone for healing in the practice of the religion of such organization and where services are provided in accordance with those teachings. **No provision of this article or any other provision of law shall be construed to: (a) limit the volume of mental health or substance use disorder services that can be provided by a provider of primary care services licensed under this article and authorized to provide integrated services in accordance with regulations issued by the commissioner in consultation with the commissioner of the office of mental health and the commissioner of the office of alcoholism and substance abuse services, including regulations issued pursuant to subdivision seven of section three hundred sixty-five-l of the social services law or part L of chapter fifty-six of the laws of two thousand twelve; (b) require a provider licensed pursuant to article thirty-one of the mental hygiene law or certified pursuant to article thirty-two of the mental hygiene law to obtain an operating certificate from the department if such provider has been authorized to provide integrated services in accordance with regulations issued by the commissioner in consultation with the commissioner of the office of mental health and the commissioner of the office of alcoholism and substance abuse services, including regulations issued pursuant to subdivision seven of section three hundred sixty-five-l of the social services law or part L of chapter fifty-six of the laws of two thousand twelve.**

§ 2. Section 31.02 of the mental hygiene law is amended by adding a new subdivision (f) to read as follows:

(f) No provision of this article or any other provision of law shall be construed to require a provider licensed pursuant to article twenty-eight of the public health law or certified pursuant to article thirty-two of this chapter to obtain an operating certificate from the office of mental health if such provider has been authorized to provide integrated services in accordance with regulations issued by the commissioner of the office of mental health in consultation with the commissioner

of the department of health and the commissioner of the office of alcoholism and substance abuse services, including regulations issued pursuant to subdivision seven of section three hundred sixty-five-l of the social services law or part L of chapter fifty-six of the laws of two thousand twelve.

§ 3. Subdivision (b) of section 32.05 of the mental hygiene law, as amended by chapter 204 of the laws of 2007, is amended to read as follows:

(b) (i) Methadone, or such other controlled substance designated by the commissioner of health as appropriate for such use, may be administered to an addict, as defined in section thirty-three hundred two of the public health law, by individual physicians, groups of physicians and public or private medical facilities certified pursuant to article twenty-eight or thirty-three of the public health law as part of a chemical dependence program which has been issued an operating certificate by the commissioner pursuant to subdivision (b) of section 32.09 of this article, provided, however, that such administration must be done in accordance with all applicable federal and state laws and regulations. Individual physicians or groups of physicians who have obtained authorization from the federal government to administer buprenorphine to addicts may do so without obtaining an operating certificate from the commissioner. (ii) No provision of this article or any other provision of law shall be construed to require a provider licensed pursuant to article twenty-eight of the public health law or article thirty-one of this chapter to obtain an operating certificate from the office of alcoholism and substance abuse services if such provider has been authorized to provide integrated services in accordance with regulations issued by the commissioner of alcoholism and substance abuse services in consultation with the commissioner of the department of health and the commissioner of the office of mental health, including regulations issued pursuant to subdivision seven of section three hundred sixty-five-l of the social services law or part L of chapter fifty-six of the laws of two thousand twelve.

§ 4. This act shall take effect on the one hundred eightieth day after it shall have become a law; provided, however, that the commissioner of the department of health, the commissioner of the office of mental health, and the commissioner of the office of alcoholism and substance abuse services are authorized to issue any rule or regulation necessary for the implementation of this act on or before its effective date.

SUBPART C

Section 1. Paragraphs (s) and (t) of subdivision 2 of section 2999-cc of the public health law, as amended by chapter 454 of the laws of 2015, are amended and a new paragraph (u) is added to read as follows:

(s) a hospice as defined in article forty of this chapter; [~~and~~]

(t) credentialed alcoholism and substance abuse counselors credentialed by the office of alcoholism and substance abuse services or by a credentialing entity approved by such office pursuant to section 19.07 of the mental hygiene law;

(u) providers authorized to provide services and service coordination under the early intervention program pursuant to article twenty-five of this chapter; and

(v) any other provider as determined by the commissioner pursuant to regulation or, in consultation with the commissioner, by the commissioner of the office of mental health, the commissioner of the office of

alcoholism and substance abuse services, or the commissioner of the office for people with developmental disabilities pursuant to regulation.

§ 2. Subdivision 3 of section 2999-cc of the public health law, as separately amended by chapters 238 and 285 of the laws of 2017, is amended to read as follows:

3. "Originating site" means a site at which a patient is located at the time health care services are delivered to him or her by means of telehealth. Originating sites shall be limited to **(a)** facilities licensed under articles twenty-eight and forty of this chapter[~~,~~]**; (b)** facilities as defined in subdivision six of section 1.03 of the mental hygiene law[~~,~~]**; (c)** private physician's or dentist's offices located within the state of New York[~~,~~]**; (d)** any type of adult care facility licensed under title two of article seven of the social services law[~~,~~]; **(e)** public, private and charter elementary and secondary schools, school age child care programs, and child day care centers within the state of New York; and[~~, when a patient is receiving health care services by means of remote patient monitoring,~~] **(f)** the patient's place of residence located within the state of New York or other temporary location located within or outside the state of New York**; subject to regulation issued by the commissioner of the office of mental health, the commissioner of the office of alcoholism and substance abuse services, and the commissioner of the office for people with developmental disabilities**.

