STATE OF NEW YORK

7507--B

IN SENATE

January 18, 2018

A BUDGET BILL, submitted by the Governor pursuant to article seven of the Constitution -- read twice and ordered printed, and when printed to be committed to the Committee on Finance -- committee discharged, bill amended, ordered reprinted as amended and recommitted to said committee -- committee discharged, bill amended, ordered reprinted as amended and recommitted to said committee

AN ACT to amend the public health law, in relation to the general hospital indigent care pool; to amend the social services law, in relation to standard coverage for physical therapy services under medical assistance for needy persons programs; to amend the public health law, in relation to payments to rural hospitals designated as critical access hospitals; to amend the public authorities law, in relation to authorizing the Westchester health care corporation to enter into agreements for the creation and operation of a health care delivery system network and to amend the public health law, in relation to reimbursement rates for certain residential health care facilities (Part A); to amend the social services law, in relation to assisted living program providers licensed in the state; to amend the public health law, in relation to eligibility for medical assistance; to amend the public health law, in relation to payments for home and community based long term care services; to amend the social services law, in relation to payments for certain medical assistance provided to eligible persons participating in the New York traumatic brain injury waiver program; to amend the public health law, in relation to requiring the department of health to oversee the appropriateness of services provided to certain high needs patients; to authorize the commissioner of health to conduct a study of home and community based services available to Medicaid recipients in rural areas; to amend the public health law, in relation to medical assistance payments for care in hospice residences; to amend the public health law, in relation to the public health priority initiative; to amend the public health law, in relation to restricting the altering of case-mix adjustments; to amend the public health law, in relation to a review of licensed home care service agencies; and to amend the social services law, in relation to the provision of services to certain persons suffering from traumatic brain injuries or qualifying for nursing home diversion and transition services (Part B); to amend the public health law and

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

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the social services law, in relation to health homes and penalties for managed care providers; to amend the social services law, in relation to the statewide patient centered medical home program; to amend the public health law, in relation to the multipayor patient centered medical home program; and to amend the social services law in relation to school-based health centers (Part C); to amend the social services law and the public health law, in relation to drug coverage; to amend the public health law, in relation to enacting the drug take back act; to amend the public health law, in relation to prescribing opioids to a minor; to amend the public health law, in relation to limiting the initial prescription of a controlled substance for the alleviation of acute pain from a seven-day supply to a three-day supply and requiring the commissioner of health to develop guidelines for the prescribing of opioid antagonists; to amend the social services law, in relation to limiting medical assistance coverage for opioids; to amend the insurance law, in relation to limiting coverage for opioids; to amend the public health law, in relation to establishing an opioid alternative pilot project; to amend the public health law, in relation to requiring hospital and emergency room physicians to notify a patient's prescriber that such patient is being treated for a controlled substance overdose; to amend the public health law in relation to the labeling of opioids; to amend the public health law, in relation to children and recovering mothers; to amend the public health law, in relation to establishing the infant recovery centers pilot program; to amend the public health law, in relation to requiring facilities to screen newborns for neonatal abstinence syndrome through toxicological screening of infants' meconium or urine; and providing for the repeal of such provisions upon expiration thereof; to amend the insurance law, in relation to providing that coverage for outpatient diagnosis and treatment of substance use disorder shall not be subject to preauthorization; to amend the mental hygiene law and the education law, in relation to integrated care and the location of pharmacies; to amend the public health law, in relation to audits of pharmacies; to amend the public health law, in relation to prohibited activities by pharmacy benefit managers; and providing for the repeal of certain provisions upon expiration thereof (Part D); to amend the social services law, in relation to reimbursement of transportation costs and reimbursement of emergency transportation services (Part E); intentionally omitted (Part F); to amend the public health law, in relation to authorizing the establishment of limited service clinics (Part G); intentionally omitted (Part H); to amend the social services law and the public health law, in relation to managed care organizations (Part I); to amend the state finance law, in relation to establishing a medicaid false claims act reserve fund (Part J); authorizing the department of health to require certain health care providers to report on costs incurred; to amend chapter 59 of the laws of 2011 amending the public health law and other laws relating to known and projected department of health state fund medicaid expenditures, in relation to extending the medicaid global cap; to amend chapter 59 of the laws of 2011, amending the public health law and other laws relating to general hospital reimbursement for annual rates, in relation to certain time periods; to amend the public health law, in relation to the kidney disease outreach and education program; and to repeal section 6 of part S of chapter 57 of the laws of 2017 relating to authorizing the commissioner of health to sell accounts receivables balances owed to the state by Medicaid providers to financial insti-

tutions (Part K); to amend the social services law, in relation to the child health insurance program; to amend the insurance law, in relation to the definition of small group and in relation to meetings and reports of the New York state health care quality and cost containment commission; to amend the insurance law, in relation to clarifying that continuing care retirement communities are not subject to department of financial services cybersecurity regulations; and to repeal section 7 of chapter 12 of the laws of 2016 relating to directing the superintendent of financial services to contract with an independent entity to conduct an assessment regarding the impact of the prohibition on the sale of stop loss, catastrophic and reinsurance coverage to the small group market relating thereto (Part L); to amend chapter 266 of the laws of 1986, amending the civil practice law and rules and other laws relating to malpractice and professional medical conduct, in relation to apportioning premium for certain policies; to amend part J of chapter 63 of the laws of 2001 amending chapter 266 of the laws of 1986, amending the civil practice law and rules and other laws relating to malpractice and professional medical conduct, relating to the effectiveness of certain provisions of such chapter, in relation to extending certain provisions concerning the hospital excess liability pool; and to amend part H of chapter 57 of the laws of 2017, amending the New York Health Care Reform Act of 1996 and other laws relating to extending certain provisions relating thereto, in relation to extending provisions relating to excess coverage (Part M); to amend part C of chapter 57 of the laws of 2006, establishing a cost of living adjustment for designated human services, in relation to the determination thereof; and to repeal certain provisions thereof relating to eligible programs (Part N); intentionally omitted (Part O); to amend the public health law, in relation to the health force retraining program; and to repeal subdivision 9 of section 2803 of such law relating to hospital audits (Part P); to amend the public health law, in relation to the health care facility transformation program (Part Q); to amend the public health law, in relation to granting schools access to a student's blood lead test results in the statewide immunization information system; lead screening of child care or pre-school enrollees and kindergarten students; and appointments to the advisory council on lead poisoning prevention; and to amend the public health law, in relation to requiring the department of health to establish a statewide plan for lead service line replacement (Part R); to amend the public health law, in relation to authorizing collaborative programs for community paramedicine services (Subpart A); to amend the public health law and the mental hygiene law, in relation to integrated services (Subpart B); and to amend the public health law, in relation to the definitions of telehealth provider, originating site and remote patient monitoring; and to amend the social services law, in relation to telehealth under medical assistance (Subpart C)(Part S); to amend chapter 59 of the laws of 2016, amending the social services law and other laws relating to authorizing the commissioner of health to apply federally established consumer price index penalties for generic drugs, and authorizing the commissioner of health to impose penalties on managed care plans for reporting late or incorrect encounter data, in relation to the effectiveness of certain provisions of such chapter; to amend chapter 58 of the laws of 2007, amending the social services law and other laws relating to adjustments of rates, in relation to the effectiveness of certain provisions of such chapter; to amend chapter 54 of the laws of

2016, amending part C of chapter 58 of the laws of 2005, authorizing reimbursements for expenditures made by or on behalf of social services districts for medical assistance for needy persons and administration thereof relating to authorizing the commissioner of health to establish a statewide Medicaid integrity and efficiency initiative, in relation to the effectiveness thereof; to amend chapter 906 of the laws of 1984, amending the social services law relating to expanding medical assistance eligibility and the scope of services available to certain persons with disabilities, in relation to the effectiveness thereof; to amend chapter 56 of the laws of 2013, amending chapter 59 of the laws of 2011 amending the public health law and other laws relating to general hospital reimbursement for annual rates relating to the cap on local Medicaid expenditures, in relation to rates of payments and to amend chapter 426 of the laws of 1983, amending the public health law relating to professional misconduct proceedings; and to amend the public health law, in relation to professional misconduct proceedings and the effectiveness of certain provisions thereof (Part T); to amend part NN of chapter 58 of the laws of 2015 amending the mental hygiene law relating to clarifying the authority of the commissioners in the department of mental hygiene to design and implement time-limited demonstration programs, in relation to the effectiveness thereof (Part U); to amend chapter 62 of the laws of 2003, amending the mental hygiene law and the state finance law relating to the community mental health support and workforce reinvestment program, the membership of subcommittees for mental health of community services boards and the duties of such subcommittees and creating the community mental health and workforce reinvestment account, in relation to extending such provisions relating thereto (Part V); intentionally omitted (Part W); to amend chapter 111 of the laws of 2010 amending the mental hygiene law relating to the receipt of federal and state benefits received by individuals receiving care in facilities operated by an office of the department of mental hygiene, in relation to the effectiveness thereof (Part X); to amend the education law, in relation to persons practicing in certain licensed programs or services who are exempt from practice requirements of professionals licensed by the department of education; and establishing a mental health professions task force (Part Y); to amend the social services law, in relation to adding demonstration waivers to waivers allowable for home and community-based services; to amend the social services law, in relation to adding successor federal waivers to waivers granted under subsection (c) of section 1915 of the federal social security law, in relation to nursing facility services; to amend the social services law, in relation to waivers for high quality and integrated care; to amend the mental hygiene law, in relation to adding new and successor federal waivers to waivers in relation to home and community-based services; to amend part A of chapter 56 of the laws of 2013, amending the social services law and other laws relating to enacting the major components of legislation necessary to implement the health and mental hygiene budget for the 2013-2014 state fiscal year, in relation to the effectiveness of certain provisions thereof; to amend the public health law, in relation to expansion of comprehensive health services plans; to amend chapter 659 of the laws of 1997, amending the public health law and other laws relating to creation of continuing care retirement communities, in relation to extending provisions thereof; to amend the public health law, in relation to managed long term care plans, health and long term care services and

developmental disability individual support and care coordination organizations; to amend chapter 165 of the laws of 1991, amending the public health law and other laws relating to establishing payments for medical assistance, in relation to extending the provisions thereof; to amend the mental hygiene law, in relation to reimbursement rates; and to amend chapter 710 of the laws of 1988, amending the social services law and the education law relating to medical assistance eligibility of certain persons and providing for managed medical care demonstration programs, in relation to extending the provisions thereof (Part Z); to amend part C of chapter 57 of the laws of 2006, relating to establishing a cost of living adjustment for designated human services programs, in relation to the inclusion and development of certain cost of living adjustments and to providing funding to increase salaries and related fringe benefits to direct care workers, direct support professionals and clinical workers employed by not-for-profits funded by the office for people with developmental disabilities, the office of mental health and the office of alcoholism and substance abuse services (Part AA); to amend the public health law and the penal law, in relation to expanding the list of controlled substances; and to repeal paragraph 6 of subdivision (c) of schedule II of section 3306 of the public health law, relating thereto (Part BB); intentionally omitted (Part CC); to amend the education law, in relation to authorizing a licensed pharmacist to administer influenza vaccine to children between two and eighteen years of age pursuant to a non-patient specific regimen; to amend chapter 563 of the laws of 2008, amending the education law and the public health law relating to immunizing agents to be administered to adults by pharmacists, in relation to the effectiveness of such provisions; to amend chapter 116 of the laws of 2012, amending the education law relating to authorizing a licensed pharmacist and certified nurse practitioner to administer certain immunizing agents, in relation to the effectiveness of such provisions; and to amend chapter 21 of the laws of 2011, amending the education law relating to authorizing pharmacists to perform collaborative drug therapy management with physicians in certain settings, in relation to the effectiveness of such provisions (Part DD); to amend the social services law and the elder law, in relation to providing protective services to certain individuals (Part EE); to amend the mental hygiene law, in relation to treatment of sex offenders in certain facilities (Part FF); to amend the mental hygiene law, in relation to prohibiting the collocation of certain facilities (Part GG); to amend the mental hygiene law, in relation to notice to local governments of the potential for significant service reductions at certain state-operated hospitals (Part HH); to amend the mental hygiene law, in relation to notification of the closure or transfer of a state-operated individualized residential alternative; and to amend part Q of chapter 59 of the laws of 2016 amending the mental hygiene law relating to the closure or transfer of a state-operated individualized residential alternative, in relation to extending the effectiveness thereof (Part II); to amend the mental hygiene law, in relation to authorizing the office of alcoholism and substance abuse services to provide funding to substance use disorder and/or compulsive gambling programs operated by for profit agencies (Part JJ); to amend the mental hygiene law, in relation to opioid overdose reversal and peer to peer support services (Part KK); to amend the mental hygiene law, in relation to prohibiting deceptive acts and practices for substance use disorder treatment (Part LL); to amend the mental

hygiene law, in relation to establishing the family support and recovery services demonstration program; and providing for the repeal of such provisions upon expiration thereof (Part MM); to amend the mental hygiene law, in relation to alcohol and drug free housing (Part NN); to amend the mental hygiene law, in relation to establishing protocols for assisted outpatient treatment for substance abuse (Part OO); to amend the mental hygiene law, in relation to requiring the commissioner of alcoholism and substance abuse services to include a report for services to persons with substance use or compulsive gambling disorders in the statewide comprehensive plan of services for persons with mental disabilities (Part PP); to amend the mental hygiene law, in relation to directing the office of alcoholism and substance abuse, services to provide an ombudsman for substance use disorder insurance coverage (Part QQ); to amend the mental hygiene law, in relation to implementing a jail-based substance use disorder treatment and transition services (Part RR); to amend the public health law, in relation to establishing an emergent contaminant contingency fund; to amend the public health law, in relation to the promulgation of regulations for tests for water contaminants by small public water suppliers; to amend the public health law, in relation to public water system coordination summits; and to amend the public health law, in relation to authorizing a voluntary public water system consolidation study (Part SS); and to amend the public health law, in relation to the cancer detection and education program; to amend the public health law, in relation to the implementation of an electronic death registration system; to amend the public health law, in relation to a court ordered guardianship demonstration program; to amend the public health law, in relation to grants for not-for-profit corporations which provide family intervention services relating to Alzheimer's disease; to direct the New York state department of health to conduct a study on the high incidence of asthma and related pulmonary disorders in the boroughs of Brooklyn and Manhattan in the city of New York and to prepare a remedial plan; to direct a study of the impact of insurance laws relating to fertility and in vitro fertilization benefits; to amend the public buildings law, in relation to requiring the establishment of lactation rooms in certain public buildings; to amend the insurance law, in relation to requiring donated breast milk to be covered by certain insurance policies; to amend the executive law, in relation to standards requiring assembly group A occupancies and mercantile group M occupancies to have diaper changing stations available for use by both male and female occupants; and to amend the public buildings law, in relation to requiring full family service restroom facilities in public buildings; to amend the public health law, the executive law and the insurance law, in relation to sexual assault forensic exams; to amend the public health law and the executive law, in relation to establishing a sexual assault survivor bill of rights; and to amend the executive law, in relation to maintenance of sexual assault evidence, establishing a victim's right to notice prior to destruction and requiring a study relating to the feasibility of establishing a statewide tracking system for sexual offense evidence kits; and to amend the public health law, in relation to establishing the sexual assault forensic examination telemedicine pilot program (Part TT)

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

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

PART A

Section 1. Intentionally omitted.

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

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

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

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

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

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

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

(iii)(A) Such regulations shall establish transition adjustments to the distributions made pursuant to clauses (A) and (B) of subparagraph (ii) of this paragraph such that no facility experiences a reduction in indigent care pool payments pursuant to this subdivision that is greater

than the percentages, as specified in clause (C) of this subparagraph as compared to the average distribution that each such facility received for the three calendar years prior to two thousand thirteen pursuant to this section and section twenty-eight hundred seven-w of this article.

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

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

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

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

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

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

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

§ 3. Intentionally omitted.

§ 3-a. Subdivision 14-a of section 2807 of the public health law is amended by adding a new paragraph (c) to read as follows:

(c) Notwithstanding any contrary provision of law, the commissioner shall not take any action with the purpose of reducing payment for general hospital emergency services visits provided to patients eligible for medical assistance pursuant to title eleven of article five of the social services law, including such patients enrolled in organizations operating in accordance with the provisions of article forty-four of this chapter or in health maintenance organizations organized and operating in accordance with article forty-three of the insurance law.

§ 4. Intentionally omitted.

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

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

§ 6. Subdivision 2-a of section 2807 of the public health law is amended by adding a new paragraph (j) to read as follows:

(j) Notwithstanding any other provision of this subdivision or any other provision of law to the contrary and, subject to an appropriation therefor, on and after April first, two thousand nineteen, rates of payment for diagnostic and treatment center services, emergency services, general hospital inpatient and outpatient services, ambulatory surgical services and referred ambulatory services, provided by a rural hospital designated as a critical access hospital in accordance with title XVIII of the federal social security act shall be equal to one hundred one percent of the reasonable costs of a facility in providing such services to patients eligible for payments made in accordance with this subdivision. Reasonable costs shall be determined in a manner consistent with that used to determine payment for outpatient critical access hospital services provided to beneficiaries of title XVIII of the federal social security act. For facilities without adequate cost experience, such rates shall be based on budgeted costs subsequently adjusted to one hundred one percent of reasonable actual costs.

§ 7. Notwithstanding any inconsistent provision of law or regulation, the commissioner of health shall not alter the weights under the ambulatory patient group methodology unless such alteration is part of a rebasing of all the weights assigned to ambulatory patient groups.

§ 8. Section 3306 of the public authorities law is amended by adding a new subdivision 8 to read as follows:

8. As set forth in section thirty-three hundred one of this title, the creation and operation of the Westchester County Health Care Corporation is for the benefit of the residents of the state of New York and the county of Westchester, including persons in need of health care services without the ability to pay, and is a state, county, and public purpose. The corporation has advised that it intends to engage in certain collaborative activities with and limited to, health care providers in the eight lower Hudson valley counties of Westchester, Rockland, Dutchess, Orange, Ulster, Putnam, Sullivan, and Delaware, as set forth in section thirty-three hundred one of this title, for the purpose of promoting, and only to the extent necessary to promote, improved quality of and access to health care services and improved clinical outcomes, consisting of: (a) development of a non-exclusive joint health information technology platform; (b) development of a joint set of clinical quality standards; (c) coordination and integration of clinical service to reduce redundancy and increase efficiency; (d) joint discussions with rural hospitals regarding the possibility of coordinating and integrating clinical services; and (e) joint purchasing of services, supplies and equipment related to the provisions of health care services. To promote improved quality of and access to health care services and

improved clinical outcomes, and consistent with the corporation's furtherance of its health care purposes through the exercise of the special powers exercised pursuant to this section and the general powers exercised pursuant to this title, it is the policy of the state to supplant competition for the purpose of immunizing the planning and implementation of the enumerated activities by the corporation in collaboration with any one of the aforementioned entities from liability under the federal and state antitrust laws; provided, however, that nothing in this subdivision shall be construed to extend such declaration of policy to any activities other than those specifically enumerated and described in this subdivision, which remain subject to any and all applicable state and federal antitrust laws; and provided further that such declaration of policy shall not apply to any activities that improperly restrict competitive labor markets in violation of all applicable state and federal antitrust laws.

§ 9. Section 4403-f of the public health law is amended by adding a new subdivision 8-a to read as follows:

8-a. Rates for certain residential health care facilities. Notwithstanding any other provision of law or regulation to the contrary, any residential health care facility established pursuant to article twenty-eight of this chapter located in a county with a population of more than seventy-two thousand and less than seventy-five thousand persons based on the two thousand ten federal census shall be reimbursed by any managed long term care plan, approved pursuant to this section and contracting with the department, at a rate of no less than one hundred four percent of the average rate of reimbursement in existence on March first, two thousand eighteen for such county.

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

(g) Notwithstanding any other provision of law or regulation to the contrary, any residential health care facility established pursuant to this article located in a county with a population of more than seventy-two thousand and less then seventy-five thousand persons based on the two thousand ten federal census, and operating between one hundred ten and one hundred thirty beds, being reimbursed by the department on a fee-for-services basis, shall be reimbursed at a rate of no less than one hundred seventeen percent of the fee-for-service rate of reimbursement calculated pursuant to this section for that facility for inpatient services provided on or after March first, two thousand eighteen.

§ 10. This act shall take effect immediately; provided, however, that the implementation of the provisions of section six of this act shall be subject to the appropriation of moneys specifically for the purposes thereof; and provided, further, that the amendments to section 4403-f of the public health law made by section nine of this act, shall not affect the repeal of such section and shall be deemed repealed therewith.

PART B

Section 1. Intentionally omitted.

§ 2. Subdivision 3 of section 461-l of the social services law, as added by chapter 165 of the laws of 1991, subparagraph (iii) of paragraph (a) as amended by chapter 438 of the laws of 1994, paragraphs (b), (c), (e) and (f) as amended by section 82 of part A of chapter 58 of the laws of 2010, paragraph (d) as amended by chapter 591 of the laws of 1999, paragraph (g) as amended by chapter 397 of the laws of 2012, paragraph (h) as added by section 20 of part B of chapter 58 of the laws of

2007, paragraph (i) as amended by section 67 of part C of chapter 60 of the laws of 2014, and paragraph (j) as added by section 70 of part A of chapter 56 of the laws of 2013, is amended to read as follows:

3. Assisted living program approval. (a) An eligible applicant proposing to operate an assisted living program **or increase the number of beds within an existing program** shall submit an application to the [~~department. Upon receipt, the department shall transmit a copy of the application and accompanying documents to the~~] department of health. [~~Such~~] **To the extent applicable, such** application shall be in a format and a quantity determined by the department **of health** and shall include, but not be limited to:

(i) a copy of or an application for an adult care facility operating certificate;

(ii) a copy of or an application for a home care services agency license or a copy of a certificate for a certified home health agency or authorization as a long term home health care program;

(iii) a copy of a proposed contract with a social services district or in a social services district with a population of one million or more, a copy of a proposed contract with the social services district or the department;

(iv) if the applicant is not a long term home health care program or certified home health agency, a copy of a proposed contract with a long term home health care program or certified home health agency for the provisions of services in accordance with article thirty-six of the public health law; and

(v) a detailed description of the proposed program including budget, staffing and services.

(b) If the application for the proposed program includes an application for licensure as a home care service agency, the department of health shall forward the application for the proposed program and accompanying documents to the public health and health planning council for its written approval in accordance with the provisions of section thirty-six hundred five of the public health law.

(c) An application for an assisted living program shall not be approved unless the commissioner is satisfied as to:

(i) the character, competence and standing in the community of the operator of the adult care facility;

(ii) the financial responsibility of the operator of the adult care facility;

(iii) that the buildings, equipment, staff, standards of care and records of the adult care facility to be employed in the operation comply with applicable law, rule and regulation;

(iv) the commissioner of health is satisfied that the licensed home care agency has received the written approval of the public health and health planning council as required by paragraph (b) of this subdivision and the equipment, personnel, rules, standards of care, and home care services provided by the licensed home care agency and certified home health agency or long term home health care program are fit and adequate and will be provided in the manner required by article thirty-six of the public health law and the rules and regulations thereunder; and

(v) [~~the commissioner and~~] the commissioner of health [~~are~~] **is** satisfied as to the public need for the assisted living program **beds being proposed after giving consideration to the specific population being served and relative concentration of assisted living program beds in existence in the area to be served. In approving applications for**

assisted living program beds, the commissioner of health shall give priority to applicants which:

(1) are an existing assisted living provider who is seeking approval for less than ten beds under the department's expedited review process and whose average occupancy over the prior twelve month period is greater than ninety percent;

(2) are in counties where there are two or fewer operational assisted living program providers and where existing providers in such counties have occupancy over the prior twelve month period in excess of eighty-five percent; or

(3) are in counties where existing assisted living program beds which provide services predominantly to individuals over the age of sixty-five have an average occupancy in excess of eighty-five percent over the prior twelve month period.

(d) The department of health shall not approve an application for an assisted living program or an expansion of an existing program for any eligible applicant who does not meet the requirements of this article, including but not limited to, an eligible applicant who is already or within the past ten years has been an incorporator, director, sponsor, principal stockholder, member or owner of any adult care facility which has been issued an operating certificate by the board or the department, or of a halfway house, hostel or other residential facility or institution for the care, custody or treatment of the mentally disabled which is subject to approval by an office of the department of mental hygiene, or of any residential health care facility or home care agency as defined in the public health law, unless the department, in conjunction with the department of health, finds by substantial evidence as to each such applicant that a substantially consistent high level of care has been rendered in each such facility or institution under which such person is or was affiliated. For the purposes of this paragraph, there may be a finding that a substantially consistent high level of care has been rendered despite a record of violations of applicable rules and regulations, if such violations (i) did not threaten to directly affect the health, safety or welfare of any patient or resident, and (ii) were promptly corrected and not recurrent.

(e) The commissioner of health shall provide written notice of approval or disapproval of portions of the proposed application concerning a licensed home care agency, certified home health agency or long term home health care program, and, where applicable, of the approval or disapproval of the public health and health planning council [~~to the commissioner~~]. If an application receives all the necessary approvals, the commissioner of health shall notify the applicant in writing. The commissioner's written approval shall constitute authorization to operate an assisted living program.

(f) No assisted living program may be operated without the written approval of [~~the department,~~] the department of health and, where applicable, the public health and health planning council.

(g) Notwithstanding any other provision of law to the contrary, any assisted living program having less than seventy-five authorized bed slots, located in a county with a population of more than one hundred ten thousand and less than one hundred fifty thousand persons based upon the decennial federal census for the year two thousand, and which at any point in time is unable to accommodate individuals awaiting placement into the assisted living program, shall be authorized to increase the number of assisted living beds available for a specified period of time as part of a demonstration program by up to thirty percent of its

approved bed level; provided, however, that such program shall otherwise satisfy all other assisted living program requirements as set forth in this section. In addition, any program which receives such authorization and which at any point on or after July first, two thousand five is unable to accommodate individuals awaiting placement into the assisted program, shall be authorized to further increase the number of assisted living beds available as part of this demonstration program by up to twenty-five percent of its bed level as of July first, two thousand five; provided, however, that such program shall otherwise satisfy all other assisted living program requirements as set forth in this section.

(h) The commissioner is authorized to add one thousand five hundred assisted living program beds to the gross number of assisted living program beds having been determined to be available as of April first, two thousand seven.

(i) (a) The commissioner of health is authorized to add up to six thousand assisted living program beds to the gross number of assisted living program beds having been determined to be available as of April first, two thousand nine. Nothing herein shall be interpreted as prohibiting any eligible applicant from submitting an application for any assisted living program bed so added. The commissioner of health shall not be required to review on a comparative basis applications submitted for assisted living program beds made available under this paragraph. The commissioner of health shall only authorize the addition of six thousand beds pursuant to a seven year plan ending prior to January first, two thousand seventeen.

(b) The commissioner of health shall provide an annual written report to the chair of the senate standing committee on health and the chair of the assembly health committee no later than January first of each year. Such report shall include, but not be limited to, the number of assisted living program beds made available pursuant to this section by county, the total number of assisted living program beds by county, the number of vacant assisted living program beds by county, and any other information deemed necessary and appropriate.

(j) The commissioner of health is authorized to add up to four thousand five hundred assisted living program beds to the gross number of assisted living program beds having been determined to be available as of April first, two thousand twelve. Applicants eligible to submit an application under this paragraph shall be limited to adult homes established pursuant to section four hundred sixty-one-b of this article with, as of September first, two thousand twelve, a certified capacity of eighty beds or more in which twenty-five percent or more of the resident population are persons with serious mental illness as defined in regulations promulgated by the commissioner of health. The commissioner of health shall not be required to review on a comparative basis applications submitted for assisted living program beds made available under this paragraph.

(k)(i) For periods on and after April first, two thousand eighteen, the commissioner of health is authorized to issue up to one thousand assisted living program beds. Applicants under this subparagraph shall be able to submit such applications for beds beginning no later than September first, two thousand eighteen;

(ii) For periods on and after April first, two thousand twenty, the commissioner of health is authorized to issue up to an additional one thousand assisted living program beds. Applicants under this subparagraph shall be able to submit such applications for beds beginning no later than September first, two thousand twenty;

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

(l) Notwithstanding any other provision of law to the contrary, the department shall develop an expedited review and approval process for applications for up to nine additional beds to an existing assisted living program qualified as being in good standing under section four hundred sixty-one-b of this article. In no event shall the review by the department of health of an application under the expedited approval process exceed ninety days.

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

§ 3. Intentionally omitted.

§ 4. Intentionally omitted.

§ 5. Clauses 11 and 12 of subparagraph (v) of paragraph (b) of subdivision 7 of section 4403-f of the public health law, as amended by section 48 of part A of chapter 56 of the laws of 2013, are amended and three new clauses 13, 14 and 15 are added to read as follows:

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

(12) Native Americans[~~.~~];

(13) a person participating in a long term inpatient rehabilitation program for head injured nursing home residents;

(14) a person participating in a specialized program for nursing home residents requiring behavioral interventions; and

(15) a person who is permanently placed in a nursing home for a consecutive period of three months or more, provided however such person shall be notified they are being designated permanently placed and shall have the right to appeal their designation. Implementation of this provision shall include policies and procedures to ensure Americans with Disabilities Act and federal Olmstead compliance.

§ 5-a. Paragraph (c) of subdivision 18 of section 364-j of the social services law, as added by section 55 of part B of chapter 57 of the laws of 2015, is amended to read as follows:

(c) (i) In setting such reimbursement methodologies, the department shall consider costs borne by the managed care program to ensure that each plan receives actuarially sound and adequate rates of payment to ensure quality of care for its enrollees. The department of health shall require the independent actuary selected pursuant to paragraph (b) of this subdivision to provide a complete actuarial memorandum, along with all actuarial assumptions made and all other data, materials and methodologies used in the development of rates, to managed care providers

thirty days prior to submission of such rates to the centers for medicare and medicaid services for approval. Managed care providers may request additional review of the actuarial soundness of the rate setting process and/or methodology.

(ii) In fulfilling the requirements of this paragraph, the department of health, in consultation with the independent actuary, the affected managed care providers and other interested parties, shall develop and utilize statistically validated assessment tools to determine the care needs of individuals enrolled in managed care plans, which shall involve consideration of variables including, but not limited to, physical and behavioral functioning, activities of daily living and instrumental activities of daily living, and primary or secondary diagnoses of cognitive impairment or mental illness.

(iii) The department shall establish separate rate cells to reflect the costs of care for specific high-need and/or high-cost enrollees of managed care providers operating on a full capitation basis and in managed long term care plans operating in accordance with the provisions of section forty-four hundred three-f of the public health law. By June thirtieth, two thousand eighteen the commissioner shall submit to the Centers for Medicare and Medicaid Services a state plan amendment or other appropriate approval of a capitated rate which includes a separate rate cell or cells and shall also include policies and procedures to ensure Americans with Disabilities Act and federal Olmstead compliance for covering the cost of care for each of the following:

(A) individuals in managed care providers operating on a full capitation basis and individuals in managed long term care plans that are either already residing in a skilled nursing home or are placed in a skilled nursing home;

(B) individuals in managed long term care plans, who remain in the community and who daily receive live-in or twelve hours or more of personal care or home health services;

(C) individuals in fully-capitated plans who satisfy the criteria for inclusion in a health and recovery plan for persons with serious mental illness, but have not been enrolled in such a plan; and

(D) such other individuals who, based on the assessment of their care needs, their diagnosis or other factors, are determined to present uniquely high-needs and are likely to generate high costs, as may be identified by the department.

