STATE OF NEW YORK

9507--B

IN ASSEMBLY

January 18, 2018

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 -- again reported from said committee with amendments, ordered reprinted as amended and recommitted to said committee

AN ACT to amend the public health law, in relation to distributing the general hospital indigent care pool; establishing a temporary workgroup on the general hospital indigent care pool methodology; to amend the social services law, in relation to standard coverage for physical therapy services under medical assistance for needy persons programs; and directing the commissioner of health to conduct a study on the feasibility of creating a burn center in Kings County Medical Center in collaboration with SUNY Downstate Medical Center's University Hospital of Brooklyn (Part A); to amend the public health law, in relation to payments to residential health care facilities; to amend the social services law and the public health law, in relation to assisted living program providers licensed in the state; to amend the social services law, in relation to payments for certain medical assistance provided to eligible persons participating in the New York traumatic brain injury waiver program and long term care plans; and to amend the public health law, in relation to community based service providers, home health care and medical assistance payments for care in hospice residences (Part B); to amend the social services law, in relation to health homes and penalties for managed care providers (Part C); to amend the social services law and the public health law, in relation to drug coverage, updating the professional dispensing fee, and in relation to extending the preferred drug program to medicaid managed care providers and offering the program to other health plans; and to repeal certain provisions of the social services law relating thereto (Part D); to amend the social services law, in relation to reimbursement of transportation costs (Part E); intentionally omitted (Part F); intentionally omitted (Part G); intentionally omitted (Part H); to amend the social services law and the public health law, in relation to managed care providers (Part I); to amend the state finance law, in relation to the false claims act (Part J); to amend the public health law and the social services law, in

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

LBD12671-03-8

relation to authorizing the department of health to require certain health care providers to report on costs incurred; and to amend chapter 59 of the laws of 2011 amending the public health law and other laws relating to known and projected department of health state fund medicaid expenditures, in relation to extending the medicaid global cap (Part K); intentionally omitted (Part L); to amend chapter 266 of the laws of 1986, amending the civil practice law and rules and other laws relating to malpractice and professional medical conduct, in relation to apportioning premium for certain policies; to amend part J of chapter 63 of the laws of 2001 amending chapter 266 of the laws of 1986, amending the civil practice law and rules and other laws relating to malpractice and professional medical conduct, relating to the effectiveness of certain provisions of such chapter, in relation to extending certain provisions concerning the hospital excess liability pool; and to amend part H of chapter 57 of the laws of 2017, amending the New York Health Care Reform Act of 1996 and other laws relating to extending certain provisions relating thereto, in relation to extending provisions relating to excess coverage (Part M); intentionally omitted (Part N); to amend the public health law, in relation to funding early intervention services; and to repeal certain provisions of the public health law and the insurance law relating thereto (Part O); to amend the public health law, in relation to the empire clinical research investigator program and hospital resident hour audits (Part P); to amend the public health law, in relation to the health care facility transformation program (Part Q); intentionally omitted (Part R); Intentionally omitted (Subpart A); to amend the public health law and the mental hygiene law, in relation to integrated services (Subpart B); and to amend the social services law, in relation to telehealth under medical assistance; and to repeal article 29-G of the public health law relating to telehealth delivery of services (Subpart C)(Part S); to amend chapter 59 of the laws of 2016, amending the social services law and other laws relating to authorizing the commissioner of health to apply federally established consumer price index penalties for generic drugs, and authorizing the commissioner of health to impose penalties on managed care plans for reporting late or incorrect encounter data, in relation to the effectiveness of certain provisions of such chapter; to amend chapter 58 of the laws of 2007, amending the social services law and other laws relating to adjustments of rates, in relation to the effectiveness of certain provisions of such chapter; to amend chapter 54 of the laws of 2016, amending part C of chapter 58 of the laws of 2005, authorizing reimbursements for expenditures made by or on behalf of social services districts for medical assistance for needy persons and administration thereof relating to authorizing the commissioner of health to establish a statewide Medicaid integrity and efficiency initiative, in relation to the effectiveness thereof; to amend chapter 906 of the laws of 1984, amending the social services law relating to expanding medical assistance eligibility and the scope of services available to certain persons with disabilities, in relation to the effectiveness thereof; and to amend the social services law, in relation to agreements relating to pharmaceutical utilization (Part T); to amend part NN of chapter 58 of the laws of 2015 amending the mental hygiene law relating to clarifying the authority of the commissioners in the department of mental hygiene to design and implement time-limited demonstration programs, in relation to the effectiveness thereof (Part U); to amend chapter 62 of the laws of 2003, amending the mental hygiene law and

the state finance law relating to the community mental health support and workforce reinvestment program, the membership of subcommittees for mental health of community services boards and the duties of such subcommittees and creating the community mental health and workforce reinvestment account, in relation to extending such provisions relating thereto (Part V); intentionally omitted (Part W); to amend chapter 111 of the laws of 2010 amending the mental hygiene law relating to the receipt of federal and state benefits received by individuals receiving care in facilities operated by an office of the department of mental hygiene, in relation to the effectiveness thereof (Part X); to amend the education law, in relation to persons practicing in certain licensed programs or services who are exempt from practice requirements of professionals licensed by the department of education; to amend chapter 420 of the laws of 2002, amending the education law relating to the profession of social work, in relation to extending the expiration of certain provisions thereof; to amend chapter 676 of the laws of 2002, amending the education law relating to the practice of psychology, in relation to extending the expiration of certain provisions; and to amend chapter 130 of the laws of 2010, amending the education law and other laws relating to the registration of entities providing certain professional services and licensure of certain professions, in relation to extending certain provisions thereof (Part Y); to amend the social services law, in relation to adding demonstration waivers to waivers allowable for home and community-based services; to amend the social services law, in relation to adding successor federal waivers to waivers granted under subsection (c) of section 1915 of the federal social security law, in relation to nursing facility services; to amend the social services law, in relation to waivers for high quality and integrated care; to amend the mental hygiene law, in relation to adding new and successor federal waivers to waivers in relation to home and community-based services; to amend part A of chapter 56 of the laws of 2013, amending the social services law and other laws relating to enacting the major components of legislation necessary to implement the health and mental hygiene budget for the 2013-2014 state fiscal year, in relation to the effectiveness of certain provisions thereof; to amend the public health law, in relation to expansion of comprehensive health services plans; to amend chapter 659 of the laws of 1997, amending the public health law and other laws relating to creation of continuing care retirement communities, in relation to extending provisions thereof; to amend the public health law, in relation to managed long term care plans, health and long term care services and developmental disability individual support and care coordination organizations; to amend chapter 165 of the laws of 1991, amending the public health law and other laws relating to establishing payments for medical assistance, in relation to extending the provisions thereof; to amend the mental hygiene law, in relation to reimbursement rates; and to amend chapter 710 of the laws of 1988, amending the social services law and the education law relating to medical assistance eligibility of certain persons and providing for managed medical care demonstration programs, in relation to extending the provisions thereof (Part Z); to amend part C of chapter 57 of the laws of 2006, relating to establishing a cost of living adjustment for designated human services programs, in relation to the inclusion and development of certain cost of living adjustments (Part AA); to amend the public health law, in relation to expanding the list of controlled substances (Part BB); to amend the public health law, in

relation to summary action for professional misconduct (Part CC); to amend the education law, in relation to authorizing a licensed pharmacist to administer influenza vaccine to children between two and eighteen years of age pursuant to a non-patient specific regimen; to amend the public health law, in relation to reporting immunizations; to amend chapter 563 of the laws of 2008, amending the education law and the public health law relating to immunizing agents to be administered to adults by pharmacists, in relation to making the provisions permanent; to amend chapter 116 of the laws of 2012, amending the education law relating to authorizing a licensed pharmacist and certified nurse practitioner to administer certain immunizing agents, in relation to extending the effectiveness thereof; and to amend chapter 21 of the laws of 2011, amending the education law relating to authorizing pharmacists to perform collaborative drug therapy management with physicians in certain settings, in relation to making technical corrections (Part DD); to amend the mental hygiene law, in relation to state-operated individualized residential alternatives; and to amend part Q of chapter 59 of the laws of 2016, amending the mental hygiene law relating to the closure or transfer of a state-operated individualized residential alternative, in relation to the effectiveness thereof (Part EE); 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 FF); to amend the insurance law, in relation to the purchase of prescription drugs (Part GG); to amend the mental hygiene law, in relation to establishing the office of the independent behavioral health ombudsman (Part HH); to amend the public health law and the state finance law, in relation to disposition of charitable assets and establishing a health care stabilization account (Part II); and in relation to the availability of federal financial participation and payments made to certain managed care providers; and to repeal section 3-d of part B of chapter 58 of the laws of 2010, amending 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 reimbursement (Part JJ)

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

Section 1. This act enacts into law major components of legislation which are necessary to implement the state fiscal plan for the 2018-2019 state fiscal year. Each component is wholly contained within a Part identified as Parts A through JJ. 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. Intentionally omitted.

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

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

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

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

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

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

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

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

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

(C) No facility shall experience a reduction in indigent care pool payments pursuant to this subdivision that: for the calendar year beginning January first, two thousand thirteen, is greater than two and one-half percent; for the calendar year beginning January first, two thou-

sand fourteen, is greater than five percent; and, for the calendar year beginning on January first, two thousand fifteen[~~,~~]; is greater than seven and one-half percent, and for the calendar year beginning on January first, two thousand sixteen, is greater than ten percent; and for the calendar year beginning on January first, two thousand seventeen, is greater than twelve and one-half percent; and for the calendar year beginning on January first, two thousand eighteen, is greater than fifteen percent; and for the calendar year beginning on January first, two thousand nineteen, is greater than seventeen and one-half percent.

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

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

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

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

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

§ 2-a. Temporary workgroup on the general hospital indigent care pool methodology. No later than June first, two thousand eighteen, the commissioner of health shall convene a temporary workgroup to develop recommendations for modifying the distribution methodology of the indigent care pool to target payments to facilities that provide a disproportionate share of uncompensated care to uninsured, underinsured and medicaid populations; to develop recommendations for modifying indigent care distributions in the event of aggregate reductions in federal Medicaid disproportionate share hospital funding; to evaluate the financial impacts of recent modifications to the indigent care pool made pursuant to subdivision five-d of section 2807-k of the public health law; and to evaluate the effectiveness of financial aid policies and procedures as mandated by subdivision nine-a of section 2807-k of the public health law. The workgroup shall include representatives of providers that provide such care, consumer advocates, members of the legislature, health care workers, the department of health, and other appropriate stakeholders. No later than December first, two thousand eighteen, the workgroup shall report on its findings and recommendations to the governor, the temporary president of the senate, and the speaker of the assembly, including any analysis of facility impacts by region and sponsorship as well as any additional information it deems appropriate.

§ 3. Notwithstanding any inconsistent provision of law or regulation to the contrary, the medical assistance program shall allocate ten million dollars annually to expand preventative services as the commissioner of health may determine in regulation. Such preventative services may include but not be limited to mental health counseling provided by a licensed clinical social worker or a licensed master social worker,

physical therapy, diabetes prevention, or treatment by an applied behavior analyst.

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

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

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

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

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

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

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

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

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

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

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

§ 5-a. The commissioner of health is directed to conduct a study and do research as to the feasibility of creating a burn center in Kings County Medical Center in collaboration with SUNY Downstate Medical Center's University Hospital of Brooklyn.

The study shall be conducted in accordance with rules, regulations and standards determined by the commissioner of health. The study shall concentrate on provisions of optimal care to burn patients for the time of injury through rehabilitation with the goal of establishing a framework for the establishment of an accredited burn unit that provides high quality patient care while meeting the standards for organizational structure, personnel qualifications, facilities resources and medical care services pursuant to the Guidelines for the Operation of Burn Centers of the American Burn Association.

The commissioner of health shall report his or her findings to the governor, the speaker of the assembly, the minority leader of the assembly, the temporary president of the senate and the minority leader of the senate on or before one year from the date this act shall take effect.

§ 6. This act shall take effect immediately.

PART B

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

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

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

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

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

(l) The commissioner of health is authorized to solicit and award applications for up to a total of five hundred new assisted living program beds in those counties where there is one or no assisted living program providers, pursuant to criteria to be determined by the commissioner.

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

(i) Serve only public pay individuals;

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

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

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

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

(o) For periods on and after April first, two thousand twenty, the commissioner of health is authorized to issue assisted living program beds for any eligible applicant, other than an applicant that applied under subparagraph (ii) of paragraph (k) of this subdivision, that satisfactorily demonstrates the public need for such beds in the area to be served and meets all other applicable requirements of this section. Demonstrated public need shall be determined on a case by case basis whenever the public health and health planning council is satisfied that public need exists at the time and place and under circumstances proposed by the applicant; provided, however, the prior bed authorizations in paragraphs (h), (i), (j) and (k) of this subdivision shall continue in full force and effect.

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

(i) (1) The commissioner shall, to the extent necessary, submit the appropriate waivers, including, but not limited to, those authorized pursuant to sections eleven hundred fifteen and nineteen hundred fifteen of the federal social security act, or successor provisions, and any other waivers necessary to achieve the purposes of high quality, integrated, and cost effective care and integrated financial eligibility policies under the medical assistance program or pursuant to title XVIII of the federal social security act. In addition, the commissioner is authorized to submit the appropriate waivers, including but not limited to those authorized pursuant to sections eleven hundred fifteen and nineteen hundred fifteen of the federal social security act or successor

provisions, and any other waivers necessary to require on or after April first, two thousand twelve, medical assistance recipients who are twenty-one years of age or older and who require community-based long term care services, as specified by the commissioner, for more than one hundred and twenty days, to receive such services through an available plan certified pursuant to this section or other program model that meets guidelines specified by the commissioner that support coordination and integration of services. Such guidelines shall address the requirements of paragraphs (a), (b), (c), (d), (e), (f), (g), (h), and (i) of subdivision three of this section as well as payment methods that ensure provider accountability for cost effective quality outcomes. Such other program models may include long term home health care programs that comply with such guidelines. Copies of such original waiver applications and amendments thereto shall be provided to the chairs of the senate finance committee, the assembly ways and means committee and the senate and assembly health committees simultaneously with their submission to the federal government.

