STATE OF NEW YORK

3007--A

IN ASSEMBLY

January 23, 2017

A BUDGET BILL, submitted by the Governor pursuant to article seven of the Constitution -- read once and referred to the Committee on Ways and Means -- committee discharged, bill amended, ordered reprinted as amended and recommitted to said committee

AN ACT to amend the insurance law, in relation to the early intervention program for infants and toddlers with disabilities and their families (Part A); intentionally omitted (Part B); to amend the social services law, in relation to requiring monthly premium payments for the Essential Plan (Part C); to amend the public health law, in relation to high cost drugs; to amend the tax law, in relation to surcharges on high priced drugs; to amend the tax law, in relation to secrecy provisions; to amend the state finance law, in relation to the high priced drug reimbursement fund; to amend the social services law, in relation to the drug utilization review board; to amend the social services law, in relation to prescription drugs in Medicaid managed care programs; to amend the public health law, in relation to the use of preferred drug program and clinical drug review program; to amend the social services law, in relation to Medicaid reimbursement of covered outpatient drugs; to authorize the suspension of a provider's Medicaid enrollment for inappropriate prescribing of opioids; to amend the social services law, in relation to refills of controlled substances; to amend the social services law, in relation to aligning pharmacy copayment requirements with federal regulations, and to adjusting consumer price index penalties for generic drugs; and to repeal subdivisions 25 and 25-a of section 364-j of the social services law, relating to the coverage of certain medically necessary prescription drugs by managed care providers (Part D); intentionally omitted (Part E); to amend the social services law, in relation to carving out transportation from managed long term care benefit and adult day health care programs located at a licensed residential health care facility (Part F); intentionally omitted (Part G); to amend the New York Health Care Reform Act of 1996, in relation to extending certain provisions relating thereto; to amend the New York Health Care Reform Act of 2000, in relation to extending the effectiveness of provisions thereof; to amend the public health law, in relation to the distribution of pool allocations and graduate medical education; to amend the public health law, in relation to health care

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

LBD12571-02-7

initiative pool distributions; to amend the social services law, in relation to extending payment provisions for general hospitals; to amend the public health law, in relation to the assessments on covered lives; to amend chapter 62 of the laws of 2003 amending the general business law and other laws relating to enacting major components necessary to implement the state fiscal plan for the 2003-04 state fiscal year, in relation to the deposit of certain funds; to amend chapter 600 of the laws of 1986 amending the public health law relating to the development of pilot reimbursement programs for ambulatory care services, in relation to the effectiveness of such chapter; to amend chapter 600 of the laws of 1986 amending the public health law relating to the development of pilot reimbursement programs for ambulatory care services, in relation to the effectiveness of such chapter; to amend chapter 520 of the laws of 1978 relating to providing for a comprehensive survey of health care financing, education and illness prevention and creating councils for the conduct thereof, in relation to extending the effectiveness of portions thereof; to amend the public health law, in relation to extending access to community health care services in rural areas; to amend the social services law, in relation to rates of payment for personal care service providers; to amend the public health law, in relation to the comprehensive diagnostic and treatment centers indigent care program; and to amend the public health law, in relation to health care initiative pool distributions (Part H); to amend chapter 884 of the laws of 1990, amending the public health law relating to authorizing bad debt and charity care allowances for certified home health agencies, in relation to the effectiveness thereof; to amend chapter 60 of the laws of 2014 amending the social services law relating to eliminating prescriber prevails for brand name drugs with generic equivalents, in relation to the effectiveness thereof; to amend the public health law, in relation to extending the nursing home cash assessment; to amend chapter 474 of the laws of 1996, amending the education law and other laws relating to rates for residential health care facilities, in relation to the effectiveness thereof; to amend 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, in relation to delay of certain administrative cost; to amend chapter 81 of the laws of 1995, amending the public health law and other laws relating to medical reimbursement and welfare reform, in relation to the effectiveness thereof; to amend chapter 109 of the laws of 2010, amending the social services law relating to transportation costs, in relation to the effectiveness thereof; 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 the effectiveness thereof; to amend chapter 2 of the laws of 1998, amending the public health law and other laws relating to expanding the child health insurance plan, in relation to the effectiveness thereof; to amend chapter 19 of the laws of 1998, amending the social services law relating to limiting the method of payment for prescription drugs under the medical assistance program, in relation to the effectiveness thereof; to amend the public health law, in relation to continuing nursing home upper payment limit payments; to amend chapter 904 of the laws of 1984, amending the public health law and the social services law relating to encouraging comprehensive

health services, in relation to the effectiveness thereof; to amend chapter 62 of the laws of 2003, amending the public health law relating to allowing for the use of funds of the office of professional medical conduct for activities of the patient health information and quality improvement act of 2000, in relation to extending the provisions thereof; to amend chapter 59 of the laws of 2011, amending the public health law relating to the statewide health information network of New York and the statewide planning and research cooperative system and general powers and duties, in relation to the effectiveness thereof; to amend chapter 58 of the laws of 2008, amending the elder law and other laws relating to reimbursement to participating provider pharmacies and prescription drug coverage, in relation to extending the expiration of certain provisions thereof; and to amend the public health law, in relation to extending the authority of the commissioner of health to issue ACO certificates (Part I); to amend the insurance law, in relation to pharmacy benefit managers and the purchase of prescription drugs; and to amend the public health law, in relation to pharmacy benefit managers; and to repeal certain provisions of such law relating thereto (Part J); to amend the public health law, in relation to the health care facility transformation program (Part K); intentionally omitted (Part L); to amend the public health law, in relation to creating the "Emerging Contaminant Monitoring Act" (Part M); to amend the public health law, the real property law, and the environmental conservation law, in relation to creating the "residential well testing act" (Part N); intentionally omitted (Part O); 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 extending government rates for behavioral services and adding a value based payment requirement; and to amend chapter 111 of the laws of 2010 relating to increasing Medicaid payments to providers through managed care organizations and providing equivalent fees through an ambulatory patient group methodology, in relation to extending government rates for behavioral services and adding a value based payment requirement (Part P); intentionally omitted (Part Q); to amend chapter 266 of the laws of 1986, amending the civil practice law and rules and other laws relating to malpractice and professional medical conduct, in relation to apportioning premium for certain policies; and to amend part J of chapter 63 of the laws of 2001 amending chapter 266 of the laws of 1986, amending the civil practice law and rules and other laws relating to malpractice and professional medical conduct, in relation to extending certain provisions concerning the hospital excess liability pool (Part R); to direct the commissioner of developmental disabilities to report on the housing needs of individuals with developmental disabilities and the implementation of the transformation panel's recommendations; and providing for the repeal of such provisions upon expiration thereof (Part S); to amend the penal law, in relation to criminal possession of a controlled substance in the seventh degree; to amend the general business law, in relation to drug-related paraphernalia; to amend the public health law, in relation to the sale and possession of hypodermic syringes and needles; and to repeal section 220.45 of the penal law relating to criminally possessing a hypodermic instrument (Part T); in relation to the Western New York Children's Psychiatric Center (Part U); to amend the social services law, in relation to school-based health centers and sponsoring organ-

izations for managed care programs (Part V); to amend the social services law, in relation to fiscal intermediary certification under the consumer directed personal assistance program; to amend the social services law and the public health law, in relation to needs assessment and rate adequacy for medicaid; to amend the social services law, in relation to the nursing home benchmark rate; to amend the public health law, in relation to home care workforce recruitment and retention funding; and to amend the public health law, in relation to home care worker wage parity (Part W); to amend the social services law, in relation to requiring the commissioner of health to provide written notice thirty days prior to implementing or adjusting a rate, premium, component of premium, add-on payment, quality pool, or other rate component related to a managed care provider (Part X); relating to the number of workers accruing overtime in state agencies and requiring certain agencies to maintain all full time equivalent positions from the previous year (Part Y); in relation to the transfer of inpatient services (Part Z); to amend the social services law, in relation to establishing the enhanced safety net hospital program; and to prohibit the commissioner of health from reducing payment for general hospital emergency services visits (Part AA); and to amend chapter 495 of the laws of 2004 amending the insurance law and the public health law relating to the New York state health insurance continuation assistance demonstration project, in relation to the effectiveness thereof (Part BB)

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 2017-2018 state fiscal year. Each component is wholly contained within a Part identified as Parts A through BB. 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. Paragraph 2 of subsection (d) of section 3224-a of the insurance law, as amended by section 57-b of part A of chapter 56 of the laws of 2013, is amended to read as follows:

(2) "health care provider" shall mean an entity licensed or certified pursuant to article twenty-eight, thirty-six or forty of the public health law, a facility licensed pursuant to article nineteen or thirty-one of the mental hygiene law, a fiscal intermediary operating under section three hundred sixty five-f of the social services law, **an individual or agency approved by the department of health pursuant to title two-A of article twenty-five of the public health law,** a health care professional licensed, registered or certified pursuant to title eight of the education law, a dispenser or provider of pharmaceutical

products, services or durable medical equipment, or a representative designated by such entity or person.

§ 2. 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.

(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. **When such policy of accident and health insurance, including a contract issued pursuant to article forty-three of this chapter, provides coverage for services that constitutes early intervention services as set forth in paragraph (h) of subdivision seven of section twenty five-hundred forty-one of the public health law or early intervention evaluation services as set forth in subdivision nine of section twenty-five hundred forty-one of the public health law, or provides coverage for autism spectrum disorder pursuant to paragraph twenty-five of subsection (i) of section thirty-two hundred sixteen, paragraph seventeen of subsection (l) of section thirty-two hundred twenty-one, or subsection (ee) of section forty-three hundred three of this chapter, the insurer shall pay for such services to the extent that the services are a covered benefit under the policy. Any documentation obtained pursuant to clause (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 sufficient to meet precertification, preauthorization and/or medical necessity requirements 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) **A policy of accident and health insurance, including a contract issued pursuant to article forty-three of this chapter, shall not deny coverage based upon the following:**

(i) the location where services are provided; or

(ii) the duration of the child's condition and/or that the child's condition is not amendable to significant improvement within a certain period of time as specified in the policy.

(d) 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~~] **An insurer shall, within fifteen business days of receipt of a notice of**

right of subrogation, notify the provider, in a format determined by the department of health, through the department of health's designated fiscal agent whether the insurer is acting as a third party administrator.

(e) Upon receipt of written request and notice from the municipality and service coordinator 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, including whether the insurer is acting as a third party administrator, 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)~~] (f) 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.

§ 3. This act shall take effect immediately and shall be deemed to have been in full force and effect on or after April 1, 2017; provided however, that the amendments to section 3224-a of the insurance law as made by section one of this act and the amendments to section 3235-a of the insurance law as made by section two of this act shall apply only to policies and contracts issued, renewed, modified, altered or amended on or after such date.

PART B

Intentionally Omitted

PART C

Section 1. Subdivision 5 of section 369-gg of the social services law, as added by section 51 of part C of chapter 60 of the laws of 2014, is amended to read as follows:

5. Premiums and cost sharing. (a) Subject to federal approval, the commissioner shall establish premium payments enrollees shall pay to approved organizations for coverage of health care services pursuant to this title. Such premium payments shall be established in the following manner:

(i) up to twenty dollars monthly for an individual with a household income above one hundred and fifty percent of the federal poverty line but at or below two hundred percent of the federal poverty line defined and annually revised by the United States department of health and human services for a household of the same size; and

(ii) no payment is required for individuals with a household income at or below one hundred and fifty percent of the federal poverty line defined and annually revised by the United States department of health and human services for a household of the same size.

(b) The commissioner shall establish cost sharing obligations for enrollees, subject to federal approval, provided, however, for individuals with a household income from one hundred thirty-eight to one hundred fifty percent of the federal poverty level cost sharing provisions shall maintain an actuarial value of 99.68 percent, and for

individuals with a household income from one hundred fifty-one to two hundred percent of the federal poverty level cost sharing provisions shall maintain an actuarial value of 90.02 percent.

§ 2. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after January 1, 2017.

PART D

Section 1. The public health law is amended by adding a new section 280 to read as follows:

§ 280. High cost drugs. 1. High priced drugs. The department may identify, for review, drugs which:

(a) when first introduced on the market, are prohibitively expensive for patients who could benefit from the drug; or

(b) suddenly or over a relatively brief period of time experience a large price increase and such increase is not explained by a significant increase in ingredient costs or by some other relevant factor; or

(c) have been determined to be priced disproportionally in relation to their therapeutic benefits.

2. Reporting requirements. (a) Drug manufacturers shall provide the department, upon request, the following information with respect to drugs identified by the department for review:

(i) the actual cost of developing, manufacturing, producing (including the cost per dose of production), and distributing the drug;

(ii) research and development costs of the drug, including payments to predecessor entities conducting research and development, such as biotechnology companies, universities and medical schools, and private research institutions;

(iii) administrative, marketing, and advertising costs for the drug, apportioned by marketing activities that are directed to consumers, marketing activities that are directed to prescribers, and the total cost of all marketing and advertising that is directed primarily to consumers and prescribers in New York, including but not limited to prescriber detailing, copayment discount programs, and direct-to-consumer marketing;

(iv) the extent of utilization of the drug;

(v) prices for the drug that are charged to purchasers outside the United States;

(vi) prices charged to typical purchasers in the state, including but not limited to pharmacies, pharmacy chains, pharmacy wholesalers, or other direct purchasers;

(vii) the average rebates and discounts provided per payer type;

(viii) the average profit margin of each drug over the prior five-year period; and

(ix) any other information the manufacturer feels is necessary to provide to justify the drug price, including but not limited to, costs incurred for research and development for predecessor drugs, or other drugs related to the drug brought to market.

(b) The department shall develop a standard reporting form that satisfies the requirements of paragraph (a) of this subdivision.

(c) All information disclosed pursuant to paragraph (a) of this subdivision shall be considered confidential and shall not be disclosed by the department in a form that identifies a specific manufacturer or prices charged for drugs by such manufacturer.

3. Review of drug cost and pricing. The department may refer cost and pricing information collected pursuant to subdivision two of this

section with respect to a particular drug to the drug utilization review board, and request the board to recommend a per-unit benchmark price for the drug, taking into consideration such cost and pricing information as well as other factors, including but not limited to:

(a) the seriousness and prevalence of the disease or condition that is treated by the drug;

(b) the extent of utilization of the drug;

(c) the effectiveness of the drug in treating the conditions for which it is prescribed or improve a patient's health, quality of life, or overall health outcomes;

(d) the likelihood that use of the drug will reduce the need for other medical care, including hospitalization;

(e) the average wholesale price and retail price of the drug;

(f) the number of pharmaceutical manufacturers that produce the drug; and

(g) whether there are pharmaceutical equivalents to the drug.

4. Designation of high priced drugs. (a) If the drug utilization review board recommends a benchmark price for a drug, such recommendation, along with the documentation supporting such recommendation, shall be submitted to the attorney general for review. The attorney general shall approve, deny, or refer the recommendation back to the drug utilization review board for further review. The attorney general shall only approve a recommended benchmark price once he or she is satisfied that the price is adequate to guarantee patient access to such drug.

(b) If the price at which a drug is being sold by a manufacturer exceeds the benchmark price for the drug determined by the department pursuant to this section, the commissioner shall designate such drug a high priced drug and notify the manufacturer of such drug of such designation. The commissioner shall publish on the department website a list of drugs designated as high priced drugs pursuant to this subdivision, along with the date on which each drug first appeared on such list and the benchmark price for such drug determined by the department.

5. Rebates. (a) The commissioner may require a drug manufacturer to provide rebates to the department for a drug determined to be a high priced drug pursuant to subdivision three of this section when such drug is paid for under the Medicaid program. In determining the amount of any such rebate, the commissioner may consider information provided by the drug manufacturer with respect to surcharges paid by the manufacturer, or decreases in the price of the drug as a result of surcharges paid by others, pursuant to article twenty-C of the tax law.

(b) Rebates required by this section shall be in addition to any rebates payable to the department pursuant to any other provision of federal or state law. The additional rebates authorized pursuant to this subparagraph shall apply to drugs dispensed to enrollees of managed care providers pursuant to section three hundred sixty-four-j of the social services law and to drugs dispensed to Medicaid recipients who are not enrollees of such providers.

§ 2. The tax law is amended by adding a new article 20-C to read as follows:

ARTICLE 20-C
SURCHARGE ON HIGH PRICED DRUGS

Section 492. Definitions.
493. Imposition of surcharge.
494. Returns to be secret.

§ 492. Definitions. 1. The following terms shall have the following meanings when used in this section.

(a) "High priced drug" shall mean a drug determined to be a high priced drug pursuant to section two hundred eighty of the public health law, but not until the fifteenth day after the manufacturer was notified of such designation and appeared on a list of such drugs to be maintained by the state department of health on its website pursuant to subdivision seven of section four hundred ninety-three of this article.

(b) "Gross receipt" shall mean the amount received in or by reason of any sale of a high priced drug, conditional or otherwise, or in or by reason of the furnishing of such high priced drug. Gross receipt is expressed in money, whether paid in cash, credit or property of any kind or nature, and shall be determined without any deduction therefrom on account of the cost of the service sold or the cost of materials, labor or services used or other costs, interest or discount paid, or any other expenses whatsoever. "Amount received" for the purpose of the definition of gross receipt, as used throughout this article, means the amount charged for the sale or provision of a high priced drug.

(c) "Establishment" shall mean any person, firm, corporation or association required to be registered with the education department pursuant to section six thousand eight hundred eight or section six thousand eight hundred eight-b of the education law, except for a "pharmacy" defined in subdivision one of section six thousand eight hundred two of the education law and any person, firm, corporation or association that would be required to be registered with the education department pursuant to section six thousand eight hundred eight-b of the education law but for the exception in subdivision two of such section, except for a "pharmacy" defined in subdivision one of section six thousand eight hundred two of the education law.

(d) "Excess charge amount of the gross receipt" shall mean the difference between the price charged by an establishment for a high priced drug and the benchmark price for such drug as determined by the department of health pursuant to section two hundred eighty of the public health law.

(e) "Invoice" shall mean the invoice, sales slip, memorandum of sale, or other document evidencing a sale of a high priced drug.

§ 493. Imposition of surcharge. 1. There is hereby imposed a surcharge on the excess charge amount of the gross receipt from the first sale in the state of a high priced drug by an establishment at the rate of sixty percent. The surcharge imposed by this article shall be charged against and be paid by the establishment making such first sale and shall not be added as a separate charge or line item on any invoice given to the customer or otherwise passed down to the customer. However, an establishment liable for the surcharge imposed by this article shall clearly note on the invoice for the first sale of such high priced drug in the state its liability for the surcharge imposed by this article with regard to such sale, along with its name, address, and taxpayer identification number. Any sale of a high priced drug in this state shall be presumed to be the first sale of such drug in the state unless the seller with regard to such sale can prove that the surcharge imposed by this article is due from another establishment in the chain of title of such drug, which burden can be satisfied, among other ways, by producing an invoice from the establishment owing such surcharge in which such establishment has noted its liability for such surcharge.

2. Every establishment liable for the surcharge imposed by this article shall, on or before the twentieth date of each month, file with the commissioner a return, on forms to be prescribed by the commissioner, showing the total excess charge amount of its gross receipt from the

first sale in the state of high priced drugs during the preceding calendar month and the amount of surcharge due thereon. Such returns shall contain such further information as the commissioner may require. Every establishment required to file a return under this section shall, at the time of filing such return, pay to the commissioner the total amount of surcharge due on such first sales of high priced drugs for the period covered by such return. If a return is not filed when due, the surcharge shall be due on the day on which the return is required to be filed.

3. Establishments making sales of high priced drugs in this state shall maintain all invoices pertaining to such sales for three years after such sales unless the commissioner provides for a different retention period by rule or regulation. The establishment shall produce such records upon demand by the department.

4. Whenever the commissioner shall determine that any moneys received under the provisions of this article were paid in error, he may cause the same to be refunded, with interest, in accordance with such rules and regulations as he or she may prescribe, except that no interest shall be allowed or paid if the amount thereof would be less than one dollar. Such interest shall be at the overpayment rate set by the commissioner pursuant to subdivision twenty-sixth of section one hundred seventy-one of this chapter, or if no rate is set, at the rate of six percent per annum, from the date when the surcharge, penalty or interest to be refunded was paid to a date preceding the date of the refund check by not more than thirty days. Provided, however, that for the purposes of this subdivision, any surcharge paid before the last day prescribed for its payment shall be deemed to have been paid on such last day. Such moneys received under the provisions of this article that the commissioner shall determine were paid in error, may be refunded out of funds in the custody of the comptroller to the credit of such surcharges provided an application therefor is filed with the commissioner within two years from the time the erroneous payment was made.

5. The provisions of article twenty-seven of this chapter shall apply to the surcharge imposed by this article in the same manner and with the same force and effect as if the language of such article had been incorporated in full into this section and had expressly referred to the surcharge imposed by this article, except to the extent that any provision of such article is either inconsistent with a provision of this article or is not relevant to this article.

6. (a) The surcharges, interest, and penalties imposed by this article and collected or received by the commissioner shall be deposited daily with such responsible banks, banking houses or trust companies, as may be designated by the superintendent of financial services, to the credit of the high priced drug reimbursement fund established pursuant to section eighty-nine-j of the state finance law. An account may be established in one or more of such depositories. Such deposits will be kept separate and apart from all other money in the possession of the superintendent of financial services. The superintendent of financial services shall require adequate security from all such depositories. Of the total revenue collected or received under this article, the superintendent of financial services shall retain such amount as the commissioner may determine to be necessary for refunds under this article. The commissioner is authorized and directed to deduct from the amounts it receives under this article, before deposit into the trust accounts designated by the superintendent of financial services, a reasonable amount necessary to effectuate refunds of appropriations of the depart-

ment to reimburse the department for the costs incurred to administer, collect and distribute the surcharges imposed by this article.

(b) On or before the twelfth and twenty-sixth day of each succeeding month, after reserving such amount for such refunds and deducting such amounts for such costs, as provided for in paragraph (a) of this subsection, the commissioner shall certify to the superintendent of financial services the amount of all revenues so received during the prior month as a result of the surcharges, interest and penalties so imposed. The amount of revenues so certified shall be paid over by the fifteenth and the final business day of each succeeding month from such account into the high priced drug reimbursement fund established pursuant to section eighty-nine-j of the state finance law.

7. The state department of health shall maintain and publish on its website a list of drugs determined, pursuant to section two hundred eighty of the public health law, to be high priced drugs, along with the date on which each drug first appeared on that list and the benchmark price for such drug determined pursuant to section two hundred eighty of the public health law by the department of health. Promptly after including a high priced drug on such list, the state department of health shall notify the manufacturer of such drug and the department that the drug has been determined to be a high priced drug.

8. The state department of education and the state department of health shall cooperate with the department in administering this surcharge, including sharing with the department pertinent information about establishments upon the request of the commissioner.

9. The commissioner may make, adopt and amend rules, regulations, procedures and forms necessary for the proper administration of this article.

§ 494. Returns to be secret. 1. Except in accordance with proper judicial order or as in this section or otherwise provided by law, it shall be unlawful for the commissioner, any officer or employee of the department, or any officer or person who, pursuant to this section, is permitted to inspect any return or report or to whom a copy, an abstract or a portion of any return or report is furnished, or to whom any information contained in any return or report is furnished, or any person engaged or retained by such department on an independent contract basis or any person who in any manner may acquire knowledge of the contents of a return or report filed pursuant to this article to divulge or make known in any manner the contents or any other information relating to the business of an establishment contained in any return or report required under this article. The officers charged with the custody of such returns or reports shall not be required to produce any of them or evidence of anything contained in them in any action or proceeding in any court, except on behalf of the state, the state department of health, the state department of education or the commissioner in an action or proceeding under the provisions of this chapter or on behalf of the state or the commissioner in any other action or proceeding involving the collection of a tax due under this chapter to which the state or the commissioner is a party or a claimant or on behalf of any party to any action or proceeding under the provisions of this article, when the returns or the reports or the facts shown thereby are directly involved in such action or proceeding, or in an action or proceeding relating to the regulation or surcharge of high priced drugs on behalf of officers to whom information shall have been supplied as provided in subsection two of this section, in any of which events the court may require the production of, and may admit in evidence so much of said

returns or reports or of the facts shown thereby as are pertinent to the action or proceeding and no more. Nothing herein shall be construed to prohibit the commissioner, in his or her discretion, from allowing the inspection or delivery of a certified copy of any return or report filed under this article or of any information contained in any such return or report by or to a duly authorized officer or employee of the state department of health or the state department of education; or by or to the attorney general or other legal representatives of the state when an action shall have been recommended or commenced pursuant to this chapter in which such returns or reports or the facts shown thereby are directly involved; or the inspection of the returns or reports required under this article by the comptroller or duly designated officer or employee of the state department of audit and control, for purposes of the audit of a refund of any surcharge paid by an establishment or other person under this article; nor to prohibit the delivery to an establishment, or a duly authorized representative of such establishment, a certified copy of any return or report filed by such establishment pursuant to this article, nor to prohibit the publication of statistics so classified as to prevent the identification of particular returns or reports and the items thereof.

2. The commissioner, in his or her discretion and pursuant to such rules and regulations as he or she may adopt, may permit the commissioner of internal revenue of the United States, or the appropriate officers of any other state which regulates or surcharges high priced drugs, or the duly authorized representatives of such commissioner or of any such officers, to inspect returns or reports made pursuant to this article, or may furnish to such commissioner or other officers, or duly authorized representatives, a copy of any such return or report or an abstract of the information therein contained, or any portion thereof, or may supply such commissioner or any such officers or such representatives with information relating to the business of an establishment making returns or reports hereunder. The commissioner may refuse to supply information pursuant to this subsection to the commissioner of internal revenue of the United States or to the officers of any other state if the statutes of the United States, or of the state represented by such officers, do not grant substantially similar privileges to the commissioner, but such refusal shall not be mandatory. Information shall not be supplied to the commissioner of internal revenue of the United States or the appropriate officers of any other state which regulates or surcharges high priced drugs, or the duly authorized representatives of such commissioner or of any of such officers, unless such commissioner, officer or other representatives shall agree not to divulge or make known in any manner the information so supplied, but such officers may transmit such information to their employees or legal representatives when necessary, who in turn shall be subject to the same restrictions as those hereby imposed upon such commissioner, officer or other representatives.

3. (a) Any officer or employee of the state who willfully violates the provisions of subsection one or two of this section shall be dismissed from office and be incapable of holding any public office in this state for a period of five years thereafter.

(b) A violation of this article shall be considered a violation of secrecy provisions under article thirty-seven of this chapter.

