STATE OF NEW YORK

S. 6407 A. 9007

SENATE - ASSEMBLY

January 14, 2016

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

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

AN ACT to amend chapter 58 of the laws of 2005, relating to authorizing reimbursements for expenditures made by or on behalf of social services districts for medical assistance for needy persons and the administration thereof, in relation to the expenditure cap for the medical assistance program for needy persons (Part A); to amend the social services law, in relation to provisions relating to transportation in the managed long term care program; to amend the public health law, in relation to restricting the managed long term care benefit to those who are nursing home eligible; to amend the social services law, in relation to conforming with federal law provisions relating to spousal contributions, community spouse resource budgeting; to amend the social services law, in relation to authorizing price ceilings on blockbuster drugs and reducing reimbursement rates for specialty drugs; to amend the public health law, in relation to expanding prior authorization for the clinical drug review program and eliminating prescriber prevails; to amend the social services law, in relation to authorizing the commissioner of health to apply federally established consumer price index penalties for generic drugs, to facilitate supplemental rebates for fee-for-service pharmaceuticals, to apply prior authorization requirements for opioid drugs, to impose penalties on managed care plans for reporting late or incorrect encounter data, to apply cost sharing limits to medicare Part C claims and to authorize funding for the criminal justice pilot program within health home rates; 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 expiration of certain provisions thereof; and to repeal certain provisions of the social services law relating to the authorization of prescriber prevails in the managed care program (Part B); to amend chapter 266 of the laws of 1986, amending the civil practice law and

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

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rules and other laws relating to malpractice and professional medical conduct, in relation to apportioning premium for certain policies and to amend part J of chapter 63 of the laws of 2001 amending chapter 266 of the laws of 1986, amending the civil practice law and rules and other laws relating to malpractice and professional medical conduct, in relation to extending certain provisions concerning the hospital excess liability pool (Part C); to amend chapter 474 of the laws of 1996, amending the education law and other laws relating to rates for residential healthcare facilities, in relation to extending the authority of the department of health to make disproportionate share payments to public hospitals outside of New York City; to amend chapter 649 of the laws of 1996, amending the public health law, the mental hygiene law and the social services law relating to authorizing the establishment of special needs plans, in relation to the effectiveness thereof; to repeal subdivision 8 of section 84 of part A of chapter 56 of the laws of 2013, amending the public health law and other laws relating to general hospital reimbursement for annual rates, relating to the effectiveness thereof; to repeal subdivision (f) of section 129 of part C of chapter 58 of the laws of 2009, amending the public health law relating to payment by governmental agencies for general hospital inpatient services, relating to the effectiveness thereof; and to repeal subdivision (c) of section 122 of part E of chapter 56 of the laws of 2013, amending the public health law relating to the general public health work program, relating to the effectiveness thereof (Part D); to amend the public health law and the insurance law, in relation to the early intervention program for infants and toddlers with disabilities and their families (Part E); to amend the public health law, in relation to the health care facility transformation program (Part F); to amend the public health law, in relation to authorizing the establishment of limited service clinics (Part G); to amend part D of chapter 111 of the laws of 2010 relating to the recovery of exempt income by the office of mental health for community residences and family-based treatment programs, in relation to the effectiveness thereof (Part H); to amend chapter 723 of the laws of 1989 amending the mental hygiene law and other laws relating to comprehensive psychiatric emergency programs, in relation to the effectiveness of certain provisions thereof (Part I); to amend chapter 420 of the laws of 2002 amending the education law relating to the profession of social work, in relation to extending the expiration of certain provisions thereof; to amend chapter 676 of the laws of 2002 amending the education law relating to the practice of psychology, in relation to extending the expiration of certain provisions; and to amend chapter 130 of the laws of 2010 amending the education law and other laws relating to registration of entities providing certain professional services and licensure of certain professions, in relation to extending certain provisions thereof (Part J); to amend the criminal procedure law, in relation to authorizing restorations to competency within correctional facility based residential settings (Part K); to amend the mental hygiene law, in relation to the appointment of temporary operators for the continued operation of programs and the provision of services for persons with serious mental illness and/or developmental disabilities (Part L); to amend the mental hygiene law, in relation to sharing clinical records with managed care organizations (Part M); and to amend the facilities development corporation act, in relation to the definition of mental hygiene facility (Part N)

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 2016-2017 state fiscal year. Each component is wholly contained within a Part identified as Parts A through N. 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. Section 1 of part C of chapter 58 of the laws of 2005, relating to authorizing reimbursements for expenditures made by or on behalf of social services districts for medical assistance for needy persons and the administration thereof, subdivision (a) as amended by section 3-e of part B of chapter 58 of the laws of 2010, subdivision (b) as amended by section 24 of part B of chapter 109 of the laws of 2010, subdivision (c-1) as added by section 1 of part F of chapter 56 of the laws of 2012, subdivision (f) as amended by section 23 of part B of chapter 109 of the laws of 2010, paragraph (iii) of subdivision (g) as amended by section 2 of part F of chapter 56 of the laws of 2012, subdivision (h) as added by section 61 of part D of chapter 56 of the laws of 2012, is amended to read as follows:

Section 1. (a) Notwithstanding the provisions of section 368-a of the social services law, or any other provision of law, the department of health shall provide reimbursement for expenditures made by or on behalf of social services districts for medical assistance for needy persons, and the administration thereof, in accordance with the provisions of this section; provided, however, that this section shall not apply to amounts expended for health care services under former section 369-ee of the social services law, which amounts shall be reimbursed in accordance with paragraph (t) of subdivision 1 of section 368-a of such law and shall be excluded from all calculations made pursuant to this section; and provided further that amounts paid to the public hospitals pursuant to subdivision 14-f of section 2807-c of the public health law and amounts expended pursuant to: subdivision 12 of section 2808 of the public health law; sections 211 and 212 of chapter 474 of the laws of 1996, as amended; and sections 11 through 14 of part A and sections 13 and 14 of part B of chapter 1 of the laws of 2002; and amounts paid to public diagnostic and treatment centers as provided in sections 3-a and 3-b of part B of [the] chapter 58 of the laws of 2010 [which amended this subdivision], amounts paid to public general hospitals as certified public expenditures as provided in section 3-c of part B of [the] chapter 58 of the laws of 2010 [which amended this subdivision], and amounts paid to managed care providers pursuant to section 3-d of part B of [the] chapter 58 of the laws of 2010 [which amended this subdivision], shall be excluded from all calculations made pursuant to this section.

(b) Commencing with the period April 1, 2005 though March 31, 2006, a social services district's yearly net share of medical assistance expenditures shall be calculated in relation to a reimbursement base

year which, for purposes of this section, is defined as January 1, 2005 through December 31, 2005. The final base year expenditure calculation for each social services district shall be made by the commissioner of health, and approved by the director of the division of the budget, no later than June 30, 2006. Such calculations shall be based on actual expenditures made by or on behalf of social services districts, and revenues received by social services districts, during the base year and shall be made without regard to expenditures made, and revenues received, outside the base year that are related to services provided during, or prior to, the base year. Such base year calculations shall be based on the social services district medical assistance shares provisions in effect on January 1, 2005. Subject to the provisions of subdivision four of section six of this part, the state/local social services district relative percentages of the non-federal share of medical assistance expenditures incurred prior to January 1, 2006 shall not be subject to adjustment on and after July 1, 2006.

(c) Commencing with the calendar year beginning January 1, 2006, calendar year social services district medical assistance expenditure amounts for each social services district shall be calculated by multiplying the results of the calculations performed pursuant to paragraph (b) of this section by a non-compounded trend factor, as follows:

(i) 2006 (January 1, 2006 through December 31, 2006): 3.5%;

(ii) 2007 (January 1, 2007 through December 31, 2007): 6.75% (3.25% plus the prior year's 3.5%);

(iii) 2008 (January 1, 2008 through December 31, 2008): 9.75% (3% plus the prior year's 6.75%);

(iv) 2009 (January 1, 2009 through December 31, 2009), and each succeeding calendar year: prior year's trend factor percentage plus 3%.

(c-1) Notwithstanding any provisions of subdivision (c) of this section to the contrary, effective April 1, 2013, for the period January 1, 2013 through December 31, 2013 and for each calendar year thereafter, the medical assistance expenditure amount for the social services district for such period shall be equal to the previous calendar year's medical assistance expenditure amount, except that:

(1) for the period January 1, 2013 through December 31, 2013, the previous calendar year medical assistance expenditure amount will be increased by 2%;

(2) for the period January 1, 2014 through December 31, 2014, the previous calendar year medical assistance expenditure amount will be increased by 1%.

(c-2) Notwithstanding any provisions of subdivision (c-1) of this section to the contrary, effective April 1, 2016, for the period January 1, 2016 through December 31, 2016 and for each calendar year thereafter, the medical assistance expenditure amount for a social services district having a population of more than five million shall be equal to the amount calculated pursuant to subdivisions (b) and (c) of this section.

(d) The base year expenditure amounts calculated pursuant to paragraph (b) of this section and the calendar year social services district expenditure amounts calculated pursuant to paragraph (c) of this section shall be converted into state fiscal year social services district expenditure cap amounts for each social services district such that each such state fiscal year amount is proportional to the portions of the two calendar years within each fiscal year, as follows:

(i) fiscal year 2005-2006 (April 1, 2005 through March 31, 2006): 75% of the base year amount plus 25% of the 2006 calendar year amount;

(ii) fiscal year 2006-2007 (April 1, 2006 through March 31, 2007): 75% of the 2006 year calendar amount plus 25% of the 2007 calendar year amount;

(iii) each succeeding fiscal year: 75% of the first calendar year within that fiscal year's amount plus 25% of the second calendar year within that fiscal year's amount.

(d-1) Notwithstanding any provisions of subdivision (d) of this section to the contrary, for fiscal years 2015-2016 and 2016-2017, the base year expenditure amount calculated pursuant to paragraph (b) of this section and the calendar year social services district expenditure amount calculated pursuant to paragraph (c) of this section shall be converted into a state fiscal year social services district expenditure cap amount for a social services district having a population of more than five million as follows:

(i) fiscal year 2015-2016 (April 1, 2015 through March 31, 2016): 75% of the 2015 base year amount plus 25% of the 2016 calendar year amount, if such 2016 calendar year amount were calculated without regard to the provisions of subdivision (c-2) of this section;

(ii) fiscal year 2016-2017 (April 1, 2016 through March 31, 2017): 75% of the 2016 base year amount plus 25% of the 2017 calendar year amount; this cap amount shall be reduced by one-half of the difference between this amount and the cap amount for this period that would result if calculated without regard to the provisions of subdivision (c-2) of this section.

(e) No later than April 1, 2007, the commissioner of health shall certify the 2006-2007 fiscal year social services district expenditure cap amounts for each social services district calculated pursuant to subparagraph (ii) of paragraph (d) of this section and shall communicate such amounts to the commissioner of taxation and finance.

(f) Subject to paragraph (g) of this section, the state fiscal year social services district expenditure cap amount calculated for each social services district pursuant to paragraph (d) of this section shall be allotted to each district during that fiscal year and paid to the department in equal weekly amounts in a manner to be determined by the commissioner and communicated to such districts and, subject to the provisions of subdivision four of section six of this part, shall represent each district's maximum responsibility for medical assistance expenditures governed by this section. However, for fiscal year 2016-2017, the expenditure cap amount calculated for a social services district having a population of more than five million shall be paid to the department in weekly amounts in a manner to be determined by the commissioner, in consultation with the director of the division of the budget, and communicated to such district.

