§ 367-a. Payments; insurance. 1. (a) Any inconsistent provision of this chapter or other law notwithstanding, no assignment of the claim of any supplier of medical assistance shall be valid and enforceable as against any social services district or the department, and any payment with respect to any medical assistance shall be made to the person, institution, state department or agency or municipality supplying such medical assistance at rates established by the appropriate social services district and contained in its approved local medical plan, except as otherwise permitted or required by applicable federal and state provisions, including the regulations of the department; provided, however, that for those districts for whom the department has assumed payment responsibilities pursuant to section three hundred sixty-seven-b of this chapter, rates shall be established by the department, except as otherwise required by applicable provisions of federal or state law. A social services official may apply to the department for local variations in rates to be applicable, upon approval by the department, to recipients for whom such district is responsible. Claims for payment shall be made in such form and manner as the department shall determine.

(b) Where an applicant for or recipient of public assistance or medical assistance has health insurance in force, is enrolled in a group health insurance plan or group health plan covering care and other medical benefits provided under this title, payment or part-payment of the premium, co-insurance, any deductible amounts and other cost-sharing obligations for such insurance may also be made when deemed cost-effective pursuant to the regulations of the department.

(c) Any inconsistent provisions of this title or other law notwithstanding and to the extent that federal financial participation is available therefor and in accordance with the regulations of the commissioner, payment of the premium for coverage under a group health insurance plan or group health plan may be made under the medical assistance program on behalf of a person not otherwise entitled to public assistance or medical assistance if the social services official determines that the savings in expenditures to the program as a result of such coverage are likely to exceed the amount of the premiums paid and such person has:

(i) income (as determined in accordance with the methodology used to determine eligibility for benefits under the federal supplemental

security income program) in an amount less than or equal to one hundred per cent of the federal income official poverty line (as defined and annually revised by the federal office of management and budget) applicable to the person's family size;

(ii) resources (as determined in accordance with the methodology used to determine eligibility for benefits under the federal supplemental security income program) less than or equal to twice the maximum amount an individual is permitted to have to obtain benefits under the federal supplemental security income program; and

(iii) coverage available under a group health insurance plan or an employer-based group health plan provided pursuant to title XXII of the federal public health services act, section 4980B of the federal internal revenue code of 1986, or title VI of the employee retirement income security act of 1974.

(d) (i) Amounts payable under this title for medical assistance for items and services provided to eligible persons who are also beneficiaries under part A of title XVIII of the federal social security act and items and services provided to qualified medicare beneficiaries under part A of title XVIII of the federal social security act shall not be less than the amount of any deductible and co-insurance liability of such eligible persons or for which such eligible persons or such qualified medicare beneficiaries would be liable under federal law were they not eligible for medical assistance or were they not qualified medicare beneficiaries with respect to such benefits under such part A.

(ii) Amounts payable under this title for medical assistance for items and services provided to eligible persons who are also beneficiaries under part B of title XVIII of the federal social security act and items and services provided to qualified medicare beneficiaries under part B of title XVIII of the federal social security act shall not be less than the amount of any deductible liability of such eligible persons or for which such eligible persons or such qualified medicare beneficiaries would be liable under federal law were they not eligible for medical assistance or were they not qualified medicare beneficiaries with respect to such benefits under such part B.

* (iii) With respect to items and services provided to eligible persons who are also beneficiaries under part B of title XVIII of the federal social security act and items and services provided to qualified

medicare beneficiaries under part B of title XVIII of the federal social security act, the amount payable for services covered under this title shall be the amount of any co-insurance liability of such eligible persons pursuant to federal law were they not eligible for medical assistance or were they not qualified medicare beneficiaries with respect to such benefits under such part B, but shall not exceed the amount that otherwise would be made under this title if provided to an eligible person other than a person who is also a beneficiary under part B or is a qualified medicare beneficiary minus the amount payable under part B; provided, however, amounts payable under this title for items and services provided to eligible persons who are also beneficiaries under part B or to qualified medicare beneficiaries by an ambulance service under the authority of an operating certificate issued pursuant to article thirty of the public health law, a psychologist licensed under article one hundred fifty-three of the education law, or a facility under the authority of an operating certificate issued pursuant to article sixteen, thirty-one or thirty-two of the mental hygiene law and with respect to outpatient hospital and clinic items and services provided by a facility under the authority of an operating certificate issued pursuant to article twenty-eight of the public health law, shall not be less than the amount of any co-insurance liability of such eligible persons or such qualified medicare beneficiaries, or for which such eligible persons or such qualified medicare beneficiaries would be liable under federal law were they not eligible for medical assistance or were they not qualified medicare beneficiaries with respect to such benefits under part B.

* NB Effective until April 1, 2027

* (iii) With respect to items and services provided to eligible persons who are also beneficiaries under part B of title XVIII of the federal social security act and items and services provided to qualified medicare beneficiaries under part B of title XVIII of the federal social security act, the amount payable for services covered under this title shall be the amount of any co-insurance liability of such eligible persons pursuant to federal law were they not eligible for medical assistance or were they not qualified medicare beneficiaries with respect to such benefits under such part B, but shall not exceed the amount that otherwise would be made under this title if provided to an

eligible person other than a person who is also a beneficiary under part B or is a qualified medicare beneficiary minus the amount payable under part B; provided, however, amounts payable under this title for items and services provided to eligible persons who are also beneficiaries under part B or to qualified medicare beneficiaries by an ambulance service under the authority of an operating certificate issued pursuant to article thirty of the public health law, or a facility under the authority of an operating certificate issued pursuant to article sixteen, thirty-one or thirty-two of the mental hygiene law and with respect to outpatient hospital and clinic items and services provided by a facility under the authority of an operating certificate issued pursuant to article twenty-eight of the public health law, shall not be less than the amount of any co-insurance liability of such eligible persons or such qualified medicare beneficiaries, or for which such eligible persons or such qualified medicare beneficiaries would be liable under federal law were they not eligible for medical assistance or were they not qualified medicare beneficiaries with respect to such benefits under part B.