§ 3. Section 1825 of the tax law, as amended by section 89 of part A of chapter 59 of the laws of 2014, is amended to read as follows:

§ 1825. Violation of secrecy provisions of the tax law.--Any person who violates the provisions of subdivision (b) of section twenty-one, subdivision one of section two hundred two, subdivision eight of section two hundred eleven, subdivision (a) of section three hundred fourteen, subdivision one or two of section four hundred thirty-seven, section four hundred eighty-seven, **section four hundred ninety-four,** subdivision one or two of section five hundred fourteen, subsection (e) of section six hundred ninety-seven, subsection (a) of section nine hundred ninety-four, subdivision (a) of section eleven hundred forty-six, section twelve hundred eighty-seven, subdivision (a) of section fourteen hundred eighteen, subdivision (a) of section fifteen hundred eighteen, subdivision (a) of section fifteen hundred fifty-five of this chapter, and subdivision (e) of section 11-1797 of the administrative code of the city of New York shall be guilty of a misdemeanor.

§ 4. The state finance law is amended by adding a new section 89-j to read as follows:

§ 89-j. High Priced Drug Reimbursement Fund. 1. There is hereby established in the sole custody of the superintendent of financial services an agency fund, to be known as the "High Priced Drug Reimbursement Fund."

2. Such fund shall consist of revenues derived from the surcharge on high priced drugs imposed by article twenty-C of the tax law and all other moneys credited or transferred thereto from any other fund or source pursuant to law.

3. All moneys retained in such fund shall be held on behalf of health insurers and the New York Medicaid program, and paid out by the superintendent of financial services to health insurers and the New York Medicaid program in proportion to health insurers' and the New York Medicaid program's respective costs attributable to each pharmaceutical product for which the surcharge on high price drugs was imposed. The superintendent of financial services shall establish regulations to apportion such revenues derived to reflect health insurers' and the New York Medicaid program's respective costs for such drugs.

4. All moneys distributed from the high priced drug reimbursement fund to a health insurer shall be, at the discretion of the superintendent of financial services, either (1) credited to the premiums charged by such health insurer for the next policy period or (2) credited to policyholders pursuant to procedures that the superintendent of financial services shall establish by regulations.

5. For purposes of this section: (a) "health insurer" shall mean an insurance company authorized in this state to write accident and health insurance, a company organized pursuant to article forty-three of the insurance law, a municipal cooperative health benefit plan established pursuant to article forty-seven of the insurance law, a health maintenance organization certified pursuant to article forty-four of the public health law, an institution of higher education certified pursuant to section one thousand one hundred twenty-four of the insurance law, the New York state health insurance plan established under article eleven of the civil service law, or an employer with an employee benefit plan, as defined by the federal Employee Retirement Income Security Act of 1974, provided that the employer voluntarily elects;

(b) "New York Medicaid program" shall mean the medical assistance program for needy persons established pursuant to title eleven of article five of the social services law.

6. The superintendent of financial services may issue such rules and regulations as he or she shall deem necessary to implement this section and administer the high priced drug reimbursement fund.

7. The funds so received and deposited in the high priced drug reimbursement fund shall not be deemed to be state funds.

8. Moneys distributed from the fund shall not be subject to appropriation.

9. No amounts may be paid out of this fund prior to April first, two thousand eighteen.

§ 5. Subdivision 1 and paragraph (f) of subdivision 2 of section 369-bb of the social services law, subdivision 1 as amended and paragraph (f) of subdivision 2 as added by section 20 of part A of chapter 56 of the laws of 2013, are amended and two new paragraphs (g) and (h) are added to subdivision 2 to read as follows:

1. A [~~nineteen-member~~] twenty-three member drug utilization review board is hereby created in the department. The board is responsible for the establishment and implementation of medical standards and criteria for the retrospective and prospective DUR program.

(f)(i) The commissioner shall designate a person from the department to serve as chairperson of the board.

(ii) Two persons who are health care economists.

(g) One person who is an actuary.

(h) One person representing the department of financial services.

§ 6. Paragraphs (g), (h) and (i) of subdivision 8 of section 369-bb of the social services law are relettered paragraphs (h), (i) and (j) and a new paragraph (g) is added to read as follows:

(g) The review of the drug cost and pricing of specific drugs submitted to the board pursuant to section two hundred eighty of the public health law, and the formulation of recommendations as to a per-unit benchmark price for such drugs, in accordance with the provisions of such section.

§ 7. The social services law is amended by adding a new section 365-i to read as follows:

§ 365-i. Prescription drugs in medicaid managed care programs. 1. Definitions. (a) The definitions of terms in section two hundred seventy of the public health law shall apply to this section.

(b) As used in this section, unless the context clearly requires otherwise:

(i) "Managed care provider" means a managed care provider under section three hundred sixty-four-j of this title, a managed long term care plan under section forty-four hundred three-f of the public health law, or any other entity that provides or arranges for the provision of medical assistance services and supplies to participants directly or indirectly (including by referral), including case management, and the managed care provider's authorized agents.

(ii) "Participant" means a medical assistance recipient who receives, is required to receive or elects to receive his or her medical assistance services from a managed care provider.

2. Providing and payment for prescription drugs for medicaid managed care provider participants. Prescription drugs eligible for reimbursement under this article prescribed in relation to a service provided by a managed care provider shall be provided and paid for under the preferred drug program and the clinical drug review program under title one of article two-a of the public health law. The managed care provider shall account to and reimburse the department for the net cost to the department for prescription drugs provided to the managed care provid-

er's participants. Payment for prescription drugs shall be included in the capitation payments to the managed care provider for services or supplies provided to a managed care provider's participants.

§ 8. Section 270 of the public health law is amended by adding a new subdivision 15 to read as follows:

15. "Third-party health care payer" has its ordinary meanings and includes an entity such as a fiscal administrator, or administrative services provider that participates in the administration of a third-party health care payer system.

§ 9. The public health law is amended by adding a new section 274-a to read as follows:

§ 274-a. Use of preferred drug program and clinical drug review program. The commissioner shall contract with any third-party health care payer that so chooses, to use the preferred drug program and the clinical drug review program to provide and pay for prescription drugs for the third-party health care payer's enrollees. To contract under this section, the third-party health care payer shall provide coverage for prescription drugs authorized under this title. The third-party health care payer shall account to and reimburse the department for the net cost to the department for prescription drugs provided to the third-party health care payers' enrollees. The contract shall include terms required by the commissioner.

§ 10. Section 272 of the public health law is amended by adding a new subdivision 12 to read as follows:

12. (a) As used in this section, unless the context clearly requires otherwise, "high-priced drug" means a drug which:

(i) when first introduced on the market, is prohibitively expensive for patients who could benefit from the drug; or

(ii) suddenly or over a relatively brief period of time experiences a large price increase and such increase is not explained by a significant increase in ingredient costs or by some other relevant factor; or

(iii) has been determined to be priced disproportionally in relation to its therapeutic benefits.

(b) Where a drug meets the criteria in paragraph (a) of this subdivision:

(i) the commissioner may negotiate with the manufacturer of the drug for payment of an enhanced supplemental rebate, including under any provision of this section, and designate the drug to be on the preferred drug list; and

(ii) the high-priced drug shall not be placed on the preferred drug list in the absence of a negotiated enhanced supplemental rebate under this subdivision, or a rebate under section two hundred eighty of this article, notwithstanding paragraph (b) of subdivision ten of this section.

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

§ 12. The opening paragraph and subparagraphs (i) and (ii) of paragraph (b) and paragraph (d) of subdivision 9 of section 367-a of the social services law, the opening paragraph and paragraph (d) as amended by chapter 19 of the laws of 1998, subparagraphs (i) and (ii) of paragraph (b) as amended by section 2 of part C of chapter 60 of the laws of 2014, subparagraph (i) of paragraph (d) as amended by section 10-a of part H of chapter 59 of the laws of 2011 and subparagraph (ii) of paragraph (d) as amended by section 48 of part C of chapter 58 of the laws of 2009, are amended to read as follows:

Notwithstanding any inconsistent provision of law or regulation to the contrary, for those drugs which may not be dispensed without a prescription as required by section sixty-eight hundred ten of the education law and for which payment is authorized pursuant to paragraph (g) of subdivision two of section three hundred sixty-five-a of this title, and for those drugs that are available without a prescription as required by section sixty-eight hundred ten of the education law but are reimbursed as items of medical assistance pursuant to paragraph (a) of subdivision four of section three hundred sixty-five-a of this title, payments under this title shall be made at the following amounts:

(i) [~~if the drug dispensed is a multiple source prescription drug for which an upper limit has been set by the federal centers for medicare and medicaid services, the lower of: (A) an amount equal to the specific upper limit set by such federal agency for the multiple source prescription drug; (B) the estimated acquisition cost of such drug to pharmacies which, for purposes of this subparagraph, shall mean the average wholesale price of a prescription drug based on the package size dispensed from, as reported by the prescription drug pricing service used by the department, less twenty-five percent thereof; (C) the maximum acquisition cost, if any, established pursuant to paragraph (e) of this subdivision, provided that the methodology used by the department to establish a maximum acquisition cost shall not include average acquisition cost as determined by department surveys; or (D) the dispensing pharmacy's usual and customary price charged to the general public; and~~] if the drug dispensed is a generic prescription drug, or is a drug that is available without a prescription as required by section sixty-eight hundred ten of the education law but is reimbursed as an item of medical assistance pursuant to paragraph (a) of subdivision four of section three hundred sixty-five-a of this title, the lower of: (A) an amount equal to the national average drug acquisition cost set by the federal centers for medicare and medicaid services for the drug, if any, or if such amount if not available, the wholesale acquisition cost of the drug based on the package size dispensed from, as reported by the prescription drug pricing service used by the department; (B) the federal upper limit, if any, established by the federal centers for medicare and medicaid services; (C) the state maximum acquisition cost, if any, established pursuant to paragraph (e) of this subdivision; or (D) the dispensing pharmacy's usual and customary price charged to the general public;

(ii) if the drug dispensed is [~~a multiple source prescription drug or~~] a brand-name prescription drug [~~for which no specific upper limit has been set by such federal agency~~], the lower of [~~the estimated acquisition cost of such drug to pharmacies or the dispensing pharmacy's usual and customary price charged to the general public. For sole and multiple source brand name drugs, estimated acquisition cost means the average wholesale price of a prescription drug based upon the package size dispensed from, as reported by the prescription drug pricing service used by the department, less seventeen percent thereof or the wholesale acquisition cost of a prescription drug based upon package size dispensed from, as reported by the prescription drug pricing service used by the department, minus zero and forty-one hundredths percent thereof, and updated monthly by the department. For multiple source generic drugs, estimated acquisition cost means the lower of the average wholesale price of a prescription drug based on the package size dispensed from, as reported by the prescription drug pricing service used by the department, less twenty-five percent thereof, or the maximum~~

~~acquisition cost, if any, established pursuant to paragraph (e) of this subdivision, provided that the methodology used by the department to establish a maximum acquisition cost shall not include average acquisition cost as determined by department surveys.~~]:

(A) an amount equal to the national average drug acquisition cost set by the federal centers for medicare and medicaid services for the drug, if any, or if such amount is not available, the wholesale acquisition cost of the drug based on the package size dispensed from, as reported by the prescription drug pricing service used by the department; or (B) the dispensing pharmacy's usual and customary price charged to the general public; and

(d) In addition to the amounts paid pursuant to paragraph (b) of this subdivision [~~to pharmacies for those drugs which may not be dispensed without a prescription, as required by section sixty-eight hundred ten of the education law and for which payment is authorized pursuant to paragraph (g) of subdivision two of section three hundred sixty-five-a of this title~~], the department shall pay a professional pharmacy dispensing fee for each such [~~prescription~~] drug dispensed[~~, which dispensing fee shall not be less than the following amounts:~~

~~(i) for prescription drugs categorized as generic by the prescription drug pricing service used by the department, three dollars and fifty cents per prescription; and~~

~~(ii) for prescription drugs categorized as brand-name prescription drugs by the prescription drug pricing service used by the department, three dollars and fifty cents per prescription, provided, however, that for brand name prescription drugs reimbursed pursuant to subparagraph (ii) of paragraph (a-1) of subdivision four of section three hundred sixty-five-a of this title, the dispensing fee shall be four dollars and fifty cents per prescription~~] in the amount of ten dollars 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.

§ 13. It shall be an unacceptable practice in the Medicaid program established pursuant to title 11 of article 5 of the social services law for a provider to prescribe opioids in violation of the requirements of paragraph (g-1) of subdivision 2 of section 365-a of such law, in violation of any other applicable law limiting or restricting the prescribing of opioids, and/or contrary to recommendations issued by the drug utilization review board established by section 369-bb of the social services law, such practice may result in the provider being sanctioned pursuant to 18 NYCRR 515.

§ 14. Paragraph (g-1) of subdivision 2 of section 365-a of the social services law, as amended by section 5 of part C of chapter 60 of the laws of 2014, is amended to read as follows:

(g-1) drugs provided on an in-patient basis, those drugs contained on the list established by regulation of the commissioner of health pursuant to subdivision four of this section, and those drugs which may not be dispensed without a prescription as required by section sixty-eight hundred ten of the education law and which the commissioner of health shall determine to be reimbursable based upon such factors as the availability of such drugs or alternatives at low cost if purchased by a medicaid recipient, or the essential nature of such drugs as described by such commissioner in regulations, provided, however, that such drugs, exclusive of long-term maintenance drugs, shall be dispensed in quanti-

ties no greater than a thirty day supply or one hundred doses, whichever is greater; provided further that the commissioner of health is authorized to require prior authorization for any refill of a prescription when more than a ten day supply of the previously dispensed amount should remain were the product used as normally indicated, or in the case of a controlled substance, as defined in section thirty-three hundred two of the public health law, when more than a seven day supply of the previously dispensed amount should remain were the product used as normally indicated; provided further that the commissioner of health is authorized to require prior authorization of prescriptions of opioid analgesics in excess of four prescriptions in a thirty-day period in accordance with section two hundred seventy-three of the public health law; medical assistance shall not include any drug provided on other than an in-patient basis for which a recipient is charged or a claim is made in the case of a prescription drug, in excess of the maximum reimbursable amounts to be established by department regulations in accordance with standards established by the secretary of the United States department of health and human services, or, in the case of a drug not requiring a prescription, in excess of the maximum reimbursable amount established by the commissioner of health pursuant to paragraph (a) of subdivision four of this section;

§ 15. Subparagraph (iii) of paragraph (c) of subdivision 6 of section 367-a of the social services law, as amended by section 9 of part C of chapter 60 of the laws of 2014, is amended to read as follows:

(iii) Notwithstanding any other provision of this paragraph, co-payments charged for each generic prescription drug dispensed shall be one dollar and for each brand name prescription drug dispensed shall be [~~three dollars~~] two dollars and fifty cents; provided, however, that the co-payments charged for [~~each brand name prescription drug on the preferred drug list established pursuant to section two hundred seventy-two of the public health law or, for managed care providers operating pursuant to section three hundred sixty-four-j of this title, for each brand name prescription drug on a managed care provider's formulary that such provider has designated as a preferred drug, and the co-payments charged for~~] each brand name prescription drug reimbursed pursuant to subparagraph (ii) of paragraph (a-1) of subdivision four of section three hundred sixty-five-a of this title shall be one dollar.

§ 16. Subparagraphs 1 and 5 of paragraph (f) of subdivision 7 of section 367-a of the social services law, as added by section 11 of part B of chapter 59 of the laws of 2016, are amended to read as follows:

(1) The department may require manufacturers of drugs other than single source drugs and innovator multiple source drugs, as such terms are defined in 42 U.S.C. § 1396r-8(k), to provide rebates to the department for any drug that has increased more than three hundred percent of its state maximum acquisition cost (SMAC)[~~, on or after~~] during the period April 1, 2016 through March 31, 2017, or that has increased more than seventy-five percent of its SMAC on or after April 1, 2017, in comparison to its SMAC at any time during the course of the preceding twelve months. The required rebate shall be limited to the amount by which the current SMAC for the drug exceeds [~~three hundred percent~~] the applicable percentage of the SMAC for the same drug at any time during the course of the preceding twelve months. Such rebates shall be in addition to any rebates payable to the department pursuant to any other provision of federal or state law. Nothing herein shall affect the department's obligation to reimburse for covered outpatient drugs pursuant to paragraph (d) of this subdivision.

(5) Beginning in two thousand seventeen, the department shall provide an annual report to the legislature no later than February first setting forth:

(i) The number of drugs that exceeded the ceiling price established in this paragraph during the preceding year in comparison to the number of drugs that experienced at least a three hundred percent price increase during two thousand fourteen and two thousand fifteen**, or at least a seventy-five percent price increase during two thousand fifteen and two thousand sixteen**;

(ii) The average percent amount above the ceiling price of drugs that exceeded the ceiling price in the preceding year in comparison to the number of drugs that experienced a price increase more than three hundred percent during two thousand fourteen and two thousand fifteen**, or at least a seventy-five percent price increase during two thousand fifteen and two thousand sixteen**;

(iii) The number of generic drugs available to enrollees in Medicaid fee for service or Medicaid managed care, by fiscal quarter, in the preceding year in comparison to the drugs available, by fiscal quarter, during two thousand fourteen [~~and~~]**,** two thousand fifteen**, and two thousand sixteen**; and

(iv) The total drug spend on generic drugs for the preceding year in comparison to the total drug spend on generic drugs during two thousand fourteen [~~and~~]**,** two thousand fifteen**, and two thousand sixteen**.

§ 17. Severability. If any clause, sentence, paragraph, or subdivision of this section 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, or subdivision 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 section would have been enacted even if such invalid provisions had not been included herein.

§ 18. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2017; provided, however, that sections fourteen, fifteen, and sixteen of this act shall take effect July 1, 2017; provided, further, that the amendments to paragraph (c) of subdivision 6 of section 367-a of the social services law made by section fifteen of this act shall not affect the repeal of such paragraph and shall be deemed repealed therewith; provided, further, that the amendments to paragraph (f) of subdivision 7 of section 367-a of the social services law made by section sixteen of this act shall not affect the repeal of such paragraph and shall be deemed repealed therewith; and provided, further, that the amendments to subdivision 9 of section 367-a of the social services law made by section twelve of this act shall not affect the expiration of such subdivision and shall be deemed to expire therewith.

PART E

Intentionally Omitted

PART F

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; **and adult day health care programs located at a licensed residential health care facility as defined by section twenty-eight hundred one of the public health law or an approved extension site thereof**. 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. This act shall take effect October 1, 2017; provided, further, that the amendments to 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 be deemed repealed therewith.

PART G

Intentionally Omitted

PART H

Section 1. Subdivision 5 of section 168 of chapter 639 of the laws of 1996, constituting the New York Health Care Reform Act of 1996, as amended by section 1 of part B of chapter 60 of the laws of 2014, is amended to read as follows:

5. sections 2807-c, 2807-j, 2807-s and 2807-t of the public health law, as amended or as added by this act, shall expire on December 31, [~~2017~~] **2020**, and shall be thereafter effective only in respect to any act done on or before such date or action or proceeding arising out of such act including continued collections of funds from assessments and allowances and surcharges established pursuant to sections 2807-c, 2807-j, 2807-s and 2807-t of the public health law, and administration and distributions of funds from pools established pursuant to sections 2807-c, 2807-j, 2807-k, 2807-l, 2807-m, 2807-s and 2807-t of the public health law related to patient services provided before December 31,

[~~2017~~] 2020, and continued expenditure of funds authorized for programs and grants until the exhaustion of funds therefor;

§ 2. Subdivision 1 of section 138 of chapter 1 of the laws of 1999, constituting the New York Health Care Reform Act of 2000, as amended by section 2 of part B of chapter 60 of the laws of 2014, is amended to read as follows:

1. sections 2807-c, 2807-j, 2807-s, and 2807-t of the public health law, as amended by this act, shall expire on December 31, [~~2017~~] 2020, and shall be thereafter effective only in respect to any act done before such date or action or proceeding arising out of such act including continued collections of funds from assessments and allowances and surcharges established pursuant to sections 2807-c, 2807-j, 2807-s and 2807-t of the public health law, and administration and distributions of funds from pools established pursuant to sections 2807-c, 2807-j, 2807-k, 2807-l, 2807-m, 2807-s, 2807-t, 2807-v and 2807-w of the public health law, as amended or added by this act, related to patient services provided before December 31, [~~2017~~] 2020, and continued expenditure of funds authorized for programs and grants until the exhaustion of funds therefor;

§ 3. Subparagraph (xv) of paragraph (a) of subdivision 6 of section 2807-s of the public health law, as amended by section 3 of part B of chapter 60 of the laws of 2014, is amended to read as follows:

(xv) A gross annual statewide amount for the period January first, two thousand fifteen through December thirty-first, two thousand [~~seventeen~~] twenty, shall be one billion forty-five million dollars.

§ 4. Subparagraph (xiii) of paragraph (a) of subdivision 7 of section 2807-s of the public health law, as amended by section 4 of part B of chapter 60 of the laws of 2014, 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 [~~seventeen~~] twenty;

§ 5. Subparagraphs (iv) and (v) of paragraph (a) of subdivision 9 of section 2807-j of the public health law, as amended by section 5 of part B of chapter 60 of the laws of 2014, are amended to read as follows:

(iv) seven hundred sixty-five million dollars annually of the funds accumulated for the periods January first, two thousand through December thirty-first, two thousand [~~sixteen~~] nineteen, and

(v) one hundred ninety-one million two hundred fifty thousand dollars of the funds accumulated for the period January first, two thousand [~~seventeen~~] twenty through March thirty-first, two thousand [~~seventeen~~] twenty.

§ 6. Subdivisions 5-a and 7 of section 2807-m of the public health law, as amended by section 9 of part B of chapter 60 of the laws of 2014, subparagraphs (iv), (v) and (vi) of paragraph (d) of subdivision 5-a as added by section 4 of part W of chapter 57 of the laws of 2015, are amended to read as follows:

5-a. Graduate medical education innovations pool. (a) Supplemental distributions. (i) Thirty-one million dollars for the period January first, two thousand eight through December thirty-first, two thousand eight, shall be set aside and reserved by the commissioner from the regional pools established pursuant to subdivision two of this section and shall be available for distributions pursuant to subdivision five of this section and in accordance with section 86-1.89 of title 10 of the codes, rules and regulations of the state of New York as in effect on January first, two thousand eight; provided, however, for purposes of funding the empire clinical research investigation program (ECRIP) in

accordance with paragraph eight of subdivision (e) and paragraph two of subdivision (f) of section 86-1.89 of title 10 of the codes, rules and regulations of the state of New York, distributions shall be made using two regions defined as New York city and the rest of the state and the dollar amount set forth in subparagraph (i) of paragraph two of subdivision (f) of section 86-1.89 of title 10 of the codes, rules and regulations of the state of New York shall be increased from sixty thousand dollars to seventy-five thousand dollars.

(ii) For periods on and after January first, two thousand nine, supplemental distributions pursuant to subdivision five of this section and in accordance with section 86-1.89 of title 10 of the codes, rules and regulations of the state of New York shall no longer be made and the provisions of section 86-1.89 of title 10 of the codes, rules and regulations of the state of New York shall be null and void.

(b) Empire clinical research investigator program (ECRIP). 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, [~~and~~] 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 within amounts appropriated for each state fiscal year for periods on and after April first, two thousand seventeen**, 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:

Distributions shall first be made to consortia and teaching general hospitals for the empire clinical research investigator program (ECRIP) to help secure federal funding for biomedical research, train clinical researchers, recruit national leaders as faculty to act as mentors, and train residents and fellows in biomedical research skills based on hospital-specific data submitted to the commissioner by consortia and teaching general hospitals in accordance with clause (G) of this subparagraph. Such distributions shall be made in accordance with the following methodology:

(A) The greatest number of clinical research positions for which a consortium or teaching general hospital may be funded pursuant to this subparagraph shall be one percent of the total number of residents training at the consortium or teaching general hospital on July first, two thousand eight for the period January first, two thousand nine through December thirty-first, two thousand nine rounded up to the nearest one position.

(B) Distributions made to a consortium or teaching general hospital shall equal the product of the total number of clinical research positions submitted by a consortium or teaching general hospital and accepted by the commissioner as meeting the criteria set forth in paragraph (b) of subdivision one of this section, subject to the reduction calculation set forth in clause (C) of this subparagraph, times one hundred ten thousand dollars.

(C) If the dollar amount for the total number of clinical research positions in the region calculated pursuant to clause (B) of this subparagraph exceeds the total amount appropriated for purposes of this paragraph, including clinical research positions that continue from and were funded in prior distribution periods, the commissioner shall eliminate one-half of the clinical research positions submitted by each consortium or teaching general hospital rounded down to the nearest one position. Such reduction shall be repeated until the dollar amount for the total number of clinical research positions in the region does not exceed the total amount appropriated for purposes of this paragraph. If the repeated reduction of the total number of clinical research positions in the region by one-half does not render a total funding amount that is equal to or less than the total amount reserved for that region within the appropriation, the funding for each clinical research position in that region shall be reduced proportionally in one thousand dollar increments until the total dollar amount for the total number of clinical research positions in that region does not exceed the total amount reserved for that region within the appropriation. Any reduction in funding will be effective for the duration of the award. No clinical research positions that continue from and were funded in prior distribution periods shall be eliminated or reduced by such methodology.

(D) Each consortium or teaching general hospital shall receive its annual distribution amount in accordance with the following:

(I) Each consortium or teaching general hospital with a one-year ECRIP award shall receive its annual distribution amount in full upon completion of the requirements set forth in items (I) and (II) of clause (G) of this subparagraph. The requirements set forth in items (IV) and (V) of clause (G) of this subparagraph must be completed by the consortium or teaching general hospital in order for the consortium or teaching general hospital to be eligible to apply for ECRIP funding in any subsequent funding cycle.

(II) Each consortium or teaching general hospital with a two-year ECRIP award shall receive its first annual distribution amount in full upon completion of the requirements set forth in items (I) and (II) of clause (G) of this subparagraph. Each consortium or teaching general hospital will receive its second annual distribution amount in full upon completion of the requirements set forth in item (III) of clause (G) of this subparagraph. The requirements set forth in items (IV) and (V) of clause (G) of this subparagraph must be completed by the consortium or teaching general hospital in order for the consortium or teaching general hospital to be eligible to apply for ECRIP funding in any subsequent funding cycle.

(E) Each consortium or teaching general hospital receiving distributions pursuant to this subparagraph shall reserve seventy-five thousand dollars to primarily fund salary and fringe benefits of the clinical research position with the remainder going to fund the development of faculty who are involved in biomedical research, training and clinical care.

(F) Undistributed or returned funds available to fund clinical research positions pursuant to this paragraph for a distribution period shall be available to fund clinical research positions in a subsequent distribution period.

