STATE OF NEW YORK

S. 2007 A. 3007

SENATE - ASSEMBLY

January 23, 2017

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

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

AN ACT to amend the insurance law and the public health law, in relation to the early intervention program for infants and toddlers with disabilities and their families (Part A); to amend the public health law, in relation to the general public health work program (Part B); to amend the social services law, in relation to requiring monthly premium payments for the Essential Plan (Part C); to amend the public health law, in relation to high cost drugs; to amend the tax law, in relation to surcharges on high priced drugs; to amend the tax law, in relation to secrecy provisions; to amend the state finance law, in relation to the high priced drug reimbursement fund; to amend the social services law, in relation to the drug utilization review board; to amend the social services law, in relation to Medicaid reimbursement of covered outpatient drugs; to authorize the suspension of a provider's Medicaid enrollment for inappropriate prescribing of opioids; to amend the social services law, in relation to refills of controlled substances; to amend the public health law and the social services law, in relation to eliminating prescriber prevails with the exception of mental health medications; to amend the public health law, in relation to authorizing for comprehensive medication management by pharmacists; to amend the social services law, in relation to reducing Medicaid coverage and increasing copayments for non-prescription drugs, to aligning pharmacy copayment requirements with federal regulations, and to adjusting consumer price index penalties for generic drugs; and to repeal subdivision 25-a of section 364-j of the social services law, relating to the coverage of certain medically necessary prescription drugs by managed care providers (Part D); to amend the public health law, in relation to restricting enrollment in the medicaid managed long term care program to individuals who require a nursing home level of care and to eliminate payments to nursing homes for bed hold days; to amend the social services law, in relation

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

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to conforming with federal law with regard to spousal contributions; to amend the social services law, in relation to hospice services covered under title XVIII of the federal social security act; and to repeal subdivision 25 of section 2808 of the public health law relating to reserved bed days (Part E); to amend the social services law, in relation to carving out transportation from the managed long term care benefit; to repeal subdivision 5 of section 365-h of the social services law, relating to rural transit assistance payments to counties; and to repeal section 367-s of the social services law, relating to emergency medical transportation services (Part F); to amend 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, in relation to extending the Medicaid global cap; to create an avenue for contract staff and student assistants in the department of health's office of health insurance programs to qualify for open competitive positions and to establish a health care service career internship program; and to amend 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 the administration thereof, in relation to an administrative cap on such program (Part G); to amend the New York Health Care Reform Act of 1996, in relation to extending certain provisions relating thereto; to amend the New York Health Care Reform Act of 2000, in relation to extending the effectiveness of provisions thereof; to amend the public health law, in relation to the distribution of pool allocations and graduate medical education; to amend the public health law, in relation to health care initiative pool distributions; to amend the social services law, in relation to extending payment provisions for general hospitals; and to amend the public health law, in relation to the assessments on covered lives (Part H); to amend chapter 884 of the laws of 1990, amending the public health law relating to authorizing bad debt and charity care allowances for certified home health agencies, in relation to the effectiveness thereof; to amend chapter 60 of the laws of 2014 amending the social services law relating to eliminating prescriber prevails for brand name drugs with generic equivalents, in relation to the effectiveness thereof; to amend the public health law, in relation to extending the nursing home cash assessment; to amend chapter 474 of the laws of 1996, amending the education law and other laws relating to rates for residential health care facilities, in relation to the effectiveness thereof; to amend chapter 58 of the laws of 2007, amending the social services law and other laws relating to enacting the major components of legislation necessary to implement the health and mental hygiene budget for the 2007-2008 state fiscal year, in relation to delay of certain administrative cost; to amend chapter 81 of the laws of 1995, amending the public health law and other laws relating to medical reimbursement and welfare reform, in relation to the effectiveness thereof; to amend chapter 109 of the laws of 2010, amending the social services law relating to transportation costs, in relation to the effectiveness thereof; to amend chapter 56 of the laws of 2013 amending chapter 59 of the laws of 2011, amending the public health law and other laws relating to general hospital reimbursement for annual rates relating to the cap on local Medicaid expenditures, in relation to the effectiveness thereof; to amend chapter 2 of the laws of 1998, amending the public health law and other laws relating to expanding the child health insurance plan, in relation to the effectiveness thereof;

to amend chapter 19 of the laws of 1998, amending the social services law relating to limiting the method of payment for prescription drugs under the medical assistance program, in relation to the effectiveness thereof; to amend the public health law, in relation to continuing nursing home upper payment limit payments; to amend chapter 904 of the laws of 1984, amending the public health law and the social services law relating to encouraging comprehensive health services, in relation to the effectiveness thereof; to amend chapter 62 of the laws of 2003, amending the public health law relating to allowing for the use of funds of the office of professional medical conduct for activities of the patient health information and quality improvement act of 2000, in relation to extending the provisions thereof; to amend chapter 59 of the laws of 2011, amending the public health law relating to the statewide health information network of New York and the statewide planning and research cooperative system and general powers and duties, in relation to the effectiveness thereof; and to amend chapter 58 of the laws of 2008, amending the elder law and other laws relating to reimbursement to participating provider pharmacies and prescription drug coverage, in relation to extending the expiration of certain provisions thereof (Part I); to amend the insurance law, in relation to pharmacy benefit managers (Part J); to amend the public health law, in relation to the health care facility transformation program (Part K); to amend the public health law, in relation to establishing a health care regulation modernization team within the department of health (Part L); to amend the public health law, in relation to creating the "Emerging Contaminant Monitoring Act" (Part M); to amend the public health law, the real property law, and the environmental conservation law, in relation to creating the "residential well testing act" (Part N); to amend the criminal procedure law, in relation to authorizing restorations to competency within correctional facility based residential settings; and providing for the repeal of such provisions upon expiration thereof (Part O); to amend chapter 56 of the laws of 2013 amending chapter 59 of the laws of 2011 amending the public health law and other laws relating to general hospital reimbursement for annual rates relating to the cap on local Medicaid expenditures, in relation to extending government rates for behavioral services and adding a value based payment requirement; and to amend chapter 111 of the laws of 2010 relating to increasing Medicaid payments to providers through managed care organizations and providing equivalent fees through an ambulatory patient group methodology, in relation to extending government rates for behavioral services and adding a value based payment requirement (Part P); and to amend chapter 57 of the laws of 2006, relating to establishing a cost of living adjustment for designated human services programs, in relation to forgoing such adjustment during the 2017-2018 state fiscal year and the effectiveness thereof (Part Q)

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

Section 1. This act enacts into law major components of legislation which are necessary to implement the state fiscal plan for the 2017-2018 state fiscal year. Each component is wholly contained within a Part identified as Parts A through Q. The effective date for each particular provision contained within such Part is set forth in the last section of

such Part. Any provision in any section contained within a Part, including the effective date of the Part, which makes a reference to a section "of this act", when used in connection with that particular component, shall be deemed to mean and refer to the corresponding section of the Part in which it is found. Section three of this act sets forth the general effective date of this act.

PART A

Section 1. Paragraph 2 of subsection (d) of section 3224-a of the insurance law, as amended by section 57-b of part A of chapter 56 of the laws of 2013, is amended to read as follows:

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

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

§ 3235-a. Payment for early intervention services. (a) No policy of accident and health insurance, including contracts issued pursuant to article forty-three of this chapter, shall exclude coverage for otherwise covered services solely on the basis that the services constitute early intervention program services under title two-A of article twenty-five of the public health law.

(b) Where a policy of accident and health insurance, including a contract issued pursuant to article forty-three of this chapter, provides coverage for an early intervention program service, such coverage shall not be applied against any maximum annual or lifetime monetary limits set forth in such policy or contract. **When such policy of accident and health insurance, including a contract issued pursuant to article forty-three of this chapter, provides coverage for services that constitutes early intervention services as set forth in paragraph (h) of subdivision seven of section twenty five-hundred forty-one of the public health law or early intervention evaluation services as set forth in subdivision nine of section twenty-five hundred forty-one of the public health law, or provides coverage for autism spectrum disorder pursuant to paragraph twenty-five of subsection (i) of section thirty-two hundred sixteen, paragraph seventeen of subsection (l) of section thirty-two hundred twenty-one, or subsection (ee) of section forty-three hundred three of this chapter, the insurer shall pay for such services to the extent that the services are a covered benefit under the policy. Any documentation obtained pursuant to clause (ii) of paragraph (a) of subdivision three of section twenty-five hundred fifty-nine of the public health law and submitted to the insurer shall be sufficient to meet precertification, preauthorization and/or medical necessity requirements imposed under such policy of accident and health insurance, including a contract issued pursuant to article forty-three of this**

chapter. Visit limitations and other terms and conditions of the policy will continue to apply to early intervention services. However, any visits used for early intervention program services shall not reduce the number of visits otherwise available under the policy or contract for such services.

(c) A policy of accident and health insurance, including a contract issued pursuant to article forty-three of this chapter, shall not deny coverage based upon the following:

(i) the location where services are provided; or

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

(d) Any right of subrogation to benefits which a municipality or provider is entitled in accordance with paragraph (d) of subdivision three of section twenty-five hundred fifty-nine of the public health law shall be valid and enforceable to the extent benefits are available under any accident and health insurance policy. The right of subrogation does not attach to insurance benefits paid or provided under any accident and health insurance policy prior to receipt by the insurer of written notice from the municipality or provider, as applicable. [~~The~~] An insurer shall, within fifteen business days of receipt of a notice of right of subrogation, notify the provider, in a format determined by the department of health, through the department of health's designated fiscal agent, whether the policy is fully insured or whether the insurer is acting as a third party administrator.

(e) Upon receipt of written request and notice from the municipality and service coordinator the insurer shall provide [~~the~~] such municipality and service coordinator with information on the extent of benefits available to the covered person under such policy, including whether the policy is fully insured or whether the insurer is acting as a third party administrator, within fifteen days of the insurer's receipt of written request and notice authorizing such release. The service coordinator shall provide such information to the rendering provider assigned to provide services to the child.

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

§ 3. Subdivision 3 of section 2543 of the public health law, as added by section 2 of part B3 of chapter 62 of the laws of 2003, is amended to read as follows:

3. [~~The~~] In a format prescribed by the department, the parent of the eligible child shall provide and the early intervention official, service coordinator, and provider shall collect such information and or documentation as is necessary and sufficient to determine the eligible child's third party payor coverage and to seek payment from all third party payors including the medical assistance program and other governmental agency payors.

§ 4. Subdivision 3-a of section 2557 of the public health law, as added by section 3 of part L1 of chapter 63 of the laws of 2003, is amended to read as follows:

3-a. Each municipality may perform an audit, which may include site visitation, of evaluators and providers of such services within its

municipality in accordance with standards established by the commissioner. The municipality shall submit the results of any such audit to the commissioner for review and, if warranted, adjustments in state aid reimbursement pursuant to subdivision three of this section[~~, as well as for~~]. The results shall also include any recovery by the municipality of its share of any disallowances identified in such audit.