(g) (i) No allotment pursuant to paragraph (f) of this section shall be applied against a social services district during the period April 1, 2005 through December 31, 2005. Social services district medical assistance shares shall be determined for such period pursuant to shares provisions in effect on January 1, 2005.

(ii) For the period January 1, 2006 through June 30, 2006, the commissioner is authorized to allot against each district an amount based on the commissioner's best estimate of the final base year expenditure calculation required by paragraph (b) of this section. Upon completion of such calculation, the commissioner shall, no later than December 31, 2006, reconcile such estimated allotments with the fiscal year social services district expenditure cap amounts calculated pursuant to subparagraphs (i) and (ii) of paragraph (d) of this section.

(iii) During each state fiscal year subject to the provisions of this section and prior to state fiscal year 2015-16, the commissioner shall maintain an accounting, for each social services district, of the net amounts that would have been expended by, or on behalf of, such district had the social services district medical assistance shares provisions in effect on January 1, 2005 been applied to such district. For purposes of this paragraph, fifty percent of the payments made by New York State to the secretary of the federal department of health and human services pursuant to section 1935(c) of the social security act shall be deemed to be payments made on behalf of social services districts; such fifty percent share shall be apportioned to each district in the same ratio as the number of "full-benefit dual eligible individuals," as that term is defined in section 1935(c)(6) of such act, for whom such district has fiscal responsibility pursuant to section 365 of the social services law, relates to the total of such individuals for whom districts have fiscal responsibility. As soon as practicable after the conclusion of each such fiscal year, but in no event later than six months after the conclusion of each such fiscal year, the commissioner shall reconcile such net amounts with such fiscal year's social services district expenditure cap amount. Such reconciliation shall be based on actual expenditures made by or on behalf of social services districts, and revenues received by social services districts, during such fiscal year and shall be made without regard to expenditures made, and revenues received, outside such fiscal year that are related to services provided during, or prior to, such fiscal year. The commissioner shall pay to each social services district the amount, if any, by which such district's expenditure cap amount exceeds such net amount.

(h) Notwithstanding the provisions of section 368-a of the social services law or any other contrary provision of law, no reimbursement shall be made for social services districts' claims submitted on and after the effective date of this paragraph, for district expenditures incurred prior to January 1, 2006, including, but not limited to, expenditures for services provided to individuals who were eligible for medical assistance pursuant to section three hundred sixty-six of the social services law as a result of a mental disability, formerly referred to as human services overburden aid to counties.

§ 2. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2016.

PART B

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

4. The commissioner of health is authorized to assume responsibility from a local social services official for the provision and reimbursement of transportation costs under this section. If the commissioner elects to assume such responsibility, the commissioner shall notify the local social services official in writing as to the election, the date upon which the election shall be effective and such information as to transition of responsibilities as the commissioner deems prudent. The commissioner is authorized to contract with a transportation manager or managers to manage transportation services in any local social services district[, other than transportation services provided or arranged for enrollees of managed long term care plans issued certificates of authority under section forty-four hundred three-f of the public health law].

Any transportation manager or managers selected by the commissioner to manage transportation services shall have proven experience in coordinating transportation services in a geographic and demographic area similar to the area in New York state within which the contractor would manage the provision of services under this section. Such a contract or contracts may include responsibility for: review, approval and processing of transportation orders; management of the appropriate level of transportation based on documented patient medical need; and development of new technologies leading to efficient transportation services. If the commissioner elects to assume such responsibility from a local social services district, the commissioner shall examine and, if appropriate, adopt quality assurance measures that may include, but are not limited to, global positioning tracking system reporting requirements and service verification mechanisms. Any and all reimbursement rates developed by transportation managers under this subdivision shall be subject to the review and approval of the commissioner.

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

(i) The commissioner shall, to the extent necessary, submit the appropriate waivers, including, but not limited to, those authorized pursuant to sections eleven hundred fifteen and nineteen hundred fifteen of the federal social security act, or successor provisions, and any other waivers necessary to achieve the purposes of high quality, integrated, and cost effective care and integrated financial eligibility policies under the medical assistance program or pursuant to title XVIII of the federal social security act. In addition, the commissioner is authorized to submit the appropriate waivers, including but not limited to those authorized pursuant to sections eleven hundred fifteen and nineteen hundred fifteen of the federal social security act or successor provisions, and any other waivers necessary to require on or after April first, two thousand twelve, medical assistance recipients who are twenty-one years of age or older and who require community-based long term care services, as specified by the commissioner, for more than one hundred and twenty days, to receive such services through an available plan certified pursuant to this section or other program model that meets guidelines specified by the commissioner that support coordination and integration of services; provided, however, that the commissioner may, through such waivers, limit eligibility to available plans to enrollees that require nursing facility level of care. Notwithstanding the foregoing, medical assistance recipients enrolled in a managed long term care plan on April first, two thousand sixteen may continue to be eligible for such plans, irrespective of whether the enrollee meets any applicable nursing facility level of care requirements, provided, however, that once such recipients are disenrolled from their managed long term care plan, any applicable nursing facility level of care requirements would apply to future eligibility determinations. Such guidelines shall address the requirements of paragraphs (a), (b), (c), (d), (e), (f), (g), (h), and (i) of subdivision three of this section as well as payment methods that ensure provider accountability for cost effective quality outcomes. Such other program models may include long term home health care programs that comply with such guidelines. Copies of such original waiver applications and amendments thereto shall be provided to the chairs of the senate finance committee, the assembly ways and means committee and the senate and assembly health committees simultaneously with their submission to the federal government.

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

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

§ 4. Subparagraph (i) of paragraph (d) of subdivision 2 of section 366-c of the social services law is amended by adding a new clause (C) to read as follows:

(C) on and after July first, two thousand sixteen, twenty-three thousand eight hundred forty-four dollars or such greater amount as may be required under federal law;

§ 5. Subdivision 7 of section 367-a of the social services law is amended by adding a new paragraph (g) to read as follows:

(g)(i) The department shall develop a list of critical prescription drugs for which there is a significant public interest in ensuring rational pricing by drug manufacturers. In selecting drugs for possible inclusion in such list, factors to be considered by the department shall include, but not be limited to: the seriousness and prevalence of the disease or condition that is treated by the drug; the extent of utilization of the drug; the average wholesale price and retail price of the drug; the number of pharmaceutical manufacturers that produce the drug; whether there are pharmaceutical equivalents to the drug; and the potential impact of the cost of the drug on public health care programs, including Medicaid.

(ii) For each prescription drug included on the critical prescription drug list, the department shall require the manufacturers of said prescription drug to report the following information:

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

(B) research and development costs of the drug including payments to predecessor entities conducting research and development, including but not limited to biotechnology companies, universities and medical schools, and private research institutions;

(C) 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;

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

(E) prices charged to typical purchasers in New York, including but not limited to pharmacies, pharmacy chains, pharmacy wholesalers or other direct purchasers;

(F) the average rebates and discounts provided per payor type;

(G) the average profit margin of each drug over the prior five year period and the projected profit margin anticipated for such drug; and

(H) clinical information including but not limited to clinical trials and clinical outcomes research.

(iii) The department shall develop a standard reporting form that satisfies the requirements of subparagraph (ii) of this paragraph. Manufacturers shall provide the required information within ninety days of the department's request. All information disclosed pursuant to subparagraph (ii) of this paragraph is confidential and shall not be disclosed by the department or its actuary in a form that discloses the identity of a specific manufacturer, or prices charged for drugs by such manufacturer, except as the commissioner determines is necessary to carry out the provisions of this section, or to allow the department, the attorney general, the state comptroller, or the centers for medicare and Medicaid services to perform audits or investigations authorized by law.

(iv) For each critical prescription drug identified by the department, the department shall direct its actuary to utilize the information provided pursuant to subparagraph (ii) of this paragraph to conduct a value-based assessment of such drug and establish a reasonable ceiling price.

(v) The commissioner may require a drug manufacturer to provide rebates to the department for a critical prescription drug whose price exceeds the ceiling price for the drug established by the department's actuary pursuant to subparagraph (iv) of this paragraph. Such rebates shall be in addition to any rebates payable to the department pursuant to any other provision of federal or state law. The additional rebates authorized pursuant to this subparagraph shall apply to critical prescription drugs dispensed to enrollees of managed care providers pursuant to section three hundred sixty-four-j of this title and to critical prescription drugs dispensed to Medicaid recipients who are not enrollees of such providers.

§ 6. Paragraph (b) of subdivision 9 of section 367-a of the social services law is amended by adding a new subparagraph (iv) to read as follows:

(iv) notwithstanding subparagraphs (i) and (ii) of this paragraph, if the drug dispensed is a drug that one or more managed care providers operating pursuant to section three hundred sixty-four-j of this title have designated as a specialty drug, an amount that does not exceed the amount such providers pay for the drug, as determined by the commissioner based on managed care providers' encounter data for the drug.

§ 7. Section 274 of the public health law is amended by adding a new subdivision 15 to read as follows:

15. Notwithstanding any inconsistent provision of this section, the commissioner may require prior authorization for any drug after evaluating the factors set forth in subdivision three of this section and prior to obtaining the board's evaluation and recommendation required by subdivision four of this section. The board may recommend to the commissioner, pursuant to subdivision six of this section, that any such prior authorization requirement be modified, continued or removed.

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

(b) In the event that the patient does not meet the criteria in paragraph (a) of this subdivision, the prescriber may provide additional information to the program to justify the use of a prescription drug

that is not on the preferred drug list. The program shall provide a reasonable opportunity for a prescriber to reasonably present his or her justification of prior authorization. [If, after consultation with the program, the prescriber, in his or her reasonable professional judgment, determines that the use of a prescription drug that is not on the preferred drug list is warranted, the prescriber's determination shall be final.] The program will consider the additional information and the justification presented to determine whether the use of a prescription drug that is not on the preferred drug list is warranted. In the case of atypical antipsychotics and antidepressants, if after consultation with the program, the prescriber, in his or her reasonable professional judgment, determines that the use of a prescription drug that is not on the preferred drug list is warranted, the prescriber's determination shall be final.

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

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

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

§ 11. Subdivision 7 of section 367-a of the social services law is amended by adding a new paragraph (f) to read as follows:

(f) The commissioner may require manufacturers of drugs other than single source drugs and innovator multiple source drugs, as such terms are defined in 42 U.S.C. § 1396r-8(k), to provide rebates to the department for generic drugs whose prices increase at a rate greater than the rate of inflation. Such rebates shall be in addition to any rebates payable to the department pursuant to any other provision of federal or state law. In determining the amount of such additional rebates for generic drugs, the commissioner may use a methodology similar to that used by the Centers for Medicare & Medicaid Services in determining the amount of any additional rebates for single source and innovator multiple source drugs, as set forth in 42 U.S.C. § 1396r-8(c)(2). The additional rebates authorized pursuant to this paragraph shall apply to generic prescription drugs dispensed to enrollees of managed care providers pursuant to section three hundred sixty-four-j of this title and to generic prescription drugs dispensed to medicaid recipients who are not enrollees of such providers.