(G) In order to be eligible for distributions pursuant to this subparagraph, each consortium and teaching general hospital shall provide to the commissioner by July first of each distribution period, the following data and information on a hospital-specific basis. Such data and

information shall be certified as to accuracy and completeness by the chief executive officer, chief financial officer or chair of the consortium governing body of each consortium or teaching general hospital and shall be maintained by each consortium and teaching general hospital for five years from the date of submission:

(I) For each clinical research position, information on the type, scope, training objectives, institutional support, clinical research experience of the sponsor-mentor, plans for submitting research outcomes to peer reviewed journals and at scientific meetings, including a meeting sponsored by the department, the name of a principal contact person responsible for tracking the career development of researchers placed in clinical research positions, as defined in paragraph (c) of subdivision one of this section, and who is authorized to certify to the commissioner that all the requirements of the clinical research training objectives set forth in this subparagraph shall be met. Such certification shall be provided by July first of each distribution period;

(II) For each clinical research position, information on the name, citizenship status, medical education and training, and medical license number of the researcher, if applicable, shall be provided by December thirty-first of the calendar year following the distribution period;

(III) Information on the status of the clinical research plan, accomplishments, changes in research activities, progress, and performance of the researcher shall be provided upon completion of one-half of the award term;

(IV) A final report detailing training experiences, accomplishments, activities and performance of the clinical researcher, and data, methods, results and analyses of the clinical research plan shall be provided three months after the clinical research position ends; and

(V) Tracking information concerning past researchers, including but not limited to (A) background information, (B) employment history, (C) research status, (D) current research activities, (E) publications and presentations, (F) research support, and (G) any other information necessary to track the researcher; and

(VI) Any other data or information required by the commissioner to implement this subparagraph.

(H) Notwithstanding any inconsistent provision of this subdivision, for periods on and after April first, two thousand thirteen, ECRIP grant awards shall be made in accordance with rules and regulations promulgated by the commissioner. Such regulations shall, at a minimum:

(1) provide that ECRIP grant awards shall be made with the objective of securing federal funding for biomedical research, training clinical researchers, recruiting national leaders as faculty to act as mentors, and training residents and fellows in biomedical research skills;

(2) provide that ECRIP grant applicants may include interdisciplinary research teams comprised of teaching general hospitals acting in collaboration with entities including but not limited to medical centers, hospitals, universities and local health departments;

(3) provide that applications for ECRIP grant awards shall be based on such information requested by the commissioner, which shall include but not be limited to hospital-specific data;

(4) establish the qualifications for investigators and other staff required for grant projects eligible for ECRIP grant awards; and

(5) establish a methodology for the distribution of funds under ECRIP grant awards.

(c) Ambulatory care training. Four million nine hundred thousand dollars for the period January first, two thousand eight through Decem-

ber thirty-first, two thousand eight, four million nine hundred thousand dollars for the period January first, two thousand nine through December thirty-first, two thousand nine, four million nine hundred thousand dollars for the period January first, two thousand ten through December thirty-first, two thousand ten, one million two hundred twenty-five thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven, four million three hundred thousand dollars each state fiscal year for the period April first, two thousand eleven through March thirty-first, two thousand fourteen, [~~and~~] up to four million sixty thousand dollars each state fiscal year for the period April first, two thousand fourteen through March thirty-first, two thousand seventeen**, and within amounts appropriated for each state fiscal year for periods on and after April first, two thousand seventeen**, shall be set aside and reserved by the commissioner from the regional pools established pursuant to subdivision two of this section and shall be available for distributions to sponsoring institutions to be directed to support clinical training of medical students and residents in free-standing ambulatory care settings, including community health centers and private practices. Such funding shall 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 distributed to sponsoring institutions in each region pursuant to a request for application or request for proposal process with preference being given to sponsoring institutions which provide training in sites located in underserved rural or inner-city areas and those that include medical students in such training.

(d) Physician loan repayment program. One million nine hundred sixty thousand dollars for the period January first, two thousand eight through December thirty-first, two thousand eight, one million nine hundred sixty thousand dollars for the period January first, two thousand nine through December thirty-first, two thousand nine, one million nine hundred sixty thousand dollars for the period January first, two thousand ten through December thirty-first, two thousand ten, four hundred ninety thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven, one million seven hundred thousand dollars each state fiscal year for the period April first, two thousand eleven through March thirty-first, two thousand fourteen, [~~and~~] up to one million seven hundred five thousand dollars each state fiscal year for the period April first, two thousand fourteen through March thirty-first, two thousand seventeen**, and within amounts appropriated for each state fiscal year for periods on and after April first, two thousand seventeen**, shall be set aside and reserved by the commissioner from the regional pools established pursuant to subdivision two of this section and shall be available for purposes of physician loan repayment in accordance with subdivision ten of this section. Notwithstanding any contrary provision of this section, sections one hundred twelve and one hundred sixty-three of the state finance law, or any other contrary provision of law, such funding shall be allocated regionally with one-third of available funds going to New York city and two-thirds of available funds going to the rest of the state and shall be distributed in a manner to be determined by the commissioner without a competitive bid or request for proposal process as follows:

(i) Funding shall first be awarded to repay loans of up to twenty-five physicians who train in primary care or specialty tracks in teaching

general hospitals, and who enter and remain in primary care or specialty practices in underserved communities, as determined by the commissioner.

(ii) After distributions in accordance with subparagraph (i) of this paragraph, all remaining funds shall be awarded to repay loans of physicians who enter and remain in primary care or specialty practices in underserved communities, as determined by the commissioner, including but not limited to physicians working in general hospitals, or other health care facilities.

(iii) In no case shall less than fifty percent of the funds available pursuant to this paragraph be distributed in accordance with subparagraphs (i) and (ii) of this paragraph to physicians identified by general hospitals.

(iv) In addition to the funds allocated under this paragraph, for the period April first, two thousand fifteen through March thirty-first, two thousand sixteen, two million dollars shall be available for the purposes described in subdivision ten of this section;

(v) In addition to the funds allocated under this paragraph, for the period April first, two thousand sixteen through March thirty-first, two thousand seventeen, two million dollars shall be available for the purposes described in subdivision ten of this section;

(vi) Notwithstanding any provision of law to the contrary, and subject to the extension of the Health Care Reform Act of 1996, sufficient funds shall be available for the purposes described in subdivision ten of this section in amounts necessary to fund the remaining year commitments for awards made pursuant to subparagraphs (iv) and (v) of this paragraph.

(e) Physician practice support. Four million nine hundred thousand dollars for the period January first, two thousand eight through December thirty-first, two thousand eight, four million nine hundred thousand dollars annually for the period January first, two thousand nine through December thirty-first, two thousand ten, one million two hundred twenty-five thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven, four million three hundred thousand dollars each state fiscal year for the period April first, two thousand eleven through March thirty-first, two thousand fourteen, [~~and~~] up to four million three hundred sixty thousand dollars each state fiscal year for the period April first, two thousand fourteen through March thirty-first, two thousand seventeen**, and within amounts appropriated for each state fiscal year for periods on and after April first, two thousand seventeen**, shall be set aside and reserved by the commissioner from the regional pools established pursuant to subdivision two of this section and shall be available for purposes of physician practice support. Notwithstanding any contrary provision of this section, sections one hundred twelve and one hundred sixty-three of the state finance law, or any other contrary provision of law, such funding shall be allocated regionally with one-third of available funds going to New York city and two-thirds of available funds going to the rest of the state and shall be distributed in a manner to be determined by the commissioner without a competitive bid or request for proposal process as follows:

(i) Preference in funding shall first be accorded to teaching general hospitals for up to twenty-five awards, to support costs incurred by physicians trained in primary or specialty tracks who thereafter establish or join practices in underserved communities, as determined by the commissioner.

(ii) After distributions in accordance with subparagraph (i) of this paragraph, all remaining funds shall be awarded to physicians to support

the cost of establishing or joining practices in underserved communities, as determined by the commissioner, and to hospitals and other health care providers to recruit new physicians to provide services in underserved communities, as determined by the commissioner.

(iii) In no case shall less than fifty percent of the funds available pursuant to this paragraph be distributed to general hospitals in accordance with subparagraphs (i) and (ii) of this paragraph.

(e-1) Work group. For funding available pursuant to paragraphs (d) and (e) of this subdivision:

(i) The department shall appoint a work group from recommendations made by associations representing physicians, general hospitals and other health care facilities to develop a streamlined application process by June first, two thousand twelve.

(ii) Subject to available funding, applications shall be accepted on a continuous basis. The department shall provide technical assistance to applicants to facilitate their completion of applications. An applicant shall be notified in writing by the department within ten days of receipt of an application as to whether the application is complete and if the application is incomplete, what information is outstanding. The department shall act on an application within thirty days of receipt of a complete application.

(f) Study on physician workforce. Five hundred ninety thousand dollars annually for the period January first, two thousand eight through December thirty-first, two thousand ten, one hundred forty-eight thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven, five hundred sixteen thousand dollars each state fiscal year for the period April first, two thousand eleven through March thirty-first, two thousand fourteen, [~~and~~] up to four hundred eighty-seven thousand dollars each state fiscal year for the period April first, two thousand fourteen through March thirty-first, two thousand seventeen**, and within amounts appropriated for each state fiscal year for periods on and after April first, two thousand seventeen**, shall be set aside and reserved by the commissioner from the regional pools established pursuant to subdivision two of this section and shall be available to fund a study of physician workforce needs and solutions including, but not limited to, an analysis of residency programs and projected physician workforce and community needs. The commissioner shall enter into agreements with one or more organizations to conduct such study based on a request for proposal process.

(g) Diversity in medicine/post-baccalaureate program. Notwithstanding any inconsistent provision of section one hundred twelve or one hundred sixty-three of the state finance law or any other law, one million nine hundred sixty thousand dollars annually for the period January first, two thousand eight through December thirty-first, two thousand ten, four hundred ninety thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven, one million seven hundred thousand dollars each state fiscal year for the period April first, two thousand eleven through March thirty-first, two thousand fourteen, [~~and~~] up to one million six hundred five thousand dollars each state fiscal year for the period April first, two thousand fourteen through March thirty-first, two thousand seventeen**, and within amounts appropriated for each state fiscal year for periods on and after April first, two thousand seventeen**, shall be set aside and reserved by the commissioner from the regional pools established pursuant to subdivision two of this section and shall be available for distributions to the Associated Medical Schools of New York to fund its diversity program

including existing and new post-baccalaureate programs for minority and economically disadvantaged students and encourage participation from all medical schools in New York. The associated medical schools of New York shall report to the commissioner on an annual basis regarding the use of funds for such purpose in such form and manner as specified by the commissioner.

(h) In the event there are undistributed funds within amounts made available for distributions pursuant to this subdivision, such funds may be reallocated and distributed in current or subsequent distribution periods in a manner determined by the commissioner for any purpose set forth in this subdivision.

7. Notwithstanding any inconsistent provision of section one hundred twelve or one hundred sixty-three of the state finance law or any other law, up to one million dollars for the period January first, two thousand through December thirty-first, two thousand, one million six hundred thousand dollars annually for the periods January first, two thousand one through December thirty-first, two thousand eight, one million five hundred thousand dollars annually for the periods January first, two thousand nine through December thirty-first, two thousand ten, three hundred seventy-five thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven, one million three hundred twenty thousand dollars each state fiscal year for the period April first, two thousand eleven through March thirty-first, two thousand fourteen, [~~and~~] up to two million seventy-seven thousand dollars each state fiscal year for the period April first, two thousand fourteen through March thirty-first, two thousand seventeen**, and within amounts appropriated for each state fiscal year for periods on and after April first, two thousand seventeen**, shall be set aside and reserved by the commissioner from the regional pools established pursuant to subdivision two of this section and shall be available for distributions to the New York state area health education center program for the purpose of expanding community-based training of medical students. In addition, one million dollars annually for the period January first, two thousand eight through December thirty-first, two thousand ten, two hundred fifty thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven, and eight hundred eighty thousand dollars each state fiscal year for the period April first, two thousand eleven through March thirty-first, two thousand fourteen, shall be set aside and reserved by the commissioner from the regional pools established pursuant to subdivision two of this section and shall be available for distributions to the New York state area health education center program for the purpose of post-secondary training of health care professionals who will achieve specific program outcomes within the New York state area health education center program. The New York state area health education center program shall report to the commissioner on an annual basis regarding the use of funds for each purpose in such form and manner as specified by the commissioner.

§ 7. Paragraph (a) of subdivision 12 of section 367-b of the social services law, as amended by section 10 of part B of chapter 60 of the laws of 2014, is amended to read as follows:

(a) For the purpose of regulating cash flow for general hospitals, the department shall develop and implement a payment methodology to provide for timely payments for inpatient hospital services eligible for case based payments per discharge based on diagnosis-related groups provided during the period January first, nineteen hundred eighty-eight through

March thirty-first two thousand [~~seventeen~~] twenty, by such hospitals which elect to participate in the system.

§ 8. Subdivision 6 of section 2807-t of the public health law, as amended by section 15 of part B of chapter 60 of the laws of 2014, is amended to read as follows:

6. Prospective adjustments. (a) The commissioner shall annually reconcile the sum of the actual payments made to the commissioner or the commissioner's designee for each region pursuant to section twenty-eight hundred seven-s of this article and pursuant to this section for the prior year with the regional allocation of the gross annual statewide amount specified in subdivision six of section twenty-eight hundred seven-s of this article for such prior year. The difference between the actual amount raised for a region and the regional allocation of the specified gross annual amount for such prior year shall be applied as a prospective adjustment to the regional allocation of the specified gross annual payment amount for such region for the year next following the calculation of the reconciliation. The authorized dollar value of the adjustments shall be the same as if calculated retrospectively.

(b) Notwithstanding the provisions of paragraph (a) of this subdivision, for covered lives assessment rate periods on and after January first, two thousand fifteen through December thirty-first, two thousand [~~seventeen~~] twenty, for amounts collected in the aggregate in excess of one billion forty-five million dollars on an annual basis, prospective adjustments shall be suspended if the annual reconciliation calculation from the prior year would otherwise result in a decrease to the regional allocation of the specified gross annual payment amount for that region, provided, however, that such suspension shall be lifted upon a determination by the commissioner, in consultation with the director of the budget, that sixty-five million dollars in aggregate collections on an annual basis over and above one billion forty-five million dollars on an annual basis have been reserved and set aside for deposit in the HCRA resources fund. Any amounts collected in the aggregate at or below one billion forty-five million dollars on an annual basis, shall be subject to regional adjustments reconciling any decreases or increases to the regional allocation in accordance with paragraph (a) of this subdivision.

§ 9. Section 34 of part A3 of chapter 62 of the laws of 2003 amending the general business law and other laws relating to enacting major components necessary to implement the state fiscal plan for the 2003-04 state fiscal year, as amended by section 6 of part B of chapter 60 of the laws of 2014, is amended to read as follows:

§ 34. (1) Notwithstanding any inconsistent provision of law, rule or regulation and effective April 1, 2008 through March 31, [~~2017~~] 2020, the commissioner of health is authorized to transfer and the state comptroller is authorized and directed to receive for deposit to the credit of the department of health's special revenue fund - other, health care reform act (HCRA) resources fund - 061, provider collection monitoring account, within amounts appropriated each year, those funds collected and accumulated pursuant to section 2807-v of the public health law, including income from invested funds, for the purpose of payment for administrative costs of the department of health related to administration of statutory duties for the collections and distributions authorized by section 2807-v of the public health law.

(2) Notwithstanding any inconsistent provision of law, rule or regulation and effective April 1, 2008 through March 31, [~~2017~~] 2020, the commissioner of health is authorized to transfer and the state comp-

troller is authorized and directed to receive for deposit to the credit of the department of health's special revenue fund - other, health care reform act (HCRA) resources fund - 061, provider collection monitoring account, within amounts appropriated each year, those funds collected and accumulated and interest earned through surcharges on payments for health care services pursuant to section 2807-s of the public health law and from assessments pursuant to section 2807-t of the public health law for the purpose of payment for administrative costs of the department of health related to administration of statutory duties for the collections and distributions authorized by sections 2807-s, 2807-t, and 2807-m of the public health law.

(3) Notwithstanding any inconsistent provision of law, rule or regulation and effective April 1, 2008 through March 31, [~~2017~~] 2020, the commissioner of health is authorized to transfer and the comptroller is authorized to deposit, within amounts appropriated each year, those funds authorized for distribution in accordance with the provisions of paragraph (a) of subdivision 1 of section 2807-l of the public health law for the purposes of payment for administrative costs of the department of health related to the child health insurance plan program authorized pursuant to title 1-A of article 25 of the public health law into the special revenue funds - other, health care reform act (HCRA) resources fund - 061, child health insurance account, established within the department of health.

(4) Notwithstanding any inconsistent provision of law, rule or regulation and effective April 1, 2008 through March 31, [~~2017~~] 2020, the commissioner of health is authorized to transfer and the comptroller is authorized to deposit, within amounts appropriated each year, those funds authorized for distribution in accordance with the provisions of paragraph (e) of subdivision 1 of section 2807-l of the public health law for the purpose of payment for administrative costs of the department of health related to the health occupation development and workplace demonstration program established pursuant to section 2807-h and the health workforce retraining program established pursuant to section 2807-g of the public health law into the special revenue funds - other, health care reform act (HCRA) resources fund - 061, health occupation development and workplace demonstration program account, established within the department of health.

(5) Notwithstanding any inconsistent provision of law, rule or regulation and effective April 1, 2008 through March 31, [~~2017~~] 2020, the commissioner of health is authorized to transfer and the comptroller is authorized to deposit, within amounts appropriated each year, those funds allocated pursuant to paragraph (j) of subdivision 1 of section 2807-v of the public health law for the purpose of payment for administrative costs of the department of health related to administration of the state's tobacco control programs and cancer services provided pursuant to sections 2807-r and 1399-ii of the public health law into such accounts established within the department of health for such purposes.

(6) Notwithstanding any inconsistent provision of law, rule or regulation and effective April 1, 2008 through March 31, [~~2017~~] 2020, the commissioner of health is authorized to transfer and the comptroller is authorized to deposit, within amounts appropriated each year, the funds authorized for distribution in accordance with the provisions of section 2807-l of the public health law for the purposes of payment for administrative costs of the department of health related to the programs funded pursuant to section 2807-l of the public health law into the special revenue funds - other, health care reform act (HCRA) resources fund -

061, pilot health insurance account, established within the department of health.

(7) Notwithstanding any inconsistent provision of law, rule or regulation and effective April 1, 2008 through March 31, [~~2017~~] **2020**, the commissioner of health is authorized to transfer and the comptroller is authorized to deposit, within amounts appropriated each year, those funds authorized for distribution in accordance with the provisions of subparagraph (ii) of paragraph (f) of subdivision 19 of section 2807-c of the public health law from monies accumulated and interest earned in the bad debt and charity care and capital statewide pools through an assessment charged to general hospitals pursuant to the provisions of subdivision 18 of section 2807-c of the public health law and those funds authorized for distribution in accordance with the provisions of section 2807-l of the public health law for the purposes of payment for administrative costs of the department of health related to programs funded under section 2807-l of the public health law into the special revenue funds - other, health care reform act (HCRA) resources fund - 061, primary care initiatives account, established within the department of health.

(8) Notwithstanding any inconsistent provision of law, rule or regulation and effective April 1, 2008 through March 31, [~~2017~~] **2020**, the commissioner of health is authorized to transfer and the comptroller is authorized to deposit, within amounts appropriated each year, those funds authorized for distribution in accordance with section 2807-l of the public health law for the purposes of payment for administrative costs of the department of health related to programs funded under section 2807-l of the public health law into the special revenue funds - other, health care reform act (HCRA) resources fund - 061, health care delivery administration account, established within the department of health.

(9) Notwithstanding any inconsistent provision of law, rule or regulation and effective April 1, 2008 through March 31, [~~2017~~] **2020**, the commissioner of health is authorized to transfer and the comptroller is authorized to deposit, within amounts appropriated each year, those funds authorized pursuant to sections 2807-d, 3614-a and 3614-b of the public health law and section 367-i of the social services law and for distribution in accordance with the provisions of subdivision 9 of section 2807-j of the public health law for the purpose of payment for administration of statutory duties for the collections and distributions authorized by sections 2807-c, 2807-d, 2807-j, 2807-k, 2807-l, 3614-a and 3614-b of the public health law and section 367-i of the social services law into the special revenue funds - other, health care reform act (HCRA) resources fund - 061, provider collection monitoring account, established within the department of health.

§ 10. Section 2 of chapter 600 of the laws of 1986 amending the public health law relating to the development of pilot reimbursement programs for ambulatory care services, as amended by section 11 of part B of chapter 60 of the laws of 2014, is amended to read as follows:

§ 2. This act shall take effect immediately, except that this act shall expire and be of no further force and effect on and after April 1, [~~2017~~] **2020**; provided, however, that the commissioner of health shall submit a report to the governor and the legislature detailing the objective, impact, design and computation of any pilot reimbursement program established pursuant to this act, on or before March 31, 1994 and annually thereafter. Such report shall include an assessment of the finan-

cial impact of such payment system on providers, as well as the impact of such system on access to care.

§ 11. Paragraph (i) of subdivision (b) of section 1 of chapter 520 of the laws of 1978, relating to providing for a comprehensive survey of health care financing, education and illness prevention and creating councils for the conduct thereof, as amended by section 12 of part B of chapter 60 of the laws of 2014, is amended to read as follows:

(i) oversight and evaluation of the inpatient financing system in place for 1988 through March 31, [~~2017~~] **2020**, and the appropriateness and effectiveness of the bad debt and charity care financing provisions;

§ 12. Paragraph (l) of subdivision 9 of section 3614 of the public health law, as added by section 13 of part B of chapter 60 of the laws of 2014, is amended to read as follows:

(l) for the period April first, two thousand sixteen through March thirty-first, two thousand [~~seventeen~~] **twenty**, up to one hundred million dollars **annually**.

§ 13. Paragraph (p) of subdivision 1 of section 367-q of the social services law, as added by section 14 of part B of chapter 60 of the laws of 2014, is amended to read as follows:

(p) for the period April first, two thousand sixteen through March thirty-first, two thousand [~~seventeen~~] **twenty**, up to twenty-eight million five hundred thousand dollars **annually**.

§ 14. Subdivision 4-c of section 2807-p of the public health law, as amended by section 16 of part B of chapter 60 of the laws of 2014, is amended to read as follows:

4-c. Notwithstanding any provision of law to the contrary, the commissioner shall make additional payments for uncompensated care to voluntary non-profit diagnostic and treatment centers that are eligible for distributions under subdivision four of this section in the following amounts: for the period June first, two thousand six through December thirty-first, two thousand six, in the amount of seven million five hundred thousand dollars, for the period January first, two thousand seven through December thirty-first, two thousand seven, seven million five hundred thousand dollars, for the period January first, two thousand eight through December thirty-first, two thousand eight, seven million five hundred thousand dollars, for the period January first, two thousand nine through December thirty-first, two thousand nine, fifteen million five hundred thousand dollars, for the period January first, two thousand ten through December thirty-first, two thousand ten, seven million five hundred thousand dollars, for the period January first, two thousand eleven though December thirty-first, two thousand eleven, seven million five hundred thousand dollars, for the period January first, two thousand twelve through December thirty-first, two thousand twelve, seven million five hundred thousand dollars, for the period January first, two thousand thirteen through December thirty-first, two thousand thirteen, seven million five hundred thousand dollars, for the period January first, two thousand fourteen through December thirty-first, two thousand fourteen, seven million five hundred thousand dollars, for the period January first, two thousand fifteen through December thirty-first, two thousand fifteen, seven million five hundred thousand dollars, for the period January first two thousand sixteen through December thirty-first, two thousand sixteen, seven million five hundred thousand dollars, and for the period January first, two thousand [~~seventeen~~] **twenty** through March thirty-first, two thousand [~~seventeen~~] **twenty**, in the amount of one million six hundred thousand dollars, provided, however, that for periods on and after January first, two

thousand eight, such additional payments shall be distributed to voluntary, non-profit diagnostic and treatment centers and to public diagnostic and treatment centers in accordance with paragraph (g) of subdivision four of this section. In the event that federal financial participation is available for rate adjustments pursuant to this section, the commissioner shall make such payments as additional adjustments to rates of payment for voluntary non-profit diagnostic and treatment centers that are eligible for distributions under subdivision four-a of this section in the following amounts: for the period June first, two thousand six through December thirty-first, two thousand six, fifteen million dollars in the aggregate, and for the period January first, two thousand seven through June thirtieth, two thousand seven, seven million five hundred thousand dollars in the aggregate. The amounts allocated pursuant to this paragraph shall be aggregated with and distributed pursuant to the same methodology applicable to the amounts allocated to such diagnostic and treatment centers for such periods pursuant to subdivision four of this section if federal financial participation is not available, or pursuant to subdivision four-a of this section if federal financial participation is available. Notwithstanding section three hundred sixty-eight-a of the social services law, there shall be no local share in a medical assistance payment adjustment under this subdivision.