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

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

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

(ii) [~~Parents~~] In a timeline and format as prescribed by the department, the municipality shall request from the parent, and the parent shall provide the municipality [~~and the service coordinator~~], who shall provide such documentation to the service coordinator and provider, with: (A) a written order, referral [~~from a~~] or recommendation, signed by the child's primary health care provider, for the medical necessity of early intervention evaluation services to determine program eligibility or early intervention services;

(B) a copy of an individualized family service plan agreed upon pursuant to section twenty-five hundred forty-five of this title that contains documentation, signed by the child's primary [~~care~~] health care provider [~~as documentation, for eligible children, of~~] on the medical necessity of early intervention services included in the individualized family services plan;

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

(D) written consent to contact the child's primary health care provider for purposes of obtaining a signed documentation of the medical necessity of early intervention services contained within the individualized family service plan agreed upon pursuant to section twenty-five hundred forty-five of this title.

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

(iv) In accordance with criteria established by the department, which may include, but not be limited to, medical necessity, coordination of benefits, or utilization review, for pursuit of appeals by a provider to an insurer when a claim has been denied by such insurer, the department or the department's fiscal agent may request the provider appeal a denial for payment by a third party payor prior to claiming payment to

the municipality for the services provided in accordance with section twenty-five hundred fifty-seven of this title. Providers shall not discontinue or delay services to eligible children pending payment of the claim or determinations of any appeal denials.

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

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

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

PART B

Section 1. Subdivision 2 of section 605 of the public health law, as amended by section 20 of part E of chapter 56 of the laws of 2013, is amended to read as follows:

2. State aid reimbursement for public health services provided by a municipality under this title, shall be made if the municipality is providing some or all of the core public health services identified in section six hundred two of this title, pursuant to an approved application for state aid, at a rate of no less than thirty-six per centum**, except for a city with a population of one million or more persons, which shall receive no less than twenty-nine per centum,** of the difference between the amount of moneys expended by the municipality for public health services required by section six hundred two of this title during the fiscal year and the base grant provided pursuant to subdivision one of this section. No such reimbursement shall be provided for services that are not eligible for state aid pursuant to this article.

§ 2. Subdivision 1 of section 616 of the public health law, as amended by section 27 of part E of chapter 56 of the laws of 2013, is amended to read as follows:

1. The total amount of state aid provided pursuant to this article shall be limited to the amount of the annual appropriation made by the legislature. In no event, however, shall such state aid be less than an amount to provide the full base grant and, as otherwise provided by [~~paragraph (a) of~~] subdivision two of section six hundred five of this article, at least thirty-six per centum**, except for a city with a population of one million or more persons, which shall receive no less than twenty-nine per centum,** of the difference between the amount of moneys

expended by the municipality for eligible public health services pursuant to an approved application for state aid during the fiscal year and the base grant provided pursuant to subdivision one of section six hundred five of this article.

§ 3. This act shall take effect July 1, 2017.

PART C

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

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

(i) up to twenty dollars monthly for an individual with a household income above one hundred and [~~fifty~~] **thirty-eight** percent of the federal poverty line but at or below two hundred percent of the federal poverty line defined and annually revised by the United States department of health and human services for a household of the same size; **beginning in two thousand eighteen and annually thereafter, such amount shall be increased based on the percentage increase in the medical consumer price index, rounded up to the nearest dollar;** and

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

(b) The commissioner shall establish cost sharing obligations for enrollees, subject to federal approval.

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

PART D

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

§ 280. High cost drugs. 1. Legislative purpose. There is hereby declared to be a significant public interest in the transparency of the costs and prices of drugs, and in being able to review the economic value of certain drugs to the public. This would benefit the citizens of the state who have a medical need for such drugs and whose tax dollars contribute to making such drugs available to the recipients of public health insurance programs. It is therefore intended that the department collect information related to drug costs and prices, and with the assistance of the drug utilization review board established by section three hundred sixty-nine-bb of the social services law, identify high priced drugs for which a per-unit benchmark price can be determined. Such drugs will be subject to the rebate provisions of subdivision six of this section if the drugs are paid for by the Medicaid program, and to a surcharge in accordance with the provisions of article twenty-C of the tax law.

2. High priced drugs. (a) The department may identify, for review, drugs which:

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

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

(iii) are priced disproportionally given that they offer limited therapeutic benefits.

(b) Drugs identified by the department for review may include:

(i) brand name or generic drugs;

(ii) drugs produced by multiple manufacturers or by a single manufacturer;

(iii) drugs reimbursed by commercial and/or public payers; and

(iv) prescription and non-prescription drugs.

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

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

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

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

(iv) the extent of utilization of the drug;

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

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

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

(viii) the average profit margin of each drug over the prior five-year period and the projected profit margin anticipated for such drug.

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

(c) All information disclosed pursuant to paragraph (a) of this subdivision shall be considered confidential and shall not be disclosed by the department in a form that identifies a specific manufacturer or prices charged for drugs by such manufacturer, except as the commissioner determines is necessary to carry out this section, or to allow the department, the attorney general, the state comptroller, or the centers for Medicare and Medicaid services to perform audits or investigations authorized by law.

4. Review of drug cost and pricing. The department may refer cost and pricing information collected pursuant to subdivision three of this section with respect to a particular drug to the drug utilization review board, and request the board to recommend a value-based, per-unit benchmark price for the drug, taking into consideration such cost and pricing information as well as other factors, including but not limited to:

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

(b) the extent of utilization of the drug;

(c) the effectiveness of the drug in treating the conditions for which it is prescribed;

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

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

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

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

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

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

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

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

ARTICLE 20-C
SURCHARGE ON HIGH PRICED DRUGS

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

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

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

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

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

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

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

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

2. Every establishment liable for the surcharge imposed by this article shall, on or before the twentieth date of each month, file with the commissioner a return, on forms to be prescribed by the commissioner, showing the total excess charge amount of its gross receipt from the first sale in the state of high priced drugs during the preceding calendar month and the amount of surcharge due thereon. Such returns shall contain such further information as the commissioner may require. Every establishment required to file a return under this section shall, at the time of filing such return, pay to the commissioner the total amount of surcharge due on such first sales of high priced drugs for the period covered by such return. If a return is not filed when due, the surcharge shall be due on the day on which the return is required to be filed.

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

4. Whenever the commissioner shall determine that any moneys received under the provisions of this article were paid in error, he may cause the same to be refunded, with interest, in accordance with such rules and regulations as he or she may prescribe, except that no interest shall be allowed or paid if the amount thereof would be less than one dollar. Such interest shall be at the overpayment rate set by the

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

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

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

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

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

health shall notify the manufacturer of such drug and the department that the drug has been determined to be a high priced drug.

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

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

§ 494. Returns to be secret. 1. Except in accordance with proper judicial order or as in this section or otherwise provided by law, it shall be unlawful for the commissioner, any officer or employee of the department, or any officer or person who, pursuant to this section, is permitted to inspect any return or report or to whom a copy, an abstract or a portion of any return or report is furnished, or to whom any information contained in any return or report is furnished, or any person engaged or retained by such department on an independent contract basis or any person who in any manner may acquire knowledge of the contents of a return or report filed pursuant to this article to divulge or make known in any manner the contents or any other information relating to the business of an establishment contained in any return or report required under this article. The officers charged with the custody of such returns or reports shall not be required to produce any of them or evidence of anything contained in them in any action or proceeding in any court, except on behalf of the state, the state department of health, the state department of education or the commissioner in an action or proceeding under the provisions of this chapter or on behalf of the state or the commissioner in any other action or proceeding involving the collection of a tax due under this chapter to which the state or the commissioner is a party or a claimant or on behalf of any party to any action or proceeding under the provisions of this article, when the returns or the reports or the facts shown thereby are directly involved in such action or proceeding, or in an action or proceeding relating to the regulation or surcharge of high priced drugs on behalf of officers to whom information shall have been supplied as provided in subsection two of this section, in any of which events the court may require the production of, and may admit in evidence so much of said returns or reports or of the facts shown thereby as are pertinent to the action or proceeding and no more. Nothing herein shall be construed to prohibit the commissioner, in his or her discretion, from allowing the inspection or delivery of a certified copy of any return or report filed under this article or of any information contained in any such return or report by or to a duly authorized officer or employee of the state department of health or the state department of education; or by or to the attorney general or other legal representatives of the state when an action shall have been recommended or commenced pursuant to this chapter in which such returns or reports or the facts shown thereby are directly involved; or the inspection of the returns or reports required under this article by the comptroller or duly designated officer or employee of the state department of audit and control, for purposes of the audit of a refund of any surcharge paid by an establishment or other person under this article; nor to prohibit the delivery to an establishment, or a duly authorized representative of such establishment, a certified copy of any return or report filed by such establishment pursuant to this article, nor to prohibit the publication of statistics so classified as

to prevent the identification of particular returns or reports and the items thereof.

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

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

(b) Cross-reference: For criminal penalties, see article thirty-seven of this chapter.

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

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

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

§ 89-j. High Priced Drug Reimbursement Fund. 1. There is hereby established in the sole custody of the superintendent of financial

services an agency fund, to be known as the "High Priced Drug Reimbursement Fund."

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

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

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

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

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

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

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

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

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

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

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

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

(ii) Two persons who are health care economists.
(g) One person who is an actuary.
(h) One person representing the department of financial services.

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

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

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

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

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

(C) the state maximum acquisition cost, if any, established pursuant to paragraph (e) of this subdivision; or (D) the dispensing pharmacy's usual and customary price charged to the general public;

(ii) if the drug dispensed is [~~a multiple source prescription drug or~~] a brand-name prescription drug [~~for which no specific upper limit has been set by such federal agency~~], the lower of [~~the estimated acquisition cost of such drug to pharmacies or the dispensing pharmacy's usual and customary price charged to the general public. For sole and multiple source brand name drugs, estimated acquisition cost means the average wholesale price of a prescription drug based upon the package size dispensed from, as reported by the prescription drug pricing service used by the department, less seventeen percent thereof or the wholesale acquisition cost of a prescription drug based upon package size dispensed from, as reported by the prescription drug pricing service used by the department, minus zero and forty-one hundredths percent thereof, and updated monthly by the department. For multiple source generic drugs, estimated acquisition cost means the lower of the average wholesale price of a prescription drug based on the package size dispensed from, as reported by the prescription drug pricing service used by the department, less twenty-five percent thereof, or the maximum acquisition cost, if any, established pursuant to paragraph (e) of this subdivision, provided that the methodology used by the department to establish a maximum acquisition cost shall not include average acquisition cost as determined by department surveys.~~]:

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

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

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

~~(ii) for prescription drugs categorized as brand-name prescription drugs by the prescription drug pricing service used by the department, three dollars and fifty cents per prescription, provided, however, that for brand name prescription drugs reimbursed pursuant to subparagraph (ii) of paragraph (a-1) of subdivision four of section three hundred sixty-five-a of this title, the dispensing fee shall be four dollars and fifty cents per prescription~~] in the amount of ten dollars per prescription or written order of a practitioner; provided, however that this professional dispensing fee will not apply to drugs that are available without a prescription as required by section sixty-eight hundred ten of the education law but do not meet the definition of a covered outpatient drug pursuant to Section 1927K of the Social Security Act.

