Amendments to Senate S.7507; Assembly A.9507
(HMH Article VII Bill)

Part A, relating to Health Care Reform Act (HCRA) Reauthorization, is amended to:

- Restore two Graduate Medical Education programs including Diversity in Medicine and Empire Clinical Research Investigation Program (ECRIP)to continue reaching underserved people in diverse communities.
- Limit the allocation for the Excess Medical Malpractice program to June 30, 2020, for discussion under the Medicaid Redesign Team II.

Part C, relating to Early Intervention program pay and Pursue, is amended to:

- Make a technical correction.

Part D, relating to availability of Enhanced Quality of Adult Living program grants, is amended to:

- Clarify uses of grant funding.

Part E, relating to miscellaneous public health recommendations, is amended to:

- Repeal an additional section of law pertaining to the Health Occupation Development and Workplace Program.
- Make various technical corrections.

Part F, relating to various public health extenders, is amended to:

- Extend the Indigent Care Pool's current methodology.
- Extend and expand the authority for the Office of Temporary and Disability Assistance to perform fair hearings for fully integrated products.
- Make various technical corrections.

Part I, relating to pharmacy adult immunization expansion and collaborative drug therapy management, is amended to:

- Expand the definition of "administer" in law to include additional adult immunizations identified by the Center for Disease Control for consistency.
- Remove a provision that would have given physician assistants the authority to issue prescriptions under a collaborative drug therapy management agreement.

- Clarify the definition of "clinical services" to reduce confusion regarding prescribing to manage drug therapy.

Part J, relating to Health-Related Consumer Protections, is amended to:

- Remove language associated with managed care reforms and make conforming effective date changes.

Part L, relating to Physician Integrity, is amended to:

- Make a technical correction.

Part N, relating to Antimicrobial Resistance Prevention, is amended to:

- Clarify the specific health care professionals who must receive mandated antimicrobial resistance training.
- Make a technical change.

Part R, relating to Local Medicaid Spending Reforms, is amended to:

- Ensure that a county that fails the property tax cap in a single year but does not in the subsequent year or thereafter receives savings prospectively at a higher base.
- Tie the year to year growth metric to the Medicaid Global Cap growth metric in lieu of a fixed 3 percent.
- Define Medicaid local spending growth rate. Fix the base year of the growth calculation in FY 2020 so the base year does not annually reset.
- Allow localities that hold costs below 3 percent to be rewarded with 25 percent of the savings.
- Clarify that being over or under the base calculation in a given year does not impact the growth calculation.

Part S, relating to the Certificate of Need surcharge, is amended to:

- Make various technical corrections.

Part T, relating to physician's excess medical malpractice, is amended to:

- Make a technical correction.

Part Y, relating to comprehensive psychiatric emergency programs (CPEPs), is amended to:

- Make a technical correction to eliminate a duplicative reference to Part M of Chapter 57 of the Laws of 2006.

Part BB, relating to the jurisdiction of DOH over health homes or subcontractor of health homes, is amended to:

- Make various technical corrections, primarily restoring language that inadvertently deleted health homes from the jurisdiction of DOH.

New Part CC, relating to Children and Youth with Special Health Care Needs, is added to:

- Rename the program originally known as the "Physically Handicapped Children Program" to the "Children and Youth with Special Health Care Needs Support Services Program".

New Part DD, relating to OPWDD, OMH and OCFS services exemption to employ qualified professionals to provide services which may otherwise fall within the scope of practice for Applied Behavior Analysis, is added to:

- Extend the authorization to 2025.

New Part EE, relating to expanding access of Medication Assisted Treatment (MAT) prescription drugs for opioid use disorder, is added to:

- Create a statewide formulary for Medication Assisted Treatment.
- Make various amendments to remove prior authorization for methadone when used to treat opioid use disorder.

Amend Senate S7507, Assembly A9507, AN ACT to amend the public health law,

Page	Line	Amendment
Page 2,	Unnumbered line 8 (AN ACT CLAUSE),	After "(Part D);" strike out "to amend the public health law, in relation to eliminating programs that do not support the department of health's core mission;"
Page 2,	Unnumbered line 12(AN ACT CLAUSE),	After "amend" strike out "the public health law,"
Page 3,	Unnumbered line 7 (AN ACT CLAUSE),	After "rebates" strike out ";" and insert ","
Page 4,	Unnumbered line 24 (AN ACT CLAUSE),	After "sites" strike out "," and insert ";"
Page 4,	Unnumbered line 37 (AN ACT CLAUSE),	After "(Part AA);" strike out "and"
Page 4,	Unnumbered line 39 (AN ACT CLAUSE),	After "(Part BB)" insert ";to amend the public health law, in relation to the renaming of the Physically Handicapped Children's Program (Part CC); to amend education law and other laws relating to applied behavior analysis, in relation to extending the expiration of certain provisions thereof (Part DD); and to amend the social services law, the public health law and the insurance law, in relation to creating a single preferred-drug list for medication assisted treatment; to amend chapter 57 of the laws of 2015, amending the social services law and other laws relating to supplemental rebates, in relation to the effectiveness thereof; to amend chapter 165 of the laws of 1991, amending the public health law and other laws relating to establishing payments for medical assistance, in relation to the effectiveness thereof; to amend chapter 710 of the laws of 1988, amending the social services law and the education law relating to medical assistance eligibility of certain persons and providing for managed medical care demonstration programs, in relation to the effectiveness there-of; and providing for the repeal of certain provisions upon expiration thereof (Part EE)"
Page 4,	Line 4,	After "through" strike out "BB" and insert "EE"
Page 22,	Line 7,	After "(a)" strike out "["
Page 23,	Line 30,	After "(d)" strike out "]"
Page 23,	Line 37,	Before "(e)" strike out "[" and after "e" strike out "] <u>(b)</u>"
Page 23,	Line 39,	Before "(f)" strike out "[" and after "(f)" strike out "] <u>(c)</u>"

Page	Line	Amendment
Page 23,	Line 41,	Before "(g)" strike out "[" and after "(g)" strike out "] (d)"
Page 23,	Line 43,	Before "(h)" strike out "[" and after "(h)" strike out "] (e)"
Page 23,	Line 48,	Before "(i)" strike out "[" and after "(i)" strike out "] (f)"
Page 23,	Line 55,	Before "(j)" strike out "[" and after "(j)" strike out "] (g)"
Page 24,	Line 5,	Before "(k)" strike out "[" and after "(k)" strike out "] (h)"
Page 24,	Line 8,	Before "(l)" strike out "[" and after "(l)" strike out "] (i)"
Page 24,	Line 12,	Before "(m)" strike out "[" and after "(m)" strike out "] (j)"
Page 24,	Line 19,	Before "(n)" strike out "[" and after "(n)" strike out "] (k)"
Page 24,	Line 23,	Before "(o)" strike out "[" and after "(o)" strike out "] (l)"
Page 24,	Line 28,	Before "(p)" strike out "[" and
Page 24,	Line 31,	after "(q)" strike out "] (m)" and
Page 24,	Line 35,	Before "(r)" strike out "[" and after "(r)" strike out "] (n)"
Page 24,	Line 48,	Before "(s)" strike out "[" and after "(s)" strike out "] (o)"
Page 25,	Line 24,	After "paragraph" strike out "[" and after "(t)" strike out "] (p)"
Page 25,	Line 28,	Before "(t)" strike out "[" and after "(t)" strike out "] (p)"
Page 25,	Line 30,	After "paragraph" strike out "[" and after "(s)" strike out "] (o)"
Page 25,	Line 32,	Before "(u)" strike out "[" and after "(u)" strike out "[(q)"
Page 25,	Line 33,	After "paragraph" strike out "[" and after "(s)" strike out "]"
Page 25,	Line 34,	Before "of" strike out "(o)" and
Page 25,	Line 36,	Before "(u)" strike out "[" and after "(u)" strike out "] (q)"
Page 25,	Line 39,	After "graph" strike out "[" and after "(s)" strike out "] (o)"

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Page 25,	Line 44,	After "graph" strike out "[" and after "(s)" strike out "] (o)"
Page 25,	Line 55,	After "paragraph" strike out "[" and after "(s)" strike out "] (o)"
Page 26,	Line 2,	After "paragraph" strike out "[" and after "(t)" strike out "] (p)"
Page 26,	Line 7,	After "paragraph" strike out "[" and after "(n)" strike out "] (k)"
Page 26,	Line 21,	After "paragraph" strike out "[" and after "(n)" strike out "] (k)"
Page 26,	Line 31,	After "eight" strike out "["
Page 26,	Line 40,	After "dollars" strike out "]"
Page 26,	Line 47,	After "(b)" strike out "["
Page 27,	Line 1,	After "seventeen," insert "[" and after "and" insert "]"
Page 27,	Line 4,	After "twenty," insert "and up to eight million six hundred twelve thousand dollars each state fiscal year for the period April first, two thousand twenty through March thirty-first, two thousand twenty-three,"
Pages 29 and 30,	Lines 33 through 56, and lines 1 through 5,	Before "(c)" insert "[" and after "training." Insert "]"
Page 30,	Line 6,	Before "(d)" insert "[" and after "(d)]" insert "(c)"
Page 31,	Line 8,	After "[(e)]" strike out "(c)" and insert "(d)"
Page 31,	Line 49,	After "[(e-10)]" strike out "(d)" and insert "(e)" and After "paragraphs" insert "(c) and"
Page 31,	Line 50,	Before "(d)" strike out "[" and after "(d)" strike out "]" and after "(d)" strike out "(b)and" and before "(e)" strike out "[" and after "(e)" strike out "]" and after "(e)" strike out "(c)"
Page 32,	Line 7,	Before "(f)" strike out "[" and after "(f)" strike out "] (e)"
Page 32,	Line 29,	Before "(g)" strike out "["
Page 32	Line 40	After "seventeen" Strike out "and"
Page 32,	Line 43,	After "twenty," insert "and up to one million six hundred five thousand dollars each state fiscal year for the period April first, two

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		thousand twenty through March thirty-first, two thousand twenty-three,"
Page 32,	Line 53,	After "(h)" strike out "[(f)"
Page 33,	Line 5,	After "[(d)]" strike out "(b)" and insert "(c)"
Page 33,	Line 7,	After "[(e)]" strike out "] (c)" and insert "(d)"
Page 33,	Line 29,	After "paragraph" strike out "[" and after "(s)" strike out "] (o)"
Page 33,	Line 38,	After "paragraphs" strike out "(b)," and after "(c)," strike out "[" and after "(d)," strike out "] and"
Page 33,	Line 39,	Before "(e)" insert out "[" and After "(e)" insert "]" and strike out "[" and After "(g)" strike out "]"
Page 77,	Line 9,	After "Such" strike out "recoup" and insert "recoupment"
Page 77,	Line 44,	After "for" strike out "["
Page 77,	Line 46,	After "for" insert "[" and after "specified" insert "] the"
Page 77,	Line 46,	After "purposes" insert "set forth in subparagraphs (i) and (ii) of the paragraph"
Page 77,	Line 49,	After "facility" insert "[" and after "as well as" insert "],"
Page 77,	Line 49,	After "resident needs" insert "and the population of residents who receive supplemental security income or safety net assistance or who are living with a serious mental illness, as defined by the commissioner of health"
Pages 77 and 78,	Lines 51 through 54, 1 through 10,	After "funds" strike out "the following purposes: (i) to support adult care facilities in which at least twenty-five percent of the resident population or twenty-five residents, whichever is less, are persons with serious mental illness, as defined by the commissioner of health. The program shall be targeted at improving the quality of life for such adult care facility residents by means of grants to facilities to support mental hygiene training of staff employed by eligible adult care facilities, as set forth in this section, and independent skills training for residents who desire to transition from such facilities to the community. The department of health, subject to the approval of the director of the budget, shall develop an allocation methodology taking into account the financial status and size of

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		the facility, resident needs, and the population of residents with serious mental illness; and" and insert ". Grants may be used to support the following purposes: (i) to improve the quality of life for adult care facility residents by funding projects including, but not limited to, clothing allowances, resident training to support independent living skills, staff training, outdoor leisure projects, and culturally recreational and other leisure events; and resident quality of life, pursuant to subparagraph (i) of paragraph (a) of this division, or"
Page 78,	Line 11 through 15,	After "to" strike out "support adult care facilities with the highest populations of residents who receive supplemental security income, as defined in subchapter XVI of chapter 7 of title 42 of the United States Code, or safety net assistance, as defined in section one hundred fifty-nine of this chapter. The program shall be targeted at improving"
Page 78,	Line 15,	Before "the" insert "improve"
Page 78,	Line 16,	After "for" strike out "such"
Page 78,	Lines 20 through 24,	After "health." strike out "the department of health, subject to the approval of the director of the budget, shall develop an allocation methodology taking into account the financial status and size of the facility, resident needs, and the population of residents who receive supplemental security income and safety net assistance."
Page 78,	Lines 27 through 31,	After "section." strike out "Where a facility is eligible to apply for funds pursuant to both subparagraphs (i) and (ii) of paragraph (a) of this subdivision, such facility shall only be authorized to apply for those funds set forth in subparagraph (i) of paragraph (a) of this subdivision."
Page 78,	Line 34 through 35,	Before "The" strike out "[" and after "The" strike out "] Where an application is submitted pursuant to subparagraph (ii) of paragraph (a) of subdivision one of this section the"
Page 78,	Line 38,	After "survey." strike out "[" and after "The" strike out "] such"
Page 78,	Line 39,	After "to" strike out "[" and after "improve" strike out "]" and insert "resident quality of life, pursuant to subparagraph (i) of paragraph (a) of this subdivision, or"

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Page 78,	Line 40,	After "facility" insert "pursuant to subparagraph (ii) of paragraph (a) of this subdivision"
Page 78,	Line 44 through 45,	After "facility]." strike out "[" and after "the" strike out "] For all applications, the"
Page 78,	Line 48,	After "application" strike out "["
Page 78,	Line 49,	After "facility" strike out "]" and insert "and"
Page 79,	Between lines 7 and 8,	Insert "§5. Clause (B) of subparagraph (iii) of paragraph (e) of subdivision one of section twenty-eight hundred seven-c of the public health law is REPEALED."
Page 79,	Line 8,	After "§" strike out "5" and insert "6"
Page 79,	Line 9,	After "§" strike out "6" and insert "7"
Page 80,	Line 8,	After "§" strike out "7" and insert "8"
Page 80,	Line 9,	After "§" strike out "8" and insert "9"
Page 82,	Line 34,	After "§" strike out "9" and insert "10"
Page 82,	Line 48,	After "§" strike out "10" and insert 11"
Page 83,	Line 6,	After "§" strike out "11" and insert "12"
Page 83,	Line 19,	After "§" strike out "12" and insert "13"
Page 83,	Line 30,	After "§" strike out "13" and insert "14"
Page 83,	Line 53,	After "§" strike out "14" and insert "15"
Page 92,	Line 32	After "by" insert "section 5 of"
Page 92,	Between lines 35 and 36,	Insert "§17. Paragraph (e) of subdivision seven of section 367-a of the social services law, as amended by section 5-a of part T of chapter 57 of the laws of 2018, is amended to read as follows: (e) During the period from April first, two thousand fifteen through March thirty-first, two thousand [twenty] twenty-three, the commissioner may, in lieu of a managed care provider, negotiate directly and enter into an agreement with a pharmaceutical manufacturer for the provision of supplemental rebates relating to pharmaceutical utilization by enrollees of managed care providers pursuant to section three hundred sixty-four-j of this title and may also negotiate directly and enter into such an agreement relating to pharmaceutical utilization by medical assistance recipients not so enrolled. Such rebates shall be limited to, drug utilization in the following classes:

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		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 the expiration or repeal of this paragraph.”
Page 92,	Line 36,	After “§” strike out “17” and insert “18”
Page 92,	Between lines 41 and 42,	Insert “§ 19. Subdivision 4-a of section 71 of part C of chapter 60 of the laws of 2014, amending the social services law relating to fair hearings held in connection with appeals under the fully integrated duals advantage demonstration program, as amended by section 6 of chapter 106 of the laws of 2018, is amended to read as follows: 4-a. section twenty-two of this act shall take effect April 1, 2014[, and shall be deemed expired January 1, 2021]; § 20. Subdivision 2-a of section 22 of the social services law is amended to read as follows: 2-a. With regard to fair hearings held in connection with appeals [under the fully integrated duals advantage demonstration program] <u>for integrated fair hearing and appeals processes for individuals dually eligible for medical assistance and benefits available under titles XVIII and XIX of the federal social security act</u>, the commissioner may contract for the sole purpose of assisting staff of the office for such purpose. § 21. Subdivision 5-d of section 2807-k of the public health law, as amended by section 2 of part A of chapter 57 of the laws of 2018, is amended to read as follows: 5-d. (a) Notwithstanding any inconsistent provision of this section, section twenty-eight hundred seven-w of this article or any other contrary provision of law, and subject to the availability of federal financial participation, for periods on and after January first, two thousand thirteen, through March thirty-first, two thousand [~~twenty~~] <u>twenty-three</u>, all funds available for distribution pursuant to this section, except for funds distributed pursuant to subparagraph (v) of paragraph (b) of subdivision five-b of this section, and all funds available for distribution pursuant to

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		section twenty-eight hundred seven-w of this article, shall be reserved and set aside and distributed in accordance with the provisions of this subdivision. (b) The commissioner shall promulgate regulations, and may promulgate emergency regulations, establishing methodologies for the distribution of funds as described in paragraph (a) of this subdivision and such regulations shall include, but not be limited to, the following: (i) Such regulations shall establish methodologies for determining each facility's relative uncompensated care need amount based on uninsured inpatient and outpatient units of service from the cost reporting year two years prior to the distribution year, multiplied by the applicable medicaid rates in effect January first of the distribution year, as summed and adjusted by a statewide cost adjustment factor and reduced by the sum of all payment amounts collected from such uninsured patients, and as further adjusted by application of a nominal need computation that shall take into account each facility's medicaid inpatient share. (ii) Annual distributions pursuant to such regulations for the two thousand thirteen through two thousand [~~twenty~~] twenty-two calendar years shall be in accord with the following: (A) one hundred thirty-nine million four hundred thousand dollars shall be distributed as Medicaid Disproportionate Share Hospital ("DSH") payments to major public general hospitals; and (B) nine hundred ninety-four million nine hundred thousand dollars as Medicaid DSH payments to eligible general hospitals, other than major public general hospitals. (iii) (A) Such regulations shall establish transition adjustments to the distributions made pursuant to clauses (A) and (B) of subparagraph (ii) of this paragraph such that no facility experiences a reduction in indigent care pool payments pursuant to this subdivision that is greater than the percentages, as specified in clause (C) of this subparagraph as compared to the average distribution that each such facility received for the three calendar years prior to two thousand thirteen pursuant to this section and section twenty-eight hundred seven-w of this article. (B) Such regulations shall also establish adjustments limiting the increases in indigent