§ 15. Subparagraph (ii) of paragraph (c) of subdivision 1 of section 2807-l of the public health law, as amended by section 7 of part B of chapter 60 of the laws of 2014, is amended to read as follows:

(ii) deposit by the commissioner, within amounts appropriated, and the state comptroller is hereby authorized and directed to receive for deposit to, to the credit of the emergency medical services training account established in section ninety-seven-q of the state finance law or the health care reform act (HCRA) resources fund, whichever is applicable, up to sixteen million dollars on an annualized basis for the periods January first, nineteen hundred ninety-seven through December thirty-first, nineteen hundred ninety-nine, up to twenty million dollars for the period January first, two thousand through December thirty-first, two thousand, up to twenty-one million dollars for the period January first, two thousand one through December thirty-first, two thousand one, up to twenty-two million dollars for the period January first, two thousand two through December thirty-first, two thousand two, up to twenty-two million five hundred fifty thousand dollars for the period January first, two thousand three through December thirty-first, two thousand three, up to nine million six hundred eighty thousand dollars for the period January first, two thousand four through December thirty-first, two thousand four, up to twelve million one hundred thirty thousand dollars for the period January first, two thousand five through December thirty-first, two thousand five, up to twenty-four million two hundred fifty thousand dollars for the period January first, two thousand six through December thirty-first, two thousand six, up to twenty million four hundred ninety-two thousand dollars annually for the period January first, two thousand seven through December thirty-first, two thousand ten, up to five million one hundred twenty-three thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven, up to eighteen million three hundred fifty thousand dollars for the period April first, two thousand eleven through March thirty-first, two thousand twelve, up to eighteen million nine hundred fifty thousand dollars for the period April first, two thousand twelve through March thirty-first, two thousand thirteen, up to

nineteen million four hundred nineteen thousand dollars for the period April first, two thousand thirteen through March thirty-first, two thousand fourteen, and up to nineteen million six hundred fifty-nine thousand seven hundred dollars each state fiscal year for the period of April first, two thousand fourteen through March thirty-first, two thousand [~~seventeen~~] twenty;

§ 16. Clause (C) of subparagraph (ii) of paragraph (c) of subdivision 1 of section 2807-l of the public health law, as amended by section 7 of part B of chapter 60 of the laws of 2014, is amended to read as follows:

(C) for services and expenses, including grants, related to emergency assistance distributions as designated by the commissioner. Notwithstanding section one hundred twelve or one hundred sixty-three of the state finance law or any other contrary provision of law, such distributions shall be limited to providers or programs where, as determined by the commissioner, emergency assistance is vital to protect the life or safety of patients, to ensure the retention of facility caregivers or other staff, or in instances where health facility operations are jeopardized, or where the public health is jeopardized or other emergency situations exist, up to three million dollars annually for the period April first, two thousand seven through March thirty-first, two thousand eleven, up to two million nine hundred thousand dollars each state fiscal year for the period April first, two thousand eleven through March thirty-first, two thousand fourteen, and up to two million nine hundred thousand dollars each state fiscal year for the period April first, two thousand fourteen through March thirty-first, two thousand [~~seventeen~~] twenty. Upon any distribution of such funds, the commissioner shall immediately notify the chair and ranking minority member of the senate finance committee, the assembly ways and means committee, the senate committee on health, and the assembly committee on health;

§ 17. Subparagraph (iv) of paragraph (c) of subdivision 1 of section 2807-l of the public health law, as amended by section 7 of part B of chapter 60 of the laws of 2014, is amended to read as follows:

(iv) distributions by the commissioner related to poison control centers pursuant to subdivision seven of section twenty-five hundred-d of this chapter, up to five million dollars for the period January first, nineteen hundred ninety-seven through December thirty-first, nineteen hundred ninety-seven, up to three million dollars on an annualized basis for the periods during the period January first, nineteen hundred ninety-eight through December thirty-first, nineteen hundred ninety-nine, up to five million dollars annually for the periods January first, two thousand through December thirty-first, two thousand two, up to four million six hundred thousand dollars annually for the periods January first, two thousand three through December thirty-first, two thousand four, up to five million one hundred thousand dollars for the period January first, two thousand five through December thirty-first, two thousand six annually, up to five million one hundred thousand dollars annually for the period January first, two thousand seven through December thirty-first, two thousand nine, up to three million six hundred thousand dollars for the period January first, two thousand ten through December thirty-first, two thousand ten, up to seven hundred seventy-five thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven, up to two million five hundred thousand dollars each state fiscal year for the period April first, two thousand eleven through March thirty-first, two thousand fourteen, and up to three million dollars each state fiscal

year for the period April first, two thousand fourteen through March thirty-first, two thousand [~~seventeen~~] twenty; and

§ 18. Subparagraph (i) of paragraph (d) of subdivision 1 of section 2807-l of the public health law, as amended by section 7 of part B of chapter 60 of the laws of 2014, is amended to read as follows:

(i) An amount of up to twenty million dollars annually for the period January first, two thousand through December thirty-first, two thousand six, up to ten million dollars for the period January first, two thousand seven through June thirtieth, two thousand seven, up to twenty million dollars annually for the period January first, two thousand eight through December thirty-first, two thousand ten, up to five million dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven, up to nineteen million six hundred thousand dollars each state fiscal year for the period April first, two thousand eleven through March thirty-first, two thousand fourteen, and up to nineteen million six hundred thousand dollars each state fiscal year for the period April first, two thousand fourteen through March thirty-first, two thousand [~~seventeen~~] twenty, shall be transferred to the health facility restructuring pool established pursuant to section twenty-eight hundred fifteen of this article;

§ 19. Paragraph (e) of subdivision 1 of section 2807-l of the public health law, as amended by section 7 of part B of chapter 60 of the laws of 2014, is amended to read as follows:

(e) Funds shall be reserved and accumulated from year to year and shall be available, including income from invested funds, for purposes of distributions to organizations to support the health workforce retraining program established pursuant to section twenty-eight hundred seven-g of this article from the respective health care initiatives pools established for the following periods in the following amounts from the pools or the health care reform act (HCRA) resources fund, whichever is applicable, during the period January first, nineteen hundred ninety-seven through December thirty-first, nineteen hundred ninety-nine, up to fifty million dollars on an annualized basis, up to thirty million dollars for the period January first, two thousand through December thirty-first, two thousand, up to forty million dollars for the period January first, two thousand one through December thirty-first, two thousand one, up to fifty million dollars for the period January first, two thousand two through December thirty-first, two thousand two, up to forty-one million one hundred fifty thousand dollars for the period January first, two thousand three through December thirty-first, two thousand three, up to forty-one million one hundred fifty thousand dollars for the period January first, two thousand four through December thirty-first, two thousand four, up to fifty-eight million three hundred sixty thousand dollars for the period January first, two thousand five through December thirty-first, two thousand five, up to fifty-two million three hundred sixty thousand dollars for the period January first, two thousand six through December thirty-first, two thousand six, up to thirty-five million four hundred thousand dollars annually for the period January first, two thousand seven through December thirty-first, two thousand ten, up to eight million eight hundred fifty thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven, up to twenty-eight million four hundred thousand dollars each state fiscal year for the period April first, two thousand eleven through March thirty-first, two thousand fourteen, and up to twenty-six million eight hundred seventeen thousand dollars each state fiscal year for the period April first, two

thousand fourteen through March thirty-first, two thousand [~~seventeen~~] twenty, less the amount of funds available for allocations for rate adjustments for workforce training programs for payments by state governmental agencies for inpatient hospital services.

§ 20. Subparagraph (v) of paragraph (i) of subdivision 1 of section 2807-l of the public health law, as amended by section 7 of part B of chapter 60 of the laws of 2014, is amended to read as follows:

(v) from the pool or the health care reform act (HCRA) resources fund, whichever is applicable, for the period January first, two thousand four through December thirty-first, two thousand four, up to fifteen million eight hundred fifty thousand dollars, for the period January first, two thousand five through December thirty-first, two thousand five, up to nineteen million two hundred thousand dollars, for the period January first, two thousand six through December thirty-first, two thousand six, up to nineteen million two hundred thousand dollars, for the period January first, two thousand seven through December thirty-first, two thousand ten, up to eighteen million one hundred fifty thousand dollars annually, for the period January first, two thousand eleven through March thirty-first, two thousand eleven, up to four million five hundred thirty-eight thousand dollars, for each state fiscal year for the period April first, two thousand eleven through March thirty-first, two thousand fourteen, up to sixteen million two hundred thousand dollars, and up to sixteen million two hundred thousand dollars each state fiscal year for the period April first, two thousand fourteen through March thirty-first, two thousand [~~seventeen~~] twenty.

§ 21. Clause (A) of subparagraph (v) of paragraph (k) of subdivision 1 of section 2807-l of the public health law, as amended by section 7 of part B of chapter 60 of the laws of 2014, is amended to read as follows:

(A) from the pool or the health care reform act (HCRA) resources fund, whichever is applicable, for the period July first, two thousand three through December thirty-first, two thousand three, up to six million dollars, for the period January first, two thousand four through December thirty-first, two thousand six, up to twelve million dollars annually, for the period January first, two thousand seven through December thirty-first, two thousand thirteen, up to forty-eight million dollars annually, for the period January first, two thousand fourteen through March thirty-first, two thousand fourteen, up to twelve million dollars and for the period April first, two thousand fourteen through March thirty-first, two thousand [~~seventeen~~] twenty, up to forty-eight million dollars annually;

§ 22. Subparagraph (v) of paragraph (l) of subdivision 1 of section 2807-l of the public health law, as amended by section 7 of part B of chapter 60 of the laws of 2014, is amended to read as follows:

(v) from the pool or the health care reform act (HCRA) resources fund, whichever is applicable, for the periods January first, two thousand four through December thirty-first, two thousand four, up to fifty-six million dollars, for the period January first, two thousand five through December thirty-first, two thousand six, up to sixty million dollars annually, for the period January first, two thousand seven through December thirty-first, two thousand ten, up to sixty million dollars annually, for the period January first, two thousand eleven through March thirty-first, two thousand eleven, up to fifteen million dollars, each state fiscal year for the period April first, two thousand eleven through March thirty-first, two thousand fourteen, up to forty-two million three hundred thousand dollars and up to forty-one million fifty thousand dollars each state fiscal year for the period April first, two

thousand fourteen through March thirty-first, two thousand [~~seventeen~~] twenty.

§ 23. Paragraph (b) of subdivision 1 of section 2807-v of the public health law, as amended by section 8 of part B of chapter 60 of the laws of 2014, is amended to read as follows:

(b) Funds shall be reserved and accumulated from year to year and shall be available, including income from invested funds, for purposes of payment of audits or audit contracts necessary to determine payor and provider compliance with requirements set forth in sections twenty-eight hundred seven-j, twenty-eight hundred seven-s and twenty-eight hundred seven-t of this article from the tobacco control and insurance initiatives pool established for the following periods in the following amounts: five million six hundred thousand dollars annually for the periods January first, two thousand through December thirty-first, two thousand two, up to five million dollars for the period January first, two thousand three through December thirty-first, two thousand three, up to five million dollars for the period January first, two thousand four through December thirty-first, two thousand four, up to five million dollars for the period January first, two thousand five through December thirty first, two thousand five, up to five million dollars for the period January first, two thousand six through December thirty-first, two thousand six, up to seven million eight hundred thousand dollars for the period January first, two thousand seven through December thirty-first, two thousand seven, and up to eight million three hundred twenty-five thousand dollars for the period January first, two thousand eight through December thirty-first, two thousand eight, up to eight million five hundred thousand dollars for the period January first, two thousand nine through December thirty-first, two thousand nine, up to eight million five hundred thousand dollars for the period January first, two thousand ten through December thirty-first, two thousand ten, up to two million one hundred twenty-five thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven, up to fourteen million seven hundred thousand dollars each state fiscal year for the period April first, two thousand eleven through March thirty-first, two thousand fourteen, and up to eleven million one hundred thousand dollars each state fiscal year for the period April first, two thousand fourteen through March thirty-first, two thousand [~~seventeen~~] twenty.

§ 24. Subparagraph (xiv) of paragraph (j) of subdivision 1 of section 2807-v of the public health law, as amended by section 8 of part B of chapter 60 of the laws of 2014, is amended to read as follows:

(xiv) up to six million dollars each state fiscal year for the period April first, two thousand fourteen through March thirty-first, two thousand [~~seventeen~~] twenty.

§ 25. Subparagraph (xvi) of paragraph (n) of subdivision 1 of section 2807-v of the public health law, as amended by section 8 of part B of chapter 60 of the laws of 2014, is amended to read as follows:

(xvi) one hundred twenty-seven million four hundred sixteen thousand dollars each state fiscal year for the period April first, two thousand fourteen through March thirty-first, two thousand [~~seventeen~~] twenty.

§ 26. Subparagraph (xiv) of paragraph (o) of subdivision 1 of section 2807-v of the public health law, as amended by section 8 of part B of chapter 60 of the laws of 2014, is amended to read as follows:

(xiv) up to ninety-six million six hundred thousand dollars each state fiscal year for the period April first, two thousand fourteen through March thirty-first, two thousand [~~seventeen~~] twenty.

§ 27. Subparagraph (xii) of paragraph (q) of subdivision 1 of section 2807-v of the public health law, as amended by section 8 of part B of chapter 60 of the laws of 2014, is amended to read as follows:

(xii) up to five million two hundred eighty-eighty thousand dollars each state fiscal year for the period April first, two thousand fourteen through March thirty-first, two thousand [~~seventeen~~] twenty.

§ 28. Subparagraph (xii) of paragraph (w) of subdivision 1 of section 2807-v of the public health law, as amended by section 8 of part B of chapter 60 of the laws of 2014, is amended to read as follows:

(xii) up to two million one hundred thousand dollars each state fiscal year for the period April first, two thousand fourteen through March thirty-first, two thousand [~~seventeen~~] twenty.

§ 29. Clause (L) of subparagraph (i) of paragraph (bb) of subdivision 1 of section 2807-v of the public health law, as amended by section 8 of part B of chapter 60 of the laws of 2014, is amended to read as follows:

(L) up to one hundred thirty-six million dollars each state fiscal year for the period March thirty-first, two thousand fourteen through April first, two thousand [~~seventeen~~] twenty.

§ 30. Clause (L) of subparagraph (ii) of paragraph (bb) of subdivision 1 of section 2807-v of the public health law, as amended by section 8 of part B of chapter 60 of the laws of 2014, is amended to read as follows:

(L) for each state fiscal year within the period April first, two thousand fourteen through March thirty-first, two thousand [~~seventeen~~] twenty, three hundred forty million dollars.

§ 31. Subparagraph (xii) of paragraph (cc) of subdivision 1 of section 2807-v of the public health law, as amended by section 8 of part B of chapter 60 of the laws of 2014, is amended to read as follows:

(xii) up to eleven million two hundred thousand dollars each state fiscal year for the period April first, two thousand fourteen through March thirty-first, two thousand [~~seventeen~~] twenty.

§ 32. Subparagraph (xii) of paragraph (ff) of subdivision 1 of section 2807-v of the public health law, as amended by section 8 of part B of chapter 60 of the laws of 2014, is amended to read as follows:

(xii) fifteen million dollars each state fiscal year for the period April first, two thousand fourteen through March thirty-first, two thousand [~~seventeen~~] twenty.

§ 33. Subparagraph (xii) of paragraph (ii) of subdivision 1 of section 2807-v of the public health law, as amended by section 8 of part B of chapter 60 of the laws of 2014, is amended to read as follows:

(xii) eight million five hundred thousand dollars each state fiscal year for the period April first, two thousand fourteen through March thirty-first, two thousand [~~seventeen~~] twenty.

§ 34. Paragraph (aaa) of subdivision 1 of section 2807-v of the public health law, as amended by section 8 of part B of chapter 60 of the laws of 2014, is amended to read as follows:

(aaa) Funds shall be reserved and accumulated from year to year and shall be available, including income from invested funds, for services and expenses related to school based health centers, in an amount up to three million five hundred thousand dollars for the period April first, two thousand six through March thirty-first, two thousand seven, up to three million five hundred thousand dollars for the period April first, two thousand seven through March thirty-first, two thousand eight, up to three million five hundred thousand dollars for the period April first, two thousand eight through March thirty-first, two thousand nine, up to three million five hundred thousand dollars for the period April first, two thousand nine through March thirty-first, two thousand ten, up to

three million five hundred thousand dollars for the period April first, two thousand ten through March thirty-first, two thousand eleven, up to two million eight hundred thousand dollars each state fiscal year for the period April first, two thousand eleven through March thirty-first, two thousand fourteen, and up to two million six hundred forty-four thousand dollars each state fiscal year for the period April first, two thousand fourteen through March thirty-first, two thousand [~~seventeen~~] **twenty**. The total amount of funds provided herein shall be distributed as grants based on the ratio of each provider's total enrollment for all sites to the total enrollment of all providers. This formula shall be applied to the total amount provided herein.

§ 35. Subparagraph (viii) of paragraph (ccc) of subdivision 1 of section 2807-v of the public health law, as amended by section 8 of part B of chapter 60 of the laws of 2014, is amended to read as follows:

(viii) up to fifty million dollars each state fiscal year for the period April first, two thousand fourteen through March thirty-first, two thousand [~~seventeen~~] **twenty**.

§ 36. This act shall take effect immediately; provided, however, that:

(a) the amendments made to sections 2807-s and 2807-j of the public health law made by sections three, four and five of this act shall not affect the expiration of such sections and shall expire therewith; and

(b) the amendments to subdivision 6 of section 2807-t of the public health law made by section eight of this act shall not affect the expiration of such section and shall be deemed to expire therewith.

PART I

Section 1. Section 11 of chapter 884 of the laws of 1990, amending the public health law relating to authorizing bad debt and charity care allowances for certified home health agencies, as amended by section 1 of part D of chapter 57 of the laws of 2015, is amended to read as follows:

§ 11. This act shall take effect immediately and:

(a) sections one and three shall expire on December 31, 1996,

(b) sections four through ten shall expire on June 30, [~~2017~~] **2020**, and

(c) provided that the amendment to section 2807-b of the public health law by section two of this act shall not affect the expiration of such section 2807-b as otherwise provided by law and shall be deemed to expire therewith.

§ 2. Subdivision 4-a of section 71 of part C of chapter 60 of the laws of 2014 amending the social services law relating to eliminating prescriber prevails for brand name drugs with generic equivalent, as amended by section 6 of part D of chapter 59 of the laws of 2016, is amended to read as follows:

4-a. section twenty-two of this act shall take effect April 1, 2014, and shall be deemed expired January 1, [~~2018~~] **2020**;

§ 3. Subparagraph (vi) of paragraph (b) of subdivision 2 of section 2807-d of the public health law, as amended by section 3 of part D of chapter 57 of the laws of 2015, is amended to read as follows:

(vi) Notwithstanding any contrary provision of this paragraph or any other provision of law or regulation to the contrary, for residential health care facilities the assessment shall be six percent of each residential health care facility's gross receipts received from all patient care services and other operating income on a cash basis for the period April first, two thousand two through March thirty-first, two thousand

three for hospital or health-related services, including adult day services; provided, however, that residential health care facilities' gross receipts attributable to payments received pursuant to title XVIII of the federal social security act (medicare) shall be excluded from the assessment; provided, however, that for all such gross receipts received on or after April first, two thousand three through March thirty-first, two thousand five, such assessment shall be five percent, and further provided that for all such gross receipts received on or after April first, two thousand five through March thirty-first, two thousand nine, and on or after April first, two thousand nine through March thirty-first, two thousand eleven such assessment shall be six percent, and further provided that for all such gross receipts received on or after April first, two thousand eleven through March thirty-first, two thousand thirteen such assessment shall be six percent, and further provided that for all such gross receipts received on or after April first, two thousand thirteen through March thirty-first, two thousand fifteen such assessment shall be six percent, and further provided that for all such gross receipts received on or after April first, two thousand fifteen through March thirty-first, two thousand seventeen such assessment shall be six percent**, and further provided that for all such gross receipts received on or after April first, two thousand seventeen through March thirty-first, two thousand twenty such assessment shall be six percent**.

§ 4. Subdivision 1 of section 194 of chapter 474 of the laws of 1996, amending the education law and other laws relating to rates for residential health care facilities, as amended by section 5 of part D of chapter 57 of the laws of 2015, is amended to read as follows:

1. Notwithstanding any inconsistent provision of law or regulation, the trend factors used to project reimbursable operating costs to the rate period for purposes of determining rates of payment pursuant to article 28 of the public health law for residential health care facilities for reimbursement of inpatient services provided to patients eligible for payments made by state governmental agencies on and after April 1, 1996 through March 31, 1999 and for payments made on and after July 1, 1999 through March 31, 2000 and on and after April 1, 2000 through March 31, 2003 and on and after April 1, 2003 through March 31, 2007 and on and after April 1, 2007 through March 31, 2009 and on and after April 1, 2009 through March 31, 2011 and on and after April 1, 2011 through March 31, 2013 and on and after April 1, 2013 through March 31, 2015, and on and after April 1, 2015 through March 31, 2017**, and on and after April 1, 2017 through March 31, 2020** shall reflect no trend factor projections or adjustments for the period April 1, 1996, through March 31, 1997.

§ 5. Subdivision 1 of section 89-a 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 6 of part D of chapter 57 of the laws of 2015, is amended to read as follows:

1. Notwithstanding paragraph (c) of subdivision 10 of section 2807-c of the public health law and section 21 of chapter 1 of the laws of 1999, as amended, and any other inconsistent provision of law or regulation to the contrary, in determining rates of payments by state governmental agencies effective for services provided beginning April 1, 2006, through March 31, 2009, and on and after April 1, 2009 through March 31, 2011, and on and after April 1, 2011 through March 31, 2013, and on and after April 1, 2013 through March 31, 2015, and on and after

April 1, 2015 through March 31, 2017**, and on and after April 1, 2017 through March 31, 2020** for inpatient and outpatient services provided by general hospitals and for inpatient services and outpatient adult day health care services provided by residential health care facilities pursuant to article 28 of the public health law, the commissioner of health shall apply a trend factor projection of two and twenty-five hundredths percent attributable to the period January 1, 2006 through December 31, 2006, and on and after January 1, 2007, provided, however, that on reconciliation of such trend factor for the period January 1, 2006 through December 31, 2006 pursuant to paragraph (c) of subdivision 10 of section 2807-c of the public health law, such trend factor shall be the final US Consumer Price Index (CPI) for all urban consumers, as published by the US Department of Labor, Bureau of Labor Statistics less twenty-five hundredths of a percentage point.

§ 6. Subdivision 5-a of section 246 of chapter 81 of the laws of 1995, amending the public health law and other laws relating to medical reimbursement and welfare reform, as amended by section 11 of part D of chapter 57 of the laws of 2015, is amended to read as follows:

5-a. Section sixty-four-a of this act shall be deemed to have been in full force and effect on and after April 1, 1995 through March 31, 1999 and on and after July 1, 1999 through March 31, 2000 and on and after April 1, 2000 through March 31, 2003 and on and after April 1, 2003 through March 31, 2007, and on and after April 1, 2007 through March 31, 2009, and on and after April 1, 2009 through March 31, 2011, and on and after April 1, 2011 through March 31, 2013, and on and after April 1, 2013 through March 31, 2015, and on and after April 1, 2015 through March 31, 2017 **and on and after April 1, 2017 through March 31, 2020**;

§ 7. Section 64-b of chapter 81 of the laws of 1995, amending the public health law and other laws relating to medical reimbursement and welfare reform, as amended by section 12 of part D of chapter 57 of the laws of 2015, is amended to read as follows:

§ 64-b. Notwithstanding any inconsistent provision of law, the provisions of subdivision 7 of section 3614 of the public health law, as amended, shall remain and be in full force and effect on April 1, 1995 through March 31, 1999 and on July 1, 1999 through March 31, 2000 and on and after April 1, 2000 through March 31, 2003 and on and after April 1, 2003 through March 31, 2007, and on and after April 1, 2007 through March 31, 2009, and on and after April 1, 2009 through March 31, 2011, and on and after April 1, 2011 through March 31, 2013, and on and after April 1, 2013 through March 31, 2015, and on and after April 1, 2015 through March 31, 2017 **and on and after April 1, 2017 through March 31, 2020**.

§ 8. Subdivision (a) of section 40 of part B of chapter 109 of the laws of 2010, amending the social services law relating to transportation costs, as amended by section 23 of part D of chapter 57 of the laws of 2015, is amended to read as follows:

(a) sections two, three, three-a, three-b, three-c, three-d, three-e and twenty-one of this act shall take effect July 1, 2010; sections fifteen, sixteen, seventeen, eighteen and nineteen of this act shall take effect January 1, 2011; and provided further that section twenty of this act shall be deemed repealed [~~six~~] **nine** years after the date the contract entered into pursuant to section 365-h of the social services law, as amended by section twenty of this act, is executed; provided that the commissioner of health shall notify the legislative bill drafting commission upon the execution of the contract entered into pursuant to section 367-h of the social services law in order that the commission

may maintain an accurate and timely effective data base of the official text of the laws of the state of New York in furtherance of effectuating the provisions of section 44 of the legislative law and section 70-b of the public officers law;

§ 9. 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 relating to the cap on local Medicaid expenditures, as amended by section 29 of part D of chapter 57 of the laws of 2015, 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, [~~2017~~] 2018 through March 31, [~~2017~~] 2018, 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 calendar year 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 calendar year shall also be applied to rates of payment provided on and after January 1, [~~2017~~] 2018 through March 31, [~~2017~~] 2018 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, [~~2017~~] 2018 through March 31, [~~2017~~] 2018, such trend factors attributable to the [~~2017~~] 2018 calendar year shall be established at no greater than zero percent.

§ 10. Subdivisions 3 and 5 of section 47 of chapter 2 of the laws of 1998, amending the public health law and other laws relating to expanding the child health insurance plan, as amended by section 61 of part C of chapter 60 of the laws of 2014, are amended to read as follows:

3. section six of this act shall take effect January 1, 1999; provided, however, that subparagraph (iii) of paragraph (c) of subdivision 9 of section 2510 of the public health law, as added by this act, shall expire on July 1, [~~2017~~] 2020;

5. section twelve of this act shall take effect January 1, 1999; provided, however, paragraphs (g) and (h) of subdivision 2 of section 2511 of the public health law, as added by such section, shall expire on July 1, [~~2017~~] 2020;

§ 11. Section 4 of chapter 19 of the laws of 1998, amending the social services law relating to limiting the method of payment for prescription drugs under the medical assistance program, as amended by section 65 of part C of chapter 60 of the laws of 2014, is amended to read as follows:

§ 4. This act shall take effect 120 days after it shall have become a law and shall expire and be deemed repealed March 31, [~~2017~~] 2020.

§ 12. Paragraph (e-1) of subdivision 12 of section 2808 of the public health law, as amended by section 66 of part C of chapter 60 of the laws of 2014, is amended to read as follows:

(e-1) Notwithstanding any inconsistent provision of law or regulation, the commissioner shall provide, in addition to payments established pursuant to this article prior to application of this section, additional payments under the medical assistance program pursuant to title eleven of article five of the social services law for non-state operated public residential health care facilities, including public residential health care facilities located in the county of Nassau, the county of Westchester and the county of Erie, but excluding public residential health care facilities operated by a town or city within a county, in aggregate annual amounts of up to one hundred fifty million dollars in additional payments for the state fiscal year beginning April first, two thousand six and for the state fiscal year beginning April first, two thousand seven and for the state fiscal year beginning April first, two thousand eight and of up to three hundred million dollars in such aggregate annual additional payments for the state fiscal year beginning April first, two thousand nine, and for the state fiscal year beginning April first, two thousand ten and for the state fiscal year beginning April first, two thousand eleven, and for the state fiscal years beginning April first, two thousand twelve and April first, two thousand thirteen, and of up to five hundred million dollars in such aggregate annual additional payments for the state fiscal years beginning April first, two thousand fourteen, April first, two thousand fifteen and April first, two thousand sixteen **and of up to five hundred million dollars in such aggregate annual additional payments for the state fiscal years beginning April first, two thousand seventeen, April first, two thousand eighteen, and April first, two thousand nineteen**. The amount allocated to each eligible public residential health care facility for this period shall be computed in accordance with the provisions of paragraph (f) of this subdivision, provided, however, that patient days shall be utilized for such computation reflecting actual reported data for two thousand three and each representative succeeding year as applicable, and provided further, however, that, in consultation with impacted providers, of the funds allocated for distribution in the state fiscal year beginning April first, two thousand thirteen, up to thirty-two million dollars may be allocated in accordance with paragraph (f-1) of this subdivision.

§ 13. Section 18 of chapter 904 of the laws of 1984, amending the public health law and the social services law relating to encouraging comprehensive health services, as amended by section 67-c of part C of chapter 60 of the laws of 2014, is amended to read as follows:

§ 18. This act shall take effect immediately, except that sections six, nine, ten and eleven of this act shall take effect on the sixtieth day after it shall have become a law, sections two, three, four and nine of this act shall expire and be of no further force or effect on or after March 31, [~~2017~~] 2020, section two of this act shall take effect on April 1, 1985 or seventy-five days following the submission of the report required by section one of this act, whichever is later, and sections eleven and thirteen of this act shall expire and be of no further force or effect on or after March 31, 1988.