§ 5-b. The public health law is amended by adding a new section 3614-f to read as follows:

§ 3614-f. Payments for home and community based long term care services. The payment of claims submitted under contracts and/or agreements with insurers under the medical assistance program for home and community based long term care services provided under this article and by fiscal intermediaries operating pursuant to section three hundred sixty-five-f of the social services law shall provide that any funds appropriated to compensate for minimum wage pursuant to section six hundred fifty-two of the labor law, shall not be subject to managed care risk adjustment on insurers established pursuant to subdivision eight of section four thousand four hundred three-f of this chapter. In addition, the distribution of any such funds shall be provided by insurers in amendments to existing contracts with home and community based long term care services provided under this article and by fiscal intermediaries operating pursuant to section three hundred sixty-five-f of the social services law ninety days prior to the effective date of any such law or regulation impacting wages. Insurers shall provide such funds in an

amount that supplements any current contracts and/or agreements and shall not use such funds to supplant payments for existing services under the Medicaid assistance program. Such insurers shall include but not be limited to Medicaid managed care plans and Medicaid managed long term care plans.

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

11-b. Where individuals with high needs are transferred involuntarily between managed long term care plans, the department shall provide oversight to assure continuity of services and direct care providers. Where the transition is related to the closure of acquisition of a plan specializing in high need individuals, the department shall review any prior audit to ascertain the appropriateness of services provided by the plan that is closing or being acquired, and shall promptly conduct a follow-up audit of services provided during the first year after the closure of acquisition to assure that the services provided to such individuals remain substantially comparable to or greater than those services they received prior to the transfer. The follow-up audit shall be a public document. Such transfer shall not diminish any of such an individual's rights relating to continuity of care, utilization review, or fair hearing appeals.

§ 6. Intentionally omitted.

§ 7. Intentionally omitted.

§ 8. Intentionally omitted.

§ 8-a. Paragraph (e) of subdivision 1 of section 367-a of the social services law, as amended by section 41 of part D of chapter 56 of the laws of 2012, is amended to read as follows:

(e) Amounts payable under this title for medical assistance in the form of clinic services pursuant to article twenty-eight of the public health law and article sixteen of the mental hygiene law provided to eligible persons diagnosed with a developmental disability or a traumatic brain injury who are also beneficiaries under part B of title XVIII of the federal social security act, or provided to persons diagnosed with a developmental disability or a traumatic brain injury who are qualified medicare beneficiaries under part B of title XVIII of such act shall not be less than the approved medical assistance payment level less the amount payable under part B.

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

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

5. (a) Medicaid payments to hospice residences shall be in an amount equal to ninety-four percent of the weighted average medical assistance fee for service rate reimbursed to residential health care facilities located in the managed long term care region that the hospice residence is located. Such average medical assistance rate shall be inclusive of specialty units, the room and board furnished by the hospice residence, cash receipts assessments and the case mix of the residential health care facilities located in the managed long term care region that such hospice is located. Such average medical assistance rate shall also be inclusive of an efficiency factor of 1.1 multiplied by such weighted average rate; recruitment and retention monies; and any adjustments made for minimum wage, as such adjustments are applied to the residential health care facilities located in the managed long term care region in which the hospice residence is located.

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

§ 9-b. The public health law is amended by adding a new section 3620-a to read as follows:

§ 3620-a. Public health priority initiative. 1. The commissioner shall facilitate and support home care agency roles within the health care continuum for addressing public health priorities in the state, and promoting health improvement and cost savings. The commissioner shall undertake these purposes through: incorporation of home care in the department's prevention, primary care, and public health strategies; education and promotion of evidence-based, best practices that may be adopted by home care in priority public health areas; adoption of departmental policies and guidance to assist home care response and intervention; supplemental rate financing; staff training; regulatory and procedural flexibility for prioritization of public health response; data sharing; promotion of public health priority collaboratives with home care and continuum partners; and other means the commissioner determines appropriate. Effective April first, two thousand eighteen, the commissioner, with the approval of the state budget director, is authorized to determine and make available for reinvestment to participating providers through increases in provider reimbursement, a portion of cost savings achieved from such public health initiatives through home care; provided, however, provider participation under this section shall be on a voluntary basis.

2. Priority public health areas under this section may include but not be limited to: public education, screening and early intervention for sepsis; medication management, especially in care transitions and for poly-pharmacy populations; asthma and other respiratory condition management and home environmental assessment; falls prevention screening, education and prevention; opioid management and overuse or abuse prevention, including alternatives in pain management; cardiovascular health; health care disparities; high risk prenatal and post-partum care; palliative care, and other priority areas in population health which the commissioner may designate.

3. In implementing this section, the commissioner shall seek the advice of representatives of home care providers, state associations representative of home care, state associations representative of physi-

cians, state association representative of county public health services and others with home care and/or public health expertise whom the commissioner may designate.

4. The commissioner shall collect and report to the legislature data on the activities and impact of home care public health initiatives, including a determination of system savings derived/costs avoided, and shall make recommendations for further support of the goals of this section.

§ 9-c. Notwithstanding any inconsistent provision of law, rule or regulation to the contrary, residential health care facility (RHCF) rates of payment determined pursuant to article 28 of the public health law for services provided on or after October 1, 2012, in facilities which exclusively provide extensive nursing, medical, psychological and counseling support services to children with diverse and complex medical, emotional and social problems, including long-term inpatient rehabilitation services for traumatic brain-injured children, and are located in a city with a population of one million or more shall be based on the operating rate promulgated in RHCF rate appeal number 12451 dated May 24, 2013 and as adjusted by the allowable trend factor on January 1 of each subsequent year.

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

(g) For periods on and after April first, two thousand eighteen, case-mix adjustments authorized under paragraph (b) of this subdivision shall not be altered, modified or adjusted on the basis of revised regulatory limitations on the level of such adjustments or on reviews, audits or collection or submission protocols of the minimum data set; provided, however, that this paragraph shall not apply to audits performed by the office of the Medicaid inspector general nor to reviews or audits for the purposes of investigating fraud or abuse under Medicaid rules and regulations.

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

8. (a) The department, in consultation with the public health and planning council, shall conduct a review of licensed home care services agencies. Such review shall take into account considerations of access, availability of workforce personnel, unique community needs, efficiency and affordability, regional needs and variations, an analysis of average number of contracts per plan based on region, and such other factors as may be determined by the department and council.

(b) Following the review, the department and the council shall by October first, two thousand eighteen establish:

(i) a transition plan designed to limit disruption to managed long term care plan enrollees, providers and the managed long term care market taking into consideration regional needs and variations;

(ii) specific limitations on the number of contracts between managed long term care plans and licensed home care services agencies in Nassau county, Suffolk county, Westchester county and a city with a population of one million or more which shall not exceed seventy-five contracts by October first, two thousand eighteen, sixty contracts by October first, two thousand nineteen and fifty contracts by two thousand twenty;

(iii) provisions permitting managed long term care plans that cover all regions of the state to contract with the maximum allowable number of licensed home care services agencies allowable in each region;

(iv) a requirement that in applicable regions, a percentage of managed long term care contracts with licensed home care services agencies be

with qualified quality incentive vital access provider pool providers or providers who otherwise demonstrate a commitment to quality; and

(v) a requirement that a licensed home care services agency that is contracted to provide fiscal intermediary services on behalf of a consumer directed personal assistance program have both designations considered part of the contract with the managed long term care plan.

(c) The department and the council shall also review licensed home care services in upstate regions and provide recommendations on whether proportional limits are necessary in the regions.

(d) The department and the council shall also provide recommendations on incentives to encourage consolidation of such agencies and plans including, but not limited to regional state financial assistance, an expedited certificate of need process for mergers and acquisitions of licensed home care services agencies, and other changes in the licensure or certificate of need process to facilitate the change in ownership, control, merger or acquisitions of such agencies or plans. During the period of such review, the department shall impose a moratorium on the approvals of additional licensed home care services agencies serving medical assistance beneficiaries, however, the commissioner may approve additional agencies if it is in the interest of public health and safety. All licensed home care services agencies licensed as of April first, two thousand eighteen shall not engage in marketing practices until the review is complete and the department has submitted its report pursuant to paragraph (e) of this subdivision.

(e) The department shall report to the governor, the temporary president of the senate and the minority leader of the senate, and the speaker of the assembly and the minority leader of the assembly on the results of reviews required by this section by September first, two thousand eighteen.

(f) Notwithstanding any other law, rule or regulation no limitations shall be imposed on the number of contracts between managed long term care plans licensed pursuant to section forty-four hundred three-f of this chapter and certified home health care agencies or licensed home care services agencies until the requirements of paragraph (e) of this subdivision are met.

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

(d-2) Services provided pursuant to waivers, granted pursuant to subsection (c) of section 1915 of the federal social security act, to persons suffering from traumatic brain injuries or qualifying for nursing home diversion and transition services, shall not be provided to medical assistance recipients through managed care programs [~~until at least January first, two thousand eighteen~~] established pursuant to this section, and shall continue to be provided outside of managed care programs and in accordance with such waiver programs as they existed on January first, two thousand fifteen; provided, further that the commissioner of health is hereby directed to take any action required, including but not limited to filing waivers and waiver extensions as necessary with the federal government, to continue the provision of such services.

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

paragraph (b) of subdivision 7 of section 4403-f of the public health law made by section five of this act and the amendments to section 4403-f of the public health law made by section five-c of this act shall not affect the repeal of such section pursuant to chapter 659 of the laws of 1997, as amended, and shall be deemed repealed therewith; provided, further, that the amendments to section 364-j of the social services law, made by section five-a and nine-f of this act shall not affect the expiration and repeal of such section and shall expire and be deemed repealed therewith.

PART C

Section 1. Intentionally omitted.

§ 2. Intentionally omitted.

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

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

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

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

prints, provided, however, that for the purposes of determining rates of payment pursuant to article twenty-eight of this chapter for residential health care facilities, such reimbursable fees and costs shall be reflected as timely as practicable in such rates within the applicable rate period.

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

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

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

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

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

(a) The following persons and officials are required to report or cause a report to be made in accordance with this title when they have reasonable cause to suspect that a child coming before them in their professional or official capacity is an abused or maltreated child, or when they have reasonable cause to suspect that a child is an abused or maltreated child where the parent, guardian, custodian or other person legally responsible for such child comes before them in their professional or official capacity and states from personal knowledge facts, conditions or circumstances which, if correct, would render the child an abused or maltreated child: any physician; registered physician assistant; surgeon; medical examiner; coroner; dentist; dental hygienist; osteopath; optometrist; chiropractor; podiatrist; resident; intern; psychologist; registered nurse; social worker; emergency medical technician; licensed creative arts therapist; licensed marriage and family therapist; licensed mental health counselor; licensed psychoanalyst;

licensed behavior analyst; certified behavior analyst assistant; hospital personnel engaged in the admission, examination, care or treatment of persons; a Christian Science practitioner; school official, which includes but is not limited to school teacher, school guidance counselor, school psychologist, school social worker, school nurse, school administrator or other school personnel required to hold a teaching or administrative license or certificate; full or part-time compensated school employee required to hold a temporary coaching license or professional coaching certificate; social services worker; employee of a publicly-funded emergency shelter for families with children; director of a children's overnight camp, summer day camp or traveling summer day camp, as such camps are defined in section thirteen hundred ninety-two of the public health law; day care center worker; school-age child care worker; provider of family or group family day care; employee or volunteer in a residential care facility for children that is licensed, certified or operated by the office of children and family services; or any other child care or foster care worker; mental health professional; substance abuse counselor; alcoholism counselor; all persons credentialed by the office of alcoholism and substance abuse services; **employees of a health home or health home care management agency contracting with a health home as designated by the department of health and authorized under section three hundred sixty-five-l of this chapter or such employees who provide home and community based services under a demonstration program pursuant to section eleven hundred fifteen of the federal social security act;** peace officer; police officer; district attorney or assistant district attorney; investigator employed in the office of a district attorney; or other law enforcement official.

§ 8. Intentionally omitted.

§ 9. Section 364-m of the social services law is amended by adding a new subdivision 4-a to read as follows:

4-a. Notwithstanding any statute, rule, regulation, or administrative directive issued by the department of health to the contrary, consistent with the other provisions of this section, the commissioner of health shall continue to make payments pursuant to subdivision four of this section at the same rates of payment made during state fiscal year two thousand seventeen.

§ 10. Section 2959-a of the public health law is amended by adding a new subdivision 7-a to read as follows:

7-a. Notwithstanding any statute, rule, regulation, or administrative directive issued by the department to the contrary, consistent with the other provisions of this section, the commissioner shall continue to make payments pursuant to subdivision seven of this section at the same rates of payment made during state fiscal year two thousand seventeen.

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

PART D

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

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

§ 2. Intentionally omitted.

§ 3. Intentionally omitted.

§ 4. Intentionally omitted.

§ 5. Intentionally omitted.

§ 6. Intentionally omitted.

§ 7. Intentionally omitted.

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

§ 280. Medicaid drug cap. 1. The legislature hereby finds and declares that there is a significant public interest for the Medicaid program to manage drug costs in a manner that ensures patient access while providing financial stability for the state and participating providers. Since two thousand eleven, the state has taken significant steps to contain costs in the Medicaid program by imposing a statutory limit on annual growth. Drug expenditures, however, continually outpace other cost components causing significant pressure on the state, providers, and patient access operating under the Medicaid [~~global cap~~] **program**. It is therefore intended that the department establish a Medicaid drug cap as a separate component within the Medicaid [~~global cap~~] **program** as part of a focused and sustained effort to balance the growth of drug expenditures with the growth of total Medicaid expenditures.

2. The commissioner shall establish a year to year department of health [~~state funds~~] **state funds** Medicaid drug [~~spending~~] **expenditure** growth target as follows:

(a) for state fiscal year two thousand seventeen--two thousand eighteen, be limited to the ten-year [~~rolling~~] average of the medical component of the consumer price index**, as published by the United States department of labor, bureau of statistics, for the ten year period ending six months prior to the start of the coming fiscal year,** plus five percent and minus a pharmacy savings target of fifty-five million dollars; and

(b) for state fiscal year two thousand eighteen--two thousand nineteen, be limited to the ten-year [~~rolling~~] average of the medical component of the consumer price index**, as published by the United States department of labor, bureau of statistics, for the ten year period ending six months prior to the start of the coming fiscal year,** plus four percent and minus a pharmacy savings target of eighty-five million dollars.

3. The department and the division of the budget shall assess on a quarterly basis the projected total amount to be expended in the year on a cash basis by the Medicaid program for each drug, and the projected annual amount of **state funds Medicaid** drug expenditures **on a cash basis** for all drugs, which shall **not** be a component of the projected department of health state funds Medicaid expenditures calculated for purposes

of sections ninety-one and ninety-two of part H of chapter fifty-nine of the laws of two thousand eleven. For purposes of this section, state funds Medicaid drug expenditures [~~include~~] **are the sum of the** amounts expended for drugs in both the Medicaid fee-for-service **program** and **the wholesale acquisition cost for drugs utilized by recipients in** Medicaid managed care programs, minus the amount of any **required federal penalties,** drug rebates or supplemental drug rebates [~~received by~~] **due to** the department, including rebates pursuant to subdivision five of this section with respect to rebate targets. **The department and the division of the budget shall report quarterly to the drug utilization review board the projected state funds Medicaid drug expenditures including the amounts, in aggregate thereof, attributable to the net cost of: changes in the utilization of drugs by Medicaid recipients; changes in the number of Medicaid recipients; changes in the wholesale acquisition cost of name brand drugs and changes in the wholesale acquisition cost of generic drugs. The information contained in the report shall not be publicly released in a manner that allows for the identification of an individual drug or manufacturer or that is likely to compromise the financial, competitive, or proprietary nature of the information.**

(a) In the event the director of the budget determines, based on Medicaid drug expenditures for the previous quarter or other relevant information, that the total department of health state funds Medicaid drug expenditure is projected to exceed the annual growth limitation imposed by subdivision two of this section, the commissioner may identify and refer drugs to the drug utilization review board established by section three hundred sixty-nine-bb of the social services law for a recommendation as to whether a target supplemental Medicaid rebate should be paid by the manufacturer of the drug to the department and the target amount of the rebate.

(b) If the department intends to refer a drug to the drug utilization review board pursuant to paragraph (a) of this subdivision, the department shall notify the manufacturer of such drug and shall attempt to reach agreement with the manufacturer on a rebate for the drug prior to referring the drug to the drug utilization review board for review.

(c) In the event that the commissioner and the manufacturer have previously agreed to a supplemental rebate for a drug pursuant to paragraph (b) of this subdivision or paragraph (e) of subdivision seven of section three hundred sixty-seven-a of the social services law, the drug shall not be referred to the drug utilization review board for any further supplemental rebate for the duration of the previous rebate agreement.

(d) The department shall consider a drug's actual cost to the state, including current rebate amounts, prior to seeking an additional rebate pursuant to paragraph (b) or (c) of this subdivision and shall take into consideration whether the manufacturer of the drug is providing significant discounts relative to other drugs covered by the Medicaid program.

(e) The commissioner shall be authorized to take the actions described in this section only so long as total Medicaid drug expenditures are projected to exceed the annual growth limitation imposed by subdivision two of this section.

4. In determining whether to recommend a target supplemental rebate for a drug, the drug utilization review board shall consider the actual cost of the drug to the Medicaid program, including federal and state rebates, and may consider, among other things:

(a) the drug's impact on the Medicaid drug spending growth target and the adequacy of capitation rates of participating Medicaid managed care

plans, and the drug's affordability and value to the Medicaid program; or

(b) significant and unjustified increases in the price of the drug; or

(c) whether the drug may be priced disproportionately to its therapeutic benefits.

5. (a) If the drug utilization review board recommends a target rebate amount on a drug referred by the commissioner, the commissioner shall require a supplemental rebate to be paid by the drug's manufacturer in an amount not to exceed such target rebate amount. With respect to a rebate required in state fiscal year two thousand seventeen--two thousand eighteen, the rebate requirement shall apply beginning with the month of April, two thousand seventeen, without regard to the date the department enters into the rebate agreement with the manufacturer.

(b) The supplemental rebate required by paragraph (a) of this subdivision 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.

(c) If the drug utilization review board recommends a target rebate amount for a drug and the department is unable to negotiate a rebate from the manufacturer in an amount that is at least seventy-five percent of the target rebate amount, the commissioner is authorized to waive the provisions of paragraph (b) of subdivision three of section two hundred seventy-three of this article and the provisions of subdivisions twenty-five and twenty-five-a of section three hundred sixty-four-j of the social services law with respect to such drug; however, this waiver shall not be implemented in situations where it would prevent access by a Medicaid recipient to a drug which is the only treatment for a particular disease or condition. Under no circumstances shall the commissioner be authorized to waive such provisions with respect to more than two drugs in a given time.

(d) Where the department and a manufacturer enter into a rebate agreement pursuant to this section, which may be in addition to existing rebate agreements entered into by the manufacturer with respect to the same drug, no additional rebates shall be required to be paid by the manufacturer to a managed care provider or any of a managed care provider's agents, including but not limited to any pharmacy benefit manager, while the department is collecting the rebate pursuant to this section.

(e) In formulating a recommendation concerning a target rebate amount for a drug, the drug utilization review board may consider:

(i) publicly available information relevant to the pricing of the drug;

(ii) information supplied by the department relevant to the pricing of the drug;

(iii) information relating to value-based pricing;

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

(v) the extent of utilization of the drug;

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

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

(viii) the average wholesale price, wholesale acquisition cost, retail price of the drug, and the cost of the drug to the Medicaid program minus rebates received by the state;

(ix) in the case of generic drugs, the number of pharmaceutical manufacturers that produce the drug;

(x) whether there are pharmaceutical equivalents to the drug; and

(xi) information supplied by the manufacturer, if any, explaining the relationship between the pricing of the drug and the cost of development of the drug and/or the therapeutic benefit of the drug, or that is otherwise pertinent to the manufacturer's pricing decision; any such information provided shall be considered confidential and shall not be disclosed by the drug utilization review board in a form that identifies a specific manufacturer or prices charged for drugs by such manufacturer.

6. (a) If the drug utilization review board recommends a target rebate amount and the department is unsuccessful in entering into a rebate agreement with the manufacturer of the drug satisfactory to the department, the drug manufacturer shall in that event be required to provide to the department, on a standard reporting form developed by the department, the following information:

(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 in the State; 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) 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.

7. (a) If, after taking into account all rebates and supplemental rebates received by the department, including rebates received to date pursuant to this section, total Medicaid drug expenditures are still projected to exceed the annual growth limitation imposed by subdivision two of this section, the commissioner of health may: subject [~~drugs~~] **any drug of a manufacturer that the drug utilization review board recommends a target rebate amount for that has not entered into a supplemental rebate agreement required by this section** to prior approval in accordance with existing processes and procedures[~~, which may include all drugs of a manufacturer that has not entered into a supplemental rebate agreement required by this section~~]; directing managed care plans to remove from their Medicaid formularies those drugs [~~with respect to~~

~~which a~~] that the drug utilization review board recommends a target rebate amount for and the manufacturer has failed to enter into a rebate agreement required by this section; promoting the use of cost effective and clinically appropriate drugs other than those of a manufacturer who has a drug that the drug utilization review board recommends a target rebate amount and the manufacturer has failed to enter into a rebate agreement required by this section; allowing [~~manufacturers~~] a manufacturer of a drug that the drug utilization review board recommends a target rebate amount and the manufacturer has failed to enter into an agreement to accelerate rebate payments under existing rebate contracts; and such other actions as authorized by law. The commissioner shall [~~provide written notice to the legislature~~] bring any such recommended action before the drug utilization review board thirty days prior to taking action pursuant to this paragraph[~~, unless action is necessary in the fourth quarter of a fiscal year to prevent total Medicaid drug expenditures from exceeding the limitation imposed by subdivision two of this section, in which case such notice to the legislature may be less than thirty days~~].

(b) The commissioner shall be authorized to take the actions described in paragraph (a) of this subdivision only so long as total Medicaid drug expenditures are projected to exceed the annual growth limitation imposed by subdivision two of this section. In addition, no such actions shall be deemed to supersede the provisions of paragraph (b) of subdivision three of section two hundred seventy-three of this article or the provisions of subdivisions twenty-five and twenty-five-a of section three hundred sixty-four-j of the social services law, except as allowed by paragraph (c) of subdivision five of this section; provided further that nothing in this section shall prevent access by a Medicaid recipient to a drug which is the only treatment for a particular disease or condition.

8. The commissioner shall report by February first annually to the drug utilization review board on savings achieved through the drug cap in the last year. Such report shall provide data on what savings were achieved through actions pursuant to subsections three, five and seven of this section, respectively, and what savings were achieved through other means and how such savings were calculated and implemented.

§ 8-a. The public health law is amended by adding a new article 2-B to read as follows:

ARTICLE 2-B
DRUG TAKE BACK

Section 290. Definitions.
291. Drug take back.
292. Collection.
293. Violations.
294. Jurisdiction.

§ 290. Definitions. As used in this article, unless the context clearly requires otherwise:

1. "Authorized collector" means: (a) a person, company, corporation or other entity that is registered with the United States Drug Enforcement Administration to collect controlled substances for the purposes of safe disposal and destruction; (b) a law enforcement agency; (c) a municipality; or (d) a person, company, corporation or other entity authorized by the department to provide alternative collection methods for covered drugs that are not controlled substances.

2. "Covered drug" means any substance recognized as a drug under 21 USC § 321(g)(1), as amended, that is sold, offered for sale or dispensed

in the state, whether directly or through a wholesaler, in any form including prescription and nonprescription drugs, drugs in medical devices and combination products, brand and generic drugs and drugs for veterinary use; provided however, covered drug shall not include: (a) vitamins or supplements; (b) herbal-based remedies and homeopathic drugs, products or remedies; (c) cosmetics, soap (with or without germicidal agents), laundry detergent, bleach, household cleaning products, shampoos, sunscreens, toothpaste, lip balm, antiperspirants or other personal care products that are regulated as both cosmetics and nonprescription drugs under the Federal Food, Drug, and Cosmetic Act; (d) pet pesticide products contained in pet collars, powders, shampoos, topical applications, or other forms; (e) drugs that are biological products as defined in subdivision twenty-seven of section sixty-eight hundred two of the education law if the manufacturer already provides a take back program; (f) drugs for which a manufacturer provides a take back program as part of a Federal Food and Drug Administration managed risk evaluation and mitigation strategy; (g) medical devices or the component part of such devices or accessories if such device or component part contains no covered drug; and (h) drugs that are used solely in a clinical setting.

3. "Manufacturer" means a person, company, corporation or other entity engaged in the manufacture of drugs sold in the state.

4. "Pharmacies" means all pharmacies registered under section sixty-eight hundred eight of the education law that are part of a group of ten or more establishments that conduct business under the same name, or operate under a common ownership or management, or pursuant to a franchise agreement with the same franchisor, and all nonresident pharmacies registered pursuant to section sixty-eight hundred eight-b of the education law that provide covered drugs to state residents by mail.

5. "Drug take back organization" means an organization designated by a manufacturer or a group of manufacturers to act as an agent on behalf of the manufacturer or group of manufacturers to operate and implement a drug take back program as authorized by this article.

6. "Wholesaler" means any person, company, corporation or other entity that sells or distributes drugs and covered drugs for resale to an entity in the state other than a consumer.

§ 291. Drug take back. 1. Any manufacturer of a covered drug shall:

(a) operate a drug take back program approved by the department individually or jointly with other manufacturers;

(b) enter into an agreement with a drug take back organization which shall operate a drug take back program approved by the department; or

(c) enter into an agreement with the department to operate a drug take back program on its behalf.

2. Any manufacturer of a covered drug, individually or jointly, or a drug take back organization contracted by a manufacturer of a covered drug shall within one hundred eighty days from the effective date of this section submit to the department, in a manner and form determined by the department, a proposed drug take back program that meets, at a minimum, the following requirements:

(a) Certifies the drug take back program will accept all covered drugs regardless of who produced them;

(b) Provides contact information for the person submitting the planned drug take back program with whom the department shall direct all inquiries;

(c) Details a pharmacy collection system to provide convenient, ongoing collection services to all persons seeking to dispose of covered drugs pursuant to section two hundred ninety-two of this article;

(d) Describes other collection methods by which covered drugs will be collected by authorized collectors;

(e) Explains how covered drugs will be safely and securely tracked and handled from collection through final disposal and destruction, policies to ensure security and compliance with all applicable laws and regulations including disposal and destruction at a permitted hazardous waste disposal facility meeting federal requirements;

(f) Describes the public education and outreach activities that will be undertaken which shall include advertising of collection locations on a website and through use of signage and other written materials, and how effectiveness will be evaluated;

(g) Details how the costs of pharmacy collection and other authorized collectors will be reimbursed which shall include costs retroactive to the effective date of this article, and where more than one manufacturer will be involved in the planned drug take back program, a plan for the fair and reasonable manner of allocated costs among the participants in such program such that the costs paid by each manufacturer is reasonably related to the number or value of covered drugs sold in the state; and

(h) Provides any further information deemed appropriate by the department.

3. Within thirty days of the effective date of this section, each wholesaler that sells covered drugs in or into the state shall provide the department with a list of manufacturers that produce covered drugs. The department may request updated lists at its discretion.

4. A manufacturer, individually or jointly, must pay all administrative and operational fees associated with the drug take back program, including the cost of collecting, transporting and disposing of covered drugs from pharmacies and other authorized collectors and the recycling or disposal, or both, of packing collected with the covered drug. Manufacturers shall also pay costs incurred by the state in the administration and enforcement of the drug take back program. Exclusive of fines and penalties, the state shall only recover its actual cost of administration and enforcement. In instances where manufacturers jointly conduct a drug take back program, the costs of administration and enforcement shall be fairly and reasonably allocated such that the portion of costs is reasonably related to the number or value of covered drugs the manufacturers sell in the state. No manufacturer may charge a point-of-sale or other fee to consumers, or a fee that could be passed on to consumers, to recoup the cost of their drug take back program.

5. Within sixty days of receipt of a proposed drug take back program, the department, in consultation with the department of environmental conservation, shall determine whether such proposed drug take back program complies with the requirements of this article and notify the applicant. The department may conduct a noticed public hearing prior to approval. If the drug take back program is approved, the department shall notify the applicant in writing. If the drug take back program is not approved, the department shall notify the applicant in writing and the applicant shall submit a revised drug take back program proposal within thirty days. If the department rejects the subsequent proposal, the manufacturer or manufacturers at issue shall be out of compliance with this article and subject to the enforcement provisions pursuant to section two hundred ninety-four of this article. The department shall

provide, and update annually, on its website a list of all manufacturers participating in a drug take back program approved by the department.

6. At least every three years, a manufacturer, jointly or individually, or a drug take back organization shall update its drug take back program and submit an updated proposal to the department. A manufacturer who begins to offer a covered drug in the state after the effective date of this article, shall provide evidence of joining an existing approved drug take back program or submit a proposal for a drug take back program within ninety days following the initial offer for sale of a covered drug. Any proposed change to a drug take back program shall be submitted in writing and approved by the department prior to any change.

7. Each approved drug take back program shall report to the department at a date and manner set by the department. The department shall submit an annual report to the governor, speaker of the assembly and temporary president of the senate by January first detailing all program activities, the volume collected by each program, a description of collection activities, the name and location of all collection sites, public education and outreach activities, and any manufacturer out of compliance or subject to penalties pursuant to section two hundred ninety-four of this article.

§ 292. Collection. 1. All pharmacies shall provide for the safe collection of drugs, which shall include:

(a) Offering drug collection by:

(i) On-site collection receptacles meeting federal standards;

(ii) Mail-back collection by prepaid envelopes as authorized by federal law and regulation; or

(iii) Other federal drug enforcement agency approved methods of collection.

(b) Signage prominently displayed advertising such drug collection to consumers.

2. All drug take back program operators shall notify other potential authorized collectors of the opportunity to serve as an authorized collector for the drug take back program. Participation of authorized collectors besides pharmacies shall be voluntary.

3. All costs of pharmacies and other authorized collectors shall be paid or reimbursed by the manufacturer, jointly or individually, as part of the drug take back programs required by this article.

§ 293. Violations. Violation of this article shall be subject to fines pursuant to section twelve of this chapter. Each day in which the violation continues shall constitute a separate violation.

§ 294. Jurisdiction. Jurisdiction of all matters pertaining to drug disposal by this article is vested exclusively in the state. Any provision of any local law or ordinance, or any rule or regulation promulgated prior to, or upon the effective date of this section, shall be preempted.

§ 8-b. Section 3343-b of the public health law, as amended by chapter 379 of the laws of 2015, is amended to read as follows:

§ 3343-b. Safe disposal of unused controlled substances. 1. The department shall oversee a program for the safe disposal of unused controlled substances by consumers in accordance with federal law and article two-B of this chapter. Individual members of the public shall be authorized to voluntarily surrender controlled substances listed on schedule II, III, IV or V of section thirty-three hundred six of this article in a secure manner, without identifying themselves. Safe disposal methods shall be publicized consistent with the prescription pain medication awareness program established pursuant to section thir-

ty-three hundred nine-a of this article and article two-B of this chapter.

2. The surrender of a controlled substance pursuant to this section and article two-B of this chapter shall not constitute the possession, transfer or sale of such controlled substance for purposes of this article or the penal law.

[~~3. Disposal sites shall be operated by law enforcement agencies, pharmacies and other Federal Drug Enforcement Administration authorized collectors on a voluntary basis. Nothing in this section shall require any political subdivision of the state to participate in the program established in this section.~~]

§ 8-c. The department of health may adopt regulations as necessary to implement and enforce the provisions of title 4 of the public health law.