* NB Effective April 1, 2027

* (iv) If a health plan participating in part C of title XVIII of the federal social security act pays for items and services provided to eligible persons who are also beneficiaries under part B of title XVIII of the federal social security act or to qualified medicare beneficiaries, the amount payable for services under this title shall be eighty-five percent of the amount of any co-insurance liability of such eligible persons pursuant to federal law if they were not eligible for medical assistance or were not qualified medicare beneficiaries with respect to such benefits under such part B; provided, however, amounts payable under this title for items and services provided to eligible persons who are also beneficiaries under part B or to qualified medicare beneficiaries by an ambulance service under the authority of an operating certificate issued pursuant to article thirty of the public health law, or a psychologist licensed under article one hundred fifty-three of the education law, shall not be less than the amount of any co-insurance liability of such eligible persons or such qualified medicare beneficiaries, or for which such eligible persons or such qualified medicare beneficiaries would be liable under federal law were

they not eligible for medical assistance or were they not qualified medicare beneficiaries with respect to such benefits under part B.

* NB Effective until April 1, 2027

* (iv) If a health plan participating in part C of title XVIII of the federal social security act pays for items and services provided to eligible persons who are also beneficiaries under part B of title XVIII of the federal social security act or to qualified medicare beneficiaries, the amount payable for services under this title shall be the amount of any co-insurance liability of such eligible persons pursuant to federal law if they were not eligible for medical assistance or were not qualified medicare beneficiaries with respect to such benefits under such part B, but shall not exceed the amount that otherwise would be made under this title if provided to an eligible person other than a person who is also a beneficiary under part B or is a qualified medicare beneficiary minus the amount payable under part B; provided, however, amounts payable under this title for items and services provided to eligible persons who are also beneficiaries under part B or to qualified medicare beneficiaries by an ambulance service under the authority of an operating certificate issued pursuant to article thirty of the public health law shall not be less than the amount of any coinsurance liability of such eligible persons or such qualified medicare beneficiaries, or for which such eligible persons or such qualified medicare beneficiaries would be liable under federal law were they not eligible for medical assistance or were they not qualified medicare beneficiaries with respect to such benefits under part B.

* NB Effective April 1, 2027

(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, article sixteen of the mental hygiene law and independent practitioner services for individuals with developmental disabilities provided to eligible persons diagnosed with a developmental disability 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 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.

(f) Amounts payable under this title for medical assistance in the

form of outpatient mental health services under article thirty-one or outpatient chemical dependence services including opioid treatment services under article thirty-two of the mental hygiene law provided to eligible persons who are also beneficiaries under part B of title XVIII of the federal social security act or provided to 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.

(g) Notwithstanding any provision of this section to the contrary, amounts payable under this title for medical assistance in the form of hospital outpatient services or diagnostic and treatment center services pursuant to article twenty-eight of the public health law provided to eligible persons who are also beneficiaries under part B of title XVIII of the federal social security act or provided to qualified medicare beneficiaries under part B of title XVIII of such act shall not exceed the approved medical assistance payment level less the amount payable under part B.

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

2. (a) Any inconsistent provision of this chapter notwithstanding, provision for medical care and other medical benefits available under this title may be made, in whole or in part, either under this title or other appropriate provisions of this chapter, through insurance or other prepaid plans, in accordance with the regulations of the department.

(b) Any inconsistent provision of this chapter or other law notwithstanding, upon furnishing assistance under this title to any applicant or recipient of medical assistance, the local social services district or the department shall be subrogated, to the extent of the expenditures by such district or department for medical care furnished, to any rights such person may have to medical support or reimbursement

from liable third parties, including but not limited to health insurers, self-insured plans, group health plans, service benefit plans, managed care organizations, pharmacy benefit managers, or other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service. For purposes of this section, the term medical support shall mean the right to support specified as support for the purpose of medical care by a court or administrative order. The right of subrogation does not attach to insurance benefits paid or provided under any health insurance policy prior to the receipt of written notice of the exercise of subrogation rights by the carrier issuing such insurance, nor shall such right of subrogation attach to any benefits which may be claimed by a social services official or the department, by agreement or other established procedure, directly from an insurance carrier. No right of subrogation to insurance benefits available under any health insurance policy shall be enforceable unless written notice of the exercise of such subrogation right is received by the carrier within three years from the date services for which benefits are provided under the policy or contract are rendered. Liable third parties shall not deny a claim made by a social services official or the department in conformance with this paragraph solely on the basis of the date of submission of the claim, the type or format of the claim form, a failure to obtain prior authorization, or a failure to present proper documentation at the point-of-sale that is the basis of the claim. Liable third parties shall respond to a request for payment within sixty calendar days after receipt of written proof of loss or claim for payment for health care services provided to a recipient of Medicaid who is covered by the third party and shall not charge a fee to process or adjudicate a claim. The local social services district or the department shall also notify the carrier when the exercise of subrogation rights has terminated because a person is no longer receiving assistance under this title. Such carrier shall establish mechanisms to maintain the confidentiality of all individually identifiable information or records. Such carrier shall limit the use of such information or record to the specific purpose for which such disclosure is made, and shall not further disclose such information or records.

(c) In accordance with regulations of the department and to the extent

authorized by federal law and regulation, the social services district is authorized to retain, in addition to amounts retained as repayment for its share of the costs of medical assistance provided, a portion of the federal share of the amount collected as medical support or third party benefits assigned under paragraph (f) of subdivision four of section three hundred sixty-six of this article, when such district, or other governmental agency pursuant to an agreement with such district, has collected such medical support or third party benefits on behalf of a person receiving medical assistance whose rights to medical support or third party benefits have been assigned to the state or to the appropriate social services official. Where more than one district has been involved in enforcing or collecting such amounts, the federal incentive shall be apportioned among each such district in accordance with the regulations of the department.

3. (a) As used in this subdivision, the following terms shall have the following meanings:

(1) "Qualified medicare beneficiary" means a person who is entitled to hospital insurance benefits under part A of title XVIII of the federal social security act, whose income does not exceed one hundred thirty-eight percent of the official federal poverty line applicable to the person's family size and whose resources do not exceed twice the maximum amount of resources a person may have in order to qualify for benefits under the federal supplemental security income program of title XVI of the federal social security act, as determined for purposes of such program. To the extent that federal financial participation is available, a person whose resources are in excess of the amount specified in this subparagraph but otherwise meets the requirements shall be considered a "qualified medicare beneficiary".

(2) "Qualified individual" means a person who is entitled to hospital insurance benefits under part A of title XVIII of the federal social security act and whose income is greater than one hundred thirty-eight percent, but less than or equal to one hundred eighty-six percent, of the federal poverty line, for the applicable family size, and who is not otherwise eligible for medical assistance under this article; referred to as a qualified individual.