§ 3. Subdivision 7 of section 2999-cc of the public health law, as added by chapter 6 of the laws of 2015, is amended to read as follows:

7. "Remote patient monitoring" means the use of synchronous or asynchronous electronic information and communication technologies to collect personal health information and medical data from a patient at an originating site that is transmitted to a telehealth provider at a distant site for use in the treatment and management of medical conditions that require frequent monitoring. **Such technologies may include additional interaction triggered by previous transmissions, such as interactive queries conducted through communication technologies or by telephone.** Such conditions shall include, but not be limited to, congestive heart failure, diabetes, chronic obstructive pulmonary disease, wound care, polypharmacy, mental or behavioral problems, and technology-dependent care such as continuous oxygen, ventilator care, total parenteral nutrition or enteral feeding. Remote patient monitoring shall be ordered by a physician licensed pursuant to article one hundred thirty-one of the education law, a nurse practitioner licensed pursuant to article one hundred thirty-nine of the education law, or a midwife licensed pursuant to article one hundred forty of the education law, with which the patient has a substantial and ongoing relationship.

§ 4. This act shall take effect on the ninetieth day after it shall have become a law; provided, however, that the commissioner of the department of health, the commissioner of the office of mental health, the commissioner of the office of alcoholism and substance abuse services, and the commissioner of the office for people with developmental disabilities are authorized to issue any rule or regulation necessary for the implementation of this act on or before its effective date.

§ 2. Severability clause. If any clause, sentence, paragraph, subdivision, section or subpart of this act shall be adjudged by any court of competent jurisdiction to be invalid, such judgment shall not affect, impair, or invalidate the remainder thereof, but shall be confined in its operation to the clause, sentence, paragraph, subdivision, section

or subpart thereof directly involved in the controversy in which such judgment shall have been rendered. It is hereby declared to be the intent of the legislature that this act would have been enacted even if such invalid provisions had not been included herein.

§ 3. This act shall take effect immediately; provided, however, that the applicable effective date of Subparts A through C of this act shall be as specifically set forth in the last section of such Subparts.

PART T

Section 1. Subdivision (a) of section 31 of part B of chapter 59 of the laws of 2016, amending the social services law relating to authorizing the commissioner of health to apply federally established consumer price index penalties for generic drugs, and authorizing the commissioner of health to impose penalties on managed care plans for reporting late or incorrect encounter data, is amended to read as follows:

(a) section eleven of this act shall expire and be deemed repealed March 31, [~~2018~~] 2023;

§ 2. Subdivision 6-a of section 93 of part C of chapter 58 of the laws of 2007, amending the social services law and other laws relating to adjustments of rates, as amended by section 20 of part B of chapter 56 of the laws of 2013, is amended to read as follows:

6-a. section fifty-seven of this act shall expire and be deemed repealed on [~~December 31, 2018~~] March 31, 2023; provided that the amendments made by such section to subdivision 4 of section 366-c of the social services law shall apply with respect to determining initial and continuing eligibility for medical assistance, including the continued eligibility of recipients originally determined eligible prior to the effective date of this act, and provided further that such amendments shall not apply to any person or group of persons if it is subsequently determined by the Centers for Medicare and Medicaid services or by a court of competent jurisdiction that medical assistance with federal financial participation is available for the costs of services provided to such person or persons under the provisions of subdivision 4 of section 366-c of the social services law in effect immediately prior to the effective date of this act.

§ 3. Section 2 of part II of chapter 54 of the laws of 2016, amending part C of chapter 58 of the laws of 2005 authorizing reimbursements for expenditures made by or on behalf of social services districts for medical assistance for needy persons and administration thereof, is amended to read as follows:

§ 2. This act shall take effect immediately and shall expire and be deemed repealed [~~two years after it shall have become a law~~] March 31, 2023.

§ 4. Section 3 of chapter 906 of the laws of 1984, amending the social services law relating to expanding medical assistance eligibility and the scope of services available to certain persons with disabilities, as amended by section 25-a of part B of chapter 56 of the laws of 2013, is amended to read as follows:

§ 3. This act shall take effect on the thirtieth day after it shall have become a law and shall be of no further force and effect after [~~December 31, 2018~~] March 31, 2023, at which time the provisions of this act shall be deemed to be repealed.

§ 5. Section 4-a of part A of chapter 56 of the laws of 2013, amending chapter 59 of the laws of 2011 amending the public health law and other laws relating to general hospital reimbursement for annual rates relat-

ing to the cap on local Medicaid expenditures, as amended by section 9 of part I of chapter 57 of the laws of 2017, is amended to read as follows:

§ 4-a. Notwithstanding paragraph (c) of subdivision 10 of section 2807-c of the public health law, section 21 of chapter 1 of the laws of 1999, or any other contrary provision of law, in determining rates of payments by state governmental agencies effective for services provided on and after January 1, [~~2018~~] 2017 through March 31, 2019, for inpatient and outpatient services provided by general hospitals, for inpatient services and adult day health care outpatient services provided by residential health care facilities pursuant to article 28 of the public health law, except for residential health care facilities or units of such facilities providing services primarily to children under twenty-one years of age, for home health care services provided pursuant to article 36 of the public health law by certified home health agencies, long term home health care programs and AIDS home care programs, and for personal care services provided pursuant to section 365-a of the social services law, the commissioner of health shall apply no greater than zero trend factors attributable to the 2017, 2018, and 2019 calendar [~~year~~] years in accordance with paragraph (c) of subdivision 10 of section 2807-c of the public health law, provided, however, that such no greater than zero trend factors attributable to such 2017, 2018, and 2019 calendar [~~year~~] years shall also be applied to rates of payment provided on and after January 1, [~~2018~~] 2017 through March 31, 2019 for personal care services provided in those local social services districts, including New York city, whose rates of payment for such services are established by such local social services districts pursuant to a rate-setting exemption issued by the commissioner of health to such local social services districts in accordance with applicable regulations[~~.~~]; and provided further, however, that for rates of payment for assisted living program services provided on and after January 1, [~~2018~~] 2017 through March 31, 2019, such trend factors attributable to the 2017, 2018, and 2019 calendar [~~year~~] years shall be established at no greater than zero percent.