§ 8-d. The public health law is amended by adding a new section 3346 to read as follows:

§ 3346. Prescribing opioids to minors. 1. As used in this section, the following terms shall have the following meanings:

(a) "another adult authorized to consent to the minor's medical treatment" means an adult to whom a minor's parent or guardian has given written authorization to consent to the minor's medical treatment;

(b) "medical emergency" means a situation that in a practitioner's good faith medical judgment creates an immediate threat of serious risk to the life or physical health of a minor; and

(c) "minor" means an individual under eighteen years of age who is not emancipated. For purposes of this section, an individual under eighteen years of age is emancipated only if the individual has married, has entered the armed services of the United States, has become employed and self-sustaining, or otherwise has become independent from the care and control of the individual's parent, guardian, or custodian.

2. Except as provided in subdivision three of this section, before issuing for a minor the first prescription in a single course of treatment for a particular compound that is a controlled substance containing an opioid, regardless of whether the dosage is modified during that course of treatment, a practitioner shall:

(i) assess whether the minor has ever suffered, or is currently suffering, from mental health or substance abuse disorders and whether the minor has taken or is currently taking prescription drugs for treatment of those disorders;

(ii) discuss with the minor and the minor's parent, guardian, or another adult authorized to consent to the minor's medical treatment all of the following:

(A) the risks of addiction and overdose associated with the controlled substance containing an opioid;

(B) the increased risk of addiction to controlled substances of individuals suffering from both mental and substance abuse disorders;

(C) the dangers of taking controlled substances containing an opioid with benzodiazepines, alcohol, or other central nervous system depressants; and

(D) any other information in the patient counseling information section of the labeling for controlled substances containing an opioid required under 21 C.F.R. 201.57(c)(18); and

(iii) obtain written consent for the prescription from the minor's parent, guardian, or, subject to subdivision four of this section, another adult authorized to consent to the minor's medical treatment. The practitioner shall record the consent on a form prescribed by the

commissioner. The form shall be separate from any other document the practitioner uses to obtain informed consent for other treatment provided to the minor. The form shall contain all of the following:

(A) the name and quantity of the controlled substance containing an opioid being prescribed and the amount of the initial dose;

(B) a statement indicating that a controlled substance is a drug or other substance that the United States drug enforcement administration has identified as having a potential for abuse;

(C) a statement certifying that the practitioner discussed with the minor and the minor's parent, guardian, or another adult authorized to consent to the minor's medical treatment the matters described in subparagraph (ii) of this paragraph;

(D) the number of refills, if any, authorized by the prescription; and

(E) the signature of the minor's parent, guardian, or another adult authorized to consent to the minor's medical treatment and the date of signing.

3. The requirements in subdivision two of this section shall not apply:

(a) if the minor's treatment with a controlled substance containing an opioid is associated with or incident to a medical emergency;

(b) if in the practitioner's professional judgment, fulfilling the requirements of subdivision two of this section with respect to the minor's treatment would be a detriment to the minor's health or safety; or

(c) in other circumstances designated by the commissioner.

4. A signed consent form obtained under this section shall be maintained in the minor's medical record.

§ 8-e. Paragraph (b) of subdivision 5 of section 3331 of the public health law, as added by section 1 of part C of chapter 71 of the laws of 2016, is amended and a new paragraph (d) is added to read as follows:

(b) Notwithstanding the provisions of paragraph (a) of this subdivision, a practitioner, within the scope of his or her professional opinion or discretion, may not prescribe more than a [~~seven-day~~] three-day supply of any schedule II, III, or IV opioid to an ultimate user upon the initial consultation or treatment of such user for acute pain. Upon any subsequent consultations for the same pain, the practitioner may issue, in accordance with paragraph (a) of this subdivision, any appropriate renewal, refill, or new prescription for the opioid or any other drug.

(d) Prior to issuing a prescription for any schedule II, III or IV opioid to an ultimate user upon the initial consultation or treatment of such user for chronic pain, the practitioner shall consider the recommendations of the federal centers for disease control and prevention including but not limited to the recommendation that nonpharmacologic therapy and nonopioids pharmacologic therapies are preferred for chronic pain, and that an initial opioid prescription should be immediate release opioids not exceeding fifty morphine milligram equivalents.

§ 8-f. The public health law is amended by adding a new section 3346 to read as follows:

§ 3346. Guidelines for prescribing of opioid antagonists. 1. The commissioner shall adopt guidelines for the prescribing of opioid antagonists which shall include, but not be limited to:

(a) when opioid antagonists should be prescribed to individuals to whom an opioid medication is also prescribed, which shall at a minimum provide for the prescribing of an opioid antagonist to any individual

with a treatment plan that consists of opioid use for more than one month;

(b) identifying patients at risk of any opioid overdose and when prescribing an opioid antagonist to that patient or a person in a position to administer the opioid antagonists is appropriate; and

(c) information on how consumers can access opioid antagonists with or without a prescription.

2. In adopting these guidelines the commissioner shall consult with the state board of pharmacy as well as materials published by the substance abuse and mental health services administration of the United States department of health and human services, and other appropriate materials including medical journals subject to peer review and publications by medical associations.

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

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

§ 8-h. Section 4303 of the insurance law is amended by adding a new subsection (rr) to read as follows:

(rr) Every contract issued by a corporation subject to the provisions of this article which provides medical, major medical or similar comprehensive-type coverage shall not be required to cover opioids prescribed to a patient initiating or being maintained on opioid treatment for pain which has lasted more than one month or past the time of normal tissue healing, unless the medical record contains a written treatment plan that includes: goals for pain management and functional improvement based on diagnosis; information on whether non-opioid therapies have been tried and optimized or are contraindicated; a statement that the prescriber has explained to the patient the risks of and alternatives to opioid treatment; an evaluation of the patient for risk factors of harm and misuse of opioids; an assessment of the patient's adherence to treatment with respect to other conditions treated by the same provider; the signature of the patient and/or attestation by the prescriber that the patient verbally agreed to the treatment plan; and any other information required by the department. Such treatment plan shall also include a prescription for an opioid antagonist and information on the administration and use of such opioid antagonists. The treatment plan

shall be updated twice within the year immediately following its initiation and annually thereafter. The requirements of this subsection shall not apply in the case of patients who are being treated for cancer that is not in remission, who are in hospice or other end-of-life care, or whose pain is being treated as part of palliative care practices.

§ 8-i. Section 3216 of the insurance law is amended by adding a new subsection (n) to read as follows:

(n) No policy of accident and health insurance delivered or issued for delivery in this state shall provide for reimbursement or coverage of opioids prescribed to a patient initiating or being maintained on opioid treatment for pain which has lasted more than one month or past the time of normal tissue healing, unless the medical record contains a written treatment plan that includes: goals for pain management and functional improvement based on diagnosis; information on whether non-opioid therapies have been tried and optimized or are contraindicated; a statement that the prescriber has explained to the patient the risks of and alternatives to opioid treatment; an evaluation of the patient for risk factors of harm and misuse of opioids; an assessment of the patient's adherence to treatment with respect to other conditions treated by the same provider; the signature of the patient and/or attestation by the prescriber that the patient verbally agreed to the treatment plan; and any other information required by the department. Such treatment plan shall also include a prescription for an opioid antagonist and information on the administration and use of such opioid antagonists. The treatment plan shall be updated twice within the year immediately following its initiation and annually thereafter. The requirements of this subsection shall not apply in the case of patients who are being treated for cancer that is not in remission, who are in hospice or other end-of-life care, or whose pain is being treated as part of palliative care practices.

§ 8-j. Section 3221 of the insurance law is amended by adding a new subsection (j-1) to read as follows: (j-1) No policy of group or blanket accident and health insurance delivered or issued for delivery in this state shall provide for reimbursement or coverage of opioids prescribed to a patient initiating or being maintained on opioid treatment for pain which has lasted more than one month or past the time of normal tissue healing, unless the medical record contains a written treatment plan that includes: goals for pain management and functional improvement based on diagnosis; information on whether non-opioid therapies have been tried and optimized or are contraindicated; a statement that the prescriber has explained to the patient the risks of and alternatives to opioid treatment; an evaluation of the patient for risk factors of harm and misuse of opioids; an assessment of the patient's adherence to treatment with respect to other conditions treated by the same provider; the signature of the patient and/or attestation by the prescriber that the patient verbally agreed to the treatment plan; and any other information required by the department. Such treatment plan shall also include a prescription for an opioid antagonist and information on the administration and use of such opioid antagonists. The treatment plan shall be updated twice within the year immediately following its initiation and annually thereafter. The requirements of this subsection shall not apply in the case of patients who are being treated for cancer that is not in remission, who are in hospice or other end-of-life care, or whose pain is being treated as part of palliative care practices.

§ 8-k. Subparagraph (v) of paragraph (a) of subdivision 2 of section 3343-a of the public health law, as added by section 2 of part A of chapter 447 of the laws of 2012, is amended to read as follows:

(v) a practitioner prescribing a controlled substance in the emergency department of a general hospital, provided that the quantity of controlled substance prescribed does not exceed a [~~five~~] three day supply if the controlled substance were used in accordance with the directions for use;

§ 8-l. The public health law is amended by adding a new section 2827 to read as follows:

§ 2827. Opioid alternative pilot project. There shall be established an opioid alternative pilot project whereby the commissioner, in consultation with the commissioner of alcoholism and substance abuse services, shall identify at least five acute care emergency departments in the state to participate in the opioid alternative pilot project. While traditionally opioids have been the primary treatment for acute pain in emergency departments, they are not always necessary or the most effective treatment and the side effects of misuse and addiction can be deadly. The opioid alternative pilot project shall be designed to reduce the use of opioids in emergency departments by using a multimodal treatment approach to pain including coordination across providers, pharmacies, clinical staff and administrators, as well as looking at new procedures, methods of treatment and less addictive alternatives. Within one year of the effective date of this section the participants in the project shall report to the commissioner, the speaker of the assembly and the temporary president of the senate on the effectiveness of the opioid alternative pilot project in reducing opioid use and any recommendations for expansions of or alterations to the project.

§ 8-m. Paragraphs (i) and (j) of subdivision 1 of section 3371 of the public health law, as added by section 4 of part A of chapter 447 of the laws of 2012, are amended to read as follows:

(i) to a medical examiner or coroner who is an officer of or employed by a state or local government, pursuant to his or her official duties; [~~and~~]

(j) to an individual for the purpose of providing such individual with his or her own controlled substance history or, in appropriate circumstances, in the case of a patient who lacks capacity to make health care decisions, a person who has legal authority to make such decisions for the patient and who would have legal access to the patient's health care records, if requested from the department pursuant to subdivision six of section thirty-three hundred forty-three-a of this article or from a treating practitioner pursuant to subparagraph (iv) of paragraph (a) of subdivision two of this section; and

(k) to a practitioner to inform him or her that a patient is under treatment for a controlled substance overdose by hospital or emergency room practitioner for the purposes of subdivision two of this section.

§ 8-n. Paragraph (a) of subdivision 2 of section 3371 of the public health law, as amended by chapter 90 of the laws of 2014, is amended to read as follows:

(a) a practitioner, or a designee authorized by such practitioner pursuant to paragraph (b) of subdivision two of section thirty-three hundred forty-three-a or section thirty-three hundred sixty-one of this article, for the purposes of: (i) informing the practitioner that a patient may be under treatment with a controlled substance by another practitioner or that a patient is under treatment for a controlled substance overdose; (ii) providing the practitioner with notifications

of controlled substance activity as deemed relevant by the department, including but not limited to a notification made available on a monthly or other periodic basis through the registry of controlled substances activity pertaining to his or her patient; (iii) allowing the practitioner, through consultation of the prescription monitoring program registry, to review his or her patient's controlled substances history as required by section thirty-three hundred forty-three-a or section thirty-three hundred sixty-one of this article; and (iv) providing to his or her patient, or person authorized pursuant to paragraph (j) of subdivision one of this section, upon request, a copy of such patient's controlled substance history as is available to the practitioner through the prescription monitoring program registry; or

§ 8-o. Paragraph (a) of subdivision 2 of section 3371 of the public health law, as added by section 5 of part A of chapter 447 of the laws of 2012, is amended to read as follows:

(a) a practitioner, or a designee authorized by such practitioner pursuant to paragraph (b) of subdivision two of section thirty-three hundred forty-three-a of this article, for the purposes of: (i) informing the practitioner that a patient may be under treatment with a controlled substance by another practitioner **or that a patient is under treatment for a controlled substance overdose**; (ii) providing the practitioner with notifications of controlled substance activity as deemed relevant by the department, including but not limited to a notification made available on a monthly or other periodic basis through the registry of controlled substances activity pertaining to his or her patient; (iii) allowing the practitioner, through consultation of the prescription monitoring program registry, to review his or her patient's controlled substances history as required by section thirty-three hundred forty-three-a of this article; and (iv) providing to his or her patient, or person authorized pursuant to paragraph (j) of subdivision one of this section, upon request, a copy of such patient's controlled substance history as is available to the practitioner through the prescription monitoring program registry; or

§ 8-p. The opening paragraph of paragraph (a) of subdivision 2 of section 3343-a of the public health law, as added by section 2 of part A of chapter 447 of the laws of 2012, is amended to read as follows:

Every practitioner shall consult the prescription monitoring program registry prior to prescribing or dispensing any controlled substance listed on schedule II, III or IV of section thirty-three hundred six of this article, for the purpose of reviewing a patient's controlled substance history as set forth in such registry **and every emergency room or hospital practitioner shall consult the prescription monitoring program registry when treating a patient for a controlled substance overdose and shall notify the patient's prescriber of such overdose**; provided, however, that nothing in this section shall preclude an authorized practitioner, other than a veterinarian, from consulting the registry at his or her option prior to prescribing or dispensing any controlled substance. The duty to consult the registry shall not apply to:

§ 8-q. Subparagraph (iv) of paragraph (a) of subdivision 4 of section 3331 of the public health law, as added by chapter 415 of the laws of 1981, is amended to read as follows:

(iv) the legend, prominently marked or printed in either boldface or upper case lettering: "CONTROLLED SUBSTANCE, DANGEROUS UNLESS USED AS DIRECTED"; **provided however, substances listed in subdivisions (b) and (c) of schedule II, subdivisions (d) and (e) of schedule III, subdivi-**

sions (b) and (f) of schedule IV, and subdivision (b) of schedule V of section 3306 of this article, shall be affixed with a red label with text printed in a large white font to be easily and clearly readable, "OPIOID CONTROLLED SUBSTANCES TAKEN AS DIRECTED MAY LEAD TO ADDICTION";

§ 8-r. Article 25 of the public health law is amended by adding a new title 4-A to read as follows:

TITLE 4-A

CHILDREN AND RECOVERING MOTHERS

Section 2576. Recovering expectant mothers program.
2577. Newborn screening.
2578. Provider education.
2579. Workgroup.

§ 2576. Recovering expectant mothers program. There shall be established a recovering expectant mothers program within the department whereby the commissioner, in consultation with the commissioner of alcoholism and substance abuse services, shall provide guidance, education and assistance to providers caring for recovering expectant mothers, which shall include, but not be limited to:

1. establishing, in consultation with relevant health care providers, guidance on universal screening techniques for substance use disorder at prenatal visits. Such guidance shall rely on validated screening tools and questionnaires and utilize language to help reduce stigma;

2. providing information regarding use of medication assisted treatment for pregnant women, which shall include information regarding buprenorphrine training, tools for providers on effective management of women with opioid use disorder in pregnancy, and a referral list of certified providers;

3. providing referral information for substance abuse counseling, social support and basic needs referrals, which shall also include guidance on referring women to home visiting services that they may be eligible for after birth; and

4. developing a system for rapid consultation and referral linkage services for obstetricians and primary care providers statewide who provide care for expectant mothers with substance use disorder.

§ 2577. Newborn screening. The commissioner, in conjunction with the commissioner of alcoholism and substance abuse services, shall develop guidance for hospitals and midwifery birth centers on neonatal abstinence syndrome which shall include, but not be limited to, appropriate treatment methods for neonatal abstinence syndrome and information on home visiting services that recovering mothers may be eligible for, as well as other substance abuse services, social supports and basic need referrals in the community.

§ 2578. Provider education. The commissioner shall develop or approve a continuing medical education course for neonatal nurses, obstetricians, midwives, pediatricians, and other health care providers regarding treatment of expectant mothers and new mothers suffering from substance use disorder, and the treatment of newborns suffering from neonatal abstinence syndrome, which may include federally approved buprenorphine training, in order to facilitate comprehensive prenatal and postpartum care to this population.

§ 2579. Workgroup. The commissioner, in conjunction with the commissioner of alcoholism and substance abuse services, shall convene a workgroup of stakeholders, including but not limited to, hospitals, local health departments, obstetricians, midwives, pediatricians, and substance abuse providers to study and evaluate current barriers and challenges in identifying and treating expectant mothers, newborns, and

new parents with substance use disorder. The workgroup shall report on its findings and recommendations to the commissioner, the speaker of the assembly and the temporary president of the senate within one year of the effective date of this section.

§ 8-s. Title 1 of article 25 of the public health law is amended by adding a new section 2509 to read as follows:

§ 2509. Infant recovery centers pilot program. There shall be established an infant recovery centers pilot program whereby the commissioner, in consultation with the commissioner of alcohol and substance abuse services, shall establish at least four infant recovery centers in areas of need in the state. Such centers shall provide cost effective, necessary services and enhance the quality of care for targeted populations in order to demonstrate the effectiveness of such program. Eligible infants shall be under one year of age and suffer from withdrawal resulting from in utero exposure to drugs. Such infant withdrawal may be the result of conditions including, but not limited to, neonatal abstinence syndrome. The program shall provide more appropriate settings and cost effective care for these infants than hospitals, while also providing supports and services to parents preparing to bring their infants home. Access to such supports shall continue for a period after the infant has left a center.

The department shall be responsible for monitoring the quality, appropriateness and effectiveness of the centers and shall report to the legislature within one year of the establishment of the infant recovery centers and again within two years of the effective date of this section on the program's effectiveness.

§ 8-t. Subdivision (a) of section 2500-a of the public health law, as amended by chapter 184 of the laws of 2013, is amended to read as follows:

(a) It shall be the duty of the administrative officer or other person in charge of each institution caring for infants twenty-eight days or less of age and the person required in pursuance of the provisions of section forty-one hundred thirty of this chapter to register the birth of a child, to cause to have administered to every such infant or child in its or his care a test for phenylketonuria, homozygous sickle cell disease, hypothyroidism, branched-chain ketonuria, galactosemia, homocystinuria, critical congenital heart defects through pulse oximetry screening, neonatal abstinence syndrome, and such other diseases and conditions as may from time to time be designated by the commissioner in accordance with rules or regulations prescribed by the commissioner. Testing, the recording of the results of such tests, tracking, follow-up reviews and educational activities shall be performed at such times and in such manner as may be prescribed by the commissioner. The commissioner shall promulgate regulations setting forth the manner in which information describing the purposes of the requirements of this section shall be disseminated to parents or a guardian of the infant tested.

§ 8-u. Subparagraph (A) of paragraph 31 of subsection (i) of section 3216 of the insurance law, as added by chapter 41 of the laws of 2014, is amended to read as follows:

(A) Every policy that provides medical, major medical or similar comprehensive-type coverage must provide outpatient coverage for the diagnosis and treatment of substance use disorder, including detoxification and rehabilitation services. Such coverage shall not be subject to prior authorization and shall not apply financial requirements or treatment limitations to outpatient substance use disorder benefits that are more restrictive than the predominant financial requirements and treat-

ment limitations applied to substantially all medical and surgical benefits covered by the policy. Further, such coverage shall be provided consistent with the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (29 U.S.C. § 1185a).

§ 8-v. Subparagraph (A) of paragraph 7 of subsection (1) of section 3221 of the insurance law, as amended by chapter 41 of the laws of 2014, is amended to read as follows:

(A) Every policy that provides medical, major medical or similar comprehensive-type coverage must provide outpatient coverage for the diagnosis and treatment of substance use disorder, including detoxification and rehabilitation services. Such coverage shall not **be subject to prior authorization and shall not** apply financial requirements or treatment limitations to outpatient substance use disorder benefits that are more restrictive than the predominant financial requirements and treatment limitations applied to substantially all medical and surgical benefits covered by the policy. Further, such coverage shall be provided consistent with the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (29 U.S.C. § 1185a).

§ 8-w. Paragraph 1 of subsection (l) of section 4303 of the insurance law, as amended by chapter 41 of the laws of 2014, is amended to read as follows:

(1) Every contract that provides medical, major medical or similar comprehensive-type coverage must provide outpatient coverage for the diagnosis and treatment of substance use disorder, including detoxification and rehabilitation services. Such coverage shall not **be subject to prior authorization and shall not** apply financial requirements or treatment limitations to outpatient substance use disorder benefits that are more restrictive than the predominant financial requirements and treatment limitations applied to substantially all medical and surgical benefits covered by the contract. Further, such coverage shall be provided consistent with the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (29 U.S.C. § 1185a).

§ 8-x. The mental hygiene law is amended by adding a new section 7.46 to read as follows:

§ 7.46 Operating certificates.

(a) The commissioner or the commissioner of the office of alcoholism and substance abuse services shall not deny an operating certificate pursuant to section 31.02 or 32.05 of this chapter to a facility providing out-patient or non-residential services for the mentally disabled or individuals suffering from chemical abuse or dependence that includes a pharmacy within the facility, provided that the pharmacy:

(1) conforms with paragraph g of subdivision two of section sixty-eight hundred eight of the education law;

(2) is not operated by the facility;

(3) does not share revenue of the pharmacy with the facility; and

(4) does not require or otherwise coerce patients to utilize such pharmacy.

(b) Furthermore, patients, clinic staff and other individuals may traverse the common waiting area within the clinic space to access such pharmacy, and the pharmacy need not have a separate public entrance leading from outside of the building to such pharmacy. Nothing in this subdivision shall prevent the facility from collecting rent from the operator of such pharmacy if such pharmacy is leasing space from the facility.

§ 8-y. Paragraphs g and h of subdivision 2 of section 6808 of the education law are relettered paragraphs h and i and a new paragraph g is added to read as follows:

g. A pharmacy within a facility providing out-patient or non-residential services for the mentally disabled or individuals suffering from chemical abuse or dependence. When a pharmacy is operated within a facility providing out-patient or non-residential services for the mentally disabled or individuals suffering from chemical abuse or dependence under an operating certificate issued by the commissioners of the office of mental health or the office of alcoholism and substance abuse services pursuant to section 31.02 or 32.05 of the mental hygiene law, the area compromising the pharmacy shall be secured, preventing unauthorized access to the pharmacy and drugs when a pharmacist is not on duty. Identification of the area within the pharmacy by use of the words "drugs", "medicines", "drug store", or "pharmacy" or similar terms shall be restricted to the area licensed by the department as a pharmacy. Patients, clinic staff and other individuals may traverse the common waiting area within the clinic space to access such pharmacy, and such pharmacy need not have a separate public entrance leading from outside of the building to such pharmacy.

§ 8-z. Intentionally omitted.

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

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

(a) "Pharmacy benefit manager" shall have the same meaning as in section two hundred eighty-a of this article.

(b) "Pharmacy" shall mean a pharmacy that has contracted with a pharmacy benefit manager for the provision of pharmacy services.

2. When conducting an audit of a pharmacy's records, a pharmacy benefit manager shall:

(a) not conduct an on-site audit of a pharmacy at any time during the first three calendar days of a month;

(b) notify the pharmacy or its contracting agent no later than fifteen days before the date of initial on-site audit. Such notification to the pharmacy or its contracting agent shall be in writing delivered either (i) by mail or common carrier, return receipt requested, or (ii) electronically with electronic receipt confirmation, addressed to the supervising pharmacist of record and pharmacy corporate office where applicable, at least fifteen days before the date of an initial on-site audit;

(c) limit the audit period to twenty-four months after the date a claim is submitted to or adjudicated by the pharmacy benefit manager;

(d) include in the written advance notice of an on-site audit the list of specific prescription numbers to be included in the audit that may or may not include the final two digits of the prescription numbers;

(e) use the written and verifiable records of a hospital, physician or other authorized practitioner, which are transmitted by any means of communication, to validate the pharmacy records in accordance with state and federal law;

(f) limit the number of prescriptions audited to no more than one hundred randomly selected in a twelve-month period, except in cases of fraud;

(g) provide the pharmacy or its contracting agent with a copy of the preliminary audit report within forty-five days after the conclusion of the audit;

(h) be allowed to conduct a follow-up audit on-site if a remote or desk audit reveals the necessity for a review of additional claims;

(i) in the case of invoice audits, accept as validation invoices from any wholesaler registered with the department of education from which the pharmacy has purchased prescription drugs or, in the case of durable medical equipment or sickroom supplies, invoices from an authorized distributor other than a wholesaler;

(j) provide the pharmacy or its contracting agent with the ability to provide documentation to address a discrepancy or audit finding, provided that such documentation must be received by the pharmacy benefit manager no later than the forty-fifth day after the preliminary audit report was provided to the pharmacy or its contracting agent. The pharmacy benefit manager shall consider a reasonable request from the pharmacy for an extension of time to submit documentation to address or correct any findings in the report; and

(k) provide the pharmacy or its contracting agent with the final audit report no later than sixty days after the initial audit report was provided to the pharmacy or its contracting agent.

3. Any claim that was retroactively denied for a clerical error, typographical error, scrivener's error or computer error shall be paid if the prescription was properly and correctly dispensed, unless a pattern of such errors exists, fraudulent billing is alleged or the error results in actual financial loss to the entity. A clerical error is an error that does not result in actual financial harm to the covered entity or consumer and does not include the dispensing of an incorrect dose, amount or type of medication or dispensing a prescription drug to the wrong person.

4. This section shall not apply to:

(a) audits in which suspected fraudulent activity or other intentional or willful misrepresentation is evidenced by a physical review, review of claims data or statements, or other investigative methods; or

(b) audits of claims paid for by federally funded programs; or

(c) concurrent reviews or desk audits that occur within three business days of transmission of a claim and where no chargeback or recoupment is demanded.

§ 8-bb. Section 280-a of the public health law is amended by adding two new subdivisions 3 and 4 to read as follows:

3. No pharmacy benefit manager shall, with respect to contracts between such pharmacy benefit manager and a pharmacy or, alternatively, such pharmacy benefit manager and a pharmacy's contracting agent, such as a pharmacy services administrative organization:

(a) prohibit or penalize a pharmacist or pharmacy from disclosing to an individual purchasing a prescription medication information regarding:

(1) the cost of the prescription medication to the individual, or

(2) the availability of any therapeutically equivalent alternative medications or alternative methods of purchasing the prescription medication, including but not limited to, paying a cash price; or

(b) charge or collect from an individual a copayment that exceeds the total submitted charges by the pharmacy for which the pharmacy is paid. If an individual pays a copayment, the pharmacy shall retain the adjudicated costs and the pharmacy benefit manager shall not redact or recoup the adjudicated cost.

4. Any provision of a contract that violates the provisions of this section shall be deemed to be void and unenforceable.

§ 8-cc. Intentionally omitted.

§ 8-dd. Intentionally omitted.
§ 8-ee. Intentionally omitted.
§ 8-ff. Intentionally omitted.
§ 8-gg. Intentionally omitted.
§ 8-hh. Intentionally omitted.
§ 9. This act shall take effect immediately; provided, however, that:
(a) the amendments to paragraph (d) of subdivision 9 of section 367-a of the social services law made by section one of this act shall not affect the expiration of such subdivision and shall expire therewith;
(b) the amendments to subdivision 1 of section 292 of the public health law, as added by section eight-a of this act, shall take effect on the one hundred eightieth day after it shall have become a law;
(c) the provisions of sections eight-d, eight-e, eight-f, eight-g, eight-k, eight-l, eight-r, and eight-bb of this act shall take effect on the ninetieth day after it shall have become a law;
(d) sections eight-h, eight-i and eight-j of this act shall take effect on the first of January next succeeding the date on which this act shall have become a law and shall apply to all policies issued, modified or renewed on and after such date;
(e) the amendments to paragraph (a) of subdivision 2 of section 3371 of the public health law, as amended by section eight-n of this act shall be subject to the expiration and reversion of such subdivision pursuant to section 12 of chapter 90 of the laws of 2014, as amended, when upon such date the provisions of section eight-o of this act shall take effect;
(f) sections eight-q and eight-t of this act shall take effect on the one hundred eightieth day after it shall have become a law;
(g) the provisions of section eight-s of this act shall expire and be deemed repealed 4 years after such date;
(h) the provisions of section eight-t of this act shall expire and be deemed repealed on March 31, 2023;
(i) the provisions of sections eight-u, eight-v, and eight-w of this act shall apply to policies and contracts issued, renewed, modified, altered or amended on or after such date;
(j) the provisions of section eight-aa of this act shall take effect on the sixtieth day after it shall have become a law; and
(k) effective immediately, the addition, amendment and/or repeal of any rule or regulation necessary for the implementation of this act on its effective date are authorized to be made and completed on or before such effective date.

PART E

Section 1. Subdivision 4 of section 365-h of the social services law, as separately amended by section 50 of part B and section 24 of part D of chapter 57 of the laws of 2015, is amended to read as follows:
4. The commissioner of health is authorized to assume responsibility from a local social services official for the provision and reimbursement of transportation costs under this section. If the commissioner elects to assume such responsibility, the commissioner shall notify the local social services official in writing as to the election, the date upon which the election shall be effective and such information as to transition of responsibilities as the commissioner deems prudent. The commissioner is authorized to contract with a transportation manager or managers to manage transportation services in any local social services district, other than transportation services provided or arranged for

[~~enrollees of managed long term care plans issued certificates of authority under section forty-four hundred three-f of the public health law~~]: adult day health care programs located at a licensed residential health care facility as defined by section twenty-eight hundred one of the public health law or any approved extension site thereof; participants of a program designated as a program of all-inclusive care for the elderly (PACE) as authorized by federal public law 105-33, subtitle 1 of title IV of the balanced budget act of 1997; and enrollees of a managed long term care plan issued a certificate of authority under section forty-four hundred three-f of the public health law that elects to provide or arrange for transportation services directly. The commissioner shall offer managed long term care plans other than programs of all-inclusive care for the elderly, and adult day health care programs the option to arrange transportation directly or utilize a transportation manager or managers selected by the commissioner. Any transportation manager or managers selected by the commissioner to manage transportation services shall have proven experience in coordinating transportation services in a geographic and demographic area similar to the area in New York state within which the contractor would manage the provision of services under this section. Such a contract or contracts may include responsibility for: review, approval and processing of transportation orders; management of the appropriate level of transportation based on documented patient medical need; and development of new technologies leading to efficient transportation services. If the commissioner elects to assume such responsibility from a local social services district, the commissioner shall examine and, if appropriate, adopt quality assurance measures that may include, but are not limited to, global positioning tracking system reporting requirements and service verification mechanisms. Any and all reimbursement rates developed by transportation managers under this subdivision shall be subject to the review and approval of the commissioner.

§ 2. Intentionally omitted.

§ 3. Intentionally omitted.

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

PART F

Intentionally Omitted

PART G

Section 1. Section 2801-a of the public health law is amended by adding a new subdivision 17 to read as follows:

17. (a) Diagnostic or treatment centers established to provide health care services within the space of a retail business operation, such as a pharmacy or a store open to the general public, or within space used by an employer for providing health care services to its employees, may be operated by legal entities formed under the laws of the state of New York: (i) whose stockholders or members, as applicable, are not natural persons; (ii) whose principal stockholders and members, as applicable,

and controlling persons comply with all applicable requirements of this section; and (iii) that demonstrate, to the satisfaction of the public health and health planning council, sufficient experience and expertise in delivering high quality health care services, and further demonstrate a commitment to operate limited services clinics in medically underserved areas of the state. Such diagnostic and treatment centers shall be referred to in this section as "limited services clinics".