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

During the period from April first, two thousand fifteen through March thirty-first, two thousand seventeen, the commissioner may, in lieu of a managed care provider, negotiate directly and enter into an agreement with a pharmaceutical manufacturer for the provision of supplemental rebates relating to pharmaceutical utilization by enrollees of managed care providers pursuant to section three hundred sixty-four-j of this title and, notwithstanding the provisions of section two hundred seventy-two of the public health law or any other inconsistent provision of

law, may also negotiate directly and enter into such an agreement relating to pharmaceutical utilization by medical assistance recipients not so enrolled. Such rebates shall be limited to drug utilization in the following classes: antiretrovirals approved by the FDA for the treatment of HIV/AIDS and hepatitis C agents for which the pharmaceutical manufacturer has in effect a rebate agreement with the federal secretary of health and human services pursuant to 42 U.S.C. § 1396r-8, and for which the state has established standard clinical criteria. No agreement entered into pursuant to this paragraph shall have an initial term or be extended beyond March thirty-first, two thousand twenty.

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

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

§ 14. Section 364-j of the social services law is amended by adding a new subdivision 26-a to read as follows:

26-a. Managed care providers shall require prior authorization of prescriptions of opioid analgesics in excess of four prescriptions in a thirty-day period.

§ 15. Section 364-j of the social services law is amended by adding a new subdivision 32 to read as follows:

32. (a) The commissioner may, in his or her discretion, apply penalties to managed care organizations subject to this section and article forty-four of the public health law for untimely or inaccurate submission of encounter data. For purposes of this section, "encounter data" shall mean the transactions required to be reported under the model contract. Any penalty assessed under this subdivision shall be calculated as a percentage of the administrative component of the Medicaid premium calculated by the department.

(b) Such penalties shall be as follows:

(i) For encounter data submitted or resubmitted past the deadlines set forth in the model contract, Medicaid premiums shall be reduced by one and one-half percent; and

(ii) For incomplete or inaccurate encounter data that fails to conform to department developed benchmarks for completeness and accuracy, Medicaid premiums shall be reduced by one-half percent; and

(iii) For submitted data that results in a rejection rate in excess of ten percent of department developed volume benchmarks, Medicaid premiums shall be reduced by one half-percent.

(c) Penalties under this subdivision may be applied to any and all circumstances described in paragraph (b) of this subdivision at a frequency determined by the commissioner. The commissioner may, in his or her discretion, waive such penalty.

§ 16. Paragraph (d) of subdivision 1 of section 367-a of the social services law is amended by adding a new subparagraph (iv) to read as follows:

(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 who is not a beneficiary under part B or a qualified medicare beneficiary, less the amount payable by the part C health plan; 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.

§ 17. Subdivision 2-b of section 365-l of the social services law, as added by section 25 of part B of chapter 57 of the laws of 2015, is amended to read as follows:

2-b. The commissioner is authorized to make [grants] lump sum payments or adjust rates of payment to providers up to a gross amount of five million dollars, to establish coordination between the health homes and the criminal justice system and for the integration of information of health homes with state and local correctional facilities, to the extent permitted by law. Such rate adjustments may be made to health homes participating in a criminal justice pilot program with the purpose of enrolling incarcerated individuals with serious mental illness, two or more chronic conditions, including substance abuse disorders, or HIV/AIDS, into such health home. Health homes receiving funds under this subdivision shall be required to document and demonstrate the effective use of funds distributed herein.

§ 18. 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 8 of part B of chapter 57 of the laws of 2015, is amended to read as follows:

1. For state fiscal years 2011-12 through [2016-17] 2017-18, 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, 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.

§ 19. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2016; provided that:

(a) sections one, two and six of this act shall take effect October 1, 2016;

(b) 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 expiration and repeal of certain provisions of such section, and shall expire and be deemed repealed therewith;

(c) the amendments to subparagraph (i) of paragraph (b) of subdivision 7 of section 4403-f of the public health law, made by section two of this act, shall not affect the expiration of such subdivision or the repeal of such section, and shall expire or be deemed repealed therewith;

(d) sections four and sixteen of this act shall take effect July 1, 2016;

(e) the amendments to subdivision 9 of section 367-a of the social services law, made by section six of this act, shall not affect the expiration of such subdivision and shall expire therewith;

(f) sections eight, nine and ten of this act shall take effect June 1, 2016;

(g) the amendments to subdivision 25 of section 364-j 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;

(h) the amendments to paragraph (e) of subdivision 7 of section 367-a of the social services law, made by sections twelve and thirteen of this act shall not affect the repeal of such paragraph and shall be deemed repealed therewith; and

(i) subdivisions 26-a and 32 of section 364-j of the social services law, as added by sections fourteen and fifteen of this act shall be deemed repealed on the same date and in the same manner as such section is repealed.

PART C

Section 1. 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, is amended by adding a new paragraph (c) to read as follows:

(c) Starting with the policy year beginning July first, two thousand sixteen, and at least once every five years thereafter, the superintendent of financial services shall rank from highest to lowest each class and territory combination used for the purpose of apportioning premium for policies purchased from funds available in the hospital excess

liability pool according to relativities derived from the medical malpractice insurance pool's primary rates and the applicable excess tier factors. Annually, the superintendent shall determine the class and territory combinations for which a policy or policies for excess insurance coverage, or for equivalent excess insurance coverage, may be purchased for eligible physicians or dentists within the limits of the appropriation for the hospital excess liability pool. The superintendent shall grant priority for purchasing policies in each policy year in descending order beginning with the highest risk class and territory combination. The superintendent and commissioner of health shall not be obligated to purchase any more policies than the number of policies that can be purchased at the rates promulgated annually by the superintendent within the limits of the appropriation. Once the balance of the appropriation becomes insufficient to cover all physicians and dentists within a particular class and territory combination, the remaining funds for that combination shall be allocated, for the purpose of purchasing policies for selected additional physicians and dentists within that combination to general hospitals in proportion to their share of the total number of physicians or dentists practicing in such class and territory combination who were certified by the general hospitals, and for whom policies were purchased, in the prior year, provided that any share of less than one physician or dentist shall be deemed to equal zero. For the purposes of this paragraph, with regard to policies issued for the coverage period beginning July first, two thousand sixteen, "prior year" shall mean the policy year that began on July first, two thousand fifteen.

§ 2. 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 1 of part Y of chapter 57 of the laws of 2015, 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, [and] between July 1, 2015 and June 30, 2016, and between July 1, 2016 and June 30, 2017 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, [and] between July 1, 2015 and June 30, 2016, and between July 1, 2016 and June 30, 2017 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.

§ 3. 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 2 of part Y of chapter 57 of the laws of 2015, 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, [and] between July 1, 2015 and June 30, 2016<u>, and between July 1, 2016 and June 30, 2017</u> 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, [and] between July 1, 2015 and June 30, 2016, and between July 1, 2016 and June 30, 2017 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, [and] to the period July 1, 2015 and June 30, 2016, and between July 1, 2016 and June 30, 2017.

§ 4. 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 3 of part Y of chapter 57 of the laws of 2015, 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, [and] during the period July 1, 2015 and June 30, 2016, and between July 1, 2016 and June 30, 2017 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 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 peri-

od 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<u>, or covering the period July 1, 2016 to June 30, 2017</u> 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<u>, or covering the period July 1, 2016 to June 30, 2017</u> that has made payment to such provider of excess insurance coverage or equivalent excess coverage in accordance with paragraph (b) of this subdivision and of each physician and dentist who has failed, refused or neglected to make such payment.

(e) A provider of excess insurance coverage or equivalent excess coverage shall refund to the hospital excess liability pool any amount allocable to the period July 1, 1992 to June 30, 1993, and to the period

July 1, 1993 to June 30, 1994, and to the period July 1, 1994 to June 30, 1995, and to the period July 1, 1995 to June 30, 1996, and to the period July 1, 1996 to June 30, 1997, and to the period July 1, 1997 to June 30, 1998, and to the period July 1, 1998 to June 30, 1999, and to the period July 1, 1999 to June 30, 2000, and to the period July 1, 2000 to June 30, 2001, and to the period July 1, 2001 to October 29, 2001, and to the period April 1, 2002 to June 30, 2002, and to the period July 1, 2002 to June 30, 2003, and to the period July 1, 2003 to June 30, 2004, and to the period July 1, 2004 to June 30, 2005, and to the period July 1, 2005 to June 30, 2006, and to the period July 1, 2006 to June 30, 2007, and to the period July 1, 2007 to June 30, 2008, and to the period July 1, 2008 to June 30, 2009, and to the period July 1, 2009 to June 30, 2010, and to the period July 1, 2010 to June 30, 2011, and to the period July 1, 2011 to June 30, 2012, and to the period July 1, 2012 to June 30, 2013, and to the period July 1, 2013 to June 30, 2014, and to the period July 1, 2014 to June 30, 2015, and to the period July 1, 2015 to June 30, 2016, and to the period July 1, 2016 to June 30, 2017 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 for a physician or dentist where such excess insurance coverage or equivalent excess coverage is cancelled in accordance with paragraph (c) of this subdivision.

§ 5. 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 4 of part Y of chapter 57 of the laws of 2015, 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, [2016] 2017; 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, [2016] 2017, 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, [2016] 2017 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.

§ 6. Section 5 and subdivisions (a) and (e) of section 6 of part J of chapter 63 of the laws of 2001, amending chapter 266 of the laws of 1986, amending the civil practice law and rules and other laws relating to malpractice and professional medical conduct, as amended by section 5

of part Y of chapter 57 of the laws of 2015, 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, [and] June 15, 2016, and June 15, 2017 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 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 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, [and] June 15, 2016, and June 15, 2017 as applicable.

§ 7. 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 liabil-

ity pool, a full or partial policy for excess coverage or equivalent excess coverage for the coverage period ending the thirtieth of June, two thousand sixteen, shall be eligible to apply for such coverage for the coverage period beginning the first of July, two thousand sixteen; 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 sixteen exceeds the total number of physicians or dentists certified as eligible for the coverage period beginning the first of July, two thousand sixteen, 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 sixteen, 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 sixteen 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 sixteen.

§ 8. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2016, provided, however, section two of this act shall take effect July 1, 2016.