§ 6. This act shall take effect immediately.

PART U

Section 1. Section 2 of part NN of chapter 58 of the laws of 2015, amending the mental hygiene law relating to clarifying the authority of the commissioners in the department of mental hygiene to design and implement time-limited demonstration programs, is amended to read as follows:

§ 2. This act shall take effect immediately and shall expire and be deemed repealed March 31, [~~2018~~] 2021.

§ 2. This act shall take effect immediately.

PART V

Section 1. Section 7 of part R2 of chapter 62 of the laws of 2003, amending the mental hygiene law and the state finance law relating to the community mental health support and workforce reinvestment program, the membership of subcommittees for mental health of community services boards and the duties of such subcommittees and creating the community mental health and workforce reinvestment account, as amended by section

3 of part G of chapter 60 of the laws of 2014, is amended to read as follows:

§ 7. This act shall take effect immediately and shall expire March 31, [~~2018~~] **2021** when upon such date the provisions of this act shall be deemed repealed.

§ 2. This act shall take effect immediately.

PART W

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 of mental health, director of community services and the sheriff for the respective locality, 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 of mental health and the commissioner 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. In a city with a population of more than one million, any such unit shall be limited to twenty-five beds. The commissioner of mental health shall promulgate regulations for demonstration programs to implement restoration to competency within a correctional facility or local correctional facility. Subject to annual appropriation, the commissioner of mental health may, at such commissioner's discretion, make funds available for state aid grants to any county that develops and operates a mental health unit within a local correctional facility pursuant to this section. 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**.

§ 2. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2018; provided, however, this act shall expire and be deemed repealed March 31, 2023.

PART X

Section 1. Section 3 of part A of chapter 111 of the laws of 2010 amending the mental hygiene law relating to the receipt of federal and state benefits received by individuals receiving care in facilities operated by an office of the department of mental hygiene, as amended by

section 1 of part LL of chapter 58 of the laws of 2015, is amended to read as follows:

§ 3. This act shall take effect immediately; and shall expire and be deemed repealed June 30, [~~2018~~] 2021.

§ 2. This act shall take effect immediately.

PART Y

Section 1. Subdivision 10 of section 7605 of the education law, as added by section 4 of part AA of chapter 57 of the laws of 2013, is amended and a new subdivision 12 is added to read as follows:

10. (a) A person without a license from: performing assessments such as basic information collection, gathering of demographic data, and informal observations, screening and referral used for general eligibility for a program or service and determining the functional status of an individual for the purpose of determining need for services [~~unrelated to a behavioral health diagnosis or treatment plan. Such licensure shall not be required to create, develop or implement a service plan unrelated to a behavioral health diagnosis or treatment plan~~]; counseling individuals regarding the appropriateness of benefits they are eligible for; providing general counseling that is not psychotherapy and assisting individuals or groups with difficult day to day problems such as finding employment, locating sources of assistance, and organizing community groups to work on a specific problem; providing peer services; or to select for suitability and provide substance abuse treatment services or group re-entry services to incarcerated individuals in state correctional facilities.

(b) A person without a license from creating, developing or implementing a service plan or recovery plan that is not a behavioral health diagnosis or treatment plan. Such service or recovery plans shall include, but are not limited to, coordinating, evaluating or determining the need for, or the provision of the following services: job training and employability[~~,~~]; housing[~~,~~]; homeless services and shelters for homeless individuals and families; refugee services; residential, day or community habilitation services; general public assistance[~~,~~]; in home services and supports or home-delivered meals[~~, investigations conducted or assessments made by~~]; recovery supports; adult or child protective services including investigations; detention as defined in section five hundred two of the executive law; prevention and residential services for victims of domestic violence; services for runaway and homeless youth; foster care, adoption, preventive services or services in accordance with an approved plan pursuant to section four hundred four of the social services law, including, adoption and foster home studies and assessments, family service plans, transition plans [~~and~~], permanency planning activities, and case planning or case management as such terms are defined in part four hundred twenty-eight of title eighteen of the New York codes, rules and regulations; residential rehabilitation; home and community based services; and de-escalation techniques, peer services or skill development. [~~A license under this article shall not be required for persons to participate~~]

(c)(i) A person without a license from participating as a member of a multi-disciplinary team to develop or implement a [~~behavioral health services or~~] treatment plan; provided [~~however,~~] that such team shall include one or more professionals licensed under this article or articles one hundred thirty-one, one hundred thirty-nine, one hundred fifty-four or one hundred sixty-three of this chapter who must directly

observe each patient either in person or by electronic means, prior to the rendering of a diagnosis; and provided, further, that the activities performed by members of the team shall be consistent with the scope of practice for each team member licensed or authorized under title VIII of this chapter, and those who are not so authorized may not independently engage in the following restricted practices, but may assist licensed professionals or multi-disciplinary team members with: the diagnosis of mental, emotional, behavioral, addictive and developmental disorders and disabilities; patient assessment and evaluating; the provision of psychotherapeutic treatment; the provision of treatment other than psychotherapeutic treatment; [~~and/or~~] or the development and implementation of assessment-based treatment plans as defined in section seventy-seven hundred one of this [~~chapter~~] title.

(ii) As used in this subdivision, a treatment plan shall be limited to plans for treatment within the following settings: facilities or programs operating pursuant to article nineteen-G of the executive law or pursuant to articles seven, sixteen, thirty-one and thirty-two of the mental hygiene law.