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

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

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

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

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

(12) Native Americans**; and**

(13) a person who is permanently placed in a nursing home; provided however, that a person who was enrolled in a plan under this section and, while enrolled, was transferred to a nursing home from community based care, shall remain enrolled under this section for three months at

which time such person shall be deemed suspended from enrollment by such plan for an additional six month period, so that the person may return to community based care without requiring reenrollment in such plan. Plans shall be reimbursed on a prorated basis when reinstating enrollment under this clause.

§ 6. Intentionally Omitted.

§ 7. Intentionally Omitted.

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

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

§ 8-a. Paragraph (d-2) of subdivision 3 of section 364-j of the social services law, as added by section 20-a of part B of chapter 59 of the laws of 2016, is amended to read as follows:

(d-2) Services provided pursuant to waivers, granted pursuant to subsection (c) of section 1915 of the federal social security act, to persons suffering from traumatic brain injuries or qualifying for nursing home diversion and transition services, shall not be provided to medical assistance recipients through managed care programs until at least January first, two thousand [~~eighteen~~] twenty-two.

§ 8-b. Paragraph (d) of subdivision one of section 3614-c of the public health law, as amended by section 5 of part S of chapter 57 of the laws of 2017, is amended to read as follows:

(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, a person delivering care under the traumatic brain injury program pursuant to section twenty-seven hundred forty of this chapter, 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 assistance 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.

§ 9. The commissioner of health shall conduct a study of home and community based services available to recipients of the Medicaid program in rural areas of the state. Such study shall include a review and analysis of factors affecting such availability, including but not limited to transportation costs, costs of direct care personnel including home health aides, personal care attendants and other direct service personnel, opportunities for telehealth services, and technological advances to improve efficiencies. Consistent with the results of the study, the commissioner of health is authorized to provide a targeted Medicaid rate enhancement to fee-for-service personal care rates and rates under Medicaid waiver programs such as the nursing home transition and diversion

waiver and the traumatic brain injury program waiver, in an aggregate amount of three million dollars minus the cost of conducting the study; provided further, that nothing in this section shall be deemed to affect payment for the costs of the study and any related Medicaid rate enhancement if federal participation is not available for such costs.

§ 10. Paragraphs (c) and (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 reasonable 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, in relation to a long term care plan operating under section forty-four hundred three-f of the public health law, the department shall establish separate rate cells to reflect the costs of care for specific high-need enrollees. 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. The high-need rate cells established in accordance with this subparagraph shall include, but shall not be limited to:

(A) individuals who are either already residing in a skilled nursing facility or are placed in a skilled nursing 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.

§ 11. Section 4403-f of the public health law is amended by adding a new subdivision 15 to read as follows:

15. If the department places a numerical limit on the number of community based service providers licensed under article thirty-six of this chapter with which a plan may contract, it shall do so only with approval by the public health and health planning council, consistent with standards adopted by the council to assure network adequacy including but not limited to: adequate and appropriate care for the enrollees; language and cultural competence; geographical coverage; and special needs services.

§ 12. Section 224-b of the public health law, as added by section 50 of part A of chapter 58 of the laws of 2010, is amended to read as follows:

§ 224-b. Public health and health planning council; powers and duties; health care facilities, home care agencies and hospices. **1.** The public health and health planning council shall have such powers and duties as are set forth in this chapter, including the consideration of applications for the establishment and construction of health care facilities, home care agencies and hospices licensed under articles twenty-eight, thirty-six or forty of this chapter. In carrying out its powers and duties, the council shall take into account the impact of its actions and recommendations on the quality, accessibility, efficiency and cost-effectiveness of health care throughout the state. The council shall undertake a comprehensive review of regulations and council procedures governing the establishment and construction of such health care facilities, home care agencies and hospices and shall submit to the commissioner any recommendations for the revisions of such regulations. Such review shall be conducted every five years, and the first set of recommendations shall be submitted to the commissioner on or before December first, two thousand sixteen.

2. For the period beginning April first, two thousand eighteen and ending March thirty-first, two thousand nineteen, the council shall not approve applications for new licensed home care service agencies under article thirty-six of this chapter unless the purpose of the license is to consolidate existing licensees, or overcome lack of network adequacy of a managed long term care plan under section forty-four hundred three-f of this chapter or a lack of adequate and appropriate care, language and cultural competence, geographical coverage or special needs services.

3. The council shall review and revise (a) standards relating to adequate and appropriate care, language and cultural competence, geographical coverage and special needs services, and (b) needs methodology relating to the approval, closure or consolidation of licensed home care service agencies to assure a statewide system that is financially viable. Such review shall be completed by March thirty-first, two thousand nineteen.

§ 13. Subdivisions 4 and 6 of section 3605 of the public health law, subdivision 4 as amended by section 62 of part A of chapter 58 of the laws of 2010, subdivision 6 as added by chapter 959 of the laws of 1984, are amended to read as follows:

4. The public health and health planning council shall not approve an application for licensure unless it is satisfied as to **(a) the public need for the existence of the licensed home health care service agency at the time and place and under the circumstances proposed; (b)** the character, competence and standing in the community of the applicant's incorporators, directors, sponsors, stockholders or operators**; and (c) such other matters as it shall deem pertinent**.

6. Neither [~~**public need,**~~] tax status nor profit-making status shall be criteria for licensure.

§ 14. Section 4012 of the public health law is amended by adding a new subdivision 5 to read as follows:

5. (a) Medicaid payments to hospice residences shall be in an amount equal to ninety-four percent of the weighted average medical assistance fee for service rate reimbursed to residential health care facilities located in the managed long term care region that the hospice residence is located. Such average medical assistance rate shall be inclusive of

specialty units, the room and board furnished by the hospice residence, cash receipts assessments and the case mix of the residential health care facilities located in the managed long term care region that such hospice is located. Such average medical assistance rate shall also be inclusive of an efficiency factor of 1.1 multiplied by such weighted average rate; recruitment and retention monies; and any adjustments made for minimum wage, as such adjustments are applied to the residential health care facilities located in the managed long term care region in which the hospice residence is located.

(b) Under no circumstances shall the rates established pursuant to this subdivision be less than the rates established for hospice residences in effect on the effective date of this subdivision and managed care organizations shall reimburse hospice residences the rate established pursuant to this subdivision for a period of at least five years from the date hospice residents are transitioned to managed care. Such reimbursement shall be known as the hospice residence benchmark rate.

§ 15. This act shall take effect immediately; provided, however, that the amendments made to paragraph (b) of subdivision 7 of section 4403-f of the public health law made by sections three, four and five of this act shall not affect the expiration of such paragraph pursuant to subdivision (i) of section 111 of part H of chapter 59 of the laws of 2011, as amended, and shall be deemed to expire therewith; provided, further, that the amendments to section 4403-f of the public health law made by sections three, four, five and eleven of this act shall not affect the repeal of such section pursuant to chapter 659 of the laws of 1997, as amended, and shall be deemed repealed therewith; provided, further, that section four of this act shall take effect on October 1, 2018; provided, further, that the amendments to paragraph (d-2) of subdivision 3 and paragraphs (c) and (c) of subdivision 18 of section 364-j of the social services law as amended by sections eight-a and ten of this act shall not affect the repeal of such section pursuant to chapter 710 of the laws of 1988, as amended, and shall be deemed to repeal therewith.

PART C

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

2. In addition to payments made for health home services pursuant to subdivision one of this section, the commissioner is authorized to pay additional amounts: (a) to providers of health home services that meet process or outcome standards specified by the commissioner; and (b) to Medicaid managed care enrollees who are members of health homes in the form of incentive payments to reward such enrollees for participating in wellness activities and activities or behavior that have led to or may lead to a reduction in unnecessary hospitalizations and unnecessary utilization of hospital emergency department services. Provided, however, that such incentive payments shall not, in any way, prohibit, discourage, or otherwise penalize an enrollee who utilizes hospital services, including emergency services. Such additional amounts may be paid with state funds only if federal financial participation for such payments is unavailable.

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

2-d. The commissioner shall establish targets for health home participation by enrollees of special needs managed care plans designated

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

§ 3. Intentionally omitted.

§ 4. Intentionally omitted.

§ 5. Intentionally omitted.

§ 6. Intentionally omitted.

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

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

program pursuant to section eleven hundred fifteen of the federal social security act who are expected to have regular and substantial contact with children; peace officer; police officer; district attorney or assistant district attorney; investigator employed in the office of a district attorney; or other law enforcement official.

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

34. The commissioner may, in his or her discretion, require managed care providers to submit a performing provider system partnership plan by July first, two thousand eighteen, in accordance with any submission guidelines issued by the department prior thereto. For purposes of this subdivision, "performing provider system partnership plan" shall mean a plan submitted by such managed care providers to the department that includes both short and long term approaches for effective collaboration with each performing provider system within its service area. A managed care provider shall not be penalized for failure to submit such plan if it has made a good faith attempt to partner with a performing provider system.

§ 9. This act shall take effect immediately; provided, however, that the amendments made to section 364-j of the social services law made by section eight of this act shall not affect the repeal of such section and shall be deemed repealed therewith.

PART D

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

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

§ 2. Intentionally omitted.

§ 3. Intentionally omitted.

§ 4. Intentionally omitted.

§ 5. Intentionally omitted.

§ 6. Intentionally omitted.

§ 7. Section 3331 of the public health law is amended by adding a new subdivision 8 to read as follows:

8. No opioids shall be prescribed to a patient initiating or being maintained on opioid treatment for pain which has lasted more than three months or past the time of normal tissue healing, unless the medical record contains a written treatment plan that follows generally accepted national professional or governmental guidelines. The requirements of this paragraph shall not apply in the case of patients who are being treated for cancer that is not in remission, who are in hospice or other end-of-life care, or whose pain is being treated as part of palliative care practices.

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

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

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

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

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

§ 9. 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 article, 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, including 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 provider'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.

§ 10. 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.

§ 11. 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 payer's enrollees. The contract shall include terms required by the commissioner.

§ 12. Intentionally omitted.

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

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

PART E

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

4. The commissioner of health is authorized to assume responsibility from a local social services official for the provision and reimbursement of transportation costs under this section. If the commissioner elects to assume such responsibility, the commissioner shall notify the local social services official in writing as to the election, the date upon which the election shall be effective and such information as to transition of responsibilities as the commissioner deems prudent. The commissioner is authorized to contract with a transportation manager or managers to manage transportation services in any local social services district, other than transportation services provided or arranged for enrollees of managed long term care plans issued certificates of authority under section forty-four hundred three-f of the public health law; 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; and a program designated as a Program of All-Inclusive Care for the Elderly (PACE) as authorized by Federal Public law 105-33, subtitle I of title IV of the Balanced Budget Act of 1997. Any transportation manager or managers selected by the commissioner to manage transportation services shall have proven experience in coordinating transportation services in a geographic and demographic area similar to the area in New York state within which the contractor would manage the provision of services under this section. Such a contract or contracts may include responsibility for: review, approval and processing of transportation orders; management of the appropriate level of transportation based on documented patient medical need; and development of new technologies leading to efficient transportation services. If the commissioner elects to assume such responsibility from a local social services district, the commissioner shall examine and, if appropriate, adopt quality assurance measures that may include, but are not limited to, global positioning tracking system reporting requirements and service verification mechanisms. Any and all reimbursement rates developed by transportation managers under this subdivision shall be subject to the review and approval of the commissioner.

§ 2. Intentionally omitted.

§ 3. Intentionally omitted.

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

PART F

Intentionally Omitted

PART G

Intentionally Omitted

PART H

Intentionally Omitted

PART I

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

34. Monies paid by the department to managed care providers are public funds and retain their status as public funds regardless of any payments made by the managed care provider to subcontractors, medical service providers, or other entities.

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

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

(b) Where the state is unsuccessful in recovering the improper payment from the subcontractor or subcontractors or provider or providers, the Medicaid inspector general may require the managed care organization to recover the improper medical assistance payments identified in paragraph (a) of this subdivision. The managed care organization shall remit to the state the full amount of the identified improper payment no later than six months after receiving notice of the overpayment.

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

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

36. Reporting acts of fraud. (a) All managed care providers shall, without undue delay, refer to the office of the Medicaid inspector general any case reasonably believed to be potential fraud, waste, or abuse.

(b) Any managed care provider making a complaint or furnishing a report, referral, information or records pursuant to this section shall be immune from civil liability for making such complaint, referral, or

report when such complaint, referral, or report was reasonable and made in good faith.

(c) A managed care provider that willfully fails to make a referral to the Medicaid inspector general in accordance with paragraph (a) of this subdivision when there is actual knowledge that an act of fraud is being or has been committed may be subject to a civil penalty in an amount not exceeding one hundred thousand dollars.

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

§ 37. Violations of medical assistance program laws, regulations or directives; penalties. 1. (a) Any provider or entity participating in the medical assistance program that willfully violates any statute, rule, or regulation of the medical assistance program, may be subject to a civil penalty in an amount not exceeding the sum of five thousand dollars.

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

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

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

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

4. Any entity authorized to operate under article forty-four of this chapter or article forty-three of the insurance law, and participating in the medical assistance program that intentionally submits inaccurate encounter data to the state may be subject to a civil penalty in an amount not exceeding one hundred thousand dollars.