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		care pool payments experienced by facilities pursuant to this subdivision by an amount that will be, as determined by the commissioner and in conjunction with such other funding as may be available for this purpose, sufficient to ensure full funding for the transition adjustment payments authorized by clause (A) of this subparagraph. (C) No facility shall experience a reduction in indigent care pool payments pursuant to this subdivision that: for the calendar year beginning January first, two thousand thirteen, is greater than two and one-half percent; for the calendar year beginning January first, two thousand fourteen, is greater than five percent; and, for the calendar year beginning on January first, two thousand fifteen; is greater than seven and one-half percent, and for the calendar year beginning on January first, two thousand sixteen, is greater than ten percent; and for the calendar year beginning on January first, two thousand seventeen, is greater than twelve and one-half percent; and for the calendar year beginning on January first, two thousand eighteen, is greater than fifteen percent; and for the calendar year beginning on January first, two thousand nineteen, is greater than seventeen and one-half percent; and for the calendar year beginning on January first, two thousand twenty, is greater than twenty percent; and for the calendar year beginning on January first, two thousand twenty-one, is greater than twenty-two and a half percent; and for the calendar year beginning on January first, two thousand twenty-two, is greater than twenty-five percent. (iv) Such regulations shall reserve one percent of the funds available for distribution in the two thousand fourteen and two thousand fifteen calendar years, and for calendar years thereafter, pursuant to this subdivision, subdivision fourteen-f of section twenty-eight hundred seven-c of this article, and sections two hundred eleven and two hundred twelve of chapter four hundred seventy-four of the laws of nineteen hundred ninety-six, in a "financial assistance compliance pool" and shall establish methodologies for the distribution of such pool funds to facilities based on their level of compliance, as determined by the commissioner, with the provisions of subdivision nine-a of this section. (c) The commissioner shall annually report to the governor and the legislature on the distribution of funds under this subdivision including, but not limited to:

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		(i) the impact on safety net providers, including community providers, rural general hospitals and major public general hospitals; (ii) the provision of indigent care by units of services and funds distributed by general hospitals; and (iii) the extent to which access to care has been enhanced.
Page 92,	Line 42,	After "§" strike out "18" and insert "22"
Page 98,	Between lines 5 and 6,	Insert "§ 3. Paragraph (a) of subdivision 22 of section 6802 of the education law, as amended by chapter 57 of the laws of 2018, is amended to read as follows: a. the direct application of an immunizing agent to adults, whether by injection, ingestion, inhalation or any other means, pursuant to a patient specific order or non-patient specific regimen prescribed or ordered by a physician or certified nurse practitioner, who has a practice site in the county or adjoining county in which the immunization is administered, for immunizations to prevent influenza, pneumococcal, acute herpes zoster, meningococcal, tetanus, diphtheria or pertussis disease or, for patients eighteen years of age and older, any other immunizations recommended by the advisory committee on immunizations practices of the centers for disease control and prevention, and medications required for emergency treatment of anaphylaxis. If the commissioner of health determines that there is an outbreak of disease, or that there is the imminent threat of an outbreak of disease, then the commissioner of health may issue a non-patient specific regimen applicable statewide."
Page 98,	Line 6,	After "§" strike out "3" and insert "4"
Page 98,	Line 14,	After "of" insert "[" and after "and" insert "]"
Page 98,	Line 15,	After "therapy", insert "and prescribing in order to adjust or manage drug therapy"
Page 98,	Line 20,	After "physician" strike out ", physician assistant,"
Page 98,	Line 22 and 23,	After "physician" strike out ", physician assistant," and insert "or"
Page 98,	Line 23,	After "practitioner" strike out "or facility" and insert "["
Page 98,	Line 24,	After "facility" insert "]"

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Page 98,	Line 25,	After "physician" insert "or nurse practitioner,"
Page 98,	Line 29 and 30,	After "physician" strike out ", physician assistant," and insert "or"
Page 98,	Line 30,	After "nurse practitioner" strike out "or facility"
Page 98,	Line 34 and 35,	After "expressly]" strike out ", physician assistant"
Page 98,	Line 35,	After "written" insert "agreement [" and after "order" insert "]"
Page 98,	Line 36,	After "protocol" insert ", provided, however, that the pharmacist shall appropriately consider clinical benefit and cost to the patient and/or payer in discharging these responsibilities"
Page 98,	Line 41,	After "agreement," , strike out ", provided, however, that the pharmacist shall appropriately consider clinical benefit and cost to the patient and/or payer in discharging these responsibilities"
Page 98,	Line 48,	After "the" insert "written agreement or"
Page 99,	Line 9,	After "facility" strike out ", a" and insert "or"
Page 99,	Line 14,	After "dispensaries," insert "["
Page 99,	Line 15,	After "facilities" insert "]"
Page 99,	Line 21,	Before "and" Strike out "physician assistants"
Page 99,	Line 23,	After "Physician" strike out ", physician assistant"
Page 99,	Line 24,	After "physician" strike out ", physician assistant"
Page 99,	Line 33,	After "physician" strike out " physician assistant,"
Page 99,	Line 39 and 40,	After "physician" strike out ", physician assistant"
Page 99,	Line 41 and 42	After "physician," strike out "physician assistant,"
Page 100,	Line 20 and 21	After "physician" strike out " physician assistant,"
Page 100,	Line 21,	After "nurse practitioner" strike out "or facility;"

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Page 100,	Line 33,	After "physician" strike out ", physician assistant," insert "or"
Page 100,	Line 36,	After "physician", strike out ", physician assistant"
Page 100,	Line 38,	After "physician" strike out ", physician assistant"
Page 101,	Line 5 and 6,	After "physician," strike out "physician assistant,"
Page 101,	Line 8,	After "physician," strike out ", physician assistant"
Page 101,	Line 14,	After "physician," strike out "physician assistant,"
Page 101,	Line 20,	After "§" strike out "4" and insert "5"
Page 101,	Line 28,	After "§" strike out "5" and insert "6"
Page 101,	Line 49,	After "§" strike out "6" and insert "7"
Page 102,	Line 10,	After "§" strike out "7" and insert "8"
Page 102,	Line 27,	After "§" strike out "8" and insert "9"
Page 102,	Line 29,	After "section" strike out "three" and insert "four"
Pages 102 – 110,	Lines 32 through 54,	Strike out sections 1 through 13 in their entirety
Page 110,	Line 53,	After "§" strike out "14" and insert "1"
Page 111,	Line 28,	After "§" strike out "15" and insert "2"
Page 111,	Line 36,	After "§" strike out "16" and insert "3"
Page 111,	Line 38,	After "§" strike out "17" and insert "4"
Page 111,	Line 55,	After "§" strike out "18" and insert "5"
Page 112,	Line 6,	After "§" strike out "19" and insert "6"
Page 112,	Line 6,	After "immediately" strike out ";provided, however, that sections one through eleven of this act shall apply to services performed on or after January 1, 2021; and provided further, however, that sections twelve and thirteen of this act shall apply to credentialing applications received on or after July 1, 2020"
Page 121,	Line 19,	After "2020" insert "; provided, however, that the amendments to paragraph (a) of subdivision 10 of section 230 of the public health law made by sections 7 and 8 of this act shall not affect

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		the expiration of such paragraph and shall expire therewith”
Pages 123,	Line 10,	After “2803-z.” insert “Antimicrobial resistance prevention and education.”
Page 123,	Line 23,	After “law” strike out “who provide direct patient care” and insert “and who are required to complete coursework or training regarding infection control pursuant to section 239 of the public health law or section 6505-b of the education law”
Page 139,	Line 28,	After “taxes” insert “in accordance with subdivision one of this section [” and after “cap” insert “]”
Page 139,	Line 38,	After “subdivision” insert “,less any remittances imposed by application of this subdivision in prior fiscal years, provided that each imposition of a remittance pursuant to this subdivision shall be deducted only once”
Page 139,	Line 39,	Before “for” insert “[“
Page 139,	Line 41,	After “section” insert “]”
Page 139,	Lines 46 through 47,	After “budget” strike out “;” and insert “.Further, the amount of any remittances imposed by application of this subdivision shall be owed to the state in every subsequent fiscal year, regardless whether the district certifies that it has limited the increase in real property taxes in accordance with subdivision one of this section by the date specified in subdivision two of this section, provided that each imposition of a remittance pursuant to this subdivision shall be applied only once.”
Page 139,	Line 46 and 47,	Before “provided” insert “[“ and after “provided” insert “], Provided”
Page 139,	Line 48,	After “reduce” insert “[“ and after “such” insert “] any”
Page 139,	Line 48,	After “liability” insert “imposed pursuant to this subdivision”
Page 140,	Line 10,	After “adding” strike out “two”
Page 140,	Line 11,	After “4” strike out “and” and insert “,” and after “5” insert “and 6”
Page 140,	Line 27,	After “the” insert “total percentage increase in Medicaid local spending, meaning the” and after “amount” insert “that”
Page 140,	Line 29,	After “services” strike out “districts” and insert “district”

Page	Line	Amendment
Page 140,	Line 30,	After "persons" insert ", relative to such amount paid in the state fiscal year beginning April first, two thousand twenty ("Medicaid local spending growth rate"),
Page 140,	Line 30 and 31	After "exceeds" strike out "one hundred three percent of the amount reimbursed during the preceding state fiscal year" and insert "the total percentage increase in the year to year rate of growth of department of health state funds Medicaid spending, as established by section 91 of part H of chapter 59 of the laws of 2011, and as subsequently amended, over the same time period ("Medicaid global cap growth rate")
Page 140,	Line 33,	After "of" strike out "such excess amount, after first deducting therefrom any federal funds properly received or to be received on account thereof," and insert "the amount of Medicaid local spending multiplied by the difference in the Medicaid global cap growth rate and the Medicaid local spending growth rate"
Page 140,	Line 36,	After "budget." Insert "Such remittances shall not be considered when determining a district's Medicaid local spending growth in subsequent fiscal years."
Page 140,	Line 39,	After "of" strike out "this" and after "section" insert "one of part R of a chapter of the laws of 2020, concerning distribution of enhanced federal medical assistance percentage payments, as proposed in legislative bill numbers S.7507-A and A.9507-A. 6. For the state fiscal year beginning April first, two thousand twenty-one and every state fiscal year thereafter, notwithstanding the provisions of section three hundred sixty-eight-a of this title, and notwithstanding section one of part C of chapter fifty-eight of the laws of two thousand five, as amended by section one of part F of chapter fifty-six of the laws of two thousand twelve, and any subsequent amendments thereto, if a social services district's medicaid local spending growth rate is less than the medicaid global cap growth rate, both terms as defined in subdivision five of this section, the state shall remit to the social services district twenty-five percent of the amount of medical local spending, as defined in subdivision five of this section, multiplied by the difference in the medicaid global cap growth rate and the medicaid local spending growth rate, pursuant to a schedule determined by the commissioner of health in consultation with the director of the division of budget. Such remittances shall not

Page	Line	Amendment
		be considered when determining a district's medicaid local spending growth in subsequent fiscal years."
Page 140,	Line 52,	After "amended" insert "and a new paragraph (e) is added"
Page 141,	Line 13,	After "applications" insert ","
Page 141,	Line 14,	After "regulation" insert ","
Page 142,	Line 39,	After "provisions" insert "relating"
Page 158,	Line 27,	After "section 1" strike out "of part M of chapter 57 of the laws of 2006," insert "and"
Page 162,	Line 38,	After "(b)" strike out "["
Page 162,	Line 41,	After "services" insert ",including" and before "to" insert "["
Page 162,	Line 43,	After "and" insert "]"
Page 162,	Line 44,	After "age" insert ","
Page 162,	Line 45,	After "or" strike out "]" and after "law," insert "except for a health home, or any subcontractor of such health home, who contracts with or is approved or otherwise authorized by the department to provide health home services to all those enrolled pursuant to a diagnosis of a developmental disability as defined in subdivision twenty-two of section 1.03 of the mental hygiene law;" and after "or" strike out "]"
Page 162,	Line 55,	After "chapter" strike out "["
Page 163,	Line 1,	After "services" insert ",including ["
Page 163,	Line 4,	After "law and" insert "]" and after "age" insert ","
Page 163,	Line 5,	After "law," strike out "]" and insert "except for a health home, or any subcontractor of such health home, who contracts with or is approved or otherwise authorized by the department to provide health home services to all those enrolled pursuant to a diagnosis of a developmental disability as defined in subdivision twenty-two of section 1.03 of the mental hygiene law;"
Page 163,	Line 31,	After "law," strike out "["
Page 163,	Line 33,	After "services" insert ",including ["
Page 163,	Line 35,	After "and" insert "]"

Page	Line	Amendment
Page 163,	Line 36,	After "age" insert ",<u>"</u>
Page 163,	Line 37,	After "law," strike out "]" and insert "<u>except for a health home, or any subcontractor of such health home, who contracts with or is approved or otherwise authorized by the department to provide health home services to all those enrolled pursuant to a diagnosis of a developmental disability as defined in subdivision twenty-two of section 1.03 of the mental hygiene law;</u>"
Page 163,	Line 45,	After "for" strike out "["
Page 163,	Line 47,	After "services" insert "<u>,including [</u>"
Page 163,	Line 49,	After "and" insert "]"
Page 163,	Line 50,	After "age" insert "<u>,</u>"
Page 163,	Line 51,	After "law," insert "<u>except for a health home, or any subcontractor of such health home, who contracts with or is approved or otherwise authorized by the department to provide health home services to all those enrolled pursuant to a diagnosis of a developmental disability as defined in subdivision twenty-two of section 1.03 of the mental hygiene law;</u>" and after "or" strike out "]"
Page 164,	Line 8,	After "law," strike out "["
Page 164,	Line 10,	After "services" insert "<u>,including [</u>"
Page 164,	Line 12,	After "and" insert "]"
Page 164,	Line 13,	After "age" insert "<u>,</u>"
Page 164,	Line 14,	After "law," strike out "]" and insert "<u>except for a health home, or any subcontractor of such health home, who contracts with or is approved or otherwise authorized by the department to provide health home services to all those enrolled pursuant to a diagnosis of a developmental disability as defined in subdivision twenty-two of section 1.03 of the mental hygiene law;</u>"
Page 164,	Between lines 27 and 28,	Insert Part CC (LBD #71049-01-0) Insert Part DD (LBD #71047-01-0) Insert Part EE (LBD #75028-02-0)
Page 164,	Line 38,	After "through" strike out "BB" and insert "EE"

and welfare reform, in relation to extending the effectiveness of certain provisions thereof; to amend chapter 58 of the laws of 2008, amending the social services law and the public health law relating to adjustments of rates, in relation to extending the date of the expiration of certain provisions thereof; and to amend part B of chapter 57 of the laws of 2015, amending the social services law and other laws relating to supplemental rebates, in relation to the effectiveness thereof (Part F); to amend the insurance law, in relation to prescription drug pricing and creating a drug accountability board (Part G); to amend the education law, in relation to clarifying the tasks that can be performed by a licensed pharmacy technician (Part H); to amend the education law, in relation to orders or non-patient specific regimens to pharmacists for administering immunizations; to amend chapter 563 of the laws of 2008, amending the education law and the public health law relating to immunizing agents to be administered to adults by pharmacists, in relation to making the provisions permanent; to amend chapter 116 of the laws of 2012, amending the education law relating to authorizing a licensed pharmacist and certified nurse practitioner to administer certain immunizing agents, in relation to making certain provisions permanent; to amend chapter 274 of the laws of 2013, amending the education law relating to authorizing a licensed pharmacist and certified nurse practitioner to administer meningococcal disease immunizing agents, in relation to the effectiveness thereof; and to amend chapter 21 of the laws of 2011, amending the education law relating to authorizing pharmacists to perform collaborative drug therapy management with physicians in certain settings, in relation to making certain provisions permanent (Part I); to amend the insurance law, in relation to denial of payment for certain medically necessary hospital services, claims payment timeframes and payment of interest, payment and billing for out-of-network hospital emergency services, claims payment performance and creation of a workgroup to study health care administrative simplification; to amend the public health law, the insurance law, the financial services law and the civil practice law and rules, in relation to provisional credentialing of physicians and utilization review determinations and prior authorization; and to repeal certain provisions of the financial services law relating thereto (Part J); to amend the public health law, in relation to the state's physician profiles (Part K); to amend the education law and the public health law, in relation to enhancing the ability of the department of education to investigate, discipline, and monitor licensed physicians, physician assistants, and specialist assistants (Part L); to amend the public health law, in relation to the state's schedules of controlled substances (Part M); to amend the public health law, in relation to general hospital and nursing home requirements to establish antibiotic stewardship programs and antimicrobial resistance and infection prevention training programs (Part N); to amend the public health law, in relation to expanding the Sexual Assault Forensic Examiner (SAFE) Program to all New York state hospitals with an emergency department (Part O); to amend the public health law and the labor law, in relation to the state's modernization of environmental health fee (Part P); to amend the public health law, the education law, the general business law and the tax law, in relation to the tobacco and electronic cigarette omnibus state of the state proposal; and to repeal certain provisions of the public health law relating thereto (Part Q); to amend the social services law, in relation to certain Medicaid management; authorizing the director of

the division of the budget to direct the commissioner of health to distribute enhanced federal match assistance percentage payments to social services districts; and relating to state expenditures (Part R); to amend the public health law, in relation to adding a three percent surcharge to construction approval applications (Part S); to amend chapter 266 of the laws of 1986 amending the civil practice law and rules and other laws relating to malpractice and professional medical conduct, in relation to excess insurance coverage and extending the effectiveness of certain provisions thereof; and to amend part H of chapter 57 of the laws of 2017, amending the New York Health Care Reform Act of 1996 and other laws relating to extending certain provisions relating thereto, in relation to extending provisions relating to excess coverage (Part T); to amend the insurance law, in relation to the licensing of pharmacy benefit managers (Part U); to amend the mental hygiene law, in relation to admission to residential treatment facilities (RTF) for children and youth (Part V); to amend the criminal procedure law, in relation to including mental health units operating within a local correctional facility within the definition of "appropriate institution" under certain circumstances (Part W); to authorize the transfer of certain office of mental health employees to the secure treatment rehabilitation center (Part X); to amend the mental hygiene law, in relation to the amount of time an individual may be held for emergency observation, care, and treatment in CPEP and the implementation of satellite sites; 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; and to repeal paragraphs 4 and 8 of subdivision (a), and subdivision (i) of section 31.27 of the mental hygiene law, relating thereto (Part Y); to amend the insurance law, in relation to promulgating rules and regulations to establish mental health and substance use disorder parity compliance requirements; and to amend the state finance law and public health law, in relation to establishing the behavioral health parity compliance fund (Part Z); to amend the social services law, in relation to the requirement to check the statewide central register of child abuse and maltreatment for every subject of a reported allegation of abuse or neglect (Part AA); and to amend the mental hygiene law, the social services law and the public health law, in relation to providers of service (Part BB) INSERT HHH

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 necessary to implement the state health and mental hygiene budget for the 2020-2021 state fiscal year. Each component is wholly contained within a Part identified as Parts A through BB. 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.

sion 5 as added by section 10-a of part E of chapter 63 of the laws of 2005, subdivision 5-a as amended by section 6 of part H of chapter 57 of the laws of 2017 and subdivision 12 as added by section 3 of part R of chapter 59 of the laws of 2016, are amended to read as follows:

1. Definitions. For purposes of this section, the following definitions shall apply, unless the context clearly requires otherwise:

(a) "Clinical research" means patient-oriented research, epidemiologic and behavioral studies, or outcomes research and health services research that is approved by an institutional review board by the time the clinical research position is filled.