(iii) As used in this subdivision, the term "assist" shall include the provision of services within the practice of psychology, under the supervision of a person licensed under this article.

(d) Provided, further, that nothing in this subdivision shall be construed as requiring a license for any particular activity or function based solely on the fact that the activity or function is not listed in this subdivision.

12. Notwithstanding any other provision of law to the contrary, nothing in this article shall be construed to prohibit or limit the activities or services provided by any person who is employed or who commences employment in 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 section 41.03 of the mental hygiene law or a social services district as defined in section sixty-one of the social services law on or before July first, two thousand twenty. Provided, however, that any person who commences employment in such program or service after July first, two thousand twenty and performs services that are restricted under this article shall be appropriately licensed or authorized under this article.

§ 2. Paragraph (f) of subdivision 1 of section 7702 of the education law, as amended by chapter 230 of the laws of 2004, is amended and a new paragraph (m) is added to read as follows:

(f) [~~Assist~~] General counseling that is not psychotherapy, and assisting individuals or groups with difficult day to day problems such as finding employment, locating sources of assistance, and organizing community groups to work on a specific problem.

(m) Provide peer services.

§ 3. Subdivision 7 of section 7706 of the education law, as added by section 5 of part AA of chapter 57 of the laws of 2013, is amended and a new subdivision 8 is added to read as follows:

7. (a) Prevent a person without a license from: performing assessments such as basic information collection, gathering of demographic data, and informal observations, screening and referral used for general eligibility for a program or service and determining the functional status of an individual for the purpose of determining need for services [~~unrelated~~

~~to a behavioral health diagnosis or treatment plan. Such licensure shall not be required to create, develop or implement a service plan unrelated to a behavioral health diagnosis or treatment plan~~]; counseling individuals regarding the appropriateness of benefits they are eligible for; providing general counseling that is not psychotherapy and assisting individuals or groups with difficult day to day problems such as finding employment, locating sources of assistance, and organizing community groups to work on a specific problem; providing peer services; or to select for suitability and provide substance abuse treatment services or group re-entry services to incarcerated individuals in state correctional facilities.

(b) Prevent a person without a license from creating, developing or implementing a service plan or recovery plan that is not a behavioral health diagnosis or treatment plan. Such service or recovery plans shall include, but are not limited to, coordinating, evaluating or determining the need for, or the provision of the following services: job training and employability[~~,~~]; housing[~~,~~]; homeless services and shelters for homeless individuals and families; refugee services; residential, day or community habilitation services; general public assistance[~~,~~]; in home services and supports or home-delivered meals[~~, investigations conducted or assessments made by~~]; recovery supports; adult or child protective services including investigations; detention as defined in section five hundred two of the executive law; prevention and residential services for victims of domestic violence; services for runaway and homeless youth; foster care, adoption, preventive services or services in accordance with an approved plan pursuant to section four hundred four of the social services law, including, adoption and foster home studies and assessments, family service plans, transition plans [~~and~~], permanency planning activities, and case planning or case management as such terms are defined in part four hundred twenty-eight of title eighteen of the New York codes, rules and regulations; residential rehabilitation; home and community based services; and de-escalation techniques, peer services or skill development. [~~A license under this article shall not be required for persons to participate~~]

(c)(i) Prevent a person without a license from participating as a member of a multi-disciplinary team to develop or implement a [~~behavioral health services or~~] treatment plan; provided [~~however,~~] that such team shall include one or more professionals licensed under this article or articles one hundred thirty-one, one hundred thirty-nine, one hundred fifty-three or one hundred sixty-three of this chapter who must directly observe each patient either in person or by electronic means, prior to the rendering of a diagnosis; and provided, further, that the activities performed by members of the team shall be consistent with the scope of practice for each team member licensed or authorized under title VIII of this chapter, and those who are not so authorized may not independently engage in the following restricted practices, but may assist licensed professionals or multi-disciplinary team members with: the diagnosis of mental, emotional, behavioral, addictive and developmental disorders and disabilities; patient assessment and evaluating; the provision of psychotherapeutic treatment; the provision of treatment other than psychotherapeutic treatment; [~~and/or~~] or the development and implementation of assessment-based treatment plans as defined in section seventy-seven hundred one of this article.

(ii) As used in this subdivision, a treatment plan shall be limited to plans for treatment within the following settings: facilities or programs operating pursuant to article nineteen-G of the executive law

or pursuant to articles seven, sixteen, thirty-one and thirty-two of the mental hygiene law.

(iii) As used in this subdivision, the term "assist" shall include the provision of services within the practice of master social work or clinical social work, under the supervision of a person licensed under this article.

(d) Provided, further, that nothing in this subdivision shall be construed as requiring a license for any particular activity or function based solely on the fact that the activity or function is not listed in this subdivision.

8. Notwithstanding any other provision of law to the contrary, nothing in this article shall be construed to prohibit or limit the activities or services provided by any person who is employed or who commences employment in 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 section 41.03 of the mental hygiene law or a social services district as defined in section sixty-one of the social services law on or before July first, two thousand twenty. Provided however, that any person who commences employment in such program or service after July first, two thousand twenty and performs services that are restricted under this article shall be appropriately licensed or authorized under this article.

§ 4. Subdivision 8 of section 8410 of the education law, as added by section 6 of part AA of chapter 57 of the laws of 2013, is amended and a new subdivision 9 is added to read as follows:

8. (a) Prevent a person without a license from: performing assessments such as basic information collection, gathering of demographic data, and informal observations, screening and referral used for general eligibility for a program or service and determining the functional status of an individual for the purpose of determining need for services [~~unrelated to a behavioral health diagnosis or treatment plan. Such licensure shall not be required to create, develop or implement a service plan unrelated to a behavioral health diagnosis or treatment plan~~]; counseling individuals regarding the appropriateness of benefits they are eligible for; providing general counseling that is not psychotherapy and assisting individuals or groups with difficult day to day problems such as finding employment, locating sources of assistance, and organizing community groups to work on a specific problem; providing peer services; or to select for suitability and provide substance abuse treatment services or group re-entry services to incarcerated individuals in state correctional facilities.