5. The Medicaid inspector general shall have the discretion to reduce or eliminate a civil penalty under this section and also shall, in consultation with the commissioner, consider the following prior to assessing a civil penalty against a provider or entity under this section and note in its written determination any such circumstances considered:

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

(b) the amount of monetary loss to the program;

(c) any prior violations committed by the provider or entity relating to the medical assistance program or Medicare which resulted in either criminal or administrative sanction, penalty, or fine;

(d) the degree to which factors giving rise to the proscribed actions were in the control or out of the control of the provider or entity; and/or

(e) any other facts relating to the nature and seriousness of the violations including any exculpatory or mitigating information.

6. The Medicaid inspector general shall, in consultation with the commissioner, promulgate regulations enumerating those violations which may result in a civil penalty pursuant to subdivisions one and two of this section and the range and the amounts of any civil penalties which may be assessed under this section, the hearing process by which a penalty may be assessed, and the appeal rights afforded to individuals or entities subject to a fine. The regulations promulgated under this subdivision shall be no less protective of due process than section twelve-a of the this article.

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

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

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

PART J

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

(h) knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the state or a local government, or conspires to do the same; shall be liable to the state or a local government, as applicable, for a civil penalty of not less than six thousand dollars and not more than twelve thousand dollars, as adjusted to be equal to the civil penalty allowed under the federal False Claims Act, 31 U.S.C. sec. 3729, et seq., as amended, as adjusted for inflation by the Federal Civil Penalties Inflation Adjustment Act of 1990, as amended (28 U.S.C. 2461 note; Pub. L. No. 101-410), plus three times the amount of all damages, including consequential damages, which the state or local government sustains because of the act of that person.

§ 2. This act shall take effect immediately.

PART K

Section 1. Section 3612 of the public health law is amended by adding a new subdivision 8 to read as follows:

8. (a) The commissioner may require a certified home health agency or licensed home care services agency to report on the costs incurred by the certified home health agency or licensed home care services agency in rendering health care services to Medicaid beneficiaries. The department of health may specify the frequency and format of such reports, determine the type and amount of information to be submitted, and require the submission of supporting documentation, provided, however, that the department shall provide no less than ninety calendar days' notice before such reports are due.

(b) If the department determines that the cost report submitted by a provider is inaccurate or incomplete, the department shall notify the provider in writing and advise the provider of the correction or additional information that the provider must submit. The provider must submit the corrected or additional information within thirty calendar days from the date the provider receives the notice.

(c) The department shall grant a provider an additional thirty calendar days to submit the original, corrected or additional cost report when the provider, prior to the date the report is due, submits a written request to the department for an extension and establishes to the department's satisfaction that the provider cannot submit the report by the date due for reasons beyond the provider's control.

(d) All reports shall be certified by the owner, administrator, chief executive officer, or public official responsible for the operation of the provider. The cost report form shall include a certification form, which shall specify who must certify the report.

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

(i) (i) The commissioner may require a fiscal intermediary to report on the direct care and administrative costs of personal assistance services as accounted for by the fiscal intermediary. The department may specify the frequency and format of such reports, determine the type and amount of information to be submitted, and require the submission of supporting documentation, provided, however, that the department shall provide no less than ninety calendar days' notice before such reports are due.

(ii) If the department determines that the cost report submitted by a provider is inaccurate or incomplete, the department shall notify the provider in writing and advise the provider of the correction or additional information that the provider must submit. The provider must submit the corrected or additional information within thirty calendar days from the date the provider receives the notice.

(iii) The department shall grant a provider an additional thirty calendar days to submit the original, corrected or additional cost report when the provider, prior to the date the report is due, submits a written request to the department for an extension and establishes to the department's satisfaction that the provider cannot submit the report by the date due for reasons beyond the provider's control.

(iv) All reports shall be certified by the owner, administrator, chief executive officer, or public official responsible for the operation of the provider. The cost report form shall include a certification form, which shall specify who must certify the report.

§ 2. Subdivision 1 of section 92 of part H of chapter 59 of the laws of 2011, amending the public health law and other laws relating to known and projected department of health state fund medicaid expenditures, as amended by section 1 of part G of chapter 57 of the laws of 2017, is amended to read as follows:

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

§ 3. This act shall take effect immediately.

PART L

Intentionally Omitted

PART M

Section 1. Paragraph (a) of subdivision 1 of section 18 of chapter 266 of the laws of 1986, amending the civil practice law and rules and other laws relating to malpractice and professional medical conduct, as amended by section 15 of part H of chapter 57 of the laws of 2017, is amended to read as follows:

(a) The superintendent of financial services and the commissioner of health or their designee shall, from funds available in the hospital excess liability pool created pursuant to subdivision 5 of this section, purchase a policy or policies for excess insurance coverage, as authorized by paragraph 1 of subsection (e) of section 5502 of the insurance law; or from an insurer, other than an insurer described in section 5502 of the insurance law, duly authorized to write such coverage and actually writing medical malpractice insurance in this state; or shall purchase equivalent excess coverage in a form previously approved by the superintendent of financial services for purposes of providing equivalent excess coverage in accordance with section 19 of chapter 294 of the laws of 1985, for medical or dental malpractice occurrences between July 1, 1986 and June 30, 1987, between July 1, 1987 and June 30, 1988, between July 1, 1988 and June 30, 1989, between July 1, 1989 and June 30, 1990, between July 1, 1990 and June 30, 1991, between July 1, 1991 and June 30, 1992, between July 1, 1992 and June 30, 1993, between July 1, 1993 and June 30, 1994, between July 1, 1994 and June 30, 1995,

between July 1, 1995 and June 30, 1996, between July 1, 1996 and June 30, 1997, between July 1, 1997 and June 30, 1998, between July 1, 1998 and June 30, 1999, between July 1, 1999 and June 30, 2000, between July 1, 2000 and June 30, 2001, between July 1, 2001 and June 30, 2002, between July 1, 2002 and June 30, 2003, between July 1, 2003 and June 30, 2004, between July 1, 2004 and June 30, 2005, between July 1, 2005 and June 30, 2006, between July 1, 2006 and June 30, 2007, between July 1, 2007 and June 30, 2008, between July 1, 2008 and June 30, 2009, between July 1, 2009 and June 30, 2010, between July 1, 2010 and June 30, 2011, between July 1, 2011 and June 30, 2012, between July 1, 2012 and June 30, 2013, between July 1, 2013 and June 30, 2014, between July 1, 2014 and June 30, 2015, between July 1, 2015 and June 30, 2016, between July 1, 2016 and June 30, 2017, [~~and~~] between July 1, 2017 and June 30, 2018**, and between July 1, 2018 and June 30, 2019** or reimburse the hospital where the hospital purchases equivalent excess coverage as defined in subparagraph (i) of paragraph (a) of subdivision 1-a of this section for medical or dental malpractice occurrences between July 1, 1987 and June 30, 1988, between July 1, 1988 and June 30, 1989, between July 1, 1989 and June 30, 1990, between July 1, 1990 and June 30, 1991, between July 1, 1991 and June 30, 1992, between July 1, 1992 and June 30, 1993, between July 1, 1993 and June 30, 1994, between July 1, 1994 and June 30, 1995, between July 1, 1995 and June 30, 1996, between July 1, 1996 and June 30, 1997, between July 1, 1997 and June 30, 1998, between July 1, 1998 and June 30, 1999, between July 1, 1999 and June 30, 2000, between July 1, 2000 and June 30, 2001, between July 1, 2001 and June 30, 2002, between July 1, 2002 and June 30, 2003, between July 1, 2003 and June 30, 2004, between July 1, 2004 and June 30, 2005, between July 1, 2005 and June 30, 2006, between July 1, 2006 and June 30, 2007, between July 1, 2007 and June 30, 2008, between July 1, 2008 and June 30, 2009, between July 1, 2009 and June 30, 2010, between July 1, 2010 and June 30, 2011, between July 1, 2011 and June 30, 2012, between July 1, 2012 and June 30, 2013, between July 1, 2013 and June 30, 2014, between July 1, 2014 and June 30, 2015, between July 1, 2015 and June 30, 2016, between July 1, 2016 and June 30, 2017, [~~and~~] between July 1, 2017 and June 30, 2018**, and between July 1, 2018 and June 30, 2019** for physicians or dentists certified as eligible for each such period or periods pursuant to subdivision 2 of this section by a general hospital licensed pursuant to article 28 of the public health law; provided that no single insurer shall write more than fifty percent of the total excess premium for a given policy year; and provided, however, that such eligible physicians or dentists must have in force an 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 16 of part H of chapter 57 of the laws of 2017, is amended to read as follows:

(3)(a) The superintendent of financial services shall determine and certify to each general hospital and to the commissioner of health the cost of excess malpractice insurance for medical or dental malpractice occurrences between July 1, 1986 and June 30, 1987, between July 1, 1988 and June 30, 1989, between July 1, 1989 and June 30, 1990, between July 1, 1990 and June 30, 1991, between July 1, 1991 and June 30, 1992, between July 1, 1992 and June 30, 1993, between July 1, 1993 and June 30, 1994, between July 1, 1994 and June 30, 1995, between July 1, 1995 and June 30, 1996, between July 1, 1996 and June 30, 1997, between July 1, 1997 and June 30, 1998, between July 1, 1998 and June 30, 1999, between July 1, 1999 and June 30, 2000, between July 1, 2000 and June 30, 2001, between July 1, 2001 and June 30, 2002, between July 1, 2002 and June 30, 2003, between July 1, 2003 and June 30, 2004, between July 1, 2004 and June 30, 2005, between July 1, 2005 and June 30, 2006, between July 1, 2006 and June 30, 2007, between July 1, 2007 and June 30, 2008, between July 1, 2008 and June 30, 2009, between July 1, 2009 and June 30, 2010, between July 1, 2010 and June 30, 2011, between July 1, 2011 and June 30, 2012, between July 1, 2012 and June 30, 2013, and between July 1, 2013 and June 30, 2014, between July 1, 2014 and June 30, 2015, between July 1, 2015 and June 30, 2016, and between July 1, 2016 and June 30, 2017, [~~and~~] between July 1, 2017 and June 30, 2018**, and between July 1, 2018 and June 30, 2019** allocable to each general hospital for physicians or dentists certified as eligible for purchase of a policy for excess insurance coverage by such general hospital in accordance with subdivision 2 of this section, and may amend such determination and certification as necessary.

(b) The superintendent of financial services shall determine and certify to each general hospital and to the commissioner of health the cost of excess malpractice insurance or equivalent excess coverage for medical or dental malpractice occurrences between July 1, 1987 and June 30, 1988, between July 1, 1988 and June 30, 1989, between July 1, 1989 and June 30, 1990, between July 1, 1990 and June 30, 1991, between July

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

§ 3. Paragraphs (a), (b), (c), (d) and (e) of subdivision 8 of section 18 of chapter 266 of the laws of 1986, amending the civil practice law

and rules and other laws relating to malpractice and professional medical conduct, as amended by section 17 of part H of chapter 57 of the laws of 2017, are amended to read as follows:

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

(b) Each provider of excess insurance coverage or equivalent excess coverage covering the period July 1, 1992 to June 30, 1993, or covering the period July 1, 1993 to June 30, 1994, or covering the period July 1, 1994 to June 30, 1995, or covering the period July 1, 1995 to June 30, 1996, or covering the period July 1, 1996 to June 30, 1997, or covering the period July 1, 1997 to June 30, 1998, or covering the period July 1, 1998 to June 30, 1999, or covering the period July 1, 1999 to June 30, 2000, or covering the period July 1, 2000 to June 30, 2001, or covering the period July 1, 2001 to October 29, 2001, or covering the period April 1, 2002 to June 30, 2002, or covering the period July 1, 2002 to June 30, 2003, or covering the period July 1, 2003 to June 30, 2004, or covering the period July 1, 2004 to June 30, 2005, or covering the period July 1, 2005 to June 30, 2006, or covering the period July 1, 2006 to June 30, 2007, or covering the period July 1, 2007 to June 30, 2008, or covering the period July 1, 2008 to June 30, 2009, or covering the period July 1, 2009 to June 30, 2010, or covering the period July 1, 2010 to June 30, 2011, or covering the period July 1, 2011 to June 30, 2012, or covering the period July 1, 2012 to June 30, 2013, or covering the period July 1, 2013 to June 30, 2014, or covering the period July 1, 2014 to

June 30, 2015, or covering the period July 1, 2015 to June 30, 2016, or covering the period July 1, 2016 to June 30, 2017, or covering the period July 1, 2017 to June 30, 2018**, or covering the period July 1, 2018 to June 30, 2019** shall notify a covered physician or dentist by mail, mailed to the address shown on the last application for excess insurance coverage or equivalent excess coverage, of the amount due to such provider from such physician or dentist for such coverage period determined in accordance with paragraph (a) of this subdivision. Such amount shall be due from such physician or dentist to such provider of excess insurance coverage or equivalent excess coverage in a time and manner determined by the superintendent of financial services.