§ 8. It shall be an unacceptable practice in the Medicaid program established pursuant to title 11 of article 5 of the social services law

for a provider to prescribe opioids in violation of the requirements of paragraph (g-1) of subdivision 2 of section 365-a of such law, in violation of any other applicable law limiting or restricting the prescribing of opioids, and/or contrary to recommendations issued by the drug utilization review board established by section 369-bb of the social services law, and such practice may result in the provider being excluded from participation in the Medicaid program.

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

(g-1) drugs provided on an in-patient basis, those drugs contained on the list established by regulation of the commissioner of health pursuant to subdivision four of this section, and those drugs which may not be dispensed without a prescription as required by section sixty-eight hundred ten of the education law and which the commissioner of health shall determine to be reimbursable based upon such factors as the availability of such drugs or alternatives at low cost if purchased by a medicaid recipient, or the essential nature of such drugs as described by such commissioner in regulations, provided, however, that such drugs, exclusive of long-term maintenance drugs, shall be dispensed in quantities no greater than a thirty day supply or one hundred doses, whichever is greater; provided further that the commissioner of health is authorized to require prior authorization for any refill of a prescription when more than a ten day supply of the previously dispensed amount should remain were the product used as normally indicated**, or in the case of a controlled substance, as defined in section thirty-three hundred two of the public health law, when more than a seven day supply of the previously dispensed amount should remain were the product used as normally indicated**; provided further that the commissioner of health is authorized to require prior authorization of prescriptions of opioid analgesics in excess of four prescriptions in a thirty-day period in accordance with section two hundred seventy-three of the public health law; medical assistance shall not include any drug provided on other than an in-patient basis for which a recipient is charged or a claim is made in the case of a prescription drug, in excess of the maximum reimbursable amounts to be established by department regulations in accordance with standards established by the secretary of the United States department of health and human services, or, in the case of a drug not requiring a prescription, in excess of the maximum reimbursable amount established by the commissioner of health pursuant to paragraph (a) of subdivision four of this section;

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

(b) In the event that the patient does not meet the criteria in paragraph (a) of this subdivision, the prescriber may provide additional information to the program to justify the use of a prescription drug that is not on the preferred drug list. The program shall provide a reasonable opportunity for a prescriber to reasonably present his or her justification of prior authorization. [**~~If, after consultation with the program, the prescriber, in his or her reasonable professional judgment, determines that the use of a prescription drug that is not on the preferred drug list is warranted, the prescriber's determination shall be final.~~**] **The program shall consider the additional information and the justification presented to determine whether the use of a prescription drug that is not on the preferred drug list is warranted. In the case of**

atypical antipsychotics and antidepressants, if, after consultation with the program, the prescriber, in his or her reasonable professional judgment, determines that the use of a prescription drug that is not on the preferred drug list is warranted, the prescriber's determination shall be final.

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

25. [~~Effective January first, two thousand thirteen, notwithstanding~~] Notwithstanding any provision of law to the contrary, managed care providers shall cover medically necessary prescription drugs in the atypical antipsychotic and antidepressant therapeutic [~~class~~] classes, including non-formulary drugs, upon demonstration by the prescriber, after consulting with the managed care provider, that such drugs, in the prescriber's reasonable professional judgment, are medically necessary and warranted.

§ 12. Subdivision 25-a of section 364-j of the social services law is REPEALED.

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

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

(a) "qualified pharmacist" means a pharmacist who maintains a current unrestricted license pursuant to article one hundred thirty-seven of the education law and who has completed one or more programs, accredited by the Accreditation Council for Pharmacy Education, for the medication management of a chronic disease or diseases;

(b) "comprehensive medication management" means a program that ensures a patient's medications, whether prescription or nonprescription, are individually assessed to determine that each medication is appropriate for the patient, effective for the medical condition, safe given comorbidities and other medications being taken, and able to be taken by the patient as intended;

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

2. A physician licensed pursuant to article one hundred thirty-one of the education law or a nurse practitioner certified pursuant to section sixty-nine hundred ten of the education law shall be authorized to voluntarily establish a comprehensive medication management protocol with a qualified pharmacist to provide comprehensive medication management services for a patient who has not met clinical goals of therapy, is at risk for hospitalization, or for whom the physician or nurse practitioner deems it is necessary to receive comprehensive medication management services. Participation by the patient in comprehensive medication management services shall be voluntary.

3. Under a comprehensive medication management protocol, a qualified pharmacist shall be permitted to:

(a) adjust or manage a drug regimen of the patient, which may include adjusting drug strength, frequency of administration or route of administration, discontinuance of therapy or initiation of a drug which differs from that initially prescribed by the patient's physician or nurse practitioner;

(b) evaluate and only to the next extent necessary to discharge the responsibility set forth in this section, order or perform routine patient monitoring functions or disease state laboratory tests related to comprehensive medication management for the specific chronic disease or diseases, specified within the comprehensive medication management protocol;

(c) access the complete patient medical record maintained by the physician or nurse practitioner with whom he or she has the comprehensive medication management protocol and shall document any adjustments made pursuant to the protocol in the patient's medical record and shall notify the patient's treating physician or nurse practitioner in a timely manner electronically or by other means. Under no circumstances, shall the qualified pharmacist be permitted to delegate comprehensive medication management services to any other licensed pharmacist or other pharmacy personnel.

4. Any medication adjustments made by the qualified pharmacist pursuant to the comprehensive medication management protocol, including adjustments in drug strength, frequency or route of administration, or initiation of a drug which differs from that initially prescribed and as documented in the patient medical record, shall be deemed an oral prescription authorized by an agent of the patient's treating physician or nurse practitioner and shall be dispensed consistent with section sixty-eight hundred ten of the education law.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

§ 19. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2017; provided, however, that sections nine, fourteen, fifteen, sixteen, and seventeen of this act shall take effect July 1, 2017; provided, further, that the amendments to section 364-j of the social services law made by section eleven of this act shall not affect the repeal of such section and shall be deemed repealed therewith; provided, further, that the amendments to paragraph (c) of subdivision 6 of section 367-a of the social services law made by sections fifteen and sixteen of this act shall not affect the repeal of such paragraph and shall be deemed repealed therewith; provided, further, that the amendments to paragraph (f) of subdivision 7 of section 367-a of the social services law made by section seventeen of this act shall not affect the repeal of such paragraph and shall be deemed repealed therewith; and provided, further, that the amendments to subdivision 9 of section 367-a of the social services law made by section seven of this act shall not affect the expiration of such subdivision and shall be deemed to expire therewith.

PART E

Section 1. Subparagraph (i) of paragraph (b) of subdivision 7 of section 4403-f of the public health law, as amended by section 41-b of part H of chapter 59 of the laws of 2011, is amended to read as follows:

(i) The commissioner shall, to the extent necessary, submit the appropriate waivers, including, but not limited to, those authorized pursuant to sections eleven hundred fifteen and nineteen hundred fifteen of the federal social security act, or successor provisions, and any other waivers necessary to achieve the purposes of high quality, integrated, and cost effective care and integrated financial eligibility policies under the medical assistance program or pursuant to title XVIII of the federal social security act. In addition, the commissioner is authorized to submit the appropriate waivers, including but not limited to those authorized pursuant to sections eleven hundred fifteen and nineteen hundred fifteen of the federal social security act or successor provisions, and any other waivers necessary to require on or after April first, two thousand twelve, medical assistance recipients who are twenty-one years of age or older and who require community-based long term care services, as specified by the commissioner, for a continuous period of more than one hundred and twenty days from date of enrollment, 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, provided, however, that on or after October first, two thousand seventeen, the commissioner may, through such an approved waiver, further limit eligibility to available plans to enrollees that require nursing facility level of care. Notwithstanding the foregoing, medical assistance recipients enrolled in a managed long term care plan on October first, two thousand seventeen may continue to be eligible for such plans, irrespective of whether the enrollee meets any applicable nursing facility level of care requirements, provided, however, that once such recipients are disenrolled from their managed long term care plan, any applicable nursing facility level of care requirements would apply to future eligibility determinations. 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. Subdivision 25 of section 2808 of the public health law is REPEALED.

§ 3. Paragraph (b) of subdivision 5 of section 2801-e of the public health law, as amended by chapter 257 of the laws of 2005, is amended to read as follows:

(b) Notwithstanding any inconsistent provision of law or regulation to the contrary, for purposes of determining medical assistance payments by government agencies for residential health care facility services provided pursuant to title eleven of article five of the social services law for facilities that have temporarily decertified beds:

(i) the facility's capital cost reimbursement shall be adjusted to appropriately take into account the new bed capacity of the facility; and

(ii) the facility's peer group assignment for indirect cost reimbursement shall be based on its total certified beds less the number of beds that have been temporarily decertified[~~; and~~

~~(iii) the facility's vacancy rate shall be calculated on the basis of its total certified beds less the number of beds that have been temporarily decertified for purposes of determining eligibility for payments for reserved bed days for residents of residential health care facilities, provided, however, that such payments for reserved bed days for facilities that have temporarily decertified beds shall be in an amount that is fifty percent of the otherwise applicable payment amount for such beds~~].

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

(f) The commissioner shall establish a prospective per diem adjustment for all nursing homes, other than nursing homes providing services primarily to children under the age of twenty-one, beginning April first, two thousand seventeen and each year thereafter sufficient to achieve eighteen million dollars in savings in each state fiscal year.

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

(a) Medical assistance shall be furnished to applicants in cases where, although such applicant has a responsible relative with sufficient income and resources to provide medical assistance as determined by the regulations of the department, the income and resources of the responsible relative are not available to such applicant because of the absence of such relative [~~or~~] **and** the refusal or failure of such **absent** relative to provide the necessary care and assistance. In such cases, however, the furnishing of such assistance shall create an implied contract with such relative, and the cost thereof may be recovered from such relative in accordance with title six of article three **of this chapter** and other applicable provisions of law.

§ 6. Paragraph (m) of subdivision 2 of section 365-a of the social services law, as amended by chapter 725 of the laws of 1989, is amended to read as follows:

(m) hospice services provided by a hospice certified pursuant to article forty of the public health law, to the extent that federal financial participation is available **and that such services are covered under title XVIII of the federal social security act**, and, notwithstanding federal financial participation**, coverage under title XVIII of the federal social security act,** and any provision of law or regulation to the contrary, for hospice services provided pursuant to the hospice supplemental financial assistance program for persons with special needs as provided for in article forty of the public health law.

§ 7. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2017; provided however, that the amendments to section 4403-f of the public health law made by section one of this act shall take effect October 1, 2017; provided further, that the amendments to paragraph (m) of subdivision two of section 365-a of the social services law made by section six of this act shall take effect June 1, 2017; provided, further, that the amendments to subparagraph (i) of paragraph (b) of subdivision 7 of section 4403-f of the public health law made by section one of this act shall not affect the repeal of such section and shall be deemed repealed therewith; and provided, further, that the amendments to subparagraph (i) of paragraph (b) of subdivision 7 of section 4403-f of the public health law made by section one of this act shall not affect the expiration of such paragraph and shall be deemed to expire therewith.