§ 14. Section 4 of part X2 of chapter 62 of the laws of 2003, amending the public health law relating to allowing for the use of funds of the

office of professional medical conduct for activities of the patient health information and quality improvement act of 2000, as amended by section 4-b of part A of chapter 57 of the laws of 2015, is amended to read as follows:

§ 4. This act shall take effect immediately; provided that the provisions of section one of this act shall be deemed to have been in full force and effect on and after April 1, 2003, and shall expire March 31, [~~2017~~] 2020 when upon such date the provisions of such section shall be deemed repealed.

§ 15. Subdivision (o) of section 111 of part H of chapter 59 of the laws of 2011, amending the public health law relating to the statewide health information network of New York and the statewide planning and research cooperative system and general powers and duties, as amended by section 28 of part D of chapter 57 of the laws of 2015, is amended to read as follows:

(o) sections thirty-eight and thirty-eight-a of this act shall expire and be deemed repealed March 31, [~~2017~~] 2020;

§ 16. Section 32 of part A of chapter 58 of the laws of 2008, amending the elder law and other laws relating to reimbursement to participating provider pharmacies and prescription drug coverage, as amended by section 13 of part A of chapter 57 of the laws of 2015, is amended to read as follows:

§ 32. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2008; provided however, that sections one, six-a, nineteen, twenty, twenty-four, and twenty-five of this act shall take effect July 1, 2008; provided however that sections sixteen, seventeen and eighteen of this act shall expire April 1, [~~2017~~] 2020; provided, however, that the amendments made by section twenty-eight of this act shall take effect on the same date as section 1 of chapter 281 of the laws of 2007 takes effect; provided further, that sections twenty-nine, thirty, and thirty-one of this act shall take effect October 1, 2008; provided further, that section twenty-seven of this act shall take effect January 1, 2009; and provided further, that section twenty-seven of this act shall expire and be deemed repealed March 31, [~~2017~~] 2020; and provided, further, however, that the amendments to subdivision 1 of section 241 of the education law made by section twenty-nine of this act shall not affect the expiration of such subdivision and shall be deemed to expire therewith and provided that the amendments to section 272 of the public health law made by section thirty of this act shall not affect the repeal of such section and shall be deemed repealed therewith.

§ 17. Subdivision 3 of section 2999-p of the public health law, as amended by chapter 461 of the laws of 2012, is amended to read as follows:

3. The commissioner may issue a certificate of authority to an entity that meets conditions for ACO certification as set forth in regulations made by the commissioner pursuant to section twenty-nine hundred ninety-nine-q of this article. The commissioner shall not issue any new certificate under this article after December thirty-first, two thousand [~~sixteen~~] twenty.

§ 18. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2017.

PART J

Section 1. The insurance law is amended by adding a new article 29 to read as follows:

ARTICLE 29

PHARMACY BENEFIT MANAGERS

§ 2901. Definitions. For purposes of this article:

(a) "Controlling person" is any person or other entity who or which directly or indirectly has the power to direct or cause to be directed the management, control or activities of a pharmacy benefit manager.

(b) "Health insurer" means an insurance company authorized in this state to write accident and health insurance, a company organized pursuant to article forty-three of this chapter, a municipal cooperative health benefit plan established pursuant to article forty-seven of this chapter, a health maintenance organization certified pursuant to article forty-four of the public health law, an institution of higher education certified pursuant to section one thousand one hundred twenty-four of this chapter, the state public health plan as defined in section two hundred seventy of the public health law, child health plus established pursuant to title one-a of article twenty-five of the public health law, the New York state health insurance plan established under article eleven of the civil service law, or any other health plan or provider as defined in paragraph (a) of subdivision one of section two hundred eighty-a of the public health law.

(c) "Pharmacy benefit management services" means pharmacy benefit management services defined by section two hundred eighty-a of the public health law.

(d) "Pharmacy benefit manager" means a person, firm, association, corporation or other entity that, pursuant to a contract with a health insurer, provides pharmacy benefit management services, except that term shall not include:

(1) an officer or employee of a registered or licensed pharmacy benefit manager; or

(2) a health insurer, or any manager thereof, individual or corporate, or any officer, director or regular salaried employee thereof, providing pharmacy benefit management services under a policy or contract issued by the health insurer.

§ 2902. Acting without a registration. (a) No person, firm, association, corporation or other entity may act as a pharmacy benefits manager on or after the effective date of this section without having a valid registration as a pharmacy benefit manager filed with the superintendent in accordance with this article and the regulations promulgated thereunder.

(b) Following the effective date of this section, no health insurer may pay any fee or other compensation to any person, firm, association, corporation or other entity for performing pharmacy benefit management services unless the person, firm, association, corporation or other entity is registered as a pharmacy benefit manager in accordance with this article.

(c) Any person, firm, association, corporation or other entity that violates this section shall, in addition to any other penalty provided by law, be subject to a civil penalty of the greater of: (1) one thousand dollars for the first violation and two thousand five hundred dollars for each subsequent violation; or (2) the aggregate gross receipts attributable to all violations.

§ 2903. Registration requirements for pharmacy benefit managers. (a) Every pharmacy benefit manager that performs pharmacy benefit management services prior to January first, two thousand nineteen shall register with the superintendent in accordance with this article, in a manner acceptable to the superintendent, and shall pay a fee of one thousand dollars for each year in which the registration shall be valid. Every registration will expire on December thirty-first, two thousand eighteen regardless of when registration was first made.

(b) Every pharmacy benefit manager that performs pharmacy benefit management services at any time between January first, two thousand seventeen and June first, two thousand seventeen, shall register and make the registration fee payment required by subsection (a) of this section on or before June first, two thousand seventeen.

(c) Every pharmacy benefit manager not subject to subsection (b) of this section shall make the registration and fee payment required by subsection (a) of this section prior to performing pharmacy benefit management services.

(d) Each registered pharmacy benefit manager shall renew its registration and make the required fee payment by February first, two thousand eighteen for the two thousand eighteen calendar year.

§ 2904. Reporting requirements for pharmacy benefit managers. (a)(1) On or before July first of each year, beginning in two thousand seventeen, every pharmacy benefit manager shall report to the superintendent, in a statement subscribed and affirmed as true under penalties of perjury, information requested by the superintendent to enable him or her to carry out his or her duties under this article. Such information may include, without limitation, disclosure of any financial incentive or benefit for promoting the use of certain drugs and other financial arrangements affecting health insurers or their policyholders or insureds.

(2) The superintendent also may address to any pharmacy benefit manager or its officers any inquiry in relation to its provision of pharmacy benefit management services or any matter connected therewith. Every pharmacy benefit manager or person so addressed shall reply in writing to such inquiry promptly and truthfully, and such reply shall be, if required by the superintendent, subscribed by such individual, or by such officer or officers of the pharmacy benefit manager as the superintendent shall designate, and affirmed by them as true under the penalties of perjury.

(3) In addition to the other reports required by this subsection, the superintendent also may require the filing of quarterly or other statements, which shall be in such form and shall contain such matters concerning this article as the superintendent shall prescribe.

(b) In the event any pharmacy benefit manager or person does not submit the report required by paragraph one or three of subsection (a) of this section or does not provide a good faith response to an inquiry from the superintendent pursuant to paragraph two of subsection (a) of this section within a time period specified by the superintendent of not less than fifteen business days, the superintendent is authorized to levy a civil penalty, after notice and hearing, against such pharmacy benefit manager or person not to exceed five hundred dollars per day for each day beyond the date the report is due or such date specified by the superintendent for response to the inquiry.

§ 2905. Acting without a license. (a) No person, firm, association, corporation or other entity may act as a pharmacy benefit manager on or after January first, two thousand nineteen without having authority to do so by virtue of a license issued in force pursuant to the provisions of this chapter.

(b) No health insurer may pay any fee or other compensation to any person, firm, association, corporation or other entity for performing pharmacy benefit management services unless the person, firm, association, corporation or other entity is licensed as a pharmacy benefit manager in accordance with this article.

(c) Any person, firm, association, corporation or other entity that violates this section shall, in addition to any other penalty provided by law, be subject to a civil penalty of the greater of: (1) one thousand dollars for the first violation and two thousand five hundred dollars for each subsequent violation; or (2) the aggregate gross receipts attributable to all violations.

§ 2906. Licensing of a pharmacy benefit manager. (a) The superintendent may issue a pharmacy benefit manager's license to any person, firm, association or corporation who or that has complied with the requirements of this chapter, including regulations promulgated by the superintendent consistent with applicable law. The superintendent may establish, by regulation, minimum standards for the issuance of a license to a pharmacy benefit manager.

(b) The superintendent may establish, by regulation, minimum standards for the delivery of pharmacy benefit management services. The minimum standards established under this subsection may address:

(1) the elimination of conflicts of interest between pharmacy benefit managers and health insurers;

(2) the elimination of deceptive practices in connection with the performance of pharmacy benefit management services;

(3) the elimination of anti-competitive practices in connection with the performance of pharmacy benefit management services; and

(4) the elimination of unfair claims practices in connection with the performance of pharmacy benefit management services.

(c)(1) Any such license issued to a firm or association shall authorize all of the members of the firm or association and any designated employees to act as pharmacy benefit managers under the license, and all such persons shall be named in the application and supplements thereto.

(2) Any such license issued to a corporation shall authorize all of the officers and any designated employees and directors thereof to act as pharmacy benefit managers on behalf of such corporation, and all such persons shall be named in the application and supplements thereto.

(3) For each business entity, the officer or officers and director or directors named in the application shall be designated responsible for the business entity's compliance with the insurance laws, rules and regulations of this state.

(d)(1) Before a pharmacy benefit manager's license shall be issued or renewed, the prospective licensee shall properly file in the office of the superintendent a written application therefor in such form or forms and supplements thereto as the superintendent prescribes, and pay a fee of one thousand dollars for each year for which a license shall be valid.

(2) Every pharmacy benefit manager's license issued to a business entity pursuant to this section shall expire on the thirtieth day of November of even-numbered years. Every license issued pursuant to this section to an individual pharmacy benefit manager who was born in an odd-numbered year, shall expire on the individual's birthday in each odd-numbered year. Every license issued pursuant to this section to an individual pharmacy benefit manager who was born in an even-numbered year, shall expire on the individual's birthday in each even-numbered year. Every license issued pursuant to this section may be renewed for the ensuing period of twenty-four months upon the filing of an application in conformity with this subsection.

(e)(1) If an application for a renewal license shall have been filed with the superintendent before October first of the year of expiration, then the license sought to be renewed shall continue in full force and effect either until the issuance by the superintendent of the renewal license applied for or until five days after the superintendent shall have refused to issue such renewal license and given notice of such refusal to the applicant.

(2) Before refusing to renew any license pursuant to this section, the superintendent shall notify the applicant of the superintendent's intention so to do and the reasons therefor and shall give such applicant a hearing.

(f) The superintendent may refuse to issue a pharmacy benefit manager's license if, in the superintendent's judgment, the applicant or any member, principal, officer or director of the applicant, is not trustworthy and competent to act as or in connection with a pharmacy benefit manager, or has given cause for revocation or suspension of such license by violation of this article, or has failed to comply with any prerequisite for the issuance of such license.

(g) The superintendent may promulgate regulations establishing otherwise lawful methods and procedures for facilitating and verifying compliance with the requirements of this section and such other lawful regulations as necessary.

(h) The superintendent may issue a replacement for a currently in-force license that has been lost or destroyed. Before the replacement license shall be issued, there shall be on file in the office of the superintendent a written application for the replacement license, affirming under penalty of perjury that the original license has been lost or destroyed, together with a fee of one hundred dollars.

§ 2907. Revocation or suspension of a registration or license of a pharmacy benefit manager. (a) The superintendent may refuse to renew, revoke or suspend, for an appropriate period the superintendent determines, the registration or license of any pharmacy benefit manager if, after notice and hearing, there has been a determination that the registrant or licensee or any member, principal, officer, director, or controlling person of the registrant or licensee, has:

(1) in a material respect, violated any insurance law or regulation, subpoena, or order of the superintendent or of another state's insurance commissioner or any law including but not limited to section two hundred

eighty-a of the public health law, in the course of his or her dealings in such capacity;

(2) provided materially incorrect, materially misleading, materially incomplete or materially untrue information in the registration or license application;

(3) obtained or attempted to obtain a registration or license through fraud or intentional misrepresentation;

(4)(A) used fraudulent, coercive or dishonest practices;

(B) demonstrated incompetence;

(C) demonstrated untrustworthiness; or

(D) demonstrated financial irresponsibility in the conduct of business in this state or elsewhere;

(5) improperly withheld, misappropriated or converted any monies or properties received in the course of business in this state or elsewhere;

(6) intentionally misrepresented the terms of an actual or proposed insurance contract;

(7) admitted or been found to have committed any insurance unfair trade practice or fraud;

(8) had a pharmacy benefit manager registration or license, or its equivalent, denied, suspended or revoked in any other state, province, district or territory;

(9) failed to pay state income tax or comply with any administrative or court order directing payment of state income tax; or

(10) ceased to meet the requirements for registration or licensure under this article.

(b) Before revoking or suspending the registration or license of any pharmacy benefit manager pursuant to the provisions of this article, the superintendent shall give notice to the registrant or licensee and to every sub-licensee and shall hold a hearing not less than ten days after the giving of such notice except that a reasonable request for delay of a revocation hearing by a suspended registrant or licensee shall be granted.

(c) If a registration or license pursuant to the provisions of this article is revoked or suspended by the superintendent, then the superintendent shall forthwith give notice to the registrant or licensee.

(d) The revocation or suspension of any registration or license pursuant to the provisions of this article shall terminate forthwith such registration or license and the authority conferred thereby upon all sub-licensees.

(e)(1) No individual, corporation, firm or association whose registration or license as a pharmacy benefit manager subject to subsection (a) of this section has been revoked, and no firm or association of which such individual is a member, and no corporation of which such individual is an officer or director, and no controlling person of the registrant or licensee shall be entitled to obtain any registration or license under the provisions of this chapter for a period of one year after such revocation. In the event that such revocation be judicially reviewed, the one year suspension shall be in effect following a final determination thereof affirming the action of the superintendent in revoking such license and shall include any interim period of suspension.

(2) If any such registration or license held by a firm, association or corporation be revoked, no member of such firm or association and no officer or director of such corporation or any controlling person of the registrant or licensee shall be entitled to obtain any registration or license, or to be named as a sub-licensee in any such license, under

this chapter for the same period of time, unless the superintendent determines, after notice and hearing which shall be held promptly upon such request, that such member, officer or director was not directly involved in the matter on account of which such registration or license was revoked.

(f) If any person aggrieved shall file with the superintendent a verified complaint setting forth facts tending to show sufficient ground for the revocation or suspension of any pharmacy benefit manager's registration or license, then the superintendent shall, after notice and a hearing, determine whether such registration or license shall be suspended or revoked.

(g) The superintendent shall retain the authority to enforce the provisions of and impose any penalty or remedy authorized by this chapter against any person or entity who is in violation of this chapter, even if the person's or entity's registration or license has been surrendered, has expired or has lapsed by operation of law.

(h) A registrant or licensee subject to this article shall report to the superintendent any administrative action taken against the registrant or licensee in another jurisdiction or by another governmental agency in this state within thirty days of the final disposition of the matter. This report shall include a copy of the order, consent to order or other relevant legal documents documenting such final determination.

(i) Within thirty days of the initial pretrial hearing date, a registrant or licensee subject to this article shall report to the superintendent any criminal prosecution of the registrant or licensee taken in any jurisdiction. The report shall include a copy of the initial complaint filed, the order resulting from the hearing and any other relevant legal documents documenting the disposition of the matter.

§ 2908. Penalties for violations. (a) The superintendent, in lieu of revoking or suspending the registration or license of a registrant or licensee in accordance with the provisions of this article, may in any one proceeding by order, require the registrant or licensee to pay to the people of this state a civil penalty in a sum not exceeding the greater of: (1) one thousand dollars for each offense, not exceeding twenty-five hundred dollars in the aggregate for all offenses; or (2) the aggregate gross receipts attributable to all offenses.

(b) Upon the failure of such a registrant or licensee to pay the penalty ordered pursuant to subsection (a) of this section within twenty days after the mailing of the order, postage prepaid, registered, and addressed to the last known place of business of the licensee, unless the order is stayed by the superintendent or an order of a court of competent jurisdiction, the superintendent may revoke the registration or license of the registrant or licensee or may suspend the same for such period as the superintendent determines.

§ 2909. Stay or suspension of superintendent's determination. The commencement of a proceeding under article seventy-eight of the civil practice law and rules, to review the action of the superintendent in suspending or revoking or refusing to renew any certificate under this article, shall stay such action of the superintendent for a period of thirty days. Such stay may be extended for a longer period by the court, pending the final determination or further order of the court, in accordance with the relevant provisions of the civil practice law and rules.

§ 2910. Revoked registrations. (a)(1) No person, firm, association, corporation or other entity subject to the provisions of this article whose registration or license under this article has been revoked, or

whose registration or license to engage in the business of pharmacy benefit management in any capacity has been revoked by any other state or territory of the United States, shall become employed or appointed by a pharmacy benefit manager as an officer, director, manager, controlling person without the prior written approval of the superintendent, unless such services are for maintenance or are clerical or ministerial in nature.

(2) No person, firm, association, corporation or other entity subject to the provisions of this article shall knowingly employ or appoint any person or entity whose registration or license issued under this article has been revoked, or whose registration or license to engage in the business of pharmacy benefit management in any capacity has been revoked by any other state or territory of the United States, as an officer, director, manager or controlling person, without the prior written approval of the superintendent, unless such services are for maintenance or are clerical or ministerial in nature.

(3) No corporation or partnership subject to the provisions of this article shall knowingly permit any person whose registration or license issued under this article has been revoked, or whose registration or license to engage in the business of pharmacy benefit management has been revoked by any other state, or territory of the United States, to be a shareholder or have an interest in such corporation or partnership, nor shall any such person become a shareholder or partner in such corporation or partnership, without the prior written approval of the superintendent.

(b) The superintendent may approve the employment, appointment or participation of any such person whose registration or license has been revoked:

(1) if the superintendent determines that the duties and responsibilities of such person are subject to appropriate supervision and that such duties and responsibilities will not have an adverse effect upon the public, other registrants and licensees, and the registrant or licensee proposing employment or appointment of such person; or

(2) if such person has filed an application for reregistration or relicensing pursuant to this article and the application for reregistration or relicensing has not been approved or denied within one hundred twenty days following the filing thereof, unless the superintendent determines within the said time that employment or appointment of such person by a registrant or licensee in the conduct of a pharmacy benefit management business would not be in the public interest.

(c) The provisions of this section shall not apply to the ownership of shares of any corporation registered or licensed pursuant to this article if such shares of such corporation are publicly held and traded in the over-the-counter market or upon any national or regional securities exchange.

§ 2911. Change of address. A registrant or licensee under this article shall inform the superintendent by a reasonable means acceptable to the superintendent of a change of address within thirty days of the change.

§ 2912. Assessment. Pharmacy benefit managers that maintain a registration with the department or are licensed by the department shall be assessed by the superintendent for the operating expenses of the department that are solely attributable to regulating such pharmacy benefit managers in such proportions as the superintendent shall deem just and reasonable.

§ 2913. Applicability of other laws. Nothing in this article shall be construed to exempt a pharmacy benefit manager from complying with the provisions of articles twenty-one and forty-nine of this chapter, and section two hundred eighty-a and article forty-nine of the public health law or any other provision of this chapter or the financial services law.

§ 2. Subsection (b) of section 2402 of the insurance law, as amended by section 71 of part A of chapter 62 of the laws of 2011, is amended to read as follows:

(b) "Defined violation" means the commission by a person of an act prohibited by: subsection (a) of section one thousand one hundred two, section one thousand two hundred fourteen, one thousand two hundred seventeen, one thousand two hundred twenty, one thousand three hundred thirteen, subparagraph (B) of paragraph two of subsection (i) of section one thousand three hundred twenty-two, subparagraph (B) of paragraph two of subsection (i) of section one thousand three hundred twenty-four, two thousand one hundred two, two thousand one hundred seventeen, two thousand one hundred twenty-two, two thousand one hundred twenty-three, subsection (p) of section two thousand three hundred thirteen, section two thousand three hundred twenty-four, two thousand five hundred two, two thousand five hundred three, two thousand five hundred four, two thousand six hundred one, two thousand six hundred two, two thousand six hundred three, two thousand six hundred four, two thousand six hundred six, two thousand seven hundred three, **two thousand nine hundred two, two thousand nine hundred five,** three thousand one hundred nine, three thousand two hundred twenty-four-a, three thousand four hundred twenty-nine, three thousand four hundred thirty-three, paragraph seven of subsection (e) of section three thousand four hundred twenty-six, four thousand two hundred twenty-four, four thousand two hundred twenty-five, four thousand two hundred twenty-six, seven thousand eight hundred nine, seven thousand eight hundred ten, seven thousand eight hundred eleven, seven thousand eight hundred thirteen, seven thousand eight hundred fourteen and seven thousand eight hundred fifteen of this chapter; or section 135.60, 135.65, 175.05, 175.45, or 190.20, or article one hundred five of the penal law.

§ 3. Paragraph 28 of subsection (i) of section 3216 of the insurance law, as amended by chapter 11 of the laws of 2012, is amended to read as follows:

(28) **(A) Definitions. For the purpose of this paragraph:**

(1) "Same reimbursement amount" shall mean that any coverage described under subparagraph (B) of this paragraph shall provide the same benchmark index, including the same average wholesale price, maximum allowable cost and national prescription drug codes to reimburse all pharmacies participating in the insurance network regardless of whether a pharmacy is a mail order pharmacy or a non-mail order pharmacy.

(2) "Mail order pharmacy" means a pharmacy whose primary business is to receive prescriptions by mail, telefax or through electronic submissions and to dispense medication to patients through the use of the United States mail or other common or contract carrier services and provides any consultation with patients electronically rather than face-to-face.

(B) Any policy that provides coverage for prescription drugs shall permit each insured to fill any covered prescription that may be obtained at a network participating mail order or other non-retail pharmacy, at the insured's option, at a network participating non-mail order retail pharmacy provided that the network participating non-mail order

retail pharmacy agrees [~~in advance, through a contractual network agreement,~~] to the same reimbursement amount[~~, as well as the same applicable terms and conditions,~~] that the insurer has established for the network participating mail order or other non-retail pharmacy. In such a case, the policy shall not impose a co-payment fee or other condition on any insured who elects to purchase prescription drugs from a network participating non-mail order retail pharmacy which is not also imposed on insureds electing to purchase drugs from a network participating mail order or other non-retail pharmacy.

§ 4. Paragraph 18 of subsection (l) of section 3221 of the insurance law, as amended by chapter 11 of the laws of 2012, is amended to read as follows:

(18) **(A) Definitions. For the purpose of this paragraph:**

(1) "Same reimbursement amount" shall mean that any coverage described under subparagraph (B) of this paragraph shall provide the same benchmark index, including the same average wholesale price, maximum allowable cost and national prescription drug codes to reimburse all pharmacies participating in the insurance network regardless of whether a pharmacy is a mail order pharmacy or a non-mail order pharmacy.

(2) "Mail order pharmacy" means a pharmacy whose primary business is to receive prescriptions by mail, telefax or through electronic submissions and to dispense medication to patients through the use of the United States mail or other common or contract carrier services and provides any consultation with patients electronically rather than face-to-face.

(B) Any insurer delivering a group or blanket policy or issuing a group or blanket policy for delivery in this state that provides coverage for prescription drugs shall permit each insured to fill any covered prescription that may be obtained at a network participating mail order or other non-retail pharmacy, at the insured's option, at a network participating non-mail order retail pharmacy provided that the network participating non-mail order retail pharmacy agrees [~~in advance, through a contractual network agreement,~~] to the same reimbursement amount[~~, as well as the same applicable terms and conditions,~~] that the insurer has established for the network participating mail order or other non-retail pharmacy. In such a case, the policy shall not impose a co-payment fee or other condition on any insured who elects to purchase drugs from a network participating non-mail order retail pharmacy which is not also imposed on insureds electing to purchase drugs from a network participating mail order or other non-retail pharmacy; provided, however, that the provisions of this section shall not supersede the terms of a collective bargaining agreement or apply to a policy that is the result of a collective bargaining agreement between an employer and a recognized or certified employee organization.

§ 5. Subsection (kk) of section 4303 of the insurance law, as amended by chapter 11 of the laws of 2012 and as relettered by section 55 of part D of chapter 56 of the laws of 2013, is amended to read as follows:

(kk) **(1) Definitions. For the purpose of this subsection:**

(A) "Same reimbursement amount" shall mean that any coverage described under paragraph two of this subsection shall provide the same benchmark index, including the same average wholesale price, maximum allowable cost and national prescription drug codes to reimburse all pharmacies participating in the health benefit plan regardless of whether a pharmacy is a mail order pharmacy or a non-mail order pharmacy.

(B) "Mail order pharmacy" means a pharmacy whose primary business is to receive prescriptions by mail, telefax or through electronic

submissions and to dispense medication to patients through the use of the United States mail or other common or contract carrier services and provides any consultation with patients electronically rather than face-to-face.

(2) Any contract issued by a medical expense indemnity corporation, a hospital service corporation or a health services corporation that provides coverage for prescription drugs shall permit each covered person to fill any covered prescription that may be obtained at a network participating mail order or other non-retail pharmacy, at the covered person's option, at a network participating non-mail order retail pharmacy provided that the network participating non-mail order retail pharmacy agrees [~~in advance, through a contractual network agreement,~~] to the same reimbursement amount[~~, as well as the same applicable terms and conditions,~~] that the corporation has established for the network participating mail order or other non-retail pharmacy. In such a case, the contract shall not impose a copayment fee or other condition on any covered person who elects to purchase drugs from a network participating non-mail order retail pharmacy which is not also imposed on covered persons electing to purchase drugs from a network participating mail order or other non-retail pharmacy; provided, however, that the provisions of this section shall not supersede the terms of a collective bargaining agreement or apply to a contract that is the result of a collective bargaining agreement between an employer and a recognized or certified employee organization.

§ 6. Section 280-a of the public health law is REPEALED and a new section 280-a is added to read as follows:

§ 280-a. Pharmacy benefit managers. 1. Definitions. As used in this section, the following terms shall have the following meanings:

(a) "Health plan or provider" means an entity for which a pharmacy benefit manager provides pharmacy benefit management services including, but not limited to:

(i) a health benefit plan or other entity that approves, provides, arranges for, or pays for health care items or services, under which prescription drugs for beneficiaries of the entity are purchased or which provides or arranges reimbursement in whole or in part for the purchase of prescription drugs; or

(ii) a health care provider or professional, including a state or local government entity, that acquires prescription drugs to use or dispense in providing health care to patients.