PART D

Section 1. Paragraph (a) of subdivision 1 of section 212 of chapter 474 of the laws of 1996, amending the education law and other laws relating to rates for residential healthcare facilities, as amended by section 2 of part B of chapter 56 of the laws of 2013, is amended to read as follows:

(a) Notwithstanding any inconsistent provision of law or regulation to the contrary, effective beginning August 1, 1996, for the period April 1, 1997 through March 31, 1998, April 1, 1998 for the period April 1, 1998 through March 31, 1999, August 1, 1999, for the period April 1, 1999 through March 31, 2000, April 1, 2000, for the period April 1, 2000 through March 31, 2001, April 1, 2001, for the period April 1, 2001 through March 31, 2002, April 1, 2002, for the period April 1, 2002 through March 31, 2003, and for the state fiscal year beginning April 1, 2005 through March 31, 2006, and for the state fiscal year beginning April 1, 2006 through March 31, 2007, and for the state fiscal year beginning April 1, 2007 through March 31, 2008, and for the state fiscal year beginning April 1, 2008 through March 31, 2009, and for the state fiscal year beginning April 1, 2009 through March 31, 2010, and for the state fiscal year beginning April 1, 2010 through March 31, 2016, <u>and annually thereafter,</u> the department of health is authorized to pay public general hospitals, as defined in subdivision 10 of section 2801 of the public health law, operated by the state of New York or by the state university of New York or by a county, which shall not include a city with a population of over one million, of the state of New York, and those public general hospitals located in the county of Westchester, the county of Erie or the county of Nassau, additional payments for inpatient hospital services as medical assistance payments pursuant to title 11 of article 5 of the social services law for patients eligible for federal financial participation under title XIX of the federal

social security act in medical assistance pursuant to the federal laws and regulations governing disproportionate share payments to hospitals up to one hundred percent of each such public general hospital's medical assistance and uninsured patient losses after all other medical assistance, including disproportionate share payments to such public general hospital for 1996, 1997, 1998, and 1999, based initially for 1996 on reported 1994 reconciled data as further reconciled to actual reported 1996 reconciled data, and for 1997 based initially on reported 1995 reconciled data as further reconciled to actual reported 1997 reconciled data, for 1998 based initially on reported 1995 reconciled data as further reconciled to actual reported 1998 reconciled data, for 1999 based initially on reported 1995 reconciled data as further reconciled to actual reported 1999 reconciled data, for 2000 based initially on reported 1995 reconciled data as further reconciled to actual reported 2000 data, for 2001 based initially on reported 1995 reconciled data as further reconciled to actual reported 2001 data, for 2002 based initially on reported 2000 reconciled data as further reconciled to actual reported 2002 data, and for state fiscal years beginning on April 1, 2005, based initially on reported 2000 reconciled data as further reconciled to actual reported data for 2005, and for state fiscal years beginning on April 1, 2006, based initially on reported 2000 reconciled data as further reconciled to actual reported data for 2006, for state fiscal years beginning on and after April 1, 2007 through March 31, 2009, based initially on reported 2000 reconciled data as further reconciled to actual reported data for 2007 and 2008, respectively, for state fiscal years beginning on and after April 1, 2009, based initially on reported 2007 reconciled data, adjusted for authorized Medicaid rate changes applicable to the state fiscal year, and as further reconciled to actual reported data for 2009, for state fiscal years beginning on and after April 1, 2010, based initially on reported reconciled data from the base year two years prior to the payment year, adjusted for authorized Medicaid rate changes applicable to the state fiscal year, and further reconciled to actual reported data from such payment year, and to actual reported data for each respective succeeding year. The payments may be added to rates of payment or made as aggregate payments to an eligible public general hospital.

§ 2. Section 10 of chapter 649 of the laws of 1996, amending the public health law, the mental hygiene law and the social services law relating to authorizing the establishment of special needs plans, as amended by section 20 of part D of chapter 59 of the laws of 2011, is amended to read as follows:

§ 10. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after July 1, 1996[; provided, however, that sections one, two and three of this act shall expire and be deemed repealed on March 31, 2016 provided, however that the amendments to section 364-j of the social services law made by section four of this act shall not affect the expiration of such section and shall be deemed to expire therewith and provided, further, that the provisions of subdivisions 8, 9 and 10 of section 4401 of the public health law, as added by section one of this act; section 4403-d of the public health law as added by section two of this act and the provisions of section seven of this act, except for the provisions relating to the establishment of no more than twelve comprehensive HIV special needs plans, shall expire and be deemed repealed on July 1, 2000].

§ 3. Subdivision 8 of section 84 of part A of chapter 56 of the laws of 2013, amending the public health law and other laws relating to general hospital reimbursement for annual rates is REPEALED.

§ 4. Subdivision (f) of section 129 of part C of chapter 58 of the laws of 2009, amending the public health law relating to payment by governmental agencies for general hospital inpatient services, is REPEALED.

§ 5. Subdivision (c) of section 122 of part E of chapter 56 of the laws of 2013 amending the public health law relating to the general public health work program is REPEALED.

§ 6. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2016.

PART E

Section 1. Subdivisions 9 and 10 of section 2541 of the public health law, as added by chapter 428 of the laws of 1992, are amended to read as follows:

9. "Evaluation" means a multidisciplinary professional, objective [assessment] examination conducted by appropriately qualified personnel and conducted pursuant to section twenty-five hundred forty-four of this title to determine a child's eligibility under this title.

10. "Evaluator" means a [team of two or more professionals approved pursuant to section twenty-five hundred fifty-one of this title] provider approved by the department to conduct screenings and evaluations.

§ 2. Section 2541 of the public health law is amended by adding two new subdivisions 12-a and 15-a to read as follows:

12-a. "Multidisciplinary" means the involvement of two or more separate disciplines or professions, which may mean the involvement of one individual who meets the definition of qualified personnel as defined in subdivision fifteen of this section and who is qualified, in accordance with state licensure, certification or other comparable standards, to evaluate all five developmental domains.

15-a. "Screening" means the procedures used by qualified personnel, as defined in subdivision fifteen of this section, to determine whether a child is suspected of having a disability and in need of early intervention services, and shall include, where available and appropriate for the child, the administration of a standardized instrument or instruments approved by the department, in accordance with subdivision three of section twenty-five hundred forty-four of this title.

§ 3. Subdivision 3 of section 2542 of the public health law, as amended by chapter 231 of the laws of 1993, is amended to read as follows:

3. [The following persons and entities, within] (a) Unless the parent objects, within two working days of identifying an infant or toddler suspected of having a disability or at risk of having a disability, the following persons and entities shall refer such infant or toddler to the early intervention official or the health officer [of the public health district in which the infant or toddler resides, as designated by the municipality, but in no event over the objection of the parent made in accordance with procedures established by the department for use by such primary referral sources, unless the child has already been referred] of the public health district designated by the municipality in which the infant or toddler resides: hospitals, child health care providers, day care programs, local school districts, public health facilities, early childhood direction centers and such other social service and health

care agencies and providers as the commissioner shall specify in regulation[; provided, however, that the]. This shall not apply if the infant or toddler has already been referred to such early intervention official or health officer. The department shall establish procedures, including regulations if required, to ensure that primary referral sources adequately inform the parent or guardian about the early intervention program, including through brochures and written materials created or approved by the department.

(b) The primary referral sources identified in paragraph (a) of this subdivision shall, with parental consent, complete and transmit at the time of referral, a referral form developed by the department which contains information sufficient to document the primary referral source's concern or basis for suspecting the child has a disability or is at risk of having a disability, and where applicable, specifies the child's diagnosed condition that establishes the child's eligibility for the early intervention program. The primary referral source shall inform the parent of a child with a diagnosed condition that has a high probability of resulting in developmental delay, that (i) eligibility for the program may be established by medical or other records and (ii) of the importance of providing consent for the primary referral source to transmit records or reports necessary to support the diagnosis, or, for parents or guardians of children who do not have a diagnosed condition, records or reports that would assist in determining eligibility for the program.

§ 4. Section 2544 of the public health law, as added by chapter 428 of the laws of 1992, paragraph (c) of subdivision 2 as added by section 1 of part A of chapter 56 of the laws of 2012 and subdivision 11 as added by section 3 of part B3 of chapter 62 of the laws of 2003, is amended to read as follows:

§ 2544. Screening and evaluations. 1. Each child thought to be an eligible child is entitled to [a multidisciplinary] an evaluation conducted in accordance with this section, and the early intervention official shall ensure such evaluation, with parental consent.

2. (a) The parent may select an evaluator from the list of approved evaluators as described in section twenty-five hundred forty-two of this title to conduct the applicable screening and/or evaluation in accordance with this section. The parent or evaluator shall immediately notify the early intervention official of such selection. The evaluator shall review the information and documentation provided with the referral to determine the appropriate screening or evaluation process to follow in accordance with this section. The evaluator may begin the screening or evaluation no sooner than four working days after such notification, unless otherwise approved by the initial service coordinator.

(b) [the evaluator shall designate an individual as the principal contact for the multidisciplinary team] Initial service coordinators shall inform the parent of the applicable screening or evaluation procedures that may be performed. For a child referred to the early intervention official who has a diagnosed physical or mental condition that has a high probability of resulting in developmental delay, the initial service coordinator shall inform the parent that the evaluation of the child shall be conducted in accordance with the procedures set forth in subdivision five of this section.

(c) If, in consultation with the evaluator, the service coordinator identifies a child that is potentially eligible for programs or services offered by or under the auspices of the office for people with develop-

mental disabilities, the service coordinator shall, with parent consent, notify the office for people with developmental disabilities' regional developmental disabilities services office of the potential eligibility of such child for said programs or services.

3. [(a) To determine eligibility, an evaluator shall, with parental consent, either (i) screen a child to determine what type of evaluation, if any, is warranted, or (ii) provide a multidisciplinary evaluation. In making the determination whether to provide an evaluation, the evaluator may rely on a recommendation from a physician or other qualified person as designated by the commissioner.

(b)] Screenings for children referred to the early intervention program to determine whether they are suspected of having a disability. (a) For a child referred to the early intervention program, the evaluator shall first perform a screening of the child, with parental consent, to determine whether the child is suspected of having a disability.

(b) The evaluator shall utilize a standardized instrument or instruments approved by the department to conduct the screening. If the evaluator does not utilize a standardized instrument or instruments approved by the department for the screening, the evaluator shall document in writing why such standardized instrument or instruments are unavailable or inappropriate for the child.

(c) The evaluator shall explain the results of the screening to the parent and shall fully document the results in writing.

(d) If, based upon the screening, a child is [believed to be eligible, or if otherwise elected by the parent] suspected of having a disability, the child shall, with [the consent of a parent] parental consent, receive [a multidisciplinary evaluation. All evaluations shall be conducted in accordance with] an evaluation to be conducted in accordance with the procedures set forth in subdivision four of this section, the coordinated standards and procedures and with regulations promulgated by the commissioner.

(e) If, based upon the screening, a child is not suspected of having a disability, an evaluation shall not be provided, unless requested by the parent. The early intervention official shall provide the parent with written notice of the screening results, which shall include information on the parent's right to request an evaluation.

(f) A screening shall not be provided to children who are referred to the early intervention program who have a diagnosed physical or mental condition with a high probability of resulting in developmental delay that establishes eligibility for the program.

4. The evaluation of [each] a child shall:

(a) include the administration of an evaluation standardized instrument or instruments approved by the department. If the evaluator does not utilize a standardized instrument or instruments approved by the department as part of the evaluation of the child, the evaluator shall document in writing why such standardized instrument or instruments are not appropriate or available for the child;

(b) be conducted by personnel trained to utilize appropriate methods and procedures;

[(b)] (c) be based on informed clinical opinion;

[(c)] (d) be made without regard to the availability of services in the municipality or who might provide such services; [and

(d)] (e) with parental consent, include the following:

(i) a review of pertinent records related to the child's current health status and medical history; and

(ii) an evaluation of the child's level of functioning in each of the developmental areas set forth in paragraph (c) of subdivision seven of section twenty-five hundred forty-one of this title[;] to determine whether the child has a disability as defined in this title that establishes the child's eligibility for the program; and

(f) if the child has been determined eligible by the evaluator after conducting the procedures set forth in paragraphs (a) through (e) of this subdivision, the evaluation shall also include:

[(iii)] (i) an assessment [of the unique needs of the child in terms of] for the purposes of identifying the child's unique strengths and needs in each of the developmental areas [set forth in paragraph (c) of subdivision seven of section twenty-five hundred forty-one of this title, including the identification of] and the early intervention services appropriate to meet those needs;

[(iv)] (ii) a family-directed assessment, if consented to by the family, in order to identify the family's resources, priorities, and concerns and the supports necessary to enhance the family's capacity to meet the developmental needs of the child. The family assessment shall be voluntary on the part of each family member participating in the assessment;

(iii) an [evaluation] assessment of the transportation needs of the child, if any; and

[(v)] (iv) such other matters as the commissioner may prescribe in regulation.