PART F

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

4. The commissioner of health is authorized to assume responsibility from a local social services official for the provision and reimbursement of transportation costs under this section. If the commissioner elects to assume such responsibility, the commissioner shall notify the local social services official in writing as to the election, the date upon which the election shall be effective and such information as to transition of responsibilities as the commissioner deems prudent. The commissioner is authorized to contract with a transportation manager or managers to manage transportation services in any local social services district[~~, other than transportation services provided or arranged for~~

~~enrollees of managed long term care plans issued certificates of authority under section forty-four hundred three-f of the public health law~~]. 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. Subdivision 5 of section 365-h of the social services law is REPEALED.

§ 3. Section 367-s of the social services law, as amended by section 43-a of part C of chapter 109 of the laws of 2006, is REPEALED.

§ 4. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2017; 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 take effect October 1, 2017; provided, further, that the amendments to section 365-h of the social services law made by section one of this act shall not affect the repeal of such section and shall be deemed repealed therewith.

PART G

Section 1. 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 separately amended by section 1 of part JJ of chapter 54 and section 18 of part B of chapter 59 of the laws of 2016, is amended to read as follows:

1. For state fiscal years 2011-12 through [~~2017-18~~] 2018-19, 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 to the availability of federal financial participation in medicaid expenditures, or change in federal medicaid eligibility criteria,** 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.

§ 2. Notwithstanding sections 61, 63, 70, 78, 79, 81 and 81-a of the civil service law or any provisions to the contrary contained in any general, special, or local laws:

1. staff contracted by the office of health insurance programs within the department of health to assist with health insurance program initiatives, including under a contract authorized by subdivision 29 of section 364-j of the social services law, who meet the open competitive qualifications for positions established to perform these functions will be eligible for appointment to appropriate positions, designated by the office of health insurance programs in the department, that are classified to perform such functions without further examination or qualification; and, upon such appointment and satisfactory completion of a probationary period, will have all the rights and privileges of the jurisdictional classification to which such positions are allocated in the classified service of the state;

2. student assistants working in the department of health's office of health insurance programs through the department of civil service student assistant classification who meet the open competitive qualifications for traineeship classifications in titles approved by the department of civil service will be eligible for appointment to such appropriate traineeship positions, designated by the office of health insurance programs in the department of health, without further examination or qualification; and, upon such appointment and satisfactory completion of a probationary period, will have all the rights and privileges of the jurisdictional classification to which such traineeship positions are allocated in the classified service of the state; and

3. within 90 days of the effective date of this section, the department of civil service, in consultation with the department of health, shall establish a health care service career internship program. This program will be designed to prepare individuals with master's degrees in public administration or a related health care field for management positions within the department of health's office of health insurance programs. The program will offer career tracks in the health insurance program management areas of budget and finance, long term care, health homes, outpatient patient care, and health care public policy. During a two-year internship, interns will serve in a variety of professional positions within the department of health's office of health insurance programs and be provided specialized training, rotational assignments, and mentoring. After satisfactory completion of the internship, interns will advance to a permanent competitive class grade 18 position in the various titles utilized within the department of health's office of health insurance programs for health insurance program management without further examination or qualification; and, upon such appointment and satisfactory completion of a probationary period, will have all the

rights and privileges of the jurisdictional classification to which such positions are allocated in the classified service of the state.

§ 3. Section 4-a of 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 the administration thereof, is amended by adding a new subdivision (e) to read as follows:

(e) Beginning with state fiscal year 2017-18, the amount due to be reimbursed under subdivision (a) of this section to a social services district which includes a city with a population of more than five million shall be reduced annually by 50 million dollars unless:

(i) By June 30, 2017, such district has a shared savings allocation plan approved by the commissioner of health to increase by 100 million dollars the current annual dollar amount of the city's finally submitted and payable Medicaid claims for preschool and school supportive health services eligible for federal financial participation; the department of health will provide technical assistance as needed to assist the social services district in implementing the plan, which must detail: how the city will identify preschool and school-aged children who are receiving preschool and school supportive health services reimbursable under the current Medicaid state plan and submit claims for reimbursement; and how the plan will generate fifty million dollars in state savings to the Medicaid program. Such plan may be revised, subject to the review and approval of the commissioner of health, as necessary to maintain the increased level of claiming and to generate the required Medicaid state savings in subsequent fiscal years; and

(ii) On October 1, 2017 and annually thereafter, the commissioner of health determines that ongoing activities under the approved shared savings allocation plan approved pursuant to subparagraph (i) of this paragraph are likely to achieve the targeted dollar amount of payable Medicaid claims for preschool and school supportive health services for the applicable fiscal year; the social services district and city shall provide such information and documentation as the commissioner of health may require in order to make such determination.

(iii) The non-federal share of the costs of services for which claims are submitted as a result of the implementation of the shared savings allocation plan established pursuant to this paragraph shall be the responsibility of the social services district.

(iv) Any reduction in the amount due to be reimbursed under subdivision (a) of this section as a result of the operation of this subdivision shall be in addition to any reduction imposed pursuant to subdivision (c) of this section or authorized pursuant to any other applicable law.

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

PART H

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

5. sections 2807-c, 2807-j, 2807-s and 2807-t of the public health law, as amended or as added by this act, shall expire on December 31, [~~2017~~] **2020**, and shall be thereafter effective only in respect to any act done on or before such date or action or proceeding arising out of

such act including continued collections of funds from assessments and allowances and surcharges established pursuant to sections 2807-c, 2807-j, 2807-s and 2807-t of the public health law, and administration and distributions of funds from pools established pursuant to sections 2807-c, 2807-j, 2807-k, 2807-l, 2807-m, 2807-s and 2807-t of the public health law related to patient services provided before December 31, [~~2017~~] **2020**, and continued expenditure of funds authorized for programs and grants until the exhaustion of funds therefor;

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

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

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

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

§ 4. Subparagraph (xiii) of paragraph (a) of subdivision 7 of section 2807-s of the public health law, as amended by section 4 of part B of chapter 60 of the laws of 2014, is amended to read as follows:

(xiii) twenty-three million eight hundred thirty-six thousand dollars each state fiscal year for the period April first, two thousand twelve through March thirty-first, two thousand [~~seventeen~~] **twenty**;

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

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

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

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

5-a. Graduate medical education innovations pool. (a) Supplemental distributions. (i) Thirty-one million dollars for the period January first, two thousand eight through December thirty-first, two thousand eight, shall be set aside and reserved by the commissioner from the

regional pools established pursuant to subdivision two of this section and shall be available for distributions pursuant to subdivision five of this section and in accordance with section 86-1.89 of title 10 of the codes, rules and regulations of the state of New York as in effect on January first, two thousand eight; provided, however, for purposes of funding the empire clinical research investigation program (ECRIP) in accordance with paragraph eight of subdivision (e) and paragraph two of subdivision (f) of section 86-1.89 of title 10 of the codes, rules and regulations of the state of New York, distributions shall be made using two regions defined as New York city and the rest of the state and the dollar amount set forth in subparagraph (i) of paragraph two of subdivision (f) of section 86-1.89 of title 10 of the codes, rules and regulations of the state of New York shall be increased from sixty thousand dollars to seventy-five thousand dollars.

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

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

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

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

(B) Distributions made to a consortium or teaching general hospital shall equal the product of the total number of clinical research posi-

tions submitted by a consortium or teaching general hospital and accepted by the commissioner as meeting the criteria set forth in paragraph (b) of subdivision one of this section, subject to the reduction calculation set forth in clause (C) of this subparagraph, times one hundred ten thousand dollars.

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

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

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

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

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

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

shall be available to fund clinical research positions in a subsequent distribution period.

(G) In order to be eligible for distributions pursuant to this subparagraph, each consortium and teaching general hospital shall provide to the commissioner by July first of each distribution period, the following data and information on a hospital-specific basis. Such data and information shall be certified as to accuracy and completeness by the chief executive officer, chief financial officer or chair of the consortium governing body of each consortium or teaching general hospital and shall be maintained by each consortium and teaching general hospital for five years from the date of submission:

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

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

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

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

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

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

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

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

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

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

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

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

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

(d) Physician loan repayment program. One million nine hundred sixty thousand dollars for the period January first, two thousand eight through December thirty-first, two thousand eight, one million nine hundred sixty thousand dollars for the period January first, two thousand nine through December thirty-first, two thousand nine, one million nine hundred sixty thousand dollars for the period January first, two thousand ten through December thirty-first, two thousand ten, four hundred ninety thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven, one million seven hundred thousand dollars each state fiscal year for the period April first, two thousand eleven through March thirty-first, two thousand fourteen, [~~and~~] up to one million seven hundred five thousand dollars each state fiscal year for the period April first, two thousand fourteen through March thirty-first, two thousand seventeen**, and within amounts appropriated for each state fiscal year for periods on and after April first, two thousand seventeen**, shall be set aside and reserved by the commissioner from the regional pools established pursuant to subdivision two of this section and shall be available for purposes of physician loan repayment in accordance with subdivision ten of this section. Notwithstanding any contrary provision of this section, sections one hundred twelve and one hundred sixty-three of the state finance law, or any other contrary provision of law, such funding shall be allocated regionally with one-third of available funds going to New York city and

two-thirds of available funds going to the rest of the state and shall be distributed in a manner to be determined by the commissioner without a competitive bid or request for proposal process as follows:

(i) Funding shall first be awarded to repay loans of up to twenty-five physicians who train in primary care or specialty tracks in teaching general hospitals, and who enter and remain in primary care or specialty practices in underserved communities, as determined by the commissioner.

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

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

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

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

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

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

(i) Preference in funding shall first be accorded to teaching general hospitals for up to twenty-five awards, to support costs incurred by

physicians trained in primary or specialty tracks who thereafter establish or join practices in underserved communities, as determined by the commissioner.

(ii) After distributions in accordance with subparagraph (i) of this paragraph, all remaining funds shall be awarded to physicians to support the cost of establishing or joining practices in underserved communities, as determined by the commissioner, and to hospitals and other health care providers to recruit new physicians to provide services in underserved communities, as determined by the commissioner.

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

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

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

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

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

(g) Diversity in medicine/post-baccalaureate program. Notwithstanding any inconsistent provision of section one hundred twelve or one hundred sixty-three of the state finance law or any other law, one million nine hundred sixty thousand dollars annually for the period January first, two thousand eight through December thirty-first, two thousand ten, four hundred ninety thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven, one million seven hundred thousand dollars each state fiscal year for the period April first, two thousand eleven through March thirty-first, two thousand fourteen, [~~and~~] up to one million six hundred five thousand dollars each state fiscal year for the period April first, two thousand fourteen through March thirty-first, two thousand seventeen**, and within amounts**

appropriated for each state fiscal year for periods on and after April first, two thousand seventeen, shall be set aside and reserved by the commissioner from the regional pools established pursuant to subdivision two of this section and shall be available for distributions to the Associated Medical Schools of New York to fund its diversity program including existing and new post-baccalaureate programs for minority and economically disadvantaged students and encourage participation from all medical schools in New York. The associated medical schools of New York shall report to the commissioner on an annual basis regarding the use of funds for such purpose in such form and manner as specified by the commissioner.