(b) "Clinical research plan" means a plan submitted by a consortium or teaching general hospital for a clinical research position which demonstrates, in a form to be provided by the commissioner, the following:

(i) financial support for overhead, supervision, equipment and other resources equal to the amount of funding provided pursuant to subparagraph (i) of paragraph (b) of subdivision five-a of this section by the teaching general hospital or consortium for the clinical research position;

(ii) experience the sponsor-mentor and teaching general hospital has in clinical research and the medical field of the study;

(iii) methods, data collection and anticipated measurable outcomes of the clinical research to be performed;

(iv) training goals, objectives and experience the researcher will be provided to assess a future career in clinical research;

(v) scientific relevance, merit and health implications of the research to be performed;

(vi) information on potential scientific meetings and peer review journals where research results can be disseminated;

(vii) clear and comprehensive details on the clinical research position;

(viii) qualifications necessary for the clinical research position and strategy for recruitment;

(ix) non-duplication with other clinical research positions from the same teaching general hospital or consortium;

(x) methods to track the career of the clinical researcher once the term of the position is complete; and

(xi) any other information required by the commissioner to implement subparagraph (i) of paragraph (b) of subdivision five-a of this section.

(xii) The clinical review plan submitted in accordance with this paragraph may be reviewed by the commissioner in consultation with experts outside the department of health.

(c) "Clinical research position" means a post-graduate residency position which:

(i) shall not be required in order for the researcher to complete a graduate medical education program;

(ii) may be reimbursed by other sources but only for costs in excess of the funding distributed in accordance with subparagraph (i) of paragraph (b) of subdivision five-a of this section;

(iii) shall exceed the minimum standards that are required by the residency review committee in the specialty the researcher has trained or is currently training;

(iv) shall not be previously funded by the teaching general hospital or supported by another funding source at the teaching general hospital in the past three years from the date the clinical research plan is submitted to the commissioner;

(v) may supplement an existing research project;

(vi) shall be equivalent to a full-time position comprising of no less than thirty-five hours per week for one or two years;

(vii) shall provide, or be filled by a researcher who has formalized instruction in clinical research, including biostatistics, clinical trial design, grant writing and research ethics;

(viii) shall be supervised by a sponsor-mentor who shall either (A) be employed, contracted for employment or paid through an affiliated faculty practice plan by a teaching general hospital which has received at least one research grant from the National Institutes of Health in the past five years from the date the clinical research plan is submitted to the commissioner; (B) maintain a faculty appointment at a medical, dental or podiatric school located in New York state that has received at least one research grant from the National Institutes of Health in the past five years from the date the clinical research plan is submitted to the commissioner; or (C) be collaborating in the clinical research plan with a researcher from another institution that has received at least one research grant from the National Institutes of Health in the past five years from the date the clinical research plan is submitted to the commissioner; and

(ix) shall be filled by a researcher who is (A) enrolled or has completed a graduate medical education program, as defined in paragraph (i) of this subdivision; (B) a United States citizen, national, or permanent resident of the United States; and (C) a graduate of a medical, dental or podiatric school located in New York state, a graduate or resident in a graduate medical education program, as defined in paragraph (i) of this subdivision, where the sponsoring institution, as defined in paragraph (q) of this subdivision, is located in New York state, or resides in New York state at the time the clinical research plan is submitted to the commissioner.

* (d) "Consortium" means an organization or association, approved by the commissioner in consultation with the council, of general hospitals which provide graduate medical education, together with any affiliated site; provided that such organization or association may also include other providers of health care services, medical schools, payors or consumers, and which meet other criteria pursuant to subdivision six of this section.

(e) (b) "Council" means the New York state council on graduate medical education.

(f) (c) "Direct medical education" means the direct costs of residents, interns and supervising physicians.

(g) (d) "Distribution period" means each calendar year set forth in subdivision two of this section.

(h) (e) "Faculty" means persons who are employed by or under contract for employment with a teaching general hospital or are paid through a teaching general hospital's affiliated faculty practice plan and maintain a faculty appointment at a medical school. Such persons shall not be limited to persons with a degree in medicine.

(i) (f) "Graduate medical education program" means[, for purposes of subparagraph (i) of paragraph (b) of subdivision five-a of this section,] a post-graduate medical education residency in the United States which has received accreditation from a nationally recognized accreditation body or has been approved by a nationally recognized organization for medical, osteopathic, podiatric or dental residency programs including, but not limited to, specialty boards.

(j) (g) "Indirect medical education" means the estimate of costs, other than direct costs, of educational activities in teaching hospitals

as determined in accordance with the methodology applicable for purposes of determining an estimate of indirect medical education costs for reimbursement for inpatient hospital service pursuant to title XVIII of the federal social security act (medicare).

~~(k)~~ (k) "Medicare" means the methodology used for purposes of reimbursing inpatient hospital services provided to beneficiaries of title XVIII of the federal social security act.

~~(l)~~ (l) "Primary care" residents specialties shall include family medicine, general pediatrics, primary care internal medicine, and primary care obstetrics and gynecology. In determining whether a residency is in primary care, the commissioner shall consult with the council.

~~(m)~~ (m) "Regions", for purposes of this section, shall mean the regions as defined in paragraph (b) of subdivision sixteen of section twenty-eight hundred seven-c of this article as in effect on June thirtieth, nineteen hundred ninety-six. For purposes of distributions pursuant to subdivision five-a of this section, except distributions made in accordance with paragraph (a) of subdivision five-a of this section, "regions" shall be defined as New York city and the rest of the state.

~~(n)~~ (n) "Regional pool" means a professional education pool established on a regional basis by the commissioner from funds available pursuant to sections twenty-eight hundred seven-s and twenty-eight hundred seven-t of this article.

~~(o)~~ (o) "Resident" means a person in a graduate medical education program which has received accreditation from a nationally recognized accreditation body or in a program approved by any other nationally recognized organization for medical, osteopathic or dental residency programs including, but not limited to, specialty boards.

~~(p)~~ (p) "Shortage specialty" means a specialty determined by the commissioner, in consultation with the council, to be in short supply in the state of New York.

(q) ~~(q)~~ "Sponsoring institution" means the entity that has the overall responsibility for a program of graduate medical education. Such institutions shall include teaching general hospitals, medical schools, consortia and diagnostic and treatment centers.

~~(r)~~ (r) "Weighted resident count" means a teaching general hospital's total number of residents as of July first, nineteen hundred ninety-five, including residents in affiliated non-hospital ambulatory settings, reported to the commissioner. Such resident counts shall reflect the weights established in accordance with rules and regulations adopted by the state hospital review and planning council and approved by the commissioner for purposes of implementing subdivision twenty-five of section twenty-eight hundred seven-c of this article and in effect on July first, nineteen hundred ninety-five. Such weights shall not be applied to specialty hospitals, specified by the commissioner, whose primary care mission is to engage in research, training and clinical care in specialty eye and ear, special surgery, orthopedic, joint disease, cancer, chronic care or rehabilitative services.

~~(s)~~ (s) "Adjustment amount" means an amount determined for each teaching hospital for periods prior to January first, two thousand nine by:

(i) determining the difference between (A) a calculation of what each teaching general hospital would have been paid if payments made pursuant to paragraph (a-3) of subdivision one of section twenty-eight hundred seven-c of this article between January first, nineteen hundred ninety-six and December thirty-first, two thousand three were based solely on the case mix of persons eligible for medical assistance under the

medical assistance program pursuant to title eleven of article five of the social services law who are enrolled in health maintenance organizations and persons paid for under the family health plus program enrolled in approved organizations pursuant to title eleven-D of article five of the social services law during those years, and (B) the actual payments to each such hospital pursuant to paragraph (a-3) of subdivision one of section twenty-eight hundred seven-c of this article between January first, nineteen hundred ninety-six and December thirty-first, two thousand three.

(ii) reducing proportionally each of the amounts determined in subparagraph (i) of this paragraph so that the sum of all such amounts totals no more than one hundred million dollars;

(iii) further reducing each of the amounts determined in subparagraph (ii) of this paragraph by the amount received by each hospital as a distribution from funds designated in paragraph (a) of subdivision five of this section attributable to the period January first, two thousand three through December thirty-first, two thousand three, except that if such amount was provided to a consortium then the amount of the reduction for each hospital in the consortium shall be determined by applying the proportion of each hospital's amount determined under subparagraph (i) of this paragraph to the total of such amounts of all hospitals in such consortium to the consortium award;

(iv) further reducing each of the amounts determined in subparagraph (iii) of this paragraph by the amounts specified in paragraph ~~(t)~~ (o) of this subdivision; and

(v) dividing each of the amounts determined in subparagraph (iii) of this paragraph by seven.

~~(t)~~ (o) "Extra reduction amount" shall mean an amount determined for a teaching hospital for which an adjustment amount is calculated pursuant to paragraph ~~(s)~~ (o) of this subdivision that is the hospital's proportionate share of the sum of the amounts specified in paragraph ~~(u)~~ (o) of this subdivision determined based upon a comparison of the hospital's remaining liability calculated pursuant to paragraph ~~(s)~~ (o) of this subdivision to the sum of all such hospital's remaining liabilities.

~~(u)~~ (o) "Allotment amount" shall mean an amount determined for teaching hospitals as follows:

(i) for a hospital for which an adjustment amount pursuant to paragraph ~~(s)~~ (o) of this subdivision does not apply, the amount received by the hospital pursuant to paragraph (a) of subdivision five of this section attributable to the period January first, two thousand three through December thirty-first, two thousand three, or

(ii) for a hospital for which an adjustment amount pursuant to paragraph ~~(s)~~ (o) of this subdivision applies and which received a distribution pursuant to paragraph (a) of subdivision five of this section attributable to the period January first, two thousand three through December thirty-first, two thousand three that is greater than the hospital's adjustment amount, the difference between the distribution amount and the adjustment amount.

(f) Effective January first, two thousand five through December thirty-first, two thousand eight, each teaching general hospital shall receive a distribution from the applicable regional pool based on its distribution amount determined under paragraphs (c), (d) and (e) of this subdivision and reduced by its adjustment amount calculated pursuant to paragraph ~~(s)~~ (o) of subdivision one of this section and, for distributions for the period January first, two thousand five through December

thirty-first, two thousand five, further reduced by its extra reduction amount calculated pursuant to paragraph /(t)/ (6) of subdivision one of this section.

(a) Up to thirty-one million dollars annually for the periods January first, two thousand through December thirty-first, two thousand three, and up to twenty-five million dollars plus the sum of the amounts specified in paragraph /(n)/ (4) of subdivision one of this section for the period January first, two thousand five through December thirty-first, two thousand five, and up to thirty-one million dollars annually for the period January first, two thousand six through December thirty-first, two thousand seven, shall be set aside and reserved by the commissioner from the regional pools established pursuant to subdivision two of this section for supplemental distributions in each such region to be made by the commissioner to consortia and teaching general hospitals in accordance with a distribution methodology developed in consultation with the council and specified in rules and regulations adopted by the commissioner.

(d) Notwithstanding any other provision of law or regulation, for the period January first, two thousand five through December thirty-first, two thousand five, the commissioner shall distribute as supplemental payments the allotment specified in paragraph /(n)/ (4) of subdivision one of this section.

5-a. Graduate medical education innovations pool. (a) Supplemental distributions. (i) Thirty-one million dollars for the period January first, two thousand eight through December thirty-first, two thousand eight, shall be set aside and reserved by the commissioner from the regional pools established pursuant to subdivision two of this section and shall be available for distributions pursuant to subdivision five of this section and in accordance with section 86-1.89 of title 10 of the codes, rules and regulations of the state of New York as in effect on * January first, two thousand eight/; provided, however, for purposes of funding the empire clinical research investigation program (ECRIP) in accordance with paragraph eight of subdivision (e) and paragraph two of subdivision (f) of section 86-1.89 of title 10 of the codes, rules and regulations of the state of New York, distributions shall be made using two regions defined as New York city and the rest of the state and the dollar amount set forth in subparagraph (i) of paragraph two of subdivision (f) of section 86-1.89 of title 10 of the codes, rules and regulations of the state of New York shall be increased from sixty thousand * dollars to seventy-five thousand dollars/.

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

* (b) /Empire clinical research investigator program (ECRIP). Nine million one hundred twenty thousand dollars annually for the period January first, two thousand nine through December thirty-first, two thousand ten, and two million two hundred eighty thousand dollars for the period January first, two thousand eleven, through March thirty-first, two thousand eleven, nine million one hundred twenty thousand dollars each state fiscal year for the period April first, two thousand eleven through March thirty-first, two thousand fourteen, up to eight million six hundred twelve thousand dollars each state fiscal year for the period April first, two thousand fourteen through March thirty-

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

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

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

(B) Distributions made to a consortium or teaching general hospital shall equal the product of the total number of clinical research positions submitted by a consortium or teaching general hospital and accepted by the commissioner as meeting the criteria set forth in paragraph (b) of subdivision one of this section, subject to the reduction calculation set forth in clause (C) of this subparagraph, times one hundred ten thousand dollars.

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

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

the researcher shall be provided upon completion of one-half of the award term;

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

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

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

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

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

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

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

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

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

~~[(e) Ambulatory care training. Four million nine hundred thousand~~ dollars for the period January first, two thousand eight through December thirty-first, two thousand eight, four million nine hundred thousand dollars for the period January first, two thousand nine through December thirty-first, two thousand nine, four million nine hundred thousand dollars for the period January first, two thousand ten through December thirty-first, two thousand ten, one million two hundred twenty-five thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven, four million three hundred thousand dollars each state fiscal year for the period April first, two thousand eleven through March thirty-first, two thousand fourteen, up to four million sixty thousand dollars each state fiscal year for the period April first, two thousand fourteen through March thirty-first, two thousand seventeen, and up to four million sixty thousand dollars each fiscal year for the period April first, two thousand seventeen through March thirty-first, two thousand twenty, shall be set aside and reserved by the commissioner from the regional pools established pursuant to subdivision two of this section and shall be available for distributions to sponsoring institutions to be directed to support clinical training of medical students and residents in free-standing ambulatory care settings, including community health centers and private practices. Such funding shall be allocated regionally with two-thirds of the available funding going to New York city and one-third ~~of the available funding going to the rest of the state and shall be~~

~~distributed to sponsoring institutions in each region pursuant to a~~ request for application or request for proposal process with preference being given to ~~sponsoring institutions~~ which provide training in sites located ~~in underserved~~ rural or inner-city areas and those that include ~~medical students in such training.~~]

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

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

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

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

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

(v) In addition to the funds allocated under this paragraph, for the period April first, two thousand sixteen through March thirty-first, two

to funding for certain programs (Part A); to repeal subdivision 9 of section 2803 of the public health law, relating to the department of health's requirement to audit the number of working hours for hospital residents (Part B); to amend the insurance law, in relation to creating a pay and pursue model within the early intervention program (Part C); to amend the social services law, in relation to limiting the availability of enhanced quality of adult living program ("EQUAL") grants (Part D); ~~to amend the public health law, in relation to eliminating programs that do not support the department of health's core mission;~~ to amend the state finance law, in relation to transferring responsibility for the autism awareness and research fund to the office for people with developmental disabilities; to amend ~~the public health law;~~ the mental hygiene law, the insurance law and the labor law, in relation to transferring responsibility for the comprehensive care centers for eating disorders to the office of mental health; and to repeal certain provisions of the public health law relating to funding for certain programs (Part E); to amend chapter 59 of the laws of 2016 amending the public health law and other laws relating to electronic prescriptions, in relation to the effectiveness thereof; to amend chapter 19 of the laws of 1998, amending the social services law relating to limiting the method of payment for prescription drugs under the medical assistance program, in relation to the effectiveness thereof; to amend the public health law, in relation to continuing nursing home upper payment limit payments; to amend chapter 904 of the laws of 1984, amending the public health law and the social services law relating to encouraging comprehensive health services, in relation to the effectiveness thereof; to amend chapter 62 of the laws of 2003, amending the public health law relating to allowing for the use of funds of the office of professional medical conduct for activities of the patient health information and quality improvement act of 2000, in relation to extending the provisions thereof; to amend chapter 59 of the laws of 2011, amending the public health law relating to the statewide health information network of New York and the statewide planning and research cooperative system and general powers and duties, in relation to the effectiveness thereof; to amend chapter 58 of the laws of 2008, amending the elder law and other laws relating to reimbursement to participating provider pharmacies and prescription drug coverage, in relation to extending the expiration of certain provisions thereof; to amend the public health law, in relation to issuance of certificates of authority to accountable care organizations; to amend chapter 59 of the laws of 2016, amending the social services law and other laws relating to authorizing the commissioner of health to apply federally established consumer price index penalties for generic drugs, and authorizing the commissioner of health to impose penalties on managed care plans for reporting late or incorrect encounter data, in relation to the effectiveness of certain provisions of such chapter; to amend part B of chapter 57 of the laws of 2015, amending the social services law and other laws relating to supplemental rebates, in relation to the effectiveness thereof; to amend chapter 57 of the laws of 2019, amending the public health law relating to waiver of certain regulations, in relation to the effectiveness thereof; to amend chapter 474 of the laws of 1996, amending the education law and other laws relating to rates for residential health care facilities, in relation to extending the effectiveness of certain provisions thereof; to amend chapter 81 of the laws of 1995, amending the public health law and other laws relating to medical reimbursement

thousand seventeen, two million dollars shall be available for the purposes described in subdivision ten of this section;

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

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

(i) Preference in funding shall first be accorded to teaching general hospitals for up to twenty-five awards, to support costs incurred by physicians trained in primary or specialty tracks who thereafter establish or join practices in underserved communities, as determined by the commissioner.

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

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

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

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

(ii) Subject to available funding, applications shall be accepted on a continuous basis. The department shall provide technical assistance to

applicants to facilitate their completion of applications. An applicant shall be notified in writing by the department within ten days of receipt of an application as to whether the application is complete and if the application is incomplete, what information is outstanding. The department shall act on an application within thirty days of receipt of a complete application.

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

[(g)] Diversity in medicine/post-baccalaureate program. Notwithstanding any inconsistent provision of section one hundred twelve or one hundred sixty-three of the state finance law or any other law, one million nine hundred sixty thousand dollars annually for the period January first, two thousand eight through December thirty-first, two thousand ten, four hundred ninety thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven, one million seven hundred thousand dollars each state fiscal year for the period April first, two thousand eleven through March thirty-first, two thousand fourteen, up to one million six hundred five thousand dollars each state fiscal year for the period April first, two thousand fourteen through March thirty-first, two thousand seventeen, [and] up to one million six hundred five thousand dollars each state fiscal year for the period April first, two thousand seventeen through March thirty-first, two thousand twenty, [shall be set aside and reserved by the commissioner from the regional pools established pursuant to subdivision two of this section and shall be available for distributions to the Associated Medical Schools of New York to fund its diversity program including existing and new post-baccalaureate programs for minority and economically disadvantaged students and encourage participation from all medical schools in New York. The associated medical schools of New York shall report to the commissioner on an annual basis regarding the use of funds for such purpose in such form and manner as specified by the commissioner.

(h) [(f)] In the event there are undistributed funds within amounts made available for distributions pursuant to this subdivision, such funds may be reallocated and distributed in current or subsequent

distribution periods in a manner determined by the commissioner for any purpose set forth in this subdivision.

12. Notwithstanding any provision of law to the contrary, applications submitted on or after April first, two thousand sixteen, for the physician loan repayment program pursuant to paragraph [(d)](c)(b) of subdivision five-a of this section and subdivision ten of this section or the physician practice support program pursuant to paragraph [(e)](d)(c) of subdivision five-a of this section, shall be subject to the following changes:

(a) Awards shall be made from the total funding available for new awards under the physician loan repayment program and the physician practice support program, with neither program limited to a specific funding amount within such total funding available;

(b) An applicant may apply for an award for either physician loan repayment or physician practice support, but not both;

(c) An applicant shall agree to practice for three years in an underserved area and each award shall provide up to forty thousand dollars for each of the three years; and

(d) To the extent practicable, awards shall be timed to be of use for job offers made to applicants.

§ 7. Subdivision 7 of section 2807-m of the public health law is REPEALED.