5. Evaluations for children who are referred to the early intervention official with diagnosed physical or mental conditions that have a high probability of resulting in developmental delay. (a) If a child has a diagnosed physical or mental condition that has a high probability of resulting in developmental delay, the child's medical or other records shall be used, when available, to establish the child's eligibility for the program.

(b) The evaluator shall, upon review of the referral form provided in accordance with section twenty-five hundred forty-two of this title or any medical or other records, or at the time of initial contact with the child's family, determine whether the child has a diagnosed condition that establishes the child's eligibility for the program. If the evaluator has reason to believe, after speaking with the child's family, that the child may have a diagnosed condition that establishes the child's eligibility but the evaluator has not been provided with medical or other documentation of such diagnosis, the evaluator shall, with parental consent, obtain such documentation, when available, prior to proceeding with the evaluation of the child.

(c) The evaluator shall review all records received to document that the child's diagnosis as set forth in such records establishes the child's eligibility for the early intervention program.

(d) Notwithstanding subdivision four of this section, if the child's eligibility for the early intervention program is established in accordance with this subdivision, the evaluation of the child shall (i) consist of a review of the results of the medical or other records that established the child's eligibility, and any other pertinent evaluations or records available and (ii) comply with the procedures set forth in paragraph (f) of subdivision four of this section. The evaluation procedures set forth in paragraphs (a) and (e) of subdivision four shall not be required or conducted.

6. An evaluation shall not include a reference to any specific provider of early intervention services.

[6.] 7. Nothing in this section shall restrict an evaluator from utilizing, in addition to findings from his or her personal examination, other examinations, evaluations or assessments conducted for such child, including those conducted prior to the evaluation under this section, if such examinations, evaluations or assessments are consistent with the coordinated standards and procedures.

[7.] 8. Following completion of the evaluation, the evaluator shall provide the parent and service coordinator with a copy of a summary of the full evaluation. To the extent practicable, the summary shall be provided in the native language of the parent. Upon request of the parent, early intervention official or service coordinator, the evaluator shall provide a copy of the full evaluation to such parent, early intervention official or service coordinator.

[8.] 9. A parent who disagrees with the results of an evaluation may obtain an additional evaluation or partial evaluation at public expense to the extent authorized by federal law or regulation.

[9.] 10. Upon receipt of the results of an evaluation, a service coordinator may, with parental consent, require additional diagnostic information regarding the condition of the child, provided, however, that such evaluation or assessment is not unnecessarily duplicative or invasive to the child, and provided further, that:

(a) where the evaluation has established the child's eligibility, such additional diagnostic information shall be used solely to provide additional information to the parent and service coordinator regarding the child's need for services and cannot be a basis for refuting eligibility;

(b) the service coordinator provides the parent with a written explanation of the basis for requiring additional diagnostic information;

(c) the additional diagnostic procedures are at no expense to the parent; and

(d) the evaluation is completed and a meeting to develop an IFSP is held within the time prescribed in subdivision one of section twenty-five hundred forty-five of this title.

[10.] 11. (a) If the screening indicates that the infant or toddler is not an eligible child and the parent elects not to have an evaluation, or if the evaluation indicates that the infant or toddler is not an eligible child, the service coordinator shall inform the parent of other programs or services that may benefit such child, and the child's family and, with parental consent, refer such child to such programs or services.

(b) A parent may appeal a determination that a child is ineligible pursuant to the provisions of section twenty-five hundred forty-nine of this title, provided, however, that a parent may not initiate such appeal until all evaluations are completed. In addition, for a child referred to the early intervention official who has a diagnosed physical or mental condition that establishes the child's eligibility for the program in accordance with subdivision five of this section, the parent may request, and such request shall be granted, that the evaluator conduct the evaluation procedures set forth in paragraphs (a) through (e) of subdivision four of this section, provided, however, that the parent may not make such request until the evaluation conducted in accordance with subdivision five of this section is completed.

[11.] 12. Notwithstanding any other provision of law to the contrary, where a request has been made to review an IFSP prior to the six-month interval provided in subdivision seven of section twenty-five hundred forty-five of this title for purposes of increasing frequency or dura-

tion of an approved service, including service coordination, the early intervention official may require an additional evaluation or partial evaluation at public expense by an approved evaluator other than the current provider of service, with parent consent.

§ 5. Paragraph (a) of subdivision 3 of section 2559 of the public health law, is amended by adding two new subparagraphs (iv) and (v) to read as follows:

(iv) Providers shall submit all claims, in accordance with subparagraph (iii) of this paragraph and within ninety days of the date of service, unless the submission is delayed due to extraordinary circumstances documented by the provider. All claims submitted after ninety days shall be submitted within thirty days from the time the provider was relieved from the extraordinary circumstances that previously delayed a timely submission. Claims that are not submitted within timeframes set forth will not be reimbursed by the department's fiscal agent from the escrow account funded by municipal governmental payers.

(v) Providers shall enroll, on request of the department or the department's fiscal agent, with one or more health care clearinghouses, as necessary, for processing of claims to third party payors and for receipt of remittance advices in standard electronic format and in compliance with any applicable federal or state regulations with respect to electronic claims transactions.

§ 6. Section 3224-a of the insurance law, as amended by chapter 666 of the laws of 1997, the opening paragraph and subsections (a), (b) and (c) as amended and subsections (g) and (h) as added by chapter 237 of the laws of 2009, paragraph 2 of subsection (d) as amended by section 57-b of part A of chapter 56 of the laws of 2013, subsection (i) as added by chapter 297 of the laws of 2012 and subsection (j) as added by section 5 of part H of chapter 60 of the laws of 2014, is amended to read as follows:

§ 3224-a. Standards for prompt, fair and equitable settlement of claims for health care and payments for health care services. In the processing of all health care claims submitted under contracts or agreements issued or entered into pursuant to this article and articles forty-two, forty-three and forty-seven of this chapter and article forty-four of the public health law and all bills for health care services rendered by health care providers pursuant to such contracts or agreements, any insurer or organization or corporation licensed or certified pursuant to article forty-three or forty-seven of this chapter or article forty-four of the public health law shall adhere to the following standards:

(a) Except in a case where the obligation of an insurer or an organization or corporation licensed or certified pursuant to article forty-three or forty-seven of this chapter or article forty-four of the public health law to pay a claim submitted by a policyholder or person covered under such policy ("covered person") or make a payment to a health care provider is not reasonably clear, or when there is a reasonable basis supported by specific information available for review by the superintendent that such claim or bill for health care services rendered was submitted fraudulently, such insurer or organization or corporation shall pay the claim to a policyholder or covered person or make a payment to a health care provider within thirty days of receipt of a claim or bill for services rendered that is transmitted via the internet or electronic mail, or forty-five days of receipt of a claim or bill for services rendered that is submitted by other means, such as paper or facsimile.

(a-1) An insurer, organization, including an approved organization as defined in subdivision two of section twenty-five hundred ten of the public health law, or corporation shall, within fifteen business days of receipt of a claim or bill for services rendered under the early intervention program, established in title two-A of article twenty-five of the public health law, notify the health care provider, in a manner and format determined by the department of health, through the department of health's designated fiscal agent, whether the contract or agreement is subject to the provisions of this chapter.

(b) In a case where the obligation of an insurer or an organization or corporation licensed or certified pursuant to article forty-three or forty-seven of this chapter or article forty-four of the public health law to pay a claim or make a payment for health care services rendered is not reasonably clear due to a good faith dispute regarding the eligibility of a person for coverage, the liability of another insurer or corporation or organization for all or part of the claim, the amount of the claim, the benefits covered under a contract or agreement, or the manner in which services were accessed or provided, an insurer or organization or corporation shall pay any undisputed portion of the claim in accordance with this subsection and notify the policyholder, covered person or health care provider in writing within thirty calendar days of the receipt of the claim:

(1) that it is not obligated to pay the claim or make the medical payment, stating the specific reasons why it is not liable; or

(2) to request all additional information needed to determine liability to pay the claim or make the health care payment, except that with respect to a claim or bill for services rendered under the early intervention program established in title two-A of article twenty-five of the public health law, the insurer or corporation or organization, including an approved organization as defined in subdivision two of section twenty-five hundred ten of the public health law, shall request such additional information from the health care provider within fifteen business days of receipt of the claim.

Upon receipt of the information requested in paragraph two of this subsection or an appeal of a claim or bill for health care services denied pursuant to paragraph one of this subsection, an insurer or organization or corporation licensed or certified pursuant to article forty-three or forty-seven of this chapter or article forty-four of the public health law shall comply with subsection (a) of this section.

(c) (1) Except as provided in [paragraph] paragraphs two and three of this subsection, each claim or bill for health care services processed in violation of this section shall constitute a separate violation. In addition to the penalties provided in this chapter, any insurer or organization or corporation that fails to adhere to the standards contained in this section shall be obligated to pay to the health care provider or person submitting the claim, in full settlement of the claim or bill for health care services, the amount of the claim or health care payment plus interest on the amount of such claim or health care payment of the greater of the rate equal to the rate set by the commissioner of taxation and finance for corporate taxes pursuant to paragraph one of subsection (e) of section one thousand ninety-six of the tax law or twelve percent per annum, to be computed from the date the claim or health care payment was required to be made. When the amount of interest due on such a claim is less [then] than two dollars, and insurer or organization or corporation shall not be required to pay interest on such claim.

(2) Where a violation of this section is determined by the superintendent as a result of the superintendent's own investigation, examination, audit or inquiry, an insurer or organization or corporation licensed or certified pursuant to article forty-three or forty-seven of this chapter or article forty-four of the public health law shall not be subject to a civil penalty prescribed in paragraph one of this subsection, if the superintendent determines that the insurer or organization or corporation has otherwise processed at least ninety-eight percent of the claims submitted in a calendar year in compliance with this section; provided, however, nothing in this paragraph shall limit, preclude or exempt an insurer or organization or corporation from payment of a claim and payment of interest pursuant to this section. This paragraph shall not apply to violations of this section determined by the superintendent resulting from individual complaints submitted to the superintendent by health care providers or policyholders.

(3) Where an insurer or organization, including an approved organization as defined in subdivision two of section twenty-five hundred ten of the public health law, or corporation fails to adhere to the standards contained in this section in relation to a claim or bill for services submitted for a service rendered under the early intervention program established in title two-A of article twenty-five of the public health law, the claim or bill for services shall be deemed covered or payable under the contract or agreement, and the insurer or organization or corporation shall be obligated to pay such claim or bill for services at the higher of either a rate established by the commissioner of health or a rate negotiated by the insurer in accordance with regulation.

(d) For the purposes of this section:

(1) "policyholder" shall mean a person covered under such policy or a representative designated by such person; and

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

(e) Nothing in this section shall in any way be deemed to impair any right available to the state to adjust the timing of its payments for medical assistance pursuant to title eleven of article five of the social services law, or for child health insurance plan benefits pursuant to title one-a of article twenty-five of the public health law or otherwise be deemed to require adjustment of payments by the state for such medical assistance or child health insurance.

