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2016 END OF SESSION LEGISLATIVE REPORT

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New Laws

Heroin/Opioid-Related Bills

Chapter 65 of the Laws of 2016 [A.9078-B (Mayer)/S.6346-B (Carlucci)]
Pharmacies Dispensing Narcan

This law requires any chain pharmacy with twenty or more locations to pursue or maintain a non-patient specific prescription with an authorized health care professional to disperse an opioid antagonist (Narcan) to a consumer upon request, or to register with the Department of Health (DOH) as an Opioid Overdose Prevention Program. This law went into effect on June 22, 2016.

Chapter 66 of the Laws of 2016 [A.9251-A (Rosenthal)/S.6516-A (Amedore)]
Requires DOH to Report County Level Data on Opioid Overdoses and the Use of Narcan

This law clarifies that DOH must submit a report that includes county level data on both opioid overdoses and opioid overdose deaths and on both the dispensing and utilization of overdose reversal medication, on an annual basis. This report must be submitted to the Governor and the Legislature annually, on or before October 1, and made available to the public on the DOH website. The law also directs DOH to provide current, county-specific information and data on opioid overdoses and the use of overdose reversal medication to each county on a monthly basis. Chapter 70 of the Laws of 2016 amends this legislation to require DOH to provide this information to the counties on a quarterly basis. This law went into effect on June 22, 2016 and the provision directing DOH to provide current data to the counties will expire on March 31, 2021.

Chapter 68 of the Laws of 2016 [A.10364 (Gottfried)/S.7860 (Amedore)]
Public Libraries and Use of Narcan

This law authorizes the maintenance and use of opioid antagonists (Narcan) at public libraries to prevent opioid overdose deaths. The law went into effect on June 22, 2016.

Chapter 69 of the Laws of 2016 [A.10725 Rules (Steck)/S.8137 (Ortt)]

This law consists of four parts related to the treatment of individuals with heroin/opioid use disorders. **Part A requires all insurers to use an objective diagnostic tool that is approved by OASAS when making level of care determinations for all substance use disorder treatment.** All approved tools must have inter-rater

reliability testing completed by December 31, 2016. This part of the law went into effect on June 22, 2016. However, the law will apply to policies issued, renewed, modified, altered or amended starting on January 1, 2017.

Part B requires insurers to provide immediate access, without prior authorization, for a five day emergency supply of medication for the treatment of a substance use disorder when an emergency condition exists, including for a medication associated with the management of opioid withdrawal and/or stabilization. Insurers are also required to provide coverage for opioid overdose reversal medication, without prior authorization. In addition, Medicaid Managed Care Organizations must provide coverage, without prior authorization, for an initial or renewal prescription for buprenorphine or injectable naltrexone for the treatment of opioid addiction. This part of the law went into effect on June 22, 2016. However, the law will apply to policies issued, renewed, modified, altered or amended starting on January 1, 2017.

Part C extends the Heroin and Opioid Addiction Wraparound Services Demonstration Program for two years. This program provides support services to adolescents and adults for up to nine months after the successful completion of a substance use disorder inpatient or outpatient treatment program. These services may be in the form of case management services that address education, legal, financial, social service, childcare, and other issues. No later than June 30, 2018, OASAS is required to provide an evaluation of the program and recommendations on whether it should be continued or expanded to the Governor and Legislature. This part of the law went into effect on June 22, 2016 and will expire on March 31, 2019.

Part D amends MHL 22.09 and relates to emergency services for individuals intoxicated, impaired or incapacitated by alcohol and/or drugs. Currently Section 22.09 of the MHL permits law enforcement, peace officers or the DCS/designee to transport a person who appears to be incapacitated by alcohol and/or substances and is likely to be a danger to himself or herself or others to a hospital for immediate observation and treatment. That person cannot be retained for more than 48 hours.