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

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

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

(a) For the purpose of regulating cash flow for general hospitals, the department shall develop and implement a payment methodology to provide for timely payments for inpatient hospital services eligible for case based payments per discharge based on diagnosis-related groups provided during the period January first, nineteen hundred eighty-eight through March thirty-first two thousand [~~seventeen~~] twenty, by such hospitals which elect to participate in the system.

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

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

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

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

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

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

PART I

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

§ 11. This act shall take effect immediately and:

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

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

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

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

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

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

(vi) Notwithstanding any contrary provision of this paragraph or any other provision of law or regulation to the contrary, for residential health care facilities the assessment shall be six percent of each residential health care facility's gross receipts received from all patient care services and other operating income on a cash basis for the period April first, two thousand two through March thirty-first, two thousand three for hospital or health-related services, including adult day services; provided, however, that residential health care facilities' gross receipts attributable to payments received pursuant to title XVIII of the federal social security act (medicare) shall be excluded from the assessment; provided, however, that for all such gross receipts received on or after April first, two thousand three through March thirty-first, two thousand five, such assessment shall be five percent, and further provided that for all such gross receipts received on or after April first, two thousand five through March thirty-first, two thousand nine, and on or after April first, two thousand nine through March thirty-first, two thousand eleven such assessment shall be six percent, and further provided that for all such gross receipts received on or after April first, two thousand eleven through March thirty-first, two thousand thirteen such assessment shall be six percent, and further provided that for all such gross receipts received on or after April first, two thousand thirteen through March thirty-first, two thousand fifteen such assessment shall be six percent, and further provided that for all such gross receipts received on or after April first, two thousand fifteen through March thirty-first, two thousand seventeen such assessment shall be six percent**, and further provided that for all such gross receipts received on or after April first, two thousand seventeen through March thirty-first, two thousand twenty such assessment shall be six percent**.

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

1. Notwithstanding any inconsistent provision of law or regulation, the trend factors used to project reimbursable operating costs to the rate period for purposes of determining rates of payment pursuant to article 28 of the public health law for residential health care facilities for reimbursement of inpatient services provided to patients eligible for payments made by state governmental agencies on and after April

1, 1996 through March 31, 1999 and for payments made on and after July 1, 1999 through March 31, 2000 and on and after April 1, 2000 through March 31, 2003 and on and after April 1, 2003 through March 31, 2007 and on and after April 1, 2007 through March 31, 2009 and on and after April 1, 2009 through March 31, 2011 and on and after April 1, 2011 through March 31, 2013 and on and after April 1, 2013 through March 31, 2015, and on and after April 1, 2015 through March 31, 2017**, and on and after April 1, 2017 through March 31, 2020** shall reflect no trend factor projections or adjustments for the period April 1, 1996, through March 31, 1997.

§ 5. Subdivision 1 of section 89-a of part C of chapter 58 of the laws of 2007, amending the social services law and other laws relating to enacting the major components of legislation necessary to implement the health and mental hygiene budget for the 2007-2008 state fiscal year, as amended by section 6 of part D of chapter 57 of the laws of 2015, is amended to read as follows:

1. Notwithstanding paragraph (c) of subdivision 10 of section 2807-c of the public health law and section 21 of chapter 1 of the laws of 1999, as amended, and any other inconsistent provision of law or regulation to the contrary, in determining rates of payments by state governmental agencies effective for services provided beginning April 1, 2006, through March 31, 2009, and on and after April 1, 2009 through March 31, 2011, and on and after April 1, 2011 through March 31, 2013, and on and after April 1, 2013 through March 31, 2015, and on and after April 1, 2015 through March 31, 2017**, and on and after April 1, 2017 through March 31, 2020** for inpatient and outpatient services provided by general hospitals and for inpatient services and outpatient adult day health care services provided by residential health care facilities pursuant to article 28 of the public health law, the commissioner of health shall apply a trend factor projection of two and twenty-five hundredths percent attributable to the period January 1, 2006 through December 31, 2006, and on and after January 1, 2007, provided, however, that on reconciliation of such trend factor for the period January 1, 2006 through December 31, 2006 pursuant to paragraph (c) of subdivision 10 of section 2807-c of the public health law, such trend factor shall be the final US Consumer Price Index (CPI) for all urban consumers, as published by the US Department of Labor, Bureau of Labor Statistics less twenty-five hundredths of a percentage point.

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

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

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

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

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

(a) sections two, three, three-a, three-b, three-c, three-d, three-e and twenty-one of this act shall take effect July 1, 2010; sections fifteen, sixteen, seventeen, eighteen and nineteen of this act shall take effect January 1, 2011; and provided further that section twenty of this act shall be deemed repealed [~~six~~] **nine** years after the date the contract entered into pursuant to section 365-h of the social services law, as amended by section twenty of this act, is executed; provided that the commissioner of health shall notify the legislative bill drafting commission upon the execution of the contract entered into pursuant to section 367-h of the social services law in order that the commission may maintain an accurate and timely effective data base of the official text of the laws of the state of New York in furtherance of effectuating the provisions of section 44 of the legislative law and section 70-b of the public officers law;

§ 9. Section 4-a of part A of chapter 56 of the laws of 2013 amending chapter 59 of the laws of 2011 amending the public health law and other laws relating to general hospital reimbursement for annual rates relating to the cap on local Medicaid expenditures, as amended by section 29 of part D of chapter 57 of the laws of 2015, is amended to read as follows:

§ 4-a. Notwithstanding paragraph (c) of subdivision 10 of section 2807-c of the public health law, section 21 of chapter 1 of the laws of 1999, or any other contrary provision of law, in determining rates of payments by state governmental agencies effective for services provided on and after January 1, [~~2017~~] **2020** through March 31, [~~2017~~] **2020**, for inpatient and outpatient services provided by general hospitals, for inpatient services and adult day health care outpatient services provided by residential health care facilities pursuant to article 28 of the public health law, except for residential health care facilities or units of such facilities providing services primarily to children under twenty-one years of age, for home health care services provided pursuant to article 36 of the public health law by certified home health agencies, long term home health care programs and AIDS home care programs, and for personal care services provided pursuant to section 365-a of the social services law, the commissioner of health shall apply no greater than zero trend factors attributable to the [~~2017~~] **2020** calendar year in accordance with paragraph (c) of subdivision 10 of section 2807-c of the public health law, provided, however, that such no greater than zero trend factors attributable to such [~~2017~~] **2020** calendar year shall also be applied to rates of payment provided on and after January 1, [~~2017~~] **2020** through March 31, [~~2017~~] **2020** for personal care services provided

in those local social services districts, including New York city, whose rates of payment for such services are established by such local social services districts pursuant to a rate-setting exemption issued by the commissioner of health to such local social services districts in accordance with applicable regulations, and provided further, however, that for rates of payment for assisted living program services provided on and after January 1, [~~2017~~] **2020** through March 31, [~~2017~~] **2020**, such trend factors attributable to the [~~2017~~] **2020** calendar year shall be established at no greater than zero percent.

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

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

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

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

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

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

(e-1) Notwithstanding any inconsistent provision of law or regulation, the commissioner shall provide, in addition to payments established pursuant to this article prior to application of this section, additional payments under the medical assistance program pursuant to title eleven of article five of the social services law for non-state operated public residential health care facilities, including public residential health care facilities located in the county of Nassau, the county of Westchester and the county of Erie, but excluding public residential health care facilities operated by a town or city within a county, in aggregate annual amounts of up to one hundred fifty million dollars in additional payments for the state fiscal year beginning April first, two thousand six and for the state fiscal year beginning April first, two thousand seven and for the state fiscal year beginning April first, two thousand eight and of up to three hundred million dollars in such aggregate annual additional payments for the state fiscal year beginning April first, two thousand nine, and for the state fiscal year beginning April first, two thousand ten and for the state fiscal year beginning April first, two thousand eleven, and for the state fiscal years beginning April first, two thousand twelve and April first, two thousand thirteen, and of up to five hundred million dollars in such aggregate annual additional payments for the state fiscal years beginning April first, two thousand fourteen, April first, two thousand fifteen and April first, two thousand sixteen **and of up to five hundred million dollars in such aggregate annual additional payments for the state fiscal years beginning April first, two thousand seventeen, April first, two thousand eighteen, and April first, two thousand nineteen**. The

amount allocated to each eligible public residential health care facility for this period shall be computed in accordance with the provisions of paragraph (f) of this subdivision, provided, however, that patient days shall be utilized for such computation reflecting actual reported data for two thousand three and each representative succeeding year as applicable, and provided further, however, that, in consultation with impacted providers, of the funds allocated for distribution in the state fiscal year beginning April first, two thousand thirteen, up to thirty-two million dollars may be allocated in accordance with paragraph (f-1) of this subdivision.

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

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

§ 14. Section 4 of part X2 of chapter 62 of the laws of 2003, amending the public health law relating to allowing for the use of funds of the office of professional medical conduct for activities of the patient health information and quality improvement act of 2000, as amended by section 4-b of part A of chapter 57 of the laws of 2015, is amended to read as follows:

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

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

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

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

§ 32. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2008; provided however, that sections one, six-a, nineteen, twenty, twenty-four, and twenty-five of this act shall take effect July 1, 2008; provided however that sections sixteen, seventeen and eighteen of this act shall expire April 1, [~~2017~~] 2020; provided, however, that the amendments made by section twenty-eight of this act shall take effect on the same date as section 1 of chapter 281 of the laws of 2007 takes effect; provided further, that sections twenty-nine, thirty, and thirty-one of this act

shall take effect October 1, 2008; provided further, that section twenty-seven of this act shall take effect January 1, 2009; and provided further, that section twenty-seven of this act shall expire and be deemed repealed March 31, [~~2017~~] 2020; and provided, further, however, that the amendments to subdivision 1 of section 241 of the education law made by section twenty-nine of this act shall not affect the expiration of such subdivision and shall be deemed to expire therewith and provided that the amendments to section 272 of the public health law made by section thirty of this act shall not affect the repeal of such section and shall be deemed repealed therewith.

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

PART J

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

ARTICLE 29
PHARMACY BENEFIT MANAGERS

§ 2901. Definitions. For purposes of this article:

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

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

(c) "Pharmacy benefit management services" means directly or through an intermediary, managing the prescription drug coverage provided by a health insurer under a policy delivered or issued for delivery in this state or an employer that has its principal place of business in this state, including the processing and payment of claims for prescription drugs, the performance of drug utilization review, the processing of drug prior authorization requests, the adjudication of appeals or grievances related to prescription drug coverage, contracting with network pharmacies, and controlling the cost of covered prescription drugs. The term "pharmacy benefit management services" shall not include services

provided to a plan subject to section three hundred sixty-four-j of the social services law.

(d) "Pharmacy benefit manager" means a person, firm, association, corporation or other entity that, pursuant to a contract with a health insurer or an employer that has its principal place of business in this state and establishes or maintains an employee benefit plan, as defined by the federal Employee Retirement Income Security Act of 1974, provides pharmacy benefit management services, except that term shall not include:

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

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

(3) an employer or its employees with respect to the employee benefit plan, as defined by the federal Employee Retirement Income Security Act of 1974, established or maintained by the employer.