(b) "Pharmacy benefit management" means the service provided to a health plan or provider, directly or through another entity, including the procurement of prescription drugs to be dispensed to patients, or the administration or management of prescription drug benefits, including but not limited to, any of the following:

(i) mail service pharmacy;

(ii) claims processing, retail network management, or payment of claims to pharmacies for dispensing prescription drugs;

(iii) clinical or other formulary or preferred drug list development or management;

(iv) negotiation or administration of rebates, discounts, payment differentials, or other incentives, for the inclusion of particular prescription drugs in a particular category or to promote the purchase of particular prescription drugs;

(v) patient compliance, therapeutic intervention, or generic substitution programs;

(vi) disease management;

(vii) drug utilization review or prior authorization;
(viii) adjudication of appeals or grievances related to prescription drug coverage;
(ix) controlling the cost of covered prescription drugs; and
(x) contracting with network pharmacies.
(c) "Pharmacy benefit manager" means any entity that: (i) performs pharmacy benefit management services for a health plan or provider; or
(ii) is registered or licensed as a pharmacy benefit manager under article twenty-nine of the insurance law.
(d) "Maximum allowable cost price" means a maximum reimbursement amount set by the pharmacy benefit manager for therapeutically equivalent multiple source generic drugs.
2. Application of section. This section applies to the providing of pharmacy benefit management services by a pharmacy benefit manager to a particular health plan or provider.
3. Duty, accountability and transparency. (a) The pharmacy benefit manager shall have a fiduciary relationship with and obligation to the health plan or provider, and shall perform pharmacy benefit management with care, skill, prudence, diligence, and professionalism.
(b) All funds received by the pharmacy benefit manager in relation to providing pharmacy benefit management services shall be received by the pharmacy benefit manager in trust for the health plan or provider and shall be used or distributed only pursuant to the pharmacy benefit manager's contract with the health plan or provider or applicable law; except for any fee or payment expressly provided for in the contract between the pharmacy benefit manager and the health plan or provider to compensate the pharmacy benefit manager for its services.
(c) The pharmacy benefit manager shall periodically account to the health plan or provider for all funds received by the pharmacy benefit manager. The health plan or provider shall have access to all financial and utilization information of the pharmacy benefit manager in relation to pharmacy benefit management services provided to the health plan or provider.
(d) The pharmacy benefit manager shall disclose in writing to the health plan or provider the terms and conditions of any contract or arrangement between the pharmacy benefit manager and any party relating to pharmacy benefit management services provided to the health plan or provider.
(e) The pharmacy benefit manager shall disclose in writing to the health plan or provider any activity, policy, practice, contract or arrangement of the pharmacy benefit manager that directly or indirectly presents any conflict of interest with the pharmacy benefit manager's relationship with or obligation to the health plan or provider.
(f) Any information required to be disclosed by a pharmacy benefit manager to a health plan or provider under this section that is reasonably designated by the pharmacy benefit manager as proprietary or trade secret information shall be kept confidential by the health plan or provider, except as required or permitted by law, including disclosure necessary to prosecute or defend any legitimate legal claim or cause of action.
4. Prescriptions. A pharmacy benefit manager may not substitute or cause the substituting of one prescription drug for another in dispensing a prescription, or alter or cause the altering of the terms of a prescription, except with the approval of the prescriber or as explicitly required or permitted by law.

5. A pharmacy benefit manager shall, with respect to contracts between a pharmacy benefit manager and a pharmacy or, alternatively, a pharmacy benefit manager and a pharmacy's contracting agent, such as a pharmacy services administrative organization, include a reasonable process to appeal, investigate and resolve disputes regarding multi-source generic drug pricing. The appeals process shall include the following provisions:

(a) the right to appeal by the pharmacy and/or the pharmacy's contracting agent shall be limited to thirty days following the initial claim submitted for payment;

(b) a telephone number through which a network pharmacy may contact the pharmacy benefit manager for the purpose of filing an appeal and an electronic mail address of the individual who is responsible for processing appeals;

(c) the pharmacy benefit manager shall send an electronic mail message acknowledging receipt of the appeal. The pharmacy benefit manager shall respond in an electronic message to the pharmacy and/or the pharmacy's contracting agent filing the appeal within seven business days indicating its determination. If the appeal is determined to be valid, the maximum allowable cost for the drug shall be adjusted for the appealing pharmacy effective as of the date of the original claim for payment. The pharmacy benefit manager shall require the appealing pharmacy to reverse and rebill the claim in question in order to obtain the corrected reimbursement;

(d) if an update to the maximum allowable cost is warranted, the pharmacy benefit manager or covered entity shall adjust the maximum allowable cost of the drug effective for all similarly situated pharmacies in its network in the state on the date the appeal was determined to be valid; and

(e) if an appeal is denied, the pharmacy benefit manager shall identify the national drug code of a therapeutically equivalent drug, as determined by the federal Food and Drug Administration, that is available for purchase by pharmacies in this state from wholesalers registered pursuant to subdivision four of section sixty-eight hundred eight of the education law at a price which is equal to or less than the maximum allowable cost for that drug as determined by the pharmacy benefit manager.

§ 7. This act shall take effect on the one hundred eightieth day after it shall have become a law; provided, however, that effective immediately, the superintendent of financial services shall repeal, amend, or promulgate any rules and regulations necessary for the implementation of the provisions of this act on its effective date.

PART K

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

§ 2825-e. Health care facility transformation program: statewide II. 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 create financially sustainable systems of care or preserve or expand essential health care services. 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 capital 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 works or purposes that support 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. Priority shall be given to projects not funded under section twenty-eight hundred twenty-five-d of this article. 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 seven hundred 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 one hundred twenty-five 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; an alcohol and substance abuse treatment clinic licensed or granted an operating certificate under article thirty-two of the mental hygiene law; a primary care provider or a home care provider certified or licensed pursuant to article thirty-six of this chapter. Eligible applicants shall be those deemed by the commissioner to be a provider that fulfills or will fulfill a health care need for acute inpatient, outpatient, primary, home care or residential health care services in a community.

4. 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) Consideration of 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 that 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.

5. 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.

6. The department shall provide a report on a quarterly basis to the chairs of the senate finance, assembly ways and means, and senate health and assembly health committees. 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 five 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, 2017.

PART L

Intentionally Omitted

PART M

Section 1. This act shall be known and may be cited as the "Emerging Contaminant Monitoring Act."

§ 2. The public health law is amended by adding a new section 1112 to read as follows:

§ 1112. Emerging contaminant monitoring. 1. Industry and modern technology have created thousands of new chemicals that would not otherwise exist in nature. Although some of these chemicals have proven benefits, the effect of many such chemicals on human health is unknown or not fully understood. Furthermore, with the advance of science and technology, public health scientists and experts are able to identify naturally occurring contaminants that pose previously unknown hazards to human health. Where these chemicals or contaminants, collectively referred to as "emerging contaminants," enter drinking water supplies, they can present unknown but potentially serious risks to public health. New Yorkers served by public water supplies have the right to know when

potentially hazardous substances contaminate their drinking water and the department must be equipped to monitor and protect the public from these emerging contaminants.

2. a. "Emerging contaminants" shall mean any physical, chemical, microbiological or radiological substance listed as an emerging contaminant pursuant to subdivision three of this section.

b. "Notification level" shall mean the concentration level of an emerging contaminant in drinking water that the commissioner has determined, based on available scientific information, to be linked to adverse health outcomes including both physical and behavioral health, and warrants public notification pursuant to this section.

c. "Covered public water system" shall mean: (i) a public water system that serves at least five service connections used by year-round residents or regularly serves at least twenty-five year-round residents; (ii) a public water system that regularly serves at least twenty-five of the same people, four hours or more per day, for four or more days per week, for twenty-six or more weeks per year; or (iii) any other substantially similar water system as determined by the commissioner.

3. The commissioner shall promulgate regulations to identify and list substances as emerging contaminants. In determining what substances shall be identified as emerging contaminants the commissioner shall, at a minimum, examine substances that require regulation or monitoring when present in drinking water in other jurisdictions outside the state of New York; the United States environmental protection agency's human health benchmarks for pesticides; and, substances found at sites in remedial programs located inside and outside the state of New York, including but not limited to inactive hazardous waste sites. The commissioner shall, at a minimum, include the following chemicals to be identified as emerging contaminants: 1,4-dioxane; vanadium; strontium; chromium-6; chlorate; perfluorooctanesulfonic acid; and perfluorooctanoic acid. Additional substances to be identified as emerging contaminants shall meet the following criteria:

a. are not subject to any other substance-specific drinking water regulation of the department that establishes a maximum contaminant level, or other legally established threshold concentration used by the department that requires public notification or remedial action;

b. are known or anticipated to occur in public water systems; and

c. because of their quantity, concentration, or physical, chemical or infectious characteristics, may cause physical injury or illness, or otherwise pose a potential hazard to human health when present in drinking water.

4. Every covered public water system shall test drinking water for the presence of emerging contaminants in the state and unregulated contaminants monitored under the federal Safe Drinking Water Act as amended from time to time, at least once every three years in a manner and timeframe established by the department through regulation.

5. Every test conducted in accordance with this section shall be conducted by a laboratory certified by the department pursuant to section five hundred two of this chapter. Laboratories shall submit such results to the department, any other health department that the covered public water system is located in, and to the covered public water system electronically in the manner prescribed by the commissioner.

6. The commissioner shall promulgate regulations establishing notification levels for any emerging contaminant listed pursuant to subdivision three of this section. Any notification level established pursuant to this subdivision shall be equal to or lower than any federally estab-

lished concentration level that would require public notification, or remedial action for that substance.

7. Whenever one or more emerging contaminants is present in drinking water at concentrations at or above a notification level established pursuant to this section the covered public water system shall notify all owners of real property served by the covered public water system in a time and manner to be prescribed by the department. Such public notification shall occur within thirty days. The covered public water system shall consult with the department within twenty-four hours of being notified of the presence of an emerging contaminant. The department may reduce the timeframe for public notification from thirty days if it is determined that the public's interest would be best served by such reduction. The commissioner may directly notify such owners of real property if it is determined that the public's interest would be best served by such notification, or if the commissioner determines that the covered public water system is not acting, or cannot act in a timely manner.

8. The commissioner may require that the covered public water system take such actions as may be appropriate to reduce exposure to emerging contaminants. The commissioner shall work in consultation with the commissioner of the department of environmental conservation to develop educational materials, which shall be made available to the covered public water system and the general public, relating to methodologies for reducing exposure to emerging contaminants and potential actions that may be taken to remediate emerging contaminants. The commissioner shall also provide the covered public water system with information relating to potential funding sources provided by the state and federal government for remedial activities, and to reduce the exposure to emerging contaminants. Whenever the commissioner of health has required a public water system to take action to reduce exposure to emerging contaminants, the department shall undertake all reasonable and necessary measures to ensure that safe drinking water is expeditiously made available to all people in any area of the state in which emerging contaminants are known to be present. Such area shall include, at a minimum, all properties served by the covered public water system and any land and any surface or underground water sources identified by the department or department of environmental conservation as causing or contributing to the contamination. The department's measures may include installation of onsite water supplies, or the provision of alternative water supply sources.

9. Any owner of real property, including any owner's agent, to whom a covered public water system or the department has provided notification of the exceedance of a notification level established pursuant to subdivision six of this section, shall take all reasonable and necessary steps to provide, within ten days, any tenants with copies of the notification provided by the covered public water system, or the commissioner.

10. The commissioner shall promulgate regulations pursuant to which the department may provide financial assistance for compliance with the testing requirements of this section, to any covered public water system upon a showing that the costs associated with testing drinking water in compliance with this section would impose an unreasonable financial hardship.

11. The commissioner of health shall review substances that have been identified as emerging contaminants pursuant to this section and determine if the department should establish a maximum contaminant level for

the substance. Such a review shall occur, at a minimum, once every three years.

§ 3. Section 502 of the public health law is amended by adding a new subdivision 10 to read as follows:

10. The department may require an environmental laboratory to report laboratory test results to the department, or to any other health department in an electronic manner prescribed by the department.

§ 4. This act shall take effect immediately.

PART N

Section 1. This act shall be known and may be cited as the "residential well testing act".

§ 2. The public health law is amended by adding a new section 1111 to read as follows:

§ 1111. Testing of individual onsite water supply systems. 1. The commissioner shall promulgate regulations establishing standards for the testing of new or existing individual onsite water supply systems that provide potable water for humans. Such regulations shall specify the manner of testing and the amount of time such results shall be valid. Individual onsite water supplies shall be tested for character and contaminants commonly found in such water supplies, including but not limited to: bacteria (total coliform); sodium; nitrites; nitrates; iron; manganese; iron plus manganese; pH; lead; 1,4-dioxane; vanadium; strontium; chromium-6; chlorate; perfluorooctanesulfonic acid; perfluorooctanoic acid; and other emerging contaminants as such term is defined in section one thousand one hundred twelve of this title. Such regulations may require additional testing, limit testing or exclude from testing a characteristic or contaminant on a county, regional or local basis if the commissioner determines that such characteristic or contaminant is significant or not significant in that area.

2. a. For the purposes of this section residential real property shall include real property used or occupied, or intended to be used or occupied, wholly or partly, as the home or residence of one or more persons, but shall not refer to unimproved real property upon which such dwellings are to be constructed, condominium units or cooperative apartments, or property in a homeowners' association that is not owned in fee simple by the seller. Any real estate purchase contract for the sale of residential real property, which is served by an individual onsite water supply system, shall include a provision requiring, prior to and as a condition of sale, the testing of such individual onsite water supply system in a manner that meets or exceeds the standards prescribed pursuant to this section. This section shall not apply to covered public water systems, as defined by section one thousand one hundred twelve of this title.

b. Within one year after the effective date of this section, and at least once every five years thereafter, the lessor of any residential real property which is served by an individual onsite water supply system shall test such water supply in accordance with this section for at least the characteristics and contaminants required pursuant to this section. Within thirty days after the receipt of validated test results, the lessor shall provide a written copy thereof to each current tenant of a rental unit on the property. The lessor shall also provide a written copy of the most recent validated test results to a prospective tenant prior to the signing of the lease or entering into an agreement for the rental of a residential unit on the property, or to any former

tenant upon request. The department or the department's designee shall have the authority to request and receive such test results from the lessor.

3. Every test conducted in accordance with this section shall be conducted by a laboratory certified by the department pursuant to section five hundred two of this chapter. Any test results provided by the laboratory, pursuant to this section, shall include the maximum contaminant levels or other threshold concentrations, if any, prescribed by the department for each characteristic or contaminant tested. Laboratories shall submit such results to the department electronically in the manner prescribed pursuant to section five hundred two of this chapter.

4. The commissioner shall promulgate regulations pursuant to which the department may provide financial assistance to owners of residential property served by an individual onsite water supply system, upon a showing that the costs associated with testing drinking water in compliance with this section would impose an unreasonable financial hardship.

5. Nothing contained in this section shall prohibit or limit the testing of individual onsite water supply systems pursuant to any other statutory or regulatory authority.

§ 3. Section 502 of the public health law is amended by adding a new subdivision 10 to read as follows:

10. The department may require an environmental laboratory to report laboratory test results to the department, or to any other health department in an electronic manner prescribed by the department.

§ 4. The real property law is amended by adding a new section 468 to read as follows:

§ 468. Individual onsite water supply testing requirements. 1. Every real estate purchase contract for the sale of residential real property, as defined by section one thousand one hundred eleven of the public health law, which is served by an individual onsite water supply system, shall include a provision requiring as a condition of sale, the testing of such water supply for at least the standards prescribed pursuant to section eleven hundred eleven of the public health law. This section shall not apply to property that is served by a public water system, as defined in regulations promulgated by the commissioner.

2. Closing of title on the sale of such real property shall not occur unless both the buyer and the seller have received and reviewed a copy of the water test results. At closing, the buyer and seller both shall certify in writing that they have received and reviewed the water test results.

3. The requirements of this section may not be waived.

§ 5. Subdivision 3 of section 15-1525 of the environmental conservation law, as amended by section 2 of part F of chapter 59 of the laws of 2006, is amended to read as follows:

3. The certificate of registration shall require that, before the commencement of drilling of any well or wells, the water well driller shall file a preliminary notice with the department; it shall also provide that upon the completion of the drilling of any water well or water wells, a completion report be filed with the department, giving the log of the well, the size and depth thereof, the capacity of the pump or pumps attached or to be attached thereto, the laboratory results of the water sample tested in accordance with section eleven hundred eleven of the public health law, and such other information pertaining to the withdrawal of water and operation of such water well or water wells as the department by its rules and regulations may require. The water well driller shall provide a copy of such completion report to the

water well owner **and the department of health and department of environmental conservation**. The number of the certificate of registration must be displayed on the well drilling machinery of the registrant. The certificate of registration shall also contain a notice to the certificate holder that the business activities authorized by such certificate are subject to the provisions of article thirty-six-A of the general business law. The fee for such certificate of registration shall be ten dollars annually. The commissioner shall promulgate a water well completion report form which shall be utilized by all water well drillers in satisfying the requirements of this section and any other provision of state or local law which requires the submission of a water well completion report or water well log.

§ 5-a. Subdivision 1 of section 3-0315 of the environmental conservation law, as added by section 1 of part C of chapter 1 of the laws of 2003, is amended to read as follows:

1. The department shall create or modify an existing geographic information system, and maintain such system for purposes including, but not limited to, incorporating information from remedial programs under its jurisdiction, and shall also incorporate information from the source water assessment program collected by the department of health, **information collected pursuant to section eleven hundred eleven of the public health law,** data from annual water supply statements prepared pursuant to section eleven hundred fifty-one of the public health law, information from the database pursuant to title fourteen of article twenty-seven of this chapter, and any other existing data regarding soil and groundwater contamination currently gathered by the department, as well as data on contamination that is readily available from the United States geological survey and other sources determined appropriate by the department.

§ 6. This act shall take effect on the one hundred eightieth day after it shall have become a law; provided, however, that effective immediately, the commissioner of health and commissioner of environmental conservation shall be authorized to promulgate any and all rules and regulations necessary to implement the provisions of this act on its effective date.

PART O

Intentionally Omitted

PART P

Section 1. Section 48-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 relating to the cap on local Medicaid expenditures, as amended by section 29 of part B of chapter 59 of the laws of 2016, is amended to read as follows:

§ 48-a. 1. Notwithstanding any contrary provision of law, the commissioners of the office of alcoholism and substance abuse services and the office of mental health are authorized, subject to the approval of the director of the budget, to transfer to the commissioner of health state funds to be utilized as the state share for the purpose of increasing payments under the medicaid program to managed care organizations licensed under article 44 of the public health law or under article 43 of the insurance law. Such managed care organizations shall utilize such

funds for the purpose of reimbursing providers licensed pursuant to article 28 of the public health law or article 31 or 32 of the mental hygiene law for ambulatory behavioral health services, as determined by the commissioner of health, in consultation with the commissioner of alcoholism and substance abuse services and the commissioner of the office of mental health, provided to medicaid [~~eligible~~] enrolled outpatients and for all other behavioral health services except inpatient included in New York state's Medicaid redesign waiver approved by the centers for Medicare and Medicaid services (CMS). Such reimbursement shall be in the form of fees for such services which are equivalent to the payments established for such services under the ambulatory patient group (APG) rate-setting methodology as utilized by the department of health, the office of alcoholism and substance abuse services, or the office of mental health for rate-setting purposes or any such other fees pursuant to the Medicaid state plan or otherwise approved by CMS in the Medicaid redesign waiver; provided, however, that the increase to such fees that shall result from the provisions of this section shall not, in the aggregate and as determined by the commissioner of health, in consultation with the commissioner of alcoholism and substance abuse services and the commissioner of the office of mental health, be greater than the increased funds made available pursuant to this section. The increase of such ambulatory behavioral health fees to providers available under this section shall be for all rate periods on and after the effective date of section [~~1~~] 29 of part [~~C~~] B of chapter [~~57~~] 59 of the laws of [~~2015~~] 2016 through March 31, [~~2018~~] 2021 for patients in the city of New York, for all rate periods on and after the effective date of section [~~1~~] 29 of part [~~C~~] B of chapter [~~57~~] 59 of the laws of [~~2015~~] 2016 through [~~June 30, 2018~~] March 31, 2021 for patients outside the city of New York, and for all rate periods on and after the effective date of such chapter through [~~June 30, 2018~~] March 31, 2021 for all services provided to persons under the age of twenty-one; provided, however, [~~eligible providers may work with managed care plans to achieve quality and efficiency objectives and engage in shared savings~~] the commissioner of health, in consultation with the commissioner of alcoholism and substance abuse services and the commissioner of mental health, may require, as a condition of approval of such ambulatory behavioral health fees, that aggregate managed care expenditures to eligible providers meet the following value based payment metrics for the following periods: (i) for the period from April 1, 2018 through March 31, 2019, at least ten percent of such managed care expenditures are paid through level one value based payment arrangements, pursuant to the terms and conditions of the delivery system reform incentive payment program waiver approved by the centers for Medicare and Medicaid services (ii) for the period April 1, 2019 through March 31, 2020, at least fifty percent of such managed care expenditures are paid through level one value based payment arrangements and at least fifteen percent are paid through level two value based payment arrangements, pursuant to the terms and conditions of the delivery system reform incentive payment program waiver approved by the centers for Medicare and Medicaid services and (iii) for the period April 1, 2020 through March 31, 2021, at least eighty percent of such managed care expenditures are paid through level one value based payment arrangements and at least thirty-five percent are paid through level two value based payment arrangements, pursuant to the terms and conditions of the delivery system reform incentive payment program waiver approved by the centers for Medicare and Medicaid services. The commissioner of health shall, in

consultation with the commissioner of alcoholism and substance abuse services and the commissioner of the office of mental health, waive such conditions if a sufficient number of providers, as determined by the commissioner, suffer a financial hardship as a consequence of such value based payment arrangements, or if he or she shall determine that such value based payment arrangements significantly threaten individuals' access to ambulatory behavioral health services. Such waiver may be applied on a provider specific or industry wide basis. Nothing in this section shall prohibit managed care organizations and providers from negotiating different rates and methods of payment during such periods described above, subject to the approval of the department of health. The department of health shall consult with the office of alcoholism and substance abuse services and the office of mental health in determining whether such alternative rates shall be approved. The commissioner of health may, in consultation with the commissioner of alcoholism and substance abuse services and the commissioner of the office of mental health, promulgate regulations, including emergency regulations promulgated prior to October 1, 2015 to establish rates for ambulatory behavioral health services, as are necessary to implement the provisions of this section. Rates promulgated under this section shall be included in the report required under section 45-c of part A of this chapter.

2. Notwithstanding any contrary provision of law, the fees paid by managed care organizations licensed under article 44 of the public health law or under article 43 of the insurance law, to providers licensed pursuant to article 28 of the public health law or article 31 or 32 of the mental hygiene law, for ambulatory behavioral health services provided to patients enrolled in the child health insurance program pursuant to title one-A of article 25 of the public health law, shall be in the form of fees for such services which are equivalent to the payments established for such services under the ambulatory patient group (APG) rate-setting methodology or any such other fees established pursuant to the Medicaid state plan. The commissioner of health shall consult with the commissioner of alcoholism and substance abuse services and the commissioner of the office of mental health in determining such services and establishing such fees. Such ambulatory behavioral health fees to providers available under this section shall be for all rate periods on and after the effective date of this chapter through [~~June 30, 2018~~] March 31, 2021, provided, however, that managed care organizations and providers may negotiate different rates and methods of payment during such periods described above, subject to the approval of the department of health. The department of health shall consult with the office of alcoholism and substance abuse services and the office of mental health in determining whether such alternative rates shall be approved. The report required under section 16-a of part C of chapter 60 of the laws of 2014 shall also include the population of patients enrolled in the child health insurance program pursuant to title one-A of article 25 of the public health law in its examination on the transition of behavioral health services into managed care.

§ 2. Section 1 of part H of chapter 111 of the laws of 2010 relating to increasing Medicaid payments to providers through managed care organizations and providing equivalent fees through an ambulatory patient group methodology, as amended by section 30 of part B of chapter 59 of the laws of 2016, is amended to read as follows:

Section 1. a. Notwithstanding any contrary provision of law, the commissioners of mental health and alcoholism and substance abuse services are authorized, subject to the approval of the director of the

budget, to transfer to the commissioner of health state funds to be utilized as the state share for the purpose of increasing payments under the medicaid program to managed care organizations licensed under article 44 of the public health law or under article 43 of the insurance law. Such managed care organizations shall utilize such funds for the purpose of reimbursing providers licensed pursuant to article 28 of the public health law, or pursuant to article 31 or article 32 of the mental hygiene law for ambulatory behavioral health services, as determined by the commissioner of health in consultation with the commissioner of mental health and commissioner of alcoholism and substance abuse services, provided to medicaid [~~eligible~~] enrolled outpatients and for all other behavioral health services except inpatient included in New York state's Medicaid redesign waiver approved by the centers for Medicare and Medicaid services (CMS). Such reimbursement shall be in the form of fees for such services which are equivalent to the payments established for such services under the ambulatory patient group (APG) rate-setting methodology as utilized by the department of health or by the office of mental health or office of alcoholism and substance abuse services for rate-setting purposes or any such other fees pursuant to the Medicaid state plan or otherwise approved by CMS in the Medicaid redesign waiver; provided, however, that the increase to such fees that shall result from the provisions of this section shall not, in the aggregate and as determined by the commissioner of health in consultation with the commissioners of mental health and alcoholism and substance abuse services, be greater than the increased funds made available pursuant to this section. The increase of such behavioral health fees to providers available under this section shall be for all rate periods on and after the effective date of section [~~2~~] 30 of part [~~C~~] B of chapter [~~57~~] 59 of the laws of [~~2015~~] 2016 through March 31, [~~2018~~] 2021 for patients in the city of New York, for all rate periods on and after the effective date of section [~~2~~] 30 of part [~~C~~] B of chapter [~~57~~] 59 of the laws of [~~2015~~] 2016 through [~~June 30, 2018~~] March 31, 2021 for patients outside the city of New York, and for all rate periods on and after the effective date of section [~~2~~] 30 of part [~~C~~] B of chapter [~~57~~] 59 of the laws of [~~2015~~] 2016 through [~~June 30, 2018~~] March 31, 2021 for all services provided to persons under the age of twenty-one; provided, however, [~~eligible providers may work with managed care plans to achieve quality and efficiency objectives and engage in shared savings~~] the commissioner of health, in consultation with the commissioner of alcoholism and substance abuse services and the commissioner of mental health, may require, as a condition of approval of such ambulatory behavioral health fees, that aggregate managed care expenditures to eligible providers meet the following value based payment metrics for the following periods: (i) for the period from April 1, 2018 through March 31, 2019, at least ten percent of such managed care expenditures are paid through level one value based payment arrangements, pursuant to the terms and conditions of the delivery system reform incentive payment program waiver approved by the centers for Medicare and Medicaid services (ii) for the period April 1, 2019 through March 31, 2020, at least fifty percent of such managed care expenditures are paid through level one value based payment arrangements and at least fifteen percent are paid through level two value based payment arrangements, pursuant to the terms and conditions of the delivery system reform incentive payment program waiver approved by the centers for Medicare and Medicaid services (iii) for the period April 1, 2020 through March 31, 2021, at least eighty percent of such managed care expenditures are paid through

level one value based payment arrangements and at least thirty-five percent are paid through level two value based payment arrangements, pursuant to the terms and conditions of the delivery system reform incentive payment program waiver approved by the centers for Medicare and Medicaid services. The commissioner of health shall, in consultation with the commissioner of alcoholism and substance abuse services and the commissioner of the office of mental health, waive such conditions if a sufficient number of providers, as determined by the commissioner, suffer a financial hardship as a consequence of such value based payment arrangements, or if he or she shall determine that such value based payment arrangements significantly threaten individuals' access to ambulatory behavioral health services. Such waiver may be applied on a provider specific or industry wide basis. Nothing in this section shall prohibit managed care organizations and providers from negotiating different rates and methods of payment during such periods described, subject to the approval of the department of health. The department of health shall consult with the office of alcoholism and substance abuse services and the office of mental health in determining whether such alternative rates shall be approved. The commissioner of health may, in consultation with the commissioners of mental health and alcoholism and substance abuse services, promulgate regulations, including emergency regulations promulgated prior to October 1, 2013 that establish rates for behavioral health services, as are necessary to implement the provisions of this section. Rates promulgated under this section shall be included in the report required under section 45-c of part A of chapter 56 of the laws of 2013.

b. Notwithstanding any contrary provision of law, the fees paid by managed care organizations licensed under article 44 of the public health law or under article 43 of the insurance law, to providers licensed pursuant to article 28 of the public health law or article 31 or 32 of the mental hygiene law, for ambulatory behavioral health services provided to patients enrolled in the child health insurance program pursuant to title one-A of article 25 of the public health law, shall be in the form of fees for such services which are equivalent to the payments established for such services under the ambulatory patient group (APG) rate-setting methodology. The commissioner of health shall consult with the commissioner of alcoholism and substance abuse services and the commissioner of the office of mental health in determining such services and establishing such fees. Such ambulatory behavioral health fees to providers available under this section shall be for all rate periods on and after the effective date of this chapter through [~~June 30, 2018~~] March 31, 2021, provided, however, that managed care organizations and providers may negotiate different rates and methods of payment during such periods described above, subject to the approval of the department of health. The department of health shall consult with the office of alcoholism and substance abuse services and the office of mental health in determining whether such alternative rates shall be approved. The report required under section 16-a of part C of chapter 60 of the laws of 2014 shall also include the population of patients enrolled in the child health insurance program pursuant to title one-A of article 25 of the public health law in its examination on the transition of behavioral health services into managed care.