Under Part D, an incapacitated person may be transported for emergency services to a treatment facility which is defined as an Article 28 hospital or a medically managed or medically supervised withdrawal, inpatient rehabilitation, or residential stabilization treatment program that has been certified by OASAS to have appropriate medical staff available on-site at all times to provide emergency services and continued evaluation of capacity of individuals retained under Section 22.09. "Emergency services" means immediate physical examination, assessment, care and treatment of an incapacitated person for the purpose of confirming that the person is, and continues to be, incapacitated by alcohol and/or substances to the degree that there is a likelihood to result in harm to the person or others. An incapacitated person cannot be held against his or her objection beyond whichever is the shorter of the following: (i) the time that he or she is no longer incapacitated by alcohol and/or substances to the degree that there is a likelihood to result in harm to the person or others or (ii) a period longer than 72 hours. Part D also requires that individuals be discharged from the treatment facility with a discharge plan, including referrals for continuing care. This part of the law will take effect 90 days following its enactment on June 22, 2016.

<u>Please note: The Conference was successful in its lobbying efforts. This law does not include an earlier proposal which would have allowed family members and others to petition the DCS to certify for admission an individual incapacitated by alcohol and/or substances to a treatment facility for emergency services. While this proposal may have been well intended, it would have created a false hope for families and given the appearance that the DCSs could somehow force a person into longer term addiction treatment.</u>

Chapter 70 of the Laws of 2016 [A.10726 Rules (Cusick)/S.8138 (Amedore)]

This law consists of three parts related to combating the heroin and opioid abuse epidemic. **Part A authorizes trained professionals, who are otherwise prohibited from prescribing or administering drugs, to administer naloxone in emergency situations without risking their professional license**. **Part B requires the Commissioner of Health to provide county level data on opioid overdoses and the use of overdose-reversal medication on a quarterly basis.** Part A and Part B went into effect on June 22, 2016.

Part C requires hospitals to provide patients who have or are at-risk for a substance use disorder with follow-up treatment options, upon discharge. Part C also requires hospitals to develop and disseminate to the medical staff written policies and procedures for the identification, assessment and referral of individuals with a substance use disorder. This part of the law will take effect 180 days following its enactment on June 22, 2016.

Chapter 71 of the Laws of 2016 [A.10727 Rules (Rosenthal)/S.8139 (Murphy)]

This law consists of four parts related to heroin and opioid abuse prevention and treatment. **Part A requires physicians and other opioid prescribers to complete three hours of course work or training in addiction, pain management, and palliative care by July 1, 2017 and once every three years thereafter.** This part of the law went into effect on June 22, 2016.

Part B requires insurers to cover medically necessary inpatient services for the treatment of substance use disorders for as long as an individual needs them. In addition, Part B requires no prior authorization for inpatient substance abuse services and establishes that utilization review by insurers can only begin after the first 14 days of treatment. This part of the law went into effect on June 22, 2016. However, the law will apply to policies issued, renewed, modified, altered or amended starting on January 1, 2017.

Part C reduces the prescription of opioids for acute pain from a 30-day supply to a seven-day supply. This part of the law will go take effect 30 days following its enactment on June 22, 2016.

Part D requires pharmacists to provide educational materials to consumers about the risk of addiction, local treatment resources, and the safe disposal of unused prescriptions when dispensing prescribed controlled substances. Part D also allows pharmacists to offer counseling and referral services to customers purchasing hypodermic needles. This part of the law will take effect 120 days following its enactment on June 22, 2016.

Criminal Justice-Related Bill

Chapter 67 of the Laws of 2016 [A.9313-C (Rosenthal)/S.6874-A (Murphy)]
Conditions of Participation in a Judicial Drug Diversion Program

The intent of Chapter 258 of the Laws of 2015 was to establish statewide uniformity in drug treatment courts by allowing defendants to obtain medically prescribed drug treatment for an opioid use disorder while participating in a judicial diversion program. To strengthen Chapter 258, this bill would prohibit conditioning the participation of a defendant in a judicial diversion program upon the use of a specified type or brand of a medically prescribed drug for the treatment of an opioid use disorder. This law went into effect on June 22, 2016.

Bills that have passed both Houses and are awaiting action by the Governor

Heroin/Opioid-Related Bills

A.10294 (Rosenthal)/S.7301 (Amedore)
CASAC Training in Medication Assisted Treatment

This bill would require CASACs and qualified health care professionals who provide substance use disorder treatment or counseling to undergo a course of instruction related to Medication Assisted Treatment which is approved by OASAS. This training would have to be completed within 18 months of the effective date of this legislation or within a year of commencing practice, whichever would be later.