(b) For purposes of paragraph (a) of this subdivision, the public health and health planning council shall adopt and amend rules and regulations, notwithstanding any inconsistent provision of this section, to address any matter it deems pertinent to the establishment of limited services clinics. Such rules and regulations shall include, but not be limited to, provisions governing or relating to: (i) any direct or indirect changes or transfers of ownership interests or voting rights in such entities or their stockholders or members, as applicable; (ii) public health and health planning council approval of any change in controlling interests, principal stockholders, controlling persons, parent company or sponsors; (iii) oversight of the operator and its shareholders or members, as applicable, including local governance of the limited services clinics; and (iv) the character and competence and qualifications of, and changes relating to, the directors and officers of the operator and its principal stockholders, controlling persons, parent company or sponsors.

(c) The following provisions of this section shall not apply to limited services clinics: (i) paragraph (a) of subdivision three of this section; (ii) paragraph (b) of subdivision three of this section, relating to stockholders and members other than principal stockholders and principal members; (iii) paragraph (c) of subdivision four of this section, relating to the disposition of stock or voting rights; and (iv) paragraph (e) of subdivision four of this section, relating to the ownership of stock or membership.

(d) A limited services clinic shall be deemed to be a "health care provider" for the purposes of title two-D of article two of this chapter. A prescriber practicing in a limited service clinic shall not be deemed to be in the employ of a pharmacy or practicing in a hospital for purposes of subdivision two of section sixty-eight hundred seven of the education law.

(e) The commissioner shall promulgate regulations setting forth operational and physical plant standards for limited services clinics, which may be different from the regulations otherwise applicable to diagnostic or treatment centers, including, but not limited to:

(i) requiring that limited services clinics attain and maintain accreditation and requiring timely reporting to the Department if a limited services clinic loses its accreditation;

(ii) designating or limiting the treatments and services that may be provided, including:

(A) limiting the scope of services to the following, provided that such services shall not include monitoring or treatment and services over prolonged periods:

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

(2) episodic preventive and wellness treatments and services such as immunizations; and

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

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

(C) the provision of specific immunizations to patients younger than eighteen years of age;

(iii) requiring limited services clinics to accept walk-ins and offer extended business hours;

(iv) setting forth guidelines for advertising and signage, which shall include signage indicating that prescriptions and over-the-counter supplies may be purchased by a patient from any business and do not need to be purchased on-site;

(v) setting forth guidelines for disclosure of ownership interests, informed consent, record keeping, referral for treatment and continuity of care, case reporting to the patient's primary care or other health care providers, design, construction, fixtures, and equipment; and

(vi) requiring the operator to directly employ a medical director who is licensed and currently registered to practice medicine in the state of New York.

(f) Such regulations also shall promote and strengthen primary care by requiring limited services clinics to:

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

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

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

(iv) transmit, by electronic means whenever possible, records of services to patients' primary care providers;

(v) execute participation agreements with health information organizations, also known as qualified entities, pursuant to which limited services clinics agree to participate in the Statewide Health Information Network for New York (SHIN-NY); and

(vi) decline to treat any patient for the same condition or illness more than three times in a year.

(g) A limited services clinic shall provide treatment without discrimination as to source of payment.

(h) Notwithstanding this subdivision and other law or regulation to the contrary and subject to the provisions of section twenty-eight hundred two of this article, a general hospital, a diagnostic and treatment center, community health center or federally qualified health center may operate a limited services clinic which meets the regulation promulgated pursuant to paragraph (e) of this subdivision regarding operational physical plant standards.

(i) In determining whether to approve additional limited services clinic locations, the department shall consider whether the operator has fulfilled its commitment to operate limited services clinics in medically underserved areas of the state.

§ 2. This act shall take effect immediately.

PART H

Intentionally Omitted

PART I

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

34. For purposes of recouping overpayments relating to fraud and abuse, monies paid by the department to managed care organizations for covered medical assistance services, exclusive of any reimbursement for administrative expenses or care management services are public funds and retain their status as public funds when paid by the managed care organization to subcontractors or providers.

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

35. Recovery and retention of overpayments from network providers. (a) Where the Medicaid inspector general or the Medicaid fraud control unit of the office of the attorney general, during the course of an audit or investigation, identifies improper medical assistance payments made by a managed care organization to its subcontractor or subcontractors or provider or providers, the state shall, subject to paragraphs (b) and (c) of this subdivision have the right to recover the improper payment from the subcontractor or subcontractors, provider or providers, or the managed care organization.

(b) Contracts between the state and a managed care organization shall specify:

(i) The retention policies for the treatment of recoveries of all overpayments from the managed care organization to a provider, including specifically the retention policies for the treatment of recoveries of overpayments due to fraud or abuse;

(ii) The process, timeframes, and documentation required for reporting the recovery of all overpayments from network providers; and

(iii) The process, timeframes, and documentation required for payment of recoveries of overpayments to the state in situations where the managed care organization is not permitted to retain some or all of the recoveries of overpayments.

(c) Any recovery from a subcontractor or provider pursuant to this section shall be shared proportionally between the state and the managed care organization based on (i) the entity that initiated the recovery efforts and (ii) the efforts by each party to secure the recovery.

(d) This subdivision shall not apply to any amount of a recovery to be retained under False Claims Act cases.

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

36. Reporting acts of fraud. (a) All managed care organizations shall promptly refer to the office of the Medicaid inspector general all cases in which there is a reasonable suspicion of fraud or abuse.

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

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

§ 4. The public health law is amended by adding a new section 12-e to read as follows:

§ 12-e. Violations of medical assistance program laws, regulations or directives; fines. 1. (a) Any individual or entity participating in the medical assistance program that fails to comply with or violates any

statute, rule, regulation, or directive of the medical assistance program, may be fined in an amount not exceeding the sum of two thousand dollars for each violation.

(b) The penalty provided for in paragraph (a) of this subdivision may be increased to an amount not to exceed five thousand dollars for a subsequent violation if the person committed the identical violation, with respect to the same or any other person or persons, within twelve months of the initial violation for which a penalty was assessed pursuant to paragraph (a) of this subdivision and said violations were a serious threat to the health and safety of an individual or individuals.

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

(b) The penalty provided for in paragraph (a) of this subdivision may be increased to an amount not to exceed five thousand dollars for a subsequent violation if the person committed the same violation, with respect to the same or any other person or persons, within twelve months of the initial violation for which a penalty was assessed pursuant to paragraph (a) of this subdivision and said violations were a serious threat to the health and safety of an individual or individuals.

(c) The commissioner shall consider the following prior to assessing a penalty against a managed care organization and have the discretion to reduce or eliminate a penalty:

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

(ii) the amount of damages to the program;

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

(iv) the degree to which factors giving rise to the proscribed actions were out of the control of the managed care organization;

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

(vi) the timeliness of the managed care organization in curing or correcting violations;

(vii) whether the violation was caused by the managed care organization or a third party;

(viii) whether the managed care organization has taken corrective action to reduce the likelihood of future violations;

(ix) whether the managed care organization was or should have been aware of such violation; and

(x) any other facts relating to the nature and seriousness of the violations including any exculpatory facts.

3. The commissioner shall consider the following prior to assessing a fine against an individual or entity under this section and have the discretion to reduce or eliminate a fine under this section:

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

(b) the amount of damages to the program;

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

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

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

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

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

(h) any other relevant factors.

4. The commissioner may promulgate regulations enumerating those violations which may result in a fine pursuant to subdivisions one and two of this section, and the appeal rights afforded to individuals or entities subject to a fine.

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

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

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

PART J

Section 1. Section 190-a of the state finance law, as amended by section 2 of part HH of chapter 55 of the laws of 2014, is amended to read as follows:

§ 190-a. Monies recovered. 1. Notwithstanding any law to the contrary, all monies recovered or obtained under this article by a state agency or state official or employee acting in their official capacity shall be subject to subdivision eleven of section four of this chapter.

2. Expenditure of monies recovered pursuant to the false claims act related to the Medicaid program. To the extent practicable, all monies recovered pursuant to the false claims act as it relates to the Medicaid program received and/or expended during a fiscal year shall be accounted for by the head of the agency or entity recovering and/or expending the monies. The head of the agency or entity recovering and/or expending the monies, in consultation with the division of budget, shall report annually on the use of such monies to the temporary president of the senate, speaker of the assembly, chair of the senate finance committee, chair of the assembly ways and means committee, chair of the health committees in the senate and assembly by December first of each year. Such report shall include, but not be limited to, any and all filings of an action under section 190(1) of the false claims act by a local government, the

amount of monies collected and disbursed pursuant to the false claims act as it relates to the Medicaid program, recipients of such disbursements and the amount received by recipients, and estimates of all receipts, all disbursements and anticipated receipts for the current and succeeding fiscal years.

§ 2. This act shall take effect immediately.

PART K

Section 1. Notwithstanding any contrary provision of law, the department of health is authorized to require any Medicaid-enrolled licensed home care services agency, and any fiscal intermediary operating pursuant to section 365-f of the social services law, to report on costs incurred in rendering health care services to Medicaid beneficiaries, including those enrolled in managed care. The department of health may specify the frequency and format of such reports, determine the type and amount of information to be submitted, and require the submission of supporting documentation. However, licensed home care services agencies shall submit such cost reports to the department of health and the public health and planning council by July 1, 2018 for purposes of the review required by subdivision 8 of section 3612 of the public health law.

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

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

§ 3. Subdivision 1 of section 91 of part H of chapter 59 of the laws of 2011, amending the public health law and other laws relating to

general hospital reimbursement for annual rates, as amended by section 2 of part A of chapter 56 of the laws of 2013, is amended to read as follows:

1. Notwithstanding any inconsistent provision of state law, rule or regulation to the contrary, subject to federal approval, the year to year rate of growth of department of health state funds Medicaid spending shall not exceed the ten year [~~rolling~~] average of the medical component of the consumer price index as published by the United States department of labor, bureau of labor statistics, for the [~~preceding ten years~~] **ten year period ending six months prior to the start of the coming fiscal year**; provided, however, that for state fiscal year 2013-14 and for each fiscal year thereafter, the maximum allowable annual increase in the amount of department of health state funds Medicaid spending shall be calculated by multiplying the department of health state funds Medicaid spending for the previous year, minus the amount of any department of health state operations spending included therein, by such ten year [~~rolling~~] average.

§ 4. The public health law is amended by adding a new section 206-c to read as follows:

§ 206-c. Kidney disease outreach and education program. The New York Center for Kidney Transplantation shall, within amounts appropriated, establish and implement an education and outreach program for financial coordinators at kidney transplant programs in New York state to assist patients with end stage renal disease who meet the Medicare eligibility requirements, and who are waiting for kidney transplants, in accessing Medicare coverage. The center shall also establish and implement an education and outreach program for dialysis patients to ensure patients are aware of and have access to opportunities for living kidney donation.

§ 5. Section 6 of part S of chapter 57 of the laws of 2017 relating to authorizing the commissioner of health to sell accounts receivables balances owed to the state by Medicaid providers to financial institutions, is REPEALED.

§ 6. This act shall take effect immediately; provided, however, that nothing in this act shall invalidate or otherwise impact any sale of accounts receivable effected pursuant to section five of this act prior to the repeal of such section.

PART L

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

7. Notwithstanding any provision of law to the contrary, the department shall, when it determines necessary program features are in place, assume sole responsibility for commencing actions or proceedings in accordance with the provisions of this section, sections one hundred one, one hundred four, one hundred four-b, paragraph (a) of subdivision three of section three hundred sixty-six, subparagraph one of paragraph (h) of subdivision four of section three hundred sixty-six, and paragraph (b) of subdivision two of section three hundred sixty-seven-a of this chapter, to recover the cost of medical assistance furnished pursuant to this title and title eleven-D of this article. The department is authorized to contract with an entity that shall conduct activities on behalf of the department pursuant to this subdivision**, and may contract with an entity, pursuant to a request for proposal process, to conduct**

similar activities on behalf of the child health insurance program established pursuant to title one-A of article twenty-five of the public health law to the extent allowed by law. Prior to assuming such responsibility from a social services district, the department of health shall, in consultation with the district, define the scope of the services the district will be required to perform on behalf of the department of health pursuant to this subdivision.

§ 2. Intentionally omitted.

§ 3. Paragraph 1 of subsection (a) of section 3231 of the insurance law, as amended by section 69 of part D of chapter 56 of the laws of 2013, is amended to read as follows:

(1) No individual health insurance policy and no group health insurance policy covering between one and fifty employees or members of the group [~~or between one and one hundred employees or members of the group for policies issued or renewed on or after January first, two thousand sixteen~~] exclusive of spouses and dependents, hereinafter referred to as a small group, providing hospital and/or medical benefits, including medicare supplemental insurance, shall be issued in this state unless such policy is community rated and, notwithstanding any other provisions of law, the underwriting of such policy involves no more than the imposition of a pre-existing condition limitation if otherwise permitted by this article.

§ 4. Paragraph 3 of subsection (a) of section 3231 of the insurance law, as amended by section 69 of part D of chapter 56 of the laws of 2013, is amended to read as follows:

(3) Once accepted for coverage, an individual or small group cannot be terminated by the insurer due to claims experience. Termination of an individual or small group shall be based only on one or more of the reasons set forth in subsection (g) of section three thousand two hundred sixteen or subsection (p) of section three thousand two hundred twenty-one of this article. Group hospital and/or medical coverage, including medicare supplemental insurance, obtained through an out-of-state trust covering a group of fifty or fewer employees, [~~or between one and one hundred employees for policies issued or renewed on or after January first, two thousand sixteen,~~] or participating persons who are residents of this state must be community rated regardless of the situs of delivery of the policy. Notwithstanding any other provisions of law, the underwriting of such policy may involve no more than the imposition of a pre-existing condition limitation if permitted by this article, and once accepted for coverage, an individual or small group cannot be terminated due to claims experience. Termination of an individual or small group shall be based only on one or more of the reasons set forth in subsection (p) of section three thousand two hundred twenty-one of this article.

§ 5. Paragraph 1 of subsection (h) of section 3231 of the insurance law, as amended by chapter 12 of the laws of 2016, is amended to read as follows:

(1) Notwithstanding any other provision of this chapter, no insurer, subsidiary of an insurer, or controlled person of a holding company system may act as an administrator or claims paying agent, as opposed to an insurer, on behalf of small groups which, if they purchased insurance, would be subject to this section. No insurer may provide stop loss, catastrophic or reinsurance coverage to small groups which, if they purchased insurance, would be subject to this section. [~~Provided, however, the provisions of this paragraph shall not apply to: (A) the renewal of stop loss, catastrophic or reinsurance coverage issued and in~~

~~effect on January first, two thousand fifteen to small groups covering between fifty-one and one hundred employees or members of the group; and (B) the issuance between January first, two thousand sixteen and December thirty-first, two thousand sixteen, of stop loss, catastrophic or reinsurance coverage, and any renewal thereof, to a small group covering between fifty-one and one hundred employees or members of the group, provided that such group had stop loss, catastrophic or reinsurance coverage issued and in effect on January first, two thousand fifteen.~~]

§ 6. Paragraph 1 of subsection (a) of section 4317 of the insurance law, as amended by section 72 of part D of chapter 56 of the laws of 2013, is amended to read as follows:

(1) No individual health insurance contract and no group health insurance contract covering between one and fifty employees or members of the group, [~~or between one and one hundred employees or members of the group for policies issued or renewed on or after January first, two thousand sixteen~~] exclusive of spouses and dependents, including contracts for which the premiums are paid by a remitting agent for a group, hereinafter referred to as a small group, providing hospital and/or medical benefits, including Medicare supplemental insurance, shall be issued in this state unless such contract is community rated and, notwithstanding any other provisions of law, the underwriting of such contract involves no more than the imposition of a pre-existing condition limitation if otherwise permitted by this article.

§ 7. Paragraph 1 of subsection (e) of section 4317 of the insurance law, as amended by chapter 12 of the laws of 2016, is amended to read as follows:

(1) Notwithstanding any other provision of this chapter, no insurer, subsidiary of an insurer, or controlled person of a holding company system may act as an administrator or claims paying agent, as opposed to an insurer, on behalf of small groups which, if they purchased insurance, would be subject to this section. No insurer may provide stop loss, catastrophic or reinsurance coverage to small groups which, if they purchased insurance, would be subject to this section. [~~Provided, however, the provisions of this paragraph shall not apply to: (A) the renewal of stop loss, catastrophic or reinsurance coverage issued and in effect on January first, two thousand fifteen to small groups covering between fifty-one and one hundred employees or members of the group; and (B) the issuance between January first, two thousand sixteen, and December thirty-first, two thousand sixteen, of stop loss, catastrophic or reinsurance coverage, and any renewal thereof, to a small group covering between fifty-one and one hundred employees or members of the group, provided that such group had stop loss, catastrophic or reinsurance coverage issued and in effect on January first, two thousand fifteen.~~]

§ 8. Paragraph 1 of subsection (g) of section 3231 of the insurance law, as amended by chapter 12 of the laws of 2016, is amended to read as follows:

(1) [~~(A)~~] This section shall also apply to policies issued to a group defined in subsection (c) of section four thousand two hundred thirty-five of this chapter, including but not limited to an association or trust of employers, if the group includes one or more member employers or other member groups having [~~one hundred~~] **fifty** or fewer employees or members exclusive of spouses and dependents. For a policy issued or renewed on or after January first, two thousand fourteen, if the group includes one or more member small group employers eligible for coverage subject to this section, then such member employers shall be classified as small groups for rating purposes and the remaining members shall be

rated consistent with the rating rules applicable to such remaining members pursuant to paragraph two of this subsection. [~~(B) Subparagraph A of this paragraph shall not apply to either the renewal of a policy issued to a group or the issuance, between January first, two thousand sixteen and December thirty-first, two thousand sixteen, of a policy, and any renewal thereof, to a group, provided that the following three requirements are met: (I) the group had been issued a policy that was in effect on July first, two thousand fifteen; (II) the group had member employers, who, on or after July first, two thousand fifteen, have between fifty-one and one hundred employees, exclusive of spouses and dependents; and (III) the group is either: (i) comprised entirely of one or more municipal corporations or districts (as such terms are defined in section one hundred nineteen-n of the general municipal law); or (ii) comprised entirely of nonpublic schools providing education in any grade from pre-kindergarten through twelfth grade.~~]

§ 9. Paragraph 1 of subsection (d) of section 4317 of the insurance law, as amended by chapter 12 of the laws of 2016, is amended to read as follows:

(1) [~~(A)~~] This section shall also apply to a contract issued to a group defined in subsection (c) of section four thousand two hundred thirty-five of this chapter, including but not limited to an association or trust of employers, if the group includes one or more member employers or other member groups having [~~one hundred~~] **fifty** or fewer employees or members exclusive of spouses and dependents. For a contract issued or renewed on or after January first, two thousand fourteen, if the group includes one or more member small group employers eligible for coverage subject to this section, then such member employers shall be classified as small groups for rating purposes and the remaining members shall be rated consistent with the rating rules applicable to such remaining members pursuant to paragraph two of this subsection. [~~(B) Subparagraph A of this paragraph shall not apply to either the renewal of a contract issued to a group or the issuance, between January first, two thousand sixteen and December thirty-first, two thousand sixteen, of a contract, and any renewal thereof, to a group, provided that the following three requirements are met: (I) the group had been issued a contract that was in effect on July first, two thousand fifteen; (II) the group had member employers, who, on or after July first, two thousand fifteen, have between fifty-one and one hundred employees, exclusive of spouses and dependents; and (III) the group is either: (i) comprised entirely of one or more municipal corporations or districts (as such terms are defined in section one hundred nineteen-n of the general municipal law); or (ii) comprised entirely of nonpublic schools providing education in any grade from pre-kindergarten through twelfth grade.~~]

§ 10. Section 7 of chapter 12 of the laws of 2016 relating to directing the superintendent of financial services to contract with an independent entity to conduct an assessment regarding the impact of the prohibition on the sale of stop loss, catastrophic and reinsurance coverage to the small group market, is REPEALED.

§ 10-a. Section 213 of the insurance law, as added by section 1 of part L of chapter 57 of the laws of 2007, is amended to read as follows:

§ 213. New York state health care quality and cost containment commission. (a) There is hereby established within the department a commission, to be known as the "New York state health care quality and cost containment commission". The commission shall consist of thirteen members appointed by the governor, one of whom shall be the superintendent, one of whom shall be the commissioner of health, and six of whom

shall be appointed on the recommendation of the legislative leaders, two on the recommendation of the temporary president of the senate, two on the recommendation of the speaker of the assembly, one on the recommendation of the minority leader of the senate, and one on the recommendation of the minority leader of the assembly. All members shall serve at the pleasure of the governor, and vacancies shall be appointed in the same manner as original appointments. Members of the commission shall serve without compensation, but shall be reimbursed for reasonable travel expenses. In making appointments to the commission, the governor shall ensure that the interests of health care consumers, small businesses, the medical community and health plans are represented on the commission. **The commission shall be required to meet on the first Monday after the first of January of each calendar year to consider outstanding requests or duties. Any vacancies shall be deemed waived by the appointing authority for the purposes of the first meeting. Nothing in this section shall forfeit the right for an appointment authority to fill vacancies within their statutorily allowed members.**

(b)(1) The purpose of the commission shall be to analyze the impact on health insurance costs and quality of proposed legislation which would mandate that health benefits be offered or made available in individual and group health insurance policies, contracts and comprehensive health service plans, including legislation that affects the delivery of health benefits or services or the reimbursement of health care providers.

(2) [~~The~~] **Notwithstanding any other provision of law, the** governor, the chair of the senate insurance committee and the chair of the assembly insurance committee may request in writing that the commission evaluate a proposed mandated benefit. Upon receiving such a request, the commission may, by a majority vote of its members, undertake an evaluation of such proposed mandated benefit.

(3) In evaluating a proposed mandated benefit, the commission shall:

(A) investigate the current practices of health plans with regard to the proposed mandated benefit, and, to the extent possible, self-funded health benefit plans;

(B) investigate the potential premium impact of the proposed mandated benefits on all segments of the insurance market, as well as the potential for avoided costs through early detection and treatment of conditions, or more cost-effective delivery of medical services; and

(C) analyze the most current medical literature regarding the proposed mandated benefit to determine its impact on health care quality.

(4) In evaluating a proposed mandated benefit, the commission may hold one or more public hearings, and shall strive to obtain independent and verifiable information from diverse sources within the healthcare industry, medical community and among health care consumers with regard to the proposed mandated benefit.

(c) To assist the commission in its duties, and upon the direction of the commission, the superintendent is authorized to enter into one or more contracts with independent entities and organizations with demonstrable expertise in health care quality, finance, utilization and actuarial services. For the purposes of this section, the superintendent shall not enter into contracts with health plans, entities or organizations owned or controlled by health plans, or with significant business relationships with health plans.

(d) Upon completion of its evaluation of a proposed mandated benefit pursuant to this section, the commission shall deliver a written report of its findings to the chair of the assembly insurance committee and the chair of the senate insurance committee.

(e) The commission shall issue a report to the governor, the majority leader of the senate, the speaker of the assembly, the chairs of the senate and assembly insurance committees, and the chair of the senate task force on Lyme and tick-borne diseases, considering the impact on health insurance costs and quality of legislation requiring coverage of long-term and chronic Lyme disease and other tick-borne diseases. The commission shall be required to consider issues including, but not limited to, the specific medical impacts to particular geographic areas in the state including the Hudson Valley and Long Island, best practices developed for coverage for long-term and chronic Lyme disease in other states, and the associated costs of mandated coverage in addition to projected costs of untreated symptoms. The commission shall deliver a written report of its findings by May first, two thousand nineteen.

§ 10-b. Section 1119 of the insurance law is amended by adding a new subsection (d) to read as follows:

(d) Except as expressly required by this section, an organization authorized to operate under article forty-six of the public health law shall not be subject to the jurisdiction of the superintendent and required to comply with rules and regulations of the superintendent on matters unrelated to the provisions of this section, including, but not limited to, regulations relating to cybersecurity requirements for financial services companies. Such organizations shall instead be subject to the jurisdiction of the department of health on such matters unrelated to the provisions of this section, including any pertinent regulations or oversight regarding cybersecurity requirements.

§ 11. This act shall take effect immediately; provided, however that the amendments to paragraph 1 of subsection (g) and paragraph 1 of subsection (h) of section 3231, and paragraph 1 of subsection (d) and paragraph 1 of subsection (e) of section 4317 of the insurance law made by sections eight, five, nine and seven of this act respectively shall not affect the expiration and reversion of such paragraphs and shall expire and be deemed repealed therewith.

PART M

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

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

1, 1993 and June 30, 1994, between July 1, 1994 and June 30, 1995, between July 1, 1995 and June 30, 1996, between July 1, 1996 and June 30, 1997, between July 1, 1997 and June 30, 1998, between July 1, 1998 and June 30, 1999, between July 1, 1999 and June 30, 2000, between July 1, 2000 and June 30, 2001, between July 1, 2001 and June 30, 2002, between July 1, 2002 and June 30, 2003, between July 1, 2003 and June 30, 2004, between July 1, 2004 and June 30, 2005, between July 1, 2005 and June 30, 2006, between July 1, 2006 and June 30, 2007, between July 1, 2007 and June 30, 2008, between July 1, 2008 and June 30, 2009, between July 1, 2009 and June 30, 2010, between July 1, 2010 and June 30, 2011, between July 1, 2011 and June 30, 2012, between July 1, 2012 and June 30, 2013, between July 1, 2013 and June 30, 2014, between July 1, 2014 and June 30, 2015, between July 1, 2015 and June 30, 2016, between July 1, 2016 and June 30, 2017, [~~and~~] between July 1, 2017 and June 30, 2018**, and between July 1, 2018 and June 30, 2019** or reimburse the hospital where the hospital purchases equivalent excess coverage as defined in subparagraph (i) of paragraph (a) of subdivision 1-a of this section for medical or dental malpractice occurrences between July 1, 1987 and June 30, 1988, between July 1, 1988 and June 30, 1989, between July 1, 1989 and June 30, 1990, between July 1, 1990 and June 30, 1991, between July 1, 1991 and June 30, 1992, between July 1, 1992 and June 30, 1993, between July 1, 1993 and June 30, 1994, between July 1, 1994 and June 30, 1995, between July 1, 1995 and June 30, 1996, between July 1, 1996 and June 30, 1997, between July 1, 1997 and June 30, 1998, between July 1, 1998 and June 30, 1999, between July 1, 1999 and June 30, 2000, between July 1, 2000 and June 30, 2001, between July 1, 2001 and June 30, 2002, between July 1, 2002 and June 30, 2003, between July 1, 2003 and June 30, 2004, between July 1, 2004 and June 30, 2005, between July 1, 2005 and June 30, 2006, between July 1, 2006 and June 30, 2007, between July 1, 2007 and June 30, 2008, between July 1, 2008 and June 30, 2009, between July 1, 2009 and June 30, 2010, between July 1, 2010 and June 30, 2011, between July 1, 2011 and June 30, 2012, between July 1, 2012 and June 30, 2013, between July 1, 2013 and June 30, 2014, between July 1, 2014 and June 30, 2015, between July 1, 2015 and June 30, 2016, between July 1, 2016 and June 30, 2017, [~~and~~] between July 1, 2017 and June 30, 2018**, and between July 1, 2018 and June 30, 2019** for physicians or dentists certified as eligible for each such period or periods pursuant to subdivision 2 of this section by a general hospital licensed pursuant to article 28 of the public health law; provided that no single insurer shall write more than fifty percent of the total excess premium for a given policy year; and provided, however, that such eligible physicians or dentists must have in force an individual policy, from an insurer licensed in this state of primary malpractice insurance coverage in amounts of no less than one million three hundred thousand dollars for each claimant and three million nine hundred thousand dollars for all claimants under that policy during the period of such excess coverage for such occurrences or be endorsed as additional insureds under a hospital professional liability policy which is offered through a voluntary attending physician ("channeling") program previously permitted by the superintendent of financial services during the period of such excess coverage for such occurrences. During such period, such policy for excess coverage or such equivalent excess coverage shall, when combined with the physician's or dentist's primary malpractice insurance coverage or coverage provided through a voluntary attending physician ("channeling") program, total an aggregate level of two million three hundred thousand dollars for each claimant and six

million nine hundred thousand dollars for all claimants from all such policies with respect to occurrences in each of such years provided, however, if the cost of primary malpractice insurance coverage in excess of one million dollars, but below the excess medical malpractice insurance coverage provided pursuant to this act, exceeds the rate of nine percent per annum, then the required level of primary malpractice insurance coverage in excess of one million dollars for each claimant shall be in an amount of not less than the dollar amount of such coverage available at nine percent per annum; the required level of such coverage for all claimants under that policy shall be in an amount not less than three times the dollar amount of coverage for each claimant; and excess coverage, when combined with such primary malpractice insurance coverage, shall increase the aggregate level for each claimant by one million dollars and three million dollars for all claimants; and provided further, that, with respect to policies of primary medical malpractice coverage that include occurrences between April 1, 2002 and June 30, 2002, such requirement that coverage be in amounts no less than one million three hundred thousand dollars for each claimant and three million nine hundred thousand dollars for all claimants for such occurrences shall be effective April 1, 2002.

§ 2. Subdivision 3 of section 18 of chapter 266 of the laws of 1986, amending the civil practice law and rules and other laws relating to malpractice and professional medical conduct, as amended by section 16 of part H of chapter 57 of the laws of 2017, is amended to read as follows:

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

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

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

§ 3. Paragraphs (a), (b), (c), (d) and (e) of subdivision 8 of section 18 of chapter 266 of the laws of 1986, amending the civil practice law and rules and other laws relating to malpractice and professional medical conduct, as amended by section 17 of part H of chapter 57 of the laws of 2017, are amended to read as follows:

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

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

covering the period July 1, 2012 to June 30, 2013, or covering the period July 1, 2013 to June 30, 2014, or covering the period July 1, 2014 to June 30, 2015, or covering the period July 1, 2015 to June 30, 2016, or covering the period July 1, 2016 to June 30, 2017, or covering the period July 1, 2017 to June 30, 2018**, or covering the period July 1, 2018 to June 30, 2019** shall notify a covered physician or dentist by mail, mailed to the address shown on the last application for excess insurance coverage or equivalent excess coverage, of the amount due to such provider from such physician or dentist for such coverage period determined in accordance with paragraph (a) of this subdivision. Such amount shall be due from such physician or dentist to such provider of excess insurance coverage or equivalent excess coverage in a time and manner determined by the superintendent of financial services.

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

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

1999 to June 30, 2000, or covering the period July 1, 2000 to June 30, 2001, or covering the period July 1, 2001 to October 29, 2001, or covering the period April 1, 2002 to June 30, 2002, or covering the period July 1, 2002 to June 30, 2003, or covering the period July 1, 2003 to June 30, 2004, or covering the period July 1, 2004 to June 30, 2005, or covering the period July 1, 2005 to June 30, 2006, or covering the period July 1, 2006 to June 30, 2007, or covering the period July 1, 2007 to June 30, 2008, or covering the period July 1, 2008 to June 30, 2009, or covering the period July 1, 2009 to June 30, 2010, or covering the period July 1, 2010 to June 30, 2011, or covering the period July 1, 2011 to June 30, 2012, or covering the period July 1, 2012 to June 30, 2013, or covering the period July 1, 2013 to June 30, 2014, or covering the period July 1, 2014 to June 30, 2015, or covering the period July 1, 2015 to June 30, 2016, or covering the period July 1, 2016 to June 30, 2017, or covering the period July 1, 2017 to June 30, 2018**, or covering the period July 1, 2018 to June 30, 2019** that has made payment to such provider of excess insurance coverage or equivalent excess coverage in accordance with paragraph (b) of this subdivision and of each physician and dentist who has failed, refused or neglected to make such payment.