§ 3. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2017; provided, however, that the amendments to section 48-a of part A of chapter 56 of the laws of 2013 made by section one of this act shall not affect the

repeal of such section and shall be deemed repealed therewith; provided further, that the amendments to section 1 of part H of chapter 111 of the laws of 2010 made by section two of this act shall not affect the expiration of such section and shall be deemed to expire therewith.

PART Q

Intentionally Omitted

PART R

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 2 of part C of chapter 59 of the laws of 2016, 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, [~~and~~] between July 1, 2016 and June 30, 2017**, and between July 1, 2017 and June 30, 2018** 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, [~~and~~] between July 1, 2016 and June 30, 2017**, and between July 1, 2017 and June 30, 2018** 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 individual 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 3 of part C of chapter 59 of the laws of 2016, 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** 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** 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 June 30, 2018**.

§ 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 4 of part C of chapter 59 of the laws of 2016, 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 June 30, 2016, [~~and between~~] **during the period** July 1, 2016 and June 30, 2017**, and during**

the period July 1, 2017 and June 30, 2018 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** 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** 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** that has made payment to such provider of excess insurance coverage or equivalent excess coverage in accordance with paragraph (b) of this subdivision and of each physician and dentist who has failed, refused or neglected to make such payment.

(e) A provider of excess insurance coverage or equivalent excess coverage shall refund to the hospital excess liability pool any amount allocable to the period July 1, 1992 to June 30, 1993, and to the period July 1, 1993 to June 30, 1994, and to the period July 1, 1994 to June 30, 1995, and to the period July 1, 1995 to June 30, 1996, and to the period July 1, 1996 to June 30, 1997, and to the period July 1, 1997 to June 30, 1998, and to the period July 1, 1998 to June 30, 1999, and to the period July 1, 1999 to June 30, 2000, and to the period July 1, 2000 to June 30, 2001, and to the period July 1, 2001 to October 29, 2001, and to the period April 1, 2002 to June 30, 2002, and to the period July 1, 2002 to June 30, 2003, and to the period July 1, 2003 to June 30, 2004, and to the period July 1, 2004 to June 30, 2005, and to the period

July 1, 2005 to June 30, 2006, and to the period July 1, 2006 to June 30, 2007, and to the period July 1, 2007 to June 30, 2008, and to the period July 1, 2008 to June 30, 2009, and to the period July 1, 2009 to June 30, 2010, and to the period July 1, 2010 to June 30, 2011, and to the period July 1, 2011 to June 30, 2012, and to the period July 1, 2012 to June 30, 2013, and to the period July 1, 2013 to June 30, 2014, and to the period July 1, 2014 to June 30, 2015, and to the period July 1, 2015 to June 30, 2016, [~~and~~] to the period July 1, 2016 to June 30, 2017**, and to the period July 1, 2017 to June 30, 2018** 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** 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 5 of part C of chapter 59 of the laws of 2016, 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, [~~2017~~] **2018**; 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, [~~2017~~] **2018**, 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, [~~2017~~] **2018** 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, as amended by section 6 of part C of chapter 59 of the laws of 2016, 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, [~~and~~] June 15, 2017**, and June 15, 2018** 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** 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** 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, [~~and~~] June 15, 2017**, and June 15, 2018** as applicable.

§ 6. 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, shall be eligible to apply for such coverage for the coverage period beginning the first of July, two thousand seventeen; 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

exceeds the total number of physicians or dentists certified as eligible for the coverage period beginning the first of July, two thousand seventeen, 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, 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 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.

§ 7. Intentionally omitted.

§ 8. This act shall take effect immediately.

PART S

Section 1. On or before October 1, 2017, the commissioner of the office for people with developmental disabilities shall issue a report to the temporary president of the senate and the speaker of the assembly to include the following:

(a) progress the office has made in meeting the housing needs of individuals with developmental disabilities, including through:

(1) its ongoing review of the residential registration list, including information regarding services currently provided to individuals on the list and any available information on residential support categories and housing needs for such individuals;

(2) recommendations and information provided by the regional stakeholder advisory groups;

(3) increasing access to rental housing, supportive housing, and other independent living options;

(4) building understanding and awareness of housing options for independent living among people with developmental disabilities, families, public and private organizations, developers and direct support professionals; and

(5) assisting with the creation of a sustainable living environment through funding for home modifications, down payment assistance and home repairs; and

(b) an update on the implementation of the report and recommendations of the transformation panel, including implementation of the panel's recommendations to:

(1) increase and support access to self-directed models of care;

(2) enhance opportunities for individuals to access community integrated housing;

(3) increase integrated employment opportunities; and

(4) examine the program design and fiscal model for managed care to appropriately address the needs of individuals with developmental disabilities.

§ 2. This act shall take effect immediately; provided, however, that this at shall be subject to appropriations made specifically available for this purpose and shall expire and be deemed repealed April 1, 2018.

PART T

Section 1. The opening paragraph of section 220.03 of the penal law, as amended by section 4 of part I of chapter 57 of the laws of 2015, is amended to read as follows:

A person is guilty of criminal possession of a controlled substance in the seventh degree when he or she knowingly and unlawfully possesses a controlled substance; provided, however, that it shall not be a violation of this section when a person possesses a residual amount of a controlled substance and that residual amount is in or on a hypodermic syringe or hypodermic needle [~~obtained and possessed pursuant to section thirty-three hundred eighty-one of the public health law, which includes the state's syringe exchange and pharmacy and medical provider based expanded syringe access programs~~]; nor shall it be a violation of this section when a person's unlawful possession of a controlled substance is discovered as a result of seeking immediate health care as defined in paragraph (b) of subdivision three of section 220.78 of [~~the penal law~~] **this article**, for either another person or him or herself because such person is experiencing a drug or alcohol overdose or other life threatening medical emergency as defined in paragraph (a) of subdivision three of section 220.78 of [~~the penal law~~] **this article**.

§ 2. Section 220.45 of the penal law is REPEALED.

§ 3. Subdivision 2 of section 850 of the general business law, as amended by chapter 812 of the laws of 1980, is amended to read as follows:

2. **(a)** "Drug-related paraphernalia" consists of the following objects used for the following purposes:

[~~(a)~~] **(i)** Kits, used or designed for the purpose of planting, propagating, cultivating, growing or harvesting of any species of plant which is a controlled substance or from which a controlled substance can be derived;

[~~(b)~~] **(ii)** Kits, used or designed for the purpose of manufacturing, compounding, converting, producing, or preparing controlled substances;

[~~(c)~~] **(iii)** Isomerization devices, used or designed for the purpose of increasing the potency of any species of plant which is a controlled substance;

[~~(d)~~] **(iv)** Scales and balances, used or designed for the purpose of weighing or measuring controlled substances;

[~~(e)~~] **(v)** Diluents and adulterants, including but not limited to quinine hydrochloride, mannitol, mannite, dextrose and lactose, used or designed for the purpose of cutting controlled substances;

[~~(f)~~] **(vi)** Separation gins, used or designed for the purpose of removing twigs and seeds in order to clean or refine marihuana;

[~~(g) Hypodermic syringes, needles and other objects, used or designed for the purpose of parenterally injecting controlled substances into the human body;~~

~~(h)~~] **and**

(vii) Objects, used or designed for the purpose of ingesting, inhaling, or otherwise introducing marihuana, cocaine, hashish, or hashish oil into the human body.

(b) "Drug-related paraphernalia" shall not include hypodermic needles, hypodermic syringes and other objects used for the purpose of parenterally injecting controlled substances into the human body.

§ 4. Section 3381 of the public health law, as amended by section 9-a of part B of chapter 58 of the laws of 2007, subdivisions 1, 2 and 3 as amended by chapter 178 of the laws of 2010, paragraphs (e), (f) and (g) of subdivision 5 as amended by section 2 of part D of chapter 71 of the laws of 2016, is amended to read as follows:

§ 3381. Sale and possession of hypodermic syringes and hypodermic needles. 1. It shall be unlawful for any person to sell or furnish to another person or persons, a hypodermic syringe or hypodermic needle except:

(a) pursuant to a prescription of a practitioner, which for the purposes of this section shall include a patient specific prescription form as provided for in the education law; or

(b) to persons who have been authorized by the commissioner to obtain and possess such instruments; or

(c) by a pharmacy licensed under article one hundred thirty-seven of the education law, health care facility licensed under article twenty-eight of this chapter or a health care practitioner who is otherwise authorized to prescribe the use of hypodermic needles or syringes within his or her scope of practice; provided, however, that such sale or furnishing: (i) shall only be to a person eighteen years of age or older; and (ii) [~~shall be limited to a quantity of ten or less hypodermic needles or syringes; and (iii)~~] shall be in accordance with subdivision [~~five~~] four of this section[~~.~~] ; or

(d) under subdivision three of this section.

2. [~~It shall be unlawful for any person to obtain or possess a hypodermic syringe or hypodermic needle unless such possession has been authorized by the commissioner or is pursuant to a prescription, or is pursuant to subdivision five of this section.~~

~~3.~~] Any person selling or furnishing a hypodermic syringe or hypodermic needle pursuant to a prescription shall record upon the prescription, his or her signature or electronic signature, and the date of the sale or furnishing of the hypodermic syringe or hypodermic needle. Such prescription shall be retained on file for a period of five years and be readily accessible for inspection by any public officer or employee engaged in the enforcement of this section. Such prescription may be refilled not more than the number of times specifically authorized by the prescriber upon the prescription, provided however no such authorization shall be effective for a period greater than two years from the date the prescription is signed.

[~~4~~] 3. The commissioner shall, subject to subdivision [~~five~~] four of this section, designate persons, or by regulation, classes of persons who may obtain hypodermic syringes and hypodermic needles without prescription and the manner in which such transactions may take place and the records thereof which shall be maintained.

[~~5~~] 4. (a) A person eighteen years of age or older may obtain and possess a hypodermic syringe or hypodermic needle pursuant to paragraph (c) of subdivision one of this section.

(b) Subject to regulations of the commissioner, a pharmacy licensed under article one hundred thirty-seven of the education law, a health care facility licensed under article twenty-eight of this chapter or a health care practitioner who is otherwise authorized to prescribe the use of hypodermic needles or syringes within his or her scope of practice, may obtain and possess hypodermic needles or syringes for the purpose of selling or furnishing them pursuant to paragraph (c) of subdivision one of this section or for the purpose of disposing of them[~~, provided that such pharmacy, health care facility or health care practitioner has registered with the department~~].

(c) Sale or furnishing of hypodermic syringes or hypodermic needles to direct consumers pursuant to this subdivision by a pharmacy, health care facility, or health care practitioner shall be accompanied by a safety insert. Such safety insert shall be developed or approved by the commis-

sioner and shall include, but not be limited to, (i) information on the proper use of hypodermic syringes and hypodermic needles; (ii) the risk of blood borne diseases that may result from the use of hypodermic syringes and hypodermic needles; (iii) methods for preventing the transmission or contraction of blood borne diseases; (iv) proper hypodermic syringe and hypodermic needle disposal practices; (v) information on the dangers of injection drug use, and how to access drug treatment; (vi) a toll-free phone number for information on the human immunodeficiency virus; and (vii) information on the safe disposal of hypodermic syringes and hypodermic needles including the relevant provisions of the environmental conservation law relating to the unlawful release of regulated medical waste. The safety insert shall be attached to or included in the hypodermic syringe and hypodermic needle packaging, or shall be given to the purchaser at the point of sale or furnishing in brochure form.

(d) In addition to the requirements of paragraph (c) of subdivision one of this section, a pharmacy licensed under article one hundred thirty-seven of the education law may sell or furnish hypodermic needles or syringes only if such pharmacy[~~: (i) does not advertise to the public the availability for retail sale or furnishing of hypodermic needles or syringes without a prescription; and (ii) at any location where hypodermic needles or syringes are kept for retail sale or furnishing,~~] stores such needles and syringes in a manner that makes them available only to authorized personnel and not openly available to customers.

(e) A pharmacy registered under article one hundred thirty-seven of the education law may offer counseling and referral services to customers purchasing hypodermic syringes for the purpose of: preventing injection drug abuse; the provision of drug treatment; preventing and treating hepatitis C; preventing drug overdose; testing for the human immunodeficiency virus; and providing pre-exposure prophylaxis and non-occupational post-exposure prophylaxis. The content of such counseling and referral shall be at the professional discretion of the pharmacist.

(f) The commissioner shall promulgate rules and regulations necessary to implement the provisions of this subdivision which shall include**: (i) standards for advertising to the public the availability for retail sale or furnishing of hypodermic syringes or needles; and (ii)** a requirement that such pharmacies, health care facilities and health care practitioners cooperate in a safe disposal of used hypodermic needles or syringes.

(g) The commissioner may, upon the finding of a violation of this section, suspend for a determinate period of time the sale or furnishing of syringes by a specific entity.

[~~6~~] **5**. The provisions of this section shall not apply to farmers engaged in livestock production or to those persons supplying farmers engaged in livestock production, provided that:

(a) Hypodermic syringes and needles shall be stored in a secure, locked storage container.

(b) At any time the department may request a document outlining:

(i) the number of hypodermic needles and syringes purchased over the past calendar year;

(ii) a record of all hypodermic needles used over the past calendar year; and

(iii) a record of all hypodermic needles and syringes destroyed over the past calendar year.

(c) Hypodermic needles and syringes shall be destroyed in a manner consistent with the provisions set forth in section thirty-three hundred eighty-one-a of this article.

§ 5. This act shall take effect immediately.

PART U

Section 1. Notwithstanding any other inconsistent provision of law, the Western New York Children's Psychiatric Center shall be maintained as a distinct entity, both organizationally and physically, within the office of mental health, and such facility shall not be collocated or merged with any adult facility. Such facility shall have no less than forty-six beds that only serve children or adolescents, and the office of mental health shall not take any steps to limit clinically appropriate admissions or transfers to such facility.

§ 2. This act shall take effect immediately.

PART V

Section 1. Subdivision 1 of section 364-j of the social services law is amended by adding two new paragraphs (w) and (w-1) to read as follows:

(w) "School-based health center." A clinic licensed under article twenty-eight of the public health law or sponsored by a facility licensed under article twenty-eight of the public health law, which provides primary and preventative care which may include but is not limited to health maintenance, well-child care, diagnosis and treatment of injury and acute illness, diagnosis and management of chronic disease, behavioral health services directly or by referral, vision care, dental care, and nutritional or other enhanced services to children and adolescents, within an elementary, secondary or prekindergarten public school setting.

(w-1) "Sponsoring organization." A facility licensed under article twenty-eight of the public health law which acts as the sponsor for a school-based health center.

§ 2. Subdivision 3 of section 364-j of the social services law is amended by adding a new paragraph (d-3) to read as follows:

(d-3) Services provided by school-based health centers shall not be provided to medical assistance recipients through managed care programs established pursuant to this section, and shall continue to be provided outside of managed care programs in accordance with applicable reimbursement methodologies. Applicable reimbursement methodologies shall mean:

(i) for school-based health centers sponsored by a federally qualified health center, rates of reimbursement and requirements in accordance with those mandated by 42 U.S.C. Secs. 1396a(bb), 1396b(m)(2)(A)(ix) and 1396a(a)(13)(C); and

(ii) for school-based health centers sponsored by an entity licensed pursuant to article twenty-eight of the public health law that is not a federally qualified health center, rates of reimbursement at the fee for service rate for such services in effect prior to the enactment of this paragraph for the ambulatory patient group rate for the applicable service.

§ 3. This act shall take effect immediately provided, however, that the amendments to subdivisions 1 and 3 of section 364-j of the social services law made by sections one and two of this act shall not affect the repeal of such section and shall be deemed repealed therewith.

PART W

Section 1. Section 365-f of the social services law is amended by adding two new subdivisions 4-a and 4-b to read as follows:

4-a. Fiscal intermediary services. (a) For the purposes of this section:

(i) "Fiscal intermediary" means an entity that provides fiscal intermediary services and has a contract for providing such services with:

(A) a local department of social services;

(B) an organization licensed under article forty-four of the public health law; or

(C) an accountable care organization certified under article twenty-nine-E of the public health law or an integrated delivery system composed primarily of health care providers recognized by the department as a performing provider system under the delivery system reform incentive payment program.

(ii) Fiscal intermediary services shall include the following services, performed on behalf of the consumer to facilitate his or her role as the employer:

(A) wage and benefit processing for consumer directed personal assistants;

(B) processing all income tax and other required wage withholdings;

(C) complying with workers' compensation, disability and unemployment requirements;

(D) maintaining personnel records for each consumer directed personal assistant, including time sheets and other documentation needed for wages and benefit processing and a copy of the medical documentation required pursuant to regulations established by the commissioner;

(E) ensuring that the health status of each consumer directed personal assistant is assessed prior to service delivery pursuant to regulations issued by the commissioner;

(F) maintaining records of authorizations or reauthorizations of services;

(G) monitoring the consumer's or, if applicable, the designated representative's continuing ability to fulfill the consumer's responsibilities under the program and promptly notifying the authorizing entity of any circumstance that may affect the consumer's or, if applicable, the designated representative's ability to fulfill such responsibilities;

(H) complying with regulations established by the commissioner specifying the responsibilities of providers providing services under this title; and

(I) entering into a department approved memorandum of understanding with the consumer that describes the parties' responsibilities under this program.

(iii) Fiscal intermediaries are not responsible for, and fiscal intermediary services shall not include, fulfillment of the responsibilities of the consumer or, if applicable, the consumer's designated representative as established by the commissioner. A fiscal intermediary's responsibilities shall not include, and a fiscal intermediary shall not engage in: managing the plan of care including recruiting and hiring a sufficient number of individuals who meet the definition of consumer directed personal assistant, as such term is defined by the commissioner, to provide authorized services that are included on the consumer's plan of care; training, supervising and scheduling each consumer directed personal assistant; terminating the consumer directed personal assistant's employment; or assuring that each consumer directed personal assistant competently and safely performs the personal care services, home health aide services and skilled nursing tasks that are included on

the consumer's plan of care. A fiscal intermediary shall exercise reasonable care in properly carrying out its responsibilities under the program.

(b) No entity shall provide, directly or through contract, fiscal intermediary services without a certification as a fiscal intermediary issued by the commissioner in accordance with this subdivision.

(c) An application for certification as a fiscal intermediary shall be filed with the commissioner, together with such other forms and information as shall be prescribed by, or acceptable to the commissioner. Such information shall include, but not be limited to:

(i) the name, employer identification number, and Medicaid provider identification number of the organization, including any subsidiary corporations, if applicable, and any name under which the entity does business;

(ii) all addresses at which the organization operates;

(iii) the names, titles and contact information of all officers and directors in a not-for-profit company or business, or managers in a limited liability company, as well as the name and employment history of the individual ultimately accountable for operation of the fiscal intermediary; and for a not-for-profit entity, the number of director positions set by the company's by-laws, and how many are currently filled;

(iv) a history of the organization, along with an overview of the organization and all services it offers, including any relationships with outside agencies that may influence in any way the ability of the organization to provide fiscal intermediary services consistent with the manner described in its application;

(v) all policies and procedures of the fiscal intermediary, including any contracts or other documents used in communications with consumers;

(vi) plans to solicit and consider input from the fiscal intermediary's consumers, staff, personal assistants and other interested parties which may be charged with roles including, but not limited to, quality assurance review, referral, program monitoring or development or establishing and responding to community needs; such input may be in the form of a board of directors, committee, survey, or other mechanism, provided that the majority of input obtained as part of this process must be from individual consumers and consumer advocates of the fiscal intermediary;

(vii) the organization's plan to address the needs of consumers and their personal assistants in a timely manner, regardless of where they live, including, but not limited to, input from consumers, obtaining physicals and other health information from personal assistants, obtaining time records for payroll, and timely processing of payroll; and

(viii) a written sworn statement by an officer of the entity disclosing any pending litigation, unsatisfied judgments or penalties, convictions for fraud or sanctions imposed by government authorities.

(d) The entity shall reasonably promptly notify the department of any change in the information submitted to the department for certification under this subdivision.

(e) The commissioner shall not approve an application for certification unless he or she is satisfied as to the character, competence and standing in the community of the applicant's incorporators, directors, sponsors, stockholders or operators and finds that the personnel, rules, consumer contracts or agreements, and fiscal intermediary services are fit and adequate, and that the fiscal intermediary services will be provided in the manner required by this subdivision and the

rules and regulations hereunder, in a manner determined by the commissioner.

(f) The commissioner may contract with an entity with appropriate knowledge, expertise and experience possessing extensive knowledge of consumer directed personal assistance fiscal intermediary services and which has a history of providing similar services in relation to a self-directed program to develop and to assist the commissioner in evaluating applicants for certifications or readiness reviews to be a fiscal intermediary.

(g) Neither public need, tax status nor profit-making status shall be a criterion for certification under this subdivision. Status as a licensed home care services agency or other health provider shall not positively or negatively affect an application for certification under this subdivision. An organization authorized pursuant to article forty-four of the public health law shall not be a fiscal intermediary.

(h) A certification under this subdivision shall last for a period of five years. Upon application for a renewal, the fiscal intermediary shall submit up to date information to the commissioner.

(i) The commissioner shall charge applicants for the certification an application fee of one thousand dollars.

4-b. Proceedings involving the certification of a fiscal intermediary. (a) A certification of a fiscal intermediary may be revoked, suspended, limited or annulled by the commissioner on proof that it has failed to comply with the provisions of this subdivision or regulations promulgated hereunder.

(b) No such certification shall be revoked, suspended, limited, annulled or denied without a hearing. However, a certification may be temporarily suspended or limited without a hearing for a period not in excess of thirty days upon written notice to the fiscal intermediary following a finding by the department that the public health or safety is in imminent danger. Such period may be renewed upon written notice and a continued finding under this paragraph.

(c) The commissioner shall fix a time and place for the hearing. A copy of the charges, together with the notice of the time and place of the hearing, shall be served in person or mailed by registered or certified mail to the fiscal intermediary at least twenty-one days before the date fixed for the hearing. The fiscal intermediary shall file with the department not less than eight days prior to the hearing, a written answer to the charges.

(d) All orders or determinations under this subdivision shall be subject to review as provided in article seventy-eight of the civil practice law and rules.

§ 2. Section 365-a of the social services law is amended by adding a new subdivision 10 to read as follows:

10. For any determination of the amount, nature and manner of providing long term care assistance under this article for which an assessment tool is used, the department, in consultation with the independent actuary, representatives of medical assistance recipients, representatives of the managed care programs, representatives of long term care providers and other interested parties, shall evaluate existing assessment tools and develop additional professionally and statistically valid assessment tools to be used to assist in determining the amount, nature and manner of services and care needs of individuals which shall involve consideration of variables including but not limited to physical and behavioral functioning; activities of daily living and instrumental activities of daily living; family, social or geographic determinants of

health; primary or secondary diagnoses of cognitive impairment or mental illness; and other appropriate conditions or factors.

§ 3. Paragraphs (c) of subdivision 18 of section 364-j of the social services law, as added by sections 40-c and 55 of part B of chapter 57 of the laws of 2015, are amended to read as follows:

(c) (i) In setting such reimbursement methodologies, the department shall consider costs borne by the managed care program to ensure actuarially sound and adequate rates of payment to ensure quality of care for its enrollees and shall reflect the costs associated with all applicable federal and state laws and regulations, including, but not limited to, those relating to wages, labor, and actuarial soundness.

[~~(c)~~] (ii) The department [~~of health~~] shall require the independent actuary selected pursuant to paragraph (b) of this subdivision to provide a complete actuarial memorandum, along with all actuarial assumptions made and all other data, materials and methodologies used in the development of rates, to managed care providers thirty days prior to submission of such rates to the centers for medicare and medicaid services for approval. Managed care providers may request additional review of the actuarial soundness of the rate setting process and/or methodology.