A.10478 (Cusick)/S.6962-A (Hannon)
Access to Abuse-Deterrent Opioid Medications

This bill would require insurance plans to offer at least one abuse-deterrent opioid analgesic drug on their drug formulary. In addition, insurance plans would not be able to require a patient to first use an opioid prescription drug lacking abuse-deterrent technology in order to have access to an abuse-deterrent opioid analgesic drug. Insurance plans would also not be able to charge higher co-pays for an abuse-deterrent opioid analgesic drug.

Criminal Justice-Related Bill

A.9104-A (Gunther)/S.6322-A (Ranzenhofer)
Conditions of Participation in a Judicial Drug Diversion Program

This bill would allow a court to permit a defendant who is eligible to participate in a judicial drug diversion program in its jurisdiction to obtain substance use disorder treatment and other services in the jurisdiction where the defendant resides or in another jurisdiction.

OPWDD-Related Bills

A.10053-A (Gunther)/S.7644-A (Ortt)
Quarterly Reporting on Implementation of Transformation Panel Recommendations

This bill would require OPWDD to provide quarterly updates to the Legislature, beginning on or before January 1, 2017, regarding the implementation of the report and recommendations of the Transformation Panel. These updates would have to be posted on OPWDD's website and include the following: (a) progress made by the Office in developing plans for and implementing the recommendations of the Transformation Panel; (b) any identified statutory or regulatory obstacles to implementation; and (c) any other information the office deems necessary and appropriate to keep stakeholders and the public informed about the implementation of the Transformation Panel recommendations. This provision would expire on April 1, 2018.

A.10262 (Richardson)/S.7899 (Ortt)
OPWDD Departmental Bill regarding the Future Employment of Former State Employees

This bill would amend the Public Officers Law and allow former state employees who were employed to provide direct care, clinical care, case management or other support services to not be barred from providing those services in the future to the same individuals whom they served while in state employment.

A.10409 (Gunther)/S.7677-A (Ortt)
Study on Recruitment and Retention of Direct Support Professionals

This bill would require the Commissioner of OPWDD to conduct a study and submit a report on the recruitment and retention of direct support professionals working with people with developmental disabilities by November 1, 2016. The report would enumerate the causes of the increasingly high vacancy and turnover rates for direct support professionals working with people with developmental disabilities and identify the fiscal resources needed to maintain a quality workforce in sufficient number as to assure the health and safety of individuals with developmental disabilities and to reverse the unacceptably high vacancy and turnover rates.

A.10461-A (Englebright)/S.6915-B (Ortt)
Eligibility for Dependents of Military Service Members for certain Developmental Disability Services

This bill would allow for a dependent of a military service member to retain eligibility for developmental disability services under a Medicaid home and community based services program regardless of leaving the state as long as they remain a legal resident of New York State and remain eligible for the services. The bill also allows a dependent who resides out-of-state to be placed on the waiting list for services if they left the state due to the military service member's military assignment.

A.10556 Rules (Titone)/S.7410-A (Carlucci)
OPWDD Departmental Bill regarding Access to Criminal History Information

This bill would allow OPWDD to access criminal history information, contained in the Central Data Facility established by the Division of Criminal Justice Services (DCJS), in the same manner as OMH. This information would be used for making decisions regarding the care and treatment, health and safety, privileges and discharge planning for individuals residing in state-operated developmental centers.

A.10558-A Rules (Santabarbara)/S.8036-A (Nozzolio)
Autism Spectrum Disorders Advisory Board

This bill would direct OPWDD to create a 19 member Autism Spectrum Disorders Advisory Board. The board would report annually to the Governor and the Legislature on its activities and recommendations. The board would have the following tasks and duties: (1) Study and review the effectiveness of supports and services currently being provided to people diagnosed with autism spectrum disorders; (2) Identify legislative and regulatory activity which may be required to improve existing service systems that support people diagnosed with autism spectrum disorders; (3) Identify methods of improving interagency coordination of services and maximize the impact and effectiveness of services and agency functions; and (4) Such other matters as may be deemed appropriate by the members of the board.