(e) "Principal place of business" means the state or country where an employer maintains its headquarters and where the employer's high-level officers direct, control, and coordinate the business activities; provided, however, that if the employer's high-level officers direct, control, and coordinate the business activities in more than one state or country, then the state or country where the greatest number of employees are located.

§ 2902. Acting without a registration. (a) No person, firm, association, corporation or other entity may act as a pharmacy benefits manager prior to January first, two thousand nineteen without having a valid registration as a pharmacy benefit manager filed with the superintendent in accordance with this article and any regulations promulgated thereunder.

(b) Prior to January first, two thousand nineteen, no health insurer may pay any fee or other compensation to any person, firm, association, corporation or other entity for performing pharmacy benefit management services unless the person, firm, association, corporation or other entity is registered as a pharmacy benefit manager in accordance with this article.

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

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

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

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

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

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

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

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

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

(c) All information disclosed by a pharmacy benefit manager shall be deemed confidential and not subject to disclosure unless the superintendent determines that such disclosure is in the public interest, or is necessary to carry out this chapter or to allow the department to perform examinations or investigations authorized by law.

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

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

(c) Any person, firm, association, corporation or other entity that violates this section shall, in addition to any other penalty provided

by law, be subject to a penalty of the greater of: (1) one thousand dollars for the first violation and two thousand five hundred dollars for each subsequent violation; or (2) the aggregate gross receipts attributable to all violations.

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

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

(1) the elimination of conflicts of interest between pharmacy benefit managers and health insurers or employee benefit plans, as defined by the federal Employee Retirement Income Security Act of 1974, for whom they perform pharmacy benefit management services;

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

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

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

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

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

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

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

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

(e)(1) If an application for a renewal license shall have been filed with the superintendent before October first of the year of expiration, then the license sought to be renewed shall continue in full force and effect either until the issuance by the superintendent of the renewal

license applied for or until five days after the superintendent shall have refused to issue such renewal license and given notice of such refusal to the applicant.

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

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

(g) Licensees under this section shall be subject to examination by the superintendent as often as the superintendent may deem it expedient. The superintendent may promulgate regulations establishing methods and procedures for facilitating and verifying compliance with the requirements of this section and such other regulations as necessary.

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

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

(1) violated any insurance laws, or violated any regulation, subpoena or order of the superintendent or of another state's insurance commissioner, or has violated any law in the course of his or her dealings in such capacity;

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

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

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

(B) demonstrated incompetence;

(C) demonstrated untrustworthiness; or

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

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

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

(7) has been convicted of a felony;

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

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

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

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

(b) Before revoking or suspending the registration or license of any pharmacy benefit manager pursuant to the provisions of this article, the superintendent shall give notice to the registrant or licensee and to every sub-licensee and shall hold, or cause to be held, a hearing not less than ten days after the giving of such notice.

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

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

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

(2) If any such registration or license held by a firm, association or corporation be revoked, no member of such firm or association and no officer or director of such corporation or any controlling person of the registrant or licensee shall be entitled to obtain any registration or license, or to be named as a sub-licensee in any such license, under this chapter for the same period of time, unless the superintendent determines, after notice and hearing, that such member, officer or director was not personally at fault in the matter on account of which such registration or license was revoked.

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

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

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

(i) Within thirty days of the initial pretrial hearing date, a registrant or licensee subject to this article shall report to the superintendent any criminal prosecution of the registrant or licensee taken

in any jurisdiction. The report shall include a copy of the initial complaint filed, the order resulting from the hearing and any other relevant legal documents.

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

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

§ 2909. Stay or suspension of superintendent's determination. The commencement of a proceeding under article seventy-eight of the civil practice law and rules, to review the action of the superintendent in suspending or revoking or refusing to renew any certificate under this article, shall stay such action of the superintendent for a period of thirty days. Such stay shall not be extended for a longer period unless the court shall determine, after a preliminary hearing of which the superintendent is notified forty-eight hours in advance, that a stay of the superintendent's action, pending the final determination or further order of the court, will not unduly injure the interests of the people of the state.

§ 2910. Revoked registrations. (a)(1) No person, firm, association, corporation or other entity subject to the provisions of this article whose registration or license under this article has been revoked, or whose registration or license to engage in the business of pharmacy benefit management in any capacity has been revoked by any other state or territory of the United States, shall become employed or appointed by a pharmacy benefit manager as an officer, director, manager, controlling person or for other services, without the prior written approval of the superintendent, unless such services are for maintenance or are clerical or ministerial in nature.

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

(3) No corporation or partnership subject to the provisions of this article shall knowingly permit any person whose registration or license issued under this article has been revoked, or whose registration or license to engage in the business of pharmacy benefit management in any capacity has been revoked by any other state, or territory of the United States, to be a shareholder or have an interest in such corporation or partnership, nor shall any such person become a shareholder or partner

in such corporation or partnership, without the prior written approval of the superintendent.

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

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

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

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

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

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

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

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

(b) "Defined violation" means the commission by a person of an act prohibited by: subsection (a) of section one thousand one hundred two, section one thousand two hundred fourteen, one thousand two hundred seventeen, one thousand two hundred twenty, one thousand three hundred thirteen, subparagraph (B) of paragraph two of subsection (i) of section one thousand three hundred twenty-two, subparagraph (B) of paragraph two of subsection (i) of section one thousand three hundred twenty-four, two thousand one hundred two, two thousand one hundred seventeen, two thousand one hundred twenty-two, two thousand one hundred twenty-three, subsection (p) of section two thousand three hundred thirteen, section two thousand three hundred twenty-four, two thousand five hundred two, two thousand five hundred three, two thousand five hundred four, two thousand six hundred one, two thousand six hundred two, two thousand six hundred three, two thousand six hundred four, two thousand six hundred six, two thousand seven hundred three, two thousand nine hundred two, two thousand nine hundred five, three thousand one hundred nine, three thousand two hundred twenty-four-a, three thousand four hundred twenty-

nine, three thousand four hundred thirty-three, paragraph seven of subsection (e) of section three thousand four hundred twenty-six, four thousand two hundred twenty-four, four thousand two hundred twenty-five, four thousand two hundred twenty-six, seven thousand eight hundred nine, seven thousand eight hundred ten, seven thousand eight hundred eleven, seven thousand eight hundred thirteen, seven thousand eight hundred fourteen and seven thousand eight hundred fifteen of this chapter; or section 135.60, 135.65, 175.05, 175.45, or 190.20, or article one hundred five of the penal law.

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

PART K

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

§ 2825-e. Health care facility transformation program: statewide II. 1. A statewide health care facility transformation program is hereby established under the joint administration of the commissioner and the president of the dormitory authority of the state of New York for the purpose of strengthening and protecting continued access to health care services in communities. The program shall provide funding in support of capital projects, debt retirement, working capital or other non-capital projects that facilitate health care transformation activities including, but not limited to, merger, consolidation, acquisition or other activities intended to create financially sustainable systems of care or preserve or expand essential health care services. Grants shall not be available to support general operating expenses. The issuance of any bonds or notes hereunder shall be subject to section sixteen hundred eighty-r of the public authorities law and the approval of the director of the division of the budget, and any projects funded through the issuance of bonds or notes hereunder shall be approved by the New York state public authorities control board, as required under section fifty-one of the public authorities law.

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

twenty-eight hundred twenty-five-b of this article shall not be eligible for grants or awards made available under this section.

3. Notwithstanding section one hundred sixty-three of the state finance law or any inconsistent provision of law to the contrary, up to five hundred million dollars of the funds appropriated for this program shall be awarded without a competitive bid or request for proposal process for grants to health care providers (hereafter "applicants"). Provided, however, that a minimum of thirty million dollars of total awarded funds shall be made to community-based health care providers, which for purposes of this section shall be defined as a diagnostic and treatment center licensed or granted an operating certificate under this article; a mental health clinic licensed or granted an operating certificate under article thirty-one of the mental hygiene law; an alcohol and substance abuse treatment clinic licensed or granted an operating certificate under article thirty-two of the mental hygiene law; a primary care provider or a home care provider certified or licensed pursuant to article thirty-six of this chapter. Eligible applicants shall be those deemed by the commissioner to be a provider that fulfills or will fulfill a health care need for acute inpatient, outpatient, primary, home care or residential health care services in a community.

4. Notwithstanding subdivision two of this section or any inconsistent provision of law to the contrary, and upon approval of the director of the budget, the commissioner may award all or a portion of the funds made available pursuant to this section for unfunded project applications submitted in response to the request for applications number 1607010255 issued by the department on July twentieth, two thousand sixteen pursuant to section twenty-eight hundred twenty-five-d of this article, provided however that the provisions of subdivision three of this section shall apply. The commissioner shall notify the chair of the senate finance committee and the chair of the assembly ways and means committee no later than thirty days prior to awarding funds pursuant to this subdivision.

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) Consideration of geographic distribution of funds;

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

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

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

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

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

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

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 health and assembly health committees. Such reports shall be submitted no later than sixty days after the close of the quarter, and shall include, for each award, the name of the applicant, a description of the project or purpose, the amount of the award, disbursement date, and status of achievement of process and performance metrics and milestones pursuant to subdivision five of this section.

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

PART L

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

ARTICLE 29-H

HEALTH CARE REGULATION MODERNIZATION

Section 2999-ee. Health care regulation modernization team.

§ 2999-ee. Health care regulation modernization team. 1. A health care regulation modernization team is hereby created within the department for the purpose of providing guidance for, and advice to, the governor toward a fundamental restructuring of the statutes, policies and regulations that govern the licensure and oversight of health care facilities and home care to better align with recent and ongoing changes in the health care delivery system that are designed to increase quality, reduce costs and improve health outcomes.

2. Definitions. For the purpose of this article, unless the context clearly requires otherwise:

(a) "State agency" or "agency" shall mean any state agency, department, office, board, bureau, division, committee, council or office.

(b) "Public authority" or "authority" shall mean a public authority or public benefit corporation created by or existing under any New York state law, with one or more of its members appointed by the governor, or who serve as members by virtue of holding a civil office of New York state, other than an interstate or international authority or public benefit corporation, and including any subsidiaries of such public authority or public benefit corporation.

(c) "State officer or employee" shall have the meaning given in section seventy-three of the public officers law.

(d) "Public health and health planning council" shall have the meaning given in section two hundred twenty of this chapter.

3. (a) The governor shall appoint up to twenty-five voting members of the health care regulation modernization team. The members of the health care regulation modernization team shall include: state officers or employees with relevant expertise; the chair and co-chair of the public health and health planning council; two members of the New York state assembly, one recommended by the speaker of the assembly and one recommended by the minority leader of the assembly, or their representatives; two members of the New York state senate, one recommended by the tempo-

rary president of the senate and one recommended by the minority leader of the senate, or their representatives; and stakeholders with expertise in areas, including but not limited to: inpatient and outpatient health care delivery; behavioral health care delivery; home health care; community based organizations; health care insurance; health care workforce; health care facility design and construction; consumer rights; and other relevant areas.

(b) Vacancies shall be filled by the governor, and the governor may appoint additional voting and non-voting members to the health care regulation modernization team as necessary.