(c) If a physician or dentist liable for payment of a portion of the costs of excess insurance coverage or equivalent excess coverage covering the period July 1, 1992 to June 30, 1993, or covering the period July 1, 1993 to June 30, 1994, or covering the period July 1, 1994 to June 30, 1995, or covering the period July 1, 1995 to June 30, 1996, or covering the period July 1, 1996 to June 30, 1997, or covering the period July 1, 1997 to June 30, 1998, or covering the period July 1, 1998 to June 30, 1999, or covering the period July 1, 1999 to June 30, 2000, or covering the period July 1, 2000 to June 30, 2001, or covering the period July 1, 2001 to October 29, 2001, or covering the period April 1, 2002 to June 30, 2002, or covering the period July 1, 2002 to June 30, 2003, or covering the period July 1, 2003 to June 30, 2004, or covering the period July 1, 2004 to June 30, 2005, or covering the period July 1, 2005 to June 30, 2006, or covering the period July 1, 2006 to June 30, 2007, or covering the period July 1, 2007 to June 30, 2008, or covering the period July 1, 2008 to June 30, 2009, or covering the period July 1, 2009 to June 30, 2010, or covering the period July 1, 2010 to June 30, 2011, or covering the period July 1, 2011 to June 30, 2012, or covering the period July 1, 2012 to June 30, 2013, or covering the period July 1, 2013 to June 30, 2014, or covering the period July 1, 2014 to June 30, 2015, or covering the period July 1, 2015 to June 30, 2016, or covering the period July 1, 2016 to June 30, 2017, or covering the period July 1, 2017 to June 30, 2018**, or covering the period July 1, 2018 to June 30, 2019** determined in accordance with paragraph (a) of this subdivision fails, refuses or neglects to make payment to the provider of excess insurance coverage or equivalent excess coverage in such time and manner as determined by the superintendent of financial services pursuant to paragraph (b) of this subdivision, excess insurance coverage or equivalent excess coverage purchased for such physician or dentist in accordance with this section for such coverage period shall be cancelled and shall be null and void as of the first day on or after the commencement of a policy period where the liability for payment pursuant to this subdivision has not been met.

(d) Each provider of excess insurance coverage or equivalent excess coverage shall notify the superintendent of financial services and the commissioner of health or their designee of each physician and dentist eligible for purchase of a policy for excess insurance coverage or equivalent excess coverage covering the period July 1, 1992 to June 30, 1993, or covering the period July 1, 1993 to June 30, 1994, or covering the period July 1, 1994 to June 30, 1995, or covering the period July 1, 1995 to June 30, 1996, or covering the period July 1, 1996 to June 30, 1997, or covering the period July 1, 1997 to June 30, 1998, or covering the period July 1, 1998 to June 30, 1999, or covering the period July 1, 1999 to June 30, 2000, or covering the period July 1, 2000 to June 30, 2001, or covering the period July 1, 2001 to October 29, 2001, or cover-

ing the period April 1, 2002 to June 30, 2002, or covering the period July 1, 2002 to June 30, 2003, or covering the period July 1, 2003 to June 30, 2004, or covering the period July 1, 2004 to June 30, 2005, or covering the period July 1, 2005 to June 30, 2006, or covering the period July 1, 2006 to June 30, 2007, or covering the period July 1, 2007 to June 30, 2008, or covering the period July 1, 2008 to June 30, 2009, or covering the period July 1, 2009 to June 30, 2010, or covering the period July 1, 2010 to June 30, 2011, or covering the period July 1, 2011 to June 30, 2012, or covering the period July 1, 2012 to June 30, 2013, or covering the period July 1, 2013 to June 30, 2014, or covering the period July 1, 2014 to June 30, 2015, or covering the period July 1, 2015 to June 30, 2016, or covering the period July 1, 2016 to June 30, 2017, or covering the period July 1, 2017 to June 30, 2018**, or covering the period July 1, 2018 to June 30, 2019** that has made payment to such provider of excess insurance coverage or equivalent excess coverage in accordance with paragraph (b) of this subdivision and of each physician and dentist who has failed, refused or neglected to make such payment.

(e) A provider of excess insurance coverage or equivalent excess coverage shall refund to the hospital excess liability pool any amount allocable to the period July 1, 1992 to June 30, 1993, and to the period July 1, 1993 to June 30, 1994, and to the period July 1, 1994 to June 30, 1995, and to the period July 1, 1995 to June 30, 1996, and to the period July 1, 1996 to June 30, 1997, and to the period July 1, 1997 to June 30, 1998, and to the period July 1, 1998 to June 30, 1999, and to the period July 1, 1999 to June 30, 2000, and to the period July 1, 2000 to June 30, 2001, and to the period July 1, 2001 to October 29, 2001, and to the period April 1, 2002 to June 30, 2002, and to the period July 1, 2002 to June 30, 2003, and to the period July 1, 2003 to June 30, 2004, and to the period July 1, 2004 to June 30, 2005, and to the period July 1, 2005 to June 30, 2006, and to the period July 1, 2006 to June 30, 2007, and to the period July 1, 2007 to June 30, 2008, and to the period July 1, 2008 to June 30, 2009, and to the period July 1, 2009 to June 30, 2010, and to the period July 1, 2010 to June 30, 2011, and to the period July 1, 2011 to June 30, 2012, and to the period July 1, 2012 to June 30, 2013, and to the period July 1, 2013 to June 30, 2014, and to the period July 1, 2014 to June 30, 2015, and to the period July 1, 2015 to June 30, 2016, to the period July 1, 2016 to June 30, 2017, and to the period July 1, 2017 to June 30, 2018**, and to the period July 1, 2018 to June 30, 2019** received from the hospital excess liability pool for purchase of excess insurance coverage or equivalent excess coverage covering the period July 1, 1992 to June 30, 1993, and covering the period July 1, 1993 to June 30, 1994, and covering the period July 1, 1994 to June 30, 1995, and covering the period July 1, 1995 to June 30, 1996, and covering the period July 1, 1996 to June 30, 1997, and covering the period July 1, 1997 to June 30, 1998, and covering the period July 1, 1998 to June 30, 1999, and covering the period July 1, 1999 to June 30, 2000, and covering the period July 1, 2000 to June 30, 2001, and covering the period July 1, 2001 to October 29, 2001, and covering the period April 1, 2002 to June 30, 2002, and covering the period July 1, 2002 to June 30, 2003, and covering the period July 1, 2003 to June 30, 2004, and covering the period July 1, 2004 to June 30, 2005, and covering the period July 1, 2005 to June 30, 2006, and covering the period July 1, 2006 to June 30, 2007, and covering the period July 1, 2007 to June 30, 2008, and covering the period July 1, 2008 to June 30, 2009, and covering the period July 1, 2009 to June 30, 2010, and covering the period July 1, 2010 to June 30, 2011, and covering the period

July 1, 2011 to June 30, 2012, and covering the period July 1, 2012 to June 30, 2013, and covering the period July 1, 2013 to June 30, 2014, and covering the period July 1, 2014 to June 30, 2015, and covering the period July 1, 2015 to June 30, 2016, and covering the period July 1, 2016 to June 30, 2017, and covering the period July 1, 2017 to June 30, 2018**, and covering the period July 1, 2018 to June 30, 2019** for a physician or dentist where such excess insurance coverage or equivalent excess coverage is cancelled in accordance with paragraph (c) of this subdivision.

§ 4. Section 40 of chapter 266 of the laws of 1986, amending the civil practice law and rules and other laws relating to malpractice and professional medical conduct, as amended by section 18 of part H of chapter 57 of the laws of 2017, is amended to read as follows:

§ 40. The superintendent of financial services shall establish rates for policies providing coverage for physicians and surgeons medical malpractice for the periods commencing July 1, 1985 and ending June 30, [~~2018~~] **2019**; provided, however, that notwithstanding any other provision of law, the superintendent shall not establish or approve any increase in rates for the period commencing July 1, 2009 and ending June 30, 2010. The superintendent shall direct insurers to establish segregated accounts for premiums, payments, reserves and investment income attributable to such premium periods and shall require periodic reports by the insurers regarding claims and expenses attributable to such periods to monitor whether such accounts will be sufficient to meet incurred claims and expenses. On or after July 1, 1989, the superintendent shall impose a surcharge on premiums to satisfy a projected deficiency that is attributable to the premium levels established pursuant to this section for such periods; provided, however, that such annual surcharge shall not exceed eight percent of the established rate until July 1, [~~2018~~] **2019**, at which time and thereafter such surcharge shall not exceed twenty-five percent of the approved adequate rate, and that such annual surcharges shall continue for such period of time as shall be sufficient to satisfy such deficiency. The superintendent shall not impose such surcharge during the period commencing July 1, 2009 and ending June 30, 2010. On and after July 1, 1989, the surcharge prescribed by this section shall be retained by insurers to the extent that they insured physicians and surgeons during the July 1, 1985 through June 30, [~~2018~~] **2019** policy periods; in the event and to the extent physicians and surgeons were insured by another insurer during such periods, all or a pro rata share of the surcharge, as the case may be, shall be remitted to such other insurer in accordance with rules and regulations to be promulgated by the superintendent. Surcharges collected from physicians and surgeons who were not insured during such policy periods shall be apportioned among all insurers in proportion to the premium written by each insurer during such policy periods; if a physician or surgeon was insured by an insurer subject to rates established by the superintendent during such policy periods, and at any time thereafter a hospital, health maintenance organization, employer or institution is responsible for responding in damages for liability arising out of such physician's or surgeon's practice of medicine, such responsible entity shall also remit to such prior insurer the equivalent amount that would then be collected as a surcharge if the physician or surgeon had continued to remain insured by such prior insurer. In the event any insurer that provided coverage during such policy periods is in liquidation, the property/casualty insurance security fund shall receive the portion of surcharges to which the insurer in liquidation would have been entitled.

The surcharges authorized herein shall be deemed to be income earned for the purposes of section 2303 of the insurance law. The superintendent, in establishing adequate rates and in determining any projected deficiency pursuant to the requirements of this section and the insurance law, shall give substantial weight, determined in his discretion and judgment, to the prospective anticipated effect of any regulations promulgated and laws enacted and the public benefit of stabilizing malpractice rates and minimizing rate level fluctuation during the period of time necessary for the development of more reliable statistical experience as to the efficacy of such laws and regulations affecting medical, dental or podiatric malpractice enacted or promulgated in 1985, 1986, by this act and at any other time. Notwithstanding any provision of the insurance law, rates already established and to be established by the superintendent pursuant to this section are deemed adequate if such rates would be adequate when taken together with the maximum authorized annual surcharges to be imposed for a reasonable period of time whether or not any such annual surcharge has been actually imposed as of the establishment of such rates.

§ 5. Section 5 and subdivisions (a) and (e) of section 6 of part J of chapter 63 of the laws of 2001, amending chapter 266 of the laws of 1986, amending the civil practice law and rules and other laws relating to malpractice and professional medical conduct, relating to the effectiveness of certain provisions of such chapter, as amended by section 19 of part H of chapter 57 of the laws of 2017, are amended to read as follows:

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

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

to June 30, 2008, or July 1, 2008 to June 30, 2009, or July 1, 2009 to June 30, 2010, or July 1, 2010 to June 30, 2011, or July 1, 2011 to June 30, 2012, or July 1, 2012 to June 30, 2013, or July 1, 2013 to June 30, 2014, or July 1, 2014 to June 30, 2015, or July 1, 2015 to June 30, 2016, or July 1, 2016 to June 30, 2017, or July 1, 2017 to June 30, 2018**, or July 1, 2018 to June 30, 2019** as applicable.

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

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

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

§ 7. This act shall take effect immediately.

PART N

Intentionally Omitted

PART O

Section 1. Intentionally omitted.
§ 2. Intentionally omitted.
§ 3. Intentionally omitted.
§ 4. Intentionally omitted.
§ 5. Intentionally omitted.
§ 6. Intentionally omitted.
§ 7. Intentionally omitted.
§ 8. Intentionally omitted.
§ 9. Intentionally omitted.
§ 10. Intentionally omitted.
§ 11. Intentionally omitted.
§ 12. Intentionally omitted.
§ 13. Intentionally omitted.
§ 14. Intentionally omitted.
§ 15. Intentionally omitted.
§ 16. Intentionally omitted.

§ 17. Providers of early intervention services shall receive a two percent increase in rates of reimbursement for early intervention services provided that for payments made for early intervention services to persons eligible for medical assistance pursuant to title eleven of article five of the social services law, the two percent increase shall be subject to the availability of federal financial participation.

§ 17-a. The public health law is amended by adding a new section 2807-o to read as follows:

§ 2807-o. Early intervention services pool. 1. Definitions. The following words or phrases as used in this section shall have the following meanings:

(a) "Early intervention services" shall mean services delivered to an eligible child, pursuant to an individualized family service plan under the early intervention program.

(b) "Early intervention program" shall mean the early intervention program for toddlers with disabilities and their families as created by title two-A of article twenty-five of this chapter.

(c) "Municipality" shall mean any county outside of the city of New York or the city of New York.

2. Payments for early intervention services. (a) The commissioner shall, from funds allocated for such purpose under paragraph (g) of subdivision six of section twenty-eight hundred seven-s of this article, make payments to municipalities and the state for the delivery of early intervention services.

(b) Payments under this subdivision shall be made to municipalities and the state by the commissioner. Each municipality and the state of New York shall receive a share of such payments equal to its proportionate share of the total approved statewide dollars not reimbursable by the medical assistance program paid to providers of early intervention services by the state and municipalities on account of early intervention services in the last complete state fiscal year for which such data is available.

§ 17-b. Subdivision 6 of section 2807-s of the public health law is amended by adding two new paragraphs (g) and (h) to read as follows:

(g) A further gross statewide amount for the state fiscal year two thousand nineteen and each state fiscal year thereafter shall be twenty-five million dollars.

(h) The amount specified in paragraph (g) of this subdivision shall be allocated under section twenty-eight hundred seven-o of this article among the municipalities and the state of New York based on each municipality's share and the state's share of early intervention program expenditures not reimbursable by the medical assistance program for the latest twelve month period for which such data is available.