(3) "Qualified disabled and working individual" means an individual

who is not otherwise eligible for medical assistance and:

(i) who is entitled to enroll for hospital insurance benefits under section 1818A of part A of title XVIII of the federal social security act;

(ii) whose income does not exceed two hundred percent of the official federal poverty line applicable to the person's family size; and

(iii) whose resources do not exceed twice the maximum amount of resources that an individual or a couple, in the case of a married individual, may have and obtain federal supplemental security income benefits under title XVI of the federal social security act, as determined for purposes of that program.

For purposes of this subparagraph, income and resources are determined by the same methodology as is used for determining eligibility under the federal supplemental security income benefits under title XVI of the federal social security act.

(b) Payment of premiums for enrolling qualified disabled and working individuals and qualified medicare beneficiaries under Part A of title XVIII of the federal social security act and for enrolling such beneficiaries and eligible recipients of public assistance under part B of title XVIII of the federal social security act, together with the costs of the applicable co-insurance and deductible amounts on behalf of such beneficiaries, and recipients, and premiums under section 1839 of the federal social security act shall be made and the cost thereof borne by the state or by the state and social services districts, respectively, in accordance with the regulations of the department, provided, however, that the share of the cost to be borne by a social services district, if any, shall in no event exceed the proportionate share borne by such district with respect to other expenditures under this title. Moreover, if the director of the budget approves, payment of premiums for enrolling persons who have been determined to be eligible for medical assistance only may be made and the cost thereof borne or shared pursuant to this subdivision.

(c) (1) Beginning April first, two thousand two and to the extent that federal financial participation is available at a one hundred percent federal Medical assistance percentage and subject to sections 1933 and 1902(a)(10)(E)(iv) of the federal social security act, medical

assistance shall be available for full payment of medicare part B premiums for qualified individuals.

(2) Premium payments for the individuals described in subparagraph one of this paragraph will be one hundred percent federally funded up to the amount of the federal allotment. The department shall discontinue enrollment into the program when the part B premium payments made pursuant to subparagraph one of this paragraph meet the yearly federal allotment.

(3) (i) The commissioner of health shall develop a simplified application form, consistent with federal law, for payments pursuant to this section. The commissioner of health, in cooperation with the office for the aging, shall publicize the availability of such payments to medicare beneficiaries.

(ii) Low-income subsidy data transmitted from the social security administration to local departments of social services in accordance with section 1144(c)(3) of the federal social security act shall be treated as an application for the medicare savings program, without requiring submission of another application. Any information verified by the social security administration shall be accepted without further verification, if the information provided through low-income subsidy data supports a determination of eligibility under this subdivision. The commissioner of health shall report on an annual basis on the status of the medicare savings program and the number of applications received by local social services districts under this article.

(d) (1) Payment of premiums for enrolling individuals in qualified health plans offered through a health insurance exchange established pursuant to the federal Patient Protection and Affordable Care Act (P.L. 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (P.L. 111-152), shall be available to individuals who:

(i) immediately prior to being enrolled in the qualified health plan, were or would have been eligible under the family health plus program as a parent or stepparent of a child under the age of twenty-one, and whose MAGI household income, as defined in subparagraph eight of paragraph (a) of subdivision one of section three hundred sixty-six of this title, exceeds one hundred thirty-three percent of the federal poverty line for the applicable family size;

(ii) are not otherwise eligible for medical assistance under this title; and

(iii) are enrolled in a standard health plan in the silver level, as defined in 42 U.S.C. 18022.

(2) Payment pursuant to this paragraph shall be for premium obligations of the individual under the qualified health plan and shall continue only if and for so long as the individual's MAGI household income exceeds one hundred thirty-three percent, but does not exceed one hundred fifty percent, of the federal poverty line for the applicable family size, or, if earlier, until the individual is eligible for enrollment in a standard health plan pursuant to section three hundred sixty-nine-gg of this article.

(3) The commissioner of health shall submit amendments to the state plan for medical assistance and/or submit one or more applications for waivers of the federal social security act as may be necessary to receive federal financial participation in the costs of payments made pursuant to this paragraph; provided further, however, that nothing in this subparagraph shall be deemed to affect payments for premiums pursuant to this paragraph if federal financial participation in the costs of such payments is not available.

4. No social services district shall make final payments pursuant to title XIX of the federal social security act for benefits available under title XVIII of such act without documentation that title XVIII claims have been filed and denied.

5. (a) When medical care, services and supplies are furnished an eligible person on behalf of a social services district under this title, such social services district is authorized to utilize any appropriate organization as a fiscal intermediary to audit and make payment for such district's share of the cost of such care, services and supplies.

(b) To carry out the purposes of paragraph (a), the department, on behalf of itself and any of the social services districts, may enter into agreements with appropriate organizations to act as fiscal intermediaries.

6. (a) Notwithstanding any inconsistent provision of law, payment for claims for services as specified in paragraph (d) of this subdivision furnished to eligible persons under this title, subject to paragraph (b) of this subdivision shall be reduced in accordance with the provisions of paragraph (c) of this subdivision by an amount not to exceed the maximum amount authorized by federal law and regulations as a co-payment amount, which co-payment amount the provider of such services may charge the recipient, provided, however, no provider may deny such services to an individual eligible for services based on the individual's inability to pay the co-payment amount.

(b) Co-payments shall apply to all eligible persons for the services defined in paragraph (d) of this subdivision with the exception of:

(i) individuals under twenty-one years of age;

(ii) pregnant women;

(iii) individuals who are inpatients in a medical facility who have been required to spend all of their income for medical care, except their personal needs allowance or residents of community based residential facilities licensed by the office of mental health or the office for people with developmental disabilities who have been required to spend all of their income, except their personal needs allowance;

(iv) individuals enrolled in health maintenance organizations or other entities which provide comprehensive health services, or other managed care programs for services covered by such programs, except that such persons, other than persons otherwise exempted from co-payments pursuant to subparagraphs (i), (ii), (iii) and (v) of this paragraph, and other than those persons enrolled in a managed long term care program, shall be subject to co-payments as described in subparagraph (v) of paragraph (d) of this subdivision;

(v) individuals whose family income is less than one hundred percent of the federal poverty line, as defined in subparagraph four of paragraph (a) of subdivision one of section three hundred sixty-six of this title, for a family of the same size; and

(vi) any other individuals required to be excluded by federal law or regulations.

(b-1) The commissioner is authorized to submit any request or application to the Centers for Medicare and Medicaid Services as may be necessary to be granted a waiver of the requirement for the department

of health to calculate its Medicaid payments to managed care organizations to include cost sharing established under the state plan for medical assistance for enrollees who are not exempt from cost sharing. In the absence of such a waiver, the commissioner shall adjust Medicaid payments to managed care organizations beginning October first, two thousand fifteen or on the date the Centers for Medicare and Medicaid Services commences enforcement of such requirement, whichever is later.