Health Insurance-Related Bills

A.2834-D (Titone)/S.3419-C (Young)
Regulation of Step Therapy Protocols for Prescription Drugs

The bill would regulate step therapy or fail first health insurance protocols for prescription drugs. Step therapy is a cost saving measure used by insurers to require patients to try and fail on other less expensive drugs before covering the cost of the drug initially prescribed by the patient's physician. This bill would require clinical review criteria used by insurers to establish step therapy policies be based on evidence-based and peer reviewed clinical practice guidelines. It would also require access to a clear and expedient appeals process that can be used by physicians and other prescribers to request an override of a step

therapy/fail first requirement. For an override to be granted a patient's physician would have to provide documentation to demonstrate that the drug(s) being required by the insurer will likely cause patient harm, is expected to be ineffective, has been tried by the patient and was proven ineffective, the patient is stable on the drug being recommended by the physician, or the drug is otherwise not in the best interest of the patient. A determination would have to be made within 48 hours of the receipt of all information from the patient's physician or health care provider.

A.6983-A (McDonald)/S.4721-A (Hannon)
Establish Standards for Prior Authorization Requests for Prescription Drug Coverage

This bill would require the Commissioner of Health, in conjunction with the superintendent of the Department of Financial Services, to develop a standardized process for prior authorization requests to be utilized by all health care plans for the purposes of submitting a request for a utilization review determination for coverage of prescription drug benefits. Chapter 466 of the Laws of 2012 required DOH to create a standardized form for health care providers to use for requesting prior authorization of prescription medications for patients enrolled in Medicaid managed care plans.

Hospital Reimbursement-Related Bill

A.9476-A (Gottfried)/S.6948-A (Hannon)
Increased Medicaid Reimbursement for Enhanced Safety Net Hospitals

This bill would provide enhanced safety net hospitals with a Medicaid supplemental rate adjustment. An "enhanced safety net hospital" is defined as a hospital which: (1) not less than 50 percent of the patients it treats are on Medicaid or are medically uninsured; (2) not less than 40 percent of its inpatient discharges are covered by Medicaid; (3) 25 percent or less of its discharged patients are commercially insured; (4) not less than three percent of the patients it provides services to are attributed to the care of uninsured patients; and (5) provides care to uninsured patients in its emergency room, hospital based clinics and community based clinics, including the provision of important community services, such as dental care and prenatal care; (6) is a public hospital operated by a county, municipality or public benefit corporation; or (7) is federally designated as a critical access or sole community hospital. In addition, payment of the non-federal share of the Medicaid payments would be the sole responsibility of the state and must not include a local share. However, no new funding was included in the bill to cover the cost of the rate adjustment. If approved, the rate increase would not take effect until April 1, 2017, and the cost would become a budget issue in State Fiscal Year 2017-18.

OMH-Related Bills

A.9620-A (Gunther)/S.6916-C (Ortt)
Injuries Caused by Persons Confined in State Forensic Psychiatric Centers

This bill would require the Commissioner of OMH to report to the Legislature on at least a quarterly basis on the number and types of injuries that have occurred in the state's forensic psychiatric centers as a result of an assault between a confined person and any staff member or other confined person. The Commissioner of OMH would be required to develop detailed definitions of at least four types or categories of injuries that may occur and which would be used to describe the injuries included in the reports to the Legislature.

A.10557 Rules (Gunther)/s.7627 (Ortt)
Public Notice of Significant Service Reductions at State Psychiatric Centers

This bill would require that public notice of the potential for significant service reductions at State Psychiatric Centers must be given at least twelve months and at most one year and one month prior to the commencement of any service reduction. Current law allows for notice to be given at least twelve months prior to a service reduction.

Health Education-Related Bill

A.3887-B (Nolan)/S.6046-A (Marcellino)
Health and Mental Health Education

This bill would update the State Education Law to reflect state regulation and codify that mental health and its relationship to physical health must be part of the health education curriculum in our schools. Current statute only refers to health education as addressing alcohol, drugs, tobacco abuse and the prevention and detection of certain cancers.