(f) In any action brought by the superintendent pursuant to this section or article twenty-four of this chapter relating to this section regarding payments for medical assistance pursuant to title eleven of article five of the social services law, child health insurance plan benefits pursuant to title one-a of article twenty-five of the public health law, benefits under the voucher insurance program pursuant to section one thousand one hundred twenty-one of this chapter, and benefits under the New York state small business health insurance partnership program pursuant to article nine-A of the public health law, it

shall be a mitigating factor that the insurer, corporation or organization is owed any premium amounts, premium adjustments, stop-loss recoveries or other payments from the state or one of its fiscal intermediaries under any such program.

(g) Time period for submission of claims. (1) Except as otherwise provided by law, health care claims must be initially submitted by health care providers within one hundred twenty days after the date of service to be valid and enforceable against an insurer or organization or corporation licensed or certified pursuant to article forty-three or article forty-seven of this chapter or article forty-four of the public health law. Provided, however, that nothing in this subsection shall preclude the parties from agreeing to a time period or other terms which are more favorable to the health care provider. Provided further that, in connection with contracts between organizations or corporations licensed or certified pursuant to article forty-three of this chapter or article forty-four of the public health law and health care providers for the provision of services pursuant to section three hundred sixty-four-j or three hundred sixty-nine-ee of the social services law or title I-A of article twenty-five of the public health law, nothing herein shall be deemed: (i) to preclude the parties from agreeing to a different time period but in no event less than ninety days; or (ii) to supersede contract provisions in existence at the time this subsection takes effect except to the extent that such contracts impose a time period of less than ninety days.

(2) This subsection shall not abrogate any right or reduce or limit any additional time period for claim submission provided by law or regulation specifically applicable to coordination of benefits in effect prior to the effective date of this subsection.

(h) (1) An insurer or organization or corporation licensed or certified pursuant to article forty-three or article forty-seven of this chapter or article forty-four of the public health law shall permit a participating health care provider to request reconsideration of a claim that is denied exclusively because it was untimely submitted pursuant to subsection (g) of this section. The insurer or organization or corporation shall pay such claim pursuant to the provisions of paragraph two of this subsection if the health care provider can demonstrate both that: (i) the health care provider's non-compliance was a result of an unusual occurrence; and (ii) the health care provider has a pattern or practice of timely submitting claims in compliance with [subdivision] <u>subsection</u> (g) of this section.

(2) An insurer or organization or corporation licensed or certified pursuant to article forty-three or article forty-seven of this chapter or article forty-four of the public health law may reduce the reimbursement due to a health care provider for an untimely claim that otherwise meets the requirements of paragraph one of this subsection by an amount not to exceed twenty-five percent of the amount that would have been paid had the claim been submitted in a timely manner; provided, however, that nothing in this subsection shall preclude a health care provider and an insurer or organization or corporation from agreeing to a lesser reduction. The provisions of this subsection shall not apply to any claim submitted three hundred sixty-five days after the date of service, in which case the insurer or organization or corporation may deny the claim in full.

(i) Except where the parties have developed a mutually agreed upon process for the reconciliation of coding disputes that includes a review of submitted medical records to ascertain the correct coding for

payment, a general hospital certified pursuant to article twenty-eight of the public health law shall, upon receipt of payment of a claim for which payment has been adjusted based on a particular coding to a patient including the assignment of diagnosis and procedure, have the opportunity to submit the affected claim with medical records supporting the hospital's initial coding of the claim within thirty days of receipt of payment. Upon receipt of such medical records, an insurer or an organization or corporation licensed or certified pursuant to article forty-three or forty-seven of this chapter or article forty-four of the public health law shall review such information to ascertain the correct coding for payment and process the claim in accordance with the time-frames set forth in subsection (a) of this section. In the event the insurer, organization, or corporation processes the claim consistent with its initial determination, such decision shall be accompanied by a statement of the insurer, organization or corporation setting forth the specific reasons why the initial adjustment was appropriate. An insurer, organization, or corporation that increases the payment based on the information submitted by the general hospital, but fails to do so in accordance with the timeframes set forth in subsection (a) of this section, shall pay to the general hospital interest on the amount of such increase at the rate set by the commissioner of taxation and finance for corporate taxes pursuant to paragraph one of subdivision (e) of section one thousand ninety-six of the tax law, to be computed from the end of the forty-five day period after resubmission of the addi-tional medical record information. Provided, however, a failure to remit timely payment shall not constitute a violation of this section. Neither the initial or subsequent processing of the claim by the insur-er, organization, or corporation shall be deemed an adverse determi-nation as defined in section four thousand nine hundred of this chapter if based solely on a coding determination. Nothing in this subsection shall apply to those instances in which the insurer or organization, or corporation has a reasonable suspicion of fraud or abuse.

(j) An insurer or an organization or corporation licensed or certified pursuant to article forty-three or forty-seven of this chapter or arti-cle forty-four of the public health law or a student health plan estab-lished or maintained pursuant to section one thousand one hundred twen-ty-four of this chapter shall accept claims submitted by a policyholder or covered person, in writing, including through the internet, by elec-tronic mail or by facsimile.

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

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

(b) Where a policy of accident and health insurance, including a contract issued pursuant to article forty-three of this chapter, provides coverage for an early intervention program service, such cover-age shall not be applied against any maximum annual or lifetime monetary limits set forth in such policy or contract. Visit limitations [and other terms and conditions of the policy] will continue to apply to early intervention services. However, any visits used for early inter-

vention program services shall not reduce the number of visits otherwise available under the policy or contract for such services. When such policy of accident and health insurance, including a contract issued pursuant to article forty-three and section eleven hundred twenty of this chapter, provides coverage for essential health benefits, as defined in section 1302(b) of the Affordable Care Act, 42 U.S.C. § 18022(b), and constitutes early intervention services as set forth in paragraph (h) of subdivision seven of section twenty-five hundred forty-one of the public health law, or early intervention evaluation services as set forth in subdivision nine of section twenty-five hundred forty-one of the public health law, a written order, referral, recommendation for diagnostic services to determine program eligibility, or the individualized family services plan certified by the early intervention official, as defined in section twenty-five hundred forty-one of the public health law or such official's designee, shall be sufficient to meet precertification, preauthorization and/or medical necessity requirements imposed under such policy.

(c) Reimbursement for any early intervention program service, as set forth in paragraph (h) of subdivision seven of section twenty-five hundred forty-one of the public health law, or early intervention evaluation service, as set forth in subdivision nine of section twenty-five hundred forty-one of the public health law, that is a covered service under the policy of accident and health insurance, including a contract issued pursuant to article forty-three of this chapter, shall be at the higher of either a rate established by the commissioner of health or a rate negotiated by the insurer in accordance with regulation.

(d) A policy of accident and health insurance, including a contract issued pursuant to article forty-three and section eleven hundred twenty of this chapter, shall not deny coverage based on the following:

(i) the location where services are provided;

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

(iii) the service is not a covered benefit but is an essential health benefit as defined in section 1302(b) of the Affordable Care Act, 42 U.S.C. § 18022(b); or

(iv) the provider of services is not a participating provider in the insurer's network.

[(c)] (e) Any right of subrogation to benefits which a municipality or provider is entitled in accordance with paragraph (d) of subdivision three of section twenty-five hundred fifty-nine of the public health law shall be valid and enforceable to the extent benefits are available under any accident and health insurance policy. The right of subrogation does not attach to insurance benefits paid or provided under any accident and health insurance policy prior to receipt by the insurer of written notice from the municipality or provider, as applicable. If an insurer makes payment in whole or in part for a claim or bill for services rendered under the early intervention program established in title two-A of article twenty-five of the public health law, such payment shall be made to the provider who submitted the claim and not to the rendering professional who delivered the service or the covered person regardless of whether such provider is in the insurer's network. The insurer shall provide the municipality and service coordinator with information on the extent of benefits available to the covered person under such policy within fifteen days of the insurer's receipt of written request and notice authorizing such release. The service coordinator

shall provide such information to the rendering provider assigned to provide services to the child.

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

§ 8. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2016; provided however, that the amendments to section 3224-a of the insurance law as made by section six of this act and the amendments to section 3235-a of the insurance law as made by section seven of this act shall apply only to policies, benefit packages, and contracts issued, renewed, modified, altered or amended on or after such date.

PART F

Section 1. Section 2825-b of the public health law, as added by section 2 of part J of chapter 60 of the laws of 2015, is amended to read as follows:

§ 2825-b. [Oneida county health] Health care facility transformation program: [Oneida county project] Statewide. 1. [An Oneida county] 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 capital funding in support of projects [located in the largest population center in Oneida county that consolidate multiple licensed health care facilities into an integrated system of care] that replace inefficient and outdated facilities as part of a merger, consolidation, acquisition or other significant corporate restructuring activity that is part of an overall transformation plan intended to create a financially sustainable system of care. The issuance of any bonds or notes hereunder shall be subject to 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 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 and the president of the authority for capital grants to general hospitals [for the purposes of consolidating multiple licensed health care facilities into an integrated system of care], residential health care facilities, diagnostic and treatment centers and clinics licensed pursuant to this chapter or the mental hygiene law, primary care providers, and home care providers certified or licensed pursuant to article thirty-six of this chapter, for capital non-operational works or purposes that support the purposes set forth in this section. A copy of such agreement, and any amendments thereto, shall be provided to the chair of the senate finance committee, the chair of the assembly ways and means committee, and the director of the

division of 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 section twenty-eight hundred twenty-five 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 [three] two hundred million dollars of the funds appropriated for this program shall be awarded without a competitive bid or request for proposal process for capital grants to health care providers (hereafter "applicants") [located in the county of Oneida]. Eligible applicants shall be those deemed by the commissioner to be a provider that fulfills or will fulfill a health care need for acute inpatient, outpatient, primary, home care or residential health care services in a community.

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

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

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

(c) consideration of geographic distribution of funds;

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

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

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

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

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

[(g)] (i) the extent to which the proposed capital 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 health care transformation and provider sustainability 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, senate health and assembly health committees. Such reports shall be submitted no later than sixty days after the close of the quarter, and shall [conform to the reporting requirements of subdivision twenty of section twenty-eight hundred seven of this article, as applicable] 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, 2016.

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 services 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 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

Section 1. Section 1 of part D of chapter 111 of the laws of 2010 relating to the recovery of exempt income by the office of mental health for community residences and family-based treatment programs, as amended by section 1 of part JJ of chapter 58 of the laws of 2015, is amended to read as follows:

Section 1. The office of mental health is authorized to recover funding from community residences and family-based treatment providers licensed by the office of mental health, consistent with contractual obligations of such providers, and notwithstanding any other inconsistent provision of law to the contrary, in an amount equal to 50 percent of the income received by such providers which exceeds the fixed amount of annual Medicaid revenue limitations, as established by the commissioner of mental health. Recovery of such excess income shall be for the following fiscal periods: for programs in counties located outside of the city of New York, the applicable fiscal periods shall be January 1, 2003 through December 31, 2009 and January 1, 2011 through December 31, [2016] 2019; and for programs located within the city of New York, the applicable fiscal periods shall be July 1, 2003 through June 30, 2010 and July 1, 2011 through June 30, [2016] 2019.

§ 2. This act shall take effect immediately.

PART I

Section 1. Sections 19 and 21 of chapter 723 of the laws of 1989 amending the mental hygiene law and other laws relating to comprehensive psychiatric emergency programs, as amended by section 1 of part K of chapter 56 of the laws of 2012, are amended to read as follows:

§ 19. Notwithstanding any other provision of law, the commissioner of mental health shall, until July 1, [2016] 2020, be solely authorized, in his or her discretion, to designate those general hospitals, local governmental units and voluntary agencies which may apply and be considered for the approval and issuance of an operating certificate pursuant to article 31 of the mental hygiene law for the operation of a comprehensive psychiatric emergency program.