* (c) (i) Co-payments charged pursuant to this subdivision for non-institutional services shall not exceed the following table, provided, however, that the department may establish standard co-payments for services based upon the average or typical payment for that service:

State's payment for the services	Maximum co-payment chargeable to recipient
$10 or less	$.50
$10.01 to $25	$1.00
$25.01 to $50	$2.00
$50.01 or more	$3.00

(ii) co-payments charged pursuant to this subdivision for each discharge for inpatient care shall be twenty-five dollars.

(iii) Notwithstanding any other provision of this paragraph, co-payments charged for each generic prescription drug dispensed shall be one dollar and for each brand name prescription drug dispensed shall be two dollars and fifty cents; provided, however, that the co-payments charged for each brand name prescription drug reimbursed pursuant to subparagraph (ii) of paragraph (a-1) of subdivision four of section three hundred sixty-five-a of this title shall be one dollar.

(iv) When an individual is initially dispensed or prescribed a seven or fewer days supply of an opioid pursuant to paragraph (b) of subdivision five of section three thousand three hundred thirty-one of the public health law, and is subsequently dispensed or prescribed an additional supply of such opioid for the same underlying condition, the total co-payment that may be charged to such an individual for the initial prescription plus all subsequent prescriptions for the same underlying condition for up to a total of thirty-days supply of such opioid shall not exceed the amount set forth in subparagraph (iii) of

this paragraph.

* NB Repealed March 31, 2029

(d) Co-payments shall apply to the following services, subject to such exceptions for subcategories of these services as recognized by the commissioner in regulations, provided in accordance with section three hundred sixty-five-a of this article and the regulations of the department, to the extent permitted by title XIX of the federal social security act:

(i) in-patient care in a general hospital, as defined in subdivision ten of section twenty-eight hundred one of the public health law;

(ii) out-patient hospital and clinic services except for mental health services, and developmental disability services, alcohol and substance abuse services and methadone maintenance services;

(iii) home health services, including services provided under the long term home health care program, provided however, home health providers shall not require employees providing services in the home to collect the co-payment amount;

(iv) sickroom supplies;

(v) drugs, excepting psychotropic drugs and drugs with FDA approved indications for the treatment of tuberculosis as specified by the department and those drugs intended for use by residents of adult care facilities licensed by the department of health who have been required to spend all of their income, except their personal needs allowance;

(vi) clinical laboratory services;

(vii) x-rays;

(viii) emergency room services provided for non-urgent or non-emergency medical care, provided however, co-payments shall not be required for emergency services or family planning services and supplies;

(e) In the period from January first, nineteen hundred ninety-three to March thirty-first, nineteen hundred ninety-three no recipient shall be required to pay more than a total of fifty dollars in co-payments required by this subdivision for drugs, nor shall reductions in payments as a result of such co-payments exceed fifty dollars for any recipient.

(f) (i) In the year commencing April first, nineteen hundred ninety-three and for each year thereafter, and ending in the year concluding on March thirty-first, two thousand five, no recipient shall

be required to pay more than a total of one hundred dollars in co-payments required by this subdivision, nor shall reductions in payments as a result of such co-payments exceed one hundred dollars for any recipient.

(ii) In the year commencing April first, two thousand five and for each year thereafter, no recipient shall be required to pay more than a total of two hundred dollars in co-payments required by this subdivision, nor shall reductions in payments as a result of such co-payments exceed two hundred dollars for any recipient.

(g) The commissioner shall promptly:

(i) promulgate a regulation making it an unacceptable practice under the medical assistance program for a provider to deny services to an individual eligible for services based on the individual's inability to pay the co-pay amount required by this subdivision;

(ii) establish and maintain a toll-free hotline which may be used to report a violation of the regulation promulgated pursuant to subparagraph (i) of this paragraph; and

(iii) provide notice to all recipients summarizing their rights and obligations under this subdivision.

7. (a) Every manufacturer or wholesaler of drugs, prescriptions or poisons registered under the provisions of section sixty-eight hundred eight of the education law, shall, upon request of the department for any information pertaining to wholesale prices charged to pharmacists for any drugs available under the medical assistance program, make the requested information available to the department on a monthly basis, or such other periodic basis as the department shall request.

(b) The department shall provide for financial arrangements with any manufacturer or wholesaler of drugs, prescriptions or poisons as may be necessary to reimburse such manufacturer or wholesaler for its actual and necessary costs included in furnishing the requested information.

(c) Any information obtained pursuant to the provisions of this subdivision shall not be made available for public inspection or copying under the provisions of article six of the public officers law. The department shall not disclose such information to any person, firm, department or agency, except any state agency or department as may be necessary for the administration of the medical assistance program under

the provisions of this chapter or any other law.

(d) Notwithstanding any inconsistent provision of law, if a manufacturer (as defined under section 1927 of the federal social security act) has entered into a rebate agreement with the department or with the federal secretary of health and human services on behalf of the department under section 1927 of the federal social security act, the department shall reimburse for covered outpatient drugs which are dispensed under the medical assistance program to all persons in receipt of medical assistance benefits as a result of their eligibility having been established under subparagraph one or nine of paragraph (a) of subdivision one of section three hundred sixty-six of this title, and which are dispensed to all persons eligible for health care services as a result of their eligibility having been established under subdivision two of section three hundred sixty-nine-ee of this article, only pursuant to the terms of the rebate agreement between the department and such manufacturer; provided, however, that any agreement between the department and a manufacturer entered into before August first, nineteen hundred ninety-one, shall be deemed to have been entered into on April first, nineteen hundred ninety-one; and provided further, that if a manufacturer has not entered into an agreement with the department before August first, nineteen hundred ninety-one, such agreement shall not be effective until April first, nineteen hundred ninety-two, unless such agreement provides that rebates will be retroactively calculated as if the agreement had been in effect on April first, nineteen hundred ninety-one. The rebate agreement between such manufacturer and the department shall utilize for single source drugs and innovator multiple source drugs the identical formula used to determine the basic rebate for federal financial participation single source drugs and innovator multiple source drugs, pursuant to paragraph one of subdivision (c) of section 1927 of the federal social security act, to determine the amount of the rebate pursuant to this paragraph. The rebate agreement between such manufacturer and the department shall utilize for non-innovator multiple source drugs the identical formula used to determine the basic rebate for federal financial participation non-innovator multiple source drugs, pursuant to paragraphs three and four of subdivision (c) of section 1927 of the federal social security act, to determine the amount of the rebate pursuant to this paragraph. The terms and conditions of