(c) Members of the team shall serve at the pleasure of the governor.

(d) The governor shall designate a chair or co-chairs from among the members of the health care regulation modernization team.

(e) The governor shall appoint a state officer or employee with relevant experience as executive director of the health care regulation modernization team.

(f) A majority of the total members of the health care regulation modernization team who have been appointed shall constitute a quorum, and all recommendations of the health care regulation modernization team shall require approval of a majority of its total members.

(g) The health care regulation modernization team shall attempt to engage and solicit the input of a broad and diverse range of groups, organizations and individuals.

4. Every agency or authority of New York state shall provide the health care regulation modernization team with assistance and cooperation which may be necessary or desirable to fulfill the purposes of this article, including the use of New York state facilities. Staff support necessary for the conduct of the work of the health care modernization team may be furnished by agencies and authorities, subject to the approval of the boards of directors of such authorities.

5. The health care regulation modernization team shall deliberate and engage health care industry stakeholders for the purpose of conducting a comprehensive review of and making recommendations to address matters that may include, but are not limited to:

(a) streamlining state agency certificate of need and other licensure or construction approval processes to support system-level planning and restructuring activities, including reviewing the applicability of current health care service and facility need methodologies in the context of ongoing changes in the health care system delivery system;

(b) identifying, streamlining, and aligning statutes, regulations and polices where there is duplication and inconsistency in federal and state standards for physical environment, quality of care, information technology, reporting, surveillance, and licensure;

(c) creating more flexible rules on licensing and scope of practice for clinicians and caregivers, which shall be considered in collaboration with the workforce workgroup convened by the department in relation to the state health innovation plan and the delivery system reform incentive payment program;

(d) streamlining and simplifying the provision of primary care, mental health and substance use disorder services in an integrated clinic setting;

(e) integrating, standardizing and increasing flexibility of state agency regulations governing the delivery of and reimbursement for telehealth programs;

(f) allowing more flexible use of observation beds, ambulatory surgery centers, diagnostic and treatment centers, nursing homes, assisted

living, home health care, off campus emergency departments, community paramedicine and other models of delivering health care services;

(g) modernizing the licensing and regulation of services provided in the home, including home care, care management and other services to better support the adoption of new models of care;

(h) aligning care models around home and community based services consistent with the report issued by the Olmstead Development and Implementation Cabinet;

(i) exploring circumstances where statewide regulatory requirements may not be appropriate for regions or communities characterized by isolation, poverty, or other factors impacting access;

(j) calibrating facility and home care inspections and the scope of certificate of need reviews based on provider performance on quality and other outcome metrics;

(k) increasing the opportunities for public notification, consumer education and community engagement prior to major community health system changes;

(l) evaluating where changes in statute, regulation and policy can support timely and effective emergency medical services and pre-hospital care throughout the state; and

(m) notwithstanding any other provision of law, where permanent changes in statute or regulation may not yet be appropriate, authorizing the commissioner, the commissioner of mental health, and the commissioner of the office of alcoholism and substance abuse services to implement time-limited demonstration programs to test and evaluate new and innovative procedures and processes for organizing, financing and delivering health care services that are not permissible under current statute or regulation, provided that no such demonstration program shall be implemented without prior public notice and a thirty day period of comment.

6. At the direction of the health care regulation modernization team, the executive director shall notify stakeholders of the purposes of the health care regulation modernization team, the opportunities for stakeholder participation and the means and schedule for such participation. Meetings with stakeholders shall be held in various regions of the state. Participating stakeholders may be assigned to specific working groups, consistent with their areas of expertise and interest.

7. The health care regulation modernization team shall commence its work no later than July first, two thousand seventeen and shall submit a report to the governor of its findings and recommendations no later than December thirty-first, two thousand seventeen. A copy of such report shall be provided to the chair of the senate health committee and the chair of the assembly health committee.

8. No later than January thirty-first, two thousand eighteen, the commissioner shall recommend to the governor whether the health care regulation modernization team should continue or terminate its duties and responsibilities pursuant to this article.

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

PART M

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

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

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

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

b. "Notification level" means the concentration level of an emerging contaminant in drinking water that the commissioner has determined, based on available scientific information, warrants public notification pursuant to this section.

c. "Covered public water system" shall mean a community or nontransient noncommunity water system, as defined in the state sanitary code.

3. The commissioner shall promulgate regulations that list substances identified as emerging contaminants that meet the following criteria:

a. are not subject to any other substance-specific drinking water regulation of the department that establishes a maximum contaminant level or other threshold concentration;

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

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

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

5. Every test conducted in accordance with this section shall be conducted by a laboratory certified by the department pursuant to section five hundred two of this chapter. Laboratories shall submit such results to the department electronically in the manner prescribed pursuant to section five hundred two of this chapter.

6. The commissioner may promulgate regulations establishing notification levels for any emerging contaminant listed pursuant to subdivision three of this section.

7. The commissioner may, by declaration, add any physical, chemical, microbiological or radiological substance to the list of emerging contaminants established pursuant to subdivision three of this section, or establish a notification level for such substance, if the commissioner determines that such substance poses or has the potential to pose a hazard to human health when present in drinking water, provided that the commissioner must promulgate regulations adding the new emerging contaminant or establishing such notification level within one year of such declaration.

8. Whenever a covered public water system determines or is advised by the state that one or more emerging contaminants is present in drinking water at concentrations above a notification level established pursuant to this section:

a. the covered public water system shall notify the state and all owners of real property served by the covered public water system in a time and manner to be prescribed by the department; and

b. the commissioner may require that the covered public water system take such actions as may be appropriate to reduce exposure to emerging contaminants.

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

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

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

10. The department may require an environmental laboratory to report laboratory test results to the department, or to any full-time city, county or part-county health department in an electronic manner prescribed by the department.

§ 4. This act shall take effect immediately.

PART N

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

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

§ 1111. Testing of individual onsite water supply systems. 1. a. The commissioner shall promulgate regulations establishing standards for the testing of new or existing individual onsite water supply systems for characteristics and contaminants, including listing the characteristics and contaminants that each individual onsite water supply shall be tested for. Such regulations may require additional testing, limit testing or exclude from testing a characteristic or contaminant on a county, regional or local basis if the commissioner determines that such characteristic or contaminant is significant or not significant in that area.

b. The commissioner may, by declaration, add any characteristic or contaminant to the list promulgated pursuant to paragraph a of this subdivision, provided that the commissioner shall promulgate regulations adding such characteristic or contaminant within one year of such declaration.

2. a. Any real estate purchase contract for the sale of residential real property, as defined in section four hundred sixty-one of the real property law, which is served by an individual onsite water supply system, shall include a provision requiring, prior to and as a condition of sale, the testing of such individual onsite water supply system in a manner that meets or exceeds the standards prescribed pursuant to this

section. This section shall not apply to public water systems, as defined in regulations promulgated by the department.

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

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

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

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

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

10. The department may require an environmental laboratory to report laboratory test results to the department, or to any full-time city, county or part-county health department in an electronic manner prescribed by the department.

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

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

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

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

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

3. The certificate of registration shall require that, before the commencement of drilling of any well or wells, the water well driller shall file a preliminary notice with the department; it shall also provide that upon the completion of the drilling of any water well or water wells, a completion report be filed with the department, giving the log of the well, the size and depth thereof, the capacity of the pump or pumps attached or to be attached thereto, **the laboratory results of the water sample tested in accordance with section eleven hundred eleven of the public health law,** and such other information pertaining to the withdrawal of water and operation of such water well or water wells as the department by its rules and regulations may require. The water well driller shall provide a copy of such completion report to the water well owner **and the department of health and department of environmental conservation**. The number of the certificate of registration must be displayed on the well drilling machinery of the registrant. The certificate of registration shall also contain a notice to the certificate holder that the business activities authorized by such certificate are subject to the provisions of article thirty-six-A of the general business law. The fee for such certificate of registration shall be ten dollars annually. The commissioner shall promulgate a water well completion report form which shall be utilized by all water well drillers in satisfying the requirements of this section and any other provision of state or local law which requires the submission of a water well completion report or water well log.

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

PART O

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

9. "Appropriate institution" means: (a) a hospital operated by the office of mental health or a developmental center operated by the office for people with developmental disabilities; [~~or~~] (b) a hospital licensed by the department of health which operates a psychiatric unit licensed by the office of mental health, as determined by the commissioner provided, however, that any such hospital that is not operated by the state shall qualify as an "appropriate institution" only pursuant to the terms of an agreement between the commissioner and the hospital**; or (c) a mental health unit operating within a correctional facility or local correctional facility; provided however, that any such mental health unit operating within a local correctional facility shall qualify as an "appropriate institution" only pursuant to the terms of an agreement between the commissioner of mental health, director of community services and the sheriff for the respective locality, and any such mental health unit operating within a correctional facility shall qualify as an "appropriate institution" only pursuant to the terms of an agreement between the commissioner of mental health and the commissioner of the department of corrections and community supervision**. Nothing in this article shall be construed as requiring a hospital**, correctional facility or local correctional facility** to consent to providing care and

treatment to an incapacitated person at such hospital**, correctional facility or local correctional facility**. **In a city with a population of more than one million, any such unit shall be limited to twenty-five beds. The commissioner of mental health shall promulgate regulations for demonstration programs to implement restoration to competency within a correctional facility or local correctional facility. Subject to annual appropriation, the commissioner of mental health may, at the commissioner's discretion, make funds available for state aid grants to any county that develops and operates a mental health unit within a local correctional facility pursuant to this section. Nothing in this article shall be construed as requiring a hospital, correctional facility or local correctional facility to consent to providing care and treatment to an incapacitated person at such hospital, correctional facility or local correctional facility.**

§ 2. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2017; provided, however, that this act shall expire and be deemed repealed March 31, 2022.