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

2009, and covering the period July 1, 2009 to June 30, 2010, and covering the period July 1, 2010 to June 30, 2011, and covering the period July 1, 2011 to June 30, 2012, and covering the period July 1, 2012 to June 30, 2013, and covering the period July 1, 2013 to June 30, 2014, and covering the period July 1, 2014 to June 30, 2015, and covering the period July 1, 2015 to June 30, 2016, and covering the period July 1, 2016 to June 30, 2017, and covering the period July 1, 2017 to June 30, 2018**, and covering the period July 1, 2018 to June 30, 2019** for a physician or dentist where such excess insurance coverage or equivalent excess coverage is cancelled in accordance with paragraph (c) of this subdivision.

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

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

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

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

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

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

1, 2003 to June 30, 2004, or July 1, 2004 to June 30, 2005, or July 1, 2005 to June 30, 2006, or July 1, 2006 to June 30, 2007, or July 1, 2007 to June 30, 2008, or July 1, 2008 to June 30, 2009, or July 1, 2009 to June 30, 2010, or July 1, 2010 to June 30, 2011, or July 1, 2011 to June 30, 2012, or July 1, 2012 to June 30, 2013, or July 1, 2013 to June 30, 2014, or July 1, 2014 to June 30, 2015, or July 1, 2015 to June 30, 2016, or July 1, 2016 to June 30, 2017, or July 1, 2017 to June 30, 2018**, or July 1, 2018 to June 30, 2019** as applicable.

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

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

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

§ 7. This act shall take effect immediately.

PART N

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

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

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

§ 3. This act shall take effect immediately.

PART O

Intentionally Omitted

PART P

Section 1. Intentionally omitted.

§ 1-a. Section 2807-g of the public health law, as added by chapter 1 of the laws of 1999, is amended to read as follows:

§ 2807-g. Health workforce retraining program. 1. The commissioner shall, to the extent of funds available therefor pursuant to section twenty-eight hundred seven-l of this article, make grants to eligible organizations to support the training and retraining of health care employees to address changes in the health workforce. Requests for proposals shall be issued by the commissioner within sixty days of the effective date of this section in the first year after it shall take effect, and by the first day of March in each succeeding year. All proposals shall be due not later than sixty days after the issuance of the request for proposals, and all grant awards shall be made not later than one hundred twenty days after the date on which the proposals are due.

2. Grants shall be made on a competitive basis by region, in accordance with the amount raised in the region with preference within regions given to areas and eligible organizations that have experienced or are likely to experience job loss because of changes in the health care system. If, at the conclusion of the regional competitive contract award process, there are excess funds available within any regional allocation, such funds shall be redistributed to regions where there is a shortage of funds available for programs which otherwise qualify for funding pursuant to this section.

3. Eligible organizations shall include health worker unions, general hospitals, long-term care facilities, other health care facilities, health care facilities trade associations, labor-management committees, joint labor-management training funds established pursuant to the

provisions of the Federal Taft-Hartley Act, and educational institutions. **Eligible organizations may also include certified home health agencies, licensed home care services agencies, long term home health care programs and hospices in collaborative programs with hospitals and long term facilities for cross-training and cross-utilization of facility nursing, therapy, social work and other direct care personnel to meet patient and community needs in the changing health care system.**

4. Eligible programs shall include programs which provide one or more of the following services in connection with training an eligible worker to: (i) obtain a new position, (ii) continue to meet the requirements of an existing position, or (iii) otherwise meet the requirements of the changing health care industry: (a) assessments to help determine training needs; (b) remediation, including preparation in English for speakers or writers of other languages, instruction in basic reading or mathematics, or completion of requirements for a general equivalency diploma (GED); (c) basic skills development; (d) reorientation; [~~and~~] (e) skills and educational enhancement, including, where appropriate, the provision of college level or college degree course work**; and (f) cross-training for the provision of nursing, therapy or social work services in facility and community settings**. To the extent that an eligible program is providing services to train eligible workers to obtain a new position or to continue to meet the requirements of an existing position only, reimbursement shall also be available to an eligible organization for the actual cost of any employment or employment-related expenses incurred by the eligible organization in fulfilling the duties and responsibilities of such employees while they are engaged in such training programs.

§ 2. Intentionally omitted.

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

§ 4. This act shall take effect immediately.

PART Q

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

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

shall be approved by the New York state public authorities control board, as required under section fifty-one of the public authorities law.

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

3. Notwithstanding section one hundred sixty-three of the state finance law or any inconsistent provision of law to the contrary, up to five hundred million dollars of the funds appropriated for this program shall be awarded without a competitive bid or request for proposal process for grants to health care providers (hereafter "applicants"). Provided, however, that a minimum of: (a) seventy million dollars of total awarded funds shall be made to community-based health care providers, which for purposes of this section shall be defined as a diagnostic and treatment center licensed or granted an operating certificate under this article; a mental health clinic licensed or granted an operating certificate under article thirty-one of the mental hygiene law; a substance use disorder treatment clinic licensed or granted an operating certificate under article thirty-two of the mental hygiene law; a children's residential treatment facility licensed pursuant to article thirty-one of the mental hygiene law; or a primary care provider; (b) a minimum of twenty-five million dollars of total awarded funds shall be made to assisted living programs approved by the department pursuant to subdivision one of section four hundred sixty-one-l of the social services law; or hospices licensed or granted an operating certificate pursuant to article forty of this chapter; (c) a minimum of twenty-five million dollars of the total awarded funds shall be made available to home care providers licensed or certified pursuant to article thirty-six of this chapter with priority given to projects related to the adoption of an electronic medical records system; and (d) sixty million dollars of the total awarded funds shall be made to residential health care facilities, including facilities for special needs populations, with priority given to projects related to the adoption of an electronic medical records system.

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

(a) the extent to which the proposed project will contribute to the integration of health care services or the long term sustainability of

the applicant or preservation of essential health services in the community or communities served by the applicant;

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

(c) the geographic distribution of funds;

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

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

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

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

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

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

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

6. The department shall provide a report on a quarterly basis to the chairs of the senate finance, assembly ways and means, and senate and assembly health committees, until such time as the department determines that the projects that receive funding pursuant to this section are substantially complete. Such reports shall be submitted no later than sixty days after the close of the quarter, and shall include, for each award, the name of the applicant, a description of the project or purpose, the amount of the award, disbursement date, and status of achievement of process and performance metrics and milestones pursuant to subdivision 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, 2018.

PART R

Section 1. Intentionally omitted.

§ 2. Intentionally omitted.

§ 3. Intentionally omitted.

§ 3-a. Subparagraph (i) of paragraph (d) of subdivision 8 of section 2168 of the public health law, as amended by chapter 154 of the laws of 2013, is amended to read as follows:

(i) schools for the purpose of verifying immunization status for eligibility for admission and for the purpose of confirming students have been screened for elevated blood lead levels when entering child care, pre-school or kindergarten, and identifying individual student blood lead information for the provision of appropriate educational training on lead and the dangers of lead to the student and the parents or legal guardians of the student as well as information on programs that are available to the student and the parents or legal guardians of the student;

§ 4. Intentionally omitted.

§ 4-a. Subdivision 1 of section 1370-b of the public health law, as added by section 79 of part A of chapter 62 of the laws of 2011, is amended to read as follows:

1. The New York state advisory council on lead poisoning prevention is hereby established in the department, to consist of the following, or their designees: the commissioner; the commissioner of labor; the commissioner of environmental conservation; the commissioner of housing and community renewal; the commissioner of children and family services; the commissioner of temporary and disability assistance; the secretary of state; and fifteen public members**, of which nine shall be** appointed by the governor**, three by the speaker of the assembly and three by the temporary president of the senate**. The public members shall have a demonstrated expertise or interest in lead poisoning prevention and at least one public member shall be representative of each of the following: local government; community groups; labor unions; real estate; industry; parents; educators; local housing authorities; child health advocates; environmental groups; professional medical organizations and hospitals. The public members of the council shall have fixed terms of three years; except that five of the initial appointments shall be for two years and five shall be for one year. The council shall be chaired by the commissioner or his or her designee.

§ 5. Intentionally omitted.

§ 5-a. Section 1370-d of the public health law, as added by chapter 485 of the laws of 1992, is amended to read as follows:

§ 1370-d. Lead screening of child care or pre-school enrollees **and kindergarten students**. 1. Except as provided pursuant to regulations of the department, each child care provider, public and private nursery school and pre-school licensed, certified or approved by any state or local agency**, and every school district enrolling students in kindergarten** shall, prior to or within three months after initial enrollment of a child under [~~six~~] **seven** years of age, obtain from a parent or guardian of the child evidence that said child has been screened for lead.

2. Whenever there exists no evidence of lead screening as provided for in subdivision one of this section or other acceptable evidence of the child's screening for lead, the child care provider, principal, teacher, owner or person in charge of the nursery school [~~or~~]**,** pre-school **or kindergarten** shall provide the parent or guardian of the child with information on lead poisoning in children and lead poisoning prevention and refer the parent or guardian to a primary care provider or the local health authority.

3. (a) If any parent or guardian to such child is unable to obtain lead testing, such person may present such child to the health officer of the county in which the child resides, who shall then perform or arrange for the required screening.

(b) The local public health district shall develop and implement a fee schedule for households with incomes in excess of two hundred percent of the federal poverty level for lead screening pursuant to section six hundred six of this chapter, which shall vary depending on patient household income.

§ 6. Section 1114 of the public health law, as added by section 3 of part T of chapter 57 of the laws of 2017, is amended to read as follows:

§ 1114. Lead service line replacement grant program. 1. [~~To the extent practicable, the~~] **The** department shall allocate appropriated funds equitably among regions of the state. Within each region, the department shall give priority to municipalities that have a high percentage of

elevated childhood blood lead levels, based on the most recent available data. In distributing the awards allocated for each region to such priority municipalities, the department shall also consider whether the community is low income and the number of lead service lines in need of replacement. The department may request that such municipalities provide such documentation as the department may require to confirm award eligibility.

2. **Further, the department shall establish a statewide plan for lead service line replacement, which shall include, at a minimum, an analysis of lead service lines throughout the state, lead service lines present in those areas of high risk as designated pursuant to sections thirteen hundred seventy-b and thirteen hundred seventy-three of this chapter, the actual cost of replacing lead service lines, recommendations for municipalities on methods for evaluating the status lead service lines present and guidance on replacement, regardless of whether or not the municipality meets the award threshold.**

3. The department shall publish information, application forms, procedures and guidelines relating to the program on its website and in a manner that is accessible to the public and all potential award recipients.

§ 7. This act shall take effect immediately.

PART S

Section 1. Intentionally omitted.

§ 2. Intentionally omitted.

§ 3. Intentionally omitted.

§ 4. Intentionally omitted.

§ 5. Section 2805-x of the public health law, as added by section 48 of part B of chapter 57 of the laws of 2015, is amended to read as follows:

§ 2805-x. Hospital-home care-physician collaboration program. 1. The purpose of this section shall be to facilitate innovation in hospital, home care agency and physician collaboration in meeting the community's health care needs. It shall provide a framework to support voluntary initiatives in collaboration to improve patient care access and management, patient health outcomes, cost-effectiveness in the use of health care services and community population health. Such collaborative **hospital-home care-physician** initiatives may also include payors, skilled nursing facilities**, emergency medical services** and other interdisciplinary providers, practitioners and service entities **as part of such hospital-home care-physician collaborative provided, however, that in the case of collaborative community paramedicine as set forth in this section and article thirty of this chapter, the collaborative shall minimally comprise hospital, home care, physician, and emergency medical services partners**.

2. For purposes of this section:

(a) "Hospital" shall include a general hospital as defined in this article or other inpatient facility for rehabilitation or specialty care within the definition of hospital in this article.

(b) "Home care agency" shall mean a certified home health agency, long term home health care program or licensed home care services agency as defined in article thirty-six of this chapter.

(c) "Payor" shall mean a health plan approved pursuant to article forty-four of this chapter, or article thirty-two or forty-three of the insurance law.

(d) "Practitioner" shall mean any of the health, mental health or health related professions licensed pursuant to title eight of the education law.

(e) "Emergency medical services" (EMS) shall mean the services of an ambulance service or an advanced life support first response service certified under article thirty of this chapter staffed by emergency medical technicians or advanced emergency medical technicians to provide basic or advanced life support and, for the purposes of the community paramedicine collaboration model set forth in subdivision four of this section, also to provide such services pursuant to such models in circumstances other than the initial emergency medical care and transportation of sick and injured persons.

3. The commissioner is authorized to provide financing including, but not limited to, grants or positive adjustments in medical assistance rates or premium payments, to the extent of funds available and allocated or appropriated therefor, including funds provided to the state through federal waivers, funds made available through state appropriations and/or funding through section twenty-eight hundred seven-v of this article, as well as waivers of regulations under title ten of the New York codes, rules and regulations, to support the voluntary initiatives and objectives of this section. **Nothing in this section shall be construed to limit, or to imply the need for state approval of, collaborative initiatives enumerated in this section which are otherwise permissible under law or regulation, provided however that the approval of the commissioner shall be required for either state funding or regulatory waivers as provided for under this section.**

4. Hospital-home care-physician collaborative initiatives under this section may include, but shall not be limited to:

(a) Hospital-home care-physician integration initiatives, including but not limited to:

(i) transitions in care initiatives to help effectively transition patients to post-acute care at home, coordinate follow-up care and address issues critical to care plan success and readmission avoidance;

(ii) clinical pathways for specified conditions, guiding patients' progress and outcome goals, as well as effective health services use;

(iii) application of telehealth/telemedicine services in monitoring and managing patient conditions, and promoting self-care/management, improved outcomes and effective services use;

(iv) facilitation of physician house calls to homebound patients and/or to patients for whom such home visits are determined necessary and effective for patient care management;

(v) additional models for prevention of avoidable hospital readmissions and emergency room visits;

(vi) health home development;

(vii) development and demonstration of new models of integrated or collaborative care and care management not otherwise achievable through existing models; [~~and~~]

(viii) bundled payment demonstrations for hospital-to-post-acute-care for specified conditions or categories of conditions, in particular, conditions predisposed to high prevalence of readmission, including those currently subject to federal/state penalty, and other discharges with extensive post-acute needs; **and**

(ix) models of community paramedicine, under which hospitals, emergency medical services who utilize employed or volunteer emergency medical technicians or advanced emergency medical technicians, physicians and home care agencies, in joint partnership, may develop and implement a

plan for the collaborative provision of services in community settings. In addition to emergency services provided under article thirty of this chapter, models of community paramedicine may include collaborative services to at-risk individuals living in the community to prevent emergencies, avoidable emergency room need, avoidable transport and potentially avoidable hospital admissions and readmissions; community paramedicine services to individuals with behavioral health conditions, or developmental or intellectual disabilities, shall further include the collaboration of appropriate providers of behavioral health services licensed or certified under the mental hygiene law;

(b) Recruitment, training and retention of hospital/home care direct care staff and physicians, in geographic or clinical areas of demonstrated need. Such initiatives may include, but are not limited to, the following activities:

(i) outreach and public education about the need and value of service in health occupations;

(ii) training/continuing education and regulatory facilitation for cross-training to maximize flexibility in the utilization of staff, including:

(A) training of hospital nurses in home care;

(B) dual certified nurse aide/home health aide certification; [~~and~~]

(C) dual personal care aide/HHA certification; and

(D) orientation and/or collaborative training of EMS, hospital, home care, physician and, as necessary, other participating provider staff in community paramedicine;

(iii) salary/benefit enhancement;

(iv) career ladder development; and

(v) other incentives to practice in shortage areas; and

(c) Hospital - home care - physician collaboratives for the care and management of special needs, high-risk and high-cost patients, including but not limited to best practices, and training and education of direct care practitioners and service employees.

5. Hospitals and home care agencies which are provided financing or waivers pursuant to this section shall report to the commissioner on the patient, service and cost experiences pursuant to this section, including the extent to which the project goals are achieved. The commissioner shall compile and make such reports available on the department's website.

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

§ 3001-a. Community paramedicine services. Notwithstanding any inconsistent provision of this article, an emergency medical technician or advanced emergency medical technician in course of his or her work as an employee or volunteer of an ambulance service or an advanced life support first response service certified under this article to provide emergency medical services may also participate in models of community paramedicine pursuant to section twenty-eight hundred five-x of this chapter.

§ 6. This act shall take effect immediately.

SUBPART B

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

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

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

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

social services law or part L of chapter fifty-six of the laws of two thousand twelve.

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

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

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

SUBPART C

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

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

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

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

(v) clinics operated under article sixteen of the mental hygiene law, and, notwithstanding any other section of law, certified and non-certified day and residential programs funded or operated by the office for people with developmental disabilities;

(w) residential health care facilities including facilities for special needs populations; and

(x) any other provider as determined by the commissioner pursuant to regulation or, in consultation with the commissioner, by the commissioner of the office of mental health, the commissioner of the office of alcoholism and substance abuse services, or the commissioner of the office for people with developmental disabilities pursuant to regulation.

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

3. "Originating site" means a site at which a patient is located at the time health care services are delivered to him or her by means of telehealth. Originating sites shall be limited to (a) facilities licensed under articles twenty-eight and forty of this chapter[~~,~~]; (b) facilities as defined in subdivision six of section 1.03 of the mental hygiene law[~~,~~]; (c) private physician's or dentist's offices located within the state of New York[~~,~~]; (d) any type of adult care facility licensed under title two of article seven of the social services law[~~,~~]; (e) public, private and charter elementary and secondary schools, school age child care programs, and child day care centers within the state of New York; and[~~, when a patient is receiving health care services by means of remote patient monitoring,~~] (f) the patient's place of residence located within the state of New York or other temporary location located within or outside the state of New York, including, but not limited to, residential health care facilities and certified and non-certified day and residential programs funded or operated by the office for people with developmental disabilities; subject to regulation issued by the commissioner of the office of mental health, the commissioner of the office of alcoholism and substance abuse services, and the commissioner of the office for people with developmental disabilities, provided such regulations shall be consistent and coordinated so as to enable integration of services and reduce barriers to care.

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

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

§ 4. The section heading and subdivision 2 of section 367-u of the social services law, the section heading as added by section 63-c of

part C of chapter 58 of the laws of 2007, subdivision 2 as amended by chapter 6 of the laws of 2015, are amended to read as follows:

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

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

§ 5. The public health law is amended by adding a new section 2999-ee to read as follows:

§ 2999-ee. Telehealth rules, regulations, policies and guidance. To reduce barriers that limit the use of telehealth services by practitioners and entities certified or licensed under this chapter, the mental hygiene law or the education law, the commissioners of the department of health, office of mental health, office for people with developmental disabilities, and the office of alcoholism and substance abuse services shall coordinate to identify and implement methods to align and streamline rules, regulations, policies and guidance regarding the development and integration of service as provided through telehealth. Where possible, such methods to align and streamline shall also ensure that descriptions and definitions are consistent across agencies. Such commissioners shall also provide ongoing coordinated guidance where additional clarification and uniformity is desirable across agencies in order to reduce barriers and facilitate the use of telehealth.

§ 6. This act shall take effect on the ninetieth day after it shall have become a law; provided, however, that the commissioner of the department of health, the commissioner of the office of mental health, the commissioner of the office of alcoholism and substance abuse services, and the commissioner of the office for people with developmental disabilities shall issue rules or regulations for the implementation of this act on or before its effective date; provided such regulations shall be consistent and coordinated across the different agencies so as to enable integration of services and reduce barriers to care, and further provided that such agencies shall partake in ongoing coordinated guidance where additional clarification and uniformity is desirable across agencies in order to reduce barriers and facilitate the use of telehealth.

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

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

PART T

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

(a) section eleven of this act shall expire and be deemed repealed March 31, [~~2018~~] 2019;

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

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

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

§ 2. This act shall take effect immediately and shall expire and be deemed repealed [~~two years after it shall have become a law~~] March 31, 2019.

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

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

§ 5. Section 4-a of part A of chapter 56 of the laws of 2013, amending chapter 59 of the laws of 2011 amending the public health law and other laws relating to general hospital reimbursement for annual rates relating to the cap on local Medicaid expenditures, as amended by section 9 of part I of chapter 57 of the laws of 2017, is amended to read as follows:

§ 4-a. Notwithstanding paragraph (c) of subdivision 10 of section 2807-c of the public health law, section 21 of chapter 1 of the laws of 1999, or any other contrary provision of law, in determining rates of payments by state governmental agencies effective for services provided on and after January 1, [~~2019~~] 2017 through March 31, 2019, for inpa-

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

§ 5-a. Section 5 of chapter 426 of the laws of 1983, amending the public health law relating to professional misconduct proceedings, as amended by section 22 of part B of chapter 56 of the laws of 2013, is amended to read as follows:

§ 5. This act shall take effect June 1, 1983 and shall remain in full force and effect until March 31, [~~2018~~] **2023**.

§ 5-b. Subparagraph (ii) of paragraph (c) of subdivision 11 of section 230 of the public health law, as amended by section 24 of part B of chapter 56 of the laws of 2013, is amended to read as follows:

(ii) Participation and membership during a three year demonstration period in a physician committee of the Medical Society of the State of New York or the New York State Osteopathic Society whose purpose is to confront and refer to treatment physicians who are thought to be suffering from alcoholism, drug abuse**, stress** or mental illness. Such demonstration period shall commence on April first, nineteen hundred eighty and terminate on May thirty-first, nineteen hundred eighty-three. An additional demonstration period shall commence on June first, nineteen hundred eighty-three and terminate on March thirty-first, nineteen hundred eighty-six. An additional demonstration period shall commence on April first, nineteen hundred eighty-six and terminate on March thirty-first, nineteen hundred eighty-nine. An additional demonstration period shall commence April first, nineteen hundred eighty-nine and terminate March thirty-first, nineteen hundred ninety-two. An additional demonstration period shall commence April first, nineteen hundred ninety-two and terminate March thirty-first, nineteen hundred ninety-five. An additional demonstration period shall commence on April first, nineteen hundred ninety-five and terminate on March thirty-first, nineteen hundred ninety-eight. An additional demonstration period shall commence on April first, nineteen hundred ninety-eight and terminate on March thirty-first, two thousand three. An additional demonstration period

shall commence on April first, two thousand three and terminate on March thirty-first, two thousand thirteen. An additional demonstration period shall commence April first, two thousand thirteen and terminate on March thirty-first, two thousand eighteen**. An additional demonstration period shall commence April first, two thousand eighteen and terminate on March thirty-first, two thousand twenty-three** provided, however, that the commissioner may prescribe requirements for the continuation of such demonstration program, including periodic reviews of such programs and submission of any reports and data necessary to permit such reviews. During these additional periods, the provisions of this subparagraph shall also apply to a physician committee of a county medical society.

§ 6. This act shall take effect immediately; provided however that the amendments to subparagraph (ii) of paragraph (c) of subdivision 11 of section 230 of the public health law made by section five-b of this act shall not affect the expiration of such subparagraph and shall be deemed to expire therewith.

PART U

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

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

§ 2. This act shall take effect immediately.

PART V

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

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

§ 2. This act shall take effect immediately.

PART W

Intentionally Omitted

PART X

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

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

§ 2. This act shall take effect immediately.

PART Y

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

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

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

(c)(i) A person without a license from participating as a member of a multi-disciplinary team to [~~implement~~] assist in the development of or implementation of a behavioral health services or treatment plan; provided [~~however,~~] that such team shall include one or more professionals licensed under this article or articles one hundred thirty-one, one hundred thirty-nine, one hundred fifty-four or one hundred sixty-three of this chapter who must approve and oversee implementation of such treatment plan and who must directly observe each patient either in person or by electronic means, prior to the rendering of a diagnosis;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

12. Any person who is employed prior to July first, two thousand eighteen in a program or service operated, regulated, funded, or approved by

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

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

1. Practice of licensed master social work.

(a) The practice of licensed master social work shall mean the professional application of social work theory, principles, and the methods to prevent, assess, evaluate, formulate and implement a plan of action based on client needs and strengths, and intervene to address mental, social, emotional, behavioral, developmental, and addictive disorders, conditions and disabilities, and of the psychosocial aspects of illness and injury experienced by individuals, couples, families, groups, communities, organizations, and society.

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

(c) **Counseling in the practice of licensed master social work is the application of social work theories, principles and methods used to assist individuals in learning how to solve problems and make decisions about personal, health, social, education, vocational, financial and other interpersonal concerns.**

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

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

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

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

(m) Provide peer services.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

ating; the provision of psychotherapeutic treatment; the provision of treatment other than psychotherapeutic treatment; [~~and/or~~] or the development and implementation of assessment-based treatment plans as defined in section seventy-seven hundred one of this chapter.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

9. Any person who is employed prior to July first, two thousand eighteen in a program or service operated, regulated, funded, or approved by the department of mental hygiene, the office of children and family services, the department of corrections and community supervision, the office of temporary and disability assistance, the state office for the aging and the department of health or a local government unit as that term is defined in section 41.03 of the mental hygiene law or a social services district as defined in section sixty-one of the social services

law from performing services within the practice of mental health counseling, marriage and family therapy, creative arts therapy, and psychoanalysis, as defined in this article, provided that such person maintains such employment with such entity within the context of such employment. Any person who commences employment in such program or service after July first, two thousand eighteen shall be appropriately licensed under this article.

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

§ 7. Mental health professions taskforce. 1. Purpose. A mental health professions taskforce is hereby created within the state education department in conjunction with representatives of the office of mental health, the office of alcoholism and substance abuse, the office of aging, the office of people with developmental disabilities, the office of children and family services, the department of corrections and community service, the department of health, representatives from the professional associations representing mental health practitioners licensed under articles 154 and 163 of the education law and community mental health providers for the purpose of identifying and providing guidance to the governor related to the provision of mental health services and where workforce investments are required. The mental health professions taskforce shall deliberate and engage the mental 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: identification of licensed professions shortage areas, identification of barriers to hiring licensees, the identification of need for resources to fortify the states mental health workforce.

2. Composition of the taskforce. This taskforce shall consist of seventeen members, as follows:

(a) two representatives from the state education department, of which shall be the board secretaries for the article 154 and article 163 of the education law professions or their designees;

(b) one representative from the office of mental health;

(c) one representative from the office of alcoholism and substance abuse;

(d) one representative from the office of aging;

(e) one representative from the office of people with developmental disabilities;

(f) one representative from the office of children and family services;

(g) one representative from the department of corrections and community service;

(h) one representative from the department of health;

(i) four representatives from the professional associations representing mental health practitioners licensed under articles 154 and 163 of the education law; and

(j) four representatives from the community mental health providers.

3. Manner of appointment. The governor shall appoint each representative from the office of mental health, the office of alcoholism and substance abuse, the office of aging, the office of people with developmental disabilities, the office of children and family services, the department of corrections and community supervision, and the department of health. The temporary president of the senate shall appoint two representatives from the professional associations representing mental

health practitioners licensed under articles 154 and 163 of the education law, and two representatives from the community mental health providers. The speaker of the assembly shall apoint two representatives from the professional associations representing mental health practitioners licensed under articles 154 and 163, and two representatives from the community mental health providers. The chair of the senate higher education shall appoint one representative from the state education department. The chair of the assembly higher education committee shall appoint one representative from the state education department.

4. Co-chairs. The members of the taskforce shall select co-chairs from among the members. A majority of the members of the taskforce shall constitute a quorum, and all recommendations, including those in the final report issued by the taskforce, shall require approval of two-thirds of the total members of the taskforce.

5. Meeting. The taskforce shall meet no less than once a month either in person or through electronic means.

6. Report. The taskforce shall issue a report to the governor, legislature, the chair of the senate higher education committee and the chair of the assembly higher education committee, by no later than eighteen months after the final appointment is made to the taskforce.

7. Expenses. Members of the taskforce shall receive no compensation for their services, but shall be allowed their actual and necessary expenses incurred in the performance of their functions hereunder. All members of the taskforce shall serve at the pleasure of the governor and vacancies shall be filled in the same manner as original appointments.

8. Cooperation. Every agency, department, office, division of public authority of this state shall cooperate with the taskforce and furnish such information and assistance as the taskforce determines is reasonably necessary to accomplish its purpose.

§ 8. This act shall take effect immediately.

PART Z

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

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

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

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

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

7-c. The commissioner of health in consultation with the commissioner of developmental disabilities is authorized to submit the appropriate waivers, including, but not limited to, those authorized pursuant to

section eleven hundred fifteen of the federal social security act, in order to achieve the purposes of high-quality and integrated care and services for a population of persons with developmental disabilities, as such term is defined in section 1.03 of the mental hygiene law.

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

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

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

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

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

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

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

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

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

(b) "A patient in need of surrogate decision-making" means a patient as defined in subdivision twenty-three of section 1.03 of this chapter who is: a resident of a mental hygiene facility including a resident of housing programs funded by an office of the department or whose federal funding application was approved by an office of the department or for whom such facility maintains legal admission status therefor; or, receiving home and community-based services for persons with mental disabilities provided pursuant to section 1915 **or 1115** of the federal social security act; or receiving individualized support services; or, case management or service coordination funded, approved, or provided by the office for people with developmental disabilities; and, for whom major medical treatment is proposed, and who is determined by the surrogate decision-making committee to lack the ability to consent to or refuse such treatment, but shall not include minors with parents or persons with legal guardians, committees or conservators who are legally authorized, available and willing to make such health care decisions. Once a person is eligible for surrogate decision-making, such person may continue to receive surrogate decision-making as authorized by this section regardless of a change in residential status.

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

1-a. sections seventy-three through eighty-a shall expire and be deemed repealed September 30, [~~2019~~] **2020;**

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

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

§ 11. Section 97 of chapter 659 of the laws of 1997, amending the public health law and other laws relating to creation of continuing care

retirement communities, as amended by section 20 of part D of chapter 57 of the laws of 2015, is amended to read as follows:

§ 97. This act shall take effect immediately, provided, however, that the amendments to subdivision 4 of section 854 of the general municipal law made by section seventy of this act shall not affect the expiration of such subdivision and shall be deemed to expire therewith and provided further that sections sixty-seven and sixty-eight of this act shall apply to taxable years beginning on or after January 1, 1998 and provided further that sections eighty-one through eighty-seven of this act shall expire and be deemed repealed on December 31, [~~2010~~] 2024 and provided further, however, that the amendments to section ninety of this act shall take effect January 1, 1998 and shall apply to all policies, contracts, certificates, riders or other evidences of coverage of long term care insurance issued, renewed, altered or modified pursuant to section 3229 of the insurance law on or after such date.

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

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

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

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

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

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

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

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

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

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

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

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

the rate of payment that the applicable government agency would otherwise pay for such rendered hospital services.

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

§ 11. This act shall take effect immediately; except that the provisions of sections one, two, three, four, eight and ten of this act shall take effect on the ninetieth day after it shall have become a law; and except that the provisions of sections five, six and seven of this act shall take effect January 1, 1989; and except that effective immediately, the addition, amendment and/or repeal of any rule or regulation necessary for the implementation of this act on its effective date are authorized and directed to be made and completed on or before such effective date; provided, however, that the provisions of section 364-j of the social services law, as added by section one of this act shall expire and be deemed repealed on and after March 31, [~~2019~~] 2024, the provisions of section 364-k of the social services law, as added by section two of this act, except subdivision 10 of such section, shall expire and be deemed repealed on and after January 1, 1994, and the provisions of subdivision 10 of section 364-k of the social services law, as added by section two of this act, shall expire and be deemed repealed on January 1, 1995.