such rebate agreement with respect to periodic payment of the rebate, provision of information by the department, audits, manufacturer provision of information verification of surveys, penalties, confidentiality of information, and length of the agreement shall apply to drugs of the manufacturer dispensed under the medical assistance program to all persons in receipt of medical assistance benefits as a result of their eligibility having been established under subparagraph one or nine of paragraph (a) of subdivision one of section three hundred sixty-six of this title, and which are dispensed to all persons eligible for health care services as a result of their eligibility having been established under subdivision two of section three hundred sixty-nine-ee of this article. The department in providing utilization data to a manufacturer (as provided for under section 1927.4(b)(1)(A) of the federal social security act) shall provide such data by zip code, if requested, for drugs covered under a rebate agreement.

* (e) During the period from April first, two thousand fifteen through March thirty-first, two thousand twenty-nine, the commissioner may, in lieu of a managed care provider or pharmacy benefit manager, negotiate directly and enter into an arrangement with a pharmaceutical manufacturer for the provision of supplemental rebates relating to pharmaceutical utilization by enrollees of managed care providers pursuant to section three hundred sixty-four-j of this title and may also negotiate directly and enter into such an agreement relating to pharmaceutical utilization by medical assistance recipients not so enrolled. Such rebate arrangements shall be limited to the following: antiretrovirals approved by the FDA for the treatment of HIV/AIDS, accelerated approval drugs established pursuant to this paragraph, opioid dependence agents and opioid antagonists listed in a statewide formulary established pursuant to subparagraph (vii) of this paragraph, hepatitis C agents, high cost drugs as provided for in subparagraph (viii) of this paragraph, gene therapies as provided for in subparagraph (ix) of this paragraph, and any other class or drug designated by the commissioner for which the pharmaceutical manufacturer has in effect a rebate arrangement with the federal secretary of health and human services pursuant to 42 U.S.C. § 1396r-8, and for which the state has established standard clinical criteria. No agreement entered into pursuant to this paragraph shall have an initial term or be extended

beyond the expiration or repeal of this paragraph. For purposes of this paragraph, an "accelerated approval" is a drug or labeled indication of a drug authorized by the Federal Food, Drug and Cosmetic Act for drugs approved under Subpart H of 21 CFR Part 314 and Subpart E of 21 CFR Part 601 for serious conditions that fill an unmet medical need based on whether the drug has an effect on a surrogate clinical endpoint, and is pending verification of clinical benefit in confirmatory trials.

(i) The manufacturer shall not enter into any rebate arrangements with a managed care provider, or any of a managed care provider's agents, including but not limited to any pharmacy benefit manager on the gene therapy, drug, or drug classes subject to this paragraph when the state has a rebate arrangement in place and standard clinical criteria are imposed on the managed care provider.

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

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

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

(v) All clinical criteria, including requirements for prior approval, and all utilization review determinations established by the state as described in this paragraph for the gene therapies, drugs, or drug classes subject to this paragraph shall be developed using

evidence-based and peer-reviewed clinical review criteria in accordance with article two-A of the public health law, as applicable.

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

(vii) The department shall publish a statewide formulary of opioid dependence agents and opioid antagonists, which shall include as "preferred drugs" all drugs in such classes, which shall include all subclasses of a given drug that have a different pharmacological route of administration, provided that:

(A) for all drugs that are included as of the date of the enactment of this subparagraph on a formulary of a managed care provider, as defined in section three hundred sixty-four-j of this title, or in the Medicaid fee-for-service preferred drug program pursuant to section two hundred seventy-two of the public health law, the cost to the department for such drug is equal to or less than the lowest cost paid for the drug by any managed care provider or by the Medicaid fee-for-service program after the application of any rebates, as of the date that the department implements the statewide formulary established by this subparagraph. Where there is a generic version of the drug approved by the Food and Drug Administration as bioequivalent to a brand name drug pursuant to 21 U.S.C. § 355(j)(8)(B), the cost to the department for the brand and generic versions shall be equal to or less than the lower of the two maximum costs determined pursuant to the previous sentence; and

(B) for all drugs that are not included as of the date of the enactment of this subparagraph on a formulary of a managed care provider, as defined in section three hundred sixty-four-j of this title, or in the Medicaid fee-for-service preferred drug program pursuant to section two hundred seventy-two of the public health law, the department is able to obtain the drug at a cost that is equal to or less than the lowest cost to the department of other comparable drugs in the class, after the application of any rebates. Where there is a

generic version of the drug approved by the Food and Drug Administration as bioequivalent to a brand name drug pursuant to 21 U.S.C. § 355(j)(8)(B), the cost to the department for the brand and generic versions shall be equal to or less than the lower of the two maximum costs determined pursuant to the previous sentence.

(viii) The commissioner may identify and refer high cost drugs, as defined in clause (D) of this subparagraph, that are not included as of the date of the enactment of this subparagraph on a formulary of a managed care provider or covered by the Medicaid fee for service of program to the drug utilization review board established by section three hundred sixty-nine-bb of this article 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.

(A) If the commissioner intends to refer a high cost drug to the drug utilization review board pursuant to this subparagraph, the commissioner shall notify the manufacturer of such drug and shall attempt to reach agreement with the manufacturer on a rebate arrangement satisfactory to the commissioner for the drug prior to referring the drug to the drug utilization review board for review. Such arrangement may be based on evidence based research, including, but not limited to, such research operated or conducted by or for other state governments, the federal government, the governments of other nations, and third party payers or multi-state coalitions, provided however that the department shall account for 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, and the likelihood that use of the drug will reduce the need for other medical care, including hospitalization.

(B) In the event that the commissioner and the manufacturer have previously agreed to a rebate arrangement for a drug pursuant to this paragraph, the drug shall not be referred to the drug utilization review board for any further rebate agreement for the duration of the previous rebate agreement, provided however, the commissioner may refer a drug to the drug utilization review board if the commissioner determines there are significant and substantiated utilization or market changes, new evidence-based research, or statutory or federal regulatory changes that

warrant additional rebates. In such cases, the department shall notify the manufacturer and provide evidence of the changes or research that would warrant additional rebates, 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) If the commissioner is unsuccessful in entering into a rebate arrangement 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 information as described in subdivision six of section two hundred eighty of the public health law. All information disclosed pursuant to this clause 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.