§ 17-c. Subdivision 7 of section 2807-s of the public health law is amended by adding a new paragraph (d) to read as follows:

(d) funds shall be added to the funds collected by the commissioner for distribution in accordance with section twenty-eight hundred seven-o of this article, in the following amount: fifteen million dollars for the period beginning April first, two thousand nineteen, and continuing each state fiscal year thereafter.

§ 17-d. Subdivision 1 of section 2557 of the public health law, as amended by section 4 of part C of chapter 1 of the laws of 2002, is amended to read as follows:

1. The approved costs for an eligible child who receives an evaluation and early intervention services pursuant to this title shall be a charge upon the municipality wherein the eligible child resides or, where the services are covered by the medical assistance program, upon the social services district of fiscal responsibility with respect to those eligible children who are also eligible for medical assistance. All approved costs shall be paid in the first instance and at least quarterly by the appropriate governing body or officer of the municipality upon vouchers presented and audited in the same manner as the case of other claims against the municipality. Notwithstanding the insurance law or regulations thereunder relating to the permissible exclusion of payments for services under governmental programs, no such exclusion shall apply with respect to payments made pursuant to this title. Notwithstanding the insurance law or any other law or agreement to the contrary, benefits under this title shall be considered secondary to [~~any plan of insurance or state government benefit~~] the medical assistance program under which an eligible child may have coverage. [~~Nothing in this section shall increase or enhance coverages provided for within an insurance contract subject to the provisions of this title.~~]

§ 17-e. Subdivision 2 of section 2557 of the public health law, as amended by section 9-a of part A of chapter 56 of the laws of 2012, is amended to read as follows:

2. The department shall reimburse the approved costs paid by a municipality for the purposes of this title, other than those reimbursable by the medical assistance program [~~or by third party payors~~], in an amount of fifty percent of the amount expended in accordance with the rules and regulations of the commissioner; provided, however, that in the discretion of the department and with the approval of the director of the division of the budget, the department may reimburse municipalities in an amount greater than fifty percent of the amount expended. Such state reimbursement to the municipality shall not be paid prior to April first of the year in which the approved costs are paid by the municipality, provided, however that, subject to the approval of the director of the budget, the department may pay such state aid reimbursement to the municipality prior to such date.

§ 17-f. The section heading of section 2559 of the public health law, as added by chapter 428 of the laws of 1992, is amended to read as follows:

[~~Third party insurance and medical~~] Medical assistance program payments.

§ 17-g. Subdivision 3 of section 2559 of the public health law, as added by chapter 428 of the laws of 1992, paragraphs (a), (c) and (d) as amended by section 11 of part A of chapter 56 of the laws of 2012 and paragraph (b) as further amended by section 104 of part A of chapter 62 of the laws of 2011, is amended to read as follows:

3. (a) [~~Providers of evaluations and early intervention services, hereinafter collectively referred to in this subdivision as "provider" or "providers", shall in the first instance and where applicable, seek payment from all third party payors including governmental agencies prior to claiming payment from a given municipality for evaluations conducted under the program and for services rendered to eligible children, provided that, the obligation to seek payment shall not apply to a payment from a third party payor who is not prohibited from applying such payment, and will apply such payment, to an annual or lifetime limit specified in the insured's policy.~~

~~(i) Parents shall provide the municipality and service coordinator information on any insurance policy, plan or contract under which an eligible child has coverage.~~

~~(ii)~~] Parents shall provide the municipality and the service coordinator with a written referral from a primary care provider as documentation, for eligible children, of the medical necessity of early intervention services.

[~~(iii) providers~~] **(b) Providers** shall utilize the department's fiscal agent and data system for claiming payment for evaluations and services rendered under the early intervention program.

[~~(b) The commissioner, in consultation with the director of budget and the superintendent of financial services, shall promulgate regulations providing public reimbursement for deductibles and copayments which are imposed under an insurance policy or health benefit plan to the extent that such deductibles and copayments are applicable to early intervention services.~~

~~(c) Payments made for early intervention services under an insurance policy or health benefit plan, including payments made by the medical assistance program or other governmental third party payor, which are provided as part of an IFSP pursuant to section twenty-five hundred forty-five of this title shall not be applied by the insurer or plan administrator against any maximum lifetime or annual limits specified in the policy or health benefits plan, pursuant to section eleven of the chapter of the laws of nineteen hundred ninety-two which added this title.~~

~~(d)~~] **(c)** A municipality, or its designee, and a provider shall be subrogated, to the extent of the expenditures by such municipality or for early intervention services furnished to persons eligible for benefits under this title, to any rights such person may have or be entitled to from [~~third party reimbursement~~] **the medical assistance program**. The provider shall submit notice to the insurer or plan administrator of his or her exercise of such right of subrogation upon the provider's assignment as the early intervention service provider for the child. The right of subrogation does not attach to benefits paid or provided [~~under any health insurance policy or health benefits plan~~] prior to receipt of written notice of the exercise of subrogation rights [~~by the insurer or plan administrator providing such benefits~~]. **Notwithstanding any inconsistent provision of this title, except as provided for herein, no third party payor other than the medical assistance program shall be required to reimburse for early intervention services provided under this title.**

§ 17-h. Subdivision 3 of section 2543 of the public health law is REPEALED.

§ 17-i. Section 3235-a of the insurance law is REPEALED.

§ 17-j. Subparagraph (F) of paragraph 25 of subsection (i) of section 3216 of the insurance law is REPEALED.

§ 17-k. Subparagraph (F) of paragraph 17 of subsection (1) of section 3221 of the insurance law is REPEALED.

§ 17-l. Paragraph 6 of subsection (ee) of section 4303 of the insurance law is REPEALED.

§ 18. This act shall take effect immediately; provided, however, that the amendments to section 2807-s of the public health law made by sections seventeen-b and seventeen-c of this act shall not affect the expiration of such section and shall be deemed to expire therewith. Effective immediately, the addition, amendment and/or repeal of any rule or regulation necessary for the implementation of this act on its effective date are authorized to be made and completed by the commissioner of health, on or before such effective date.

PART P

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

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

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

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

§ 3. Intentionally omitted.

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

PART Q

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

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

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

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

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

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

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

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

(c) the geographic distribution of funds;

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

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

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

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

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

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

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

7. The department shall provide a report on a quarterly basis to the chairs of the senate finance, assembly ways and means, and senate and assembly health committees, until such time as the department determines that the projects that receive funding pursuant to this section are substantially complete. Such reports shall be submitted no later than sixty days after the close of the quarter, and shall include, for each award, the name of the applicant, a description of the project or purpose, the amount of the award, disbursement date, and status of achievement of process and performance metrics and milestones pursuant to subdivision six of this section.

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

PART R

Intentionally Omitted

PART S

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

SUBPART A

Section 1. Intentionally omitted.

SUBPART B

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

1. "Hospital" means a facility or institution engaged principally in providing services by or under the supervision of a physician or, in the case of a dental clinic or dental dispensary, of a dentist, or, in the case of a midwifery birth center, of a midwife, for the prevention, diagnosis or treatment of human disease, pain, injury, deformity or physical condition, including, but not limited to, a general hospital, public health center, diagnostic center, treatment center, dental clinic, dental dispensary, rehabilitation center other than a facility used solely for vocational rehabilitation, nursing home, tuberculosis hospital, chronic disease hospital, maternity hospital, midwifery birth center, lying-in-asylum, out-patient department, out-patient lodge, dispensary and a laboratory or central service facility serving one or more such institutions, but the term hospital shall not include an institution, sanitarium or other facility engaged principally in providing services for the prevention, diagnosis or treatment of mental disability and which is subject to the powers of visitation, examination, inspection and investigation of the department of mental hygiene except for those distinct parts of such a facility which provide hospital service. The provisions of this article shall not apply to a facility or institution engaged principally in providing services by or under the supervision of the bona fide members and adherents of a recognized religious organization whose teachings include reliance on spiritual means through prayer alone for healing in the practice of the religion of such organization and where services are provided in accordance with those teachings. **No provision of this article or any other provision of law**

shall be construed to: (a) limit the volume of mental health or substance use disorder services that can be provided by a provider of primary care services licensed under this article and authorized to provide integrated services in accordance with regulations issued by the commissioner in consultation with the commissioner of the office of mental health and the commissioner of the office of alcoholism and substance abuse services, including regulations issued pursuant to subdivision seven of section three hundred sixty-five-l of the social services law or part L of chapter fifty-six of the laws of two thousand twelve; (b) require a provider licensed pursuant to article thirty-one of the mental hygiene law or certified pursuant to article thirty-two of the mental hygiene law to obtain an operating certificate from the department if such provider has been authorized to provide integrated services in accordance with regulations issued by the commissioner in consultation with the commissioner of the office of mental health and the commissioner of the office of alcoholism and substance abuse services, including regulations issued pursuant to subdivision seven of section three hundred sixty-five-l of the social services law or part L of chapter fifty-six of the laws of two thousand twelve.

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

(f) No provision of this article or any other provision of law shall be construed to require a provider licensed pursuant to article twenty-eight of the public health law or certified pursuant to article thirty-two of this chapter to obtain an operating certificate from the office of mental health if such provider has been authorized to provide integrated services in accordance with regulations issued by the commissioner of the office of mental health in consultation with the commissioner of the department of health and the commissioner of the office of alcoholism and substance abuse services, including regulations issued pursuant to subdivision seven of section three hundred sixty-five-l of the social services law or part L of chapter fifty-six of the laws of two thousand twelve.

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

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

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

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

SUBPART C

Section 1. Article 29-G of the public health law is REPEALED.

§ 2. The section heading and subdivision 2 of section 367-u of the social services law, the section heading as added by section 63-c of part C of chapter 58 of the laws of 2007, subdivision 2 as amended by chapter 6 of the laws of 2015, are amended to read as follows:

Payment for [~~home~~] telehealth services.

2. (a) Subject to federal financial participation and the approval of the director of the budget, [~~the commissioner shall not exclude from the payment of medical assistance funds the delivery of health care services through telehealth, as defined in subdivision four of section two thousand nine hundred ninety-nine-cc of the public health law~~] medical assistance shall not exclude from coverage a service that is otherwise covered under medical assistance because the service is delivered via telehealth. Such services shall meet the requirements of federal law, rules and regulations for the provision of medical assistance pursuant to this title.

(b) For purposes of this subdivision, "telehealth" means the use of electronic information and communication technologies by a health care provider to deliver health care services to an individual while such individual is located at a site that is different from the site where the health care provider is located.

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

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

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

PART T

Section 1. Subdivision (a) of section 31 of part B of chapter 59 of the laws of 2016, amending the social services law and other laws relating to authorizing the commissioner of health to apply federally established consumer price index penalties for generic drugs, and authorizing

the commissioner of health to impose penalties on managed care plans for reporting late or incorrect encounter data, is amended to read as follows:

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

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

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

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

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

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

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

§ 5. Intentionally omitted.

§ 5-a. Paragraph (e) of subdivision 7 of section 367-a of the social services law, as added by section 1 of part B of chapter 57 of the laws of 2015, the opening paragraph as amended by section 12 and subparagraph (iv) as amended by section 13 of part B of chapter 59 of the laws of 2016, is amended to read as follows:

(e) During the period from April first, two thousand fifteen through March thirty-first, two thousand [~~seventeen~~] twenty, the commissioner may, in lieu of a managed care provider, negotiate directly and enter into an agreement with a pharmaceutical manufacturer for the provision of supplemental rebates relating to pharmaceutical utilization by enrollees of managed care providers pursuant to section three hundred sixty-four-j of this title and may also negotiate directly and enter into such an agreement relating to pharmaceutical utilization by medical assistance recipients not so enrolled. Such rebates shall be limited to drug

utilization in the following classes: antiretrovirals approved by the FDA for the treatment of HIV/AIDS and hepatitis C agents for which the pharmaceutical manufacturer has in effect a rebate agreement with the federal secretary of health and human services pursuant to 42 U.S.C. § 1396r-8, and for which the state has established standard clinical criteria. No agreement entered into pursuant to this paragraph shall have an initial term or be extended beyond March thirty-first, two thousand twenty.

(i) The manufacturer shall not pay supplemental rebates to a managed care provider, or any of a managed care provider's agents, including but not limited to any pharmacy benefit manager on the two classes of drugs subject to this paragraph when the state is collecting supplemental rebates and standard clinical criteria are imposed on the managed care provider.

(ii) The commissioner shall establish adequate rates of reimbursement which shall take into account both the impact of the commissioner negotiating such rebates and any limitations imposed on the managed care provider's ability to establish clinical criteria relating to the utilization of such drugs. In developing the managed care provider's reimbursement rate, the commissioner shall identify the amount of reimbursement for such drugs as a separate and distinct component from the reimbursement otherwise made for prescription drugs as prescribed by this section.

(iii) The commissioner shall submit a report to the temporary president of the senate and the speaker of the assembly annually by December thirty-first. The report shall analyze the adequacy of rates to managed care providers for drug expenditures related to the classes under this paragraph.

(iv) Nothing in this paragraph shall be construed to require a pharmaceutical manufacturer to enter into a supplemental rebate agreement with the commissioner relating to pharmaceutical utilization by enrollees of managed care providers pursuant to section three hundred sixty-four-j of this title or relating to pharmaceutical utilization by medical assistance recipients not so enrolled.

(v) All clinical criteria, including requirements for prior approval, and all utilization review determinations established by the state as described in this paragraph for either of the drug classes subject to this paragraph shall be developed using evidence-based and peer-reviewed clinical review criteria in accordance with article two-A of the public health law, as applicable.

(vi) All prior authorization and utilization review determinations related to the coverage of any drug subject to this paragraph shall be subject to article forty-nine of the public health law, section three hundred sixty-four-j of this title, and article forty-nine of the insurance law, as applicable. Nothing in this paragraph shall diminish any rights relating to access, prior authorization, or appeal relating to any drug class or drug afforded to a recipient under any other provision of law.