(b) Prevent a person without a license from creating, developing or implementing a service plan or recovery plan that is not a behavioral health diagnosis or treatment plan. Such service or recovery plans shall include, but are not limited to, coordinating, evaluating or determining the need for, or the provision of the following services: job training and employability[~~,~~]; housing[~~,~~]; homeless services and shelters for homeless individuals and families; refugee services; residential, day or community habilitation services; general public assistance[~~,~~]; in home services and supports or home-delivered meals[~~, investigations conducted or assessments made by~~]; recovery supports; adult or child protective services including investigations; detention as defined in section five hundred two of the executive law; prevention and residential services

for victims of domestic violence; services for runaway and homeless youth; foster care, adoption, preventive services or services in accordance with an approved plan pursuant to section four hundred four of the social services law, including, adoption and foster home studies and assessments, family service plans, transition plans [~~and~~], permanency planning activities, and case planning or case management as such terms are defined in part four hundred twenty-eight of title eighteen of the New York codes, rules and regulations; residential rehabilitation; home and community based services; and de-escalation techniques, peer services or skill development. [~~A license under this article shall not be required for persons to participate~~]

(c)(i) Prevent a person without a license from participating as a member of a multi-disciplinary team to develop or implement a [~~behavioral health services or~~] treatment plan; provided [~~however,~~] that such team shall include one or more professionals licensed under this article or articles one hundred thirty-one, one hundred thirty-nine, one hundred fifty-three or one hundred fifty-four of this chapter who must directly observe each patient either in person or by electronic means, prior to the rendering of a diagnosis; and provided, further, that the activities performed by members of the team shall be consistent with the scope of practice for each team member licensed or authorized under title VIII of this chapter, and those who are not so authorized may not independently engage in the following restricted practices, but may assist licensed professionals or multidisciplinary team members with: the diagnosis of mental, emotional, behavioral, addictive and developmental disorders and disabilities; patient assessment and evaluating; the provision of psychotherapeutic treatment; the provision of treatment other than psychotherapeutic treatment; [~~and/or~~] or the development and implementation of assessment-based treatment plans as defined in section seventy-seven hundred one of this chapter.

(ii) As used in this subdivision, a treatment plan shall be limited to plans for treatment within the following settings: facilities or programs operating pursuant to article nineteen-G of the executive law or pursuant to articles seven, sixteen, thirty-one and thirty-two of the mental hygiene law.

(iii) As used in this subdivision, the term "assist" shall include the provision of services within the practice of mental health counseling, marriage and family therapy, creative arts therapy or psychoanalysis, under the supervision of a person licensed under this article.

(d) Provided, further, that nothing in this subdivision shall be construed as requiring a license for any particular activity or function based solely on the fact that the activity or function is not listed in this subdivision.

9. Notwithstanding any other provision of law to the contrary, nothing in this article shall be construed to prohibit or limit the activities or services provided by any person who is employed or who commences employment in 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 section 41.03 of the mental hygiene law or a social services district as defined in section sixty-one of the social services law on or before July first, two thousand twenty. Provided however, that any person who commences employment in such program or service after July first, two thousand twenty and

performs services that are restricted under this article shall be appropriately licensed or authorized under this article.

§ 5. Not later than July 1, 2019 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, or the department of health (hereinafter referred to as "agencies") shall individually or collectively consult with the state education department (hereinafter referred to as "department") to develop formal guidance for service providers authorized to operate under the respective agencies to identify the tasks and functions performed by each agency's service provider workforce categorized as tasks and functions restricted to licensed personnel including tasks and functions that do not require a license under articles 153, 154 and 163 of the education law. Subsequent to such consultation, and not later than December 31, 2019, the department shall issue guidance to each such agency with respect to each agency's service provider workforce. Each agency may issue additional guidance from time to time, subject to consultation with the department. Notwithstanding any provision of law to the contrary, no person shall be held liable for unauthorized practice of a profession subject to licensure under articles 153, 154 and 163 of the education law if such person acts in accordance with such agency guidance until July 1, 2020, to allow further consultation on guidance as necessary. Upon issuance by such state agency of guidance, the department shall have 180 days from the date of the issuance of such guidance to issue a statement of disagreement with the agency's guidance. If the department has issued a statement of disagreement, the department and state agency shall engage in a collaborative process to gather input from stakeholders to resolve the issues.

§ 6. Programs and services 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 the term is defined in section 41.03 of the mental hygiene law or a social services district as defined in section 61 of the social services law shall not be required to receive a waiver pursuant to section 6503-a of the education law and, further, such programs and services shall also be considered to be approved settings for the receipt of supervised experience for the professions governed by articles 153, 154 and 163 of the education law.

§ 7. 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 J of chapter 59 of the laws of 2016, 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, [~~2018~~] 2020.

§ 8. 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 J of chapter 59 of the laws of 2016, 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, [~~2018~~] 2020.

§ 9. 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 J of chapter 59 of the laws of 2016, is amended to read as follows:

§ 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, [~~2018~~] 2020; 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.

§ 10. This act shall take effect immediately.