§ 8. Subparagraph (xvi) of paragraph (a) of subdivision 7 of section 2807-s of the public health law, as amended by section 30 of part H of chapter 59 of the laws of 2011, is amended to read as follows:

(xvi) provided further, however, for periods prior to July first, two thousand nine, amounts set forth in this paragraph shall be reduced by an amount equal to the actual distribution reductions for all facilities pursuant to paragraph (s)(b) of subdivision one of section twenty-eight hundred seven-m of this article.

§ 9. Subdivision (c) of section 92-dd of the state finance law, as amended by section 75-f of part C of chapter 58 of the laws of 2008, is amended to read as follows:

(c) The pool administrator shall, from appropriated funds transferred to the pool administrator from the comptroller, continue to make payments as required pursuant to sections twenty-eight hundred seven-k, twenty-eight hundred seven-m (not including payments made pursuant to [subparagraph (ii) of paragraph (b) and] paragraphs (b), (c), (d), and [(e)](f), (f) and (g) of subdivision five-a [and subdivision seven] of section twenty-eight hundred seven-m), and twenty-eight hundred seven-w of the public health law, paragraph (e) of subdivision twenty-five of section twenty-eight hundred seven-c of the public health law, paragraphs (b) and (c) of subdivision thirty of section twenty-eight hundred seven-c of the public health law, paragraph (b) of subdivision eighteen of section twenty-eight hundred eight of the public health law, subdivision seven of section twenty-five hundred-d of the public health law and section eighty-eight of chapter one of the laws of nineteen hundred ninety-nine.

§ 10. Subdivision 4-c of section 2807-p of the public health law, as amended by section 13 of part H of chapter 57 of the laws of 2017, is amended to read as follows:

4-c. Notwithstanding any provision of law to the contrary, the commissioner shall make additional payments for uncompensated care to voluntary non-profit diagnostic and treatment centers that are eligible for distributions under subdivision four of this section in the following amounts: for the period June first, two thousand six through December

vention program service was medically necessary. The insurer shall notify the state fiscal agent as designated pursuant to section two thousand five hundred fifty-seven of the public health law of the external appeal agent's or independent third-party review agent's determination. If the external appeal agent or the independent third-party review agent determines that the early intervention program service provided was not medically necessary, in whole or in part, the insurer may recoup, offset, or otherwise require a refund of any overpayment resulting from the determination. Such ~~recoup~~, offset or other required recoupment refund shall be a charge to the appropriate municipality and state. The state fiscal agent designated pursuant to section two thousand five hundred fifty-seven of the public health law shall process the recoupment, offset, or refund submitted by the insurer within ninety days of receipt of the notification of the external appeal agent's or independent third-party review agent's determination.

(3) If the external appeal agent or independent third-party review agent determines that the early intervention program services rendered by the provider were not medically necessary, in whole or in part, more than sixty percent of the time in any twelve-month period, the insurer may for the subsequent twelve-month period review the provider's early intervention program services claims for medical necessity prior to making payment, in accordance with title one of article forty-nine of this chapter or title one of article forty-nine of the public health law.

(4) Nothing in this subsection shall prohibit an insurer from requiring preauthorization for early intervention program services. A claim for an early intervention program service for which an insurer denied a preauthorization request shall not be subject to this subsection.

(f) For purposes of this section, "insurer" shall mean an insurer authorized to write accident and health insurance in this state, a corporation organized pursuant to article forty-three of this chapter, a municipal cooperative health benefit plan certified pursuant to article forty-seven of this chapter, or a health maintenance organization certified pursuant to article forty-four of the public health law.

§ 2. This act shall take effect January 1, 2021 and shall apply to health care services provided on and after such date.

PART D

Section 1. Subdivisions 1 and 3 of section 461-s of the social services law, subdivision 1 as amended by section 4 of part R of chapter 59 of the laws of 2016 and subdivision 3 as amended by section 6 of part A of chapter 57 of the laws of 2015, are amended to read as follows:

1. (a) The commissioner of health shall establish the enhanced quality of adult living program (referred to in this section as the "EQUAL program" or the "program") for adult care facilities. The program shall be targeted at improving the quality of life for adult care facility residents by means of grants to facilities for [specified] the purposes. insert HMH 77A The department of health, subject to the approval of the director of the budget, shall develop an allocation methodology taking into account the financial status and size of the facility [as well as] resident needs. insert HMH 77B On or before June first of each year, the department shall make available the application for EQUAL program funds ~~the following purposes:~~

Insert HMH 77C → ~~(i) to support adult care facilities in which at least twenty-five percent of the resident population or twenty-five residents, whichever is less, are persons with serious mental illness, as defined by the~~

Grants may be used to support the following purposes:

commissioner of health. ~~The program shall be targeted at improving the quality of life for such adult care facility residents by means of grants to facilities to support mental hygiene training of staff employed by eligible adult care facilities, as set forth in this section, and independent skills training for residents who desire to transition from such facilities to the community. The department of health, subject to the approval of the director of the budget, shall develop an allocation methodology taking into account the financial status and size of the facility, resident needs, and the population of residents with serious mental illness; and~~

(ii) to ~~support adult care facilities with the highest populations of residents who receive supplemental security income, as defined in subchapter XVI of chapter 7 of title 42 of the United States Code, or safety net assistance, as defined in section one hundred fifty nine of this chapter. The program shall be targeted at improving~~ the quality of life for ~~such~~ adult care facility residents by financing capital improvement projects that will enhance the physical environment of the facility and promote a higher quality of life for residents. Any capital related expense generated by such capital expenditure must receive approval by the department of health. ~~The department of health, subject to the approval of the director of the budget, shall develop an allocation methodology taking into account the financial status and size of the facility, resident needs, and the population of residents who receive supplemental security income and safety net assistance.~~

(b) On or before June first of each year, the department shall make available the application for EQUAL program funds to eligible adult care facilities, as set forth in this section. ~~Where a facility is eligible to apply for funds pursuant to both subparagraphs (i) and (ii) of paragraph (a) of this subdivision, such facility shall only be authorized to apply for those funds set forth in subparagraph (i) of paragraph (a) of this subdivision.~~

3. Prior to applying for EQUAL program funds, a facility shall receive approval of its expenditure plan from the residents' council for the facility. [The] ~~Where an application is submitted pursuant to subparagraph (ii) of paragraph (a) of subdivision one of this section the~~ residents' council shall adopt a process to identify the priorities of the residents for the use of the program funds and document residents' top preferences by means that may include a vote or survey. [The] ~~Such~~ plan shall detail how program funds will be used to [improve] support sustainable enhancements to the physical environment of the facility [or the quality of care and services rendered to residents and may include, but not be limited to, staff training, air conditioning in residents' areas, clothing, improvements in food quality, furnishings, equipment, security, and maintenance or repairs to the facility]. [The] ~~For all applications, the~~ facility's application for EQUAL program funds shall include a signed attestation from the president or chair-person of the residents' council or, in the absence of a residents' council, at least three residents of the facility, stating that the application [reflects the priorities of the residents of the facility] has been reviewed and approved by the residents' council. The department shall investigate reports of resident abuse and retaliation related to program applications and expenditures.

§ 2. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2020.

PART E

Section 1. Section 2807-bbb of the public health law is REPEALED.

§ 2. Subdivision 10 of section 2808 of the public health law is REPEALED.

§ 3. Subdivision 6 of section 3614 of the public health law, as added by chapter 563 of the laws of 1991, is REPEALED.

§ 4. Subdivision 4 of section 4012 of the public health law is REPEALED.

§ [illegible] Article 27-G of the public health law is REPEALED.

§ [illegible] Section 95-e of the state finance law, as added by chapter 301 of the laws of 2004, subdivision 2 as amended by chapter 483 of the laws of 2015, subdivision 2-a as added by section 27-i of part UU of chapter 54 of the laws of 2016, is amended to read as follows:

§ 95-e. The New York state autism awareness and research fund. 1. There is hereby established in the joint custody of the commissioner of taxation and finance and the comptroller, a special fund to be known as the New York state autism awareness and research fund.

2. Such fund shall consist of all revenues received pursuant to the provisions of section four hundred four-v of the vehicle and traffic law, as added by chapter three hundred one of the laws of two thousand four, all revenues received pursuant to section six hundred thirty-d of the tax law and all other moneys appropriated, credited, or transferred thereto from any other fund or source pursuant to law. Nothing contained in this section shall prevent the state from receiving grants, gifts or bequests for the purposes of the fund as defined in this section and depositing them into the fund according to law.

2-a. On or before the first day of February each year, the commissioner of [health] the office for people with developmental disabilities shall provide a written report to the temporary president of the senate, speaker of the assembly, chair of the senate finance committee, chair of the assembly ways and means committee, chair of the senate committee on health, chair of the assembly health committee, the state comptroller and the public. Such report shall include how the monies of the fund were utilized during the preceding calendar year, and shall include:

(i) the amount of money disbursed from the fund and the award process used for such disbursements;

(ii) recipients of awards from the fund;

(iii) the amount awarded to each;

(iv) the purposes for which such awards were granted; and

(v) a summary financial plan for such monies which shall include estimates of all receipts and all disbursements for the current and succeeding fiscal years, along with the actual results from the prior fiscal year.

3. (a) Monies of the fund shall be expended only for autism awareness projects or autism research projects approved by the [department of health] office for people with developmental disabilities in New York state provided, however, that no more than ten percent of monies from such fund shall be expended on the aggregate number of autism research projects approved in a fiscal year.

(b) As used in this section, the term "autism research project" means scientific research approved by the [department of health] office for people with developmental disabilities into the causes and/or treatment of autism, and the term "autism awareness project" means a project approved by the [department of health] office for people with developmental disabilities aimed toward educating the general public about the causes, symptoms, and treatments of autism.

4. Monies shall be payable from the fund on the audit and warrant of the comptroller on vouchers approved and certified by the commissioner of [health] the office for people with developmental disabilities.

5. To the extent practicable, the commissioner of [health] the office for people with developmental disabilities shall ensure that all monies received during a fiscal year are expended prior to the end of that fiscal year.

§ 7. Article 27-J of the public health law is REPEALED.

§ 8. Title E of the mental hygiene law is amended by adding a new article 30 to read as follows:

ARTICLE 30

COMPREHENSIVE CARE CENTERS FOR EATING DISORDERS

Section 30.01 Legislative findings.
30.02 Definitions.
30.03 Comprehensive care centers for eating disorders; established.
30.04 Qualifying criteria.
30.05 State identification of comprehensive care centers for eating disorders; commissioner's written notice.
30.06 Restricted use of title.

§ 30.01 Legislative findings.

The legislature hereby finds that effective diagnosis and treatment for citizens struggling with eating disorders, a complex and potentially life-threatening condition, requires a continuum of interdisciplinary providers and levels of care. Such effective diagnosis and treatment further requires the coordination and comprehensive management of an individualized plan of care specifically oriented to the distinct needs of each individual.

The legislature further finds that, while there are numerous health care providers in the state with expertise in eating disorder treatment, there is no generally accessible, comprehensive system for responding to these disorders. Due to the lack of such a system the legislature finds that treatment, information/referral, prevention and research activities are fragmented and incomplete. In addition, due to the broad, multifaceted needs of individuals with eating disorders, insurance payments for the necessary plan of care and providers is usually fragmented as well, leaving citizens with insufficient coverage for essential services and, therefore, at risk of incomplete treatment, relapse, deterioration and potential death.

The legislature therefore declares that the state take positive action to facilitate the development and public identification of provider networks and care centers of excellence to provide a coordinated, comprehensive system for the treatment of such disorders, as well as to conduct community education, prevention, information/referral and research activities. The legislature further declares that health coverage by insurers and health maintenance organizations should include covered services provided through such centers and that, to the extent possible and practicable, health plan reimbursement should be structured in a manner to facilitate the individualized, comprehensive and integrated plans of care which such centers are required to provide.

§ 30.02 Definitions.

For purposes of this article:

(a) "Eating disorder" is defined to include, but not be limited to, conditions such as anorexia nervosa, bulimia and binge eating disorder, identified as such in the ICD-9-CM International Classification of Disease or the most current edition of the Diagnostic and Statistical

(c) The commissioner shall seek the recommendation of the commissioner of health prior to identifying an applicant as a comprehensive care center under this article.

§ 30.05 State identification of comprehensive care centers for eating disorders; commissioner's written notice.

(a) The commissioner shall identify a sufficient number of comprehensive centers to ensure adequate access to services in all regions of the state, provided that, to the extent possible, the commissioner shall identify such care centers geographically dispersed throughout the state, and provided further, however, that the commissioner shall, to the extent possible, initially identify at least three such centers.

(b) The commissioner's identification of a comprehensive care center for eating disorders under this article shall be valid for not more than a two year period from the date of issuance. The commissioner may reissue such identifications for subsequent periods of up to five years, provided that the comprehensive care center has notified the commissioner of any material changes in structure or operation based on its original application, or since its last written notice by the commissioner, and that the commissioner is satisfied that the center continues to meet the criteria required pursuant to this article.

(c) The commissioner may suspend or revoke his or her written notice upon a determination that the comprehensive care center has not met, or would not be able to meet, the criteria required pursuant to this article, provided, however that the commissioner shall afford such center an opportunity for a hearing, in accordance section 31.17 of this chapter, to review the circumstances of and grounds for such suspension or revocation and to appeal such determination.

§ 30.06 Restricted use of title.

No person or entity shall claim, advertise or imply to consumers, health plans or other health care providers that such provider or practitioner is a state-identified comprehensive care center for eating disorders unless it is qualified pursuant to section 30.04 of this article.

§ 9. Section 31.25 of the mental hygiene law, as added by chapter 24 of the laws of 2008, is amended to read as follows:

§ 31.25 Residential services for treatment of eating disorders.

The commissioner shall establish, pursuant to regulation, licensed residential providers of treatment and/or supportive services to children, adolescents, and adults with eating disorders, as that term is defined in section [twenty-seven hundred ninety-nine-e of the public health law] 30.02 of this title. Such regulations shall be developed in consultation with representatives from each of the comprehensive care centers for eating disorders established pursuant to article [twenty-seven-J of the public health law] thirty of this chapter and licensed treatment professionals, such as physicians, psychiatrists, psychologists and therapists, with demonstrated expertise in treating patients with eating disorders.

§ 10. Paragraph 14 of subsection (k) of section 3221 of the insurance law, as added by chapter 114 of the laws of 2004, is amended to read as follows:

(14) No group or blanket policy delivered or issued for delivery in this state which provides medical, major medical or similar comprehensive-type coverage shall exclude coverage for services covered under such policy when provided by a comprehensive care center for eating disorders pursuant to article [twenty-seven-J of the public health] thirty of the mental hygiene law; provided, however, that reimbursement

under such policy for services provided through such comprehensive care centers shall, to the extent possible and practicable, be structured in a manner to facilitate the individualized, comprehensive and integrated plans of care which such centers' network of practitioners and providers are required to provide.

§ 11.12 Subsection (dd) of section 4303 of the insurance law, as added by chapter 114 of the laws of 2004, is amended to read as follows:

(dd) No health service corporation or medical service expense indemnity corporation which provides medical, major medical or similar comprehensive-type coverage shall exclude coverage for services covered under such policy when provided by a comprehensive care center for eating disorders pursuant to article [twenty-seven-J of the public health] thirty of the mental hygiene law; provided, however, that reimbursement by such corporation for services provided through such comprehensive care centers shall, to the extent possible and practicable, be structured in a manner to facilitate the individualized, comprehensive and integrated plans of care which such centers' network of practitioners and providers are required to provide.

§ 12.13 Paragraph 27 of subsection (b) of section 4322 of the insurance law, as added by chapter 114 of the laws of 2004, is amended to read as follows:

(27) Services covered under such policy when provided by a comprehensive care center for eating disorders pursuant to article [twenty-seven-J of the public health] thirty of the mental hygiene law; provided, however, that reimbursement under such policy for services provided through such comprehensive care centers shall, to the extent possible and practicable, be structured in a manner to facilitate the individualized, comprehensive and integrated plans of care which such centers' network of practitioners and providers are required to provide.

§ 13.14 Subdivision 1 of section 154 of the labor law, as added by chapter 675 of the laws of 2007, is amended to read as follows:

1. The commissioner, in consultation with the commissioner of health and the commissioner of mental health, shall establish a child performer advisory board for the purpose of recommending guidelines for the employment of child performers and models under the age of eighteen and preventing eating disorders such as anorexia nervosa and bulimia nervosa amongst such persons. The advisory board shall consist of at least sixteen but no more than twenty members appointed by the commissioner, and shall include: representatives of professional organizations or unions representing child performers or models; employers representing child performers or models; physicians, nutritionists and mental health professionals with demonstrated expertise in treating patients with eating disorders; at least one representative from each of the comprehensive care centers for eating disorders established pursuant to article [twenty-seven-J of the public health] thirty of the mental hygiene law; advocacy organizations working to prevent and treat eating disorders; and other members deemed necessary by the commissioner. In addition, the commissioner of health and the commissioner of mental health, or their designees, shall serve on the advisory board. The members of the advisory board shall receive no compensation for their services but shall be reimbursed their actual and necessary expenses incurred in the performance of their duties.

§ 14.15 This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2020.

PART F

Part F

not at least three percentage points higher than the statewide base percentage. The percentage calculated pursuant to this paragraph shall be called the 1997, 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019 [and], 2020, 2021, 2022 and 2023 statewide reduction percentage respectively. If the 1997, 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019 [and], 2020, 2021, 2022 and 2023 statewide target percentage for the respective year is at least three percentage points higher than the statewide base percentage, the statewide reduction percentage for the respective year shall be zero.

§ 15. Subparagraph (iii) of paragraph (b) of subdivision 4 of section 64 of chapter 81 of the laws of 1995, amending the public health law and other laws relating to medical reimbursement and welfare reform, as amended by chapter 49 of the laws of 2017, is amended to read as follows:

(iii) The 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019 [and], 2020, 2021, 2022 and 2023 statewide reduction percentage shall be multiplied by one hundred two million dollars respectively to determine the 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019 [and], 2020, 2021, 2022 and 2023 statewide aggregate reduction amount. If the 1998 and the 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019 [and], 2020, 2021, 2022 and 2023 statewide reduction percentage shall be zero respectively, there shall be no 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019 [and] 2020, 2021, 2022 and 2023 reduction amount.

§ 16. Subdivision (i-1) of section 79 of part C of chapter 58 of the laws of 2008, amending the social services law and the public health law relating to adjustments of rates, as amended by chapter 49 of the laws of 2017, is amended to read as follows:

(i-1) section thirty-one-a of this act shall be deemed repealed July 1, [2020] 2021;

§ [17.] 18. Subdivision 1 of section 60 of part B of chapter 57 of the laws of 2015, amending the social services law and other laws relating to supplemental rebates, as amended by section 5-b of part T of chapter 57 of the laws of 2018, is amended to read as follows:

1. section one of this act shall expire and be deemed repealed March 31, [2023] 2026;

§ [18.] 22. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2020.

PART G

Section 1. The insurance law is amended by adding a new section 111 to read as follows:

§ 111. Investigation by the superintendent with respect to prescription drugs. (a) Whenever it shall appear to the superintendent, either upon complaint or otherwise, that in the advertisement, purchase or sale within this state of any prescription drug, which is contemplated to be paid by a policy approved by the department for offering within the state, has increased over the course of any twelve months by more than one hundred percent and if it is suspected that any person, partnership, corporation, company, trust or association, or any agent or

insert HMH 92 A

section 5 of

insert HMH 92 B and insert HMH 92 C

and older, any other immunizations recommended by the advisory committee on immunization practices of the centers for disease control and prevention, and medications required for emergency treatment of anaphylaxis. Nothing in this subdivision shall authorize unlicensed persons to administer immunizations, vaccines or other drugs.