§ 6. This act shall take effect immediately; provided, however, that the amendments to paragraph (e) of subdivision 7 of section 367-a of the social services law made by section five-a of this act shall not affect the repeal of such paragraph and shall be deemed repealed therewith.

PART U

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

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

§ 2. This act shall take effect immediately.

PART V

Section 1. Section 7 of part R2 of chapter 62 of the laws of 2003, amending the mental hygiene law and the state finance law relating to the community mental health support and workforce reinvestment program, the membership of subcommittees for mental health of community services boards and the duties of such subcommittees and creating the community mental health and workforce reinvestment account, as amended by section 3 of part G of chapter 60 of the laws of 2014, is amended to read as follows:

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

§ 2. This act shall take effect immediately.

PART W

Intentionally Omitted

PART X

Section 1. Section 3 of part A of chapter 111 of the laws of 2010 amending the mental hygiene law relating to the receipt of federal and state benefits received by individuals receiving care in facilities operated by an office of the department of mental hygiene, as amended by section 1 of part LL of chapter 58 of the laws of 2015, is amended to read as follows:

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

§ 2. This act shall take effect immediately.

PART Y

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

10. **(a)** A person without a license from**:** performing assessments [~~such as~~]**, including but not limited to,** basic information collection, gathering of demographic data, and informal observations, screening and referral used for [~~general~~] eligibility for a program or service and determining the functional status of an individual for the purpose of determining need for services [~~unrelated to a behavioral health diagnosis or treatment plan. Such licensure shall not be required to create, develop or implement a service plan unrelated to a behavioral health diagnosis or treatment plan~~]**; advising individuals regarding benefits they may be eligible for; providing general advice and guidance and assisting individuals or groups with difficult day to day problems such**

as finding employment, locating sources of assistance, and organizing community groups to work on a specific problem; providing peer services; or to provide substance use disorder treatment services or re-entry services to incarcerated individuals in state and local correctional facilities.

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

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

(ii) For the purposes of this subdivision "assist" shall include the provision of services in accordance with subparagraph (i) of this paragraph that do not require clinical assessment, evaluation, interpretation or other professional judgment of a licensed professional. Such services may include, but not be limited to:

(1) Helping an individual with the completion of forms or questionnaires;

(2) Reviewing existing case records and collecting general background information about an individual which may be used by the licensed professional or multi-disciplinary team;

(3) Gathering and reporting information about previous behavioral health interventions, hospitalizations, diagnosis, or prior treatment for review by the licensed professional and multi-disciplinary team;

(4) Discussing with the individual his or her situation, needs, concerns, and thoughts in order to help identify services that support the individual's goals, independence, and quality of life;

(5) Providing advice, information, and assistance to individuals and family members to identify needs and available resources in the community to help meet the needs of the individual or family member;

(6) Engaging in immediate and long term problem solving, engaging in the development of social skills, or providing general help in areas including, but not limited to, housing, employment, child care, parenting, community based services, and finances;

(7) Distributing paper copies of self-administered tests for the individual to complete when such tests do not require the observation and judgment of a licensed professional;

(8) Monitoring treatment in accordance with the treatment plan and providing verbal or written reports to the multi-disciplinary team;

(9) Identifying gaps in services and coordinating access to or arranging services for individuals such as home care, community based services, housing, employment, transportation, child care, vocational training, or health care;

(10) Offering education programs that provide information about disease identification and recommended treatments that may be provided, and how to access such treatment;

(11) Reporting on behavior, actions, and responses to treatment as part of a multi-disciplinary team;

(12) Using de-escalation techniques as authorized; and

(13) Advocating with educational, judicial or other systems to ensure protection of the individual's rights and access to appropriate services.

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

12. Any person who is employed prior to July first, two thousand twenty in a program or service operated, regulated, funded, or approved by the department of mental hygiene or the office of children and family services, or a local government unit as that term is defined in section 41.03 of the mental hygiene law or a social services district as defined in section sixty-one of the social services law from performing services within the practice of psychology, as defined in this article, provided that such person maintains such employment with such entity within the context of such employment. Any person who commences employment in such program or service after July first, two thousand twenty shall be appropriately licensed under this article.

§ 2. Subdivision 1 of section 7701 of the education law, as amended by chapter 230 of the laws of 2004, is amended to read as follows:

1. Practice of licensed master social work.

(a) The practice of licensed master social work shall mean the professional application of social work theory, principles, and the methods to prevent, assess, evaluate, formulate and implement a plan of action based on client needs and strengths, and intervene to address mental,

social, emotional, behavioral, developmental, and addictive disorders, conditions and disabilities, and of the psychosocial aspects of illness and injury experienced by individuals, couples, families, groups, communities, organizations, and society.

(b) Licensed master social workers engage in the administration of tests and measures of psychosocial functioning, social work advocacy, case management, counseling, consultation, research, administration and management, and teaching.

(c) Licensed master social workers provide [~~all forms of~~] administrative supervision [~~other than~~] but not supervision of the practice of licensed clinical social work as defined in subdivision two of this section.

(d) Licensed master social workers practice licensed clinical social work in facility settings or other supervised settings approved by the department under supervision in accordance with the commissioner's regulations.

§ 3. Paragraph (f) of subdivision 1 of section 7702 of the education law, as amended by chapter 230 of the laws of 2004, is amended and two new paragraphs (m) and (n) are added to read as follows:

(f) [~~Assist~~] General advice and guidance, and assisting individuals or groups with difficult day to day problems such as finding employment, locating sources of assistance, and organizing community groups to work on a specific problem.

(m) Provide peer services.

(n) Collect basic information, gathering of demographic data, and informal observations, screening and referral used for general eligibility for a program or service and determining the functional status of an individual for the purpose of determining the need for services.

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

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

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

~~or assessments made by~~]; recovery supports; adult or child protective services including investigations; detention as defined in section five hundred two of the executive law; prevention and residential services for victims of domestic violence; services for runaway and homeless youth; foster care, adoption, preventive services or services in accordance with an approved plan pursuant to section four hundred four of the social services law, including, adoption and foster home studies and assessments, family service plans, transition plans [~~and~~], permanency planning activities, and case planning or case management as such terms are defined by regulations by the office of children and family services; residential rehabilitation; home and community based services; and de-escalation techniques, peer services or skill development. [~~A license under this article shall not be required for persons to participate~~]

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

(ii) For the purposes of this subdivision "assist" shall include the provision of services in accordance with subparagraph (i) of this paragraph that do not require clinical assessment, evaluation, interpretation or other professional judgment of a licensed professional. Such services may include, but not be limited to:

(1) Helping an individual with the completion of forms or questionnaires;

(2) Reviewing existing case records and collecting general background information about an individual which may be used by the licensed professional or multi-disciplinary team;

(3) Gathering and reporting information about previous behavioral health interventions, hospitalizations, diagnosis or prior treatment for review by the licensed professional and multi-disciplinary team;

(4) Discussing with the individual his or her situation, needs, concerns, and thoughts in order to help identify services that support the individual's goals, independence, and quality of life;

(5) Providing advice, information, and assistance to individuals and family members to identify needs and available resources in the community to help meet the needs of the individual or family member;

(6) Engaging in immediate and long term problem solving, engaging in the development of social skills, or providing general help in areas including but not limited to, housing, employment, child care, parenting, community based services, and finances;

(7) Distributing paper copies of self-administered tests for the individual to complete when such tests do not require the observation and judgment of a licensed professional;

(8) Monitoring treatment in accordance with the treatment plan and providing verbal or written reports to the multi-disciplinary team;

(9) Identifying gaps in services and coordinating access to or arranging services for individuals such as home care, community based services, housing, employment, transportation, child care, vocational training, or health care;

(10) Offering education programs that provide information about disease identification and recommended treatments that may be provided, and how to access such treatment;

(11) Reporting on behavior, actions, and responses to treatment as part of a multi-disciplinary team;

(12) Using de-escalation techniques as authorized; and

(13) Advocating with educational, judicial or other systems to ensure protection of the individual's rights and access to appropriate services.

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

8. Any person who is employed prior to July first, two thousand twenty in a program or service operated, regulated, funded, or approved by the department of mental hygiene, the office of children and family services, the department of corrections and community supervision, the office of temporary and disability assistance, the state office for the aging and the department of health or a local government unit as that term is defined in section 41.03 of the mental hygiene law or a social services district as defined in section sixty-one of the social services law from performing services within the practice of licensed master social work and licensed clinical social work, as defined in this article, provided that such person maintains such employment with such entity within the context of such employment. Any person who commences employment in such program or service after July first, two thousand twenty shall be appropriately licensed under this article.

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

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

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

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

(ii) For the purposes of this subdivision "assist" shall include the provision of services in accordance with subparagraph (i) of this paragraph that do not require clinical assessment, evaluation, interpretation or other professional judgment of a licensed professional. Such services may include, but not be limited to:

(1) Helping an individual with the completion of forms or questionnaires;

(2) Reviewing existing case records and collecting general background information about an individual which may be used by the licensed professional or multi-disciplinary team;

(3) Gathering and reporting information about previous behavioral health interventions, hospitalizations, diagnosis or prior treatment for review by the licensed professional and multi-disciplinary team;

(4) Discussing with the individual his or her situation, needs, concerns, and thoughts in order to help identify services that support the individual's goals, independence, and quality of life;

(5) Providing advice, information, and assistance to individuals and family members to identify needs and available resources in the community to help meet the needs of the individual or family member;

(6) Engaging in immediate and long term problem solving, engaging in the development of social skills, or providing general help in areas, including but not limited to, housing, employment, child care, parenting, community based services, and finances;

(7) Distributing paper copies of self-administered tests for the individual to complete when such tests do not require the observation and judgment of a licensed professional;

(8) Monitoring treatment in accordance with the treatment plan and providing verbal or written reports to the multi-disciplinary team;

(9) Identifying gaps in services and coordinating access to or arranging services for individuals such as home care, community based services, housing, employment, transportation, child care, vocational training, or health care;

(10) Offering education programs that provide information about disease identification and recommended treatments that may be provided; and how to access such treatment;

(11) Reporting on behavior, actions, and responses to treatment as part of a multi-disciplinary team;

(12) Using de-escalation techniques as authorized; and

(13) Advocating with educational, judicial or other systems to ensure protection of the individual's rights and access to appropriate services.

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

8. Any person who is employed prior to July first, two thousand twenty in a program or service operated, regulated, funded, or approved by the department of mental hygiene, the office of children and family services, the department of corrections and community supervision, the office of temporary and disability assistance, the state office for the aging and the department of health or a local government unit as that term is defined in section 41.03 of the mental hygiene law or a social services district as defined in section sixty-one of the social services law from performing services within the practice of licensed master social work and licensed clinical social work, as defined in this article, provided that such person maintains such employment with such entity within the context of such employment. Any person who commences employment in such program or service after July first, two thousand twenty shall be appropriately licensed under this article.

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

8. (a) Prevent a person without a license from: performing assessments such as basic information collection, gathering of demographic data, and informal observations, screening and referral used for general eligibility for a program or service and determining the functional status of an individual for the purpose of determining need for services [~~unrelated to a behavioral health diagnosis or treatment plan. Such licensure shall not be required to create, develop or implement a service plan~~

~~unrelated to a behavioral health diagnosis or treatment plan~~]; advising individuals regarding the appropriateness of benefits they are eligible for; providing general advice and guidance and assisting individuals or groups with difficult day to day problems such as finding employment, locating sources of assistance, and organizing community groups to work on a specific problem; providing peer services; or to select for suitability and provide substance abuse treatment services or group re-entry services to incarcerated individuals in state correctional facilities.

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

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

(ii) For the purposes of this subdivision "assist" shall include the provision of services that do not require assessment, evaluation, interpretation or other professional judgment. Such services may include:

(1) Helping a patient with the completion of forms or questionnaires;

(2) Reviewing existing case records and collecting general background information about a patient which may be used by the licensed professional or multi-disciplinary team to provide appropriate services;

(3) Gathering information about previous mental health interventions, hospitalizations, emergency interventions and other forms of treatment for review by the licensed professional;

(4) Discussing with the patient his or her situation, needs, concerns, and thoughts in order to help identify services that support the patient's goals, independence, and quality of life;

(5) Providing advice, information, and assistance to patients and family members to identify needs and available resources in the community to help meet the needs of the patient or family member;

(6) Engaging in immediate and long term problem solving, engaging in the development of social skills, or giving practical help in areas such as, but not limited to, housing, employment, child care, parenting, community based services, and finances;

(7) Distributing paper copies of self-administered tests for the patient to complete when such tests do not require the observation and judgment of a licensed professional;

(8) Monitoring treatment in accordance with the treatment plan and providing verbal or written reports to the multi-disciplinary team;

(9) Identifying gaps in necessary services and coordinating access to or arranging services for patients such as home care, community based services, housing, employment, transportation, child care, vocational training, or health care;

(10) Offering education programs that provide information about disease identification and recommended treatments that may be provided by licensed professionals;

(11) Reporting observations about behavior, action, and responses to treatment as part of a multi-disciplinary team;

(12) Using de-escalation techniques to respond appropriately to dangerous or threatening behaviors and intervening as authorized to ensure the immediate safety of the patient and others; and

(13) Advocating with educational, judicial or other systems to ensure protection of the individual's rights and access to appropriate services.