§ 21. This act shall take effect immediately, and sections one, two and four through twenty of this act shall remain in full force and effect, until July 1, [2016] 2020, at which time the amendments and additions made by such sections of this act shall be deemed to be repealed, and any provision of law amended by any of such sections of

this act shall revert to its text as it existed prior to the effective date of this act.

§ 2. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2016.

PART J

Section 1. Subdivision a of section 9 of chapter 420 of the laws of 2002 amending the education law relating to the profession of social work, as amended by section 1 of part AA of chapter 57 of the laws of 2013, is amended to read as follows:

a. Nothing in this act shall prohibit or limit the activities or services on the part of any person in the employ of a program or service operated, regulated, funded, or approved by the department of mental hygiene, the office of children and family services, the office of temporary and disability assistance, the department of corrections and community supervision, the state office for the aging, the department of health, or a local governmental unit as that term is defined in article 41 of the mental hygiene law or a social services district as defined in section 61 of the social services law, provided, however, this section shall not authorize the use of any title authorized pursuant to article 154 of the education law, except that this section shall be deemed repealed on July 1, [2016] 2021.

§ 2. Subdivision a of section 17-a of chapter 676 of the laws of 2002 amending the education law relating to the practice of psychology, as amended by section 2 of part AA of chapter 57 of the laws of 2013, is amended to read as follows:

a. In relation to activities and services provided under article 153 of the education law, nothing in this act shall prohibit or limit such activities or services on the part of any person in the employ of a program or service operated, regulated, funded, or approved by the department of mental hygiene or the office of children and family services, or a local governmental unit as that term is defined in article 41 of the mental hygiene law or a social services district as defined in section 61 of the social services law. In relation to activities and services provided under article 163 of the education law, nothing in this act shall prohibit or limit such activities or services on the part of any person in the employ of a program or service operated, regulated, funded, or approved by the department of mental hygiene, the office of children and family services, the department of corrections and community supervision, the office of temporary and disability assistance, the state office for the aging and the department of health or a local governmental unit as that term is defined in article 41 of the mental hygiene law or a social services district as defined in section 61 of the social services law, pursuant to authority granted by law. This section shall not authorize the use of any title authorized pursuant to article 153 or 163 of the education law by any such employed person, except as otherwise provided by such articles respectively. This section shall be deemed repealed July 1, [2016] 2021.

§ 3. Section 16 of chapter 130 of the laws of 2010 amending the education law and other laws relating to the registration of entities providing certain professional services and the licensure of certain professions, as amended by section 3 of part AA of chapter 57 of the laws of 2013, is amended to read as follows:

§ 16. This act shall take effect immediately; provided that sections thirteen, fourteen and fifteen of this act shall take effect immediately

and shall be deemed to have been in full force and effect on and after June 1, 2010 and such sections shall be deemed repealed July 1, [2016] 2021; provided further that the amendments to section 9 of chapter 420 of the laws of 2002 amending the education law relating to the profession of social work made by section thirteen of this act shall repeal on the same date as such section repeals; provided further that the amendments to section 17-a of chapter 676 of the laws of 2002 amending the education law relating to the practice of psychology made by section fourteen of this act shall repeal on the same date as such section repeals.

§ 4. This act shall take effect immediately.

PART K

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

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

§ 2. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2016.

PART L

Section 1. The mental hygiene law is amended by adding a new section 16.25 to read as follows:

§ 16.25 Temporary operator.

(a) For the purposes of this section:

(1) "Established operator" shall mean the provider of services that has been established and issued an operating certificate pursuant to this article.

(2) "Extraordinary financial assistance" shall mean state funds provided to, or requested by, a program for the express purpose of preventing the closure of the program that the commissioner finds provides essential and necessary services within the community.

(3) "Serious financial instability" shall include but not be limited to defaulting or violating material covenants of bond issues, missed

mortgage payments, missed rent payments, a pattern of untimely payment of debts, failure to pay its employees or vendors, insufficient funds to meet the general operating expenses of the program, failure to maintain required debt service coverage ratios and/or, as applicable, factors that have triggered a written event of default notice to the office by the dormitory authority of the state of New York.

(4) "Temporary operator" shall mean any provider of services that has been established and issued an operating certificate pursuant to this article or which is directly operated by the office, that:

a. agrees to provide services certified pursuant to this article on a temporary basis in the best interests of its individuals served by the program; and

b. has a history of compliance with applicable laws, rules, and regulations and a record of providing care of good quality, as determined by the commissioner; and

c. prior to appointment as temporary operator, develops a plan determined to be satisfactory by the commissioner to address the program's deficiencies.

(b) (1) In the event that: (i) the established operator is seeking extraordinary financial assistance; (ii) office collected data demonstrates that the established operator is experiencing serious financial instability issues; (iii) office collected data demonstrates that the established operator's board of directors or administration is unable or unwilling to ensure the proper operation of the program; or (iv) office collected data indicates there are conditions that seriously endanger or jeopardize continued access to necessary services within the community, the commissioner shall notify the established operator of his or her intention to appoint a temporary operator to assume sole responsibility for the provider of services' operations for a limited period of time. The appointment of a temporary operator shall be effectuated pursuant to this section, and shall be in addition to any other remedies provided by law.

(2) The established operator may at any time request the commissioner to appoint a temporary operator. Upon receiving such a request, the commissioner may, if he or she determines that such an action is necessary, enter into an agreement with the established operator for the appointment of a temporary operator to restore or maintain the provision of quality care to the individuals until the established operator can resume operations within the designated time period or other action is taken as described in section 16.17 of this article.

(c) (1) A temporary operator appointed pursuant to this section shall use his or her best efforts to implement the plan deemed satisfactory by the commissioner to correct or eliminate any deficiencies in the program and to promote the quality and accessibility of services in the community served by the provider of services.

(2) During the term of appointment, the temporary operator shall have the authority to direct the staff of the established operator as necessary to appropriately provide services for individuals. The temporary operator shall, during this period, provide services in such a manner as to promote safety and the quality and accessibility of services in the community served by the established operator until either the established operator can resume operations or until the office revokes the operating certificate for the services issued under this article.

(3) The established operator shall grant access to the temporary operator to the established operator's accounts and records in order to address any deficiencies related to the program experiencing serious

financial instability or an established operator requesting financial assistance in accordance with this section. The temporary operator shall approve any financial decision related to an established provider's day to day operations or the established provider's ability to provide services.

(4) The temporary operator shall not be required to file any bond. No security interest in any real or personal property comprising the established operator or contained within the established operator or in any fixture of the program, shall be impaired or diminished in priority by the temporary operator. Neither the temporary operator nor the office shall engage in any activity that constitutes a confiscation of property.

(d) The temporary operator shall be entitled to a reasonable fee, as determined by the commissioner and subject to the approval of the director of the division of the budget, and necessary expenses incurred while serving as a temporary operator. The temporary operator shall be liable only in its capacity as temporary operator for injury to person and property by reason of its operation of such program; no liability shall incur in the temporary operator's personal capacity, except for gross negligence and intentional acts.

(e) (1) The initial term of the appointment of the temporary operator shall not exceed ninety days. After ninety days, if the commissioner determines that termination of the temporary operator would cause significant deterioration of the quality of, or access to, care in the community or that reappointment is necessary to correct the deficiencies that required the appointment of the temporary operator, the commissioner may authorize an additional ninety-day term. However, such authorization shall include the commissioner's requirements for conclusion of the temporary operatorship to be satisfied within the additional term.

(2) Within fourteen days prior to the termination of each term of the appointment of the temporary operator, the temporary operator shall submit to the commissioner and to the established operator a report describing:

a. the actions taken during the appointment to address the identified program deficiencies, the resumption of program operations by the established operator, or the revocation of an operating certificate issued by the office;

b. objectives for the continuation of the temporary operatorship if necessary and a schedule for satisfaction of such objectives; and

c. if applicable, the recommended actions for the ongoing provision of services subsequent to the temporary operatorship.

(3) The term of the initial appointment and of any subsequent reappointment may be terminated prior to the expiration of the designated term, if the established operator and the commissioner agree on a plan of correction and the implementation of such plan.

(f) (1) The commissioner shall, upon making a determination of an intention to appoint a temporary operator pursuant to paragraph one of subdivision (b) of this section, cause the established operator to be notified of the intention by registered or certified mail addressed to the principal office of the established operator. Such notification shall include a detailed description of the findings underlying the intention to appoint a temporary operator, and the date and time of a required meeting with the commissioner and/or his or her designee within ten business days of the receipt of such notice. At such meeting, the established operator shall have the opportunity to review and discuss all relevant findings. At such meeting, the commissioner and the estab-

lished operator shall attempt to develop a mutually satisfactory plan of correction and schedule for implementation. In such event, the commissioner shall notify the established operator that the commissioner will abstain from appointing a temporary operator contingent upon the established operator remediating the identified deficiencies within the agreed upon timeframe.

(2) Should the commissioner and the established operator be unable to establish a plan of correction pursuant to paragraph one of this subdivision, or should the established operator fail to respond to the commissioner's initial notification, there shall be an administrative hearing on the commissioner's determination to appoint a temporary operator to begin no later than thirty days from the date of the notice to the established operator. Any such hearing shall be strictly limited to the issue of whether the determination of the commissioner to appoint a temporary operator is supported by substantial evidence. A copy of the decision shall be sent to the established operator.

(3) If the decision to appoint a temporary operator is upheld such temporary operator shall be appointed as soon as is practicable and shall provide services pursuant to the provisions of this section.

(g) Notwithstanding the appointment of a temporary operator, the established operator shall remain obligated for the continued provision of services. No provision contained in this section shall be deemed to relieve the established operator or any other person of any civil or criminal liability incurred, or any duty imposed by law, by reason of acts or omissions of the established operator or any other person prior to the appointment of any temporary operator of the program hereunder; nor shall anything contained in this section be construed to suspend during the term of the appointment of the temporary operator of the program any obligation of the established operator or any other person for the maintenance and repair of the facility, provision of utility services, payment of taxes or other operating and maintenance expenses of the facility, nor of the established operator or any other person for the payment of mortgages or liens.

§ 2. The mental hygiene law is amended by adding a new section 31.20 to read as follows:

§ 31.20 Temporary operator.

(a) For the purposes of this section:

(1) "Established operator" shall mean the operator of a mental health program that has been established and issued an operating certificate pursuant to this article.

(2) "Extraordinary financial assistance" shall mean state funds provided to, or requested by, a program for the express purpose of preventing the closure of the program that the commissioner finds provides essential and necessary services within the community.

(3) "Mental health program" shall mean a provider of services for persons with serious mental illness, as such terms are defined in section 1.03 of this chapter, which is licensed or operated by the office.

(4) "Office" shall mean the office of mental health.

(5) "Serious financial instability" shall include but not be limited to defaulting or violating material covenants of bond issues, missed mortgage payments, a pattern of untimely payment of debts, failure to pay its employees or vendors, insufficient funds to meet the general operating expenses of the program, failure to maintain required debt service coverage ratios and/or, as applicable, factors that have trig-

gered a written event of default notice to the office by the dormitory authority of the state of New York.