(D) For the purposes of this subparagraph, the term "high cost drug" shall mean a brand name drug or biologic that has a launch wholesale acquisition cost of thirty thousand dollars or more per year or course of treatment, or a biosimilar drug that has a launch wholesale acquisition cost that is not at least fifteen percent lower than the referenced brand biologic at the time the biosimilar is launched, or a generic drug that has a wholesale acquisition cost of one hundred dollars or more for a thirty day supply or recommended dosage approved for labeling by the federal Food and Drug Administration, or a brand name drug or biologic that has a wholesale acquisition cost increase of three thousand dollars or more in any twelve-month period, or course of treatment if less than twelve months.

(ix) For purposes of this paragraph, a "gene therapy" is a drug (A) approved under section 505 of the Federal Food, Drug and Cosmetics Act or licensed under subsection (a) or (k) of section 351 of the Public Health Services Act; (B) that treats a rare disease or condition, as defined in 21 USC § 360bb(a)(2), that is life-threatening, as defined in 42 CFR 321.18; (C) is considered a gene therapy by the federal Food and Drug Administration for which a biologics license pursuant to 21 CFR 600-680 is held; (D) if administered in accordance with the labeling of such drug, is expected to result in either the cure of such disease or condition or a reduction in the symptoms of such disease or condition that materially improves the patient's length or quality of life; and

(E) is expected to achieve the result described in clause (D) of this subparagraph after not more than three administrations.

* NB Repealed March 31, 2032

* 8. No government agency shall purchase, pay for, or make reimbursement or grants-in-aid for any service in a residential treatment facility for children and youth or a comprehensive psychiatric emergency program unless at the time such service was provided, the residential treatment facility for children and youth or comprehensive psychiatric emergency program possessed a valid operating certificate authorizing such service. Notwithstanding any inconsistent provision of law, no government agency shall make payments pursuant to this title or title nineteen of the federal social security act to a residential treatment facility for children and youth for service to a person whose need for care and treatment in such a facility was not certified pursuant to section 9.51 of the mental hygiene law.

* NB Effective until July 1, 2027

* 8. No government agency shall purchase, pay for, or make reimbursement or grants-in-aid for any service in a residential treatment facility for children and youth unless at the time such service was provided, the residential treatment facility for children and youth possessed a valid operating certificate authorizing such service. Notwithstanding any inconsistent provision of law, no government agency shall make payments pursuant to this title or title nineteen of the federal social security act to a residential treatment facility for children and youth for service to a person whose need for care and treatment in such a facility was not certified pursuant to section 9.51 of the mental hygiene law.

* NB Effective July 1, 2027

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

payments under this title shall be made at the following amounts:

(a) for drugs provided by medical practitioners and claimed separately by the practitioners the lower of:

(i) (1) an amount equal to the national average drug acquisition cost set by the federal centers for medicare and medicaid services for the drug, if any, or if such amount is not available, the wholesale acquisition cost of the drug based on the package size dispensed from, as reported by the prescription drug pricing service used by the department, (2) the federal upper limit, if any, established by the federal centers for medicare and medicaid services; (3) the state maximum acquisition cost, if any, established pursuant to paragraph (e) of this subdivision; or (4) the actual cost of the drug to the practitioner.

(ii) Notwithstanding subparagraph (i) of this paragraph and paragraph (e) of this subdivision, for the Medicaid fee-for-service program, if a drug has been purchased from a manufacturer by a covered entity pursuant to section 340B of the federal public health service act (42 USCA § 256b), the actual amount paid by such covered entity. For purposes of this subparagraph, a "covered entity" is an entity that meets the requirements of paragraph four of subdivision (a) of such section that elects to participate in the program established by such section, and that causes claims for payment for drugs covered by this subparagraph to be submitted to the medical assistance program, either directly or through an authorized contract pharmacy. No medical assistance payments may be made to a covered entity or to an authorized contract pharmacy of a covered entity for drugs that are eligible for purchase under the section 340B program and are dispensed on an outpatient basis to patients of the covered entity, other than under the provisions of this subparagraph. Medical practitioners submitting claims for reimbursement of drugs purchased pursuant to section 340B of the public health service act shall notify the department that the claim is eligible for purchase under the 340B program, consistent with claiming instructions issued by the department to identify such claims.

(iii) In no event shall a medical practitioner be reimbursed at an amount that is lower than the state maximum acquisition cost, or for drugs that do not have a state maximum acquisition cost, the wholesale acquisition cost of the drug based on the package size.

(b) for drugs dispensed by pharmacies:

(i) (A) if the drug dispensed is a generic prescription drug, the lower of: (1) an amount equal to the national average drug acquisition cost set by the federal centers for medicare and medicaid services for the drug, if any, or if such amount if not available, the wholesale acquisition cost of the drug based on the package size dispensed from, as reported by the prescription drug pricing service used by the department, less seventeen and one-half percent thereof; (2) the federal upper limit, if any, established by the federal centers for medicare and medicaid services; (3) the state maximum acquisition cost, if any, established pursuant to paragraph (e) of this subdivision; or (4) the dispensing pharmacy's usual and customary price charged to the general public; (B) if the drug dispensed is available without a prescription as required by section sixty-eight hundred ten of the education law but is reimbursed as an item of medical assistance pursuant to paragraph (a) of subdivision four of section three hundred sixty-five-a of this title, the lower of (1) an amount equal to the national average drug acquisition cost set by the federal centers for medicare and medicaid services for the drug, if any, or if such amount is not available, the wholesale acquisition cost of the drug based on the package size dispensed from, as reported by the prescription drug pricing service used by the department, (2) the federal upper limit, if any, established by the federal centers for medicare and medicaid services; (3) the state maximum acquisition cost if any, established pursuant to paragraph (e) of this subdivision; or (4) the dispensing pharmacy's usual and customary price charged to the general public;

(ii) if the drug dispensed is a brand-name prescription drug, the lower of:

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

(iii) notwithstanding subparagraphs (i) and (ii) of this paragraph and paragraphs (d) and (e) of this subdivision, if the drug dispensed is a

drug that has been purchased from a manufacturer by a covered entity pursuant to section 340B of the federal public health service act (42 USCA § 256b), the actual amount paid by such covered entity pursuant to such section, plus the reasonable administrative costs, as determined by the commissioner, incurred by the covered entity or by an authorized contract pharmacy in connection with the purchase and dispensing of such drug and the tracking of such transactions. For purposes of this subparagraph, a "covered entity" is an entity that meets the requirements of paragraph four of subsection (a) of such section, that elects to participate in the program established by such section, and that causes claims for payment for drugs covered by this subparagraph to be submitted to the medical assistance program, either directly or through an authorized contract pharmacy. No medical assistance payments may be made to a covered entity or to an authorized contract pharmacy of a covered entity for drugs that are eligible for purchase under the section 340B program and are dispensed on an outpatient basis to patients of the covered entity, other than under the provisions of this subparagraph. Pharmacies submitting claims for reimbursement of drugs purchased pursuant to section 340B of the public health service act shall notify the department that the claim is eligible for purchase under the 340B program, consistent with claiming instructions issued by the department to identify such claims.