PART P

Section 1. Section 48-a of part A of chapter 56 of the laws of 2013 amending chapter 59 of the laws of 2011 amending the public health law and other laws relating to general hospital reimbursement for annual rates relating to the cap on local Medicaid expenditures, as amended by section 29 part B of chapter 59 of the laws of 2016, is amended to read as follows:

§ 48-a. 1. Notwithstanding any contrary provision of law, the commissioners of the office of alcoholism and substance abuse services and the office of mental health are authorized, subject to the approval of the director of the budget, to transfer to the commissioner of health state funds to be utilized as the state share for the purpose of increasing payments under the medicaid program to managed care organizations licensed under article 44 of the public health law or under article 43 of the insurance law. Such managed care organizations shall utilize such funds for the purpose of reimbursing providers licensed pursuant to article 28 of the public health law or article 31 or 32 of the mental hygiene law for ambulatory behavioral health services, as determined by the commissioner of health, in consultation with the commissioner of alcoholism and substance abuse services and the commissioner of the office of mental health, provided to medicaid [~~eligible~~] **enrolled** outpatients **and for all other behavioral health services except inpatient included in New York state's Medicaid redesign waiver approved by the centers for medicare and Medicaid services (CMS)**. Such reimbursement shall be in the form of fees for such services which are equivalent to the payments established for such services under the ambulatory patient group (APG) rate-setting methodology as utilized by the department of health, the office of alcoholism and substance abuse services, or the office of mental health for rate-setting purposes **or any such other fees pursuant to the Medicaid state plan or otherwise approved by CMS in the Medicaid redesign waiver**; provided, however, that the increase to such fees that shall result from the provisions of this section shall not, in the aggregate and as determined by the commissioner of health, in consultation with the commissioner of alcoholism and substance abuse services and the commissioner of the office of mental health, be greater than the increased funds made available pursuant to this section. The

increase of such ambulatory behavioral health fees to providers available under this section shall be for all rate periods on and after the effective date of section [~~1~~] 29 of part [~~C~~] B of chapter [~~57~~] 59 of the laws of [~~2015~~] 2016 through March 31, [~~2018~~] 2020 for patients in the city of New York, for all rate periods on and after the effective date of section [~~1~~] 29 of part [~~C~~] B of chapter [~~57~~] 59 of the laws of [~~2015~~] 2016 through [~~June 30, 2018~~] March 31, 2020 for patients outside the city of New York, and for all rate periods on and after the effective date of such chapter through [~~June 30, 2018~~] March 31, 2020 for all services provided to persons under the age of twenty-one; provided, however, [~~eligible providers may work with managed care plans to achieve quality and efficiency objectives and engage in shared savings~~] the commissioner of health, in consultation with the commissioner of alcoholism and substance abuse services and the commissioner of mental health, may require, as a condition of approval of such ambulatory behavioral health fees, that aggregate managed care expenditures to eligible providers meet the following value based payment metrics for the following periods: (i) for the period from April 1, 2017 through March 31, 2018, at least ten percent of such managed care expenditures are paid through level one value based payment arrangements, as such level is defined in the department of health's value based payment roadmap (ii) for the period April 1, 2018 through March 31, 2019, at least fifty percent of such managed care expenditures are paid through level one value based payment arrangements and fifteen percent are paid through level two value based payment arrangements, as such levels are defined in the department of health's value based payment roadmap and (iii) for the period April 1, 2019 through March 31, 2020, at least eighty percent of such managed care expenditures are paid through level one value based payment arrangements and thirty-five percent are paid through level two value based payment arrangements, as such levels are defined in the department of health's value based payment roadmap. The commissioner of health may, in consultation with the commissioner of alcoholism and substance abuse services and the commissioner of the office of mental health, waive such conditions if a sufficient number of providers, as determined by the commissioner, suffer a financial hardship as a consequence of such value based payment arrangements, or if he or she shall determine that such value based payment arrangements significantly threaten individuals' access to ambulatory behavioral health services. Such waiver may be applied on a provider specific or industry wide basis. Nothing in this section shall prohibit managed care organizations and providers from negotiating different rates and methods of payment during such periods described above, subject to the approval of the department of health. The department of health shall consult with the office of alcoholism and substance abuse services and the office of mental health in determining whether such alternative rates shall be approved. The commissioner of health may, in consultation with the commissioner of alcoholism and substance abuse services and the commissioner of the office of mental health, promulgate regulations, including emergency regulations promulgated prior to October 1, 2015 to establish rates for ambulatory behavioral health services, as are necessary to implement the provisions of this section. Rates promulgated under this section shall be included in the report required under section 45-c of part A of this chapter.

2. Notwithstanding any contrary provision of law, the fees paid by managed care organizations licensed under article 44 of the public health law or under article 43 of the insurance law, to providers

licensed pursuant to article 28 of the public health law or article 31 or 32 of the mental hygiene law, for ambulatory behavioral health services provided to patients enrolled in the child health insurance program pursuant to title one-A of article 25 of the public health law, shall be in the form of fees for such services which are equivalent to the payments established for such services under the ambulatory patient group (APG) rate-setting methodology **or any such other fees established pursuant to the Medicaid state plan**. The commissioner of health shall consult with the commissioner of alcoholism and substance abuse services and the commissioner of the office of mental health in determining such services and establishing such fees. Such ambulatory behavioral health fees to providers available under this section shall be for all rate periods on and after the effective date of this chapter through [~~June 30, 2018~~] **March 31, 2020**, provided, however, that managed care organizations and providers may negotiate different rates and methods of payment during such periods described above, subject to the approval of the department of health. The department of health shall consult with the office of alcoholism and substance abuse services and the office of mental health in determining whether such alternative rates shall be approved. The report required under section 16-a of part C of chapter 60 of the laws of 2014 shall also include the population of patients enrolled in the child health insurance program pursuant to title one-A of article 25 of the public health law in its examination on the transition of behavioral health services into managed care.

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

Section 1. a. Notwithstanding any contrary provision of law, the commissioners of mental health and alcoholism and substance abuse services are authorized, subject to the approval of the director of the budget, to transfer to the commissioner of health state funds to be utilized as the state share for the purpose of increasing payments under the medicaid program to managed care organizations licensed under article 44 of the public health law or under article 43 of the insurance law. Such managed care organizations shall utilize such funds for the purpose of reimbursing providers licensed pursuant to article 28 of the public health law, or pursuant to article 31 or article 32 of the mental hygiene law for ambulatory behavioral health services, as determined by the commissioner of health in consultation with the commissioner of mental health and commissioner of alcoholism and substance abuse services, provided to medicaid [~~eligible~~] **enrolled** outpatients **and for all other behavioral health services except inpatient included in New York state's Medicaid redesign waiver approved by the centers for medicare and Medicaid services (CMS)**. Such reimbursement shall be in the form of fees for such services which are equivalent to the payments established for such services under the ambulatory patient group (APG) rate-setting methodology as utilized by the department of health or by the office of mental health or office of alcoholism and substance abuse services for rate-setting purposes **or any such other fees pursuant to the Medicaid state plan or otherwise approved by CMS in the Medicaid redesign waiver**; provided, however, that the increase to such fees that shall result from the provisions of this section shall not, in the aggregate and as determined by the commissioner of health in consultation with the commissioners of mental health and alcoholism and

substance abuse services, be greater than the increased funds made available pursuant to this section. The increase of such behavioral health fees to providers available under this section shall be for all rate periods on and after the effective date of section [~~2~~] 30 of part [~~C~~] B of chapter [~~57~~] 59 of the laws of [~~2015~~] 2016 through March 31, [~~2018~~] 2020 for patients in the city of New York, for all rate periods on and after the effective date of section [~~2~~] 30 of part [~~C~~] B of chapter [~~57~~] 59 of the laws of [~~2015~~] 2016 through [~~June 30, 2018~~] March 31, 2020 for patients outside the city of New York, and for all rate periods on and after the effective date of section [~~2~~] 30 of part [~~C~~] B of chapter [~~57~~] 59 of the laws of [~~2015~~] 2016 through [~~June 30, 2018~~] March 31, 2020 for all services provided to persons under the age of twenty-one; provided, however, [~~eligible providers may work with managed care plans to achieve quality and efficiency objectives and engage in shared savings~~] the commissioner of health, in consultation with the commissioner of alcoholism and substance abuse services and the commissioner of mental health, may require, as a condition of approval of such ambulatory behavioral health fees, that aggregate managed care expenditures to eligible providers meet the following value based payment metrics for the following periods: (i) for the period from April 1, 2017 through March 31, 2018, at least ten percent of such managed care expenditures are paid through level one value based payment arrangements, as such level is defined in the department of health's value based payment roadmap (ii) for the period April 1, 2018 through March 31, 2019, at least fifty percent of such managed care expenditures are paid through level one value based payment arrangements and fifteen percent are paid through level two value based payment arrangements, as such levels are defined in the department of health's value based payment roadmap and (iii) for the period April 1, 2019 through March 31, 2020, at least eighty percent of such managed care expenditures are paid through level one value based payment arrangements and thirty-five percent are paid through level two value based payment arrangements, as such levels are defined in the department of health's value based payment roadmap. The commissioner of health may, in consultation with the commissioner of alcoholism and substance abuse services and the commissioner of the office of mental health, waive such conditions if a sufficient number of providers, as determined by the commissioner, suffer a financial hardship as a consequence of such value based payment arrangements, or if he or she shall determine that such value based payment arrangements significantly threaten individuals' access to ambulatory behavioral health services. Such waiver may be applied on a provider specific or industry wide basis. Nothing in this section shall prohibit managed care organizations and providers from negotiating different rates and methods of payment during such periods described, subject to the approval of the department of health. The department of health shall consult with the office of alcoholism and substance abuse services and the office of mental health in determining whether such alternative rates shall be approved. The commissioner of health may, in consultation with the commissioners of mental health and alcoholism and substance abuse services, promulgate regulations, including emergency regulations promulgated prior to October 1, 2013 that establish rates for behavioral health services, as are necessary to implement the provisions of this section. Rates promulgated under this section shall be included in the report required under section 45-c of part A of chapter 56 of the laws of 2013.

b. Notwithstanding any contrary provision of law, the fees paid by managed care organizations licensed under article 44 of the public health law or under article 43 of the insurance law, to providers licensed pursuant to article 28 of the public health law or article 31 or 32 of the mental hygiene law, for ambulatory behavioral health services provided to patients enrolled in the child health insurance program pursuant to title one-A of article 25 of the public health law, shall be in the form of fees for such services which are equivalent to the payments established for such services under the ambulatory patient group (APG) rate-setting methodology. The commissioner of health shall consult with the commissioner of alcoholism and substance abuse services and the commissioner of the office of mental health in determining such services and establishing such fees. Such ambulatory behavioral health fees to providers available under this section shall be for all rate periods on and after the effective date of this chapter through [~~June 30, 2018~~] **March 31, 2020**, provided, however, that managed care organizations and providers may negotiate different rates and methods of payment during such periods described above, subject to the approval of the department of health. The department of health shall consult with the office of alcoholism and substance abuse services and the office of mental health in determining whether such alternative rates shall be approved. The report required under section 16-a of part C of chapter 60 of the laws of 2014 shall also include the population of patients enrolled in the child health insurance program pursuant to title one-A of article 25 of the public health law in its examination on the transition of behavioral health services into managed care.

§ 3. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2017; provided, however, that the amendments to section 48-a of part A of chapter 56 of the laws of 2013 made by section one of this act shall not affect the repeal of such section and shall be deemed repealed therewith; provided further, that the amendments to section 1 of part H of chapter 111 of the laws of 2010 made by section two of this act shall not affect the expiration of such section and shall be deemed to expire therewith.

PART Q

Section 1. Subdivisions 3-b and 3-c of section 1 and section 4 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 I of chapter 60 of the laws of 2014, 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**, the commissioners shall not include a COLA for the purpose of establishing rates of payments, contracts or any other form of reimbursement.

3-c. Notwithstanding any inconsistent provision of law, beginning April 1, [~~2016~~] **2018** and ending March 31, [~~2019~~] **2021**, 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.

§ 4. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2006; provided section one of this act shall expire and be deemed repealed April 1, [~~2019~~] **2021**; provided, further, that sections two and three of this act shall expire and be deemed repealed December 31, 2009.

§ 2. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2017; provided, however, that the amendments to 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, made by section one of this act, shall not affect the repeal of such subdivisions and shall be deemed repealed therewith.

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

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