County Mandate Relief-Related Bill

A.10706 Rules (Fahy)/S.8114 (DeFrancisco)
State Funding for Indigent Defense Services

This bill would require the state to reimburse the counties for the full cost of indigent defense services. The state takeover would be phased-in over seven years. Due to the settlement in 2014 of a suit brought by the New York Civil Liberties Union (NYCLU) over the inadequacy of indigent legal services, the state currently funds public defense programs in five counties, including Ontario, Onondaga, Schuyler, Suffolk and Washington. Under the bill, the same system of reimbursement would apply to the rest of the counties in the state. After Medicaid, indigent legal costs are the highest state-mandated expense for counties.

Other Legislation of Interest

Bills Supported by the Conference

A.10498 (Ortiz)/S.7663 (Ortt)
Uncompensated Care Pool Funding and Article 31 Mental Health Clinics

This bill was introduced to strike the language from statute that requires a federal Medicaid match in order for the state to distribute funding from the Uncompensated Care Pool to Article 31 mental health clinics. This legislation would allow state funding to be paid to the Article 31 mental health clinics for providing care to the uninsured regardless of federal participation and allow all clinics that are receiving uncompensated care funding to be treated equally.

Under a formula developed in 2010, the State's mental health clinics, including those operated by counties and community organizations, are supposed to receive $10 million in state funding ($20 million in federal and state funding) from the Uncompensated Care Pool to help offset the cost of providing mental health services to the uninsured. The payment of state funding to the mental health clinics is contingent upon federal participation. This requirement is unique to the mental health clinics and does not apply to any of the other clinics receiving funding from the Uncompensated Care Pool. Because of a lapse in the federal waiver to allow for the federal matching funds, mental health clinics have not received their share of federal or state Uncompensated Care Pool funding for services rendered in 2013 or 2014. The Conference issued a Memo in Support of this legislation.

Status: S.7663 passed the Senate and A.10498 died in the Assembly Health Committee.

Bills Successfully Opposed by the Conference

A.1275 (Gunther)/ S.4722 (Young)
Expands the Requirements of the AOT Program and Makes the Program Permanent

This bill or a similar version, which is strongly opposed by the Conference, has been in existence since 2010. The bill includes the following provisions:

1. Requires AOT Coordinators to ensure that local programs adequately review needs of AOT patients prior to expiration of an order, in consideration of prospective renewal of such order. Requires the AOT Coordinator to also monitor the AOT training needs of local judges and court employees.
2. Requires OMH to develop an educational pamphlet on the process of petitioning for AOT to be made available to persons wishing to submit reports of persons who may be in need of AOT treatment and disseminated to family members and other individuals who are eligible to petition for AOT.
3. Requires the DCS to receive and investigate reports by hospital directors discharging patients who were initially admitted on an involuntary basis in cases when the hospital director does not petition for an AOT order upon release.
4. Requires AOT Program Directors to include additional information in quarterly reports regarding court order expirations, including whether a renewal order was filed, the basis for the renewal/non-renewal, and the court's disposition of the order.
5. Adds new services to be provided under AOT which include: medication or symptom management education; appointment of a representative payee or other financial management services; and other clinical or non-clinical services.
6. Requires that in instances of an AOT patient moving to a location within the state of New York not served by the director overseeing the original AOT order, that the program coordinator transmit the treatment plan to the appropriate DCS in the LGU in which the AOT patient has relocated.
7. Requires that within 30 days before the expiration of an AOT order, that the Program Director reviews the order and submits documentation to the relevant AOT Coordinator to support the determination that continuance of the order is not required.

Status: A.1275 died in the Assembly Mental Health Committee and S.4722 passed the Senate.

A.1823 (Gunther)/S.631 (Carlucci)
AOT for Substance Abuse

This bill would establish an AOT program for substance abuse and was first introduced two years ago as part of the initial Senate bill package to combat the heroin and opioid epidemic. The bill attempts to apply the current AOT program for people with mental illness to individuals with substance use disorders. However, the only real sanction imposed on a person who refuses to follow the court order under the bill, is an action under the current Section 22.09 of the Mental Hygiene Law. This bill is strongly opposed by the Conference.

Status: A.1823 died in the Assembly Alcoholism and Drug Abuse Committee and S.631 passed the Senate.