§ [5.] 4. Section 6801-a of the education law, as amended by chapter 238 of the laws of 2015, is amended to read as follows:

§ 6801-a. Collaborative drug therapy management [demonstration program]. 1. As used in this section, the following terms shall have the following meanings:

a. "Board" shall mean the state board of pharmacy as established by section sixty-eight hundred four of this article.

b. "Clinical services" shall mean the collection and interpretation of patient data for the purpose of [initiating, modifying and] monitoring drug therapy with associated accountability and responsibility for outcomes in a direct patient care setting.

c. "Collaborative drug therapy management" shall mean the performance of clinical services by a pharmacist relating to the review, evaluation and management of drug therapy to a patient, who is being treated by a physician, ~~physician assistant~~, or nurse practitioner for a specific disease or associated disease states, in accordance with a written agreement or protocol with a voluntarily participating physician, ~~physician assistant~~, nurse practitioner ~~or facility~~ [and in accordance with the policies, procedures, and protocols of the facility]. Such agreement or protocol as entered into by the physician and a pharmacist, may include[, and shall be limited to]:

(i) [adjusting or managing] prescribing in order to adjust or manage a drug regimen of a patient, pursuant to a patient specific order or non-patient specific protocol made by the patient's physician, ~~physician assistant~~, nurse practitioner ~~or facility~~, which may include adjusting drug strength, frequency of administration or route of administration[. Adjusting the drug regimen shall not include substituting] or selecting a [different] drug which differs from that initially prescribed by the patient's physician [unless such substitution is expressly] ~~physician assistant~~ or nurse practitioner as authorized in the written [order] or protocol. The pharmacist shall be required to immediately document in the patient record changes made to the patient's drug therapy and shall use any reasonable means or method established by the facility or practice to notify the patient's other treating physicians, physician assistants, nurse practitioners and other professionals as required by the facility or the collaborative practice agreement, ~~provided, however, that the pharmacist shall appropriately consider clinical benefit and cost to the patient and/or payer in discharging these responsibilities~~ [with whom he or she does not have a written agreement or protocol regarding such changes. The patient's physician may prohibit, by written instruction, any adjustment or change in the patient's drug regimen by the pharmacist];

(ii) evaluating and[, only if specifically] as authorized by the protocol and only to the extent necessary to discharge the responsibilities set forth in this section, ordering disease state laboratory tests related to the drug therapy management for the specific disease or disease [state] states specified within the written agreement or protocol; and

(iii) [only if specifically] as authorized by the written agreement or protocol and only to the extent necessary to discharge the responsibilities set forth in this section, ordering or performing routine patient

monitoring functions as may be necessary in the drug therapy management[, including the collecting and reviewing of patient histories, and ordering or checking patient vital signs, including pulse, temperature, blood pressure and respiration].

d. "Facility" shall mean[: (i)] a [teaching hospital or] general hospital, [including any] diagnostic center, treatment center, or hospital-based outpatient department as defined in section twenty-eight hundred one of the public health law[; or (ii)], a residential health care facility, or nursing home with an on-site pharmacy staffed by a licensed pharmacist or any facility as defined in section twenty-eight hundred one of the public health law or other entity that provides direct patient care under the auspices of a medical director; provided, however, for the purposes of this section the term "facility" shall not include dental clinics, dental dispensaries, ~~residential health care facilities~~ and rehabilitation centers.

For the purposes of this section, [a "teaching hospital" shall mean a hospital licensed pursuant to article twenty-eight of the public health law that is eligible to receive direct or indirect graduate medical education payments pursuant to article twenty-eight of the public health law.] a "practice" shall mean a place or situation in which physicians, physician ~~assistants~~ and nurse practitioners either alone or in group practices provide diagnostic and treatment care for patients.

e. "Physician, ~~physician assistant~~ or nurse practitioner" shall mean the physician, ~~physician assistant~~ or nurse practitioner selected by or assigned to a patient, who has primary responsibility for the treatment and care of the patient for the disease and associated disease states that are the subject of the collaborative drug therapy management.

f. "Written agreement or protocol" shall mean a written document, pursuant to and consistent with any applicable state or federal requirements, that addresses a specific disease or associated disease states and that describes the nature and scope of collaborative drug therapy management to be undertaken by the pharmacists, in collaboration with the participating physician, ~~physician assistant~~, nurse practitioner or facility in accordance with the provisions of this section.

2. a. A pharmacist who meets the experience requirements of paragraph b of this subdivision and who is [employed by or otherwise affiliated with a facility] certified by the department to engage in collaborative drug therapy management and who is either employed by or otherwise affiliated with a facility or is participating with a practicing physician, ~~physician assistant~~ or nurse practitioner shall be permitted to enter into a written agreement or protocol with a physician, ~~physician assistant~~, nurse practitioner or facility authorizing collaborative drug therapy management, subject to the limitations set forth in this section, within the scope of such employment [or], affiliation or participation. Only pharmacists so certified may engage in collaborative drug therapy management as defined in this section.

b. A participating pharmacist must[:

(i)(A) have been awarded either a master of science in clinical pharmacy or a doctor of pharmacy degree;

(B)] maintain a current unrestricted license[;], and

[(C) have a minimum of two years experience, of which at least one year of such experience shall include clinical experience in a health facility, which involves consultation with physicians with respect to drug therapy and may include a residency at a facility involving such consultation; or

(ii)(A) have been awarded a bachelor of science in pharmacy;

(B) maintain a current unrestricted license; and

(C) within the last seven years, have a minimum of three years experience, of which at least one year of such experience shall include clinical experience in a health facility, which involves consultation with physicians with respect to drug therapy and may include a residency at a facility involving such consultation; and

(iii) meet any additional education, experience, or other requirements set forth by the department in consultation with the board.] shall satisfy any two of the following criteria:

(i) certification in a relevant area of practice including but not limited to ambulatory care, critical care, geriatric pharmacy, nuclear pharmacy, nutrition support pharmacy, oncology pharmacy, pediatric pharmacy, pharmacotherapy, or psychiatric pharmacy, from a national accrediting body as approved by the department;

(ii) postgraduate residency through an accredited postgraduate program requiring at least fifty percent of the experience be in direct patient care services with interdisciplinary terms; or

(iii) have provided clinical services to patients for at least one year either:

(A) under a collaborative practice agreement or protocol with a physician, ~~physician assistant,~~ nurse practitioner ~~or facility~~ or

(B) has documented experience in provision of clinical services to patients for at least one year or one thousand hours, and deemed acceptable to the department upon recommendation of the board of pharmacy.

c. Notwithstanding any provision of law, nothing in this section shall prohibit a licensed pharmacist from engaging in clinical services associated with collaborative drug therapy management, in order to gain experience necessary to qualify under [clause (C) of subparagraph (i) or (ii) of paragraph b] clause (B) of subparagraph (iii) of paragraph b of this subdivision, provided that such practice is under the supervision of a pharmacist that currently meets the referenced requirement, and that such practice is authorized under the written agreement or protocol with the physician, ~~physician assistant,~~ nurse practitioner or facility.

d. Notwithstanding any provision of this section, nothing herein shall authorize the pharmacist to diagnose disease. In the event that a treating physician, ~~physician assistant~~ or nurse practitioner may disagree with the exercise of professional judgment by a pharmacist, the judgment of the treating physician, ~~physician assistant~~ or nurse practitioner shall prevail.

3. [The physician who is a party to a written agreement or protocol authorizing collaborative drug therapy management shall be employed by or otherwise affiliated with the same facility with which the pharmacist is also employed or affiliated.

4. The existence of a written agreement or protocol on collaborative drug therapy management and the patient's right to choose to not participate in collaborative drug therapy management shall be disclosed to any patient who is eligible to receive collaborative drug therapy management. Collaborative drug therapy management shall not be utilized unless the patient or the patient's authorized representative consents, in writing, to such management. If the patient or the patient's authorized representative consents, it shall be noted on the patient's medical record. If the patient or the patient's authorized representative who consented to collaborative drug therapy management chooses to no longer participate in such management, at any time, it shall be noted on the patient's medical record. In addition, the existence of the written agreement or protocol and the patient's consent to such management shall

be disclosed to the patient's primary physician and any other treating physician or healthcare provider.

5.] A pharmacist who is certified by the department to engage in collaborative drug therapy management may enter into a written collaborative practice agreement or protocol with a physician, ~~physician assistant,~~ nurse practitioner or practice as an independent health care provider or as an employee of a pharmacy or other health care provider. In a facility, the physician, ~~physician assistant~~ or nurse practitioner and the pharmacist who are parties to a written agreement or protocol authorizing collaborative drug therapy management shall be employed by or be otherwise affiliated with the facility.

4. Participation in a written agreement or protocol authorizing collaborative drug therapy management shall be voluntary, and no patient, physician, ~~physician assistant,~~ nurse practitioner, pharmacist, or facility shall be required to participate.

[6. Nothing in this section shall be deemed to limit the scope of practice of pharmacy nor be deemed to limit the authority of pharmacists and physicians to engage in medication management prior to the effective date of this section and to the extent authorized by law.]

§ 4. Section 8 of chapter 563 of the laws of 2008, amending the education law and the public health law relating to immunizing agents to be administered to adults by pharmacists, as amended by section 3 of part DD of chapter 57 of the laws of 2018, is amended to read as follows:

§ 8. This act shall take effect on the ninetieth day after it shall have become a law [and shall expire and be deemed repealed July 1, 2020].

§ 5. Section 5 of chapter 116 of the laws of 2012, amending the education law relating to authorizing a licensed pharmacist and certified nurse practitioner to administer certain immunizing agents, as amended by section 4 of part DD of chapter 57 of the laws of 2018, is amended to read as follows:

§ 5. This act shall take effect on the ninetieth day after it shall have become a law[, provided, however, that the provisions of sections one, two and four of this act shall expire and be deemed repealed July 1, 2020 provided, that:

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

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

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

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

§ 6. Section 4 of chapter 274 of the laws of 2013, amending the education law relating to authorizing a licensed pharmacist and certified nurse practitioner to administer meningococcal disease immunizing agents, is amended to read as follows:

§ 4. This act shall take effect on the ninetieth day after it shall have become a law[; provided, that:

(a) the amendments to subdivision 7 of section 6527 of the education law, made by section one of this act shall not affect the expiration and

reversion of such subdivision, as provided in section 6 of chapter 116 of the laws of 2012, and shall be deemed to expire therewith; and

(b) the amendments to subdivision 7 of section 6909 of the education law, made by section two of this act shall not affect the expiration and reversion of such subdivision, as provided in section 6 of chapter 116 of the laws of 2012, and shall be deemed to be expire therewith; and

(c) the amendments to subdivision 22 of section 6802 of the education law made by section three of this act shall not affect the expiration of such subdivision and shall be deemed to expire therewith].

§ 7. Section 5 of chapter 21 of the laws of 2011, amending the education law relating to authorizing pharmacists to perform collaborative drug therapy management with physicians in certain settings, as amended by section 5 of part DD of chapter 57 of the laws of 2018, is amended to read as follows:

§ 5. This act shall take effect on the one hundred twentieth day after it shall have become a law[, provided, however, that the provisions of sections two, three, and four of this act shall expire and be deemed repealed July 1, 2020; provided, however, that the amendments to subdivision 1 of section 6801 of the education law made by section one of this act shall be subject to the expiration and reversion of such subdivision pursuant to section 8 of chapter 563 of the laws of 2008, when upon such date the provisions of section one-a of this act shall take effect; provided, further, that effective]. Effective immediately, the addition, amendment and/or repeal of any rule or regulation necessary for the implementation of this act on its effective date are authorized and directed to be made and completed on or before such effective date.

§ 8. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2020; provided, however, that section ~~three~~ of this act shall take effect on the one hundred eightieth day after it shall have become a law.

PART J

Section 1. ~~Subsection (j) of~~ section 3217-b of the insurance law, as added by chapter 297 of the laws of 2012, is amended to read as follows:

(j) (1) [An] No insurer shall [not] by contract, written policy or procedure, or by any other means, deny payment to a general hospital certified pursuant to article twenty-eight of the public health law for a claim for medically necessary inpatient services [resulting from an emergency admission], observation services, or emergency department services provided by a general hospital solely on the basis that the general hospital did not [timely notify] comply with certain administrative requirements of such insurer [that the services had been provided] with respect to those services.

(2) Nothing in this subsection shall preclude a general hospital and an insurer from agreeing to certain administrative requirements [for] relating to payment for inpatient services, observation services, or emergency department services, including but not limited to timely notification that medically necessary inpatient services [resulting from an emergency admission] have been provided and to reductions in payment for failure to comply with certain administrative requirements including timely [notify] notification; provided, however that: [(i)] (A) any requirement for timely notification must provide for a reasonable extension of timeframes for notification for [emergency] services provided on weekends or federal holidays, [(ii)] (B) any agreed to reduction in payment for failure to meet administrative requirements, including time-

ly [notify] notification shall not exceed the lesser of two thousand dollars or twelve percent of the payment amount otherwise due for the services provided, and [(iii)] (C) any agreed to reduction in payment for failure to meet administrative requirements including timely [notify] notification shall not be imposed if the patient's insurance coverage could not be determined by the hospital after reasonable efforts at the time the [inpatient] services were provided.

(3) Nothing in this subsection shall preclude an insurer from denying payment for a claim: (A) based on a reasonable belief of fraud or intentional misconduct, or abusive billing; (B) when required by a state or federal government program or coverage that is provided by this state or a municipality thereof to its respective employees, retirees or members; or (C) that it believes is fraudulently submitted, is a duplicate claim, or is for services for a benefit that is not covered under the insured's policy or for a patient determined to be ineligible for coverage.

(4) For purposes of this subsection, an "administrative requirement" shall not include requirements: (A) imposed on an insurer or provider pursuant to federal or state laws, regulations or guidance; or (B) established by the state or federal government applicable to insurers offering benefits under a state or federal government program.

(5) The prohibition on denials set forth in this subsection shall not apply to claims for services for which a request for preauthorization was denied by the insurer prior to delivery of the service.

§ 2. Subsection (k) of section 4325 of the insurance law, as added by chapter 297 of the laws of 2012, is amended to read as follows:

(k) (1) [A] No corporation organized under this article shall [not] by written contract, written policy or procedure, or by any other means, deny payment to a general hospital certified pursuant to article twenty-eight of the public health law for a claim for medically necessary inpatient services [resulting from an emergency admission], observation services, or emergency department services provided by a general hospital solely on the basis that the general hospital did not [timely notify] comply with certain administrative requirements of such [insurer that the services had been provided] corporation with respect to those services.

(2) Nothing in this subsection shall preclude a general hospital and a corporation from agreeing to certain administrative requirements [for] relating to payment for inpatient services, observation services, or emergency department services, including, but not limited to timely notification that medically necessary inpatient services [resulting from an emergency admission] have been provided and to reductions in payment for failure to comply with certain administrative requirements including timely [notify] notification; provided, however that: [(i)] (A) any requirement for timely notification must provide for a reasonable extension of timeframes for notification for [emergency] services provided on weekends or federal holidays, [(ii)] (B) any agreed to reduction in payment for failure to meet administrative requirements including timely [notify] notification shall not exceed the lesser of two thousand dollars or twelve percent of the payment amount otherwise due for the services provided, and [(iii)] (C) any agreed to reduction in payment for failure to meet administrative requirements including timely notification shall not be imposed if the patient's insurance coverage could not be determined by the hospital after reasonable efforts at the time the [inpatient] services were provided.

(3) Nothing in this subsection shall preclude a corporation from denying payment for a claim: (A) based on a reasonable belief of fraud or

intentional misconduct, or abusive billing; (B) when required by a state or federal government program or coverage that is provided by this state or a municipality thereof to its respective employees, retirees or members; or (C) that it believes is fraudulently submitted, is a duplicate claim or is for services for a benefit that is not covered under the insured's contract or for a patient determined to be ineligible for coverage.

(4) For purposes of this subsection, an "administrative requirement" shall not include requirements: (A) imposed on a corporation or provider pursuant to federal or state laws, regulations or guidance; (B) established by the state or federal government applicable to corporations offering benefits under a state or federal government program.

(5) The prohibition on denials set forth in this subsection shall not apply to claims for services for which a request for preauthorization was denied by the corporation prior to delivery of the service.

§ 3. Subdivision 8 of section 4406-c of the public health law, as added by chapter 297 of the laws of 2012, is amended to read as follows:

8. (a) [A] No health care plan shall [not] by contract, written policy or procedure, or by any other means, deny payment to a general hospital certified pursuant to article twenty-eight of this chapter for a claim for medically necessary inpatient services [resulting from an emergency admission], observation services, or emergency department services provided by a general hospital solely on the basis that the general hospital did not [timely notify such health care plan that the services had been provided] comply with certain administrative requirements of such health care plan with respect to those services.

(b) Nothing in this subdivision shall preclude a general hospital and a health care plan from agreeing to certain administrative requirements [for] relating to payment for inpatient services, observation services, or emergency department services, including, but not limited to, timely notification that medically necessary inpatient services [resulting from an emergency admission] have been provided and to reductions in payment for failure to comply with certain administrative requirements including timely [notify] notification, provided, however that: (i) any requirement for timely notification must provide for a reasonable extension of timeframes for notification for [emergency] services provided on weekends or federal holidays, (ii) any agreed to reduction in payment for failure to meet administrative requirements, including timely [notify] notification shall not exceed the lesser of two thousand dollars or twelve percent of the payment amount otherwise due for the service provided, and (iii) any agreed to reduction in payment for failure to meet administrative requirements including timely notification shall not be imposed if the patient's coverage could not be determined by the hospital after reasonable efforts at the time the [inpatient] services were provided.

(c) Nothing in this subdivision shall preclude a health care plan from denying payment for a claim: (i) based on a reasonable belief of fraud or intentional misconduct, or abusive billing; (ii) when required by a state or federal government program or coverage that is provided by this state or a municipality thereof to its respective employees, retirees or members; (iii) that it believes is fraudulently submitted, is a duplicate claim, or is for services for a benefit that is not covered under the insured's contract or for a patient determined to be ineligible for coverage.

(d) For purposes of this subdivision, an "administrative requirement" shall not include requirements: (i) imposed on a health care plan or

provider pursuant to federal or state laws, regulations or guidance; or (ii) established by the state or federal government applicable to health care plans offering benefits under a state or federal government program.

(e) The prohibition on denials set forth in this subdivision shall not apply to claims for services for which a request for preauthorization was denied by the health care plan prior to delivery of the service.

§ 4. Subsection (b) of section 3224-a of the insurance law, as amended by chapter 237 of the laws of 2009, is amended to read as follows:

(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, but not with respect to cases as set forth in subsection (a) of this section, 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, and through the internet or other electronic means for claims submitted in that manner, 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; and

(3) of the specific type of plan or product the policyholder or covered person is enrolled in; provided that nothing in this section shall authorize discrimination based on the source of payment.

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; provided, that if the 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 determines that payment or additional payment is due on the claim, such payment shall be made to the policyholder or covered person or health care provider within fifteen days of the determination and shall include interest on the amount to be paid in accordance with subsection (c) of this section, which shall be computed from the date thirty days after initial receipt of the claim if transmitted electronically or forty-five days after initial receipt of the claim if transmitted by paper or facsimile.