(c) Notwithstanding subparagraph (i) of paragraph (b) of this subdivision, if a qualified prescriber certifies "brand medically necessary" or "brand necessary" in his or her own handwriting directly on the face of a prescription, or in the case of electronic prescriptions, inserts an electronic direction to clarify "brand medically necessary" or "brand necessary", for a multiple source drug for which a specific upper limit of reimbursement has been established by the federal agency, in addition to writing "d a w" in the box provided for such purpose on the prescription form, payment under this title for such drug must be made under the provisions of subparagraph (ii) of such paragraph.

(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.

(e) For a multiple source generic drug for which no specific upper payment limit has been established by the federal centers for medicare and medicaid services, the commissioner of health may establish a maximum acquisition cost for such drug which shall be effective until such time as a specific federal upper payment limit has been established for such drug. The department shall use a similar methodology in establishing such an interim price as that utilized by the centers for medicare and Medicaid services in establishing the federal upper payment limit. For this purpose, the department is authorized to enter into a contract with an entity to provide technical and administrative support to the commissioner of health.

(g) Notwithstanding any other provision of this subdivision to the contrary, the department is authorized to implement a specialty pharmacy program for the purpose of procuring certain specialty drugs at reduced cost. The department is authorized to enter into contracts with one or more contractors in order to obtain certain specialty drugs from a limited number of sources at reduced prices. For purposes of this paragraph, specialty drugs include, but are not limited to, chemotherapy agents, hydration therapy agents, pain therapy agents, intravenous administration of antibiotics or other drugs, and total parenteral nutrition. All contracts entered into by the department to effectuate the provisions of this section shall require the contractors to take steps to assure that drugs provided pursuant to such contracts will be readily accessible to consumers in a fashion that is no more restrictive than that which was in effect prior to the implementation of the specialty pharmacy program. This paragraph shall be effective only to the extent that federal financial participation is available in the cost of drugs obtained pursuant to this paragraph. The commissioner of health is authorized to submit amendments to the state plan for medical assistance and to submit applications for waivers under the social security act to obtain the federal approvals necessary to implement this paragraph. However, any pharmacy owned and operated by a not-for-profit

organization solely for the purpose of providing drugs to individuals diagnosed with cystic fibrosis as part of a comprehensive clinical care program approved by the national organization that accredits cystic fibrosis care centers and maintains a national registry of cystic fibrosis clinical data shall be exempt from the specialty pharmacy program.

(h) The commissioner of health is authorized to establish a medication therapy management pilot program in one or more counties or regions of the state for the purpose of improving compliance with drug therapies and improving clinical outcomes. Payments under such program may be made to retail pharmacies for the provision of one-on-one medication regimen counseling services for persons determined by the commissioner to be eligible to receive such services. The commissioner is authorized to establish fees for such counseling services, subject to the approval of the director of the division of the budget. The provisions of this paragraph shall not take effect unless all necessary approvals under federal law and regulation have been obtained to receive federal financial participation in the costs of services provided under this paragraph.

(i)(i) The department of health shall establish a program for synchronization of medications. Under the synchronization program, a health care practitioner may prescribe a refill of one or more of the patient's medications for a shorter period than would ordinarily be provided, for the purpose of synchronizing refill dates of one or more of the patient's medications subject to the synchronization when it is agreed among the recipient, the health care practitioner and a pharmacist that synchronization of multiple prescriptions for the treatment of a chronic illness is in the best interest of the patient for the management or treatment of a chronic illness provided that the following apply to such medications:

(A) are covered by the department of health pursuant to this title;

(B) are used for treatment and management of a chronic illness that are subject to refills;

(C) are not a schedule II controlled substance, nor a schedule III controlled substance that contains hydrocodone or other opioid medication as scheduled in section thirty-three hundred six of the public health law, or a controlled substance under the federal

Controlled Substances Act;

(D) meet all prior authorization criteria specific to the medications at the time of the synchronization request;

(E) are of a formulation that can be effectively and lawfully aligned over required short fill periods to achieve synchronization; and

(F) do not have quantity limits or dose optimization criteria or state or federal requirements that would be violated in fulfilling synchronization.

(ii) The department of health shall not deny coverage for the dispensing of a medication by a pharmacy for a partial supply when it is for the purpose of synchronizing the patient's medications. When applicable to permit synchronization, the department of health shall allow a pharmacy to override any denial codes indicating that a prescription is being refilled too soon for the purposes of medication synchronization.

(iii) The dispensing fee paid to the pharmacy contracted to provide services pursuant to this section for a partial supply associated with medication synchronization shall be paid in accordance with the Medicaid state plan as approved by the Centers for Medicare and Medicaid Services.

(iv) The requirement of this paragraph applies only once for each prescription drug subject to medication synchronization except when either of the following occurs:

(I) the prescriber changes the dosage or frequency of administration of the prescription drug subject to a medication synchronization; or

(II) the prescriber prescribes a different drug.

(v) Nothing in this paragraph shall be deemed to require health care practitioners and pharmacists to synchronize the refilling of multiple prescriptions for a recipient.

(vi) The provisions of this paragraph are subject to compliance with all applicable federal and state laws and regulations, including the Centers for Medicare and Medicaid Services approved Medicaid state plan. The commissioner shall apply for waivers and submit state Medicaid plan amendments as are necessary to implement the program for synchronization of medications.