PART Z

Section 1. Subparagraph (vii) of paragraph e of subdivision 3 of section 364-j of the social services law, as amended by section 38 of part A of chapter 56 of the laws of 2013, is amended to read as follows:

(vii) a person with a developmental or physical disability who receives home and community-based services or care-at-home services through a demonstration waiver under section eleven hundred fifteen of the federal social security act, existing waivers under section nineteen

hundred fifteen (c) of the federal social security act, or who has characteristics and needs similar to such persons;

§ 2. Clause (x) of subparagraph 1 of paragraph (e) of subdivision 5 of section 366 of the social services law, as added by section 26-a of part C of chapter 109 of the laws of 2006, is amended to read as follows:

(x) "nursing facility services" means nursing care and health related services provided in a nursing facility; a level of care provided in a hospital which is equivalent to the care which is provided in a nursing facility; and care, services or supplies provided pursuant to a waiver granted pursuant to subsection (c) of section 1915 of the federal social security act **or successor federal waiver**.

§ 3. Section 366 of the social services law is amended by adding a new subdivision 7-c to read as follows:

7-c. The commissioner of health in consultation with the commissioner of developmental disabilities is authorized to submit the appropriate waivers, including, but not limited to, those authorized pursuant to section eleven hundred fifteen of the federal social security act, in order to achieve the purposes of high-quality and integrated care and services for a population of persons with developmental disabilities, as such term is defined in section 1.03 of the mental hygiene law.

§ 4. Subdivision 6-a of section 93 of part C of chapter 58 of the laws of 2007, amending the social services law and other laws relating to enacting the major components of legislation necessary to implement the health and mental hygiene budget for the 2007-2008 state fiscal year, as amended by section 20 of part B of chapter 56 of the laws of 2013, is amended to read as follows:

6-a. section fifty-seven of this act shall expire and be deemed repealed on December 31, [~~2018~~] **2024**; provided that the amendments made by such section to subdivision 4 of section 366-c of the social services law shall apply with respect to determining initial and continuing eligibility for medical assistance, including the continued eligibility of recipients originally determined eligible prior to the effective date of this act, and provided further that such amendments shall not apply to any person or group of persons if it is subsequently determined by the Centers for Medicare and Medicaid services or by a court of competent jurisdiction that medical assistance with federal financial participation is available for the costs of services provided to such person or persons under the provisions of subdivision 4 of section 366-c of the social services law in effect immediately prior to the effective date of this act.

§ 5. Paragraph (a) of subdivision 2 of section 366-c of the social services law, as amended by section 68 of part A of chapter 56 of the laws of 2013, is amended to read as follows:

(a) For purposes of this section an "institutionalized spouse" is a person (i) who is in a medical institution or nursing facility and expected to remain in such facility or institution for at least thirty consecutive days; or (ii) who is receiving care, services and supplies pursuant to a waiver pursuant to subsection (c) of section nineteen hundred fifteen of the federal social security act**, or successor to such waiver,** or is receiving care, services and supplies in a managed long-term care plan pursuant to section eleven hundred fifteen of the social security act; and (iii) who is married to a person who is not in a medical institution or nursing facility or is not receiving waiver services described in subparagraph (ii) of this paragraph; provided, however, that medical assistance shall be furnished pursuant to this paragraph only if, for so long as, and to the extent that federal finan-

cial participation is available therefor. The commissioner of health shall make any amendments to the state plan for medical assistance, or apply for any waiver or approval under the federal social security act that are necessary to carry out the provisions of this paragraph.

§ 6. The closing paragraph of subdivision 4 of section 366-c of the social services law, as amended by section 42 of part D of chapter 58 of the laws of 2009, is amended to read as follows:

provided, however, that, to the extent required by federal law, the terms of this subdivision shall not apply to persons who are receiving care, services and supplies pursuant to the following waivers under section 1915(c) of the federal social security act: the nursing facility transition and diversion waiver authorized pursuant to subdivision six-a of section three hundred sixty-six of this title; the traumatic brain injury waiver authorized pursuant to section twenty-seven hundred forty of the public health law, the long term home health care program waiver authorized pursuant to section three hundred sixty-seven-c of this title, and the home and community based services waiver for persons with developmental disabilities, **or successor to such waiver,** administered by the office [~~of mental retardation and~~] **for people with** developmental disabilities pursuant to an agreement with the federal centers for medicare and Medicaid services.

§ 7. Paragraph 4 of subdivision (a) of section 16.03 of the mental hygiene law, as added by section 6 of part MM of chapter 58 of the laws of 2015, is amended to read as follows:

(4) The provision of home and community based services approved under a waiver program authorized pursuant to **section eleven hundred fifteen of the federal social security act or** subdivision (c) of section nineteen hundred fifteen of the federal social security act and subdivisions seven and seven-a of section three hundred sixty-six of the social services law, provided that an operating certificate issued pursuant to this paragraph shall only authorize services in a home or community setting.

§ 8. Paragraph 2 of subdivision (a) of section 16.11 of the mental hygiene law, as added by section 10 of part MM of chapter 58 of the laws of 2015, is amended to read as follows:

(2) The review of providers of services, as defined in paragraph four of subdivision (a) of section 16.03 of this article, shall ensure that the provider of services complies with all the requirements of the applicable federal home and community based services waiver program**, or other successor Medicaid waiver program,** and applicable federal regulation, subdivisions seven and seven-a of section three hundred sixty-six of the social services law and rules and regulations adopted by the commissioner.