§ 5. Subsection (i) of section 3224-a of the insurance law, as added by chapter 297 of the laws of 2012, is amended to read as follows:

(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 based on national coding guidelines accepted by the centers for Medicare and Medicaid services or the American medical association, including ICD-10 guidelines, and process the claim, including the correct coding, in accordance with the timeframes 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] subsection (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 additional medical record information] the date thirty days after initial receipt of the claim if transmitted electronically or forty-five days after initial receipt of the claim if transmitted by paper or facsimile. 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 insurer, organization, or corporation shall be deemed an adverse determination 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.

§ 6. Section 3224-a of the insurance law is amended by adding a new subsection (k) to read as follows:

(k) The superintendent, in conjunction with the commissioner of health, shall convene a health care administrative simplification workgroup. The workgroup shall consist of stakeholders, including but not limited to, insurers, hospitals, physicians and consumers or their representatives, to study and evaluate mechanisms to reduce health care administrative costs and complexities through standardization, simplification and technology. Areas to be examined by the workgroup shall include claims submission and payment, claims attachments, preauthorization practices, provider credentialing and insurance eligibility verification. The workgroup shall report on its findings and recommendations to the superintendent, the commissioner of health, the speaker of the assembly and the temporary president of the senate within one year of the effective date of this subsection.

§ 7. The insurance law is amended by adding a new section 345 to read as follows:

§ 345. Health care claims reports. An insurer authorized to write accident and health insurance in the state, a corporation organized pursuant to article forty-three of this chapter, or a health maintenance organization certified pursuant to article forty-four of the public health law shall report to the superintendent quarterly and annually on

health care claims payment performance with respect to comprehensive health insurance coverage. The reports shall be submitted in the manner and form prescribed by the superintendent after consultation with representatives of insurers and health care providers but at minimum shall include the number and dollar value of health care claims by major line of business and categorized as follows: health care claims received, health care claims paid, health care claims pended and health care claims denied during the respective quarter or year. The data shall be provided in the aggregate and by major category of health care provider. The reports shall be due to the superintendent no later than forty-five days after the end of the respective quarter or year and shall be made publicly available including on the department's website. The superintendent, in conjunction with the commissioner of health, may promulgate regulations requiring additional reporting requirements on insurers, corporations, or health maintenance organizations or health care providers to assess the effectiveness of the payment policies set forth in this section, which may be informed by the administrative simplification workgroup authorized by subsection (k) of section three thousand two hundred twenty-four-a of this chapter.

§ 8. Paragraph (a) of subdivision 2 of section 4903 of the public health law, as amended by chapter 371 of the laws of 2015, is amended to read as follows:

(a) A utilization review agent shall make a utilization review determination involving health care services which require pre-authorization and provide notice of a determination to the enrollee or enrollee's designee and the enrollee's health care provider by telephone and in writing within three business days of receipt of the necessary information, or for inpatient rehabilitation services provided by a hospital or skilled nursing facility, within one business day of receipt of the necessary information. To the extent practicable, such written notification to the enrollee's health care provider shall be transmitted electronically, in a manner and in a form agreed upon by the parties. The notification shall identify; (i) whether the services are considered in-network or out-of-network; (ii) and whether the enrollee will be held harmless for the services and not be responsible for any payment, other than any applicable co-payment or co-insurance; (iii) as applicable, the dollar amount the health care plan will pay if the service is out-of-network; and (iv) as applicable, information explaining how an enrollee may determine the anticipated out-of-pocket cost for out-of-network health care services in a geographical area or zip code based upon the difference between what the health care plan will reimburse for out-of-network health care services and the usual and customary cost for out-of-network health care services.

§ 9. Paragraph 1 of subsection (b) of section 4903 of the insurance law, as amended by chapter 371 of the laws of 2015, is amended to read as follows:

(1) A utilization review agent shall make a utilization review determination involving health care services which require pre-authorization and provide notice of a determination to the insured or insured's designee and the insured's health care provider by telephone and in writing within three business days of receipt of the necessary information, or for inpatient rehabilitation services provided by a hospital or skilled nursing facility, within one business day of receipt of the necessary information. To the extent practicable, such written notification to the enrollee's health care provider shall be transmitted electronically, in a manner and in a form agreed upon by the parties. The notification

shall identify: (i) whether the services are considered in-network or out-of-network; (ii) whether the insured will be held harmless for the services and not be responsible for any payment, other than any applicable co-payment, co-insurance or deductible; (iii) as applicable, the dollar amount the health care plan will pay if the service is out-of-network; and (iv) as applicable, information explaining how an insured may determine the anticipated out-of-pocket cost for out-of-network health care services in a geographical area or zip code based upon the difference between what the health care plan will reimburse for out-of-network health care services and the usual and customary cost for out-of-network health care services.

§ 10. Subdivision 3 of section 4904 of the public health law, as amended by chapter 586 of the laws of 1998 and paragraph (b) as further amended by section 104 of part A of chapter 62 of the laws of 2011, is amended to read as follows:

3. A utilization review agent shall establish a standard appeal process which includes procedures for appeals to be filed in writing or by telephone. A utilization review agent must establish a period of no less than forty-five days after receipt of notification by the enrollee of the initial utilization review determination and receipt of all necessary information to file the appeal from said determination. The utilization review agent must provide written acknowledgment of the filing of the appeal to the appealing party within fifteen days of such filing and shall make a determination with regard to the appeal within [sixty] thirty days of the receipt of necessary information to conduct the appeal and, upon overturning the adverse determination, shall comply with subsection (a) of section three thousand two hundred twenty-four-a of the insurance law as applicable. The utilization review agent shall notify the enrollee, the enrollee's designee and, where appropriate, the enrollee's health care provider, in writing, of the appeal determination within two business days of the rendering of such determination. The notice of the appeal determination shall include:

(a) the reasons for the determination; provided, however, that where the adverse determination is upheld on appeal, the notice shall include the clinical rationale for such determination; and

(b) a notice of the enrollee's right to an external appeal together with a description, jointly promulgated by the commissioner and the superintendent of financial services as required pursuant to subdivision five of section forty-nine hundred fourteen of this article, of the external appeal process established pursuant to title two of this article and the time frames for such external appeals.

§ 11. Subsection (c) of section 4904 of the insurance law, as amended by chapter 586 of the laws of 1998, is amended to read as follows:

(c) A utilization review agent shall establish a standard appeal process which includes procedures for appeals to be filed in writing or by telephone. A utilization review agent must establish a period of no less than forty-five days after receipt of notification by the insured of the initial utilization review determination and receipt of all necessary information to file the appeal from said determination. The utilization review agent must provide written acknowledgment of the filing of the appeal to the appealing party within fifteen days of such filing and shall make a determination with regard to the appeal within [sixty] thirty days of the receipt of necessary information to conduct the appeal and, upon overturning the adverse decision, shall comply with subsection (a) of section three thousand two hundred twenty-four-a of this chapter as applicable. The utilization review agent shall notify

the insured, the insured's designee and, where appropriate, the insured's health care provider, in writing of the appeal determination within two business days of the rendering of such determination.

The notice of the appeal determination shall include:

(1) the reasons for the determination; provided, however, that where the adverse determination is upheld on appeal, the notice shall include the clinical rationale for such determination; and

(2) a notice of the insured's right to an external appeal together with a description, jointly promulgated by the superintendent and the commissioner of health as required pursuant to subsection (e) of section four thousand nine hundred fourteen of this article, of the external appeal process established pursuant to title two of this article and the time frames for such external appeals.

§ 12. Subsection (a) of section 4803 of the insurance law is amended by adding a new paragraph 3 to read as follows:

(3) A newly-licensed physician, a physician who has recently relocated to this state from another state and has not previously practiced in this state, or a physician who has changed his or her corporate relationship such that it results in the issuance of a new tax identification number under which such physician's services are billed for, who is employed by a general hospital or diagnostic and treatment center licensed pursuant to article twenty-eight of the public health law, or a facility licensed under article sixteen, article thirty-one or article thirty-two of the mental hygiene law, and whose other employed physicians participate in the in-network portion of an insurer's network, shall be deemed "provisionally credentialed" and may participate in the in-network portion of an insurer's network upon: (A) the insurer's receipt of the hospital and physician's completed sections of the insurer's credentialing application; and (B) the insurer being notified in writing that the health care professional has been granted hospital privileges pursuant to the requirements of section twenty-eight hundred five-k of the public health law. However, a provisionally credentialed physician shall not be designated as an insured's primary care physician until such time as the physician has been fully credentialed by the insurer. An insurer shall not be required to make any payments to the licensed general hospital, the licensed diagnostic and treatment center or a facility licensed under article sixteen, article thirty-one or article thirty-two of the mental hygiene law for the service provided by a provisionally credentialed physician, until and unless the physician is fully credentialed by the insurer, provided, however, that upon being fully credentialed, the licensed general hospital, the licensed diagnostic and treatment center or a facility licensed under article sixteen, article thirty-one or article thirty-two of the mental hygiene law shall be paid for all services that the credentialed physician provided to the insurer's insureds from the date the physician fully met the requirements to be provisionally credentialed pursuant to this paragraph. Should the application ultimately be denied by the insurer, the insurer shall not be liable for any payment to the licensed general hospital, the licensed diagnostic and treatment center or a facility licensed under article sixteen, article thirty-one or article thirty-two of the mental hygiene law for the services provided by the provisionally credentialed health care professional that exceeds any out-of-network benefits payable under the insured's contract with the insurer; and the licensed general hospital, the licensed diagnostic and treatment center or a facility licensed under article sixteen, article thirty-one or article thirty-two of the mental hygiene law shall not pursue reimburse-

ment from the insured, except to collect the copayment or coinsurance or deductible amount that otherwise would have been payable had the insured received services from a health care professional participating in the in-network portion of an insurer's network.

§ 13. Subdivision 1 of section 4406-d of the public health law is amended by adding a new paragraph (c) to read as follows:

(c) A newly-licensed physician, a physician who has recently relocated to this state from another state and has not previously practiced in this state, or a physician who has changed his or her corporate relationship such that it results in the issuance of a new tax identification number under which such physician's services are billed for, who is employed by a general hospital or diagnostic and treatment center licensed pursuant to article twenty-eight of this chapter, or a facility licensed under article sixteen, article thirty-one or article thirty-two of the mental hygiene law, and whose other employed physicians participate in the in-network portion of a health care plan's network, shall be deemed "provisionally credentialed" and may participate in the in-network portion of a health care plan's network upon: (i) the health care plan's receipt of the hospital and physician's completed sections of the insurer's credentialing application; and (ii) the health care plan being notified in writing that the health care professional has been granted hospital privileges pursuant to the requirements of section twenty-eight hundred five-k of this chapter. However, a provisionally credentialed physician shall not be designated as an enrollee's primary care physician until such time as the physician has been fully credentialed by the health care plan. A health care plan shall not be required to make any payments to the licensed general hospital, the licensed diagnostic and treatment center or a facility licensed under article sixteen, article thirty-one or article thirty-two of the mental hygiene law for the service provided by a provisionally credentialed physician, until and unless the physician is fully credentialed by the health care plan, provided, however, that upon being fully credentialed, the licensed general hospital, the licensed diagnostic and treatment center or a facility licensed under article sixteen, article thirty-one or article thirty-two of the mental hygiene law shall be paid for all services that the credentialed physician provided to the health care plan's insureds from the date the physician fully met the requirements to be provisionally credentialed pursuant to this paragraph. Should the application ultimately be denied by the health care plan, the health care plan shall not be liable for any payment to the licensed general hospital, the licensed diagnostic and treatment center or a facility licensed under article sixteen, article thirty-one or article thirty-two of the mental hygiene law for the services provided by the provisionally credentialed health care professional that exceed any out-of-network benefits payable under the insured's contract with the health care plan; and the licensed general hospital, the licensed diagnostic and treatment center or a facility licensed under article sixteen, article thirty-one or article thirty-two of the mental hygiene law shall not pursue reimbursement from the insured, except to collect the copayment or coinsurance or deductible amount that otherwise would have been payable had the insured received services from a health care professional participating in the in-network portion of a health care plan's network.

§ [illegible] Paragraphs 1 and 2 of subsection (a) of section 605 of the financial services law, as amended by chapter 377 of the laws of 2019, are amended to read as follows:

(1) When a health care plan receives a bill for emergency services from a non-participating physician or hospital, including a bill for inpatient services which follow an emergency room visit, the health care plan shall pay an amount that it determines is reasonable for the emergency services, including inpatient services which follow an emergency room visit, rendered by the non-participating physician or hospital, in accordance with section three thousand two hundred twenty-four-a of the insurance law, except for the insured's co-payment, coinsurance or deductible, if any, and shall ensure that the insured shall incur no greater out-of-pocket costs for the emergency services, including inpatient services which follow an emergency room visit, than the insured would have incurred with a participating physician or hospital [pursuant to subsection (c) of section three thousand two hundred forty-one of the insurance law]. If an insured assigns benefits to a non-participating physician or hospital in relation to emergency services, including inpatient services which follow an emergency room visit, provided by such non-participating physician or hospital, the non-participating physician or hospital may bill the health care plan for the [emergency] services rendered. Upon receipt of the bill, the health care plan shall pay the non-participating physician or hospital the amount prescribed by this section and any subsequent amount determined to be owed to the hospital in relation to the emergency services provided, including inpatient services which follow an emergency room visit.

(2) A non-participating physician or hospital or a health care plan may submit a dispute regarding a fee or payment for emergency services, including inpatient services which follow an emergency room visit, for review to an independent dispute resolution entity.

§ ~~[15]~~ 2. Paragraph 1 of subsection (b) of section 605 of the financial services law, as amended by chapter 377 of the laws of 2019, is amended to read as follows:

(1) A patient that is not an insured or the patient's physician may submit a dispute regarding a fee for emergency services, including inpatient services which follow an emergency room visit, for review to an independent dispute resolution entity upon approval of the superintendent.

§ ~~[16]~~ 3. Subsection (d) of section 605 of the financial services law is REPEALED and subsection (e) is relettered subsection (d).

§ ~~[17]~~ 4. Section 606 of the financial services law, as added by section 26 of part H of chapter 60 of the laws of 2014, is amended to read as follows:

§ 606. Hold harmless and assignment of benefits [for surprise bills] for insureds. (a) When an insured assigns benefits for a surprise bill in writing to a non-participating physician that knows the insured is insured under a health care plan, the non-participating physician shall not bill the insured except for any applicable copayment, coinsurance or deductible that would be owed if the insured utilized a participating physician.

(b) When an insured assigns benefits for emergency services, including inpatient services which follow an emergency room visit, to a non-participating physician or hospital that knows the insured is insured under a health care plan, the non-participating physician or hospital shall not bill the insured except for any applicable copayment, coinsurance or deductible that would be owed if the insured utilized a participating physician or hospital.

§ ~~[18]~~ 5. The civil practice law and rules is amended by adding a new section 213-d to read as follows:

§ 213-d. Actions to be commenced within three years; medical debt. An action on a medical debt by a hospital licensed under article twenty-eight of the public health law or a health care professional authorized under title eight of the education law shall be commenced within three years of treatment.

§ ~~(d)~~. This act shall take effect immediately~~; provided, however, that sections one through eleven of this act shall apply to services performed on or after January 1, 2021; and provided further, however, that sections twelve and thirteen of this act shall apply to credentialing applications received on or after July 1, 2020~~.

PART K

Section 1. Paragraphs (n), (p) and (q) of subdivision 1 of section 2995-a of the public health law, as added by chapter 542 of the laws of 2000, are amended and three new paragraphs (r), (s) and (t) are added to read as follows:

(n) (i) the location of the licensee's primary practice setting identified as such; [and]

(ii) [the names of any licensed physicians with whom the licensee shares a group practice, as defined in subdivision five of section two hundred thirty-eight of this chapter] hours of operation of the licensee's primary practice setting;

(iii) availability of assistive technology at the licensee's primary practice setting; and

(iv) whether the licensee is accepting new patients;

(p) whether the licensee participates in the medicaid or medicare program or any other state or federally financed health insurance program; [and]

(q) health care plans with which the licensee has contracts, employment, or other affiliation[.] provided that the reporting and accuracy of such information shall not be the responsibility of the physician, but shall be included and updated by the department utilizing provider network participation information, or other reliable sources of information submitted by the health care plans;

(r) the physician's website and social media accounts;

(s) the names of any licensed physicians with whom the licensee shares a group practice, as defined in subdivision five of section two hundred thirty-eight of this chapter; and

(t) workforce research and planning information as determined by the commissioner.

§ 2. Section 2995-a of the public health law is amended by adding a new subdivision 1-b to read as follows:

1-b. (a) For the purposes of this section, a physician licensed and registered to practice in this state may authorize a designee to register, transmit, enter or update information on his or her behalf, provided that:

(i) the designee so authorized is employed by the physician or the same professional practice or is under contract with such practice;

(ii) the physician takes reasonable steps to ensure that such designee is sufficiently competent in the profile requirements;

(iii) the physician remains responsible for ensuring the accuracy of the information provided and for any failure to provide accurate information; and

(iv) the physician shall notify the department upon terminating the authorization of any designee, in a manner determined by the department.

title eight of the education law or of a medical resident with such facility for reasons related in any way to alleged mental or physical impairment, incompetence, malpractice or misconduct or impairment of patient safety or welfare; the voluntary or involuntary resignation or withdrawal of association or of privileges with such facility to avoid the imposition of disciplinary measures; notification by the hospital or facility, to any entity providing personnel to perform professional services to such hospital or facility, that the entity shall not assign a particular individual to provide such services to the hospital or facility, for reasons related in any way to alleged mental or physical impairment, incompetence, malpractice or misconduct or impairment of patient safety or welfare; or the receipt of information which indicates that any professional licensee or medical resident has been convicted of a crime; the denial of staff privileges to a physician if the reasons stated for such denial are related to alleged mental or physical impairment, incompetence, malpractice, misconduct or impairment of patient safety or welfare.

§ 14. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2020.

PART M

Section 1. Paragraphs 56 and 57 of subdivision (b) of schedule I of section 3306 of the public health law, as added by section 4 of part BB of chapter 57 of the laws of 2018, are amended to read as follows:

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

(57) [N-(1-phenethylpiperidin-4-yl)-N-phenylacetamide (Acetyl Fentanyl)] N-(1-phenethylpiperidin-4-yl)-N-phenylacetamide. Some trade or other names: Acetyl Fentanyl.

§ 2. Subdivision (b) of schedule I of section 3306 of the public health law is amended by adding twenty-four new paragraphs 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80 and 81 to read as follows:

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

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

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

(61) 3,4-Dichloro-N-{2-(dimethylamino) cyclohexyl}-N-methylbenzamide. Other name: U-47700.

(62) N-(1-phenethylpiperidin-4-yl)-N-phenylacrylamide. Other names: Acryl Fentanyl or Acryloylfentanyl.

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

(64) N-(2-fluorophenyl)-N-(1-phenethylpiperidin-4-yl)propionamide. Other names: ortho-fluorofentanyl or 2-fluorofentanyl.

(65) N-(1-phenethylpiperidin-4-yl)-N-phenyltetrahydrofuran-2-carboxamide. Other name: tetrahydrofuranyl fentanyl.

(66) 2-methoxy-N-(1-phenethylpiperidin-4-yl)-N-phenylacetamide. Other name: methoxyacetyl fentanyl.

(67) N-(1-phenethylpiperidin-4-yl)-N-phenylcyclopropanecarboxamide. Other name: cyclopropyl fentanyl.