* NB Effective until March 31, 2029

* 9. Notwithstanding any inconsistent provision of law or regulation

to the contrary, for those drugs which may not be dispensed without a prescription as required by section sixty-eight hundred ten of the education law and for which payment is authorized pursuant to paragraph (g) of subdivision two of section three hundred sixty-five-a of this title, payments under this title shall be made at the following amounts:

(a) for drugs provided by medical practitioners and claimed separately by the practitioners, the actual cost of the drugs to the practitioners; and

(b) for drugs dispensed by pharmacies:

(i) if the drug dispensed is a multiple source prescription drug for which an upper limit has been set by the federal health care financing administration, an amount equal to the specific upper limit set by such federal agency for the multiple source prescription drug, and

(ii) if the drug dispensed is a multiple source prescription drug or a brand-name prescription drug for which no specific upper limit has been set by such federal agency, the lower of the estimated acquisition cost of such drug to pharmacies, or the dispensing pharmacy's usual and customary price charged to the general public. Estimated acquisition cost means the average wholesale price of a prescription drug based upon the package size dispensed from, as reported by the prescription drug pricing service used by the department, less ten percent thereof, and updated monthly by the department.

(c) Notwithstanding subparagraph (i) of paragraph (b) of this subdivision, if a qualified prescriber certifies "brand medically necessary" or "brand necessary" in his or her own handwriting directly on the face of a prescription for a multiple source drug for which a specific upper limit of reimbursement has been established by the federal agency, in addition to writing "d a w" in the box provided for such purpose on the prescription form, payment under this title for such drug must be made under the provisions of subparagraph (ii) of such paragraph.

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

each such prescription drug dispensed, which dispensing fee shall not be less than the following amounts:

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

(ii) for prescription drugs categorized as brand-name prescription drug by the prescription drug pricing service used by the department, four dollars and fifty cents per prescription.

* NB Effective March 31, 2029

10. Any provider except for those providers certified under article twenty-eight of the public health law, of ordered services or supplies under the medical assistance program may be required to provide financial security to assure that funds are available to repay any overpayments made to the provider under this title and to assure the financial security of the medical assistance program. For the purposes of this subdivision, "ordered services or supplies" shall mean those services or supplies described in paragraphs (g), (i) and (j) of subdivision two of section three hundred sixty-five-a of this title.

(a) Any financial security required by this subdivision must meet the requirements of this paragraph. Financial security may be provided through a bond with a corporate surety, from a company authorized to do business in this state, or an irrevocable letter of credit or certificate of deposit from a New York state or federally chartered bank, trust company, savings bank or savings and loan association qualified to do business in New York state and insured by the federal deposit insurance corporation.

(b) The bond, letter of credit or certificate of deposit shall be payable in favor of the people of the state of New York for the purpose of indemnifying the medical assistance program against any overpayments made to the provider.

(c) The bond, letter of credit or certificate of deposit filed and maintained pursuant to this section shall not be cancelled, revoked or terminated except after notice to, and with the consent of, the department at least forty-five days in advance of such cancellation, revocation or termination.

(d) The department may bring and maintain an action against the

provider and the surety or bank, trust company, savings bank or savings and loan association for any claimed overpayments made to the provider.

(e) Financial security shall not be required for providers which do not submit claims for payment under the medical assistance program exceeding five hundred thousand dollars per annum or forty-two thousand dollars per month.

(f) Financial security shall be in an amount equal to the provider's estimated claims for payment for a one year period and may be adjusted bi-annually in accordance with the dollar amount of claims actually submitted. If the commissioner is satisfied from an investigation of the financial condition of a provider that the provider is solvent and possessed of sufficient assets to provide reasonable assurance of recovery of any overpayments, the commissioner may modify the amount of financial security to be provided by such provider.

(g) Financial security must be submitted by a provider upon initial application for enrollment as a provider of medical assistance and with each subsequent enrollment. A change in ownership of a provider shall not release, cancel or terminate liability under this section under any bond, letter of credit or certificate of deposit filed for a provider while such bond, letter of credit or certificate of deposit is in effect unless the transferee, purchaser, successor or assignee of such provider obtains a bond, letter of credit or certificate of deposit under this section for the benefit of such new owner. All providers enrolled in the medical assistance program on the effective date of this subdivision will be required to submit financial security within ninety days of notice of such requirements by the department.

(h) The department may make the submission of the financial security required by this subdivision a condition of participation in the medical assistance program.

11. (a) Any inconsistent provisions of this title or other law notwithstanding, no health insurer, self-insured plan, managed care organization, pharmacy benefit manager, or other party that is, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service, employer or organization who has a plan, including an employee retirement income security act or service benefit plan, providing care and other medical benefits for

persons, whether by insurance or otherwise, shall exclude a person from eligibility, coverage or entitlement to medical benefits by reason of the eligibility of such person for medical assistance under this title, or by reason of the fact that such person would, except for such plan, be eligible for benefits under this title.

(b) Any inconsistent provisions of this title or other law notwithstanding, no insurer may impose requirements on the department or a social services district which has been assigned the rights of an individual who is eligible for medical assistance under this title and who is covered for health benefits from the insurer, that are different from requirements applicable to an agent or assignee of any other individual so covered.

(c) Any inconsistent provisions of this title or other law notwithstanding, the department may, to the extent necessary to reimburse the department and the social services districts for expenditures under this title, certify to the commissioner of taxation and finance pursuant to section one hundred seventy-one-f of the tax law amounts to be withheld from tax refunds otherwise due to any individual who is required by court order to provide medical support in the form of health insurance benefits for a child who is eligible for medical assistance under this title and who has received payment from a third-party for the cost of such services for such child but has not used such payments to reimburse either the other parent or guardian of such child or the provider of such services or the appropriate social services district; provided however, that any claims for current or past-due child support shall take priority over any such claims for the costs of such services and care. Such amounts shall be withheld pursuant to section one hundred seventy-one-f of the tax law, and shall be credited to unreimbursed medical assistance incurred on behalf of such child. The department shall by regulation establish procedures consistent with paragraphs (a) and (b) of subdivision four of section one hundred seventy-one-c of the tax law by which any individual who is the subject of a certification may contest such certification.

12. Prior to receiving medical assistance under subparagraphs five and six of paragraph (c) of subdivision one of section three hundred sixty-six of this title, a person whose net available income is at least

one hundred fifty percent of the applicable federal income official poverty line, as defined and updated by the United States department of health and human services, must pay a monthly premium, in accordance with a procedure to be established by the commissioner. The amount of such premium shall be twenty-five dollars for an individual who is otherwise eligible for medical assistance under such subparagraphs, and fifty dollars for a couple, both of whom are otherwise eligible for medical assistance under such subparagraphs. No premium shall be required from a person whose net available income is less than one hundred fifty percent of the applicable federal income official poverty line, as defined and updated by the United States department of health and human services.