§ 9. Subdivision (b) of section 80.03 of the mental hygiene law, as amended by chapter 37 of the laws of 2011, is amended to read as follows:

(b) "A patient in need of surrogate decision-making" means a patient as defined in subdivision twenty-three of section 1.03 of this chapter who is: a resident of a mental hygiene facility including a resident of housing programs funded by an office of the department or whose federal funding application was approved by an office of the department or for whom such facility maintains legal admission status therefor; or, receiving home and community-based services for persons with mental disabilities provided pursuant to section 1915 **or 1115** of the federal social security act; or receiving individualized support services; or, case management or service coordination funded, approved, or provided by

the office for people with developmental disabilities; and, for whom major medical treatment is proposed, and who is determined by the surrogate decision-making committee to lack the ability to consent to or refuse such treatment, but shall not include minors with parents or persons with legal guardians, committees or conservators who are legally authorized, available and willing to make such health care decisions. Once a person is eligible for surrogate decision-making, such person may continue to receive surrogate decision-making as authorized by this section regardless of a change in residential status.

§ 10. Subdivision 1-a of section 84 of part A of chapter 56 of the laws of 2013, amending the social services law and other laws relating to enacting the major components of legislation necessary to implement the health and mental hygiene budget for the 2013-2014 state fiscal year, is amended to read as follows:

[~~1-a. sections seventy-three through eighty-a shall expire and be deemed repealed September 30, 2019~~]

§ 11. Paragraph (a-1) of subdivision 8 of section 4403 of the public health law, as amended by chapter 474 of the laws of 2015, is amended to read as follows:

(a-1) If the commissioner and the commissioner of the office for people with developmental disabilities determine that such organization lacks the experience required in paragraph (a) of this subdivision, the organization shall have an affiliation arrangement with an entity or entities that are **controlled by** non-profit **organizations** with experience serving persons with developmental disabilities, **as demonstrated by criteria to be determined by the commissioner and the commissioner of the office for people with developmental disabilities, with such criteria** including, but not limited to, residential, day, and employment services such that the affiliated entity will coordinate and plan services operated, certified, funded, authorized or approved by the office for people with developmental disabilities or will oversee and approve such coordination and planning;

§ 12. Section 97 of chapter 659 of the laws of 1997, amending the public health law and other laws relating to creation of continuing care retirement communities, as amended by section 20 of part D of chapter 57 of the laws of 2015, is amended to read as follows:

§ 97. This act shall take effect immediately, provided, however, that the amendments to subdivision 4 of section 854 of the general municipal law made by section seventy of this act shall not affect the expiration of such subdivision and shall be deemed to expire therewith and provided further that sections sixty-seven and sixty-eight of this act shall apply to taxable years beginning on or after January 1, 1998 and provided further that sections eighty-one through eighty-seven of this act shall expire and be deemed repealed on December 31, [~~2019~~] **2024** and provided further, however, that the amendments to section ninety of this act shall take effect January 1, 1998 and shall apply to all policies, contracts, certificates, riders or other evidences of coverage of long term care insurance issued, renewed, altered or modified pursuant to section 3229 of the insurance law on or after such date.

§ 13. Paragraph (a-1) of subdivision 12 of section 4403-f of the public health law, as amended by chapter 474 of the laws of 2015, is amended to read as follows:

(a-1) If the commissioner and the commissioner of the office for people with developmental disabilities determine that such plan lacks the experience required in paragraph (a) of this subdivision, the plan shall have an affiliation arrangement with an entity or entities that

are **controlled by** non-profit **organizations** with experience serving persons with developmental disabilities, **as demonstrated by criteria to be determined by the commissioner and the commissioner of the office for people with developmental disabilities, with such criteria** including, but not limited to, residential, day and employment services, such that the affiliated entity will coordinate and plan services operated, certified, funded, authorized or approved by the office for people with developmental disabilities or will oversee and approve such coordination and planning;

§ 14. Paragraph (d) of subdivision 1 of section 4403-g of the public health law, as added by section 73 of part A of chapter 56 of the laws of 2013, is amended to read as follows:

(d) "Health and long term care services" means **comprehensive health** services **and other services as determined by the commissioner and the commissioner of the office for people with developmental disabilities**, whether provided by state-operated programs or not-for-profit entities, including, but not limited to, habilitation services, home and community-based and institution-based long term care services, and ancillary services, that shall include medical supplies and nutritional supplements, that are necessary to meet the needs of persons whom the plan is authorized to enroll[~~, and may include primary care and acute care if the DISCO is authorized to provide or arrange for such services~~]. Each person enrolled in a DISCO shall receive health and long term care services designed to achieve person-centered outcomes, to enable that person to live in the most integrated setting appropriate to that person's needs, and to enable that person to interact with nondisabled persons to the fullest extent possible in social, workplace and other community settings, provided that all such services are consistent with such person's wishes to the extent that such wishes are known and in accordance with such person's needs.

§ 15. Paragraph (b) of subdivision 3 of section 4403-g of the public health law, as added by section 73 of part A of chapter 56 of the laws of 2013, is amended to read as follows:

(b) A description of the services to be covered by such DISCO**, which must include all health and long term care services, as defined in paragraph (d) of subdivision one of this section, and other services as determined by the commissioner and the commissioner of the office for people with developmental disabilities**;

§ 16. Paragraph (j) of subdivision 4 of section 4403-g of the public health law, as added by section 73 of part A of chapter 56 of the laws of 2013, is amended to read as follows:

(j) Readiness and capability [~~to arrange and manage covered services~~] **of organizing, marketing, managing, promoting and operating a health and long term care services plan, or has an affiliation agreement with an entity that has such readiness and capability**;

§ 17. Subdivision (c) of section 62 of chapter 165 of the laws of 1991, amending the public health law and other laws relating to establishing payments for medical assistance, as amended by section 17 of part D of chapter 57 of the laws of 2015, is amended to read as follows:

(c) section 364-j of the social services law, as amended by section eight of this act and subdivision 6 of section 367-a of the social services law as added by section twelve of this act shall expire and be deemed repealed on March 31, [~~2019~~] **2024** and provided further, that the amendments to the provisions of section 364-j of the social services law made by section eight of this act shall only apply to managed care programs approved on or after the effective date of this act;

§ 18. Subdivision (c) of section 13.40 of the mental hygiene law, as added by section 72-b of part A of chapter 56 of the laws of 2013, is amended to read as follows:

(c) No person with a developmental disability who is receiving or applying for medical assistance and who is receiving, or eligible to receive, services operated, funded, certified, authorized or approved by the office, shall be required to enroll in a DISCO, HMO or MLTC in order to receive such services until program features and reimbursement rates are approved by the commissioner and the commissioner of health, and until such commissioners determine that a sufficient number of plans that are authorized to coordinate care for individuals pursuant to this section or that are authorized to operate and to exclusively enroll persons with developmental disabilities pursuant to subdivision twenty-seven of section three hundred sixty-four-j of the social services law are operating in such person's county of residence to meet the needs of persons with developmental disabilities, and that such entities meet the standards of this section. No person shall be required to enroll in a DISCO, HMO or MLTC in order to receive services operated, funded, certified, authorized or approved by the office until there are at least two entities operating under this section in such person's county of residence, unless federal approval is secured to require enrollment when there are less than two such entities operating in such county. **Notwithstanding the foregoing or any other law to the contrary, any health care provider: (i) enrolled in the Medicaid program and (ii) rendering hospital services, as such term is defined in section twenty-eight hundred one of the public health law, to an individual with a developmental disability who is enrolled in a DISCO, HMO or MLTC, or a prepaid health services plan operating pursuant to section forty-four hundred three-a of the public health law, including, but not limited to, an individual who is enrolled in a plan authorized by section three hundred sixty-four-j or the social services law, shall accept as full reimbursement the negotiated rate or, in the event that there is no negotiated rate, the rate of payment that the applicable government agency would otherwise pay for such rendered hospital services.**

§ 19. Section 11 of chapter 710 of the laws of 1988, amending the social services law and the education law relating to medical assistance eligibility of certain persons and providing for managed medical care demonstration programs, as amended by section 1 of part F of chapter 73 of the laws of 2016, is amended to read as follows:

§ 11. This act shall take effect immediately; except that the provisions of sections one, two, three, four, eight and ten of this act shall take effect on the ninetieth day after it shall have become a law; and except that the provisions of sections five, six and seven of this act shall take effect January 1, 1989; and except that effective immediately, the addition, amendment and/or repeal of any rule or regulation necessary for the implementation of this act on its effective date are authorized and directed to be made and completed on or before such effective date; provided, however, that the provisions of section 364-j of the social services law, as added by section one of this act shall expire and be deemed repealed on and after March 31, [~~2010~~] **2024**, the provisions of section 364-k of the social services law, as added by section two of this act, except subdivision 10 of such section, shall expire and be deemed repealed on and after January 1, 1994, and the provisions of subdivision 10 of section 364-k of the social services law, as added by section two of this act, shall expire and be deemed repealed on January 1, 1995.

§ 20. This act shall take effect immediately; provided, however, that the amendments to subparagraph (vii) of paragraph e of subdivision 3 of section 364-j of the social services law made by section one of this act shall not affect the repeal of such section and shall be deemed repealed therewith; provided further, however, that the amendments to subdivision 4 of section 366-c of the social services law made by section six of this act shall not affect the expiration of such subdivision and shall be deemed to expire therewith; provided further, however, that the amendments to paragraph (a-1) of subdivision 12 of section 4403-f of the public health law made by section thirteen of this act shall not affect the repeal of such section and shall be deemed to be repealed therewith.

PART AA

Section 1. Subdivisions 3-b and 3-c of section 1 of part C of chapter 57 of the laws of 2006, relating to establishing a cost of living adjustment for designated human services programs, as amended by section 1 of part Q of chapter 57 of the laws of 2017, are amended to read as follows:

3-b. Notwithstanding any inconsistent provision of law, beginning April 1, 2009 and ending March 31, 2016 and beginning April 1, 2017 and ending March 31, [~~2018~~] 2019, the commissioners shall not include a COLA for the purpose of establishing rates of payments, contracts or any other form of reimbursement, provided that the commissioners of the office for people with developmental disabilities, the office of mental health, and the office of alcoholism and substance abuse services shall not include a COLA beginning April 1, 2017 and ending March 31, 2019.

3-c. Notwithstanding any inconsistent provision of law, beginning April 1, [~~2018~~] 2019 and ending March 31, [~~2021~~] 2022, the commissioners shall develop the COLA under this section using the actual U.S. consumer price index for all urban consumers (CPI-U) published by the United States department of labor, bureau of labor statistics for the twelve month period ending in July of the budget year prior to such state fiscal year, for the purpose of establishing rates of payments, contracts or any other form of reimbursement.

§ 2. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2018; provided, however, that the amendments to section 1 of part C of chapter 57 of the laws of 2006 made by section one of this act shall not affect the repeal of such section and shall be deemed repealed therewith.

§ 2. Severability clause. If any clause, sentence, paragraph, subdivision, section or part of this act shall be adjudged by any court of competent jurisdiction to be invalid, such judgment shall not affect, impair, or invalidate the remainder thereof, but shall be confined in its operation to the clause, sentence, paragraph, subdivision, section or part thereof directly involved in the controversy in which such judgment shall have been rendered. It is hereby declared to be the intent of the legislature that this act would have been enacted even if such invalid provisions had not been included herein.

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