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

9. Any person who is employed prior to July first, two thousand twenty in a program or service operated, regulated, funded, or approved by the department of mental hygiene, the office of children and family services, the department of corrections and community supervision, the office of temporary and disability assistance, the state office for the aging and the department of health or a local government unit as that term is defined in section 41.03 of the mental hygiene law or a social services district as defined in section sixty-one of the social services law from performing services within the practice of mental health counseling, marriage and family therapy, creative arts therapy, and psychoanalysis, as defined in this article, provided that such person maintains such employment with such entity within the context of such employment. Any person who commences employment in such program or service after July first, two thousand twenty shall be appropriately licensed under this article.

§ 6. The state education department shall periodically develop formal guidance to identify the tasks and functions restricted to licensed personnel under articles 153, 154 and 163 of the education law.

§ 7. Subdivision a of section 9 of chapter 420 of the laws of 2002 amending the education law relating to the profession of social work, as amended by section 1 of part J of chapter 59 of the laws of 2016, is amended to read as follows:

a. Nothing in this act shall prohibit or limit the activities or services on the part of any person in the employ of a program or service operated, regulated, funded, or approved by the department of mental hygiene, the office of children and family services, the office of temporary and disability assistance, the department of corrections and community supervision, the state office for the aging, the department of health, or a local governmental unit as that term is defined in article 41 of the mental hygiene law or a social services district as defined in section 61 of the social services law, provided, however, this section shall not authorize the use of any title authorized pursuant to article 154 of the education law, except that this section shall be deemed repealed on July 1, [~~2018~~] 2020.

§ 8. Subdivision a of section 17-a of chapter 676 of the laws of 2002, amending the education law relating to the practice of psychology, as amended by section 2 of part J of chapter 59 of the laws of 2016, is amended to read as follows:

a. In relation to activities and services provided under article 153 of the education law, nothing in this act shall prohibit or limit such activities or services on the part of any person in the employ of a program or service operated, regulated, funded, or approved by the department of mental hygiene or the office of children and family services, or a local governmental unit as that term is defined in article 41 of the mental hygiene law or a social services district as defined in section 61 of the social services law. In relation to activities and services provided under article 163 of the education law, nothing in this act shall prohibit or limit such activities or services on the part of any person in the employ of a program or service operated, regulated, funded, or approved by the department of mental hygiene, the office of children and family services, the department of corrections and community supervision, the office of temporary and disability assistance, the state office for the aging and the department of health or a local governmental unit as that term is defined in article 41 of the mental hygiene law or a social services district as defined in section 61 of the social services law, pursuant to authority granted by law. This section shall not authorize the use of any title authorized pursuant to article 153 or 163 of the education law by any such employed person, except as otherwise provided by such articles respectively. This section shall be deemed repealed July 1, [~~2018~~] 2020.

§ 9. Section 16 of chapter 130 of the laws of 2010, amending the education law and other laws relating to the registration of entities providing certain professional services and the licensure of certain professions, as amended by section 3 of part J of chapter 59 of the laws of 2016, is amended to read as follows:

§ 16. This act shall take effect immediately; provided that sections thirteen, fourteen and fifteen of this act shall take effect immediately and shall be deemed to have been in full force and effect on and after June 1, 2010 and such sections shall be deemed repealed July 1, [~~2018~~] 2020; provided further that the amendments to section 9 of chapter 420 of the laws of 2002 amending the education law relating to the profes-

sion of social work made by section thirteen of this act shall repeal on the same date as such section repeals; provided further that the amendments to section 17-a of chapter 676 of the laws of 2002 amending the education law relating to the practice of psychology made by section fourteen of this act shall repeal on the same date as such section repeals.

§ 10. This act shall take effect immediately.

PART Z

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

(vii) a person with a developmental or physical disability who receives home and community-based services or care-at-home services through **a demonstration waiver under section eleven hundred fifteen of the federal social security act,** existing waivers under section nineteen hundred fifteen (c) of the federal social security act**,** or who has characteristics and needs similar to such persons;

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

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

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

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

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

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

shall make any amendments to the state plan for medical assistance, or apply for any waiver or approval under the federal social security act that are necessary to carry out the provisions of this paragraph.

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

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

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

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

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

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

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

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

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

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

1-a. sections seventy-three through eighty-a shall expire and be deemed repealed September 30, [~~2019~~] 2024

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

PART AA

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

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

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

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

PART BB

Section 1. Intentionally omitted.

§ 2. Intentionally omitted.

§ 3. Intentionally omitted.

§ 4. Subdivision (b) of schedule I of section 3306 of the public health law is amended by adding two new paragraphs 56 and 57 to read as follows:

(56) 3,4-dichloro-N-{(1-dimethylamino) cyclohexylmethyl}benzamide. Some trade or other names: AH-7921.

(57) N-(1-phenethylpiperidin-4-yl)-N-phenylacetamide (Acetyl Fentanyl).

§ 5. Subdivision (d) of schedule I of section 3306 of the public health law is amended by adding three new paragraphs 36, 37 and 38 to read as follows:

(36) 5-methoxy-N,N-dimethyltryptamine.
(37) Alpha-methyltryptamine. Some trade or other names: AMT.
(38) 5-methoxy-N,N-diisopropyltryptamine. Some trade or other names: 5-MeO-DIPT.

§ 6. Intentionally omitted.

§ 7. Schedule I of section 3306 of the public health law is amended by adding two new subdivisions (g) and (h) to read as follows:

(g) Synthetic cannabinoids. Unless specifically excepted or unless listed in another schedule, any material, compound, mixture, or preparation, which contains any quantity of the following synthetic cannabinoid substances, or which contains any of its salts, isomers, and salts of isomers whenever the existence of such salts, isomers, and salts of isomers is possible within the specific chemical designation (for purposes of this paragraph only, the term "isomer" includes the optical, position and geometric isomers):
(1) (1-pentyl-1H-indol-3-yl)(2,2,3,3-tetramethylcyclopropyl) methanone. Some trade or other names: UR-144.
(2) {1-(5-fluro-pentyl)-1H-indol-3-yl}(2,2,3,3-tetramethylcyclopropyl) methanone. Some trade names or other names: 5-fluoro-UR-144, XLR11.
(3) N-(1-adamantyl)-1-pentyl-1H-indazole-3-carboxamide. Some trade or other names: APINACA, AKB48.
(4) quinolin-8-yl 1-pentyl-1H-indole-3-carboxylate. Some trade or other names: PB-22; QUPIC.
(5) quinolin-8-yl 1-(5-fluoropentyl)-1H-indole-3-carboxylate. Some trade or other names: 5-fluoro-PB-22; 5F-PB-22.
(6) N-(1-amino-3-methyl-1-oxobutan-2-yl)-1-(4-fluorobenzyl)-1H-indazole-3-carboxamide. Some trade or other names: AB-FUBINACA.
(7) N-(1-amino-3,3-dimethyl-1-oxobutan-2-yl)-1-pentyl-1H-indazole-3-carboxamide. Some trade or other names: ADB-PINACA.
(8) N-(1-amino-3-methyl-1-oxobutan-2-yl)-1-(cyclohexylmethyl)-1H-indazole-3-carboxamide. Some trade or other names: AB-CHMINACA.
(9) N-(1-amino-3-methyl-1-oxobutan-2-yl)-1-pentyl-1H-indazole-3-carboxamide. Some trade or other names: AB-PINACA.
(10) {1-(5-fluoropentyl)-1H-indazol-3-yl}(naphthalen-1-y1)methanone. Some trade or other names: THJ-2201.

(h) (1) Cannabimimetic agents. Unless specifically exempted or unless listed in another schedule, any material, compound, mixture, or preparation that is not approved by the federal food and drug administration (FDA) which contains any quantity of cannabimimetic agents, or which contains their salts, isomers, and salts of isomers whenever the existence of such salts, isomers, and salts of isomers is possible within the specific chemical designation.
(2) As used in this subdivision, the term "cannabimimetic agents" means any substance that is a cannabinoid receptor type 1 (CB1 receptor) agonist as demonstrated by binding studies and functional assays within any of the following structural classes:
(i) 2-(3-hydroxycyclohexyl)phenol with substitution at the 5-position of the phenolic ring by alkyl or alkenyl, whether or not substituted on the cyclohexyl ring to any extent.
(ii) 3-(1-naphthoyl)indole or 3-(1-naphthylmethane)indole by substitution at the nitrogen atom of the indole ring, whether or not further substituted on the indole ring to any extent, whether or not substituted on the naphthoyl or naphthyl ring to any extent.
(iii) 3-(1-naphthoyl)pyrrole by substitution at the nitrogen atom of the pyrrole ring, whether or not further substituted in the pyrrole ring

to any extent, whether or not substituted on the naphthoyl ring to any extent.

(iv) 1-(1-naphthylmethylene)indene by substitution of the 3-position of the indene ring, whether or not further substituted in the indene ring to any extent, whether or not substituted on the naphthyl ring to any extent.

(v) 3-phenylacetylindole or 3-benzoylindole by substitution at the nitrogen atom of the indole ring, whether or not further substituted in the indole ring to any extent, whether or not substituted on the phenyl ring to any extent.

(3) Such term includes:

(i) 5-(1,1-dimethylheptyl)-2-{(1R,3S)-3-hydroxycyclohexyl}-phenol (CP-47,497);

(ii) 5-(1,1-dimethyloctyl)-2-{(1R,3S)-3-hydroxycyclohexyl}-phenol (cannabicyclohexanol or CP-47,497 C8-homolog);

(iii) 1-pentyl-3-(1-naphthoyl)indole (JWH-018 and AM678);

(iv) 1-butyl-3-(1-naphthoyl)indole (JWH-073);

(v) 1-hexyl-3-(1-naphthoyl)indole (JWH-019);

(vi) 1-{2-(4-morpholinyl)ethyl}-3-(1-naphthoyl)indole (JWH-200);

(vii) 1-pentyl-3-(2-methoxyphenylacetyl)indole (JWH-250);

(viii) 1-pentyl-3-{1-(4-methoxynaphthoyl)}indole (JWH-081);

(ix) 1-pentyl-3-(4-methyl-1-naphthoyl)indole (JWH-122);

(x) 1-pentyl-3-(4-chloro-1-naphthoyl)indole (JWH-398);

(xi) 1-(5-fluoropentyl)-3-(1-naphthoyl)indole (AM2201);

(xii) 1-(5-fluoropentyl)-3-(2-iodobenzoyl)indole (AM694);

(xiii) 1-pentyl-3-{(4-methoxy)-benzoyl}indole (SR-19 and RCS-4);

(xiv) 1-cyclohexylethyl-3-(2-methoxyphenylacetyl)indole (SR-18 and RCS-8); and

(xv) 1-pentyl-3-(2-chlorophenylacetyl)indole (JWH-203).

§ 8. This act shall take effect on the ninetieth day after it shall have become a law.

PART CC

Section 1. Intentionally omitted.

§ 2. Intentionally omitted.

§ 3. Paragraph (b) of subdivision 12 of section 230 of the public health law, as amended by chapter 599 of the laws of 1996, is amended to read as follows:

(b) When a licensee has pleaded or been found guilty or convicted of committing an act constituting a felony under New York state law or federal law, or the law of another jurisdiction which, if committed within this state, would have constituted a felony under New York state law, or when a licensee has been charged with committing an act constituting a felony under New York state or federal law or the law of another jurisdiction, where the licensee's alleged conduct, which, if committed within this state, would have constituted a felony under New York state law, and in the commissioner's opinion the licensee's alleged conduct constitutes an imminent danger to the health of the people, or when the duly authorized professional disciplinary agency of another jurisdiction has made a finding substantially equivalent to a finding that the practice of medicine by the licensee in that jurisdiction constitutes an imminent danger to the health of its people, or when a licensee has been disciplined by a duly authorized professional disciplinary agency of another jurisdiction for acts which if committed in this state would have constituted the basis for summary action by the

commissioner pursuant to paragraph (a) of this subdivision, the commissioner, after a recommendation by a committee of professional conduct of the state board for professional medical conduct, may order the licensee, by written notice, to discontinue or refrain from practicing medicine in whole or in part or to take certain actions authorized pursuant to this title immediately. The order of the commissioner shall constitute summary action against the licensee and become public upon issuance. The summary suspension shall remain in effect until the final conclusion of a hearing which shall commence within ninety days of the date of service of the commissioner's order, end within ninety days thereafter and otherwise be held in accordance with paragraph (a) of this subdivision, provided, however, that when the commissioner's order is based upon a finding substantially equivalent to a finding that the practice of medicine by the licensee in another jurisdiction constitutes an imminent danger to the health of its people, the hearing shall commence within thirty days after the disciplinary proceedings in that jurisdiction are finally concluded. **If, at any time, the felony charge is dismissed, withdrawn or reduced to a non-felony charge, the commissioner's summary order shall terminate.**

§ 4. This act shall take effect immediately.

PART DD

Section 1. Subdivisions 2 and 4 of section 6801 of the education law, as amended by chapter 46 of the laws of 2015, are amended to read as follows:

2. A licensed pharmacist may execute a non-patient specific regimen prescribed or ordered by a physician licensed in this state or nurse practitioner certified in this state, pursuant to rules and regulations promulgated by the commissioner. When a licensed pharmacist administers an immunizing agent, he or she shall:

(a) report such administration by electronic transmission or [~~fascimile~~] **facsimile** to the patient's attending primary health care practitioner or practitioners, if any, and, to the extent practicable, make himself or herself available to discuss the outcome of such immunization, including any adverse reactions, with the attending primary health care practitioner, [~~or~~] **and** to the statewide immunization registry or the citywide immunization registry, as established pursuant to section twenty-one hundred sixty-eight of the public health law; and

(b) provide information to the patient **or, where applicable, the person legally responsible for the patient,** on the importance of having a primary health care practitioner, developed by the commissioner of health; and

(c) report such administration, absent of any individually identifiable health information, to the department of health in a manner required by the commissioner of health[~~.~~]**; and**

(d) prior to administering the immunization, inform the patient **or, where applicable, the person legally responsible for the patient,** of the total cost of the immunization or immunizations, subtracting any health insurance subsidization, if applicable. In the case the immunization is not covered, the pharmacist must inform the patient **or, where applicable, the person legally responsible for the patient,** of the possibility that the immunization may be covered when administered by a primary care physician or practitioner; and

(e) administer the immunization or immunizations according to the most current recommendations by the advisory committee for immunization prac-

tices (ACIP), provided however, that a pharmacist may administer any immunization authorized under this section when specified by a patient specific order.