§ 19. This act shall take effect immediately; provided, however, that the amendments to subparagraph (vii) of paragraph e of subdivision 3 of section 364-j of the social services law made by section one of this act shall not affect the repeal of such section and shall be deemed repealed therewith; provided further, however, that the amendments to subdivision 4 of section 366-c of the social services law made by section five of this act shall not affect the expiration of such subdivision and shall be deemed to expire therewith; provided, further, that the amendments to paragraph (a-1) of subdivision 8 of section 4403 of the public health law made by section ten of this act shall not affect the repeal of such subdivision and shall be deemed repealed therewith; provided further, however, that the amendments to paragraph (a-1) of subdivision 12 of section 4403-f of the public health law made by section twelve of this act shall not affect the repeal of such subdivision and such section and shall be deemed to be repealed therewith; and provided, further, that the amendments to section 4403-g of the public health law made by sections thirteen, fourteen and fifteen of this act shall not affect the repeal of such section and shall be deemed repealed therewith.

PART AA

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

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

health, and the office of alcoholism and substance abuse services shall not include a COLA beginning April 1, 2017 and ending March 31, [~~2019~~] 2023.

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

§ 1-a. Subdivision 3-e of section 1 of part C of chapter 57 of the laws of 2006, relating to establishing a cost of living adjustment for designated human services programs, as added by section 2 of part Q of chapter 57 of the laws of 2017, is amended to read as follows:

3-e. (i) Notwithstanding the provisions of subdivision 3-b of this section or any other inconsistent provision of law, and subject to the availability of the appropriation therefor, for the programs listed in paragraphs (i), (ii), and (iii) of subdivision 4 of this section, the commissioners shall provide funding to support (1) an overall average three and one-quarter percent (3.25%) increase to total salaries for direct care staff, direct support professionals for each eligible state-funded program beginning January 1, 2018; [~~and~~] (2) an overall average three and one-quarter percent (3.25%) increase to total salaries for direct care staff and direct support professionals, and clinical staff, including position code 351 relating to Medicaid Service Coordination, for each eligible state-funded program beginning April 1, 2018; (3) an overall average three and one-quarter percent (3.25%) increase to total salaries for direct care staff and direct support professionals, and clinical staff, including position code 351 relating to Medicaid Service Coordination, for each eligible state-funded program beginning April 1, 2019; (4) an overall average three and one-quarter percent (3.25%) increase to total salaries for direct care staff and direct support professionals, and clinical staff, including position code 351 relating to Medicaid Service Coordination, for each eligible state-funded program beginning April 1, 2020; (5) an overall average three and one-quarter percent (3.25%) increase to total salaries for direct care staff and direct support professionals, and clinical staff, including position code 351 relating to Medicaid Service Coordination, for each eligible state-funded program beginning April 1, 2021; and (6) an overall average three and one-quarter percent (3.25%) increase to total salaries for direct care staff and direct support professionals, and clinical staff, including position code 351 relating to Medicaid Service Coordination, for each eligible state-funded program beginning April 1, 2022. For the purpose of this funding increase, direct support professionals are individuals employed in consolidated fiscal reporting position title codes ranging from 100 to 199; direct care staff are individuals employed in consolidated fiscal reporting position title codes ranging from 200 to 299; and clinical staff are individuals employed in consolidated fiscal reporting position title codes ranging from 300 to 399, specifically including position code 351 relating to Medicaid Service Coordination.

(ii) The funding made available pursuant to paragraph (i) of this subdivision shall be used: (1) to help alleviate the recruitment and retention challenges of direct care staff, direct support professionals and clinical staff employed in eligible programs, including Medicaid Service Coordination; and (2) to continue and to expand efforts to

support the professionalism of the direct care workforce. Each local government unit or direct contract provider receiving such funding shall have flexibility in allocating such funding to support salary increases to particular job titles to best address the needs of its direct care staff, direct support professionals and clinical staff**, including Medicaid Service Coordination**. Each local government unit or direct contract provider receiving such funding shall also submit a written certification, in such form and at such time as each commissioner shall prescribe, attesting to how such funding will be or was used for purposes eligible under this section. Further, providers shall submit a resolution from their governing body to the appropriate commissioner, attesting that the funding received will be used solely to support salary and salary-related fringe benefit increases for direct care staff, direct support professionals and clinical staff, **including Medicaid Service Coordination,** pursuant to paragraph (i) of this subdivision. Salary increases that take effect on and after April 1, 2017 may be used to demonstrate compliance with the January 1, 2018 funding increase authorized by this section, except for salary increases necessary to comply with state minimum wage requirements. Such commissioners shall be authorized to recoup any funds as appropriated herein determined to have been used in a manner inconsistent with such standards or inconsistent with the provisions of this subdivision, and such commissioners shall be authorized to employ any legal mechanism to recoup such funds, including an offset of other funds that are owed to such local governmental unit or provider.

(iii) Where appropriate, transfers to the department of health shall be made as reimbursement for the state share of medical assistance.

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

PART BB

Section 1. Section 3302 of the public health law is amended by adding a new subdivision 44 to read as follows:

44. "Controlled substance analog" means

(a) a capsule, liquid, pill, powder, product, spray, tablet or other substance, however constituted:

(i) the chemical structure of which is derivative of, or substantially similar to, the chemical structure of a controlled substance; or

(ii) which has a stimulant, depressant, or hallucinogenic effect on the central nervous system that is substantially similar to or greater than the stimulant, depressant, or hallucinogenic effect on the central nervous system of a controlled substance; or

(iii) with respect to a particular person, which such person represents or intends to have the stimulant, depressant, or hallucinogenic effect on the central nervous system that is substantially similar to or greater than the stimulant, depressant, or hallucinogenic effect on the central nervous system of a controlled substance.

(b) "Controlled substance analog" does not include:

(i) a controlled substance;

(ii) any substance for which there is an approved new drug application;

(iii) with respect to a particular person, any substance, if an exemption is in effect for investigational use, for that person, under 21 USCA § 355, to the extent the conduct with respect to the substance is pursuant to such exemption;

(iv) any product approved by the United States food and drug administration as a drug or medical device, or approved for use pursuant to section thirty-three hundred sixty-two of this article; or

(v) any compound, mixture, or preparation that contains any controlled substance or controlled substance analog that is not for administration to a human being or animal, and that is packaged in such a form or concentration, or with adulterants or denaturants, so that as packaged it does not present any significant potential for abuse.

(c) Controlled substance analog treated as a Schedule I substance. A controlled substance analog must be treated, for the purposes of any New York State statute or regulation, as a substance included in Schedule I of section thirty-three hundred six of this article.

§ 2. Subdivision (a) of schedule I of section 3306 of the public health law, as added by chapter 664 of the laws of 1985, is amended to read as follows:

(a) Schedule I shall consist of the drugs and other substances, by whatever official name, common or usual name, chemical name, or brand name designated, listed in this section, and controlled substance analogs as defined by subdivision forty-four of section thirty-three hundred two of this title.

§ 3. Subdivision 5 of section 220.00 of the penal law, as amended by chapter 537 of the laws of 1998, is amended to read as follows:

5. "Controlled substance" means any substance listed in schedule I, II, III, IV or V of section thirty-three hundred six of the public health law other than marihuana, but including concentrated cannabis as defined in paragraph (a) of subdivision four of section thirty-three hundred two of such law, and including controlled substance analogs as defined in subdivision forty-four of section thirty-three hundred two of such law.

§ 4. Subdivision (b) of schedule I of section 3306 of the public health law is amended by adding twenty-one new paragraphs 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75 and 76 to read as follows:

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

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

(58) N-(1-phenethylpiperidin-4-yl)-N-phenylbutyramide (Butyryl Fentanyl).

(59) N-{1-{2-hydroxy-2-(thiophen-2-yl)ethyl}piperidin-4-yl}-N-phenylpropionamide (Beta-Hydroxythiofentanyl).

(60) N-(1-phenethylpiperidin-4-yl)-N-phenylfuran-2-carboxamide (Furanyl Fentanyl).

(61) U-47700(3,4-Dichloro-N-{2-(dimethylaminio)cyclohexyl}-N- methylbenzamide).

(62) N-Phenyl-N-{1-(2-phenylethyl)piperidin-4-yl}prop-2-enamide (Acryl Fentanyl or Acryloylfantanyl). Some trade or other names: N-(1-phenethylpiperidin-4-yl)-N-phenylacrylamide; N-phenyl-N-{1-(2-phenylethyl)-4-piperidinyl}-2-propenamide.

(63) N-(4-fluorophenyl)-N-(1-phenethylpiperidin-4-yl)isobutyramide. Other names: 4-fluoroisobutyryl fentanyl, para-fluoroisobutyryl fentanyl).

(64) N-(2-fluorophenyl)-N-(1-phenelthylpiperidin-4-yl)propionamide(Ortho-Fluorofentanyl or 2-fluorofentanyl).
(65) N-(1-phenelthylpiperidin-4-yl)-N-phenyltetrahydrofuran-2-carboxamide(Tetrahydrofuranyl Fentanyl).
(66) 2-methoxy-N-(1-phenethylpiperidin-4-yl)-N-phenylacetamide(Methoxyacetyl Fentanyl).
(67) N-(1-phenethylpiperidin-4-yl)-N-phenylcyclopropanecarboxamide. Some trade or other names: Cyclopropyl Fentanyl.
(68) N-(1-phenethylpiperidin-4-yl)-N-phenylpentamide. Some trade or other names: Valeryl Fentanyl.
(69) N-(4-flurophenyl)-N-(1-phenethylpiperidin-4-yl)butyramide. Some trade or other names: Para-fluorobutyryl Fentanyl.
(70) N-(4-methoxyphenyl)-N-(1-phenethylpiperidin-4-yl)butyramide. Some trade or other names: Para-methoxybutyryl Fentanyl.
(71) N-(4-chlorophenyl)-N-(1-phenethylpiperidin-4-yl)isobutyramide. Some trade or other names: Para-chlorisobutyryl Fentanyl.
(72) N-(1-phenethylpiperidin-4-yl)-N-phenylisobutyramide. Some trade or other names: Isobutyryl Fentanyl.
(73) N-(1-phenethylpiperidin-4-yl)-N-phenylcyclopentanecarboxamide. Some trade or other names: Cyclopentyl Fentanyl.
(74) N-(2-flurophenyl)-2-methoxy-N-(1-phenethylpiperidin-4-yl)acetamide. Some trade or other names: Ocfentanil.
(75) 4-chloro-N-[~~1-[2-(4-nitrophenyl)ethyl~~]-2-piperidinylidene]-benzenesulfonamide (W18).
(76) Carfentanil.

§ 5. Subdivision (d) of schedule I of section 3306 of the public health law is amended by adding thirty-six new paragraphs 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, and 71 to read as follows:

(36) 5-methoxy-N,N-dimethyltryptamine.
(37) Alpha-methyltryptamine. Some trade or other names: AMT.
(38) 5-methoxy-N,N-diisopropyltryptamine. Some trade or other names: 5-MeO-DIPT.
(39) 5-(1.1-dimethylheptyl)-2-{(1R,3S)-3-hydroxycyclohexyl}-pheno1. Some trade or other names: CP-47,497.
(40) 5-(1,1-dimethyloctyl)-2-{(1R,3S)-3-hydroxycyclohexyl}-phenol. Some trade or other names: cannabicyclohexanol or CP-47,497 C8-homolog.
(41) 1-pentyl-3-(1-naphthoyl)indole. Some trade of other names: JWH-018 and AM678.
(42) 1-butyl-3-(1-naphthoyl)indole. Some trade of other names: JWH-073.
(43) 1-hexyl-3-(1-naphthoyl)indole. Some trade of other names: JWH-019.
(44) 1-{2-(4-morpholinyl)ethyl}-3-(1-naphthoyl)indole. Some trade or other names: JWH-200.
(45) 1-pentyl-3-(2-methoxyphenylacetyl)indole. Some trade or other names: JWH-250.
(46) 1-pentyl-3-{1-(4-methoxynaphthoyl)}indole. Some trade or other names: JWH-081.
(47) 1-pentyl-3-(4-methyl-1-naphthoyl)indole. Some trade or other names: JWH-122.
(48) 1-pentyl-3-(4-chloro-1-naphthoyl)indole. Some trade or other names: JWH-398.
(49) 1-(5-fluoropentyl)-3-(1-naphthoyl)indole. Some trade or other names: AM2201.

(50) 1-(5-fluoropentyl)-3-(2-iodobenzoyl)indole. Some trade or other names: AM694.

(51) 1-pentyl-3-{(4-methoxy)-benzoyl}indole. Some trade or or other names: SR-19 and RCS-4.

(52) 1-cyclohexylethyl-3-(2-methoxyphenylacetyl)indole. Some trade or other names: SR-18 and RCS-8.

(53) 1-pentyl-3-(2-chlorophenylacetyl) indole. Some trade or other names: JWH-203.

(54) (1-pentyl-1H-indol-3-yl)(2,2,3,3-tetramethylcyclopropyl) methanone. Some trade or other names: UR-144.

(55) {1-(5-fluoro-pentyl)-1H-indol-3-yl}(2,2,3,3-tetramethylcyclopropyl) methanone. Some trade names or other names: 5-fluoro-UR-144, XLR11.

(56) N-(1-adamantyl)-1-pentyl-1H-indazole-3-carboxamide. Some trade or other names: APINACA, AKB48.

(57) quinolin-8-yl 1-pentyl-1H-indole-3-carboxylate. Some trade or other names: PB-22; QUPIC.

(58) quinolin-8-yl 1-(5-fluoropentyl)-1H-indole-3-carboxylate. Some trade or other names: 5-fluoro-PB-22; 5F-PB-22.

(59) N-(1-amino-3-methyl-1-oxobutan-2-yl)-1-(4-fluorobenzyl)-1H-indazole-3-carboxamide. Some trade or other names: AB-FUBINACA.

(60) N-(1-amino-3,3-dimethyl-1-oxobutan-2-yl)-1-pentyl-1H-indazole-3-carboxamide. Some trade or other names: ADB-PINACA.

(61) N-(1-amino-3-methyl-1-oxobutan-2-yl)-1-(cyclohexylmethyl)-1H-indazole-3-carboxamide. Some trade or other names: AB-CHMINACA.

(62) N-(1-amino-3-methyl-1-oxobutan-2-yl)-1-pentyl-1H-indazole- 3-carboxamide. Some trade or other names: AB-PINACA.

(63) {1-(5-fluoropentyl)-1H-indazol-3-yl}(naphthalen-1-y1)methanone. Some trade or other names: THJ-2201.

(64) N-(1-amino-3,3-dimethyl-1-oxobutan-2-y1)-1-(cyclohexylmethyl)-1H-indazole-3-carboxamide. Some trade or other names: MAB-CHMINACA; ADB-CHMINACA.

(65) methyl 2-(1-(5-fluoropentyl)-1H-indazole-3-carboxamido)-3, 3-dimethylbutanoate. Some trade or other names: 5F-ADB; 5F-MDMB-PINACA.

(66) methyl 2-(1-(5-fluoropentyl)-1H-indazole-3- carboxamido-3-methylbutanoate. Some trade or other names: 5F-AMB.

(67) N-(adamantan-1-yl)-1-(5-fluoropentyl)-1H-indazole-3-carboxamide. Some trade or other names: 5F-APINACA, 5F-AKB48.

(68) N-(1-amino-3,3-dimethyl-1-oxobutan-2-yl)-1-(4-fluorobenzyl)-1H-indazole-3-carboxamide. Some trade or other names: ADB-FUBINACA.

(69) methyl 2-(1-cyclohexlmethyl)-1H-indole-3-carboxamido)-3,3-dimethylbutanoate. Some trade or other names: MDMB-CHMICA, MMB-CHMINACA.

(70) methyl 2-(1-(4-fluorobenzyl)-1H-indazole-3-carboxamido)-3,3-dimethylbutanoate. Some trade or other names: MDMB-FUBINACA.

(71) methyl-2(1-(4-flurobenzyl)-1H-indazole-3-carboxamido)-3-methylbutanoate. Some trade or other names: FUB-AMB, MMB-FUBINACA, AMB-FUBINACA.

§ 6. Intentionally omitted.

§ 6-a. Paragraph 6 of subdivision (c) of schedule II of section 3306 of the public health law is REPEALED.

§ 6-b. Paragraph 11 of subdivision (d) of schedule I of section 3306 of the public health law, as added by chapter 664 of the laws of 1985, is amended to read as follows:

(11) [~~Ibogane~~] Ibogaine Some trade and other names: 7-ethyl-6, 6&, 7, 8, 9, 10, 12, 13-octahydro-2-methoxy-6, [~~9-methano-5h-pyrido~~] 9-methano-5H-pyrido {1',2':1,2} azepino {5,4-b} indole: tabernanthe iboga.

§ 6-c. Subdivision (c) of schedule II of section 3306 of the public health law is amended by adding a new paragraph 29 to read as follows:

(29) Thiafentanil (4-(methoxycarbonyl)-4-(N-phenmethoxyacetamido)-1-[2-(thienyl)ethyl]piperidine).

§ 6-d. Subdivision (c) of schedule III of section 3306 of the public health law is amended by adding a new paragraph 15 to read as follows:

(15) Xylazine (N-(2,6-dimethylphenyl)-5,6-dihydro-4H-1,3 thiazin-2-amine).

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

PART CC

Intentionally Omitted

PART DD

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

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

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

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

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

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

(e) administer the immunization or immunizations according to the most current recommendations by the advisory committee for immunization practices (ACIP), provided however, that a pharmacist may administer any immunization authorized under this section when specified by a patient specific order.

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

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

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

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

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

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

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

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

§ 8. This act shall take effect on the ninetieth day after it shall have become a law and shall expire and be deemed repealed [~~July 1, 2019~~] December 31, 2021.

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

§ 5. This act shall take effect on the ninetieth day after it shall have become a law and shall expire and be deemed repealed [~~July 1, 2019~~] December 31, 2021 provided, that:

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

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

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

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

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

§ 5. This act shall take effect on the one hundred twentieth day after it shall have become a law and shall expire [~~7 years after such effective date when upon such date the provisions of this act shall~~] and be deemed repealed July 1, 2021; provided, however, that the amendments to subdivision 1 of section 6801 of the education law made by section one of this act shall be subject to the expiration and reversion of such subdivision pursuant to section 8 of chapter 563 of the laws of 2008, when upon such date the provisions of section one-a of this act shall take effect; provided, further, that effective immediately, the addition, amendment and/or repeal of any rule or regulation necessary for the implementation of this act on its effective date are authorized and directed to be made and completed on or before such effective date.

§ 6. This act shall take effect immediately.

PART EE

Section 1. Section 473 of the social services law is amended by adding a new subdivision 9 to read as follows:

9. (a) Within amounts appropriated therefor, the office of children and family services shall establish a statewide, toll-free telephone number (a "hotline") to receive reports consistent with subdivision one of this section. The hotline shall receive reports of allegations of reportable incidents twenty-four hours per day, seven days a week. The hotline shall accept anonymous calls.

(b) When any allegation that could reasonably constitute a reportable incident is received by the hotline, the hotline shall accept and immediately transmit notice of the report orally and electronically to any appropriate state agencies or local social services office. Whenever a telephone call or electronic transmission to the hotline alleges an act or circumstances that may constitute a criminal offense or an immediate threat to an individual's health, safety or welfare, the hotline shall convey, by the most expedient means available, the information contained in such call or transmission to the appropriate law enforcement agency or district attorney and, to the extent necessary, the appropriate emergency responder, and the relevant state agency or local social services office.

(c) The commissioner is authorized to promulgate rules and regulations to facilitate the implementation and operation of the hotline, including but not limited to, procedures for timely and accurate referrals to other state agencies or entities that may have investigative or oversight authority regarding reported incidents.

§ 2. Subdivision 16 of section 202 of the elder law, as added by chapter 455 of the laws of 2016, is amended to read as follows:

16. to the extent appropriations are available, and in consultation with the office of children and family services, conduct a public education campaign that emphasizes zero-tolerance for elder abuse. Such campaign shall include information about the signs and symptoms of elder abuse, identification of potential causes of elder abuse, resources available to assist in the prevention of elder abuse, where suspected

elder abuse can be reported, **including, but not limited to, information regarding the statewide hotline as provided for in paragraph (a) of subdivision nine of section four hundred seventy-three of the social services law,** contact information for programs offering services to victims of elder abuse such as counseling, and assistance with arranging personal care and shelter. Such campaign may include, but not be limited to: printed educational and informational materials; audio, video, electronic, other media; and public service announcements or advertisements.

§ 3. This act shall take effect October 1, 2019.

PART FF

Section 1. The mental hygiene law is amended by adding a new section 9.65 to read as follows:

§ 9.65 Treatment of sex offenders in certain facilities.

Any facility operated by the state, which provides non-emergency, clinical outpatient or inpatient psychiatric treatment and which operates in the same building or physical location as a children's psychiatric center operated by the state shall determine, prior to the treatment or admission of any person, whether such person is a sex offender, as defined by subdivision one of section one hundred sixty-eight-a of the correction law. No facility which operates in the same building or physical location as a children's psychiatric center shall admit or treat a registered sex offender at such location.

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

PART GG

Section 1. Subdivision (c) of section 7.17 of the mental hygiene law, as added by chapter 978 of the laws of 1977, is amended to read as follows:

(c) The commissioner shall establish the areas which each facility under his jurisdiction shall serve and the categories of patients which each such facility shall receive, retain, or treat**; provided, however, that the Western New York Children's Psychiatric Center shall be maintained in a county with a population between nine hundred thousand and one million people as a separate and distinct entity both organizationally and physically within the office and shall not be collocated or merged with any other facility**.

§ 2. This act shall take effect immediately.

PART HH

Section 1. Paragraph 3 of subdivision (e) of section 7.17 of the mental hygiene law, as amended by chapter 83 of the laws of 1995, is amended to read as follows:

3. provide for a mechanism which may reasonably be expected to provide notice to local governments, community organizations, employee labor organizations, managerial and confidential employees, consumer and advocacy groups of the potential for significant service reductions at such state-operated hospitals and state-operated research institutes at least twelve months **and at most twenty-four months** prior to commencing such service reduction, provided, however, that this requirement shall be deemed satisfied with respect to reductions at Central Islip Psychiatric Center, Gowanda Psychiatric Center, Harlem Valley Psychiatric Center,

Kings Park Psychiatric Center, Willard Psychiatric Center and Manhattan Children's Psychiatric Center; and

§ 2. This act shall take effect immediately; provided, however, that any notice issued pursuant to paragraph 3 of subdivision (e) of section 7.17 of the mental hygiene law prior to the effective date of this act shall expire twelve months from the effective date of this act.

PART II

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

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

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

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

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

PART JJ

Section 1. Section 25.01 of the mental hygiene law, as added by chapter 471 of the laws of 1980, paragraphs 1, 2, 3 and 4 as amended and paragraphs 5, 6, 7 and 8 of subdivision (a) as added by section 3 of part G of chapter 56 of the laws of 2013, is amended to read as follows:

§ 25.01 Definitions.

[~~(a)~~] As used [~~herein~~] **in this article**:

1. "Local governmental unit" shall have the same meaning as that contained in article forty-one of this chapter.

2. "Operating expenses" shall mean expenditures approved by the office and incurred for the maintenance and operation of substance use disorder and/or compulsive gambling programs, including but not limited to expenditures for treatment, administration, personnel, and contractual services. Operating expenses do not include capital costs and debt service unless such expenses are related to the rent, financing or refinancing of the design, construction, acquisition, reconstruction, rehabilitation or improvement of a substance use disorder and/or compulsive gambling program facility pursuant to the mental hygiene facilities finance program through the dormitory authority [~~of the state of New York~~] (DASNY; successor to the Facilities Development Corporation), or otherwise approved by the office.

3. "Debt service" shall mean amounts, subject to the approval of the office, required to be paid to amortize obligations including principal and interest, assumed by or on behalf of [~~a voluntary~~] **an** agency or a program operated by a local governmental unit.

4. "Capital costs" shall mean the costs of a program operated by a local governmental unit or [~~a voluntary~~] **an** agency with respect to the acquisition of real property estates, interests, and cooperative interests in realty, their design, construction, reconstruction, rehabilitation and improvement, original furnishings and equipment, site development, and appurtenances of a facility.

5. "State aid" shall mean financial support provided through appropriations of the office to support the provision of substance use disorder treatment, compulsive gambling, prevention or other authorized services, with the exclusion of appropriations for the purpose of medical assistance.

6. [~~"Voluntary agency~~] **"Agency** contributions" shall mean revenue sources of [~~voluntary~~] agencies exclusive of state aid and local tax levy.

7. "Approved net operating cost" shall mean the remainder of total operating expenses approved by the office, less all sources of revenue, including [~~voluntary~~] agency contributions and local tax levy.

8. [~~"Voluntary agency"~~] **"Agency"** shall mean a corporation organized or existing pursuant to the not-for-profit corporation law for the purpose of**, or any business entity** providing substance use disorder, treatment, compulsive gambling, prevention or other authorized services.

§ 2. Section 25.03 of the mental hygiene law, as amended by chapter 223 of the laws of 1992, subdivisions (a) and (b) as amended and subdivision (d) as added by section 4 of part G of chapter 56 of the laws of 2013, is amended to read as follows:

§ 25.03 Financial support and disbursement of funds.

(a) In accordance with the provisions of this article, and within appropriations made available, the office may provide state aid to a program operated by a local governmental unit or [~~voluntary~~] **an** agency up to one hundred per centum of the approved net operating costs of such program operated by a local governmental unit or [~~voluntary~~] **an** agency, and state aid may also be granted to a program operated by a local governmental unit or [~~a voluntary~~] **an** agency for capital costs associated with the provision of services at a rate of up to one hundred percent of approved capital costs. Such state aid shall not be granted unless and until such program operated by a local governmental unit or [~~voluntary~~] **an** agency is in compliance with all regulations promulgated by the commissioner regarding the financing of capital projects. Such state aid for approved net operating costs shall be made available by way of advance or reimbursement, through either contracts entered into between the office and such [~~voluntary~~] agency or by distribution of such state aid to local governmental units through a grant process pursuant to section 25.11 of this article.

(b) Financial support by the office shall be subject to the approval of the director of the budget and within available appropriations.

(c) All federal financial assistance granted or allocated to the office by the United States shall only be paid out on the audit and warrant of the comptroller on the certificate of the commissioner or his authorized representative.

(d) Nothing in this section shall be construed to require the state to increase such state aid should a local governmental unit choose to remove any portion of its local tax levy support of [~~voluntary~~] agen-

cies, although the state may choose to do so to address an urgent public need, or conversely, may choose to reduce its state aid up to the same percentage as the reduction in local tax levy.

§ 3. Section 25.05 of the mental hygiene law, as amended by section 5 of part G of chapter 56 of the laws of 2013, is amended to read as follows:

§ 25.05 Reimbursement from other sources.

The office shall not provide [~~a voluntary~~] an agency or a program operated by a local governmental unit with financial support for obligations incurred by or on behalf of such program or agency for substance use disorder and/or compulsive gambling services for which reimbursement is or may be claimed under any provision of law other than this article.

§ 4. Section 25.07 of the mental hygiene law, as amended by section 7 of part G of chapter 56 of the laws of 2013, is amended to read as follows:

§ 25.07 Non-substitution.

[~~A voluntary~~] An agency or a program operated by a local governmental unit shall not substitute state monies for cash contributions, federal aid otherwise committed to or intended for use in such program or by such agency, revenues derived from the operation of such program or agency, or the other resources available for use in the operation of the program or agency.

§ 5. Section 25.09 of the mental hygiene law, as amended by section 8 of part G of chapter 56 of the laws of 2013, is amended to read as follows:

§ 25.09 Administrative costs.

Subject to the approval of the director of the budget, the office shall establish a limit on the amount of financial support which may be advanced or reimbursed to [~~a voluntary~~] an agency or a program operated by a local governmental unit for the administration of a program.

§ 6. This act shall take effect immediately.

PART KK

Section 1. The mental hygiene law is amended by adding a new section 19.18-b to read as follows:

§ 19.18-b Substance use disorder peer to peer support services program.

1. For purposes of this subdivision "peer to peer support services" means participant-centered services that emphasize knowledge and wisdom through lived experience in which peers are encouraged to share their own personal experience and first-hand knowledge of substance abuse, addiction, and recovery to support the recovery goals of individuals who use drugs and/or alcohol.

2. The commissioner, in consultation with the department of health shall develop and administer a certification process and standards of training and competency for substance use disorder peer support services.

3. Certified peer to peer support services shall include but not be limited to:

(a) developing recovery plans;

(b) raising awareness of existing social and other support services;

(c) modeling coping skills;

(d) assisting with applying for benefits;

(e) accompanying clients to medical appointments;

(f) providing non-clinical crisis support, especially after periods of hospitalization or incarceration;

(g) accompanying clients to court appearances and other appointments;
(h) working with participants to identify strengths;
(i) linking participants to formal recovery supports, including, but not limited to, medication assisted treatment;
(j) educating program participants about various modes of recovery, including, but not limited to, medication assisted treatment;
(k) peer engagement coordination with hospital emergency services to assist any patient that has been administered an opioid antagonist by a medical provider to establish connections to treatment, including, but not limited to, medication assisted treatment and other supports after an opioid overdose reversal or after discharge from another substance abuse related emergency department visit; and
(l) peer engagement coordination with law enforcement departments, fire departments and other first responder departments to assist any individual that has been administered an opioid antagonist by a first responder to establish connections to treatment, including, but not limited to, medication assisted treatment and other support services after an opioid overdose reversal.

§ 2. This act shall take effect immediately; provided, however, that effective immediately, the addition, amendment and/or repeal of any rule or regulation necessary for the implementation of this act on its effective date are authorized and directed to be made and completed on or before such effective date.

PART LL

Section 1. The mental hygiene law is amended by adding a new section 32.06 to read as follows:

§ 32.06 Prohibition on deceptive acts and practices.

(a) Definitions. As used in this section, the following terms shall have the following meanings, unless the context clearly requires otherwise:

(1) "Addiction professional" shall mean a professional who, within the scope of their license issued pursuant to title eight of the education law or credential issued pursuant to section 19.07 of this chapter, if working in an individual capacity, provides substance abuse and prevention services.

(2) "Credentialed professional" shall include any person who is in the process of applying for a credential issued by the commissioner pursuant to section 19.07 of this chapter, or who has a valid credential, or who is eligible for credential renewal;

(3) "Health care provider" shall mean a practitioner in an individual practice, group practice, partnership, professional corporation or other authorized form of association, a hospital or other health care institution issued an operating certificate pursuant to article twenty-eight of the public health law or article thirty-one of this title or this article, and any other purveyor of health or health related items or services.

(4) "Potential service recipient" shall mean a person who is a substance abuser, substance dependent, in need of services to avoid becoming a substance abuser, or substance dependent.

(5) "Substance abuse program" shall mean any public or private person, corporation, partnership, agency, either profit or non-profit, or state or municipal government which provides, or holds itself out as providing, substance abuse services, in either a residential or ambulatory setting, to persons who are substance abusers, substance dependent, in

need of services to avoid becoming substance abusers, substance dependent or to significant others.

(6) "Substance abuse services" shall include services to inhibit the onset of substance abuse or substance dependence; to address the social dysfunction, medical problems and other disabilities associated with substance abuse or substance dependence, and to rehabilitate persons suffering from substance abuse or dependence.