Provided, however, that the amendments to paragraph (a) of subdivision 16 of section 230 of the public health law made by sections 1 and 2 of this act shall not affect the expiration of such paragraph and shall expire therewith.

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.

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

Antimicrobial resistance prevention and education.

PART N

Section 1. The public health law is amended by adding a new section 2803-z to read as follows:

§ 2803-z. 1. Every general hospital and nursing home shall establish and implement an antibiotic stewardship program that meets or exceeds federal Medicare and Medicaid conditions of participation for antimicrobial stewardship programs in health care facilities. Additionally, such program shall incorporate an ongoing process to measure the impact of the program, including review, at least annually, of antimicrobial utilization data with development of response plans for high or increasing utilization.

2. Every general hospital and nursing home shall establish and implement training regarding antimicrobial resistance and infection prevention and control, or ensure that such training has taken place, in addition to or within existing infection control training programs, for all individuals licensed or certified pursuant to title eight of the education law ~~who provide direct patient care.~~

insert HMH 123

3. The commissioner shall make such rules and regulations as may be necessary and proper to carry out the provisions of this section.

§ 2. This act shall take effect on the one hundred eightieth day after it shall have become a law. Effective immediately, the addition, amendment and/or repeal of any rule or regulation necessary for the implementation of this act on its effective date are authorized to be made and completed on or before such effective date.

PART O

Section 1. Subdivisions 1, 4-b, and 7 of section 2805-i of the public health law, subdivision 1 as amended by section 1 of part HH of chapter 57 of the laws of 2018, paragraph (c) of subdivision 1 as amended by chapter 681 of the laws of 2019, subdivisions 4-b and 7 as added by chapter 1 of the laws of 2000, subparagraph 1 of paragraph (b) and paragraph (c) of subdivision 4-b as amended by chapter 292 of the laws of 2008, and subdivision 7 as renumbered by chapter 407 of the laws of 2018, are amended to read as follows:

1. [Every] When an alleged victim of a sexual offense seeks services from a hospital with an emergency department, such hospital [providing treatment to alleged victims of a sexual offense] shall be responsible for:

(a) maintaining sexual offense evidence and the chain of custody as provided in subdivision two of this section;

(b) contacting a rape crisis or victim assistance organization, if any, providing victim assistance to the geographic area served by that hospital to establish the coordination of non-medical services to sexual offense victims who request such coordination and services;

(c) offering and making available appropriate HIV post-exposure treatment therapies; including a full regimen of HIV post-exposure prophylaxis, in cases where it has been determined, in accordance with guidelines

the aggregate, do not pay a greater percentage of the non-federal share of expenditures under the state's plan for medical assistance, maintained pursuant to section 363-a of the social services law, as compared to the percentage paid by such districts during the calendar year of 2009.

§ 2. 1. Each year beginning calendar year 2020, each social services district ("district") shall certify to the department of health, in a manner to be determined by the department of health in consultation with the director of the division of the budget, whether such district has adopted a budget with respect to such district's fiscal year that begins on January first of the then current calendar year that does not exceed the tax levy limit established pursuant to section 3-c of the general municipal law or, for the City of New York, shall certify that the most recently adopted budget for such city does not exceed the tax levy limit that would have applied to such budget had the provisions of section 3-c of the general municipal law applied to such city; provided, however, that for the purposes of this subdivision, such tax levy limit shall be determined by substituting equivalent local expenditures for the exclusions provided by subparagraphs (ii), (iii) and (iv) of paragraph (g) of subdivision 2 of such section.

2. (a) Districts other than the City of New York shall make the annual certification required by subdivision one of this section by April 20, 2020, and for years beginning 2021 and thereafter, by January fifteenth of such year.

(b) The City of New York shall make the annual certification required by subdivision one of this section by July fifteenth of each year.

3. For each district that does not certify that such district has limited the increase in real property taxes by the real property tax cap by the date specified in subdivision two of this section, the department of health shall calculate the savings in medical assistance expenditures that such district realized, or would have realized, for the district's prior fiscal year as a result of application of section 1 of part C of chapter 58 of the laws of 2005, as amended by section 1 of part F of chapter 56 of the laws of 2012 and any subsequent amendments thereto ("medicaid local share cap"). Notwithstanding section 1 of part C of chapter 58 of the laws of 2005, as amended, such district's actual savings during the district's then current fiscal year shall be limited to the savings calculated in the manner prescribed in this subdivision for each year that the district does not limit the increase in real property taxes by the real property tax cap pursuant to subdivision two of this section ("limited local share savings"). The district shall be liable for and remit to the state the difference between the district's limited local share savings and the savings that the district would have realized as a result of application of the medicaid local share cap, pursuant to a schedule determined by the commissioner of health in consultation with the director of the division of the budget; provided, however, that the commissioner of health may, in consultation with the director of the division of the budget, reduce such liability to the extent necessary to achieve compliance with section 1905 of the federal social security act or any other legal requirements imposed on the subject matter hereof. Such remittances shall be separate from, and shall not affect or be affected by, any voluntary local share contributions made by any district, including the City of New York.

4. The director of the division of the budget may grant a waiver to any district that does not provide the certification required pursuant to subdivision two of this section upon a showing by such district of

in accordance with subdivision one of this section

, less any remittances imposed by application of this subdivision in prior fiscal years, provided that each imposition of a remittance pursuant to this subdivision shall be deducted only once

Provided

imposed pursuant to this subdivision

any

Insert HMH 139

financial hardship in a form and manner prescribed by the division of the budget. In evaluating an application for a financial hardship waiver, the director of the division of the budget shall consider changes in state or federal aid payments and other extraordinary costs, including the occurrence of a disaster as defined in paragraph a of subdivision two of section twenty of the executive law, repair and maintenance of infrastructure, annual growth of tax receipts, including personal income, business, and other taxes, prepayment of debt service and other expenses or such other factors that such director may determine.

§ 3. Section 363-c of the social services law is amended by adding ~~two~~ new subdivisions 4, ~~and~~ 5 and 6 to read as follows:

4. Notwithstanding any laws or regulations to the contrary, all social services districts, providers and other recipients of medical assistance program funds shall make available to the commissioner or the director of the division of budget in a prompt fashion all fiscal and statistical records and reports, other contemporaneous records demonstrating their right to receive payment, and all underlying books, records, documentation and reports, which may be requested by the commissioner or the director of the division of the budget as may be determined necessary to manage and oversee the Medicaid program.

5. For the state fiscal year beginning April first, two thousand twenty-one and every state fiscal year thereafter, notwithstanding the provisions of section three hundred sixty-eight-a of this title, and notwithstanding section one of part C of chapter fifty-eight of the laws of two thousand five, as amended by section one of part F of chapter fifty-six of the laws of two thousand twelve, and any subsequent amendments thereto, if the amount the department of health reimbursed any social services district during the prior state fiscal year for expenditures made by or on behalf of such social services ~~district~~ district for medical assistance for needy persons exceeds ~~one hundred three percent of the amount reimbursed during the preceding state fiscal year~~ the social services district shall be liable for and remit to the state one hundred percent of ~~such excess amount, after first deducting therefrom any federal funds properly received or to be received on account thereof~~ pursuant to a schedule determined by the commissioner of health in consultation with the director of the division of budget. Provided, however, that this subdivision shall not apply only to the extent that it conflicts with or would achieve less savings to the state than the application of subdivision one of ~~this~~ section: insert AMH 140 E

§ 4. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2020.

PART S

Section 1. Subdivision 7 of section 2802 of the public health law is amended by adding a new paragraph (b-1) to read as follows:

(b-1) At such time as the commissioner's written contingent approval is granted, or written approval in instances where no contingencies were applied to such approval, each applicant shall pay an additional surcharge equal to three percent of the total capital value of the application.

§ 2. Paragraph (d) of subdivision 7 of section 2802 of the public health law, as amended by section 87 of part C of chapter 58 of the laws of 2009, is amended to read as follows:

(d) (i) The fees and charges [paid by an applicant pursuant to] imposed by this subdivision [for any application for construction of a

and a new paragraph (e) is added

Insert AMH 140 A

Insert AMH 140 B

Insert AMH 140 C

Insert AMH 140 D

Insert AMH 140 F

district

total percentage increase in medicaid local spending, meaning the

that

Part S

hospital approved in accordance with this section shall be deemed allowable capital costs in the determination of reimbursement rates established pursuant to this article. The cost of such fees and charges shall not be subject to reimbursement ceiling or other penalties used by the commissioner for the purpose of establishing reimbursement rates pursuant to this article.] shall not apply to any application for which all development, design, and construction costs are being solely funded by state grants of any kind, except that such fees and charges may be imposed in such circumstances under criteria that may be adopted in regulation by the commissioner, with the approval of the director of the budget.

(ii) The commissioner, with the approval of the director of the budget, is authorized to exempt certain applications that meet criteria established by the commissioner in regulation from the surcharge imposed by paragraph (b-1) of this subdivision.

(e) Notwithstanding any other provision of law to the contrary, the fees and charges paid by an applicant pursuant to this subdivision shall not be eligible for reimbursement by the state, including the state Medicaid program.

(f) All fees pursuant to this section shall be payable to the department [of health] for deposit into the special revenue funds - other, miscellaneous special revenue fund - 339, certificate of need account.

§ 3. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2020.

PART T

Section 1. 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 F of chapter 57 of the laws of 2019, 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, [2020] 2021; 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, [2020] 2021, 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, [2020] 2021 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.

§ 2. Section 20 of part H of chapter 57 of the laws of 2017, amending the New York Health Care Reform Act of 1996 and other laws relating to extending certain provisions thereto, as amended by section 6 of part F of chapter 57 of the laws of 2019, is amended to read as follows:

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

patients pursuant to section 9.39 of this article and such person shall be evaluated for admission and, if appropriate, shall be admitted to such hospital in accordance with section 9.39 of this article, except that if the person is admitted, the fifteen day retention period of subdivision (b) of section 9.39 of this article shall be calculated from the time such person was initially [registered] received into the emergency room of the comprehensive psychiatric emergency program. Any person removed to a hospital pursuant to this paragraph shall be removed without regard to the provisions of section 29.11 or 29.15 of this chapter and shall not be considered to have been transferred or discharged to another hospital.

(f) Nothing in this section shall preclude the involuntary admission of a person to an appropriate hospital pursuant to the provisions of this article if at any time during the [seventy-two] ninety-six hour period it is determined that the person is in need of involuntary care and treatment in a hospital and the person does not agree to be admitted to a hospital as a voluntary or informal patient. Efforts shall be made to assure that any arrangements for such involuntary admissions in an appropriate hospital shall be made within a reasonable period of time.

(h) All time periods referenced in this section shall be calculated from the time such person is initially [registered] received into the emergency room of the comprehensive psychiatric emergency program.

§ 3. Paragraphs 2 and 5 of subdivision (a), paragraph 1 and subparagraph (ii) of paragraph 2 of subdivision (b) of section 31.27 of the mental hygiene law, paragraph 2 of subdivision (a) as added by chapter 723 of the laws of 1989, paragraph 5 of subdivision (a) as amended by section 1 ~~of part M of chapter 57 of the laws of 2006~~, paragraph 1 of subdivision (b) as amended by section 2 of part M of chapter 57 of the laws of 2006 and subparagraph (ii) of paragraph 2 of subdivision (b) as amended by section 2 of part E of chapter 111 of the laws of 2010, are amended and a new paragraph 12 is added to subdivision (a) to read as follows:

(2) "Crisis intervention services" means [psychiatric emergency] services provided in an emergency room located within a general hospital, which shall include but not be limited to: psychiatric and medical evaluations and assessments; prescription or adjustment of medication, counseling, and other stabilization or treatment services intended to reduce symptoms of mental illness[; extended observation beds; and other on-site psychiatric emergency services] when appropriate.

(5) "Extended observation bed" means an inpatient bed which is in or adjacent to an emergency room located within a general hospital or satellite facility approved by the commissioner, designed to provide a safe environment for an individual who, in the opinion of the examining physician, requires extensive evaluation, assessment, or stabilization of the person's acute psychiatric symptoms, except that, if the commissioner determines that the program can provide for the privacy and safety of all patients receiving services in a hospital, he or she may approve the location of one or more such beds within another unit of the hospital.

(12) "Satellite facility" means a medical facility providing psychiatric emergency services that is managed and operated by a general hospital who holds a valid operating certificate for a comprehensive psychiatric emergency program and is located away from the central campus of the general hospital.

(1) The commissioner may license the operation of comprehensive psychiatric emergency programs by general hospitals which are operated

(d) The operation of a facility or provision of services for which an operating certificate is required pursuant to this article shall be in accordance with the terms of the operating certificate and the regulations of the commissioner.

§ 3. Subdivision (a) of section 16.11 of the mental hygiene law is amended by adding a new paragraph 3 to read as follows:

(3) The review of providers of services, as defined in paragraph five of subdivision (a) of section 16.03 of this article, shall ensure that the provider of services complies with all the requirements of the applicable federal regulations and rules and the regulations adopted by the commissioner.

§ 4. Paragraph (a) of subdivision 4 of section 488 of the social services law, as amended by section 2 of part MM of chapter 58 of the laws of 2015, is amended to read as follows:

(a) a facility or program in which services are provided and which is operated, licensed or certified by the office of mental health, the office for people with developmental disabilities or the office of [alcoholism and substance abuse services] addiction services and supports, including but not limited to psychiatric centers, inpatient psychiatric units of a general hospital, developmental centers, intermediate care facilities, community residences, group homes and family care homes, provided, however, that such term shall not include a secure treatment facility as defined in section 10.03 of the mental hygiene law, services defined in [subparagraph] paragraphs four and five of subdivision (a) of section 16.03 of the mental hygiene law, or services provided in programs or facilities that are operated by the office of mental health and located in state correctional facilities under the jurisdiction of the department of corrections and community supervision;

§ 5. Subdivision 6 of section 2899 of the public health law, as amended by section 3 of part C of chapter 57 of the laws of 2018, is amended to read as follows:

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

§ 6. Paragraph (b) of subdivision 9 of section 2899-a of the public health law, as amended by section 4 of part C of chapter 57 of the laws of 2018, is amended to read as follows:

(b) Residential health care facilities licensed pursuant to article twenty-eight of this chapter and certified home health care agencies and long-term home health care programs certified or approved pursuant to article thirty-six of this chapter for a health home, or any subcontractor of such health home, who contracts with or is approved or otherwise

authorized by the department to provide health home services to all those enrolled pursuant to a diagnosis of a developmental disability as defined in subdivision twenty-two of section 1.03 of the mental hygiene law and enrollees who are under twenty-one years of age, under section three hundred sixty-five-l of the social services law, or any entity that provides home and community based services to enrollees who are under twenty-one years of age under a demonstration program pursuant to section eleven hundred fifteen of the federal social security act, may, subject to the availability of federal financial participation, claim as reimbursable costs under the medical assistance program, costs reflecting the fee established pursuant to law by the division of criminal justice services for processing a criminal history information check, the fee imposed by the federal bureau of investigation for a national criminal history check, and costs associated with obtaining the fingerprints, provided, however, that for the purposes of determining rates of payment pursuant to article twenty-eight of this chapter for residential health care facilities, such reimbursable fees and costs shall be reflected as timely as practicable in such rates within the applicable rate period.

§ 7. Subdivision 10 of section 2899-a of the public health law, as amended by section 1 of part EE of chapter 57 of the laws of 2019, is amended to read as follows:

10. Notwithstanding subdivision eleven of section eight hundred forty-five-b of the executive law, a certified home health agency, licensed home care services agency or long term home health care program certified, licensed or approved under article thirty-six of this chapter or a home care services agency exempt from certification or licensure under article thirty-six of this chapter, a hospice program under article forty of this chapter, or an adult home, enriched housing program or residence for adults licensed under article seven of the social services law, or a health home, or any subcontractor of such health home, who contracts with or is approved or otherwise authorized by the department to provide health home services to all enrollees enrolled pursuant to a diagnosis of a developmental disability as defined in subdivision twenty-two of section 1.03 of the mental hygiene law and enrollees who are under twenty-one years of age, under section three hundred sixty-five-l of the social services law, or any entity that provides home and community based services to enrollees who are under twenty-one years of age under a demonstration program pursuant to section eleven hundred fifteen of the federal social security act may temporarily approve a prospective employee while the results of the criminal history information check and the determination are pending, upon the condition that the provider conducts appropriate direct observation and evaluation of the temporary employee, while he or she is temporarily employed, and the care recipient; provided, however, that for a health home, or any subcontractor of a health home, who contracts with or is approved or otherwise authorized by the department to provide health home services to all enrollees enrolled pursuant to a diagnosis of developmental disability as defined in subdivision twenty-two of section 1.03 of the mental hygiene law and enrollees who are under twenty-one years of age, under section three hundred sixty-five-l of the social services law, or any entity that provides home and community based services to enrollees who are under twenty-one years of age under a demonstration program pursuant to section eleven hundred fifteen of the federal social security act, direct observation and evaluation of temporary employees shall not be required until July first, two thousand nineteen. The results of such

observations shall be documented in the temporary employee's personnel file and shall be maintained. For purposes of providing such appropriate direct observation and evaluation, the provider shall utilize an individual employed by such provider with a minimum of one year's experience working in an agency certified, licensed or approved under article thirty-six of this chapter or an adult home, enriched housing program or residence for adults licensed under article seven of the social services law, a health home, or any subcontractor of such health home, who contracts with or is approved or otherwise authorized by the department to provide health home services to those enrolled pursuant to a diagnosis of a developmental disability as defined in subdivision twenty-two of section 1.03 of the mental hygiene law and enrollees who are under twenty-one years of age under section three hundred sixty-five-l of the social services law, or any entity that provides home and community based services to enrollees who are under twenty-one years of age under a demonstration program pursuant to section eleven hundred fifteen of the federal social security act. If the temporary employee is working under contract with another provider certified, licensed or approved under article thirty-six of this chapter, such contract provider's appropriate direct observation and evaluation of the temporary employee, shall be considered sufficient for the purposes of complying with this subdivision.

§ 8. This act shall take effect on the ninetieth day after it shall have become a law; provided, however, that the amendments to subdivision 6 of section 2899 of the public health law made by section five of this act shall not affect the expiration of such subdivision and shall be deemed to expire therewith.