4. When administering an immunization in a pharmacy, the licensed pharmacist shall provide an area for the immunization that provides for a patient's privacy. The privacy area should include**:**

a. a clearly visible posting of the most current "Recommended Adult Immunization Schedule" published by the advisory committee for immunization practices (ACIP)**; and**

(b) education materials on influenza vaccinations for children as determined by the commissioner and the commissioner of health.

§ 2. Subdivision 22 of section 6802 of the education law, as amended by chapter 46 of the laws of 2015, is amended to read as follows:

22. "Administer", for the purpose of section sixty-eight hundred one of this article, means**:**

a. the direct application of an immunizing agent to adults, whether by injection, ingestion**, inhalation** or any other means, pursuant to a patient specific order or non-patient specific regimen prescribed or ordered by a physician or certified nurse practitioner, who has a practice site in the county or adjoining county in which the immunization is administered, for immunizations to prevent influenza, pneumococcal, acute herpes zoster, meningococcal, tetanus, diphtheria or pertussis disease and medications required for emergency treatment of anaphylaxis. If the commissioner of health determines that there is an outbreak of disease, or that there is the imminent threat of an outbreak of disease, then the commissioner of health may issue a non-patient specific regimen applicable statewide.

b. the direct application of an immunizing agent to children between the ages of two and eighteen years of age, whether by injection, ingestion, inhalation or any other means, pursuant to a patient specific order or non-patient specific regimen prescribed or ordered by a physician or certified nurse practitioner, who has a practice site in the county or adjoining county in which the immunization is administered, for immunization to prevent influenza and medications required for emergency treatment of anaphylaxis resulting from such immunization. If the commissioner of health determines that there is an outbreak of influenza, or that there is the imminent threat of an outbreak of influenza, then the commissioner of health may issue a non-patient specific regimen applicable statewide.

§ 2-a. Paragraph a of subdivision 3 of section 2168 of the public health law, as amended by chapter 420 of the laws of 2014, is amended to read as follows:

(a) **(i)** Any health care provider who administers any vaccine to a person less than nineteen years of age or, on or after September first, two thousand nine, conducts a blood lead analysis of a sample obtained from a person under eighteen years of age in accordance with paragraph (h) of subdivision two of this section; and immunizations received by a person less than nineteen years of age in the past if not already reported, shall report all such immunizations and the results of any blood lead analysis to the department in a format prescribed by the commissioner within fourteen days of administration of such immunizations or of obtaining the results of any such blood lead analysis. Health care providers administering immunizations to persons less than nineteen years of age in the city of New York shall report, in a format prescribed by the city of New York commissioner of health and mental hygiene, all such immunizations to the citywide immunization registry.

Health care providers who conduct a blood lead analysis on a person under eighteen years of age and who report the results of such analysis to the city of New York commissioner of health and mental hygiene pursuant to New York city reporting requirements shall be exempt from this requirement for reporting blood lead analysis results to the state commissioner of health; provided, however, blood lead analysis data collected from physician office laboratories by the commissioner of health and mental hygiene of the city of New York pursuant to the health code of the city of New York shall be provided to the department in a format prescribed by the commissioner.

(ii) A pharmacist who administers a vaccine pursuant to subdivision two of section sixty-eight hundred one of the education law, to a person less than nineteen years of age, shall report all such immunizations to the department in a format prescribed by the commissioner within fourteen days of administration of such immunizations. Pharmacists administering immunizations pursuant to subdivision two of section sixty-eight hundred one of the education law to persons less than nineteen years of age in the city of New York shall report, in a format prescribed by the city of New York commissioner of health and mental hygiene, all such immunizations to the citywide immunization registry.

§ 3. Section 8 of chapter 563 of the laws of 2008, amending the education law and the public health law relating to immunizing agents to be administered to adults by pharmacists, as amended by chapter 46 of the laws of 2015, is amended to read as follows:

§ 8. This act shall take effect on the ninetieth day after it shall have become a law and shall expire and be deemed repealed [~~July 1~~] **December 31**, 2019.

§ 4. Section 5 of chapter 116 of the laws of 2012, amending the education law relating to authorizing a licensed pharmacist and certified nurse practitioner to administer certain immunizing agents, as amended by chapter 46 of the laws of 2015, is amended to read as follows:

§ 5. This act shall take effect on the ninetieth day after it shall have become a law and shall expire and be deemed repealed [~~July 1~~] **December 31**, 2019 provided, that:

(a) the amendments to subdivision 7 of section 6527 of the education law made by section one of this act shall not affect the repeal of such subdivision and shall be deemed to be repealed therewith;

(b) the amendments to subdivision 7 of section 6909 of the education law, made by section two of this act shall not affect the repeal of such subdivision and shall be deemed to be repealed therewith;

(c) the amendments to subdivision 22 of section 6802 of the education law made by section three of this act shall not affect the repeal of such subdivision and shall be deemed to be repealed therewith; and

(d) the amendments to section 6801 of the education law made by section four of this act shall not affect the expiration of such section and shall be deemed to expire therewith.

§ 5. Section 5 of chapter 21 of the laws of 2011, amending the education law relating to authorizing pharmacists to perform collaborative drug therapy management with physicians in certain settings, as amended by chapter 238 of the laws of 2015, is amended to read as follows:

§ 5. This act shall take effect on the one hundred twentieth day after it shall have become a law [~~and~~]**, provided, however, that the provisions of sections two, three, and four of this act** shall expire 7 years after such effective date when upon such date the provisions of this act shall be deemed repealed; provided, however, that the amendments to subdivision 1 of section 6801 of the education law made by section one of this

act shall be subject to the expiration and reversion of such subdivision pursuant to section 8 of chapter 563 of the laws of 2008, when upon such date the provisions of section one-a of this act shall take effect; provided, further, that effective immediately, the addition, amendment and/or repeal of any rule or regulation necessary for the implementation of this act on its effective date are authorized and directed to be made and completed on or before such effective date.

§ 6. This act shall take effect immediately; provided, however the amendments to section 6801 of the education law made by section one of this act shall not affect the expiration of such section and shall be deemed to expire therewith; provided, further, that the amendments to subdivision 22 of section 6802 of the education law made by section two of this act shall not affect the expiration of such section and shall be deemed to expire therewith.

PART EE

Section 1. Subdivision (d) of section 13.17 of the mental hygiene law, as added by section 1 of part Q of chapter 59 of the laws of 2016, is amended to read as follows:

(d) In the event of a closure or transfer of a state-operated individualized residential alternative (IRA), the commissioner shall:

1. provide appropriate and timely notification to the temporary president of the senate, and the speaker of the assembly, and to appropriate representatives of impacted labor organizations. Such notification to the representatives of impacted labor organizations shall be made as soon as practicable, but no less than [~~forty-five~~] **one hundred eighty** days prior to **commencing** such closure or transfer except in the case of exigent circumstances impacting the health, safety, or welfare of the residents of the IRA as determined by the office. Provided, however, that nothing herein shall limit the ability of the office to effectuate such closure or transfer; and

2. make reasonable efforts to confer with the affected workforce and any other party he or she deems appropriate to inform such affected workforce, the residents of the IRA, and their family members, where appropriate, of the proposed closure or transfer plan.

§ 2. Section 2 of part Q of chapter 59 of the laws of 2016, amending the mental hygiene law relating to the closure or transfer of a state-operated individualized residential alternative, is amended to read as follows:

§ 2. This act shall take effect immediately and shall expire and be deemed repealed March 31, [~~2018~~] **2022**.

§ 3. This act shall take effect immediately, provided, however, that the amendments to subdivision (d) of section 13.17 of the mental hygiene law made by section one of this act shall not affect the repeal of such subdivision and shall be deemed repealed therewith.

PART FF

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 NN of chapter 58 of the laws of 2017, 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, [~~2018~~] 2019 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.

PART GG

Section 1. 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.

§ 2. 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 cover-

age 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.

§ 3. 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.

§ 4. This act shall take effect immediately.

PART HH

Section 1. The mental hygiene law is amended by adding a new section 33.27 to read as follows:

§ 33.27 Independent behavioral health ombudsman.

(a) There is hereby established the office of the independent behavioral health ombudsman under the purview of the office of alcoholism and substance abuse services and the office of mental health for the purpose of assisting individuals with a substance use disorder and/or mental illness in accessing appropriate behavioral health services.

(b) The behavioral health ombudsman shall assist: (i) individuals and their families with filing and resolving complaints regarding a denial of benefits, care, coverage or an alleged violation of state or federal parity laws; (ii) both insured and uninsured individuals and their families with understanding their rights to coverage and necessary treatment; and (iii) treatment providers with in-depth training and educational materials on how to navigate insurance coverage as well as how to address barriers to care.

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

PART II

Section 1. The public health law is amended by adding a new section 4410-a to read as follows:

§ 4410-a. Disposition of charitable asset. 1. This section applies to any transaction with respect to a health care corporation subject to article thirty-two or forty-three of the insurance law or this article involving:

(a) any sale, lease, transfer, exchange, option, conveyance, gift, joint venture, merger, consolidation or disposition of all or a material portion of the assets of the health care corporation;

(b) any transfer of control, responsibility or governance over all or substantially all of the assets of the health care corporation; or

(c) continuation of the corporate existence of the applicant by reconstituting the corporate form of the applicant from a not-for-profit corporation to a business corporation by the filing of a restated certificate of incorporation regardless of whether such changes occur in one transaction or in a series of transactions.

2. All money and other assets received by or on behalf of the state or any state governmental entity related to any transaction under this section shall be immediately deposited in the health care stabilization account under section ninety-two-gg of the state finance law, to be spent, used or disposed of only under law or appropriation referring to this section. This subdivision shall not preclude investment of any money in the account under the state finance law, provided that the proceeds of such investment shall be deposited in the account.

3. If any provision or application of this section conflicts with sections four thousand three hundred one or seven thousand three hundred seventeen of the insurance law, this section shall apply. This section shall be deemed to comply with sections five hundred ten, five hundred eleven and five hundred eleven-a of the not-for-profit corporation law.

4. Funds or assets in the health care stabilization account shall be used or disposed of for health, health care and health coverage purposes, subject to appropriation and in accordance with a memorandum of understanding signed by the governor, the temporary president of the senate and the speaker of the assembly, or their designated representatives.

5. If any provision of this section, or any application of any provision of this section, is held to be invalid, or to violate or be inconsistent with any federal law or regulation, that shall not affect the validity or effectiveness of any other provision of this section, or of any other application of any provision of this section, which can be given effect without that provision or application; and to that end, the provisions and applications of this section are severable.

§ 2. The state finance law is amended by adding a new section 92-gg to read as follows:

§ 92-gg. Health care stabilization account. 1. There is hereby established in the joint custody of the comptroller and the commissioner of taxation and finance a fund to be known as the "health care stabilization account."

2. The health care stabilization account shall consist of all moneys and assets deposited to such fund pursuant to section forty-four hundred ten-a of the public health law and any other monies credited, deposited or transferred thereto.

3. All moneys and assets in such fund shall be subject to the requirement of section forty-four hundred ten-a of the public health law and shall only be used or disposed of for health, health care and health coverage purposes, subject to appropriation and in accordance with a memorandum of understanding signed by the governor, the temporary president of the senate and the speaker of the assembly, or their designated representatives. Notwithstanding any inconsistent provision of law, funds shall not be transferred from such fund without the execution of such memorandum of understanding.

§ 3. This act shall take effect immediately.

PART JJ

Section 1. Section 3-d of part B of chapter 58 of the laws of 2010, amending 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 reimbursement, is REPEALED.

§ 2. 1. Notwithstanding any provision of law, rule or regulation to the contrary, and subject to the availability of federal financial participation, for periods on and after April 1, 2010, payments made to managed care providers sponsored by or otherwise having entered into health care services contract with a public benefit corporation located in a city of more than one million persons which provide coverage to Medicaid patients in accordance with section 364-j of the social services law may, at the election of the social services district, be increased up to the maximum amount permitted under title XIX of the social security act for the benefit of such public benefit corporation; provided, however that, notwithstanding the social services district Medicaid cap provisions of part C of chapter 58 of the laws of 2005, such social services district shall be responsible for payment of one hundred percent of the non-federal share of such increase, and provided further, however, that such payment increases shall not be applied to payments related to the Medicaid advantage program or the HIV special needs plan. Social services district funding of the non-federal share of any such payments shall be deemed to be voluntary for purposes of the increased federal medical assistance percentage provisions of the American Recovery and Reinvestment Act of 2009; provided however that, in the event the federal Centers for Medicare and Medicaid Services determines that such non-federal share payments are not voluntary payments for

purposes of such Act, the provisions of this section shall be null and void.

2. Notwithstanding any contrary provision of law, the social services district in which such public benefit corporation is primarily located shall be responsible for the increase to payments as determined in accordance with this section for services covered by such managed care provider in accordance with section 365-a of the social services law, regardless of whether another social services district or the department of health may otherwise be responsible for furnishing medical assistance to the eligible persons receiving such services.

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