(b) It is unlawful for any person, including any individual, addiction professional, credentialed professional, health care provider, health care facility or substance abuse program to:

(1) Promote, offer, give, solicit or pay any commission, bonus, rebate, kickback, or bribe, directly or indirectly, in cash or in kind, or engage in any split-fee arrangement, to induce the referral of a potential service recipient or in connection with the performance of a substance abuse service;

(2) Solicit, agree to receive or receive any commission, bonus, rebate, kickback, or bribe, directly or indirectly, in cash or in kind, or engage in any split-fee arrangement, in any form whatsoever, in return for referring a potential service recipient or in connection with the performance of a substance abuse service; or

(3) Aid, abet, advise, or otherwise participate in the conduct prohibited under paragraph one or two of this subdivision.

(c) This section shall not apply to:

(1) Any discount, payment, waiver of payment, or payment practice not prohibited by 42 U.S.C. § 1320a-7b(b) or regulations promulgated thereunder.

(2) Payments to an addiction professional, health care provider, health care facility or substance abuse program for professional consultation services.

(3) Commissions, fees, or other remuneration lawfully paid to insurance agents as provided under the insurance law.

(4) Payments by a health insurer who reimburses, provides, offers to provide, or administers health, mental health, or substance abuse services under a health benefit plan.

(5) Payments to or by an addiction professional, health care provider, health care facility, a health care provider network entity, or a substance abuse program, that has contracted with a health insurer, a health care purchasing group, or the Medicare or Medicaid program to provide health, mental health, or substance abuse services under a health benefit plan when such payments are for services under the plan.

(6) Payments by an addiction professional, health care provider, health care facility or substance abuse program to a health, mental health, or substance abuse information service that provides information upon request and without charge to consumers about providers of substance abuse services to enable consumers to select appropriate substance abuse programs, provided that such information service:

i. Does not attempt through its standard questions for solicitation of consumer criteria or through any other means to steer or lead a consumer to select or consider selection of a particular addiction professional, substance abuse services or substance abuse program;

ii. Does not provide or represent itself as providing diagnostic or counseling services or assessments of an individual's need for substance abuse services and does not make any promises of cure or guarantees of treatment;

iii. Does not provide or arrange for transportation of a consumer to or from the location of a substance abuse service or program; and

iv. Charges and collects fees from an addiction professional, health care provider, health care facility or substance abuse program participating in its services that are set in advance, are consistent with the fair market value for those information services, and are not based on the potential value of a potential service recipient or recipients to a substance abuse program or of the goods or services provided by the substance abuse program.

(d) Any individual, including an officer, partner, agent, attorney, or other representative of a partnership, association, corporation, limited liability company or partnership, public or private agency or any part thereof who knowingly fails to comply with the provisions of this section shall be guilty of a misdemeanor as defined in the penal law.

(e) If the commissioner has reason to believe that there is an individual, partnership, association, corporation, limited liability company or partnership, public or private agency or any part thereof violating subdivision (b) of this section, he or she shall proceed pursuant to applicable sections of this chapter including but not limited to sections 32.13, 32.15, 32.19 and 32.27 of this article.

(f) The party bringing an action under this section may recover reasonable expenses in obtaining injunctive relief, including, but not limited to, investigative costs, court costs, reasonable attorney's fees, witness costs, and deposition expenses.

(g) The provisions of this section are in addition to any other civil, administrative, or criminal actions provided by law and may be imposed against both corporate and individual defendants.

§ 2. This act shall take effect immediately.

PART MM

Section 1. The mental hygiene law is amended by adding a new section 19.18-b to read as follows:

§ 19.18-b Family support and recovery services demonstration program.

1. Within available appropriations, the commissioner shall develop a family support and recovery services program. This program shall provide family support and recovery services to adolescent and adult patients, and their families, during treatment, including, but not limited to, inpatient and outpatient treatment, and shall be available to such patients and their families for up to twelve months after completion of such treatment program. The commissioner shall identify where the family support and recovery services program will be established, provided, however, that one such program shall be in western New York and another such program shall be in Long Island.

2. Family support and recovery services shall include:

(a) treatment placement services;

(b) housing placement services;

(c) peer supports, including peer to peer support groups;

(d) employment support; and

(e) transportation assistance.

3. Not later than April 1, 2021, the commissioner shall provide the governor, the temporary president of the senate, the speaker of the assembly, the chair of the senate standing committee on alcoholism and drug abuse and the chair of the assembly committee on alcoholism and drug abuse with a written evaluation of the program. Such evaluation shall, at a minimum, address the overall effectiveness of this program, identify best practices for family support and recovery services provided under this program, and any additional family support and

recovery services that may be appropriate within each type of program operated, regulated, funded, or approved by the office. The written evaluation shall be made available on the office's website.

§ 2. This act shall take effect immediately and shall expire and be deemed repealed on April 1, 2021.

PART NN

Section 1. The mental hygiene law is amended by adding a new section 22.13 to read as follows:

§ 22.13 Alcohol and drug free housing.

(a) As used in this section, the following words shall have the following meanings unless the context clearly requires otherwise:

1. "Alcohol and drug free housing", a residence, commonly known as a sober home, which provides or advertises as providing, an alcohol and drug free environment for people recovering from substance use disorders; provided, however, that, alcohol and drug free housing shall not include a halfway house, treatment unit or detoxification facility regulated under article thirty-two of this chapter or any other facility licensed pursuant to article twenty-eight-a of the public health law.

2. "Certified alcohol and drug free housing", alcohol and drug free housing that has been accredited by the bureau pursuant to this section.

3. "Operator", the lawful owner of alcohol and drug free housing or a person employed and designated by the owner to have primary responsibility for the daily operation of such housing and for maintaining standards and conditions in such housing that create an environment supportive of substance use disorder recovery.

(b) The commissioner shall establish and provide for the administration of a voluntary training and accreditation program for operators of alcohol and drug free housing seeking certification under subdivision (d) of this section.

(c) The accreditation program established pursuant to this section shall maintain standards and practices which:

1. uphold industry best practices and support a safe, healthy and effective recovery environment;

2. evaluate the ability to assist persons in achieving long-term recovery goals;

3. provide for appropriate training for the operators and staff and ensure satisfactory completion of such training;

4. protect occupants of alcohol and drug free housing against unreasonable and unfair practices in setting and collecting rent payments; and

5. verify good standing with regard to local, state and federal laws and any regulations and ordinances including, but not limited to, building, maximum occupancy, fire safety and sanitation codes.

(d) The office shall include a residence on a list of certified alcohol and drug free housing as described in subdivision (f) of this section upon receipt and review of:

1. the completion of training as described in subdivision (c) of this section;

2. a deed, trust document, articles of incorporation, lease or other document acceptable to the director evidencing that the individual or entity seeking certification is the lawful owner or lessee of the parcel where the housing shall be located; and

3. appropriate documentation indicating that there are no taxes or other assessments which constitute liens on the parcel of real estate upon which the housing shall be located.

(e) The commissioner shall periodically evaluate the quality of training being provided to operators seeking certification and the integrity and efficacy of the accreditation program.

(f) The commissioner shall prepare, publish and disseminate a list of alcohol and drug free housing certified pursuant to this section; provided, however, that such list shall be updated bimonthly. The list shall be disseminated to each state agency or vendor with a statewide contract that provides substance use disorder treatment services. The commissioner shall inform all local probation departments and all courts within the state who may issue a sentence of probation on how to access the list. Such list shall also be posted on the website for the office.

(g) The commissioner, in consultation with the commissioner of the department of health, shall promulgate rules and regulations to implement this section that shall include a process for receiving complaints against certified alcohol and drug free housing and criteria by which the commissioner may exclude a residence from the list prepared under subdivision (f) of this section if the frequency and severity of complaints received supports a determination that the alcohol and drug free housing in question does not maintain standards or provide an environment that appropriately supports the recovery goals of its residents.

(h) A state agency or vendor with a statewide contract which is providing treatment or services to a person, or a state agency or officer setting terms and conditions for the release, parole or discharge of a person from custody or treatment, shall not refer such person to alcohol and drug free housing and shall not otherwise include in such terms and conditions a referral to alcohol and drug free housing unless such alcohol and drug free housing is certified pursuant to this section. Nothing in this section shall prohibit a residence which has not received certification from operating or advertising as alcohol and drug free housing or from offering residence to persons recovering from substance use disorders.

§ 2. This act shall take effect on the one hundred eightieth day after it shall have become a law. Effective immediately, the addition, amendment and/or repeal of any rule or regulation necessary for the implementation of this act on its effective date are authorized and directed to be made and completed on or before such effective date.

PART OO

Section 1. The mental hygiene law is amended by adding a new article 23 to read as follows:

ARTICLE 23

ASSISTED OUTPATIENT TREATMENT FOR SUBSTANCE ABUSE

Section 23.01 Assisted outpatient treatment for substance abuse.
23.03 Definitions.
23.05 Criteria for assisted outpatient treatment for substance abuse.
23.07 Petition to the court.
23.09 Service.
23.11 Right to counsel.
23.13 Hearing.
23.15 Written treatment plan.
23.17 Disposition.

23.19 Petitions for additional periods of treatment; petitions for an order to stay, vacate or modify; and appeals.
23.21 Failure to comply with assisted outpatient treatment.
23.23 Effect of determination that a person is in need of assisted outpatient treatment.
23.25 False petition.
23.27 Education and training.
23.29 The assisted outpatient treatment for substance abuse advisory council.

§ 23.01 Assisted outpatient treatment for substance abuse.

There is hereby established the assisted outpatient treatment for substance abuse program. This program shall serve individuals with substance use disorders who, due to opioid abuse, require services to prevent them from causing harm to themselves and others. The commissioner, in consultation with the commissioner of the department of health and the commissioner of the office of mental health, and in conjunction with the assisted outpatient treatment for substance abuse advisory council, shall promulgate all rules and regulations necessary to implement the provisions of this article.

§ 23.03 Definitions.

For the purposes of this article, the following definitions shall apply:

(a) "Assisted outpatient treatment for substance abuse" shall mean categories of services that have been ordered by the court pursuant to this article. Such treatment shall include case management services to provide care coordination, and may also include any of the following categories of services: substance use disorder services, detoxification as deemed appropriate pursuant to a written treatment plan; medication supported recovery; individual or group therapy; day or partial day programming activities; tests for the presence of alcohol or illegal drugs; supervision of living arrangements; treatment for co-occurring disorders; and any other services prescribed to treat the person's substance use disorder and to assist the person in living and functioning in the community, or to attempt to prevent a relapse or deterioration that may reasonably be predicted to result in the need for hospitalization or serious harm to the person or others.

(b) "Assisted outpatient treatment for substance abuse program" shall mean a system to arrange for, and coordinate the provision of, assisted outpatient treatment for substance abuse; to monitor treatment compliance by assisted outpatients; to take appropriate steps to address the needs of such individuals; and to ensure compliance with court orders.

(c) "Assisted outpatient" shall mean the person under a court order to receive assisted outpatient treatment for substance abuse due to a substance use disorder.

(d) "Opioid" shall mean an opiate, opium, opium poppy or poppy straw; and any salt, compound, derivative, or preparation of thereof that is chemically equivalent or identical to such substances.

(e) "Subject of the petition" or "subject" shall mean the person who is alleged in a petition, filed pursuant to the provisions of this article, to meet the criteria for assisted outpatient treatment for substance abuse.

(f) "Substance use disorder" shall mean the misuse of, dependence on, or addiction to a legal or illegal opioid leading to effects that are detrimental to the individual's physical and mental health, or the welfare of others.

§ 23.05 Criteria for assisted outpatient treatment for substance abuse.

(a) A person may be ordered to receive assisted outpatient treatment for substance abuse if the court finds that such person:

(1) is eighteen years of age or older; and

(2) is suffering from a substance use disorder; and

(3) is unlikely to survive safely in the community without supervision, based on a clinical determination; and

(4) has a history of lack of compliance with treatment for a substance use disorder, as evidenced by:

(i) prior to the filing of the petition, at least twice within the last thirty-six months, his or her substance use disorder has been a significant factor in necessitating hospitalization in a hospital, as defined in article twenty-eight of the public health law, or receipt of substance abuse treatment services in a correctional facility or a local correctional facility, not including any current period, or period ending within the last six months, during which the person was or is hospitalized or incarcerated; or

(ii) prior to the filing of the petition, resulted in one or more acts of serious violent behavior toward self or others or threats of, or attempts at, serious physical harm to self or others within the last forty-eight months, not including any current period, or period ending within the last six months, in which the person was or is hospitalized or incarcerated; provided, however, that use of an opioid alone shall not be deemed as satisfying this requirement; and

(5) is, as a result of his or her substance abuse, unlikely to voluntarily participate in substance use disorder services that would enable him or her to live safely in the community; and

(6) in view of his or her treatment history and current behavior, is in need of assisted outpatient treatment for substance abuse in order to prevent a relapse or deterioration that would be likely to result in serious harm to the person or others; and

(7) is likely to benefit from assisted outpatient treatment for substance abuse.

§ 23.07 Petition to the court.

(a) A petition for an order authorizing assisted outpatient treatment for substance abuse may be filed in the supreme or county court in the county in which the subject of the petition is present or reasonably believed to be present. A petition to obtain an order authorizing assisted outpatient treatment for substance abuse may be initiated only by the following persons:

(1) any person eighteen years of age or older with whom the subject of the petition resides; or

(2) the parent, spouse, sibling, or child of the subject of the petition who is eighteen years of age or older; or

(3) any other person deemed appropriate by the commissioner in regulation.

(b) The petition shall state:

(1) each of the criteria for assisted outpatient treatment for substance abuse as set forth in section 23.05 of this article;

(2) facts which support the petitioner's belief that the subject of the petition meets each criterion, provided that the hearing on the petition need not be limited to the stated facts; and

(3) that the subject of the petition is present, or is reasonably believed to be present, within the county where such petition is filed.

(c) The petition shall be accompanied by an affirmation or affidavit of a physician, who shall not be the petitioner, stating either that:

(1) such physician has personally examined the subject of the petition no more than ten days prior to the submission of the petition, recommends assisted outpatient treatment for substance abuse for the subject of the petition, and is willing and able to testify at the hearing on the petition; or

(2) no more than ten days prior to the filing of the petition, such physician or his or her designee has made appropriate attempts, but has not been successful in eliciting the cooperation of the subject of the petition to submit to an examination; such physician has reason to suspect that the subject of the petition meets the criteria for assisted outpatient treatment for substance abuse; and such physician is willing and able to examine the subject of the petition and testify at the hearing on the petition.

(d) In counties with a population of less than seventy-five thousand, the affirmation or affidavit required by subdivision (c) of this section may be made by a physician who is an employee of the office. The office is authorized to make available, at no cost to the county, a qualified physician for the purpose of making such affirmation or affidavit consistent with the provisions of such subdivision.

§ 23.09 Service.

The petitioner shall cause written notice of the petition to be given to the subject of the petition, and a copy thereof to be given personally or by mail to such other persons as the commissioner deems appropriate in regulation.

§ 23.11 Right to counsel.

The subject of the petition shall have the right to be represented by counsel at all stages of a proceeding commenced under this section.

§ 23.13 Hearing.

(a) Upon receipt of the petition, the court shall fix the date for a hearing. Such date shall be no later than three days from the date such petition is received by the court, excluding Saturdays, Sundays and holidays. Adjournments shall be permitted only for good cause shown. In granting adjournments, the court shall consider the need for further examination by a physician or the potential need to provide assisted outpatient treatment for substance abuse expeditiously. The court shall cause the subject of the petition, any other person receiving notice pursuant to section 23.09 of this article, the petitioner, the physician whose affirmation or affidavit accompanied the petition, and such other persons as the court may determine to be advised of such date. Upon such date, or upon such other date to which the proceeding may be adjourned, the court shall hear testimony and, if it be deemed advisable and the subject of the petition is available, examine the subject of the petition in or out of court. If the subject of the petition does not appear at the hearing, and appropriate attempts to elicit the attendance of the subject have failed, the court may conduct the hearing in the subject's absence. In such case, the court shall set forth the factual basis for conducting the hearing without the presence of the subject of the petition.

(b) The court shall not order assisted outpatient treatment for substance abuse unless an examining physician, who recommends assisted outpatient treatment for substance abuse and has personally examined the subject of the petition no more than six months before the filing of the petition, testifies in person at the hearing. Such physician shall state the facts and clinical determinations that support the allegation that the subject of the petition meets each of the criteria for assisted outpatient treatment for substance abuse. The commissioner shall in

regulation address instances in which the subject of the petition refuses examination by a physician.

(c) A physician who testifies pursuant to subdivision (b) of this section shall state: (i) the facts that support the allegation that the subject meets each of the criteria for assisted outpatient treatment for substance abuse, (ii) that the treatment is the least restrictive alternative, (iii) the recommended assisted outpatient treatment for substance abuse, and (iv) the rationale for the recommended assisted outpatient treatment for substance abuse. If the recommended assisted outpatient treatment for substance abuse includes medication supported recovery, such physician's testimony shall provide such details as the commissioner shall require in regulation.

(d) The subject of the petition shall be afforded an opportunity to present evidence, to call witnesses on his or her behalf, and to cross-examine adverse witnesses.

§ 23.15 Written treatment plan.

(a) The court shall not order assisted outpatient treatment for substance abuse unless a physician develops and provides to the court a proposed written treatment plan, in accordance with regulations promulgated by the commissioner. The written treatment plan shall include case management services to provide care coordination. The written treatment plan also shall include all categories of services that such physician recommends that the subject of the petition receive. All substance abuse programs shall be notified regarding their inclusion in the written treatment plan.

(b) The physician appointed to develop the written treatment plan shall provide the following persons with an opportunity to actively participate in the development of such plan: the subject of the petition; the treating physician, if any; and upon the request of the subject of the petition, an individual significant to the subject including any relative, close friend or individual otherwise concerned with the welfare of the subject. If the subject of the petition has executed a health care proxy, the appointed physician shall consider any directions included in such proxy in developing the written treatment plan.

(c) The court shall not order assisted outpatient treatment for substance abuse unless a physician who developed such plan testifies to explain the proposed written treatment plan. Such physician shall state the categories of assisted outpatient treatment for substance abuse recommended, the rationale for each such category, facts which establish that such treatment is the least restrictive alternative, and any other information required by the commissioner in regulation. If the subject of the petition has executed a health care proxy, such physician shall state the consideration given to any directions included in such proxy in developing the written treatment plan.

§ 23.17 Disposition.

(a) If after hearing all relevant evidence, the court does not find by clear and convincing evidence that the subject of the petition meets the criteria for assisted outpatient treatment for substance abuse, the court shall dismiss the petition.

(b) If after hearing all relevant evidence, the court finds by clear and convincing evidence that the subject of the petition meets the criteria for assisted outpatient treatment for substance abuse, and there is no appropriate and feasible less restrictive alternative, the court may order the subject to receive assisted outpatient treatment for substance abuse for an initial period not to exceed six months. In

fashioning the order, the court shall specifically make findings by clear and convincing evidence that the proposed treatment is the least restrictive treatment appropriate and feasible for the subject. The order shall state an assisted outpatient treatment for substance abuse plan, which shall include all categories of assisted outpatient treatment for substance abuse that the assisted outpatient is to receive, but shall not include any such category that has not been recommended in both the proposed written treatment plan and the testimony provided to the court pursuant to section 23.15 of this article.

(c) The commissioner shall establish in regulation procedures for the provision or arrangement for all categories of assisted outpatient treatment for substance abuse to the assisted outpatient throughout the period of the order.

(d) The director shall cause a copy of any court order issued pursuant to this section to be served personally, or by mail, facsimile or electronic means, upon the assisted outpatient, or anyone acting on the assisted outpatient's behalf, the original petitioner, identified service providers, and all others entitled to notice under section 23.09 of this article.

§ 23.19 Petitions for additional periods of treatment; petitions for an order to stay, vacate or modify; and appeals.

The commissioner shall establish in regulation such rules and procedures to ensure that assisted outpatients: receive appropriate substance use disorder services; are afforded all rights and remedies available by law with respect to the order for assisted outpatient treatment for substance abuse, including the ability to petition the court to stay, vacate or modify the order; and are given the opportunity to appeal an order issued pursuant to this article.

§ 23.21 Failure to comply with assisted outpatient treatment.

Where the subject fails to comply with the assisted outpatient for substance abuse treatment plan set forth in accordance with section 23.15 of this article, the subject shall be brought to a facility or treatment program for emergency services pursuant to section 22.09 of this title.

§ 23.23 Effect of determination that a person is in need of assisted outpatient treatment.

The determination by a court that a person is in need of assisted outpatient treatment for substance abuse shall not be construed as or deemed to be a determination that such person is incapacitated pursuant to article eighty-one of this chapter.

§ 23.25 False petition.

A person making a false statement or providing false information or false testimony in a petition or hearing under this section shall be subject to criminal prosecution pursuant to article one hundred seventy-five or article two hundred ten of the penal law.

§ 23.27 Education and training.

(a) The office of alcoholism and substance abuse services, in consultation with the office of court administration, shall prepare educational and training materials on the use of this section, which shall be made available to local governmental units, providers of services, judges, court personnel, law enforcement officials and the general public.

(b) The office, in consultation with the office of court administration, shall establish a substance abuse training program for supreme and county court judges and court personnel. Such training shall focus on the use of this section and generally address issues relating to heroin and opioid addiction.

§ 23.29 The assisted outpatient treatment for substance abuse advisory council.

There is hereby created the assisted outpatient treatment for substance abuse advisory council. (a) The council shall consist of: the commissioner, or his or her designee; the commissioner of mental health, or his or her designee; the commissioner of health, or his or her designee; and fourteen members appointed by the governor by and with the advice and consent of the senate. The governor shall designate one of the appointed members of the council as chair, who shall serve as such for a three year term. Membership shall be representative of the public, shall have broad programmatic and geographic representation, shall include both not-for-profit and proprietary providers of substance abuse services, and shall include:

(1) Five consumer representatives, including persons who are recovering from substance use disorders, their family members, and patient advocates.

(2) Five representatives of providers of services to persons with substance use disorders, including but not limited to representatives of free standing substance abuse facilities, general hospitals, residential facilities for persons who abuse or are dependent upon opioids, methadone maintenance programs, and outpatient facilities for persons who abuse or are dependent on opioids. Of these appointments, at least one representative must be a physician.

(3) Four representatives of law enforcement, local governments, and public and private payors of alcoholism substance abuse treatment.

(b) Members shall be appointed for terms of three years, provided however, that of the members first appointed, one-third shall be appointed for one year terms and one-third shall be appointed for two year terms. Vacancies shall be filled in the same manner as original appointments for the remainder of any unexpired term.

(c) The council shall meet at the request of its chair or the commissioner, but no less frequently than four times in each full calendar year.

(d) The council shall provide recommendations to the commissioner regarding policies, rules and regulations necessary to implement the assisted outpatient treatment for substance abuse program according to this article.

§ 2. This act shall take effect on the one hundred twentieth day after it shall have become a law; provided, however, that effective immediately, the addition, amendment and/or repeal of any rule or regulation necessary for the implementation of this act on its effective date are authorized and directed to be made and completed on or before such effective date.

PART PP

Section 1. Subdivision (b) of section 5.07 of the mental hygiene law is amended by adding a new paragraph 5 to read as follows:

(5) The commissioner of alcoholism and substance abuse services shall also include the following in the portion of the statewide comprehensive plan required by this subdivision for services to persons with substance use or compulsive gambling disorders:

(i) an assessment of substance abuse prevention, treatment and recovery programs and services licensed, certified or operated by the office; as well as an update on the efficacy of the implementation of these programs. The purpose of this assessment is to examine the current

status of the implementation of opioid/heroin treatment, prevention and recovery support services expansion, services targeting adolescents/youth in transition, cross system collaboration with criminal and juvenile justice systems, schools and workforce development; provide descriptive information about individuals using services; and provide descriptive information about the workforce;

(ii) for each expanded service, descriptive information on the population accessing this service including: characteristics of the population served; age, sex, race and ethnicity, educational status, student status, marital status, number of children, employment status, housing status, and U.S. military status, current criminal justice status, number of past arrests, substance or substances used in the last thirty days, number of days in drug and/or alcohol inpatient detoxification, number of emergency room episodes for which the client received treatment, number of days the client was hospitalized for non-detoxification services, hospitalizations and reason, current opiate addiction medicine, addiction medications used, physical or behavioral health related conditions and number of people in recovery;

(iii) for each expansion service, the number of addiction specialists, of this number, the number of providers who have enhanced their skills through fetal alcohol disorder training and overdose prevention training;

(iv) for certified peers and family support navigators, the number working at expanded sites, the number of face-to-face contacts with individuals in treatment facilities, including emergency rooms and inpatient settings, community based organizations and support groups; and

(v) the number of peer advocate scholarships awarded.

§ 2. On or before July 1, 2020, the office shall provide the results of the effectiveness between opioid/heroin treatment services, retention in treatment and outcomes using national outcome measures developed by the Substance Abuse and Mental Health Services Administration (SAMHSA) to the temporary president of the senate, the speaker of the assembly, and the chairs of the senate and assembly committees on alcoholism and drug abuse.

§ 3. This act shall take effect immediately.

PART QQ

Section 1. Section 19.07 of the mental hygiene law is amended by adding a new subdivision (l) to read as follows:

(l) (1) The office shall establish, either directly or through contract, an ombudsman for substance use disorder insurance coverage. Such ombudsman shall have expertise in substance use disorder treatment and advocacy, experience with insurance coverage requirements, and such other qualifications as shall be determined by the commissioner, in consultation with the superintendent of financial services.

(2) The ombudsman for substance use disorder insurance coverage shall:

(i) identify, accept, investigate, refer and resolve complaints that are made by or on behalf of consumers relative to health insurance coverage of and access to initial and continuing substance use disorder care, including medication assisted treatment, both inpatient and outpatient;

(ii) accept, investigate, refer and resolve complaints that are made by treatment providers relative to health insurance coverage of and reimbursement for initial or continuing substance use disorder care, including medication assisted treatment, both inpatient and outpatient;

(iii) accept, investigate, refer and resolve complaints that are made by or on behalf of consumers or by providers relative to network adequacy for access to and continuing substance use disorder care, including medication assisted treatment, both inpatient and outpatient; and

(iv) make recommendations to the commissioner and the superintendent of financial services biennially beginning October first, two thousand nineteen, on regulatory and/or statutory changes necessary to ensure access to appropriate care, and such recommendations shall be shared with the legislature upon issuance. Such recommendations may also include whether the ombudsman role should be extended to include broader behavioral health insurance complaints and concerns.

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

PART RR

Section 1. The mental hygiene law is amended by adding a new section 19.18-c to read as follows:

§ 19.18-c Jail-based substance use disorder treatment and transition services.

1. The commissioner, in consultation with local governmental units, county sheriffs and other stakeholders, shall implement a jail-based substance use disorder treatment and transition services program that supports the initiation, operation and enhancement of substance use disorder treatment and transition services for persons with substance use disorder who are incarcerated in jails in counties other than in the city of New York or the counties contained therein.

2. The services to be provided by such program shall be in accordance with plans developed by participating local governmental units, in collaboration with county sheriffs and approved by the commissioner and may include, but not be limited to, the following:

a. Alcohol, heroin and opioid withdrawal management;

b. Medication-assisted treatments;

c. Group and individual counseling and clinical support;

d. Peer support;

e. Discharge planning; and

f. Re-entry and transitional supports.

3. Within amounts appropriated therefor, funding shall be made available to local governmental units pursuant to criteria established by the office of alcoholism and substance abuse services in consultation with local governmental units, which shall take into consideration the local needs and resources as identified by local governmental units, the average daily jail population, the average number of persons incarcerated in the jail that require substance use disorder services and such other factors as may be deemed necessary.

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

PART SS

Section 1. The public health law is amended by adding a new section 1112-a to read as follows:

§ 1112-a. Emergent contaminant contingency fund. 1. The department shall establish and maintain a separate fund for the payment of expenses which are necessary to provide for:

(a) temporary water supply sources;

(b) water filtration systems; or
(c) remediation measures.
2. The monies in the fund shall be paid or loaned to public water supply systems, to the extent appropriations are available, in the event one or more emergent contaminants exceed acceptable levels in the water of a given supply system due to either newly amended emergent contaminant levels or to new contamination. Priority shall be given to those supply systems in jeopardy of losing the ability to adequately furnish water to their residents. The presence of the emergent contaminants shall be measured at a level set forth in section eleven hundred twelve of this article. The emerging contaminant contingency fund shall consist of monies appropriated by the clean water infrastructure act of two thousand seventeen.

§ 2. Subdivision 11 of section 1112 of the public health law, as added by section 1 of part M of chapter 57 of the laws of 2017, is amended to read as follows:

11. The commissioner [~~may~~] shall promulgate regulations pursuant to which the department may provide financial assistance for compliance with the testing requirements of this section, to any covered public water system upon a showing that the costs associated with testing drinking water in compliance with this section would impose a financial hardship. Such regulations shall, when prioritizing public water systems for eligibility for financial assistance, incorporate provisions that give preference to public water systems serving less than ten thousand individuals.

§ 3. The public health law is amended by adding a new section 1108-a to read as follows:

§ 1108-a. Public water system coordination summits. The department shall convene no less than six public water system coordination summits intended to support the safety and quality of public water systems supplies. The summits shall be held regionally as follows: the mid-Hudson region of the state, the central region of the state, the north country region of the state, the Finger Lakes region, Long Island, and the western region of the state. The department shall invite national and state experts appropriate for public water system quality and safety, including watershed experts, public water associations and organizations, and water suppliers, the members of the drinking water quality council established pursuant to section eleven hundred thirteen of this title and members of the state legislature representing the region in which the summit takes place. Summit topics shall include, but not be limited to: water infrastructure, additional testing in areas that previously detected unregulated contaminants monitored pursuant to the federal Safe Drinking Water Act (42 USC § 300g-1), challenges facing small and rural water utilities, and systematic ways to identify problems and set priorities. The department shall extend summit invitations to community water systems, transient non-community water systems, non-transient non-community water systems in each county across the state and shall invite systems representing rural, suburban and urban areas. All four summits shall be subject to the open meetings law and shall take place between April first, two thousand eighteen and July first, two thousand eighteen. The department shall post recommendations on its website within sixty days of the conclusion of each summit.

§ 4. The public health law is amended by adding a new section 1114-a to read as follows:

§ 1114-a. Voluntary public water system consolidation study. 1. There shall be established in the department, by the commissioner, a voluntary

public water system consolidation study designed to evaluate the feasibility of the joining of public water systems in order to improve water quality. Such study shall include:

(a) the feasibility of joining of two or more public water systems to form one water system;

(b) the feasibility of the consolidation of one or more public water systems into a larger public water system;

(c) the appropriate technical, managerial and financial capacity necessary for consolidation, including state funding mechanisms and incentives that could be utilized;

(d) potential public health impacts of consolidation, including ability to meet legally required water quality standards and the impact on monitoring, reporting and enforcement of drinking water standards;

(e) appropriate and sufficient guidance from the department necessary for those public water systems interested in consolidation; and

(f) recommendations for public water systems interested in voluntary consolidation.

2. Such study shall be funded within amounts appropriated. The department shall prepare and submit a report and supporting materials to the governor, the temporary president of the senate and the speaker of the assembly setting forth the information gathered and recommendations to the legislature by January first of the following year.

§ 5. This act shall take effect immediately.

PART TT

Section 1. Section 2405 of the public health law is amended by adding a new subdivision 3 to read as follows:

3. The department shall report to the speaker of the assembly and the temporary president of the senate by January first, two thousand nineteen and July first, two thousand nineteen, and biannually thereafter, on the activities of the program, the impact of the program, as well as the amounts, purposes and awardees by geographical area of any grants provided under this section.