(6) "Temporary operator" shall mean any operator of a mental health program that has been established and issued an operating certificate pursuant to this article or which is directly operated by the office of mental health, that:

a. agrees to operate a mental health program on a temporary basis in the best interests of its patients served by the program; and

b. has a history of compliance with applicable laws, rules, and regulations and a record of providing care of good quality, as determined by the commissioner; and

c. prior to appointment as temporary operator, develops a plan determined to be satisfactory by the commissioner to address the program's deficiencies.

(b) (1) In the event that: (i) the established operator is seeking extraordinary financial assistance; (ii) office collected data demonstrates that the established operator is experiencing serious financial instability issues; (iii) office collected data demonstrates that the established operator's board of directors or administration is unable or unwilling to ensure the proper operation of the program; or (iv) office collected data indicates there are conditions that seriously endanger or jeopardize continued access to necessary mental health services within the community, the commissioner shall notify the established operator of his or her intention to appoint a temporary operator to assume sole responsibility for the program's treatment operations for a limited period of time. The appointment of a temporary operator shall be effectuated pursuant to this section, and shall be in addition to any other remedies provided by law.

(2) The established operator may at any time request the commissioner to appoint a temporary operator. Upon receiving such a request, the commissioner may, if he or she determines that such an action is necessary, enter into an agreement with the established operator for the appointment of a temporary operator to restore or maintain the provision of quality care to the patients until the established operator can resume operations within the designated time period; the patients may be transferred to other mental health programs operated or licensed by the office; or the operations of the mental health program should be completely discontinued.

(c) (1) A temporary operator appointed pursuant to this section shall use his or her best efforts to implement the plan deemed satisfactory by the commissioner to correct or eliminate any deficiencies in the mental health program and to promote the quality and accessibility of mental health services in the community served by the mental health program.

(2) If the identified deficiencies cannot be addressed in the time period designated in the plan, the patients shall be transferred to other appropriate mental health programs licensed or operated by the office.

(3) During the term of appointment, the temporary operator shall have the authority to direct the staff of the established operator as necessary to appropriately treat and/or transfer the patients. The temporary operator shall, during this period, operate the mental health program in such a manner as to promote safety and the quality and accessibility of mental health services in the community served by the established operator until either the established operator can resume program operations or until the patients are appropriately transferred to other programs licensed or operated by the office.

(4) The established operator shall grant access to the temporary operator to the established operator's accounts and records in order to address any deficiencies related to a mental health program experiencing serious financial instability or an established operator requesting financial assistance in accordance with this section. The temporary operator shall approve any financial decision related to a program's day to day operations or program's ability to provide mental health services.

(5) The temporary operator shall not be required to file any bond. No security interest in any real or personal property comprising the established operator or contained within the established operator or in any fixture of the mental health program, shall be impaired or diminished in priority by the temporary operator. Neither the temporary operator nor the office shall engage in any activity that constitutes a confiscation of property.

(d) The temporary operator shall be entitled to a reasonable fee, as determined by the commissioner and subject to the approval of the director of the division of the budget, and necessary expenses incurred while serving as a temporary operator. The temporary operator shall be liable only in its capacity as temporary operator of the mental health program for injury to person and property by reason of its operation of such program; no liability shall incur in the temporary operator's personal capacity, except for gross negligence and intentional acts.

(e) (1) The initial term of the appointment of the temporary operator shall not exceed ninety days. After ninety days, if the commissioner determines that termination of the temporary operator would cause significant deterioration of the quality of, or access to, mental health care in the community or that reappointment is necessary to correct the deficiencies that required the appointment of the temporary operator, the commissioner may authorize an additional ninety-day term. However, such authorization shall include the commissioner's requirements for conclusion of the temporary operatorship to be satisfied within the additional term.

(2) Within fourteen days prior to the termination of each term of the appointment of the temporary operator, the temporary operator shall submit to the commissioner and to the established operator a report describing:

a. the actions taken during the appointment to address the identified mental health program deficiencies, the resumption of mental health program operations by the established operator, or the transfer of the patients to other providers licensed or operated by the office;

b. objectives for the continuation of the temporary operatorship if necessary and a schedule for satisfaction of such objectives; and

c. if applicable, the recommended actions for the ongoing operation of the mental health program subsequent to the temporary operatorship.

(3) The term of the initial appointment and of any subsequent reappointment may be terminated prior to the expiration of the designated term, if the established operator and the commissioner agree on a plan of correction and the implementation of such plan.

(f) (1) The commissioner shall, upon making a determination of an intention to appoint a temporary operator pursuant to paragraph one of subdivision (b) of this section cause the established operator to be notified of the intention by registered or certified mail addressed to the principal office of the established operator. Such notification shall include a detailed description of the findings underlying the intention to appoint a temporary operator, and the date and time of a

required meeting with the commissioner and/or his or her designee within ten business days of the receipt of such notice. At such meeting, the established operator shall have the opportunity to review and discuss all relevant findings. At such meeting, the commissioner and the established operator shall attempt to develop a mutually satisfactory plan of correction and schedule for implementation. In such event, the commissioner shall notify the established operator that the commissioner will abstain from appointing a temporary operator contingent upon the established operator remediating the identified deficiencies within the agreed upon timeframe.

(2) Should the commissioner and the established operator be unable to establish a plan of correction pursuant to paragraph one of this subdivision, or should the established operator fail to respond to the commissioner's initial notification, there shall be an administrative hearing on the commissioner's determination to appoint a temporary operator to begin no later than thirty days from the date of the notice to the established operator. Any such hearing shall be strictly limited to the issue of whether the determination of the commissioner to appoint a temporary operator is supported by substantial evidence. A copy of the decision shall be sent to the established operator.

(3) If the decision to appoint a temporary operator is upheld such temporary operator shall be appointed as soon as is practicable and shall operate the mental health program pursuant to the provisions of this section.

(g) Notwithstanding the appointment of a temporary operator, the established operator shall remain obligated for the continued operation of the mental health program so that such program can function in a normal manner. No provision contained in this section shall be deemed to relieve the established operator or any other person of any civil or criminal liability incurred, or any duty imposed by law, by reason of acts or omissions of the established operator or any other person prior to the appointment of any temporary operator of the program hereunder; nor shall anything contained in this section be construed to suspend during the term of the appointment of the temporary operator of the program any obligation of the established operator or any other person for the maintenance and repair of the facility, provision of utility services, payment of taxes or other operating and maintenance expenses of the facility, nor of the established operator or any other person for the payment of mortgages or liens.

§ 3. This act shall take effect immediately.

PART M

Section 1. Subdivision (d) of section 33.13 of the mental hygiene law, as amended by section 3 of part E of chapter 111 of the laws of 2010, is amended to read as follows:

(d) Nothing in this section shall prevent the electronic or other exchange of information concerning patients or clients, including identification, between and among (i) facilities or others providing services for such patients or clients pursuant to an approved local services plan, as defined in article forty-one of this chapter, or pursuant to agreement with the department, and (ii) the department or any of its licensed or operated facilities. Neither shall anything in this section prevent the exchange of information concerning patients or clients, including identification, between facilities and managed care organizations, behavioral health organizations, health homes or other

entities authorized by the department or the department of health to provide, arrange for or coordinate health care services for such patients or clients who are enrolled in or receiving services from such organizations or entities. Furthermore, subject to the prior approval of the commissioner of mental health, hospital emergency services licensed pursuant to article twenty-eight of the public health law shall be authorized to exchange information concerning patients or clients electronically or otherwise with other hospital emergency services licensed pursuant to article twenty-eight of the public health law and/or hospitals licensed or operated by the office of mental health; provided that such exchange of information is consistent with standards, developed by the commissioner of mental health, which are designed to ensure confidentiality of such information. Additionally, information so exchanged shall be kept confidential and any limitations on the release of such information imposed on the party giving the information shall apply to the party receiving the information.

§ 2. Subdivision (d) of section 33.13 of the mental hygiene law, as amended by section 4 of part E of chapter 111 of the laws of 2010, is amended to read as follows:

(d) Nothing in this section shall prevent the exchange of information concerning patients or clients, including identification, between (i) facilities or others providing services for such patients or clients pursuant to an approved local services plan, as defined in article forty-one, or pursuant to agreement with the department and (ii) the department or any of its facilities. Neither shall anything in this section prevent the exchange of information concerning patients or clients, including identification, between facilities and managed care organizations, behavioral health organizations, health homes or other entities authorized by the department or the department of health to provide, arrange for or coordinate health care services for such patients or clients who are enrolled in or receiving services for such organizations or entities. Information so exchanged shall be kept confidential and any limitations on the release of such information imposed on the party giving the information shall apply to the party receiving the information.

§ 3. This act shall take effect immediately; provided that the amendments to subdivision (d) of section 33.13 of the mental hygiene law made by section one of this act shall be subject to the expiration and reversion of such subdivision pursuant to section 18 of chapter 408 of the laws of 1999, as amended, when upon such date the provisions of section two of this act shall take effect.

PART N

Section 1. Subdivision 10 of section 3 of section 1 of chapter 359 of the laws of 1968, constituting the facilities development corporation act, as amended by chapter 723 of the laws of 1993, is amended to read as follows:

10. "Mental hygiene facility" shall mean a building, a unit within a building, a laboratory, a classroom, a housing unit, a dining hall, an activities center, a library, real property of any kind or description, or any structure on or improvement to real property, or an interest in real property, of any kind or description, owned by or under the jurisdiction of the corporation, including fixtures and equipment which are an integral part of any such building, unit, structure or improvement, a walkway, a roadway or a parking lot, and improvements and connections

for water, sewer, gas, electrical, telephone, heating, air conditioning and other utility services, or a combination of any of the foregoing, whether for patient care and treatment or staff, staff family or service use, located at or related to any psychiatric center, any developmental center, or any state psychiatric or research institute or other facility now or hereafter established under the department. A mental hygiene facility shall also mean and include a residential care center for adults, a "community mental health and retardation facility" and a treatment facility for use in the conduct of an alcoholism or substance abuse treatment program as defined in the mental hygiene law unless such residential care center for adults, community mental health and retardation facility or alcoholism or substance abuse facility is expressly excepted, or the context clearly requires otherwise, and shall also mean and include any treatment facility for use in the conduct of an alcoholism or substance abuse treatment program that is also operated as an associated health care facility. The definition contained in this subdivision shall not be construed to exclude therefrom a facility owned or leased by one or more voluntary agencies that is to be financed, refinanced, designed, constructed, acquired, reconstructed, rehabilitated or improved under any lease, sublease, loan or other financing agreement entered into with such voluntary agencies, and shall not be construed to exclude therefrom a facility to be made available from the corporation to a voluntary agency at the request of the commissioners of the offices of the department having jurisdiction thereof. The definition contained in this subdivision shall not be construed to exclude therefrom a facility with respect to which a voluntary agency has an ownership interest in, and proprietary lease from, an organization formed for the purpose of the cooperative ownership of real estate.

§ 2. Section 3 of section 1 of chapter 359 of the laws of 1968, constituting the facilities development corporation act, is amended by adding a new subdivision 20 to read as follows:

20. "Associated health care facility" shall mean a facility licensed under and operated pursuant to article 28 of the public health law or any health care facility licensed under and operated in accordance with any other provisions of the public health law or the mental hygiene law that provides health care services and/or treatment to all persons, regardless of whether such persons are persons receiving treatment or services for alcohol, substance abuse, or chemical dependency.

§ 3. This act shall take effect immediately.

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

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