(iii) In fulfilling the requirements of this paragraph, the department shall establish separate rate cells to reflect the costs of care for specific high-need enrollees in managed care providers. The commissioner shall make any necessary amendments to the state plan for medical assistance under section three hundred sixty-three-a of this title, and submit any applications for waivers of the federal social security act, as may be necessary to ensure federal financial participation. As used in this subparagraph and subparagraph (iv) of this paragraph, "managed care provider" shall mean a managed care provider operating on a full capitation basis or a managed long term care plan operating under section forty-four hundred three-f of the public health law; and "long term care entity" shall mean a residential health care facility under article twenty-eight of the public health law, home care services agency under article thirty-six of the public health law, a fiscal intermediary in the consumer directed personal assistance program, other long term care provider authorized under a home and community based waiver administered by the department or the office for people with developmental disabilities. The high-need rate cells established in accordance with this subparagraph shall be consistent with subdivision ten of section three hundred sixty-five-a of this title and include, but shall not be limited to:

(A) individuals who are in a residential health care facility;

(B) individuals enrolled with a managed care provider, who remain in the community and who daily receive live-in twenty-four hour personal care or home health services or twelve hours or more of personal care, home health services or home and community support services;

(C) such other individuals who, based on the assessment of their care needs, their diagnosis or other factors, are determined to present especially high needs related to factors that would influence the delivery (including but not limited to home location) or their use of services, as may be identified by the department.

(iv) Any contract for services under this title by a managed care provider with a long term care entity shall ensure that resources made available by the payer under such contract will support the recruitment, hiring, training and retention of a qualified workforce capable of providing quality care, including compliance with all applicable federal

and state laws and regulations, including, but not limited to, those relating to wages and labor. A managed care provider with a long term care entity shall report its method of compliance with this subdivision to the department as a component of cost reports required under section forty-four hundred three-f of the public health law.

(v) A long term care entity that contracts with a managed care provider shall annually submit written certification to the department as a component of cost reports required under sections twenty-eight hundred eight and thirty-six hundred twelve of the public health law and section three hundred sixty-seven-q of this title, as applicable, as to how it applied the amounts paid in compliance with this subdivision to support the recruitment, hiring, training and retention of a qualified workforce capable of providing quality care and consistent with section three hundred sixty-five-a of this title.

§ 4. Subparagraph (ii) of paragraph (a) and paragraph (g) of subdivision 7 and subdivision 8 of section 4403-f of the public health law, subparagraph (ii) of paragraph (a) of subdivision 7 as amended by section 43 of part C of chapter 60 of the laws of 2014, paragraph (g) of subdivision 7 as amended by section 41-b of part H of chapter 59 of the laws of 2011, subparagraph (iii) of paragraph (g) of subdivision 7 as amended by section 54 of part A of chapter 56 of the laws of 2013 and subdivision 8 as amended by section 21 of part B of chapter 59 of the laws of 2016, are amended to read as follows:

(ii) Notwithstanding any inconsistent provision of the social services law to the contrary, the commissioner shall, pursuant to regulation, determine whether and the extent to which the applicable provisions of the social services law or regulations relating to approvals and authorizations of, and utilization limitations on, health and long term care services reimbursed pursuant to title XIX of the federal social security act, including, but not limited to, fiscal assessment requirements, are inconsistent with the flexibility necessary for the efficient administration of managed long term care plans and such regulations shall provide that such provisions shall not be applicable to enrollees or managed long term care plans, provided that such determinations are consistent with applicable federal law and regulation, and subject to the provisions of [~~subdivision~~] subdivisions eight and ten of section three hundred sixty-five-a and paragraph (c) of subdivision eighteen of section three hundred sixty-four-j of the social services law.

(g) (i) Managed long term care plans and demonstrations may enroll eligible persons in the plan or demonstration upon the completion of a comprehensive assessment [~~that shall include, but not be limited to, an evaluation of the medical, social and environmental needs~~] of each prospective enrollee in such program consistent with section three hundred sixty-five-a of the social services law. This assessment shall also serve as the basis for the development and provision of an appropriate plan of care for the enrollee. Upon approval of federal waivers pursuant to paragraph (b) of this subdivision which require medical assistance recipients who require community-based long term care services to enroll in a plan, and upon approval of the commissioner, a plan may enroll an applicant who is currently receiving home and community-based services and complete the comprehensive assessment within thirty days of enrollment provided that the plan continues to cover transitional care until such time as the assessment is completed.

(ii) The assessment shall be completed by a representative of the managed long term care plan or demonstration, in consultation with the prospective enrollee's health care practitioner as necessary. The

commissioner shall prescribe the forms on which the assessment shall be made.

(iii) The enrollment application shall be submitted by the managed long term care plan or demonstration to the entity designated by the department prior to the commencement of services under the managed long term care plan or demonstration. Enrollments conducted by a plan or demonstration shall be subject to review and audit by the department or a contractor selected pursuant to paragraph (d) of this subdivision.

(iv) Continued enrollment in a managed long term care plan or demonstration paid for by government funds shall be based upon a comprehensive assessment [~~of the medical, social and environmental needs~~] of the recipient of the services **consistent with section three hundred sixty-five-a of this social services law**. Such assessment shall be performed at least every six months by the managed long term care plan serving the enrollee. The commissioner shall prescribe the forms on which the assessment will be made.

8. Payment rates for managed long term care plan enrollees eligible for medical assistance. The commissioner shall establish payment rates for services provided to enrollees eligible under title XIX of the federal social security act. Such payment rates shall be subject to approval by the director of the division of the budget and shall reflect savings to both state and local governments when compared to costs which would be incurred by such program if enrollees were to receive comparable health and long term care services on a fee-for-service basis in the geographic region in which such services are proposed to be provided. Payment rates shall be risk-adjusted to take into account the characteristics of enrollees, or proposed enrollees, including, but not limited to: frailty, disability level, health and functional status, age, gender, the nature of services provided to such enrollees, and other factors as determined by the commissioner. The risk adjusted premiums may also be combined with disincentives or requirements designed to mitigate any incentives to obtain higher payment categories. In setting such payment rates, the commissioner shall consider costs borne by the managed care program to ensure actuarially sound and adequate rates of payment to ensure quality of care [~~shall comply~~] **and the costs associated with compliance** with all applicable laws and regulations, state and federal, including [~~regulations as to~~]**, but not limited to, those relating to wages, labor and** actuarial soundness [~~for medicaid managed care~~].

§ 5. Subparagraph (i) of paragraph (g) of subdivision 7 of section 4403-f of the public health law, as added by section 65-c of part A of chapter 57 of the laws of 2006 and such paragraph as relettered by section 20 of part C of chapter 58 of the laws of 2007, is amended to read as follows:

(i) Managed long term care plans and demonstrations may enroll eligible persons in the plan or demonstration upon the completion of a comprehensive assessment [~~that shall include, but not be limited to, an evaluation of the medical, social and environmental needs~~] of each prospective enrollee in such program **consistent with section three hundred sixty-five-a of the social services law**. This assessment shall also serve as the basis for the development and provision of an appropriate plan of care for the prospective enrollee.

§ 6. Section 364-j of the social services law is amended by adding a new subdivision 33 to read as follows:

33. For services under this title provided by residential health care facilities under article twenty-eight of the public health law, the commissioner shall direct managed care organizations licensed under

article forty-four of the public health law, article forty-three of the insurance law, and this section, to continue to reimburse at a benchmark rate which is to be the fee-for-service rate calculated pursuant to section twenty-eight hundred eight of the public health law. The benchmark fee-for-service rate shall continue to be paid by such managed care organizations for all services provided by residential healthcare facilities from the effective date of this subdivision at least until December thirty-first, two thousand twenty-two.

§ 7. Subdivision 10 of section 3614 of the public health law, as amended by section 5 of part C of chapter 109 of the laws of 2006, paragraph (a) as amended by section 57 of part A of chapter 56 of the laws of 2013, is amended to read as follows:

10. (a) Such adjustments to rates of payments shall be allocated proportionally based on each certified home health agency, long term home health care program, AIDS home care and hospice program's home health aide or other direct care services total annual hours of service provided to medicaid patients, as reported in each such agency's most recently available cost report as submitted to the department or for the purpose of the managed long term care program a suitable proxy developed by the department in consultation with the interested parties. Payments made pursuant to this section shall not be subject to subsequent adjustment or reconciliation; provided that such adjustments to rates of payments to certified home health agencies shall only be for that portion of services provided to children under eighteen years of age and for services provided to a special needs population of medically complex and fragile children, adolescents and young disabled adults by a CHHA operating under a pilot program approved by the department.

(b) Programs which have their rates adjusted pursuant to this subdivision shall use such funds solely for the purposes of recruitment, training and retention of non-supervisory home care services workers or other personnel with direct patient care responsibility. Such purpose shall include the recruitment, training and retention of non-supervisory home care services workers or any worker with direct patient care responsibility employed in licensed home care services agencies under contract with such agencies. Such agencies are prohibited from using such fund for any other purpose. For purposes of the long term home health care program, such payment shall be treated as supplemental payments and not effect any current cost cap requirement. For purposes of the managed long term care program, plans shall distribute such funds in their entirety using a reasonable methodology. Such payments shall be supplemental to reimbursement rates, and plans shall provide written notification to each contracted agency indicating the amount of funds disbursed for the purpose of recruitment, training and retention of non-supervisory home care services workers or any personnel with direct patient care responsibility. Each such agency shall submit, at a time and in a manner determined by the commissioner, a written certification attesting that such funds will be used solely for the purpose of recruitment, training and retention of non-supervisory home health aides or any personnel with direct patient care responsibility. When submitting attestations to the department, managed long term care plans shall include the methodology utilized in the disbursement of funds. The commissioner is authorized to audit each such agency or program to ensure compliance with the written certification required by this subdivision and shall recoup any funds determined to have been used for purposes other than recruitment and retention of non-supervisory home health aides or other personnel with

direct patient care responsibility. Such recoupment shall be in addition to any other penalties provided by law.

(c) In the case of services provided by such agencies or programs through contracts with licensed home care services agencies, rate increases received by such agencies or programs pursuant to this subdivision shall be reflected, consistent with the purposes of this subdivision, in either the fees paid or benefits or other supports, including training, provided to non-supervisory home health aides or any other personnel with direct patient care responsibility of such contracted licensed home care services agencies and such fees, benefits or other supports shall be proportionate to the contracted volume of services attributable to each contracted agency. Such agencies or programs shall submit to providers with which they contract written certifications attesting that such funds will be used solely for the purposes of recruitment, training and retention of non-supervisory home health aides or other personnel with direct patient care responsibility and shall maintain in their files expenditure plans specifying how such funds will be used for such purposes. The commissioner is authorized to audit such agencies or programs to ensure compliance with such certifications and expenditure plans and shall recoup any funds determined to have been used for purposes other than those set forth in this subdivision. Such recoupment shall be in addition to any other penalties provided by law.

(d) Funds under this subdivision are not intended to supplant support provided by local government.

(e) The department shall provide a report to the chairs of the senate finance committee, assembly ways and means committee, and senate health and assembly health committees. Such report shall be submitted on or before January first, two thousand eighteen and shall include the distribution of monies by plan and provider of the funds set forth in this subdivision.

§ 8. Section 3614-c of the public health law, as amended by chapter 56 of the laws of 2016, subparagraph (iv) of paragraph (a) of subdivision 3 as amended by section 1 and subparagraph (iv) of paragraph (b) of subdivision 3 as amended by section 2 of part E of chapter 73 of the laws of 2016, is amended to read as follows:

§ 3614-c. Home care worker wage parity. 1. As used in this section, the following terms shall have the following meaning:

(a) "Living wage law" means any law enacted by Nassau, Suffolk or Westchester county or a city with a population of one million or more which establishes a minimum wage for some or all employees who perform work on contracts with such county or city.

(b) "Total compensation" means all wages and other direct compensation paid to or provided on behalf of the employee including, but not limited to, wages, health, education or pension benefits, supplements in lieu of benefits and compensated time off, except that it does not include employer taxes or employer portion of payments for statutory benefits, including but not limited to FICA, disability insurance, unemployment insurance and workers' compensation.

(c) "Prevailing rate of total compensation" means the average hourly amount of total compensation paid to all home care aides covered by whatever collectively bargained agreement covers the greatest number of home care aides in a city with a population of one million or more. For purposes of this definition, any set of collectively bargained agreements in such city with substantially the same terms and conditions relating to total compensation shall be considered as a single collectively bargained agreement.

(d) "Home care aide" means a home health aide, personal care aide, home attendant**, personal assistant performing consumer directed personal assistance services pursuant to section three hundred sixty-five-f of the social services law,** or other licensed or unlicensed person whose primary responsibility includes the provision of in-home assistance with activities of daily living, instrumental activities of daily living or health-related tasks; provided, however, that home care aide does not include any individual (i) working on a casual basis, or (ii) **(except for a person employed under the consumer directed personal care program under section three hundred sixty-five-f of the social services law)** who is a relative through blood, marriage or adoption of: (1) the employer; or (2) the person for whom the worker is delivering services, under a program funded or administered by federal, state or local government.

(e) "Managed care plan" means any managed care program, organization or demonstration covering personal care or home health aide services, and which receives premiums funded, in whole or in part, by the New York state medical assistance program, including but not limited to all Medicaid managed care, Medicaid managed long term care, Medicaid advantage, and Medicaid advantage plus plans and all programs of all-inclusive care for the elderly.

(f) "Episode of care" means any service unit reimbursed, in whole or in part, by the New York state medical assistance program, whether through direct reimbursement or covered by a premium payment, and which covers, in whole or in part, any service provided by a home care aide, including but not limited to all service units defined as visits, hours, days, months or episodes.

(g) "Cash portion of the minimum rate of home care [~~aid~~] **aide** total compensation" means the minimum amount of home care aide total compensation that may be paid in cash wages, as determined by the department in consultation with the department of labor.

(h) "Benefit portion of the minimum rate of home care aide total compensation" means the portion of home care aide total compensation that may be paid in cash or health, education or pension benefits, wage differentials, supplements in lieu of benefits and compensated time off, as determined by the department in consultation with the department of labor. Cash wages paid pursuant to increases in the state or federal minimum wage cannot be used to satisfy the benefit portion of the minimum rate of home care aide total compensation.

2. Notwithstanding any inconsistent provision of law, rule or regulation, no payments by government agencies shall be made to certified home health agencies, long term home health care programs [~~or~~]**,** managed care plans**, or the consumer directed personal care program under section three hundred sixty-five-f of the social services law,** for any episode of care furnished, in whole or in part, by any home care aide who is compensated at amounts less than the applicable minimum rate of home care aide total compensation established pursuant to this section.

3. (a) The minimum rate of home care aide total compensation in a city with a population of one million or more shall be:

(i) for the period March first, two thousand twelve through February twenty-eighth, two thousand thirteen, ninety percent of the total compensation mandated by the living wage law of such city;

(ii) for the period March first, two thousand thirteen through February twenty-eighth, two thousand fourteen, ninety-five percent of the total compensation mandated by the living wage law of such city;

(iii) for the period March first, two thousand fourteen through March thirty-first two thousand sixteen, no less than the prevailing rate of

total compensation as of January first, two thousand eleven, or the total compensation mandated by the living wage law of such city, whichever is greater;

(iv) for all periods on or after April first, two thousand sixteen, the cash portion of the minimum rate of home care aide total compensation shall be ten dollars or the minimum wage as laid out in paragraph (a) of subdivision one of section six hundred fifty-two of the labor law, whichever is higher. The benefit portion of the minimum rate of home care aide total compensation shall be four dollars and nine cents.

(b) The minimum rate of home care aide total compensation in the counties of Nassau, Suffolk and Westchester shall be:

(i) for the period March first, two thousand thirteen through February twenty-eighth, two thousand fourteen, ninety percent of the total compensation mandated by the living wage law as set on March first, two thousand thirteen of a city with a population of a million or more;

(ii) for the period March first, two thousand fourteen through February twenty-eighth, two thousand fifteen, ninety-five percent of the total compensation mandated by the living wage law as set on March first, two thousand fourteen of a city with a population of a million or more;

(iii) for the period March first, two thousand fifteen, through February twenty-eighth, two thousand sixteen, one hundred percent of the total compensation mandated by the living wage law as set on March first, two thousand fifteen of a city with a population of a million or more;

(iv) for all periods on or after March first, two thousand sixteen, the cash portion of the minimum rate of home care aide total compensation shall be ten dollars or the minimum wage as laid out in paragraph (b) of subdivision one of section six hundred fifty-two of the labor law, whichever is higher. The benefit portion of the minimum rate of home care aide total compensation shall be three dollars and twenty-two cents.

4. The terms of this section shall apply equally to services provided by home care aides who work on episodes of care as direct employees of certified home health agencies, long term home health care programs, or managed care plans, or as employees of licensed home care services agencies, limited licensed home care services agencies, **or the consumer directed personal care program under section three hundred sixty-five-f of the social services law,** or under any other arrangement.

5. No payments by government agencies shall be made to certified home health agencies, long term home health care programs, [~~or~~] managed care plans**, or the consumer directed personal care program under section three hundred sixty-five-f of the social services law,** for any episode of care without the certified home health agency, long term home health care program, [~~or~~] managed care plan **or the consumer directed personal care program** having delivered prior written certification to the commissioner, on forms prepared by the department in consultation with the department of labor, that all services provided under each episode of care are in full compliance with the terms of this section and any regulations promulgated pursuant to this section.

6. If a certified home health agency or long term home health care program elects to provide home care aide services through contracts with licensed home care services agencies or through other third parties, provided that the episode of care on which the home care aide works is covered under the terms of this section, the certified home health agency, long term home health care program, or managed care plan must obtain

a written certification from the licensed home care services agency or other third party, on forms prepared by the department in consultation with the department of labor, which attests to the licensed home care services agency's or other third party's compliance with the terms of this section. Such certifications shall also obligate the certified home health agency, long term home health care program, or managed care plan to obtain, on no less than a quarterly basis, all information from the licensed home care services agency or other third parties necessary to verify compliance with the terms of this section. Such certifications and the information exchanged pursuant to them shall be retained by all certified home health agencies, long term home health care programs, or managed care plans, and all licensed home care services agencies, or other third parties for a period of no less than ten years, and made available to the department upon request.

7. The commissioner shall distribute to all certified home health agencies, long term home health care programs, [~~and~~] managed care plans, and fiscal intermediaries in the consumer directed personal care program under section three hundred sixty-five-f of the social services law, official notice of the minimum rates of home care aide compensation at least one hundred twenty days prior to the effective date of each minimum rate for each social services district covered by the terms of this section.

8. The commissioner is authorized to promulgate regulations, and may promulgate emergency regulations, to implement the provisions of this section.

9. Nothing in this section should be construed as applicable to any service provided by certified home health agencies, long term home health care programs, [~~or~~] managed care plans, or consumer directed personal care program under section three hundred sixty-five-f of the social services law except for all episodes of care reimbursed in whole or in part by the New York Medicaid program.

10. No certified home health agency, managed care plan [~~or~~], long term home health care program, or fiscal intermediary in the consumer directed personal care program under section three hundred sixty-five-f of the social services law shall be liable for recoupment of payments for services provided through a licensed home care services agency or other third party with which the certified home health agency, long term home health care program, or managed care plan has a contract because the licensed agency or other third party failed to comply with the provisions of this section if the certified home health agency, long term home health care program, [~~or~~] managed care plan, or fiscal intermediary has reasonably and in good faith collected certifications and all information required pursuant to subdivisions five and six of this section.

§ 9. This act shall take effect on the first of January after it shall have become a law, provided that prior to that date, the commissioner of health shall make regulations and take other actions reasonably necessary to implement this act on that date, and provided further that:

a. sections three and four of this act shall take effect April 1, 2018;

b. the amendments to section 364-j of the social services law made by sections three and six of this act shall not affect the repeal of such section and shall be deemed repealed therewith;

c. the amendments to section 4403-f of the public health law made by section four of this act shall not affect the repeal of such section and shall be deemed repealed therewith;

d. the amendments to subparagraph (i) of paragraph (g) of subdivision 7 of section 4403-f of the public health law made by section four of this act shall not affect the expiration and reversion of such subparagraph, pursuant to subdivision (i) of section 111 of part H of chapter 59 of the laws of 2011, as amended, when upon such date the provisions of section five of this act shall take effect; and

e. any entity operating as a fiscal intermediary prior to this act becoming a law may continue to do so for one year after this act takes effect, and may continue to do so after that time only upon obtaining certification under this act.

PART X

Section 1. Section 364-j of the social services law is amended by adding a new subdivision 33 to read as follows:

33. (a) Thirty days prior to implementing or adjusting a rate, premium, component of premium, add-on payment, quality pool, or other rate component related to a managed care provider as defined in this section, the commissioner of health shall provide written notice to the chairs of the senate finance committee, the senate health committee, the assembly ways and means committee, and the assembly health committee, with regards to such actions.

(b) Such notice shall include, but not be limited to, a detailed description of all components included in the action, the fiscal impact of the action, the policy rationale for implementing the action, the specific service sectors that would be impacted by the action, the methodology used to determine the components of such action, the plan specific impacts of the action, the provider specific impacts of the action, any specific project descriptions or requirements related to such action, the multi-year impacts of the action, and the availability of federal matching funds.

(c) The commissioner of health shall provide quarterly reports to the chairs on the premiums for a managed care provider as defined in paragraph (b) of subdivision one of this section, including an itemized list of all rates, premiums, component of premiums, add-on payments, quality pools, or other rate components for the previous quarter, including a description of any modifications implemented within such period.

§ 2. This act shall take effect immediately.

PART Y

Section 1. Notwithstanding any other provision of law to the contrary, any state agency with 25 percent or more of their workforce accruing overtime in a calendar year, and absent an emergency requiring a temporary increase in overtime hours, shall maintain all full time equivalent positions from the previous year and in the event of any vacancy or vacancies such positions shall be filled as they become available. State agencies shall report the total number of agency workers and the total number of workers accruing overtime from the previous calendar year, to the legislature and the director of the budget by January 15 of each year. In addition, any agency exceeding the overtime threshold as established herein shall report on the number of full time equivalent positions that have been filled in accordance with this section and all other efforts made to reduce overtime to beneath the threshold stated herein. Each agency shall further report on the number of temporary workers and per diem workers in positions in such agency and the specif-

ic number of hours worked by each temporary and per diem worker. Such report shall include the length of time such temporary workers or per diem workers have been employed in each agency.

§ 2. This act shall take effect immediately.

PART Z

Section 1. 1. In the event that the commissioner of the office of mental health shall order the transfer of inpatient services from a state operated facility to a facility licensed by article 28 of the public health law, such article 28 facility shall:

(a) Demonstrate the ability to seek and increase payment from third party payors including commercial health insurance;

(b) Maintain inpatient capacity; and

(c) Provide a clinically appropriate level of care for each patient admitted, and effectively link each patient to appropriate after care services.

2. In the event that the facility which has accepted the transfer of inpatient services is no longer able to meet the criteria set forth in subdivision one of this section, the office of mental health shall resume the administration of such services.

3. Any savings related to the transfer of state operated inpatient services from the office of mental health as set forth in this section shall be reinvested and disbursed in accordance with section 97-dddd of the state finance law.

4. In the event that inpatient services are reduced and such service capacity is subsequently eliminated, any savings related thereto shall be reinvested and disbursed in accordance with section 97-dddd of the state finance law.

5. There shall be no reduction in any full time equivalent positions due to the transfer of inpatient services from an office of mental health state operated facility to a facility licensed by article 28 of the public health law. Any employees transferred shall be transferred pursuant to section 70 of the civil service law, without further examination or qualification to the same or similar titles and shall remain in the same collective bargaining units and shall retain their respective civil service classifications, status and rights pursuant to their collective bargaining units and collective bargaining agreements.

§ 2. This act shall take effect immediately.

PART AA

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

34. Enhanced safety net hospital program. (a) For the purposes of this subdivision, "enhanced safety net hospital" means a hospital which, in any of the previous three calendar years, has met the following criteria:

(i)(A) not less than fifty percent of the patients it treats receive medicaid or are medically uninsured;

(B) not less than forty percent of its inpatient discharges are covered by medicaid;

(C) twenty-five percent or less of its discharged patients are commercially insured;

(D) not less than three percent of the patients it provides services to are attributed to the care of uninsured patients; and

(E) provides care to uninsured patients in its emergency room, hospital based clinics and community based clinics, including the provision of important community services, such as dental care and prenatal care;

(ii) is a public hospital operated by a county, municipality, public benefit corporation, or the state university of New York; or

(iii) is federally designated as a critical access or sole community hospital.

(b) The commissioner shall establish an enhanced safety net hospital program (referred to in this subdivision as "the program") to provide for additional annual medical assistance payments under this section to enhanced safety net hospitals for the purposes of ensuring the continued availability of services by providing additional support for critically needed health care services and to ensure the continued maintenance and operation of such hospitals, to reflect the increased costs associated with being an enhanced safety net hospital. The program shall provide for increased payments by managed care providers to such hospitals in addition to what the managed care providers would ordinarily pay to such hospitals, and increased premium payments by the medical assistance program to the managed care providers to accommodate such increased payments to hospitals.

(c) Payments by managed care providers to such hospitals shall be proportional to each such hospital's number of discharges of patients who are enrolled in medical assistance under this title or are uninsured.

(d) Total payments by the medical assistance program to managed care providers under the program shall be as appropriated. The commissioner shall develop a formula for such payments considering the amount appropriated, each such hospital's number of discharges of patients who are enrolled in medical assistance under this title or are uninsured, and the amount ordinarily paid by the medical assistance program other than under this section for each such hospital's discharges.

(e) Payment of the non-federal share of the medical assistance payments made pursuant to this subdivision shall be the responsibility of the state and shall not include a local share.

(f) Payments under this subdivision shall be consistent with federal regulations and shall not be at a level that would jeopardize or diminish federal financial participation, and shall not supplant the use of other funds for enhanced safety net hospitals.

(g) For payments under this subdivision, the commissioner may establish reasonable terms and conditions, consistent with this subdivision, to ensure continued programs by enhanced safety net hospitals for health care delivery system reform.

§ 2. Notwithstanding any provision of law to the contrary, for the period April 1, 2017 to March 31, 2018, the commissioner of health shall not take any action with the purpose of reducing payment for general hospital emergency services visits provided to patients eligible for medical assistance pursuant to title eleven of article five of the social services law, including such patients enrolled in organizations operating in accordance with the provisions of article forty-four of the public health law or in health maintenance organizations organized and operating in accordance with article forty-three of the insurance law.

§ 3. This act shall take effect April 1, 2017 and shall be deemed to have been in full force and effect on and after such date; provided, however, that the amendments to 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.

PART BB

Section 1. Section 4 of chapter 495 of the laws of 2004, amending the insurance law and the public health law relating to the New York state health insurance continuation assistance demonstration project, as amended by section 1 of part AA of chapter 54 of the laws of 2016, is amended to read as follows:

§ 4. This act shall take effect on the sixtieth day after it shall have become a law; provided, however, that this act shall remain in effect until July 1, [~~2017~~] 2018 when upon such date the provisions of this act shall expire and be deemed repealed; provided, further, that a displaced worker shall be eligible for continuation assistance retroactive to July 1, 2004.

§ 2. This act shall take effect immediately.

§ 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 BB of this act shall be as specifically set forth in the last section of such Parts.