§ 2. Subdivision 1 of section 4140 of the public health law, as amended by chapter 352 of the laws of 2013, is amended to read as follows:

1. The death of each person who has died in this state shall be registered immediately and not later than seventy-two hours after death or the finding of a dead human body, by filing with the registrar of the district in which the death occurred or the body was found a certificate of such death, in a manner and format as prescribed by the commissioner, which shall [~~include~~] be through electronic means in accordance with section forty-one hundred forty-eight of this title.

§ 2-a. Section 4148 of the public health law, as added by chapter 352 of the laws of 2013, is amended to read as follows:

§ 4148. Electronic death registration system. 1. The department is hereby authorized and directed to design, fully implement and maintain an electronic death registration system for collecting, storing, recording, transmitting, amending, correcting and authenticating information, as necessary and appropriate to complete a death registration, and to generate such documents as determined by the department in relation to a death occurring in this state. As part of the design and full implementation of the system established by this section, the department shall consult with all persons authorized to use such system to the extent practicable and feasible. The payment referenced in subdivision five of

this section shall be collected for each burial or removal permit issued on or after the effective date of this section from the **registered funeral firm represented by the** licensed funeral director or undertaker to whom such permit is issued, in the manner specified by the department and shall be used solely for the purpose set forth in subdivision five of this section. Except as specifically provided in this section, the existing general duties of, and remuneration received by, local registrars in accepting and filing certificates of death and issuing burial and removal permits pursuant to any statute or regulation shall be maintained, and not altered or abridged in any way by this section.

2. Commencing on the implementation date[~~, the department shall require that~~] **all** deaths occurring within this state must be registered using the electronic death registration system established in this section. Electronic death registration may be phased in, as determined by the commissioner, for deaths occurring in the state [~~until the electronic death registration system is fully implemented in the state~~] **prior to the implementation date**. As used in this section, "implementation date" means the [~~first~~] **sixtieth** day [~~in January in the second year~~] after [~~this~~] **the chapter of the laws of two thousand eighteen that amend this** section becomes a law[~~, or as soon thereafter as the commissioner reasonably determines by regulation is feasible in light of the intent of this section~~]. **Violations of this section shall be subject to sections twelve and twelve-b of this chapter, provided that subdivision four of section twelve of this chapter shall not apply.**

3. Commencing on the implementation date, all persons required to register a death or file a certificate of death under this article, and such others as may be authorized by the commissioner, shall have access to the electronic death registration system for the purpose of entering information required to execute, complete and file a certificate of death or to retrieve such information or generate documentation from the electronic death registration system. The confidentiality provisions in section forty-one hundred forty-seven of this title shall apply to information maintained in this system.

4. Notwithstanding any provision of law to the contrary, commencing on or after January first, two thousand fifteen[~~, or on such date determined by the commissioner pursuant to subdivision two of this section~~] **but no later than the implementation date**, any requirement of this title for a signature of any person shall be deemed satisfied by the use by such person of digital signature provided such person is authorized in accordance with this section to use the electronic death registration system.

5. [~~Licensed~~] **For burial and removal permits, licensed** funeral directors and undertakers shall support the establishment and maintenance of the electronic death registration system through a payment, tendered for each burial and removal permit issued to a licensed funeral director or undertaker, in the amount of twenty dollars, provided that such payment shall be considered a cost of operation and the funeral director or undertaker shall not charge any additional fee related to such payment for funeral or other services.

§ 2-b. Subdivision 3 of section 4171 of the public health law, as amended by chapter 352 of the laws of 2013, is amended to read as follows:

3. All certificates, either of birth or death, shall be written legibly, in durable black ink, provided, however, that commencing on [~~or after~~] the implementation date under section forty-one hundred forty-eight of this article, death certificates shall be completed in accord-

ance with section forty-one hundred forty-eight of this article. No certificate[~~, whether filed in paper form or death certificate filed electronically in accordance with section forty-one hundred forty-eight of this article,~~] shall be held to be complete and correct that does not supply all of the items of information called for therein, or satisfactorily account for their omission.

§ 3. The public health law is amended by adding a new section 206-c to read as follows:

§ 206-c. Court ordered guardianship demonstration program. 1. Within amounts appropriated therefor, the commissioner shall establish a court ordered guardianship demonstration program in a county with a population of not less than one million three hundred thirty-nine thousand and not more than one million three hundred seventy thousand according to the two thousand ten federal decennial census, which shall facilitate the use of geriatric social workers, and/or other non-attorneys, to serve as guardians appointed by a court, under article eighty-one of the mental hygiene law, for incapacitated adults who lack financial resources and appropriate family supports. The demonstration program shall provide funding for geriatric social workers, or other non-lawyer guardians, when appointed by a court to assist elderly or disabled adults who are deemed incapacitated and are found appropriate for the demonstration program by the court.

2. The demonstration program shall, in addition to providing guardianship services, study the costs and savings associated with providing such guardianship services through the demonstration program, the individual's ability to maintain independence in and connection to their community, the cost avoidance to the state medical assistance program by maintaining the individual in the community rather than requiring higher levels of care, any best practices learned as a result of the demonstration program and other factors which examine the effectiveness of utilizing geriatric social workers or other non-lawyers as guardians. A report detailing the findings of the study and making recommendations for modification, continuation and/or expansion of the program shall be completed within eighteen months of the start of the demonstration program and shall be provided to the governor, the temporary president of the senate and the speaker of assembly.

§ 4. Section 2006 of the public health law, as added by chapter 657 of the laws of 1997, is amended to read as follows:

§ 2006. Grants. Subject to amounts expressly appropriated therefor, the commissioner is authorized to award grants to applicants approved by the department for the Alzheimer's Community Assistance Program (ACAP) which is hereby established within the department. Applicants shall be limited to not-for-profit corporations which have as their primary purpose providing family intervention services related to Alzheimer's disease, which are designed to postpone or prevent nursing home placements [~~on a statewide basis~~]. **The commissioner shall award grants to not-for-profit corporations which have demonstrated a capacity to provide these services within their respective geographic regions and shall endeavor to ensure that these regional grant awards result in services being available on a statewide basis.**

§ 5. Notwithstanding any contrary provision of law, the commissioner of the New York state department of health is hereby authorized and directed to prepare or have prepared a study of and a remedial plan for the high incidence of asthma and related pulmonary disorders in the boroughs of Brooklyn and Manhattan in the city of New York. Such study shall include an analysis of high risk neighborhoods examining dispari-

ties in: income, race and ethnicity, public and private housing, proximity to major sources of air pollution, including, but not limited to, highly trafficked roadways and solid waste processing facilities, and an evaluation of the effectiveness of existing medical facilities.

§ 5-a. The study and remedial plan authorized pursuant to section five of this act shall be completed within twelve months of the effective date of this act.

§ 6. Notwithstanding any provision of law to the contrary, the department of financial services, in cooperation with the department of health, shall examine the language of current state insurance laws, and health insurance policies and contracts issued pursuant to such laws, to determine their efficacy in relation to fertility and in vitro fertilization coverage benefits. The department of financial services, in its examination, shall analyze how various suggested changes to statute would impact utilization, and the effect they may have on premium rates. The study shall be completed, and a report delivered by June 1, 2018 to the majority leader of the senate, the speaker of the assembly, the chairs of the senate and assembly health and insurance committees, and to the secretary of state for publication in the state register.

§ 7. The public buildings law is amended by adding a new section 144 to read as follows:

§ 144. Lactation room in public buildings. 1. As used in this section:

(a) "covered public building" means a public building of the state of New York as described in section two of this chapter that is open to the public and contains a public restroom; and

(b) "lactation room" means a hygienic place, other than a bathroom, that:

(1) is shielded from view;

(2) is free from intrusion; and

(3) contains a chair, a working surface, and, if the public building is otherwise supplied with electricity, an electrical outlet.

2. A covered public building shall contain a lactation room that is made available for use by a member of the public to breastfeed or express breast milk.

3. A covered public building shall be excluded from the requirement of subdivision two of this section if the public building:

(a) does not contain a lactation room for employees who work in the building; and

(b) does not have a room that could be repurposed as a lactation room or a space that could be made private, at a reasonable cost; or

(c) new construction would be required to create a lactation room in the public building and the cost of such construction is unfeasible.

4. Nothing in this section shall be construed to authorize an individual to enter a public building that the individual is not otherwise authorized to enter.

§ 8. Subsection (i) of section 3216 of the insurance law is amended by adding a new paragraph 34 to read as follows:

(34) Every policy that provides coverage for hospital, surgical or medical care shall provide the following coverage for pasteurized donor human milk (PDHM), which may include fortifiers as medically indicated, for inpatient use, for which a licensed medical practitioner has issued an order for an infant who is medically or physically unable to receive maternal breast milk or participate in breast feeding or whose mother is medically or physically unable to produce maternal breast milk at all or in sufficient quantities or participate in breast feeding despite optimal lactation support. Such infant shall: (i) have a documented birth

weight of less than one thousand five hundred grams; or (ii) have a congenital or acquired condition that places the infant at a high risk for development of necrotizing enterocolitis.

§ 9. Subsection (1) of section 3221 of the insurance law is amended by adding a new paragraph 20 to read as follows:

(20) Every insurer delivering a group or blanket policy or issuing a group or blanket policy for delivery in this state that provides coverage for hospital, surgical or medical care shall provide the following coverage for pasteurized donor human milk (PDHM), which may include fortifiers as medically indicated, for inpatient use, for which a licensed medical practitioner has issued an order for an infant who is medically or physically unable to receive maternal breast milk or participate in breast feeding or whose mother is medically or physically unable to produce maternal breast milk at all or in sufficient quantities or participate in breast feeding despite optimal lactation support. Such infant shall: (i) have a documented birth weight of less than one thousand five hundred grams; or (ii) have a congenital or acquired condition that places the infant at a high risk for development of necrotizing enterocolitis.

§ 10. Section 4303 of the insurance law is amended by adding a new subsection (oo) to read as follows:

(oo) A medical expense indemnity corporation, a hospital service corporation or a health service corporation that provides coverage for hospital, surgical or medical care shall provide the following coverage for pasteurized donor human milk (PDHM), which may include fortifiers as medically indicated, for inpatient use, for which a licensed medical practitioner has issued an order for an infant who is medically or physically unable to receive maternal breast milk or participate in breast feeding or whose mother is medically or physically unable to produce maternal breast milk at all or in sufficient quantities or participate in breast feeding despite optimal lactation support. Such infant shall: (i) have a documented birth weight of less than one thousand five hundred grams; or (ii) have a congenital or acquired condition that places the infant at a high risk for development of necrotizing enterocolitis.

§ 11. Subdivision 15 of section 378 of the executive law is renumbered as subdivision 18.

§ 12. Subdivision 16 of section 378 of the executive law is renumbered subdivision 15 and two new subdivisions 16 and 17 are added to read as follows:

16. Standards requiring the installation and maintenance of at least one safe, sanitary, and convenient diaper changing station, deck, table, or similar amenity which shall be available for use by both male and female occupants and which shall comply with section 603.5 (Diaper Changing Tables) of the two thousand nine edition of the publication entitled ICC A117.1, Accessible and Usable Buildings and Facilities, published by the International Code Council, Inc., on at least one floor level containing a public toilet room in all newly constructed buildings in the state that have one or more areas classified as assembly group A occupancies or mercantile group M occupancies and in all existing buildings in the state that have one or more areas classified as assembly group A occupancies or mercantile group M occupancies and undergo a substantial renovation. The council shall prescribe the type of renovation to be deemed to be a substantial renovation for the purposes of this subdivision. The council may exempt historic buildings from the requirements of this subdivision.

17. Standards requiring that, in each building that has one or more areas classified as assembly group A occupancies or mercantile group M occupancies and in which at least one diaper changing station, deck, table, or similar amenity is installed, a sign shall be posted in a conspicuous place in each public toilet room indicating the location of the nearest diaper changing station, deck, table, or similar amenity that is available for use by the gender using such public toilet room. The requirements of this subdivision shall apply without regard to whether the diaper changing station, deck, table, or similar amenity was installed voluntarily or pursuant to subdivision sixteen of this section or any other applicable law, statute, rule, or regulation. No such sign shall be required in a public toilet room in which any diaper changing station, deck, table, or similar amenity is located.

§ 13. The public building law is amended by adding a new section 54 to read as follows:

§ 54. Restroom accessibility and equipment requirements for public buildings. 1. In addition to all of the requirements of the state building code referenced in section fifty-one of this article, all buildings covered by this article shall be required to include, at a minimum, at least one family restroom, accessible from any point within the building open to the public, which is to be equipped such that a caregiver is able to attend to the sanitary and hygienic needs of any person affected by any combination of physical and/or cognitive disabilities such that they require constant assistance with activities for daily living, including, but are not strictly limited to, an inability to utilize conventional restroom facilities.

2. The precise configuration and equipment to be included in such family restroom facilities shall be determined pursuant to rules and regulations promulgated by the department of state codes division, in cooperation with the office for persons with developmental disabilities, and with the input of an independent party, appointed by the governor, who is the parent or legal guardian of a person whose disabilities prevent their use of conventional restroom facilities. The equipment is to include a horizontal flat raised surface area suitable for safely diapering an adult person of at least two hundred fifty pounds weight and equipped with a system to temporarily cover the surface with a sanitary disposable covering. All such rules and regulations shall be promulgated and implemented within one hundred eighty days of the effective date of this section.

§ 14. Subdivision 1 of section 2805-i of the public health law, as amended by chapter 504 of the laws of 1994 and paragraph (c) as amended by chapter 39 of the laws of 2012, is amended to read as follows:

1. Every hospital providing treatment to alleged victims of a sexual offense shall be responsible for:

(a) maintaining sexual offense evidence and the chain of custody as provided in subdivision two of this section[~~.~~];

(b) contacting a rape crisis or victim assistance organization, if any, providing victim assistance to the geographic area served by that hospital to establish the coordination of non-medical services to sexual offense victims who request such coordination and services[~~.~~];

(c) offering and making available appropriate HIV post-exposure treatment therapies; including a seven day starter pack of HIV post-exposure prophylaxis, in cases where it has been determined, in accordance with guidelines issued by the commissioner, that a significant exposure to HIV has occurred, and informing the victim that payment assistance for such therapies may be available from the office of victim services

pursuant to the provisions of article twenty-two of the executive law. With the consent of the victim of a sexual assault, the hospital emergency room department shall provide or arrange for an appointment for medical follow-up related to HIV post-exposure prophylaxis and other care as appropriate**; and**

(d) ensuring sexual assault survivors are not billed for sexual assault forensic exams and are notified orally and in writing of the option to decline to provide private health insurance information and have the office of victim services reimburse the hospital for the exam pursuant to subdivision thirteen of section six hundred thirty-one of the executive law.

§ 15. Subdivision 13 of section 631 of the executive law, as amended by chapter 39 of the laws of 2012, is amended to read as follows:

13. Notwithstanding any other provision of law, rule, or regulation to the contrary, when any New York state accredited hospital, accredited sexual assault examiner program, or licensed health care provider furnishes services to any sexual assault survivor, including but not limited to a health care forensic examination in accordance with the sex offense evidence collection protocol and standards established by the department of health, such hospital, sexual assault examiner program, or licensed healthcare provider shall provide such services to the person without charge and shall bill the office directly. The office, in consultation with the department of health, shall define the specific services to be covered by the sexual assault forensic exam reimbursement fee, which must include at a minimum forensic examiner services, hospital or healthcare facility services related to the exam, and related laboratory tests and necessary pharmaceuticals; including but not limited to HIV post-exposure prophylaxis provided by a hospital emergency room at the time of the forensic rape examination pursuant to paragraph (c) of subdivision one of section twenty-eight hundred five-i of the public health law. Follow-up HIV post-exposure prophylaxis costs shall continue to be reimbursed according to established office procedure. The office, in consultation with the department of health, shall also generate the necessary regulations and forms for the direct reimbursement procedure. The rate for reimbursement shall be the amount of itemized charges not exceeding eight hundred dollars, to be reviewed and adjusted annually by the office in consultation with the department of health. The hospital, sexual assault examiner program, or licensed health care provider must accept this fee as payment in full for these specified services. No additional billing of the survivor for said services is permissible. A sexual assault survivor may voluntarily assign any private insurance benefits to which she or he is entitled for the healthcare forensic examination, in which case the hospital or healthcare provider may not charge the office**; provided, however, in the event the sexual assault survivor assigns any private health insurance benefit, such coverage shall not be subject to annual deductibles or coinsurance or balance billing by the hospital, sexual assault examiner program or licensed health care provider**. A hospital, sexual assault examiner program or licensed health care provider shall, at the time of the initial visit, request assignment of any private health insurance benefits to which the sexual assault survivor is entitled on a form prescribed by the office; provided, however, such sexual assault survivor shall be advised orally and in writing that he or she may decline to provide such information regarding private health insurance benefits if he or she believes that the provision of such information would substantially interfere with his or her personal privacy or safety and in such

event, the sexual assault forensic exam fee shall be paid by the office. Such sexual assault survivor shall also be advised that providing such information may provide additional resources to pay for services to other sexual assault victims. If he or she declines to provide such health insurance information, he or she shall indicate such decision on the form provided by the hospital, sexual assault examiner program or licensed health care provider, which form shall be prescribed by the office.

§ 16. Subsection (i) of section 3216 of the insurance law is amended by adding a new paragraph 34 to read as follows:

(34) Health care forensic examinations performed pursuant to section twenty-eight hundred five-i of the public health law covered under the policy shall not be subject to annual deductibles or coinsurance.

§ 17. Subsection (l) of section 3221 of the insurance law is amended by adding a new paragraph 20 to read as follows:

(20) Health care forensic examinations performed pursuant to section twenty-eight hundred five-i of the public health law covered under the policy shall not be subject to annual deductibles or coinsurance.

§ 18. Section 4303 of the insurance law is amended by adding a new subsection (rr) to read as follows:

(rr) Health care forensic examinations performed pursuant to section twenty-eight hundred five-i of the public health law covered under the contract shall not be subject to annual deductibles or coinsurance.

§ 19. Subdivision 2 of section 2805-i of the public health law, as amended by chapter 504 of the laws of 1994, is amended to read as follows:

2. The sexual offense evidence shall be collected and kept in a locked separate and secure area for not less than thirty days unless: (a) such evidence is not privileged and the police request its surrender before that time, which request shall be complied with; or (b) such evidence is privileged and (i) the alleged sexual offense victim nevertheless gives permission to turn such privileged evidence over to the police before that time, or (ii) the alleged sexual offense victim signs a statement directing the hospital to not collect and keep such privileged evidence, which direction shall be complied with. The sexual offense evidence shall include, but not be limited to, slides, cotton swabs, clothing and other items. Where appropriate such items must be refrigerated and the clothes and swabs must be dried, stored in paper bags and labeled. Each item of evidence shall be marked and logged with a code number corresponding to the patient's medical record. The alleged sexual offense [~~victim~~] **survivor** shall be notified [~~that after thirty days, the refrigerated~~] **ten days prior to the transfer of sexual offense evidence, that the** evidence will be [~~discarded in compliance with state and local health codes and the alleged sexual offense victim's clothes will be returned to the alleged sexual offense victim upon request~~] **transferred to a centralized location to be maintained for at least twenty years pursuant to section eight hundred thirty-eight-a of the executive law. The survivor shall be given the option of providing contact information should he or she wish to receive notice of the planned destruction of the evidence after the expiration of the twenty year period**.

§ 20. Subdivision 6 of section 2805-i of the public health law is renumbered subdivision 7 and a new subdivision 6 is added to read as follows:

6. (a) The department, in conjunction with the division of criminal justice services, the department of law and the office of victim services, in consultation with hospitals, other health care providers

and victim advocacy organizations, shall establish a sexual assault survivor bill of rights for purposes of informing sexual offense victims of their rights under state law. Such bill of rights shall be in plain, easy to understand language, and include, at a minimum:

(1) the right of the victim to consult with a local rape crisis or victim assistance organization, to have a representative of such organization accompany the victim through the sexual offense examination under paragraph (b) of subdivision one and subdivision three of this section, and to have such an organization be summoned by the medical facility, police agency or prosecutorial agency before the commencement of the physical examination or interview, unless no rape crisis or victim assistance organization can be summoned;

(2) the right of the victim to be offered and have made available at no cost appropriate post-exposure treatment therapies, including a seven day starter pack of HIV post-exposure prophylaxis under paragraph (c) of subdivision one of this section and subdivision thirteen of section six hundred thirty-one of the executive law;

(3) the right to a health care forensic examination at no cost and the right to be notified of the option to decline to provide private health insurance information and have the office of victim services reimburse the hospital for the examination under subdivision thirteen of section six hundred thirty-one of the executive law;

(4) the right to receive information relating to and the provision of emergency contraception under section twenty-eight hundred five-p of this article;

(5) the right to be offered contact information for the police agency or prosecutorial agency with jurisdiction over the sexual offense and be informed, upon request of the victim, with notice of the date and location upon which their sexual offense evidence kit was assessed for combined DNA Index System (CODIS) eligibility and analyzed, whether a CODIS eligible profile was developed and/or a DNA match was identified;

(6) the right to be notified prior to the transfer of an unreported sexual offense evidence kit from the hospital to a centralized storage facility, the right to have an unreported sexual offense evidence kit maintained at a centralized storage facility for at least twenty years and the right to be notified by such facility in a manner of communication designated by the victim at least thirty days in advance of planned destruction of the sexual offense evidence kit pursuant to subdivision four of section eight hundred thirty-eight-a of the executive law; and

(7) the right to be informed when there is any change in the status of his or her case or reopening of the case.

(b) Before a medical facility commences a physical examination of a sexual offense victim, or a police agency or prosecutorial agency commences an interview of a sexual offense victim, the health care professional conducting the exam, police agency or prosecutorial agency shall inform the victim of his or her rights and provide a copy of the sexual assault survivor bill of rights.

§ 21. Section 838-a of the executive law, as amended by chapter 6 of the laws of 2017, is amended to read as follows:

§ 838-a. Maintenance of sexual offense evidence kits. 1. The following requirements shall apply to all sexual offense evidence kits reported, surrendered to or collected by, at the request of, or with cooperation of a police agency or prosecutorial agency, with the consent of the victim:

(a) Each such police agency and prosecutorial agency shall submit any sexual offense evidence kits in its custody or control to an appropriate forensic laboratory within ten days of receipt.

(b) Each forensic laboratory receiving sexual offense evidence kits after the effective date of this section shall assess case specific information for Combined DNA Index System (CODIS) eligibility and, if eligible, analyze the kits and attempt to develop CODIS eligible profiles of any potential perpetrators from the evidence submitted. The forensic lab shall report the results to the submitting agency and appropriate prosecutorial entity within ninety days after receipt of a kit.

(c) Each police agency and prosecutorial agency that has one or more sexual offense evidence kit in its custody or control shall, within ninety days after the effective date of this paragraph, inventory such kits and report the total number of such kits to the division and to the forensic laboratory where such kits will be submitted pursuant to paragraph (a) of this subdivision. The division shall provide such inventories to the senate and assembly leaders by March first, two thousand seventeen. Every police and prosecutorial agency shall update this report each month thereafter until paragraph (a) of this subdivision has become effective.

(d) Each police agency and prosecutorial agency that, prior to the effective date of paragraph (a) of this subdivision, has one or more sexual offense evidence kits in its custody or control shall, within thirty days after the effective date of this section, submit all untested kits in its possession or control to an appropriate forensic laboratory.

(e) Each forensic laboratory, within one hundred twenty days after receiving each sexual offense evidence kit pursuant to paragraph (d) of this subdivision shall assess case specific information for CODIS eligibility and, if eligible, analyze the kits and attempt to develop CODIS eligible profiles for any potential perpetrators and shall, within ninety days of such assessment, report the results to the submitting agency and the appropriate prosecutorial entity.

(f) The failure of any such police agency, prosecutorial agency or forensic laboratory to comply with [~~a time limit specified in~~] this section **or section eight hundred thirty-eight-b of this article** shall not, in and of itself, constitute a basis for a motion to suppress evidence in accordance with section 710.20 of the criminal procedure law.

2. (a) Each forensic laboratory in the state shall report to the division, on a quarterly basis, in writing, on (i) the number of **reported** sexual offense evidence kits it received **under subdivision one of this section**, (ii) the number of such kits processed for the purpose of developing Combined DNA Index System (CODIS) eligible profiles of any potential perpetrators, and (iii) the number of **reported** kits not processed for testing, including, the reason such kits were ineligible for processing.

(b) Each police agency and prosecutorial agency shall report to the division on a quarterly basis, in writing, on (i) the number of all the sexual offense evidence kits it received, (ii) the number of such kits it submitted to a forensic laboratory for processing, (iii) the number of kits in its custody or control that have not been processed for testing, and (iv) the length of time between receipt of any such sexual offense evidence kit and the submission of any such kit to the forensic laboratory.

(c) The division shall provide to the senate and assembly leaders such quarterly reports received from the forensic labs and police and prosecutorial agencies pursuant to paragraphs (a) and (b) of this subdivision by January first, two thousand eighteen and annually thereafter.

3. **Each police agency and prosecutorial agency within this state shall adopt policies and procedures concerning contact with the victims and the provision of information to victims, upon request, concerning their sexual offense evidence kits. The policies and procedures shall be survivor-focused, meaning systematically focused on the needs and concerns of a victim to ensure the compassionate and sensitive delivery of services in a nonjudgemental manner, and shall include, at a minimum, a requirement that:**

(a) the police agency and prosecutorial agency designate at least one person, who is trained in trauma and victim response through a program meeting minimum standards established by the division of criminal justice services following national guidelines from the Substance Abuse and Mental Health Services Administration, within its agency to receive all inquiries concerning sexual offense evidence kits from victims; and

(b) at the time that a sexual offense evidence kit is collected, a victim shall be provided with contact information, including a phone number and e-mail address, for the individual designated by subdivision two of this section at the police agency and prosecutorial agency with jurisdiction over the sexual assault offense.

4. Unreported sexual offense evidence kits, meaning sexual offense evidence kits collected in instances in which a victim has not consented to report to law enforcement, shall be maintained for at least twenty years in a secure, centralized location designated by the division of criminal justice services, in conjunction with the department of health, the department of law and the office of victim services, in consultation with hospitals, other health care providers and victim advocacy organizations, taking into consideration federal guidance pertaining to maintenance of sexual offense evidence kits. Sexual offense evidence kits maintained for twenty years or more shall only be destructed upon providing at least thirty days notice to the victim, in the form of communication designated by the victim, of such planned destruction.

5. The division shall undertake actions designed to ensure that all police agencies and prosecutorial agencies in the state and all forensic laboratories are educated and aware of the provisions of this section.

§ 22. The executive law is amended by adding a new section 838-b to read as follows:

§ 838-b. Victim's right to notice. Each police agency and prosecutorial agency with jurisdiction over the sexual assault offense shall, upon request of the victim who has consented to report to law enforcement, provide the sexual offense victim with notice of the date and location upon which his or her sexual offense evidence kit was assessed for CODIS eligibility and analyzed, and whether a CODIS eligible profile was developed and/or a DNA match was identified. The police or prosecutorial agency in possession of the reported sexual assault offense evidence kit shall notify the sexual assault victim at least thirty days in advance of any planned destruction of their sexual offense evidence kit in a manner of communication designated by the victim, unless such information would impede an ongoing investigation.

§ 23. The executive law is amended by adding a new section 838-c to read as follows:

§ 838-c. Study and report on establishing a statewide sexual offense evidence kit tracking system. The division shall conduct a study and

develop a plan, in consultation with stakeholders including hospitals, other health care providers, law enforcement agencies, evidence managers, forensic laboratories, prosecutors, and victim advocacy organizations, to establish a statewide sexual offense evidence kit tracking system, to streamline law enforcement tracking, create greater transparency and accountability in ensuring compliance with this article and to provide a way for survivors to check the status of their sexual offense evidence kit throughout the entire process, from collection to conviction. The tracking system shall be secure and accessible only by authorized entities or individuals such as hospitals, law enforcement agencies, evidence mangers, prosecutors, and victims and designed to provide secure electronic access through which a victim can anonymously track the status of their sexual assault evidence kit. The commissioner shall submit a report of the division's findings and recommendations to the governor, the temporary president of the senate and the speaker of the assembly on or before May first, two thousand nineteen.

§ 24. The public health law is amended by adding a new section 2805-ii to read as follows:

§ 2805-ii. Sexual assault forensic examination telemedicine pilot program. 1. SAFE pilot establishment. The commissioner shall establish a sexual assault forensic examination (SAFE) telemedicine pilot program to assist in providing expert, comprehensive, compassionate care to adult and adolescent patients and training to support providers in health care facilities that do not have a designated sexual assault forensic examination program. The commissioner shall consult with the division of criminal justice services, where appropriate, in the establishment of such pilot program. Such SAFE telemedicine pilot shall:

(a) support patient care and provide health care provider instruction and support in a timely manner on a twenty-four hours a day, seven days a week basis to any victim of sexual assault or abuse who presents at a facility participating in such pilot for services associated with sexual assault or abuse, and consents to such services;

(b) have professionals specially trained, experienced and certified as sexual assault forensic examiners to support emergency room staff in caring for victims of sexual assault or abuse and appropriately securing forensic evidence through live audio video technology;

(c) offer to provide support through telemedicine to no less than forty-six hospitals upon the effective date of this section, including all critical access hospitals and many hospitals in rural and/or underserved areas of the state;

(d) ensure the medical records of both providers, where applicable comply with all applicable laws and regulation relating to evidence preservation; and

(e) meet any other requirements identified by the commissioner.

2. SAFE pilot evaluation. The commissioner shall evaluate, or contract with an entity to evaluate, the effectiveness of such SAFE pilot program and prepare a report on the process of care, the outcomes delivered and the outcomes received. Such report shall also evaluate how such pilot can successfully transition to a self-sustaining program where non-SAFE hospitals could subscribe to a SAFE telemedicine program. Such report shall be delivered to the governor, the temporary president of the senate and the speaker of the assembly by December first, two thousand twenty.

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

(a) section four of this act shall apply to any grants made pursuant to the Alzheimer's Community Assistance Program (ACAP) on or after January 1, 2018;

(b) section five of this act shall take effect on the one hundred twentieth day after it shall have become a law and the results of the study and the remedial plan authorized by section five of this act shall be provided to the governor and the legislature no later than eighteen months from the beginning of such study;

(c) section seven of this act shall take effect one year after it shall have become a law;

(d) section eleven of this act shall take effect January 1, 2019;

(e) sections fourteen, fifteen, sixteen, seventeen and eighteen of this act shall apply to all policies and contracts issued, renewed, modified, altered or amended on or after the first of January next succeeding such effective date;

(f) the division of criminal justice services shall designate and establish the secure centralized location required by subdivision 4 of section 838-a of the executive law, as added by section twenty-one of this act, within 180 days of the effective date of this act; and provided, further, that notwithstanding the provisions of section 2805-i of the public health law to the contrary, every hospital shall retain custody of unreported sexual offense evidence kits until such time as the centralized storage facility is established and designated pursuant to subdivision 4 of section 838-a of the executive law;

(g) such sexual assault forensic examination telemedicine pilot program, as added by section twenty-four of this act, shall be established by the commissioner of health no later than the one hundred twentieth day after it shall have become a law; and

(h) effective immediately, the addition, amendment and/or repeal of any rule or regulation necessary for the implementation of this act on its effective date are authorized to be made and completed on or before such effective date.

§ 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 judgement shall not affect, impair, or invalidate the remainder thereof, but shall be confined in its operation to clause, sentence, paragraph, subdivision, section or part thereof directly involved in the controversy in which such judgement 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 TT of this act shall be as specifically set forth in the last section of such Parts.