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

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

INSERT PART CC (LBD # 71049-01-0)
PART DD (LBD # 71047-01-0)
PART EE (LBD # 70028-02-0)

INSERT HMH 4

;to amend the public health law, in relation to the renaming of the Physically Handicapped Children's Program (Part CC); to amend education law and other laws relating to applied behavior analysis, in relation to extending the expiration of certain provisions thereof (Part DD); and to amend the social services law, the public health law and the insurance law, in relation to creating a single preferred-drug list for medication assisted treatment; to amend chapter 57 of the laws of 2015, amending the social services law and other laws relating to supplemental rebates, in relation to the effectiveness thereof; to amend chapter 165 of the laws of 1991, amending the public health law and other laws relating to establishing payments for medical assistance, in relation to the effectiveness thereof; to amend chapter 710 of the laws of 1988, amending the social services law and the education law relating to medical assistance eligibility of certain persons and providing for managed medical care demonstration programs, in relation to the effectiveness there-of; and providing for the repeal of certain provisions upon expiration thereof (Part EE)

Insert HMH 27

and up to eight million six hundred twelve thousand dollars each state fiscal year for the period April first, two thousand twenty through March thirty-first, two thousand twenty-three,

Insert HMH 32

and up to one million six hundred five thousand dollars each state fiscal year for the period April first, two thousand twenty through March thirty-first, two thousand twenty-three,

INSERT HMH 77 A

set forth in subparagraphs (i) and (ii) of this paragraph

INSERT HMH 77 B

, and the population of residents who receive supplemental security income or safety net assistance or who are living with a serious mental illness, as defined by the commissioner of health

INSERT HMH 77 C

(i) to improve the quality of life for adult care facility residents by funding projects including, but not limited to, clothing allowances, resident training to support independent living skills, staff training, outdoor leisure projects, and culturally recreational and other leisure events; and resident quality of life, pursuant to subparagraph (i) of paragraph (a) of this division, or

INSERT HMH 78

resident quality of life, pursuant to subparagraph (i) of paragraph (a) of this subdivision, or

INSERT HMH 92 A

§17. Paragraph (e) of subdivision seven of section 367-a of the social services law, as amended by section 5-a of part T of chapter 57 of the laws of 2018, is amended to read as follows:

(e) During the period from April first, two thousand fifteen through March thirty-first, two thousand [~~twenty~~] twenty-three, the commissioner may, in lieu of a managed care provider, negotiate directly and enter into an agreement with a pharmaceutical manufacturer for the provision of supplemental rebates relating to pharmaceutical utilization by enrollees of managed care providers pursuant to section three hundred sixty-four-j of this title and may also negotiate directly and enter into such an agreement relating to pharmaceutical utilization by medical assistance recipients not so enrolled. Such rebates shall be limited to, drug utilization in the following classes: antiretrovirals approved by the FDA for the treatment of HIV/AIDS and hepatitis C agents for which the pharmaceutical manufacturer has in effect a rebate agreement with the federal secretary of health and human services pursuant to 42 U.S.C. § 1396r-8, and for which the state has established standard clinical criteria. No agreement entered into pursuant to this paragraph shall have an initial term or be extended beyond the expiration or repeal of this paragraph.

INSERT HMH 92 B

§ 19. Subdivision 4-a of section 71 of part C of chapter 60 of the laws of 2014, amending the social services law relating to fair hearings held in connection with appeals under the fully integrated duals advantage demonstration program, as amended by section 6 of chapter 106 of the laws of 2018, is amended to read as follows:

4-a. section twenty-two of this act shall take effect April 1, 2014[~~, and shall be deemed expired January 1, 2021~~];

§ 20. Subdivision 2-a of section 22 of the social services law is amended to read as follows:

2-a. With regard to fair hearings held in connection with appeals [~~under the fully integrated duals advantage demonstration program~~] for integrated fair hearing and appeals processes for individuals dually eligible for medical assistance and benefits available under titles XVIII and XIX of the federal social security act, the commissioner may contract for the sole purpose of assisting staff of the office for such purpose.

INSERT HMH 92 C

§ 21. Subdivision 5-d of section 2807-k of the public health law, as amended by section 2 of part A of chapter 57 of the laws of 2018, is amended to read as follows:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Insert HMH 98 A

§ 3. Paragraph (a) of subdivision 22 of section 6802 of the education law, as amended by chapter 57 of the laws of 2018, is amended to read as follows:

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

Insert HMH 98 B

, provided, however, that the pharmacist shall appropriately consider clinical benefit and cost to the patient and/or payer in discharging these responsibilities

INSERT HMH 123

and who are required to complete coursework or training regarding infection control pursuant to section 239 of the public health law or section 6505-b if the education law

INSERT HMH 134

h) The requirements set forth in paragraphs (b) through (g) of this subdivision shall not apply to any retail tobacco business or retail electronic cigarette store, as defined by section 1399-n of this title.

Insert HMH 139

. Further, the amount of any remittances imposed by application of this subdivision shall be owed to the state in every subsequent fiscal year, regardless whether the district certifies that it has limited the increase in real property taxes in accordance with subdivision one of this section by the date specified in subdivision two of this section, provided that each imposition of a remittance pursuant to this subdivision shall be applied only once.

Insert HMH 140 A

, relative to such amount paid in the state fiscal year beginning April first, two thousand twenty ("medicaid local spending growth rate")

Insert HMH 140 B

the total percentage increase in the year to year rate of growth of department of health state funds Medicaid spending, as established by section 91 of part H of chapter 59 of the laws of 2011, and as subsequently amended, over the same time period ("medicaid global cap growth rate")

INSERT HMH 140 C

the amount of medicaid local spending multiplied by the difference in the medicaid global cap growth rate and the medicaid local spending growth rate

INSERT HMH 140 D

Such remittances shall not be considered when determining a district's medicaid local spending growth in subsequent fiscal years.

INSERT HMH 140 E

one of part R of a chapter of the laws of 2020, concerning distribution of enhanced federal medical assistance percentage payments, as proposed in legislative bill numbers S.7507-A and A.9507-A.

INSERT HMH 140 F

6. For the state fiscal year beginning April first, two thousand twenty-one and every state fiscal year thereafter, notwithstanding the provisions of section three hundred sixty-eight-a of this title, and notwithstanding section one of part C of chapter fifty-eight of the laws of two thousand five,

as amended by section one of part F of chapter fifty-six of the laws of two thousand twelve, and any subsequent amendments thereto, if a social services district's medicaid local spending growth rate is less than the medicaid global cap growth rate, both terms as defined in subdivision five of this section, the state shall remit to the social services district twenty-five percent of the amount of medical local spending, as defined in subdivision five of this section, multiplied by the difference in the medicaid global cap growth rate and the medicaid local spending growth rate, pursuant to a schedule determined by the commissioner of health in consultation with the director of the division of budget. Such remittances shall not be considered when determining a district's medicaid local spending growth in subsequent fiscal years.

INSERT HMH 162

except for a health home, or any subcontractor of such health home, who contracts with or is approved or otherwise authorized by the department to provide health home services to all those enrolled pursuant to a diagnosis of a developmental disability as defined in subdivision twenty-two of section 1.03 of the mental hygiene law;

INSERT HMH 163

except for a health home, or any subcontractor of such health home, who contracts with or is approved or otherwise authorized by the department to provide health home services to all those enrolled pursuant to a diagnosis of a developmental disability as defined in subdivision twenty-two of section 1.03 of the mental hygiene law;

INSERT HMH 164

except for a health home, or any subcontractor of such health home, who contracts with or is approved or otherwise authorized by the department to provide health home services to all those enrolled pursuant to a diagnosis of a developmental disability as defined in subdivision twenty-two of section 1.03 of the mental hygiene law;

DRAFT LBDC

A BUDGET BILL submitted by the Governor
in accordance with Article VII of the Constitution

AN ACT to amend the public health law, in relation to changing the name of the physically handicapped children's program to the children and youth with special health care needs support services program (Part);

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

PART ___

Section 1. Subdivision 1 of section 356 of the public health law, as amended by chapter 163 of the laws of 1975, is amended to read as follows:

1. The legislative body of each county having a population of less than one hundred fifty thousand according to the nineteen hundred seventy federal decennial census or the legislative body of any county whose population shall be less than one hundred fifty thousand under any future federal decennial census, except a county in which a county or part-county health district has been established under this article or a county having a county charter, optional or alternative form of government, shall constitute the board of health of such county and shall have all the powers and duties of a board of health of a county or part-county health district including the power to appoint a full-time or part-time county health director. The county health director may serve as director of the [physically handicapped children's] children and youth with special health care needs support services program and may employ such persons as shall be necessary to enable [him] the county health

director to carry into effect the orders and regulations of the board of health and the provisions of this chapter and of the sanitary code, and fix their compensation within the limits of the appropriation therefor. The members of a [legsiative] legislative body shall not receive additional compensation by reason of serving as members of a board of health. The county health director, so appointed, shall have all the powers and duties prescribed in section three hundred fifty-two of this [article] title.

§ 2. The section heading and subdivisions 1 and 2 of section 608 of the public health law, as added by chapter 901 of the laws of 1986, are amended to read as follows:

State aid; [physically handicapped children] children and youth with special health care needs support services. 1. Whenever the commissioner of health of any county or part-county health district or, in a county lacking a county or part-county health district, the medical director of the [physically handicapped children's] children and youth with special health care needs support services program, or the department of health of the city of New York, issues an authorization for medical service for a [physically handicapped] child with physical disabilities, such county or the city of New York shall be granted state aid in an amount of fifty per centum of the amount expended in accordance with the rules and regulations established by the commissioner, except that such state aid reimbursement may be withheld if, on post-audit and review, the commissioner finds that the medical service rendered and furnished was not in conformance with a plan submitted by the municipality and with the rules and regulations established by the commissioner or that the recipient of the medical service was not a [physically handicapped]

child with a physical disability as defined in section two thousand five hundred eighty-one of this chapter.

2. Whenever a court of any county issues an order for medical services for any [physically handicapped] Indian child with a physical disability, residing on an Indian reservation, such county shall be granted state aid in the amount of one hundred percent of the amount expended in accordance with the standards established by the commissioner. Such reimbursement shall be made from any funds appropriated to the department for payment of state aid for [care of physically handicapped] children with physical disabilities.

§ 3. Subdivision 10 of section 2511 of the public health law, as amended by chapter 2 of the laws of 1998, is amended to read as follows:

10. Notwithstanding any other law or agreement to the contrary, and except in the case of a child or children who also becomes eligible for medical assistance, benefits under this title shall be considered secondary to any other plan of insurance or benefit program, except the [physically handicapped children's] children and youth with special health care needs support services program and the early intervention program, under which an eligible child may have coverage.

§ 4. This act shall take effect immediately.

DRAFT LBDC

A BUDGET BILL submitted by the Governor
in accordance with Article VII of the Constitution

AN ACT to amend chapter 554 of the laws of 2013, amending the education law and other laws relating to applied behavior analysis, in relation to the effectiveness thereof (Part);

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

PART __

Section 1. Subdivision a of section 13 of chapter 554 of the laws of 2013, amending the education law and other laws relating to applied behavior analysis, as amended by chapter 8 of the laws of 2014, is amended to read as follows:

a. Nothing in this act shall be construed as prohibiting a person employed or retained by programs licensed, certified, operated, approved, registered or funded and regulated by the office for people with developmental disabilities, the office of children and family services, or the office of mental health from performing the duties of a licensed behavior analyst or a certified behavior analyst assistant in the course of such employment or retention; provided, however, that this section shall not authorize the use of any title authorized pursuant to article 167 of the education law; and provided further, however, that this section shall be deemed repealed on July 1, [2020] 2025.

§ 2. This act shall take effect immediately.

DRAFT LBDC

A BUDGET BILL submitted by the Governor
in accordance with Article VII of the Constitution

AN ACT to amend the social services law, the public health law and the insurance law, in relation to creating a single preferred-drug list for medication assisted treatment; to amend chapter 57 of the laws of 2015, amending the social services law and other laws relating to supplemental rebates, in relation to the effectiveness thereof; to amend chapter 165 of the laws of 1991, amending the public health law and other laws relating to establishing payments for medical assistance, in relation to the effectiveness thereof; to amend chapter 710 of the laws of 1988, amending the social services law and the education law relating to medical assistance eligibility of certain persons and providing for managed medical care demonstration programs, in relation to the effectiveness thereof; and providing for the repeal of certain provisions upon expiration thereof (Part _);

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

PART __

Section 1. Paragraph (e) of subdivision 7 of section 367-a of the social services law, as amended by section 5-a of part T of chapter 57 of the laws of 2018, is amended to read as follows:

(e) During the period from April first, two thousand fifteen through March thirty-first, two thousand [twenty] twenty-three, the commissioner may, in lieu of a managed care provider, negotiate directly and enter into an agreement with a pharmaceutical manufacturer for the provision of supplemental rebates relating to pharmaceutical utilization by enrollees of managed care providers pursuant to section three hundred sixty-four-j of this title and may also negotiate directly and enter into such an agreement relating to pharmaceutical utilization by medical assist-

ance 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, opioid dependence agents and opioid antagonists listed in a statewide formulary established pursuant to subparagraph (vii) of this paragraph 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 the expiration or repeal of this paragraph.

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

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

(iii) The commissioner shall submit a report to the temporary president of the senate and the speaker of the assembly annually by December

thirty-first. The report shall analyze the adequacy of rates to managed care providers for drug expenditures related to the classes under this paragraph.

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

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

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

<u>(vii) The department shall publish a statewide formulary of opioid dependence agents and opioid antagonists, which shall include all drugs in such classes, provided that:</u>

<u>(A) for all drugs that are included as of the date of the enactment of this subparagraph on a formulary of a managed care provider, as defined</u>

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

(B) for all drugs that are not included as of the date of the enactment of this subparagraph on a formulary of a managed care provider, as defined in section three hundred sixty-four-j of this title, or in the Medicaid fee-for-service preferred drug program pursuant to section two hundred seventy-two of the public health law, the department is able to obtain the drug at a cost that is equal to or less than the lowest cost to the department of other drugs in the class, after the application of any rebates. Where there is a generic version of the drug approved by the Food and Drug Administration as bioequivalent to a brand name drug pursuant to 21 U.S.C. § 355(j)(8)(B), the cost to the department for both the brand and generic versions shall be equal to or less than the lower of the two maximum costs determined pursuant to the previous sentence.

§ 2. Paragraph (a) 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 and a new paragraph (a-1) is added to read as follows:

(a) When a patient's health care provider prescribes a prescription drug that is not on the preferred drug list or the statewide formulary of opioid dependence agents and opioid antagonists established pursuant to subparagraph (vii) of paragraph (e) of subdivision seven of section three hundred sixty-seven-a of the social services law, the prescriber shall consult with the program to confirm that in his or her reasonable professional judgment, the patient's clinical condition is consistent with the criteria for approval of the non-preferred drug. Such criteria shall include:

(i) the preferred drug has been tried by the patient and has failed to produce the desired health outcomes;

(ii) the patient has tried the preferred drug and has experienced unacceptable side effects;

(iii) the patient has been stabilized on a non-preferred drug and transition to the preferred drug would be medically contraindicated; or

(iv) other clinical indications identified by the [committee for the patient's use of the non-preferred drug] drug utilization review board established pursuant to section three hundred sixty-nine-bb of the social services law, which shall include consideration of the medical needs of special populations, including children, elderly, chronically ill, persons with mental health conditions, and persons affected by HIV/AIDS, pregnant persons and persons with an opioid use disorder.

(a-1) When a patient's health care provider prescribes a prescription drug that is on the statewide formulary of opioid dependence agents and opioid antagonists established pursuant to subparagraph (vii) of paragraph (e) of subdivision seven of section three hundred sixty-seven-a of

the social services law, the department shall not require prior authorization unless required by the department's drug use review program established pursuant to section 1927(g) of the Social Security Act.

§ 3. Section 364-j of the social services law is amended by adding a new subdivision 38 to read as follows:

38. (a) When a patient's health care provider prescribes a prescription drug that is not on the statewide formulary of opioid dependence agents and opioid antagonists, the prescriber shall consult with the managed care plan to confirm that in his or her reasonable professional judgment, the patient's clinical condition is consistent with the criteria for approval of the non-preferred or non-formulary drug. Such criteria shall include:

(i) the preferred drug has been tried by the patient and has failed to produce the desired health outcomes;

(ii) the patient has tried the preferred drug and has experienced unacceptable side effects;

(iii) the patient has been stabilized on a non-preferred drug and transition to the preferred or formulary drug would be medically contraindicated; or

(iv) other clinical indications identified by the committee for the patient's use of the non-preferred drug, which shall include consideration of the medical needs of special populations, including children, elderly, chronically ill, persons with mental health conditions, persons affected by HIV/AIDS and pregnant persons with a substance use disorder.

(b) The managed care plan shall have a process for a patient, or the patient's prescribing health care provider, to request a review for a prescription drug that is not on the statewide formulary of opioid

dependence agents and opioid antagonists, consistent with 42 C.F.R. 438.210(d), or any successor regulation.

(c) A managed care plan's failure to comply with the requirements of this subdivision shall be subject to a one thousand dollar fine per violation.

§ 4. Subparagraph (A) of paragraph 7-a of subsection (l) of section 3221 of the insurance law, as added by chapter 748 of the laws of 2019, is amended to read as follows:

(A) Every policy that provides medical, major medical or similar comprehensive-type large group coverage shall provide immediate coverage for all buprenorphine products, methadone or long acting injectable naltrexone without prior authorization for the detoxification or maintenance treatment of a substance use disorder. Further, immediate coverage without prior authorization shall include methadone, when used for opioid use disorder and administered or dispensed in an opioid treatment program.

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

26-c. Managed care providers shall not require prior authorization for methadone, when used for opioid use disorder and administered or dispensed in an opioid treatment program.

§ 6. Subdivision 10 of section 273 of the public health law, as added by section 5 of part B of chapter 69 of the laws of 2016, is amended to read as follows:

10. Prior authorization shall not be required for an initial or renewal prescription for buprenorphine or injectable naltrexone for detoxification or maintenance treatment of opioid addiction unless the prescription is for a non-preferred or non-formulary form of such drug

as otherwise required by section 1927(k)(6) of the Social Security Act. Further, prior authorization shall not be required for methadone, when used for opioid use disorder and administered or dispensed in an opioid treatment program.

§ 7. Subdivision 1 of section 60 of part B of chapter 57 of the laws of 2015, amending the social services law and other laws relating to supplemental rebates, as amended by section 5-b of part T of chapter 57 of the laws of 2018, is amended to read as follows:

1. section one of this act shall expire and be deemed repealed March 31, [2023] 2026;

§ 8. Subdivision (c) of section 62 of chapter 165 of the laws of 1991, amending the public health law and other laws relating to establishing payments for medical assistance, as amended by section 16 of part Z of chapter 57 of the laws of 2018, is amended to read as follows:

(c) section 364-j of the social services law, as amended by section eight of this act and subdivision 6 of section 367-a of the social services law as added by section twelve of this act shall expire and be deemed repealed on March 31, [2024] 2026 and provided further, that the amendments to the provisions of section 364-j of the social services law made by section eight of this act shall only apply to managed care programs approved on or after the effective date of this act;

§ 9. Section 11 of chapter 710 of the laws of 1988, amending the social services law and the education law relating to medical assistance eligibility of certain persons and providing for managed medical care demonstration programs, as amended by section 18 of part Z of chapter 57 of the laws of 2018, is amended to read as follows:

§ 11. This act shall take effect immediately; except that the provisions of sections one, two, three, four, eight and ten of this act

shall take effect on the ninetieth day after it shall have become a law; and except that the provisions of sections five, six and seven of this act shall take effect January 1, 1989; and except that effective immediately, the addition, amendment and/or repeal of any rule or regulation necessary for the implementation of this act on its effective date are authorized and directed to be made and completed on or before such effective date; provided, however, that the provisions of section 364-j of the social services law, as added by section one of this act shall expire and be deemed repealed on and after March 31, [2024] 2026, the provisions of section 364-k of the social services law, as added by section two of this act, except subdivision 10 of such section, shall expire and be deemed repealed on and after January 1, 1994, and the provisions of subdivision 10 of section 364-k of the social services law, as added by section two of this act, shall expire and be deemed repealed on January 1, 1995.

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

a. the amendments to paragraph (e) of subdivision 7 of section 367-a of the social services law made by section one of this act shall not affect the repeal of such paragraph and shall be deemed expired therewith;

b. the provisions of section two of this act shall expire March 31, 2026 when upon such date the provisions of such section shall be deemed repealed;

c. the amendments to section 364-j of the social services law made by sections three and five of this act shall not affect the repeal of such section and shall be deemed expired therewith; and

d. the statewide formulary of opioid dependence agents and opioid antagonists authorized by this act shall be implemented within six months after it shall have become a law.